
National Bowel Cancer Audit State of the Nation Report

An audit of care received by people diagnosed or undergoing surgery for bowel cancer between 1 January 2023 and 31 December 2023 in England and Wales.

Published October 2025





NBOCA

National Bowel
Cancer Audit

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This document was prepared by members of the NBOCA project team:

Michael Braun – Clinical Lead, Oncology

Nicola Fearnhead – Clinical Lead, Surgery

Kate Walker – Senior Methodologist

Sarah Cook – Methodologist

Jan van der Meulen – Senior Epidemiologist

Angela Kuryba – Quantitative Analyst

Karen Darley – Senior Project Manager

Augusto Nembrini – CEU Coordinator

Adil Rashid – Clinical Fellow

Leo Watton – Clinical Fellow

Orouba Almilaji – Research Fellow

With review and input from:

[NBOCA Clinical Advisory Group](#)

[NATCAN Executive Team](#)



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HQIP

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The National Cancer Audit Collaborating Centre (NATCAN) is commissioned by the [Healthcare Quality Improvement Partnership \(HQIP\)](#) and funded by NHS England and the Welsh Government as part of the [National Clinical Audit and Patient Outcomes Programme \(NCAPOP\)](#). NATCAN delivers national audits in bowel, breast (primary and metastatic), kidney, lung, non-Hodgkin lymphoma, oesophago-gastric, ovarian, pancreatic and prostate cancers.



The Association of
Coloproctology of
Great Britain & Ireland

Association of Coloproctology of Great Britain and Ireland (ACPGBI) is a group of 1000+ surgeons, nurses, and allied health professionals who advance the knowledge and treatment of bowel diseases in Britain and Ireland. Registered Charity no: 5962281.



Association
of Cancer
Physicians

The Association of Cancer Physicians (ACP) is the specialist society for medical oncologists in the UK. It works with and for its members to support and promote the specialty and to help improve medical care for cancer patients.



NDRS

NATIONAL DISEASE REGISTRATION SERVICE

This work uses data that has been provided by people and collected by the NHS as part of their care and support. For people diagnosed in England, the data is collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.



GIG
CYMRU
NHS
WALES

Rhwydwaith
Canser Cymru
Wales Cancer
Network

NHS Wales is implementing a new cancer informatics system. As a result, the quality and completeness of data from Wales is likely to have been impacted due to implementation of this new system across multiple NHS organisations (Health Boards), which has resulted in data being supplied by both old and new systems. Additionally, and reflecting the uncertainty of data quality, the data submitted to the audit may not have undergone routine clinical validation prior to submission to the Wales Cancer Network (WCN), Public Health Wales.

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1. Introduction

The National Bowel Cancer Audit ([NBOCA](#)) measures the quality and outcomes of care for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with or undergoing surgery for bowel cancer between 1 January 2023 and 31 December 2023.

NBOCA's [quality improvement \(QI\) plan](#) sets out five QI goals covering the entire patient care pathway. Mapped to these goals, NBOCA has developed [ten performance indicators](#) with local QI targets. The aim is to increase the consistency of access to treatments and stimulate improvements in care and outcomes for people with bowel cancer.

The Audit derives its indicators using information that is routinely collected by the NHS as part of the care and support given to people diagnosed with bowel cancer, rather than data collected specifically for the Audit.¹ For people treated in England, the data are collated, maintained and quality assured by NHS England's National Disease Registration Service ([NDRS](#))². This includes 'gold standard' National Cancer Registration Data (NCRD) and Rapid Cancer Registration Data (RCRD). For people diagnosed or treated in Wales, data are provided by Wales Cancer Network ([WCN](#))³, using the Cancer Network Information System Cymru ([CaNISC](#)) or Cancer Dataset Form (CDF).

To further support quality improvement activities, NBOCA publishes [quarterly data dashboards](#) of performance indicators and data quality metrics for NHS trusts in England, which use the more timely but less complete Rapid Cancer Registration Data (RCRD). Quarterly data dashboards support NHS trusts in England to track progress alongside local quality improvement initiatives. More details regarding the timeliness of the data can be found [here](#).

For full details of the data and methods used within this report, please see the [NBOCA Methodology Supplement](#).

Table 1 overleaf and [Supplementary Table 1](#) describe the dataset and time period that defines the population for each performance indicator.

1 The audits in NATCAN do not 'collect' clinical data. The cancer audits utilise the nationally mandated flows of data from hospitals to the National Disease Registration Service (NDRS) in NHSE and the Wales Cancer Network in Public Health Wales, thereby minimising the burden of data collection on provider teams.

2 [Timeliness of the National Cancer Registration Dataset \(NCRD\) - National Cancer Audit Collaborating Centre](#)

3 NHS Wales is part way through a cancer informatics implementation programme which is designed to improve the data capture and reporting capabilities of NHS Wales. This ongoing implementation is impacting the data quality within NHS Wales in the short term with multiple systems being used and different implementation dates across cancer sites and organisations resulting in a complex data landscape. NHS Wales has committed to continue to submit audit data annually until data submissions are sourced exclusively from the new cancer informatics solution. This will be from 2027 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

Table 1. * Performance Indicators Included		
	England	Wales
PI1: Patients seen by Clinical Nurse Specialist	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
PI2: NHS trust/multidisciplinary team (MDT) volume of patients undergoing rectal cancer surgery	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
**PI3: Adjusted 90-day mortality among patients undergoing major resection	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
**PI4: Adjusted 30-day unplanned return to theatre among patients undergoing major resection	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
**PI5: Adjusted 30-day unplanned readmission among patients undergoing major resection	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
**PI6: Adjusted proportion of patients with unclosed diverting ileostomy 18-months after anterior resection	Yes (04/18 – 03/23 [^])	Yes (04/18 – 03/23 [#])
PI7: Patients with stage 3 colon cancer receiving adjuvant chemotherapy	Yes (04/21 – 10/23 [†])	Yes (04/21 – 10/23 [#])
**PI8: Adjusted severe acute toxicity after adjuvant chemotherapy for patients with stage 3 colon cancer	Yes (04/21 – 10/23 [†])	Yes (04/21 – 10/23 [#])
PI9: Rectal cancer patients undergoing major resection receiving neo-adjuvant treatment	Yes (01/23 – 12/23 [†])	Yes (01/23 – 12/23 [#])
**PI10: Adjusted 2-year survival rate among patients undergoing major resection	Yes (04/21 – 03/22 [^])	Yes (04/21 – 03/22 [#])
* See methodology supplement for the exact definitions of each performance indicator ** Risk-adjusted performance indicators [^] England data: National Cancer Registration Dataset (NCRD) [†] England data: Rapid Cancer Registration Dataset (RCRD) [#] Welsh data: Cancer Network Information System Cymru (CaNISCS)		

The time period that defines the population for performance indicators of short-term outcomes (PI 1-5) has changed since the last report to calendar year instead of financial year (Table 1) to improve data completeness of risk adjustment variables. Additionally, for performance indicators PI 3-5 the time period has been updated from a combination of diagnosis date and date of major surgery to date of major surgery alone. The six performance indicators (PIs) marked with ** are risk-adjusted and outlier-reported by NHS trust/MDT. Details of the NHS trusts/MDTs which could not have outcomes reported due to small numbers (publication at NHS trust/MDT level requires a minimum of 10 cases per indicator) or incomplete data are provided [here](#). The four performance indicators not marked with ** and the three contextual measures are process-of-care measures, assessing adherence to clinical standards rather than patient outcomes. Since they reflect delivery of care, risk adjustment is not undertaken. Data completeness of items for risk-adjustment is not outlier reported, in recognition that data submission was undertaken prior to NBOCA's move to using

routinely collected data in 2024. NBOCA anticipates that data completeness will be outlier-reported in future reports. Please refer to the [NBOCA outlier policy and process](#) for further information.

Additional materials that accompany this report include:

- A [methodology supplement](#) with details about the Audit's data sources and methods
- Information about the [outlier process](#)
- Resources to support local monitoring of practice and quality improvement, such as provider-level results on the [Data Dashboard and downloadable reports](#) and a [local action plan template](#).
- A [summary of this report for people living with bowel cancer and for the public](#) is available on the Audit's website.

2. Infographic

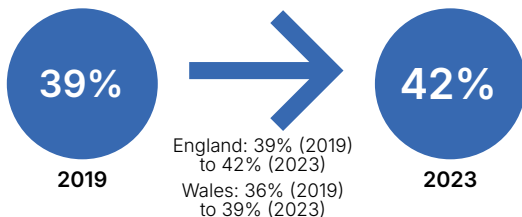
Summary of results for people diagnosed with or undergoing surgery for bowel cancer (2023), in England and Wales

Care pathways

37,730 people

were diagnosed with **bowel cancer** in England and Wales between 1 January 2023 and 31 December 2023.
England: 35,243 people Wales: 2,487 people

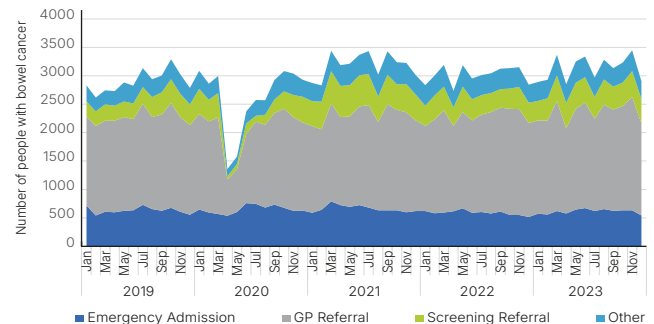
Proportion of people who presented with stage 1 or stage 2 cancer



Proportion of people recorded as being seen by a clinical nurse specialist (CNS)

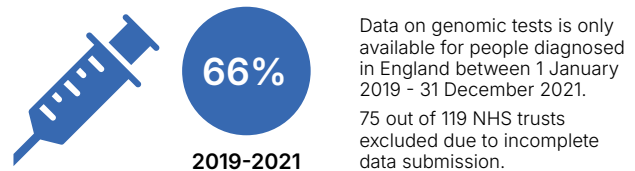


Number of patients who presented with colorectal cancer by route of diagnosis*

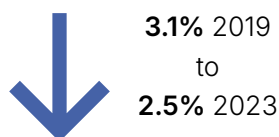


* Data were impacted by the COVID-19 pandemic

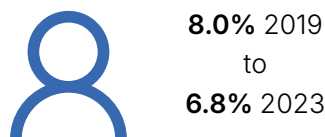
Proportion of all people with histologically confirmed Stage 4 disease in England with a record of genetic tumour profiling (KRAS, NRAS, BRAF)



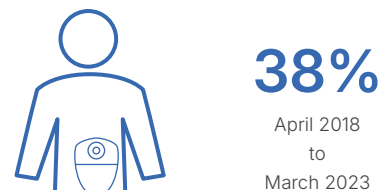
Peri-operative care



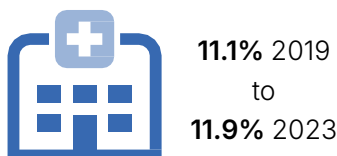
% of people who died within 90 days of surgery (year of surgery): Target ≤6%



% of people with an unplanned 30-day return to theatre after surgery (year of surgery): Target <10%



% of people with an unclosed diverting ileostomy 18-months after anterior resection (major rectal cancer surgery, year of surgery, data were impacted by the COVID-19 pandemic)*: Target <35%



% of people with an unplanned 30-day readmission after surgery (year of surgery): Target: <15%



% of trusts/multidisciplinary teams (MDTs) that performed ≥ 20 major rectal cancer operations per year (year of surgery)*



% of people who underwent major colorectal cancer surgery with a minimally invasive approach (laparoscopic or robotic, year of surgery)

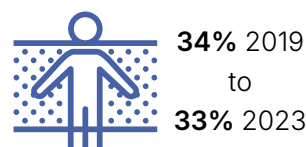
Oncological management



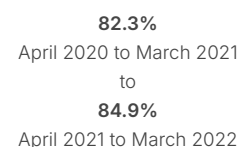
% of people who received adjuvant chemotherapy for stage 3 colon cancer (year of surgery)*: Target >55%



% of people who experienced severe acute toxicity after adjuvant chemotherapy (year of surgery)*: Target <33%



% of people with rectal cancer who received neo-adjuvant radiotherapy treatment (year of diagnosis): Target 10%-60%



% of people alive 2-years after major colorectal cancer surgery (year of surgery): Target >70%

All results relate to people in England and Wales, except for genetic tumour profiling which is only available in England.

* Comparator not available due to change in time periods or overlap in time periods.

3. Recommendations

Recommendations developed in collaboration with NBOCA Clinical Advisory Group based on key findings in this report.

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection for rectal cancer. - Support NHS trusts/ multidisciplinary teams (MDTs) to identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of variation. - Support NHS trusts/MDTs to participate and engage with the local and national quality improvement initiatives to enable more timely reversal of ileostomy. For example, NBOCA & Royal College of Surgeons of England's CloselyQuick Collaborative.	England: Cancer Alliances working with NHS trusts Wales: health boards	Performance indicator and local target: Less than 35% of people with unclosed diverting ileostomy 18-months after anterior resection. Approximately 38% of people with unclosed diverting ileostomy 18-months after anterior resection. This has not improved since last year's report. See page 11.	2: Improving perioperative care	ACPGBI: Guidelines for the Management of Cancer of the Colon, Rectum and Anus (2017) – Surgical Management. National Bowel Cancer Audit Quality Improvement Plan "Figure 3: Example driver diagram for indicator "Ileostomy closure after rectal cancer resection"
2. In units with chemotherapy utilisation following resection of stage 3 colon cancer below 55%, conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. If the resulting findings identify under-utilisation, develop appropriate local action plans to increase rates of chemotherapy whilst maintaining low levels of severe toxicity. Action plans may include integration of geriatric expertise and or rehabilitation into shared chemotherapy decision making.	England: Cancer Alliances working with NHS trusts Wales: health boards	Performance indicator and local target: More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy. In England and Wales, 14 NHS trusts were below the local target. Considerable between-unit variation in the use of adjuvant chemotherapy remains with 15 (12%) NHS trusts/MDTs below the 95% funnel limit. See page 12.	3: Improving oncological care	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). Boyle JM, et al. Measuring variation in the quality of systemic anti-cancer therapy delivery across hospitals: A national population-based evaluation. Eur J Cancer. 2023.
3. Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes. Cancer alliances and health boards to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. An example guideline is provided as a basis for regional discussions. This will aid decision making and take into account locoregional approaches to neo-adjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.	England: Cancer Alliances working with NHS trusts Wales: health boards	Performance indicator and local target: 10-60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment. Overall, 33% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs from 6% to 87%. See page 13.	3: Improving oncological care	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). An example of an agreed guideline to neo-adjuvant treatment of rectal cancer may be found here: Neo-adjuvant-and-Non-operative-Management-of-Rectal-Cancer-Guidelines-v4.pdf

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Ensure robust sustainable pathways are in place to provide timely genomic assessment where clinically appropriate. To inform personalised treatment options and/or identify those with Lynch syndrome, optimise the proportions of people undergoing: - MMR or MSI testing in stage 1 to 4 cancer - RAS and BRAF assessment in stage 4 cancer	England: Cancer Alliances working with NHS trusts Genomic Laboratory Hubs	Contextual measure: More than 70% of people with stage 4 disease at diagnosis and aged under 75 who have genetic tumour profiling (KRAS, NRAS, BRAF). Testing for KRAS, NRAS and BRAF is mandatory to determine eligibility for targeted treatment with encorafenib, cetuximab, or panitumumab. Due to gaps in genomic data submissions, NHS trusts were only included if >70% of patients with histologically confirmed stage 4 bowel cancer who received targeted treatment had a record of KRAS, NRAS or BRAF testing. As a result, data could be reported for only 44 out of 119 NHS trusts. For all patients with histologically confirmed stage 4 bowel cancer in these 44 eligible NHS trust in 2021, 66% had a record of KRAS, NRAS or BRAF testing. Data for genomic testing is only available in England. See page 8.	4: Improving management of stage four disease	National Institute for Health and Care Excellence (NICE) Guidelines: Bowel Cancer (Updated 2021). National Institute for Health and Care Excellence Diagnostics Guidance DG27 (2017)
Data Quality Recommendation				
5. Continue to improve data completeness of key items in the English cancer registration and Wales Cancer Network datasets to allow risk-adjustment of performance indicators. - Provision of a clinical local data lead responsible for working with relevant local teams (e.g. Clinical Effectiveness/Audit) to ensure the quality of data submissions to national datasets. - Data items of focus: tumour, node and metastases (TNM) stage, American Society of Anaesthesiologists' (ASA) grade and performance status.	England: NHS England, Cancer Alliances working with NHS trusts Wales: health boards	Contextual measure and local target: More than 70% data completeness of seven items for risk adjustment in people undergoing major surgery. For people who underwent major surgery for bowel cancer in 2023, 52% of NHS trusts in England and all MDTs in Wales achieved the data completeness local target. See page 8.	All	Walker K, et al. Model for risk adjustment of postoperative mortality in people with bowel cancer. Br J Surg. 2015. NBOCA Key COSD data items

4. Results for England and Wales

4.1 Quality Improvement

Each performance indicator has a local target for NHS trusts/MDTs. The targets are dynamically selected through a review of the existing literature and a consensus process with the NBOCA Clinical Advisory Group, with the aim of stimulating quality improvement. For example, for people who underwent major surgery for stage 3 colon cancer between April 2021 and October 2023, 66% received adjuvant chemotherapy – an increase from previous reports. In response to this improvement, the local target has been raised to 55%.

The ten performance indicators, the corresponding local target and the proportion of NHS trusts/MDTs meeting each target are reported in Table 2.

NBOCA provides NHS trusts/MDTs with their [results to facilitate local quality improvement](#) strategies. Furthermore, NBOCA delivers annual events to showcase successful QI initiatives. The Audit also supports Cancer Alliances and the improvement work of the NHS England Cancer Programme.

The local target met by the fewest NHS trusts/MDTs is '<35% adjusted 18-month unclosed ileostomy', with only 40% of NHS trusts/MDTs meeting the target. In response to these findings, in collaboration with the Royal College of Surgeons and ACPGBI, NBOCA has launched [Close It Quick](#) – a quality improvement collaborative designed to optimise ileostomy closure rates through:

- A data-driven intervention with participating sites gaining access to a QI dashboard. The dashboard aims to increase understanding of systems and provide evidence for change.
- Structured support from QI and clinical experts, peer collaboration, and tailored resources for pathway redesign.
- Identifying strategies to reduce system pressures and generate savings while improving patient outcomes.

Table 2. NBOCA performance indicators with national and local results, England and Wales

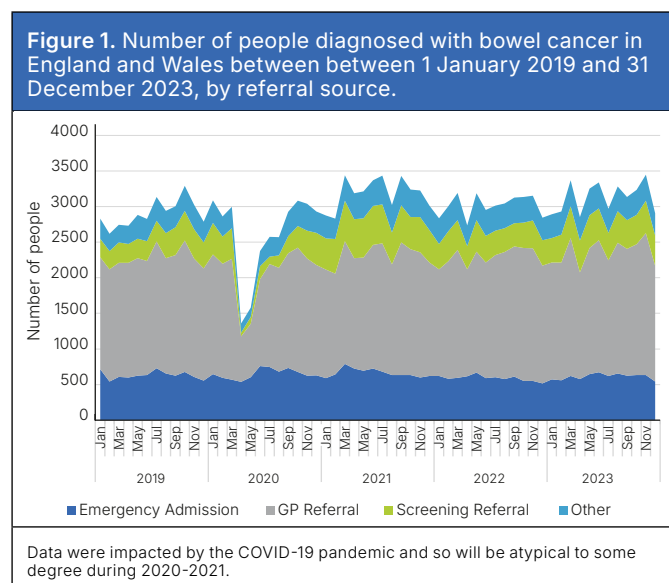
Performance indicator	Local Target	National results	Percentage of NHS trusts/MDTs meeting local target
Patients diagnosed with bowel cancer between 1 January 2023 and 31 December 2023, in England and Wales			
1. Seen by Clinical Nurse Specialist*	>95%	93%	61%
Patients who underwent rectal cancer surgery between 1 January 2023 and 31 December 2023, in England and Wales			
2. NHS trust/MDT volume for rectal cancer surgery	≥20 per year	N/A**	78%
Patients who underwent major resection between 1 January 2023 and 31 December 2023, in England and Wales			
3. Adjusted 90-day mortality after major resection	<6%	2.5%	96%
4. Adjusted 30-day unplanned return to theatre after major resection	<10%	6.8%	93%
5. Adjusted 30-day unplanned readmission after major resection	<15%	11.9%	76%
Patients who underwent anterior resection with diverting ileostomy between 1 April 2018 and 31 March 2023, in England and Wales			
6. Adjusted 18-month unclosed ileostomy after anterior resection	<35%	38%	40%
Patients who underwent major resection between 1 April 2021 and 31 October 2023, in England and Wales			
7. Stage 3 colon cancer receiving adjuvant chemotherapy	>55%	66%	89%
8. Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer	<33%	20%	99%
Patients who underwent rectal cancer surgery between 1 January 2023 and 31 December 2023, in England and Wales			
9. People with rectal cancer receiving neo-adjuvant treatment***	10%-60%	33%	84%
Patients who underwent major resection between 1 April 2021 and 31 March 2022, in England and Wales			
10. Adjusted 2-year survival rate after major resection	>70%	84.9%	100%
MDT: multidisciplinary team. Please note, for risk-adjusted performance indicators, hospitals/MDTs were excluded from the analyses if overall data completeness was less than 20%, or performance status and/or TNM stage was missing in more than 80% of patients included in the analyses. Please see the methodology supplement for further information. Where comparisons over time for a performance indicator have been made in this report (e.g. infographic), all patients have been included. This explains the slight difference in the national average for risk adjusted performance indicators. It is not possible to make direct comparisons with the percentage of NHS trusts/MDTs meeting targets in last year's report because of overlapping time periods. For performance indicator 6, 7, 8 and 10, data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.			
* Excludes people with incomplete CNS data item ** Number of rectal cancer resections cannot be reported as % of all people			
*** Neo-adjuvant therapy is currently defined as a record of neo-adjuvant radiotherapy. Neo-adjuvant therapy includes several treatment protocols.			

4.2 Characteristics of People with Bowel Cancer

Characteristics of the 37,730 people diagnosed with bowel cancer during 2023 are outlined in Table 3 and [Supplementary Table 2](#). The proportion of people diagnosed with bowel cancer who were under 50 years of age has increased from 6.4% in 2021/22 to 8.0% in 2023. This age group will be a focus of further study over the coming year.

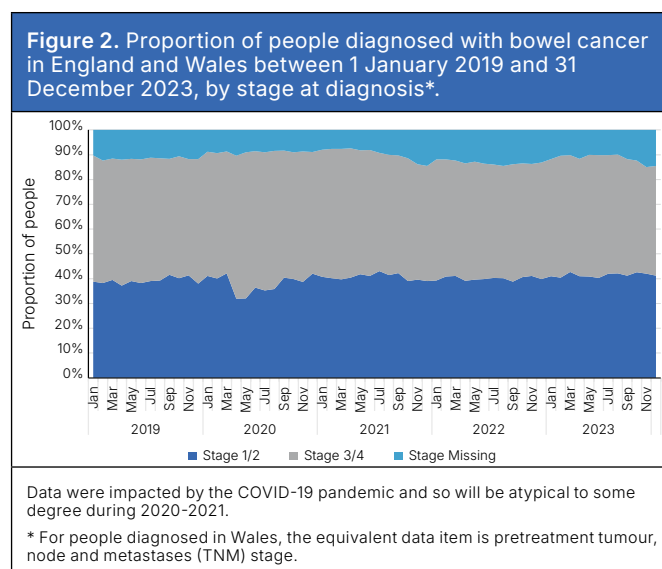
Throughout the report, 2019 data provides a pre-COVID-19 pandemic baseline for assessing recovery trends (Figure 1). Variation in diagnostic pathways by English Cancer Alliances and Wales are shown in [Supplementary Figure 1](#). The proportion of people diagnosed via screening has gradually increased, from 10.9% in 2019 to 12.2% in 2023 (Figure 1). This is associated with a slight reduction in the proportion diagnosed as an emergency (21.4% in 2019 to 19.2% in 2023). This may reflect the rollout of Faecal Immunochemical Testing and the phased expansion of [NHS bowel cancer screening](#) to people aged 50 to 74 years in [England](#) and [Wales](#). The [Cancer in the UK Report 2025](#) (Cancer Research UK) found that over the last five years, bowel cancer screening uptake has increased, with rates now ranging between 66% and 71% across the UK nations. Further work is needed to address barriers to participation.

A key ambition of the [NHS Long Term Plan](#) cancer strategy for England is that by 2028, 75% of people with cancer will be diagnosed with stage 1 or 2 disease. The detection of earlier, more treatable cancer is also a focus of the [Quality Statement for Cancer](#) in Wales.



The proportion of people diagnosed with stage 1 or 2 bowel cancer in England and Wales has increased marginally from 39.3% in 2019 to 41.5% in 2023 (Figure 2). Variation by English Cancer Alliances

and Wales is shown in [Supplementary Figure 2](#). It is important to monitor trends in stage at diagnosis. To reflect this, the accurate recording of key data items, including stage, is a contextual measure within the [NBOCA Quality Improvement Plan](#). The proportion of people with incomplete stage data has not improved from 11.5% since 2019.



Of the 37,730 people diagnosed during 2023, 21,395 (56.7%) underwent major resection and 2,132 (5.7%) underwent local excision ([Supplementary Table 3](#)).

Table 3. Characteristics of the 37,730 people diagnosed with bowel cancer between 1 January 2023 and 31 December 2023 in England and Wales.			
		Number	%
Total number of people		37,730	
Sex	Male	20,724	54.9
	Female	17,006	45.1
Age-group	Under 50 yrs	3,023	8.0
	50-59 yrs	5,214	13.8
	60-74 yrs	13,807	36.6
	75-79 yrs	5,946	15.8
	80-84 yrs	4,958	13.1
	85 yrs and above	4,766	12.6
	Missing (% of total)	16	(0.0)
Ethnicity	White	30,888	92.5
	Mixed/Multi Ethnic	197	0.6
	Asian	996	3.0
	Black	738	2.2
	Other	558	1.7
	Missing/ Not Known (% of total)	4,353	(11.5)
Index of Multiple Deprivation (Quintile)	1 (Most deprived)	6,110	16.2
	2	7,000	18.6
	3	7,914	21.0
	4	8,220	21.9
	5 (Least deprived)	8,376	22.3
	Missing (% of total)	110	(0.3)

4.3 Improving the Diagnostic Pathway

Key message: While data completeness of key items has improved, it was not possible to report risk-adjusted performance indicators for six NHS trusts/MDTs due to poor data completeness.

Contextual Measure and Local Target

More than 70% data completeness of seven items for risk-adjustment in people undergoing major surgery: 55% of trusts/MDTs

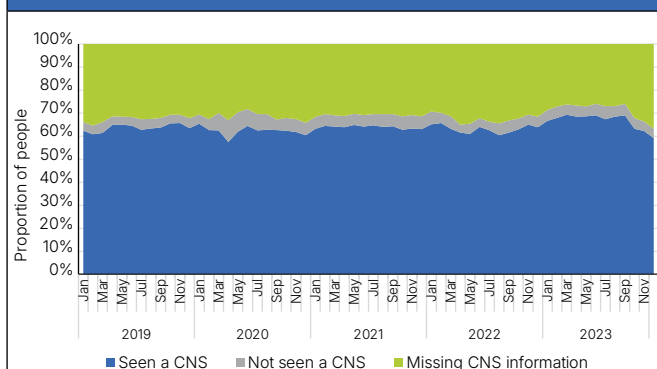
For people who underwent major surgery for bowel cancer in 2023, 52% of NHS trusts in England and 100% of MDTs in Wales achieved the data completeness local target.

Performance Indicator and Local Target 1

More than 95% of people seen by Clinical Nurse Specialist (CNS): 61% of trusts/MDTs

The clinical nurse specialist data item was poorly completed with only 71% of people having CNS status available in England and Wales datasets in 2023 (69% of people in England had CNS status recorded compared to 99% in Wales). In 2023, for all people diagnosed with bowel cancer in England and Wales, 67% were recorded as being seen by a CNS. This compares to 64% in 2019 (Figure 3). This increase is driven by a reduction in the proportion of people with missing CNS status from 32% in 2019 to 29% in 2023. In cases where CNS information was available, 93% of people with bowel cancer were seen by a CNS in 2023 compared to 94% in 2019. When focusing only on people with CNS information available, 61% of NHS trusts/MDTs met the local target.

Figure 3. Proportion of people reported to have seen a clinical nurse specialist (CNS) for those diagnosed between 1 January 2019 and 31 December 2023 in England and Wales.



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

Key message: One in three patients with stage 4 bowel cancer do not have a record of genetic tumour profiling.

Contextual Measure and Local Target

More than 70% of people with stage 4 disease at diagnosis and aged under 75 who have genetic tumour profiling (KRAS, NRAS, BRAF): 70.5% of trusts

Current [NICE guidelines](#) recommend that all people diagnosed with stage 4 bowel cancer suitable for systemic anti-cancer treatment should undergo genetic testing for RAS and BRAF mutations. Genetic testing provides an important prognostic factor and guides oncological management.

Across all English NHS trusts, completion of KRAS, NRAS or BRAF testing for people with histologically confirmed stage 4 bowel cancer between 2019 and 2021 was 39.9%. This is likely an underestimation as submission of genetic data is not mandatory.

RAS and BRAF testing are required before starting targeted treatment with encorafenib, cetuximab, or panitumumab. Hence, to address gaps in data submission, the analysis was rerun including only NHS trusts in which >70% of people receiving targeted treatment had a record of KRAS, NRAS or BRAF testing (the expected proportion would be 100%). This excluded 75 out of 119 NHS trusts due to incomplete data submission. Among all patients diagnosed with histologically confirmed stage 4 bowel cancer in 2021 in the 44 eligible trusts, completion of KRAS, NRAS or BRAF testing was 66.2% compared to 67.3% in 2020 and 65.6% in 2019. Younger people were more likely to have a record of KRAS, NRAS or BRAF testing with 75.5% of people aged under 75 years compared to 47.9% in people aged 75 years or older. This may be explained by differences in co-morbidities, fitness and the perceived risks and benefits of targeted treatments between younger and older people meaning that younger people were more likely to have an assessment of their genomics to inform treatment. For people aged under 75, 31 out of 44 NHS trusts (70.5%) met the local target. Of people with a record of KRAS, NRAS or BRAF testing, 44.9% were tested within one month of diagnosis.

The previous State of the Nation report described mismatch repair (MMR) testing data for people diagnosed with bowel cancer in England up to 2021. While data for people diagnosed after 2021 are not yet available, future NBOCA reports will continue tracking trends in testing for MMR, KRAS, NRAS and BRAF over time.

4.4 Improving Peri-operative Care

Key message: Overall 90-day mortality and unplanned return to theatre after major bowel cancer resections continues to improve.

Performance Indicator and Local Target 2

Annual rectal cancer resection volume greater than or equal to 20 cases per centre: 78% of trusts/MDTs

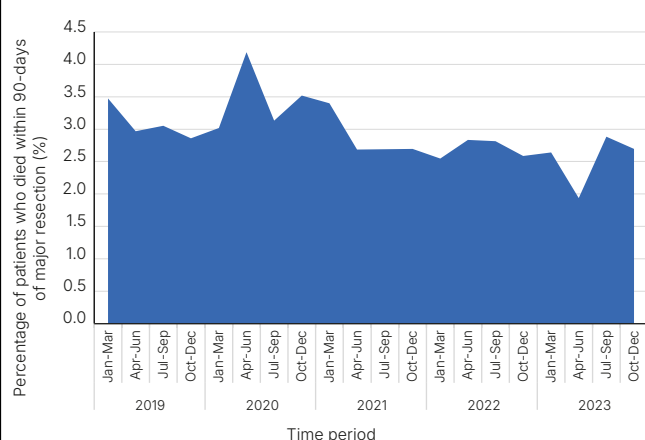
NICE guidelines recommend that providers should be performing a minimum of 10 rectal cancer resections per year. For major resections undertaken in 2023, 4 (3%) NHS trusts/MDTs performed fewer than 10 rectal cancer resections and 28 (22%) NHS trusts/MDTs performed fewer than 20 rectal cancer resections.

Performance Indicator and Local Target 3

<6% adjusted 90-day mortality after all bowel cancer resections: 96% of trusts/MDTs

20,977 people underwent major bowel cancer surgery in 2023. There has been a reduction in overall 90-day mortality after bowel cancer resections in England and Wales, from 3.1% in 2019 to 2.5% in 2023 with a temporary increase to 3.4% in 2020 impacted by the COVID-19 pandemic (Figure 4).

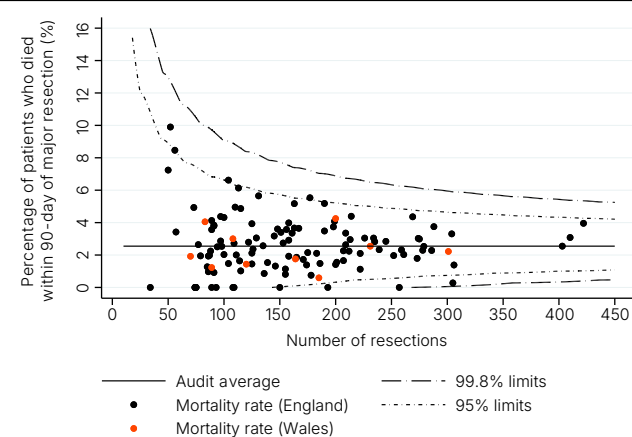
Figure 4. 90-day post-operative mortality for all people who underwent major resection between 1 January 2019 and 31 December 2023 in England and Wales.



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

After excluding NHS trusts/MDTs not eligible for risk-adjustment, 90-day post-operative mortality for people who underwent surgery in 2023 was 2.5%. Figure 5 shows risk-adjusted 90-day mortality at NHS trust/MDT level. There were four English NHS trusts above the 95% limit, with none of these above the 99.8% limit.

Figure 5. Adjusted 90-day mortality after all bowel cancer resections for people who underwent major resection between 1 January 2023 and 31 December 2023, by NHS trusts/multidisciplinary teams (MDTs) with more than ten resections (N = 20,255).

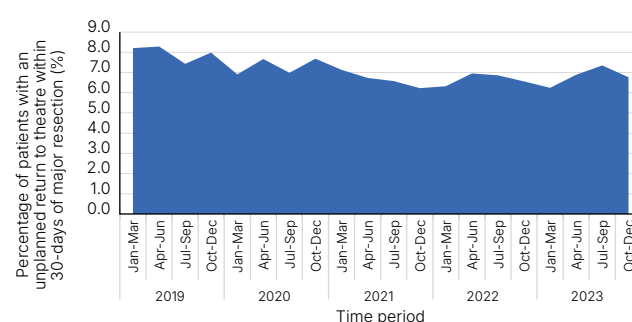


Performance Indicator and Local Target 4

<10% adjusted 30-day unplanned return to theatre after all bowel cancer resections: 93% of trusts/MDTs

The proportion of people with an [unplanned return to theatre](#) (URTT) following a major resection declined from 8.0% in 2019 to 6.7% in 2021 (Figure 6). This proportion has remained stable at 6.8% in 2023. It is important to note that return to theatre is a recognised complication of major resection and focus should be placed on prompt recognition of post-operative complications.

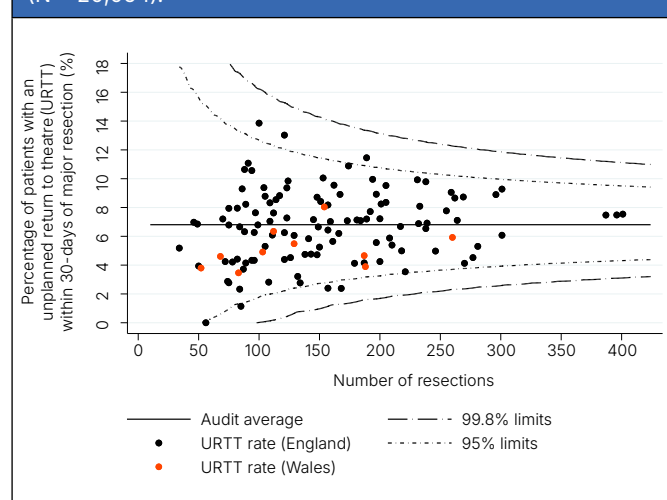
Figure 6. Percentage of people with an unplanned return to theatre (URTT) within 30-days of major resection for all people who underwent major resection between 1 January 2019 and 31 December 2023 in England and Wales.



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

After excluding NHS trusts/MDTs not eligible for risk-adjustment, URTT was 6.8% for people who underwent surgery in 2023. Figure 7 shows risk-adjusted URTT at NHS trust/MDT level. There were 3 English NHS trusts above the 95% funnel limit, with none of these above the 99.8% limit.

Figure 7. Adjusted 30-day unplanned return to theatre (elective and emergency admissions) by NHS trusts/multidisciplinary teams (MDTs) with more than ten resections for people who underwent major resection between 1 January 2023 and 31 December 2023, in England and Wales (N = 20,054).

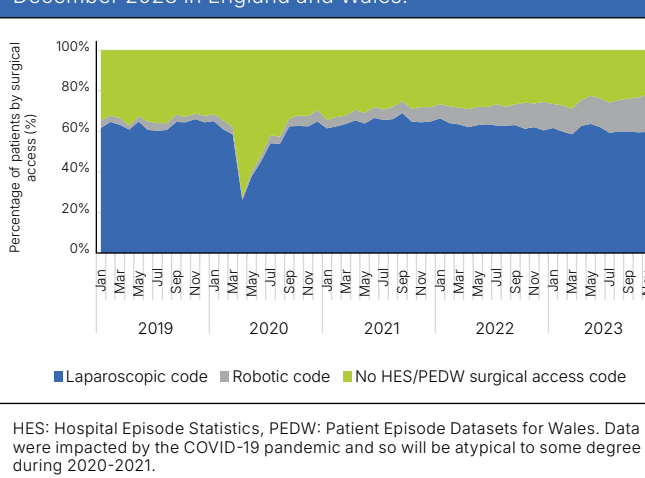


Contextual Measure and Local Target

More than 50% of all bowel cancer resections via a minimally invasive approach (laparoscopic or robotic): 95% of trusts/MDTs

Of people who underwent major resection in 2023, 75% were recorded as undergoing minimally invasive surgery (60% laparoscopic, 15% robotic). This compares to 73% of people who underwent minimally invasive surgery in 2022 (63% laparoscopic, 10% robotic) and 66% in 2019 (63% laparoscopic, 3% robotic) (Figure 8). The proportion of NHS trusts/MDTs meeting the minimally invasive surgery local target was 95% in 2023. The proportion of people undergoing robotic procedures has increased five-fold from 3% in 2019 to 15% in 2023. It is possible that the proportion of people undergoing minimally invasive surgery has been underestimated due to incomplete linkage to HES-APC for people undergoing surgery in England.

Figure 8. Surgical access for major resections for people who underwent major resection between 1 January 2019 and 31 December 2023 in England and Wales.



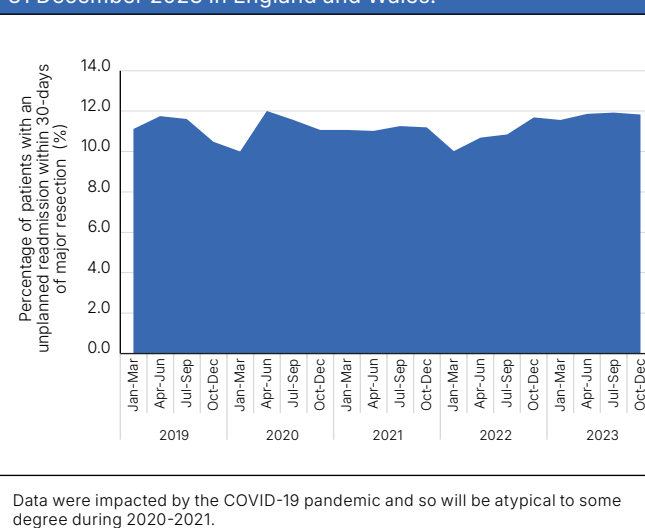
Following major resection, the median length of inpatient stay (LOS) was 6 days (IQR 4-10 days) in 2023. Surgical urgency is not available in routinely collected data; instead, mode of admission is used in this report and is classified as emergency or elective according to HES-APC/PEDW. Elective surgery median LOS was 6 days (IQR 4-9 days) compared to emergency surgery LOS of 10 days (IQR 6-17 days).

Performance Indicator and Local Target 5

<15% adjusted 30-day unplanned readmission after all bowel cancer resections: 76% of trusts/MDTs

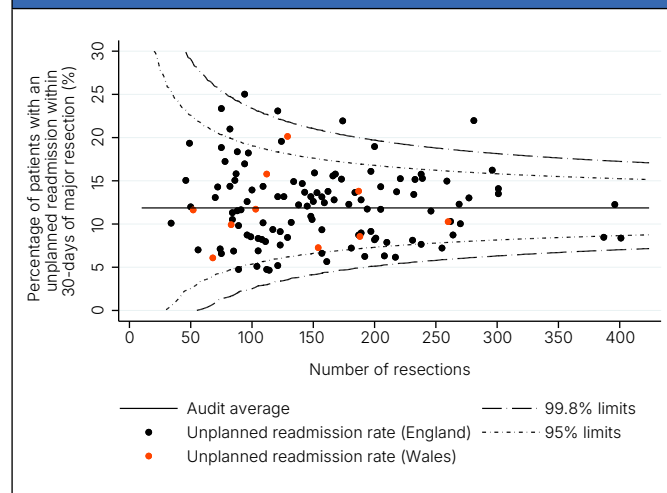
The percentage of people in England and Wales with a 30-day unplanned readmission after major resection remained stable from 11.2% in 2019 to 11.8% in 2023 (Figure 9).

Figure 9. Proportion of people with an unplanned readmission within 30-days of major resection for all people who underwent major resection between 1 January 2019 and 31 December 2023 in England and Wales.



After excluding NHS trusts/MDTs not eligible for risk-adjustment, 30-day unplanned readmission was 11.9%. Four NHS trusts/MDTs were above the 99.8% limit on unplanned readmission and will be subject to our [outlier process](#) (Figure 10).

Figure 10. Adjusted 30-day unplanned readmission by NHS trusts/ multidisciplinary teams (MDTs) with more than ten resections for people who underwent major resection between 1 January 2023 and 31 December 2023, in England and Wales (N = 20,054).



The proportion of people diagnosed with rectal cancer in England and Wales who underwent major resection has decreased from 54% in 2019 to 51% in 2022. This percentage has further decreased to 46% in 2023, however this is likely an underestimate due to a shorter follow-up period ([Supplementary Table 4](#)). This trend may reflect changes in rectal cancer management advocating for organ preservation where there is complete clinical response from neo-adjuvant therapies.

For people diagnosed with rectal cancer undergoing major resection, the proportion undergoing anterior resection appears to have stabilised around 60–62% over the past five years, with the proportion undergoing abdominoperineal excision of rectum (APER) increasing from 26.7% (2019) to 29.4% (2023) ([Supplementary Table 5](#)). This has been accompanied by a decrease in the proportion of people with a diverting ileostomy at the time of their anterior resection from 59.8% (2019) to 54.9% (2023) ([Supplementary Table 6](#)).

Key message: Approximately 4 in 10 people have an unclosed diverting ileostomy 18-months after anterior resection which has not improved.

Performance Indicator and Local Target 6

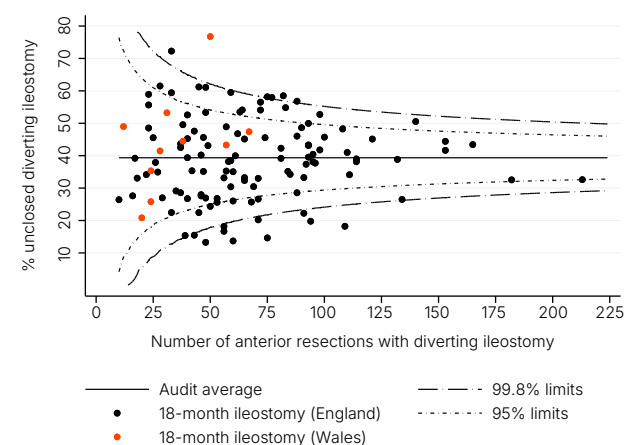
<35% adjusted proportion of people with unclosed diverting ileostomy 18 months after anterior resection: 40% of trusts/MDTs

For all people undergoing anterior resection with diverting ileostomy between April 2018 and March 2019, 33% of people did not have their diverting ileostomy reversed by 18 months. This proportion substantially increased to 48% for people undergoing surgery between April 2019 and March 2020, reflecting the impact of the COVID-19 pandemic. For people having surgery in the following year (April 2020 – March 2021), the proportion of people with an unclosed ileostomy at 18-months improved to 39%. No further improvements towards pre-pandemic performance have been observed with the proportion of people with an unclosed ileostomy at 18-months remaining at 39% for people undergoing surgery between April 2022 and March 2023.

After excluding NHS trusts/MDTs not eligible for risk-adjustment, 38% of people who underwent surgery between April 2018 and March 2023 did not have their diverting ileostomy reversed by 18 months (Figure 11). There were 19 NHS trusts/MDTs above the 95% funnel limit. Six of these were above the 99.8% funnel limit and will be subject to our [outlier process](#). This is similar to the last State of the Nation report in which 18 NHS trusts/MDTs were above the 95% funnel limit of which six were above the 99.8% funnel limit. Unwarranted between-unit variation remains for this performance indicator. Possible explanations include differential rates of post-operative complications, toxicity from adjuvant chemotherapy, or disease progression. Additionally, there are often no set pathways or protocols for stoma closure. It is likely that considerable differences exist in administrative factors such as waiting list volumes for other urgent procedures which may affect the prioritisation of stoma reversal. There were also nine NHS trusts/MDTs below the 99.8% funnel limit suggesting exceptional performance and providing an opportunity to identify best-practice.

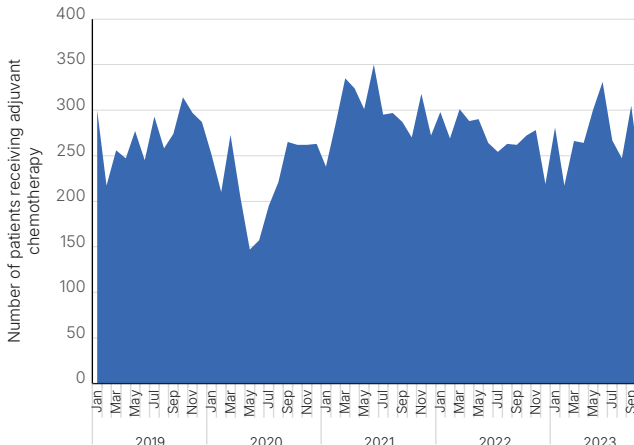
Across England and Wales, only 40% of NHS trusts/MDTs met the local target for reversal of ileostomy. This compares to 41% in last year's State of the Nation report. With evidence of the negative impact of unclosed ileostomy on quality of life for people undergoing anterior resection, and even potentially on long-term survival, this should be a key focus for future local and national quality improvement initiatives. The Close It Quick QI Collaborative aims to address this deficit and improve patient care and patient experience.

Figure 11. Adjusted 18-month unclosed ileostomy after anterior resection performed between 1 April 2018 and 31 March 2023 at English NHS trust/Welsh multidisciplinary team (MDT) level (N = 8,657).



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

Figure 12. Number of people with pathological stage 3 colon cancer in England and Wales receiving adjuvant chemotherapy following major resection between 1 January 2019 and 31 October 2023, by date of surgery.



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

4.5 Improving Oncological Management and Stage 4 Disease

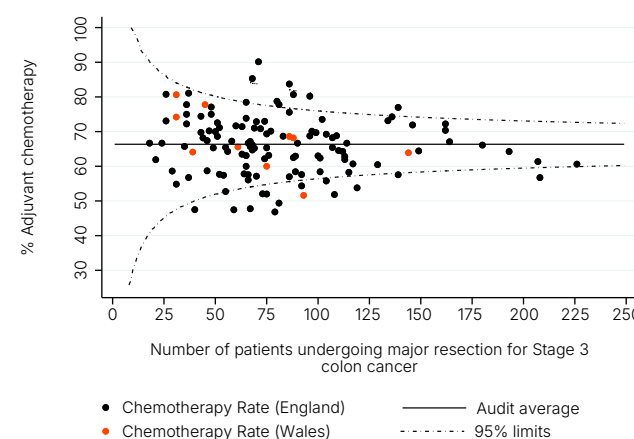
Key message: There is considerable variation between NHS trusts/MDTs in the use of adjuvant chemotherapy for people with stage 3 colon cancer and neo-adjuvant therapy for people with rectal cancer.

Performance Indicator and Local Target 7
>55% people with stage 3 colon cancer receiving adjuvant chemotherapy: 89% of trusts/MDTs

For people who underwent major resection for stage 3 colon cancer in 2019 (pre-COVID-19 pandemic), 64% received adjuvant chemotherapy. This proportion dropped to 60% in 2020, reflecting the impact of the COVID-19 pandemic. In 2021, the proportion of people who received adjuvant chemotherapy recovered to 66% and remained constant in both 2022 and January 2023 – October 2023 (Figure 12).

Between-unit variation remains in the use of adjuvant chemotherapy for stage 3 colon cancer with 15 NHS trusts/MDTs below the 95% funnel (Figure 13). Compared to the previous report, 14 NHS trusts/MDTs were below the 95% funnel limit.

Figure 13. Adjuvant chemotherapy uptake in people with stage 3 colon cancer by English NHS trusts/Welsh multidisciplinary teams (MDTs) with more than ten resections, for people undergoing major resection between 1 April 2021 and 31 October 2023 in England and Wales (N = 10,737).



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

With emerging evidence of the potential benefits of neo-adjuvant chemotherapy for people with operable stage 2/3 colon cancer, NBOCA is developing methodology to track this practice. Due to small numbers identified in this reporting period, results are not included in this report.

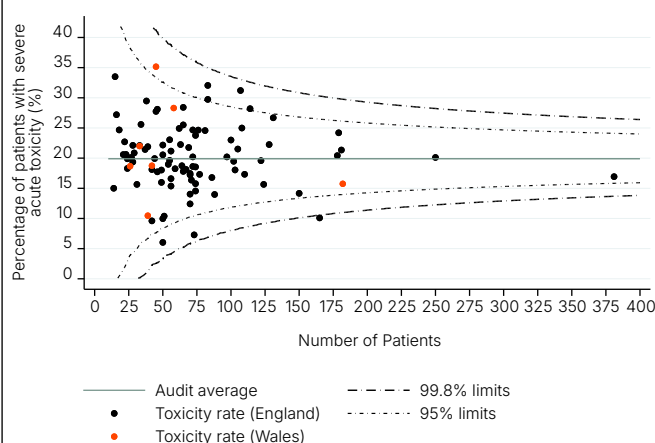
Performance Indicator and Local Target 8

<33% adjusted proportion of people experiencing severe acute toxicity related to adjuvant chemotherapy for stage 3 colon cancer: 99% of trusts/MDTs

NBOCA [methodology](#) allows capture of people who develop severe toxicity related to adjuvant chemotherapy. After excluding NHS trusts/MDTs not eligible for risk-adjustment, 20% of people experienced severe acute toxicity following adjuvant chemotherapy (major resection 1 April 2021 and 31 October 2023). This is stable compared to 21% in the last report.

The proportion of NHS trusts/MDTs meeting the local target improved from 95% to 99%. Risk-adjusted toxicity varied between NHS trusts/MDTs with an interquartile range of 17% to 25%. There were three NHS trusts/MDTs above the 95% funnel limit (Figure 14). This represents an improvement from the previous report, where six NHS trusts/MDTs were above the 95% funnel limit. There were three English NHS trusts/hospitals below the 95% funnel limit, suggesting exceptional performance.

Figure 14. Adjusted severe acute toxicity for people receiving adjuvant chemotherapy for pathological stage 3 bowel cancer, by English NHS trusts/Welsh multidisciplinary teams (MDTs) treating more than ten people after major resection between 1 April 2021 and 31 October 2023 (N = 6,995).

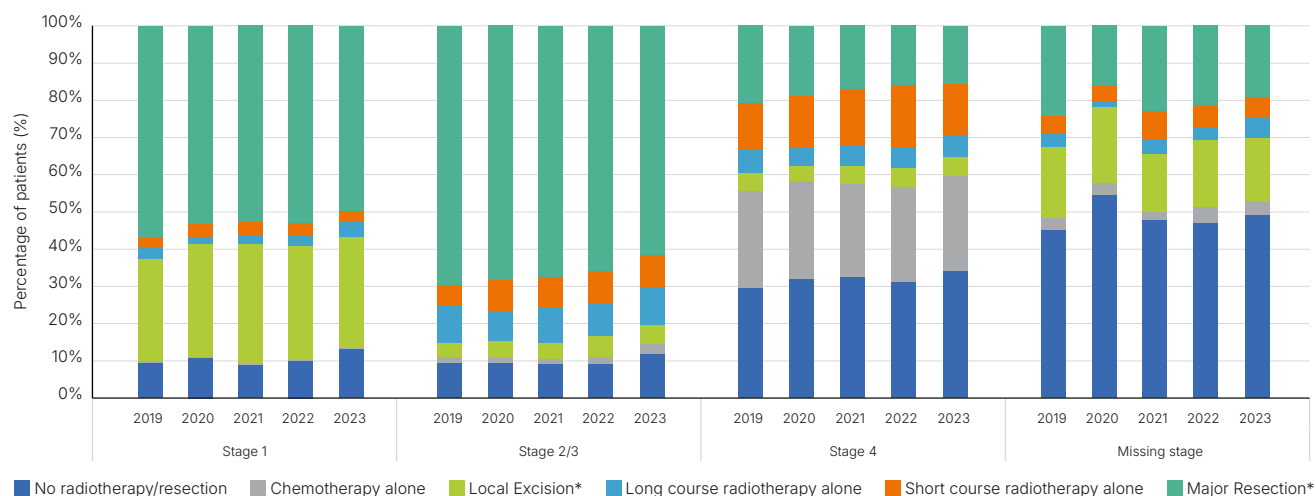


Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

Figure 15 and [Supplementary Table 7](#) show the change in rectal cancer management in England over time, separately for those with stage 1, stage 2/3, and stage 4 disease, and patient characteristics. For stage 1 rectal cancers, the proportion of people undergoing major resection continues to decrease (57% in 2019 compared to 50% in 2023). This has been associated with increased use of local excision from 27% in 2019 to 30% in 2023 which reflects advancements in trans-anal minimally invasive and endoscopic surgery as well as organ preservation strategies. For stage 2/3 rectal cancers, there has also been a reduction in the proportion of people having a major resection, from 70% in 2019 to 61% in 2023. This has been associated with an increase in both local excision and radiotherapy usage. These trends likely reflect the uptake of enhanced surveillance and organ preservation following complete clinical response from neo-adjuvant therapies ([OnCoRe](#)). For people with stage 4 rectal cancer, there is a reduction in the proportion of people undergoing major surgery from 21% in 2019 to 15% in 2023 and an increase in the proportion receiving short course radiotherapy (SCRT) alone from 12% of people in 2019 to 14% in 2023. This may represent increased utilisation of SCRT in people with significant rectal symptoms for symptomatic relief.

During the first wave of the COVID-19 pandemic in 2020, there was a temporary reduction in the use of neo-adjuvant long-course radiotherapy (LCRT), and an increase in the use of SCRT for people with rectal cancer undergoing major resection. This trend had not fully reversed by 2023, indicating ongoing increased utilisation of SCRT either on its own or incorporated into total neo-adjuvant therapy (TNT) regimens (Figure 16). It is important to be cautious when interpreting the proportion receiving surgery, radiotherapy or SACT in 2023 as it may be underestimated due to a shorter follow-up period.

Figure 15. Changes in rectal cancer management in the fifteen months following diagnosis by calendar year of diagnosis and cancer stage for people in England.



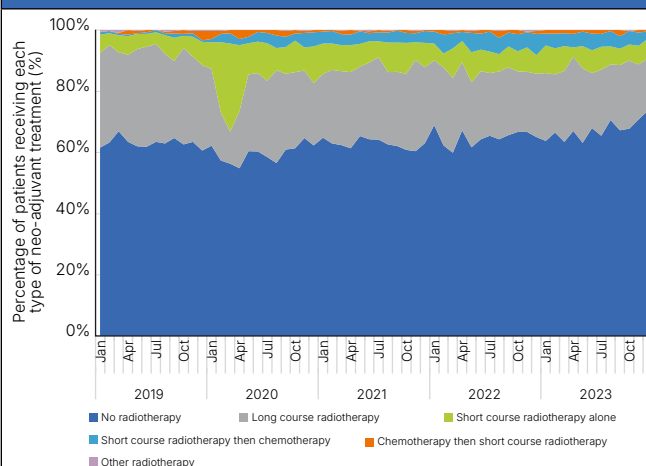
Stage 1: T1/2, N0, M0. Stage 2/3: any T, N1/N2, M0 or T3/4, N0, M0. Stage 4: any T, any N, M1.

* Represents the last treatment recorded.

Year represents calendar year of diagnosis. Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021

Welsh data not included due to differences in data collection

Figure 16. Type of neo-adjuvant treatment received by people diagnosed with rectal cancer in England prior to major resection over time according to SACT (Systemic Anti-Cancer Therapy) and RTDS (Radiotherapy Data Set).



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021. Welsh data not included due to differences in data collection.

Performance Indicator and Local Target 9

10% to 60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatment: 84% of trusts/MDTs

Thirty three percent of people diagnosed with rectal cancer across England and Wales in 2023 received neo-adjuvant therapy prior to a major resection. Overall, 84% of NHS trusts/MDTs met the local target. There was considerable variation between NHS trusts/MDTs in the use of neo-adjuvant radiotherapy from 6% to 87%.

For people that received neo-adjuvant treatment, the proportion receiving LCRT varied from 10.6% to 58% (IQR 17.5%-27.8%), and the proportion receiving SCRT varied from 0.6% to 47.5% (IQR 6.0%-15.6%) across English Cancer Alliances/Wales ([Supplementary Figure 3](#)). This represents wide variation in practice.

The increasing use of total neo-adjuvant therapy (TNT) schedules will impact on the management of rectal cancer. NBOCA plans to evaluate TNT utilisation by rectal cancer stage and geography.

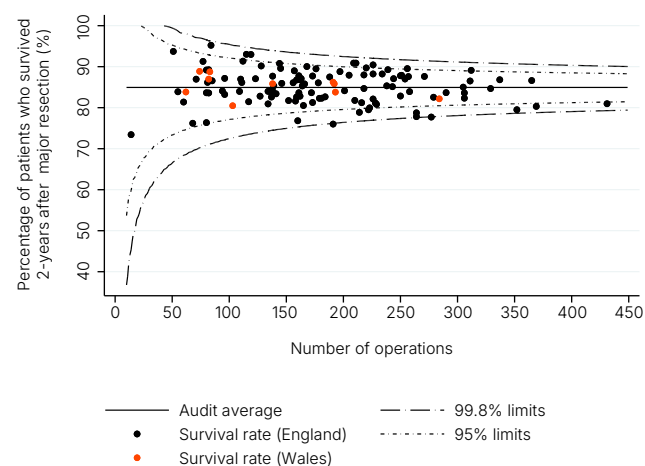
Performance Indicator and Local Target 10

>70% adjusted 2-year overall survival rate after bowel cancer resection: 100% of trusts/MDTs

Two-year overall survival rate after major resection is an important quality metric as it reflects the performance of multidisciplinary management of people with bowel cancer. After excluding NHS trusts/MDTs not eligible for risk-adjustment, for people who underwent major resection between 1 April 2021 and 31 March 2022, the 2-year all-cause adjusted survival rate was 84.9%. This represents an improvement from 82.3% in last year's State of Nation report (major resection 1 April 2020 and 31 March 2021). This positive trend may reflect recovery from the COVID-19 pandemic and improvements in the care of people with bowel cancer.

The performance of two NHS trusts fell below the 99.8% funnel limit (Figure 17), while two separate NHS trusts fell below the 95% limit for two consecutive years, suggesting poor performance. These NHS trusts will be subject to our [outlier process](#). There were eight hospitals/ NHS trusts lying above the 95% funnel limit suggesting exceptional performance.

Figure 17. Adjusted 2-year survival rate for people who underwent a major resection between 1 April 2021 and 31 March 2022, by English NHS trusts/Welsh multidisciplinary teams (MDTs) with more than ten resections. Audit average = 84.9% (N = 23,054).

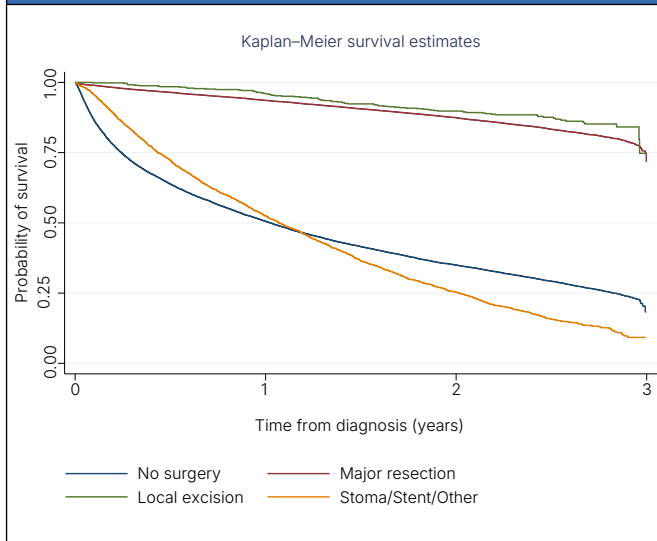


Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

[Supplementary Figure 4](#) demonstrates variation in adjusted 2-year cancer-specific survival for people undergoing major resection. Overall, there was less between-unit variation for cancer-specific survival rate compared to all-cause survival rate.

For all people diagnosed between 1 April 2021 and 31 March 2022, the observed survival 2-years after diagnosis was 87% for people undergoing major resection, 90% for local excision, 35% for people not undergoing surgery, and 25% for people undergoing surgery for a stoma or stent. The survival curves in Figure 18 demonstrate a similar pattern of survival for people undergoing major resection and local excision which are strategies that are likely to represent curative intent. The steepest decline in survival is observed in people not receiving surgery, likely reflecting advanced disease or functional status precluding resection. People undergoing stoma or stent follow a similar trajectory, in keeping with non-curative strategies. Future work by NBOCA will continue to track survival trends over time.

Figure 18. Kaplan-Meier plot of overall survival for people diagnosed in England and Wales between 1 April 2021 and 31 March 2022, by treatment strategy (N = 41,771).



Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

Future work by NBOCA will focus on developing performance indicators for the fifth Quality Improvement Goal: 'Improving end-of-life care'.

5. Commentary

The 2025 State of the Nation report from the NBOCA offers a concise overview of the care received by people with bowel cancer in England and Wales, focusing on people diagnosed or undergoing surgery in 2023.

This report highlights both progress and persistent challenges in bowel cancer care across England and Wales. While the transition to routinely collected data has reduced the burden of data collection, incomplete data hinders quality assurance and quality improvement opportunities. For example, 6 NHS trusts/MDTs were excluded from the analyses of risk-adjusted performance indicators in the current audit year due to poor data completeness. Genomic testing could not be assessed for 75 NHS trusts due to gaps in data submission. We encourage clinical teams to engage with clinical coders to continue to improve data completeness.

The proportion of people diagnosed with stage 1 or 2 bowel cancer in England and Wales has gradually increased from 39% in 2019 to 42% in 2023. Although this upward trend is encouraging, it underscores that substantial progress is required given the NHS Long Term Plan's target of 75% early-stage diagnoses by 2028.

Encouragingly, peri-operative outcomes continue to improve. 90-day postoperative mortality has decreased - falling from 3.1% in 2019 to 2.5% in 2023. A similar trend was observed for 2-year survival after surgery which increased from 82.3% in 2020/21 to 84.9% in 2021/22.

While the utilisation of adjuvant chemotherapy for people with stage 3 colon cancer has remained stable at 66%, substantial variation remains between units with 11% of NHS trusts/MDTs falling below the 55% local target. While this may be clinically appropriate, units with utilisation below 55% are encouraged to conduct individual patient analysis to review the rationale for not offering treatment against evidence-based guidelines. With one in five patients experiencing acute severe toxicity after chemotherapy, efforts to increase chemotherapy utilisation must be balanced against this risk.

Substantial variation persists in rectal cancer management, with rates of neo-adjuvant therapy in those undergoing a major resection ranging from 6-87% across NHS trusts/MDTs. Given the evolving evidence base which is resulting in increased utilisation of Total Neo-adjuvant Therapy (TNT), as well as an increased utilisation of non-operative management NBOCA endorses calls for updated NICE guidance to standardise best practice, based on high quality preoperative staging.

With nearly two in five people having an unclosed diverting ileostomy 18-months after anterior resection, NBOCA has identified this as a key priority for Quality Improvement. [The Close It Quick QI Collaborative](#) aims to address this deficit and improve patient care and patient experience. Participants gain access to expert coaching, benchmarking tools, and peer collaboration to drive local improvements in ileostomy closure pathways.

The findings of this report are intended to guide improvements in service delivery and patient outcomes and can serve as a resource for patient charities and support groups. It also demonstrates examples of best practice at a provider-level, which presents opportunities to learn and share these best practice achievements. The rollout of the [NBOCA Quarterly Data Dashboard](#) has also been a major step forward, giving NHS trusts and Cancer alliances in England (and in due course for Wales) access to more real-time data to inform local improvement work.

Looking ahead, NBOCA aims to continue enhancing bowel cancer care in England and Wales, by working closely with professional bodies to drive quality improvement. Key priorities include improving the rate of unclosed ileostomy after anterior resection, investigating regional variations in chemotherapy utilisation, and timeliness of care across the patient pathway.