NBOCA
National Bowel Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

National Bowel Cancer Audit
State of the Nation Report 2026:
Summary of findings for the public and patients

An audit of care received by people diagnosed with bowel cancer, focusing on people diagnosed with or undergoing surgery between 1 January 2024 to 31 December 2024 in England and Wales.

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This report was prepared by the NBOCA Project Team. We would like to thank the NBOCA Patient and Public Involvement Forum which consists of patient and carer representatives, as well as bowel cancer charity representatives, for their invaluable contribution to the formation of this report.

In partnership with:

The Royal College of Surgeons of England is an independent professional body committed to enabling surgeons to achieve and maintain the highest standards of surgical practice and patient care. As part of this it supports audit and the evaluation of clinical effectiveness for surgery. Registered Charity no: 212808.

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.

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

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.

This work uses data that has been provided by patients and collected by the NHS as part of their care and support. For patients 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.

NHS Wales recently implemented Cancer Dataset Forms with the latest implementation date being January 2025. These have been designed to improve the data capture and reporting capabilities of NHS Wales. This implementation has impacted the data quality within NHS Wales. 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.

This report is endorsed by:

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1. Introduction

What is the National Bowel Cancer Audit (NBOCA)?

The National Bowel Cancer Audit (NBOCA) measures the care and outcomes for patients diagnosed with bowel cancer in England and Wales. Bowel cancer includes cancers of the colon and rectum and is the 4th most common cancer. NBOCA aims to improve patient care by highlighting areas where improvements might be made. Whilst no formal reports are produced, some details are publicly available for Scotland and Northern Ireland by following the associated links.

What is this report about?

This report is a summary of the main findings and recommendations in the NBOCA State of the Nation report 2026. Results are about patients diagnosed with or treated for bowel cancer between 1 January 2024 and 31 December 2024[1]. In particular, it describes how care and outcomes have changed over time, and how they vary between hospitals. This report was produced with the NBOCA Patient and Public Involvement Forum, who represent and support the interests of patients.

An explanation of key terms used in this report can be found in section 9. These terms are marked with an asterisk (*) throughout this report.

How does NBOCA improve the quality of care for people with bowel cancer?

The NBOCA Quality Improvement (QI) Programme launched in 2021. Its aim is to support hospitals in the UK to improve the quality of the care received by patients with bowel cancer. NBOCA sets 10 QI targets for hospitals to meet. After describing how people with bowel cancer were diagnosed, the rest of the chapters in this report cover each of the 10 QI targets under the headings **Diagnosis**, **Surgery** and **Chemotherapy* and Radiotherapy***.

What's new?

- Our quarterly data dashboards are publicly available and give up-to-date reporting on data completeness and performance at Trust and by region. Currently these are only available for hospital trusts in England.
- For the first time NBOCA reports time from diagnosis to treatment decision, and from treatment decision to surgery, for people in England diagnosed with stage 1-3 colon cancer.

Important considerations and data sources

Within the report we compare results to previous years, often compared to results from 2021. This year was chosen as the first year in recovering from the COVID-19 pandemic.

This is the third year we use routinely collected data. This is information gathered by hospitals primarily for administrative purposes but includes clinical information like treatments, health conditions and operations. It is always anonymous, so no identifiable information is shared with us.

Previously our data collection relied on clinicians entering information about each person with bowel cancer. The main advantage of routine data is that we can include all people in England and Wales with bowel cancer, without missing anyone. It does however mean that occasionally we don't capture every single piece of information for each person. We are working closely with hospital trusts/MDTs* to improve data completeness.

[1] Where treatment spans over multiple calendar years, patients are included according to either their date of diagnosis or their date of surgery, depending on the QI target being analysed.

2. Recommendations and Key Messages

- Around one in three people have not had their temporary stoma* closed within 18 months of surgery. NBOCA is working to improve this through a quality improvement (QI) collaborative with The Royal College of Surgeons of England – Close It Quick.
- The use of adjuvant chemotherapy* for people with stage* 3 colon cancer varies between hospital trusts, ranging from 45-88%. 8% of hospital trusts/MDTs did not meet the QI target for adjuvant chemotherapy.
- In England 77% of people with bowel cancer with a record of genetic tumour testing had their test within one month of diagnosis. There are gaps in the data and we are working on improving this.
- There continues to be wide variation in the use of neoadjuvant radiotherapy* for people with rectal cancer having surgery. We recommend NICE and professional bodies (ACPGBI*/Royal College of Radiologists*/GIRFT*) undertake a targeted review of the management of rectal cancer.
- People diagnosed with bowel cancer through routine GP referral wait over a week longer from diagnosis to having surgery than those diagnosed through GP urgent suspected cancer referrals. We recommend review of hospital care pathways to make sure everyone is treated quickly.

3. Diagnosis

How many people were diagnosed with bowel cancer?

Altogether, 37,250 people were diagnosed with bowel cancer in England and Wales between 1 January 2024 and 31 December 2024. This is a very slight reduction from the 37,730 diagnosed in the previous year. The proportion of people diagnosed with bowel cancer who were under 50 years of age has increased from 6.3% in 2021 to 7.6% in 2024. NBOCA will study this group over the coming years.

What percentage of people presented with Stage* 1 or 2 bowel cancer?

A key aim of the NHS Long Term Plan, NHS National Cancer Plan for England and the Quality Statement for Cancer in Wales is to increase the proportion of patients diagnosed with stage 1 or 2 cancer, when cancer has not spread to nearby glands or other parts of the body and is easier to successfully treat. The percentage of patients diagnosed with stage 1 or 2 bowel cancer has increased a little over time from 45.5% in 2021 to 46.8% in 2024. This increase is too slow to meet the above mentioned national targets.

Bowel Cancer Screening

NHS bowel cancer screening checks if you could have bowel cancer. In recent years the programme has been extended to invite all people from 50 to 74 years across England and Wales. Additionally, people aged 75 and above can request a screening kit, though they will not routinely be invited. Screening can help prevent bowel cancer or find it at an early stage when it's easier to treat. Click the links to find out more about screening in England and screening in Wales.

Symptom Awareness

Bowel cancer can show signs which are important to look out for and should prompt timely medical attention if experienced. When identified earlier, bowel cancer is more treatable. Symptoms to beware of include:

- Blood in the stools, toilet bowl or on the paper.
- Changes in bowel habit – either more frequent/looser OR less frequent/harder
- Feeling of incomplete emptying after a bowel movement
- Abdominal pain
- Losing weight without trying to
- Decreased appetite
- Persistent unexplained tiredness

For a complete list of symptoms and further information please use the below links:

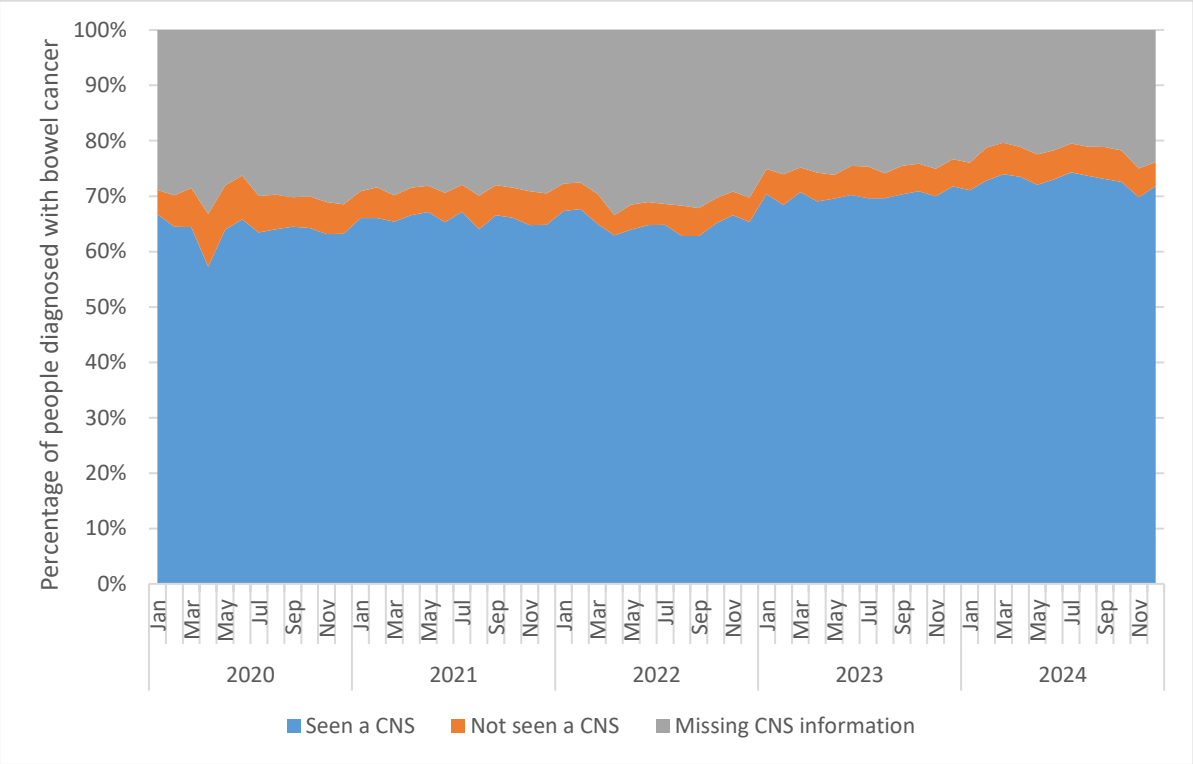
Cancer Research UK | NHS | Bowel Research UK | Bowel Cancer UK

Quality Improvement Target 1:

For more than 95% of people to be seen by a Clinical Nurse Specialist* (CNS)

Improving, but below target ↔

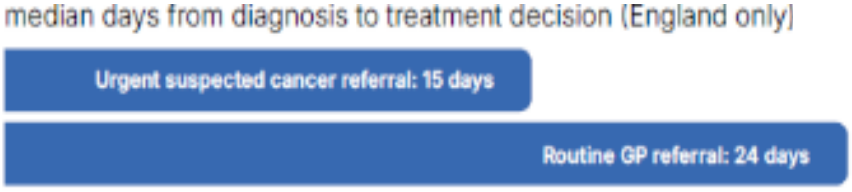
It is recommended that all people with bowel cancer meet with a CNS within 90 days of diagnosis. This is for advice and support throughout their treatment. 77% of people had complete data, of which 93.1% met a CNS within 90 days of their diagnosis. Across England and Wales 59% of hospital trusts/MDTs met the 95% CNS QI target. This target highlights that data is not always available to NBOCA on every person.



Time from diagnosis to treatment decision

Differences by how people were referred to hospital ✕

For the first time we report delays from diagnosis to surgery for people diagnosed with stage* 1-3 colon cancer in 2024. People diagnosed via urgent suspected cancer pathways waited on average 15 days from diagnosis to a treatment decision. In comparison people diagnosed via a routine GP referral waited on average 24 days (9 days longer) from diagnosis to a treatment decision. Given that this aspect of care is all within the hospitals' control, we recommend a review of hospital care pathways to make sure everyone is treated quickly.



4. Surgery

Quality Improvement Target 2:

Trusts/MDTs to perform 20 or more rectal cancer operations per year.

Progress ✓

This QI target is to make sure surgeons undertaking rectal cancer surgery carry out these operations regularly. In 2024, 83% of trusts/MDTs met this QI target, which continues to rise over time and is a modest increase from 78% last year.



83% (2024)

Quality Improvement Target 3:

For fewer than 5% of people to die within 90 days of major bowel cancer surgery.

Continuously meeting target ✓

21,245 people had major bowel cancer surgery in 2024. The proportion of people who died within 90 days of their operation was 2.6%, which remains consistently below the QI target of 5% and is an improvement when compared to 2.9% in 2021.

2.9% (2021)
to
2.6% (2024)

Quality Improvement Target 4:

For fewer than 10% of people to have an unplanned return to the operating theatre within 30 days of major bowel cancer surge

Low and stable ✓

Returning to the operating theatre is a measure of surgical com
Whilst some are unavoidable and unforeseen, this QI target allo
monitoring of surgical standards to ensure they are kept high. T
proportion of people who needed to return to the operating th
30 days of their bowel cancer surgery due to a complication has
stable and low in recent years.

6.9% (2021)
to
6.8% (2024)



11.1% (2021)
to
11.2% (2024)

Quality Improvement Target 5:

For fewer than 15% of people with an unplanned readmission to hospital within 30 days after major bowel cancer surgery.

Returned to previous levels ✓

This is another QI target which is monitored to broadly reflect complications after surgery. These may cover a variety of reasons for needing to come back to hospital on an unplanned basis. In 2023 this rose to 11.9% of people being admitted to hospital on an unplanned basis in the 30-days after a major bowel cancer operation. Reassuringly this has returned to levels found in 2021.

Quality Improvement Target 6:

Less than 35% of people with an unclosed temporary stoma 18 months after anterior resection*.

Quality improvement in action ✓

The proportion of people whose temporary stoma* has not been closed 18 months after their anterior resection* was 40% for those having surgery in 2023/24. This is the first time it has returned to levels from before the COVID-19 pandemic.

In the same group, 49% had an unclosed temporary stoma* at 12 months. Having a temporary stoma is known to affect quality of life and long-term bowel function if stoma closure is delayed. To address this issue we have collaborated with The Royal College of Surgeons of England to roll out a national quality improvement initiative *'Close It Quick'*. It launched in November 2025 and aims to continue to drive improvements in temporary stoma closure.

This QI target is reported over a 5-year period because of the lower numbers of people undergoing this treatment.



34%

unclosed temporary stoma

For people with a temporary ileostomy consider discussing with your clinical team:

When can I expect my stoma to be closed?

What needs to happen before then?

5. Chemotherapy and Radiotherapy



67%

Quality Improvement Target 7:

More than 55% of people with stage 3 colon cancer receiving adjuvant chemotherapy*.

Stable delivery of adjuvant treatment ✓

Guidelines recommend that people who have stage 3 cancer within the colon should be offered adjuvant chemotherapy* in the months after recovering from surgery as this improves their chances of survival in the longer term. Use of adjuvant chemotherapy* appears to have changed little over time, and was 67% in 2024, compared to 66% in 2023 and 2022 and 68% in 2021.

19%

Range 3-37%

Quality Improvement Target 8:

Less than 30% of people experience severe acute toxicity* after adjuvant chemotherapy for stage 3 colon cancer.

Stable with ongoing variation ↔

Chemotherapy has side effects, or 'toxicities' which can make people unwell e.g., diarrhoea, vomiting, and infections. "Severe acute toxicity"* is defined as any toxicity which requires an overnight stay in hospital. Overall, 19% of people receiving adjuvant chemotherapy had severe acute toxicity*. There continues to be variation between hospital trusts / MDTs (ranging from 3 to 37%). This suggests differences in how decisions are made about adjuvant chemotherapy between trusts/MDTs in this group of people.



34% (2021) to 27% (2024)

Quality Improvement Target 9:

10-60% of people with rectal cancer receiving neo-adjuvant radiotherapy.

Persistent wide variation ↔

Some people have treatment before surgery to shrink rectal cancers. For people undergoing major surgery for rectal cancer in 2024, 27% received neo-adjuvant* therapy, with 87% of trusts meeting the QI target. However, there was very wide variation from 0% to 84% between hospital trusts/ MDTs which was even wider than last year. There is no nationally agreed guideline on this aspect of care and we call on NICE* to address this.

6. Holistic Care

Quality Improvement Target 10:

More than 80% of people surviving at least two years after major surgery.

Target achieved ✓

For people who had major bowel cancer surgery in 2022, 2-year survival was 85.3%. There has been ongoing gradual improvement in recent years. This is likely to reflect progress across peri-operative care, surgical advances and medical treatments. This target must be reported with a 2-year lag to allow enough time to pass for us to review the target.

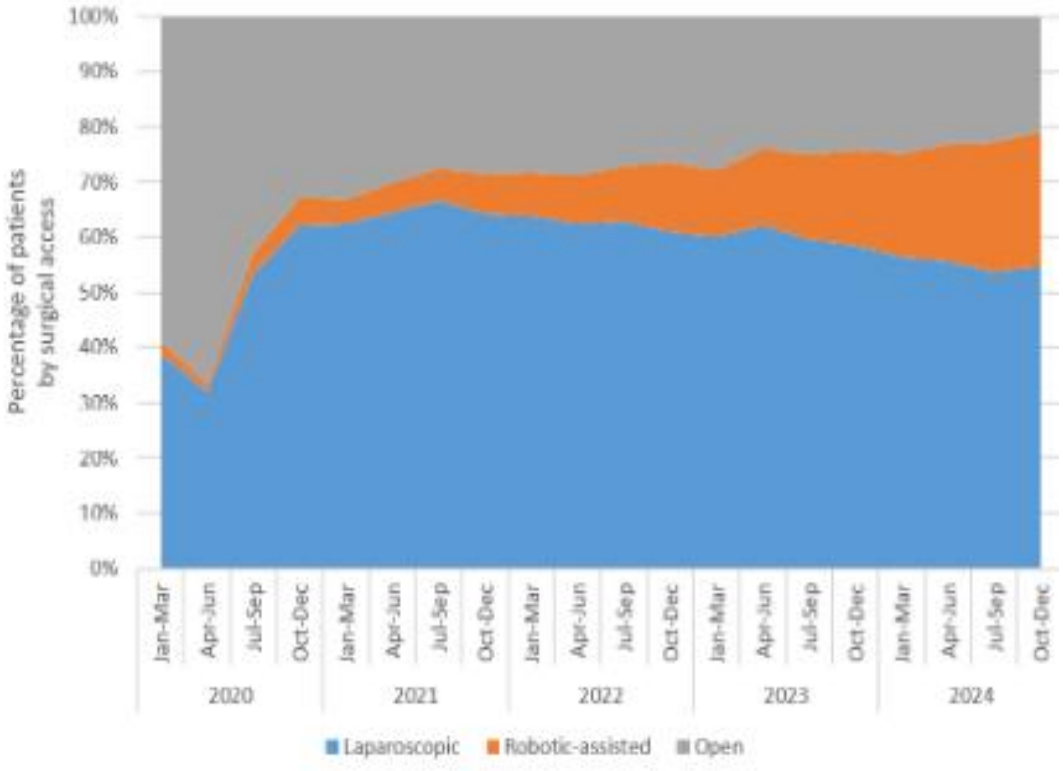
84.4% (2019) to 85.3% (2022)

7. The Future

Changes in how surgery is carried out

Over time, with advances in medicine and technology we are seeing a change in how some aspects of bowel cancer treatment are provided. We have developed **a Quality Improvement target of "more than 50% of all bowel cancer resections to be undertaken via keyhole surgery techniques".**

Minimally invasive* ("keyhole") surgery in major bowel cancer operations



70% (2021) to 77% (2024)

There is increasing evidence that keyhole surgery rather than open surgery can improve outcomes for people with colon or rectal cancer. Keyhole can be either laparoscopic* or robotic-assisted surgery*.

96% of trusts/MDTs met our local target, delivering over half of major bowel cancer operations through keyhole surgery. Since the COVID-19 pandemic, keyhole surgery continues to be widely used, with 77% of people having a record for this method of surgery during 2024. The graph also shows robotic-assisted surgery* has increased quickly in the last few years, to 22% of major bowel cancer operations, a trend seen internationally.

We suspect that some keyhole surgery is being recorded as open surgery with our relatively recent change in how data is collected. As we continue to work closely with trusts/MDTs we hope this data will also improve.

Early-onset* bowel cancer

A previous NBOCA short report highlighted that people with early-onset* bowel cancer were more likely to present as emergencies with advanced cancer and were disproportionately represented among socioeconomically deprived populations. Addressing early-onset* bowel cancer has been identified as a key priority by ACPGBI, and improving treatment pathways and outcomes for this patient group remains an important focus of NBOCA.

8. Further information

There are many different NBOCA resources which can be accessed via the website.

- All annual and patient reports
- Individual hospital trust results
- Quality improvement resources
- Published scientific papers

Follow us on LinkedIn National Bowel Cancer Audit (NBOCA) | LinkedIn to keep up-to-date with NBOCA and our work. Contact us at NBOCA@rcseng.ac.uk.

 **Find out more** For general information about bowel cancer, and how patient information is used to improve outcomes, please visit the following websites.	**General information about bowel cancer** · Bowel Cancer UK · Bowel Research UK · NHS Bowel Cancer Screening Programme – England · Bowel Screening Wales · Cancer Research UK · NHS Choices · Macmillan **How patient information is used:** use MY data

Side Effects

If you have chemotherapy or radiotherapy for bowel cancer, you should ask your bowel cancer team what side effects to look out for and who to get in touch with if you have concerns.
Bowel Cancer UK and Cancer Research UK have information on the potential side effects.

9. Explanation of terms used throughout this report

Abdomino-perineal excision of the rectum (APER) - an operation to remove the entire rectum and anal canal.

Adjuvant chemotherapy - chemotherapy given after an operation.

Association of Coloproctologists of Great Britain and Ireland – the professional body representing colorectal surgeons in Great Britain and Ireland.

Anterior resection - an operation to remove part, or all, of the rectum.

Chemotherapy - drug therapy used to treat cancer. It may be used alone, or in combination with other types of treatment (for example surgery or radiotherapy).

English Cancer Alliance – cancer services in England are organised geographically. Each Cancer Alliance contains a particular set of hospitals.

Early-onset bowel cancer – this term is used to describe when bowel cancer is diagnosed in people under the age of 50 years.

GIRFT (Get It Right First Time) – NHS England initiative to undertake reviews in specific aspects of healthcare to identify areas for improvement.

Laparoscopic surgery – one type of minimally invasive or keyhole surgery performed through small cuts in the skin instead of the larger cuts used in open surgery.

Local excision - a procedure done with instruments inserted through the anus (often during a colonoscopy), without cutting into the skin of the abdomen to remove just a small piece of the lining of the colon or rectum wall.

Temporary stoma (loop ileostomy) - a type of stoma involving the small bowel, often used for people who have an anterior resection and is not necessarily permanent.

Multidisciplinary team (MDT) - an MDT is a group of bowel cancer experts based within a hospital who discuss and plan the treatment of every person with bowel cancer. The MDT includes surgeons, cancer specialists, nurses, radiologists, histopathologists and palliative care physicians.

Neo-adjuvant – chemotherapy and/or radiotherapy given before an operation.

NICE – National Institute for Health and Care Excellence. This is the organisation responsible for producing guidance for the NHS and wider health and care systems.

Radiotherapy - the treatment of disease, especially cancer, using X-rays or similar forms of radiation. Long-course and short-course radiotherapy include different intensities and durations of treatment.

Robotic-assisted surgery – a relatively new advancement in surgery that allows surgeons to perform procedures with enhanced precision using robotic instruments. It allows surgeons to control surgical instruments whilst at a special console during the operation.

Royal College of Radiologists – The professional membership body supporting education, training and professional standards for radiology doctors.

Screening – the aim of screening is to try to detect cancers early. People aged 50-74 are invited to take part in bowel cancer screening every two years. They do this by providing a poo sample which is checked for blood.

Stage - staging is a way of describing the size of a cancer and how far it has grown. Staging is important because it helps decide which treatments are required. Stage 1 and 2 cancers are localised to the bowel. Stage 3 cancers have spread to the lymph glands. Stage 4 cancers have spread to other parts of the body, for example, the liver or lungs.

Stoma - a surgical opening in the abdomen through which the bowel is brought out onto the surface of the skin. Colostomy and ileostomy are types of stoma. Stomas may be temporary, meaning that they can be reversed (bowel put back inside the abdomen), or permanent, meaning that they cannot be reversed.

Toxicity – chemotherapy often has side effects which can make you unwell. This is called toxicity and can be of varying severity. It includes, for example, diarrhoea and vomiting.