

Foreword

It is a privilege to introduce the 2026 National Bowel Cancer Audit State of the Nation Report.

This report provides an important opportunity to pause and ask a simple question: **are we delivering the quality of bowel cancer care that every patient should expect, wherever they live and however they access the system?**

There is much here to be proud of. Surgical mortality remains low, with 90-day mortality following major resection at 2.6%, while two-year overall survival has continued to improve. Minimally invasive surgery now accounts for 77% of major resections, reflecting the continued evolution of colorectal surgery and the increasing adoption of robotic approaches. These are genuine achievements, and they demonstrate what can be delivered when clinical expertise, technology, organisation and evidence come together.

But an important message from this report is perhaps not the progress we have made but the variation that remains.

Variation is not necessarily synonymous with poor care. Patients are different, and personalised treatment should inevitably lead to some variation in clinical decisions. The challenge is to distinguish appropriate variation from **unwarranted variation** — differences that arise because of where a patient lives, how they enter the system, local resources, access to expertise, or differences in clinical practice. The scale of some of the variation described in this report is concerning.

For rectal cancer, the proportion of patients receiving neoadjuvant radiotherapy varies from 0% to 84% between providers. In stage 3 colon cancer, the proportion receiving adjuvant chemotherapy ranges from 45% to 88%. These figures do not, on their own, tell us the whole story, however, they do tell us that we need to understand much more clearly **why** these

differences exist — and whether patients are receiving genuinely equivalent opportunities for the best possible outcome.

The data on timings of ileostomy reversal is concerning. Almost half of patients remain with an unclosed ileostomy at 12 months, and 34% at 18 months, with provider-level variation ranging from 13% to 83%. Behind those percentages are patients living with a stoma for longer than intended, with implications for quality of life, wellbeing and potentially long-term outcomes. The Close It Quick collaborative is therefore an important response. But the wider lesson is even more important: we must become better at measuring the entire patient journey, rather than judging success at a single point in time.

The report also highlights one of the most persistent challenges in colorectal cancer — the profound difference between elective and emergency care. Ninety-day mortality following emergency resection was 9.2%, compared with 1.5% following elective surgery. That is a six-fold difference. We should not accept this simply as an unavoidable consequence of emergency presentation. The answer begins before the operating theatre: earlier diagnosis, better recognition of disease, timely referral, optimisation of patients before treatment, effective management of complications and, where appropriate, strategies that allow us to convert emergency presentations into safer, planned pathways.

This is particularly relevant as the epidemiology of bowel cancer continues to change. The proportion of patients diagnosed under the age of 50 has increased, while emergency presentation remains stubbornly high. Screening expansion is beginning to change the landscape, but earlier diagnosis cannot be considered

solely a screening issue. It is a whole-system responsibility, involving primary care, diagnostics, pathology, radiology, endoscopy, multidisciplinary teams and specialist treatment.

The report also points towards a future in which biology matters as much as anatomy. Progress in mismatch repair and microsatellite instability testing is encouraging, but genomic assessment remains incomplete and uneven. RAS and BRAF assessment, broader molecular profiling and emerging biomarkers will increasingly influence treatment selection, prognostication and surveillance. Technologies such as circulating tumour DNA may ultimately allow us to identify minimal residual disease and tailor treatment with far greater precision.

But technology must always serve a purpose. Robotic surgery, artificial intelligence, molecular diagnostics and increasingly sophisticated imaging are not ends in themselves. Their value will be measured by whether they help us diagnose cancer earlier, select treatment more intelligently, reduce complications, preserve function, improve quality of life and, ultimately, help more patients live longer.

A national audit should do more than tell us the national average. The real value of NBOCA is its ability to illuminate differences between organisations and pathways, stimulate difficult conversations and provide clinicians and systems with the information needed to improve. The next phase of the Audit will be particularly important. Understanding stage 4 treatment and end-of-life care, recurrence, organ preservation, access to clinical trials and the impact of new biomarkers will help move the focus further towards outcomes that matter to patients across the whole continuum of care.

We should therefore read this report with **confidence** — because there has been real and measurable progress and **concern** — because too many patients still experience very different care depending on where and how they enter the system.

Our ambition should not simply be to raise the national average. It should be to **reduce unwarranted variation, close the gaps in outcomes and ensure that excellence is not dependent on postcode**. That is the challenge set by this report. And it is a challenge that, collectively, we must meet.



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