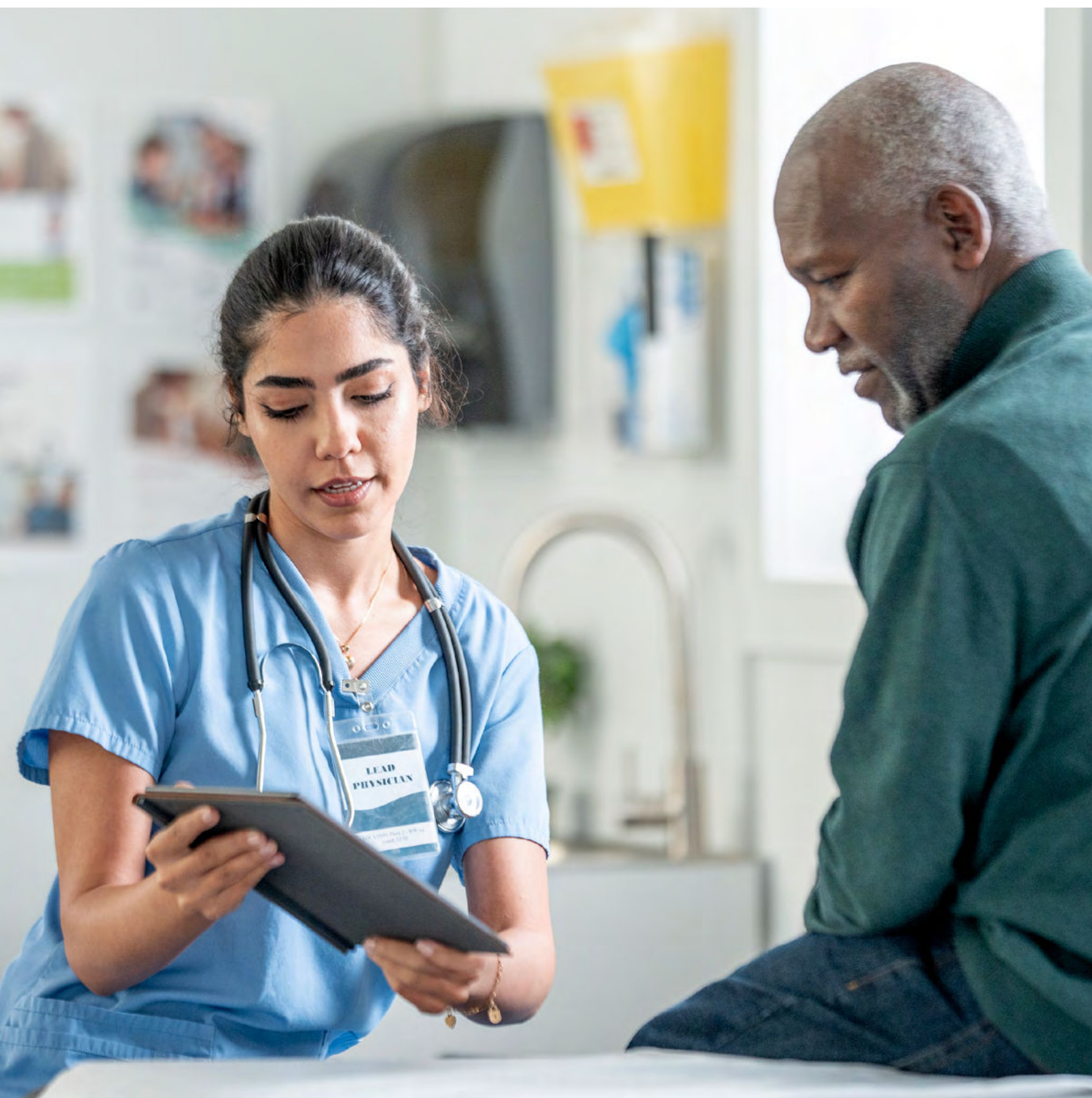

National Bowel Cancer Audit State of the Nation Report 2026

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

Published October 2026



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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
Angela Kuryba, Quantitative Analyst
Karen Darley, Senior Project Manager
Adil Rashid, Clinical Fellow
Leo Watton, Clinical Fellow

With review and input from:

[NBOCA Clinical Advisory Group](#)
[NATCAN Executive Team](#)



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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 have been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data are 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
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Performance and
Improvement

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.

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1. Introduction

The National Bowel Cancer Audit ([NBOCA](#)) measures the quality of care and outcomes for people diagnosed with bowel cancer in England and Wales. This report focuses on people diagnosed with or undergoing surgery for bowel cancer in 2024.

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 for NHS trusts in England and multidisciplinary teams (MDTs) in Wales. The aim is to increase the consistency of access to treatments and stimulate improvements in care and outcomes for people with bowel cancer.

In this report, we present the results for our ten key performance indicators (PIs), as shown in Table 1 (page 5), and set out recommendations to support performance improvement.

We use [data routinely collected](#) by the NHS, using the nationally mandated flow of data from hospitals to the National Disease Registration Service (NDRS) in NHS England and the National Cancer Team, NHS Wales Performance and Improvement. Please refer to the NBOCA [Methodology Supplement](#) for comprehensive details regarding data sources and methodology. Supporting materials, including our [Supplementary Report](#), [Glossary](#), [Local Action Plan Template](#), [Outlier Policy](#), [each NHS provider's results for performance indicators and data quality metrics](#), [Organisations excluded from the analyses](#) and our [Patient and Public Summary Report](#) are available on the NBOCA State of the Nation report 2026 [webpage](#).

In addition to this annual report, we publish quarterly updates on performance indicators and data quality on the [NBOCA Data Dashboard](#) for NHS trusts in England, to be able to track progress alongside local quality improvement initiatives.

2. Infographic

Summary of results for people diagnosed with or undergoing surgery for bowel cancer in England and Wales between 1 January 2024 and 31 December 2024

37,250 people diagnosed with bowel cancer in England and Wales between 1 January 2024 and 31 December 2024.

Key: **E** England (E) **W** Wales (W) **●** E&W Combined

E England: 35,069 **W** Wales: 2,181

Stage at diagnosis

% of people presenting with stage 1 or stage 2 cancer¹

2021 **2024**
E 46.1% → 47.1%

W 36.6% → 41.3%

Route to diagnosis

% people diagnosed via emergency admission

2022 **2024**
18.6% → 18.7%



Time to diagnosis

median days from diagnosis to treatment decision (England only)³

Urgent suspected cancer referral: 15 days

Routine GP referral: 24 days

Seen by Clinical Nurse Specialist

% people with a diagnosis of bowel cancer seen by a Clinical Nurse Specialist (target >95%) (PI 1)⁴

2022 **2024**
93% → 93%



Peri-operative care

Rectal cancer operations

% of trusts/multidisciplinary teams (MDTs) that performed ≥ 20 major rectal cancer operations (target ≥20) (PI 2)

2023 **2024**
78% → 83%

90-day mortality

90-day mortality among people undergoing surgery (target <5%) (PI 3)

2021 **2024**
2.9% → 2.6%

Unplanned return to theatre

% of people with an unplanned 30-day return to theatre after surgery (target <10%) (PI 4)

2021 **2024**
6.9% → 6.8%



Unplanned readmission

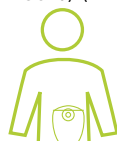
% of people with an unplanned 30-day readmission after surgery (target <15%) (PI 5)

2021 **2024**
11.1% → 11.2%

18-month unclosed ileostomy

% of people with an unclosed diverting ileostomy 18 months after anterior resection (target <35%) (PI 6)⁵

37%
Variation by provider:
13%-83%
(1 April 2019 to
31 March 2024)



Minimally invasive surgery

% of people who underwent major colorectal cancer surgery with a minimally invasive approach (laparoscopic or robotic) (target >50%)

2021 **2024**
70% → 77%



Oncological management

Adjuvant chemotherapy

% of people who received adjuvant chemotherapy for stage 3 colon cancer (target >55%) (PI 7)

(Surgery between 1 April 2022 and 31 December 2024)



67%
Variation by pro-
vider: 45%-88%

Severe acute toxicity

% of people who experienced severe acute toxicity after adjuvant chemotherapy (target <30%) (PI 8)

(Surgery between 1 April 2022 and 31 December 2024)

19%
Variation by provider:
3%-37%

Neo-adjuvant radiotherapy

% of people with rectal cancer who received neo-adjuvant radiotherapy treatment (target 10%-60%) (PI 9)



2021 **2024**
34% → 27%
Variation by provider:
0%-84%

Two-year survival

Two-year survival rate among people undergoing major resection (target >80%) (PI 10)
(Year denotes year of surgery)

2019 **2022**
84.4% → 85.3%

PI: NBOCA Performance Indicator (for a list of the ten NBOCA performance indicators, see main report) 1. Data available for 89.9% of patients in England and 91.4% of patients in Wales 2. Data not available for Wales 3. Analysis not available for Wales 4. Data available for 76.4% of patients in England and 93.8% of patients in Wales 5. This indicator focuses on a small subgroup of patients (patients undergoing anterior resection with a diverting ileostomy), so a wider reporting period is required to ensure sufficient patient numbers for reliable provider-level reporting. *Variation shown is the range across providers.

3. Recommendations

The following recommendations were developed in collaboration with the [NBOCA Clinical Advisory Group](#) based on key findings in this report. The recommendations are intended for healthcare providers and commissioners in England and Wales, including trusts, Cancer Alliances, and health boards. The [NBOCA local quality improvement action plan](#) contains suggested actions to address the recommendations described below.

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
1. Increase the proportion of people undergoing timely ileostomy closure after anterior resection, recognising that the patient's cancer treatment pathway is not complete until ileostomy reversal: - Identify and address local barriers to timely closure through process mapping (e.g. access to theatre/ radiological investigation). - Participate in local and national quality improvement initiatives aimed at reducing delays to ileostomy closure, including the Royal College of Surgeons of England's Close It Quick Collaborative.	England: Cancer Alliances working with NHS trusts Wales: health boards	Only 37% of NHS trusts/MDTs met the local target of fewer than 35% of patients having an unclosed diverting ileostomy 18 months after anterior resection. Substantial between-unit variation remained, ranging from 13% to 83%.	Goal #2: Improving peri-operative care	ACPGBI: Guidelines for the Management of Cancer of the Colon, Rectum and Anus National Bowel Cancer Audit Quality Improvement Plan Figure 3: Example driver diagram for indicator "Ileostomy closure after rectal cancer resection" Close It Quick – Ileostomy Closure QI Collaborative
2. Case selection should be optimised in units giving adjuvant chemotherapy to less than 55% of people with stage 3 colon cancer: - Develop local action plans to increase rates of chemotherapy while maintaining low levels of severe toxicity. - Integrate geriatric expertise and rehabilitation into shared chemotherapy decision making.	England: Cancer Alliances working with NHS trusts Wales: health boards	In 10 (8%) NHS trusts/MDTs, less than 55% of people with stage 3 colon cancer received adjuvant chemotherapy. Substantial between-unit variation in the use of adjuvant chemotherapy persists, ranging from 45% to 88%.	Goal #3: Improving oncological care	NICE Guidelines: Bowel Cancer Measuring variation in the quality of systemic anti-cancer therapy delivery across hospitals: A national population-based evaluation. 2023 British Geriatrics Society/Royal College of Radiologists. Implementing frailty assessment and management in oncology services
3. Optimise neo-adjuvant radiotherapy and straight to surgery treatment pathways, with improved radiological staging, for people with rectal cancer: - Protocols should be based on high-quality radiological staging using standardised reporting templates. - Support equitable access to organ preservation strategies and participation in clinical trials. - Engage with GIRFT's national programme of process mapping in delivery of rectal cancer treatment. - Develop national consensus-driven guidelines for rectal cancer to inform MDT recommendations and shared decision-making with patients. - Engage with NICE, and professional bodies (ACPGBI/ Royal College of Radiologists/GIRFT), to undertake a targeted review of the management of rectal cancer.	England: Cancer Alliances working with NHS trusts Wales: health boards	Overall, 27% of people received neo-adjuvant radiotherapy for rectal cancer with wide variation between NHS trusts/MDTs ranging from 0% to 84%.	Goal #3: Improving oncological care	MRI to guide clinical management of rectal cancer: updated consensus recommendations. 2026 Neo-adjuvant and Non-operative Management of Rectal Cancer Guidelines Watch-and-wait after neo-adjuvant treatment in rectal cancer: a practical guide to management and surveillance. 2023

Recommendation	Audience	Report Findings	Quality Improvement Goal	National Guidance/Standards/Resources
4. Optimise histopathology pathways to provide timely genomic assessment where clinically appropriate to inform personalised treatment options, improve access to clinical trials and identify people with Lynch syndrome: • Increase mismatch repair (MMR) or microsatellite instability (MSI) testing in stage 1 to 4 cancer. • Deliver RAS and BRAF assessment in stage 4 cancer, with consideration of broader molecular profiling for targeted therapies.	England: Cancer Alliances working with NHS trusts and Genomic Laboratory Hubs Wales: health boards All Wales Medical Genomics Service	The proportion with a record of MMR testing increased from 45% in 2019 to 60% in 2024. The proportion tested within one month of diagnosis increased from 66% (2019) to 77% (2024).	Goal #4: Improving management of stage 4 disease	NICE Guidelines: Bowel Cancer Guidelines for the management of hereditary colorectal cancer The National Cancer Plan for England (Section 3, Action 17) The Royal College of Pathologists Dataset for histopathological reporting of colorectal cancer
5. Ensure timely treatment decision-making, regardless of referral route, following a diagnosis of bowel cancer: • Review secondary care pathways to understand and address system-level delays from diagnosis to treatment decision-making for people diagnosed following routine GP referral. • Identify and address sources of delay, which may include patient tracking, access to radiological investigations, and streamlining MDT decision-making.	England: NHS England, Cancer Alliances working with NHS trusts Wales: health boards	People diagnosed through routine GP referrals wait over a week longer for treatment decision than those diagnosed following a GP urgent suspected cancer referral.	All	Cancer treatment delays need systematic attention. 2026 Cancer decision making needs a radical rethink. 2025 NHS England — National cancer waiting times monitoring dataset guidance
Several recommendations reinforce priorities identified in the NBOCA State of the Nation Report October 2025, reflecting their ongoing importance. Additional implementation strategies have been proposed to stimulate improvements.				

4. Results for England and Wales

4.1 Quality improvement

Each of NBOCA's ten performance indicators 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. Reflecting continuous improvements, local targets were revised for three indicators in this year's report: 90-day post-operative mortality was reduced

from <6% to <5%, two-year overall survival following bowel cancer resection was increased from >70% to >80%, and severe acute toxicity following adjuvant chemotherapy for stage 3 colon cancer was reduced from <33% to <30%.

The ten performance indicators, the corresponding local target and the proportion of NHS trusts/MDTs meeting each target are reported in Table 1. NBOCA provides NHS trusts/MDTs with their [results](#) to [facilitate local quality improvement](#) strategies.

Table 1. NBOCA performance indicators (PIs) with national and local results, England and Wales

Performance indicator	Local Target (LT)	% of eligible NHS trusts/MDTs meeting LT	National Result	Reporting period for England* and Wales#
PI 1: People with bowel cancer seen by Clinical Nurse Specialist	>95%	59%	93%	People diagnosed with bowel cancer, 01/01/24 – 31/12/24
PI 2: NHS trust/multidisciplinary team (MDT) volume of people undergoing rectal cancer surgery	≥20 per year	83%	N/A**	People who underwent rectal cancer surgery, 01/01/24 – 31/12/24
PI 3: 90-day mortality among people undergoing major resection**	<5%	92%	2.6%	People who underwent major resection, 01/01/24 – 31/12/24
PI 4: 30-day unplanned return to theatre among people undergoing major resection**	<10%	91%	6.8%	
PI 5: 30-day unplanned readmission among people undergoing major resection**	<15%	84%	11.3%	
PI 6: Proportion of people with unclosed diverting ileostomy 18 months after anterior resection**	<35%	37%	40%	People who underwent anterior resection with diverting ileostomy, 01/04/19 – 31/03/24
PI 7: People with stage 3 colon cancer receiving adjuvant chemotherapy	>55%	92%	67%	People who underwent major resection, 01/04/22 – 31/12/24
PI 8: Severe acute toxicity after adjuvant chemotherapy for people with stage 3 colon cancer**	<30%	94%	19%	
PI 9: People with rectal cancer undergoing major resection receiving neo-adjuvant treatment	10%-60%	86%	30%	People who underwent rectal cancer surgery, 01/01/24 – 31/12/24
PI 10: Two-year survival rate among people undergoing major resection**	>80%	86%	85.3%	People who underwent major resection, 01/04/22 – 31/12/22

* Risk-adjusted indicator † Subject to [NBOCA Outlier Policy](#)

^ Data for England: National Cancer Registration Dataset (NCRD) and Rapid Cancer Registration Dataset (RCRD)

Data for Wales: Cancer Network Information System Cymru (CaNISC) or Cancer Dataset Form (CDF)

** Number of rectal cancer resections cannot be reported as % of all people.

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.

Please refer to the NBOCA [Methodology Supplement](#) for comprehensive details regarding data sources and methodology

The local target met by the fewest NHS trusts/MDTs continues to be '≤35% adjusted 18-month unclosed ileostomy', with only 37% of NHS trusts/MDTs meeting the target. In response, NBOCA, in collaboration with the Royal College of Surgeons of England and ACPGBI, has launched the pilot phase of [Close It Quick](#), a quality improvement collaborative designed to optimise ileostomy closure rates through:

- Structured support from QI experts to facilitate process mapping, identify barriers, and optimise pathways.
- A data-driven intervention providing participating sites access to a QI dashboard to measure improvements.
- Peer-to-peer learning to share best practice, reduce system pressures and improve patient outcomes.

4.2 Characteristics of people with bowel cancer

Characteristics of the 37,250 people diagnosed with bowel cancer during 2024 (in England (35,069) and Wales (2,181)) are outlined in Table 2 and [Supplementary Table 1](#). The proportion of people aged under 50 increased from 6.3% in 2021 to 7.6% in 2024, consistent with the growing concern regarding early-onset colorectal cancer. A previous [NBOCA report](#) found that these patients were more likely to present as emergencies and with advanced disease and were disproportionately represented among socioeconomically deprived populations. Addressing early-onset colorectal 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.

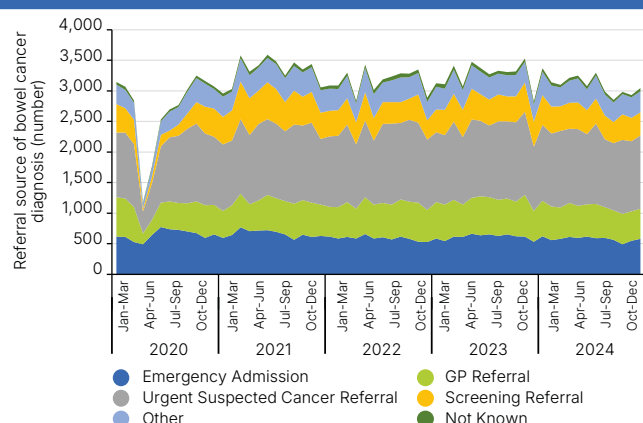
GP referral remains the most common route to diagnosis, accounting for more than half (55.4%) of bowel cancer diagnoses in 2024 in England and Wales (Figure 1). In England, approximately 40% of this total is via "Urgent Suspected Cancer Referrals" (previously known as Two Week Wait) and 15% via other GP referral. Almost one in five people (18.7%) continue to be diagnosed following an emergency presentation, which is associated with poorer outcomes. Despite national efforts to promote earlier diagnosis, little progress has been made in reducing emergency presentations over recent years, with the proportion remaining unchanged from 18.6% in 2022. This ongoing challenge was highlighted in [Bowel Cancer UK's "Behind the Emergency" report](#), which presents the experiences of people diagnosed with bowel cancer following an emergency presentation.

Approximately one in four patients aged 60–74 years were diagnosed through bowel cancer screening, with rates remaining stable between 2022 (26.7%) and 2024 (26.0%). Among patients aged 50–59 years, the proportion diagnosed through screening increased from 8.8% in 2022 to 21.1% in 2024, reflecting the phased expansion of age groups targeted by [NHS bowel cancer screening in England and Wales](#). Variation by England Cancer Alliances and Wales is shown in [Supplementary Figure 1](#).

Both the [NHS Long Term Plan](#) and the [National Cancer Plan for England \(Section 3 A Global Leader in Cancer Outcomes by 2035, Metrics to measure earlier diagnosis\)](#) aim to increase the proportion of cancers diagnosed at stage 1 or 2. The detection of earlier, more treatable cancer is also a focus of the [Quality Statement for Cancer](#) in Wales. Nationally (in England and Wales) amongst patients with available staging data, the proportion diagnosed with stage 1 or 2 bowel cancer increased marginally from 45.5% in 2021 to 46.8% in 2024 ([Supplementary Figure 2](#)). However, in Wales the increase is more significant increasing

from 36.6% in 2021 to 41.3% in 2024, getting closer to England (46.1% in 2021 to 47.1% in 2024). In 2024, this proportion ranged from 37.8% to 50.6% by England Cancer Alliances and Wales ([Supplementary Figure 3](#)).

Figure 1. Number of people diagnosed with bowel cancer in England and Wales between 1 January 2020 and 31 December 2024, by referral source.



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

Table 2. Characteristics of the 37,250 people diagnosed with bowel cancer between 1 January 2024 and 31 December 2024 in England and Wales.

		Number	%
Total number of people		37,250	
Gender	Male	20,473	55.0
	Female	16,777	45.0
	Missing (% of total)	0 (0.0)	
Age-group	<50 yrs	2,821	7.6
	50–59 yrs	5,031	13.5
	60–74 yrs	13,502	36.2
	75–79 yrs	5,992	16.1
	80–84 yrs	5,104	13.7
	85+ yrs	4,800	12.9
	Missing (% of total)	0 (0.0)	
Ethnicity	White	31,724	92.5
	Mixed/Multi Ethnic	205	0.6
	Asian	1,070	3.1
	Black	719	2.1
	Other	579	1.7
	Missing (% of total)	2,953 (7.9)	
Index of Multiple Deprivation (Quintile)	1 (Most deprived)	6,018	16.2
	2	6,839	18.4
	3	7,778	20.9
	4	8,306	22.3
	5 (Least deprived)	8,284	22.3
	Missing (% of total)	25 (0.1)	

4.3 Improving the diagnostic pathway

For the first time, NBOCA is reporting delays to surgery within secondary care for people with bowel cancer. In England, people with colon cancer diagnosed following a routine GP referral waited on average over a week longer from diagnosis to treatment decision than those diagnosed following an urgent suspected cancer referral (Table 3).

Table 3. Times from diagnosis to surgery for people diagnosed with stage 1-3 colon cancer in 2024, by route of referral* (England only)**			
Route of referral		Diagnosis to Decision to Treat (Days)	Decision to Treat to Surgery (Days)
	N (%)	Median (IQR)	Median (IQR)
Urgent suspected cancer referral (formerly two week wait)	4,442 (56.1)	15 (9-25)	20 (13-30)
GP referral	842 (10.6)	24 (13-61)	22 (13-31)
Screening	1,930 (24.4)	16 (10-25)	20 (13-30)
Other	707 (8.9)	18 (10-38)	20 (12-29)
All routes	7,921 (100)	16 (10-27)	20 (13-30)
IQR: interquartile range. *Excluding emergency referral, waiting times greater than 180 days and patients where date of diagnosis is on or after the date of surgery are excluded; **Analysis not yet available for Wales			

Performance Indicator and Local Target 1
Where known, more than 95% of people seen by Clinical Nurse Specialist (CNS): 59% of trusts/MDTs

CNS status was recorded for 77.4% of people diagnosed with bowel cancer in 2024 (76.4% in England compared with 93.8% in Wales). Among patients with CNS information available, 93% were seen by a CNS, which has remained stable over time (Supplementary Figure 4).

NICE guidelines recommend mismatch repair (MMR) testing for all people diagnosed with bowel cancer and RAS and BRAF testing for those with stage 4 disease. In England, the proportion of people with histologically confirmed bowel cancer recorded as having undergone MMR immunohistochemistry testing increased from 45% in 2019 to 60% in 2024 (Supplementary Figure 5). This is likely an underestimate as data on microsatellite instability (MSI) testing is not currently available and not all MMR results from pathology reports are received by the cancer

registry. Bowel Cancer UK reported that 90% of patients underwent testing. Overall RAS and BRAF testing rates are not currently reported because submission of genetic data is not mandatory.

Among patients with MMR immunohistochemistry testing recorded in England, the proportion tested within one month of diagnosis increased from 66% in 2019 to 77% in 2024. The proportion classified as MMR deficient (dMMR), changed little over this period, from 15% to 16%. MMR assessment informs personalised treatment options and identifies people with Lynch syndrome. The highest rates of dMMR were seen in patients aged under 30 years (25%) and 80 years or older (23%). It was more common in colon than rectal cancer (21% vs 2%) and varied by stage: 14% in stage 1, 22% in stage 2, 14% in stage 3, and 7% in stage 4 (Supplementary Table 2).

To identify patients eligible for targeted treatments, including immunotherapy, genomics is of central importance. Among people with stage 4 bowel cancer who were recorded as undergoing genetic testing, the proportion tested for BRAF, NRAS, or KRAS within one month of diagnosis increased from 35%-37% in 2019 to 46-47% in 2023. Similar to dMMR, BRAF mutations were most common in patients aged under 50 years (19%) and over 80 years old (18%) (Supplementary Table 3). They were also more common in colon (20%) than rectal tumours (6%). Following the approval of immunotherapy in 2020, the number of people with stage 4 bowel cancer and a record of immunotherapy use increased from 13 patients in 2019 to 121 in 2024.

4.4 Improving peri-operative care

Key message

Overall, outcomes after major bowel cancer resection, including 90-day mortality, 30-day unplanned return to theatre, and 30-day readmission, have remained stable since 2021.

Performance Indicator and Local Target 2

Annual rectal cancer resection volume greater than or equal to 20 cases per centre: 83% of NHS trusts/MDTs

[NICE guidelines](#) recommend that providers should be performing a minimum of 10 rectal cancer resections per year. Of the 129 NHS trusts/MDTs undertaking rectal resections in 2024, 4 (3%) performed fewer than 10 rectal cancer resections and 22 (17%) performed fewer than 20. This compares with 4 (3%) and 28 (22%) respectively in 2023.

Performance Indicator and Local Target 3

<5% adjusted 90-day mortality after all bowel cancer resections: 92% of NHS trusts/MDTs

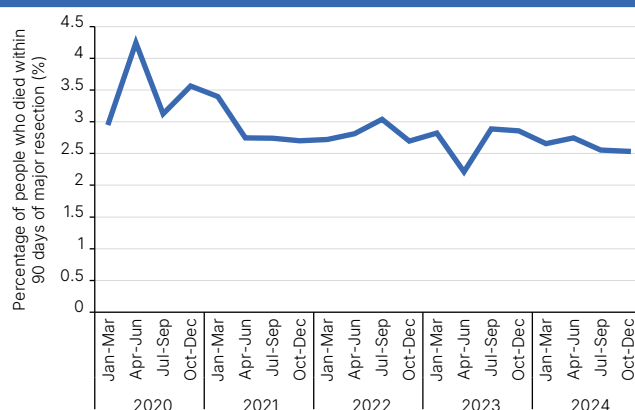
For people diagnosed in 2024, 21,245 (57%) underwent major resection. This reflects a reduction from 24,360 people (61%) in 2021 ([Supplementary Table 4](#)). [Supplementary Figure 6](#) displays variation between NHS trusts/MDTs in the proportion of people undergoing major resection. 90-day mortality after resection was 2.6% for people undergoing surgery in 2024, compared with 2.9% in 2021 (Figure 2). 90-day mortality remains substantially higher following resection within an emergency admission (2024, 9.2%) compared to those within an elective admission (2024, 1.5%) (Figure 3). In 2024, median length of stay was 10 days (IQR 7–17 days) following emergency surgery, compared with 6 days (IQR 4–9 days) following elective surgery. Figure 4 shows risk-adjusted 90-day mortality by NHS trust/MDT.

Contextual Measure and Local Target

>50% of all bowel cancer resections via a minimally invasive approach (laparoscopic or robotic): 96% of NHS trusts/MDTs.

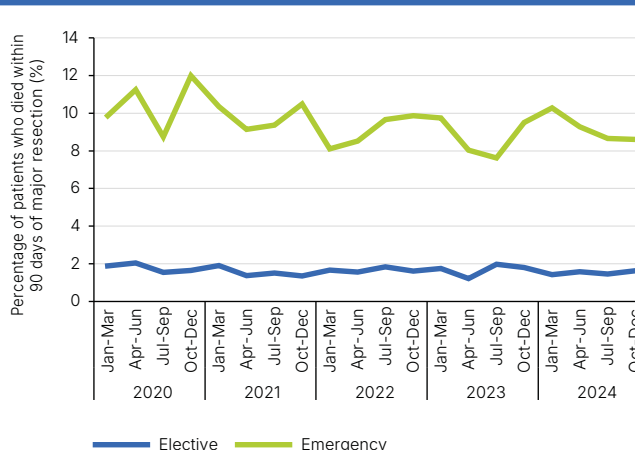
[In 2024, 77% of resections were recorded as minimally invasive (55% laparoscopic and 22% robotic-assisted) increasing from 70% in 2021. The proportion undergoing robotic-assisted surgery increased from 6% in 2021 to 22% in 2024 (Figure 5).]

Figure 2. 90-day post-operative mortality for all people who underwent major resection between 1 January 2020 and 31 December 2024 in England and Wales.



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

Figure 3. 90-day post-operative mortality by mode of admission for people who underwent major resection between 1 January 2020 and 31 December 2024 in England and Wales.



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

Figure 4. Adjusted 90-day mortality after all bowel cancer resections for people who underwent major resection in 2024, by NHS trusts/MDTs with more than ten resections (N = 21,387), England and Wales.

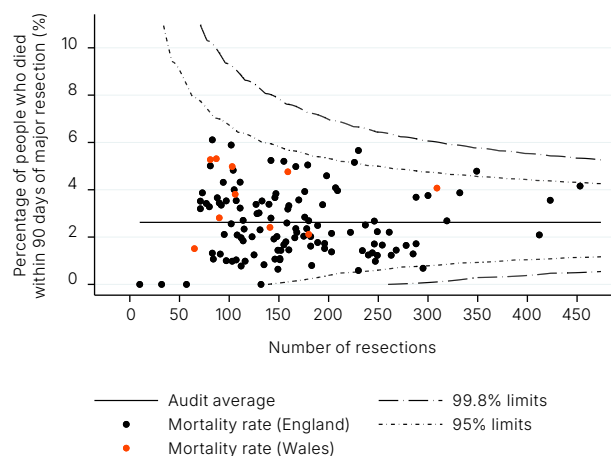
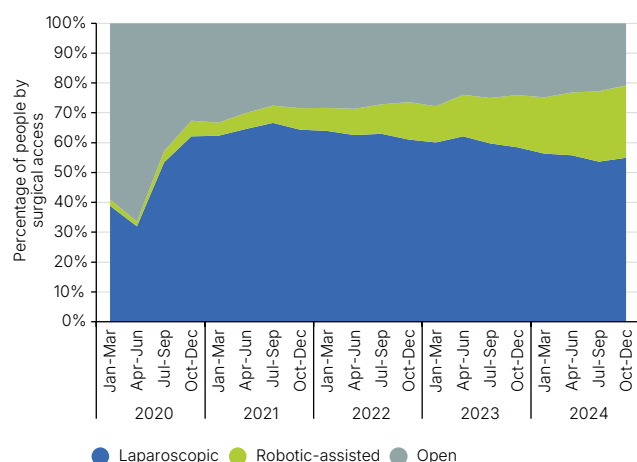


Figure 5. Surgical access for people who underwent major resection between 1 January 2020 and 31 December 2024 in England and Wales.



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

Performance Indicator and Local Target 4

<10% adjusted 30-day unplanned return to theatre after all bowel cancer resections: 91% of NHS trusts/MDTs

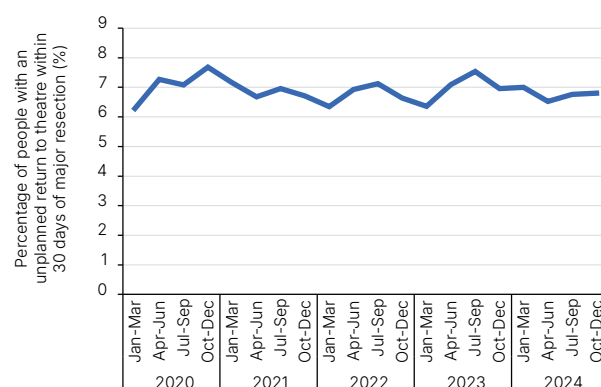
The proportion of people with an unplanned return to theatre (URTT) following major resection remained stable, at 6.9% in 2021 to 6.8% in 2024 (Figure 6). In 2024, eight NHS trusts in England were above the 95% control limit (Figure 7), including two that were above the limit for a second consecutive year and have been notified as per the [NBOCA Outlier Policy](#).

Performance Indicator and Local Target 5

<15% adjusted 30-day unplanned readmission after all bowel cancer resections: 84% of NHS trusts/MDTs

The proportion of people in England and Wales experiencing an unplanned readmission within 30 days of major resection remained stable, at 11.1% in 2021 to 11.2% in 2024 (Figure 8). In 2024, four NHS trusts were above the 99.8% limit (Figure 9). These four trusts, together with one trust that has been above the 95% control limit for two consecutive years, have been notified as per the [NBOCA Outlier Policy](#).

Figure 6. Unplanned return to theatre (URTT) within 30 days of major resection for all people who underwent major resection between 1 January 2020 and 31 December 2024 in England and Wales.



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

Figure 7. Adjusted 30-day unplanned return to theatre (URTT) for all people who underwent major resection in 2024, by NHS trusts/MDTs with more than ten resections (N = 20,459) in England and Wales.

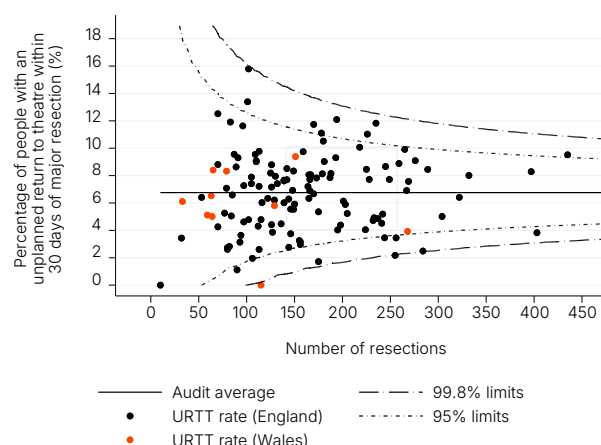
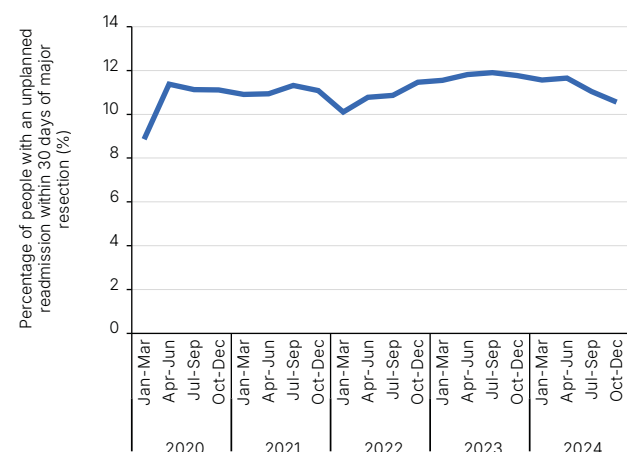
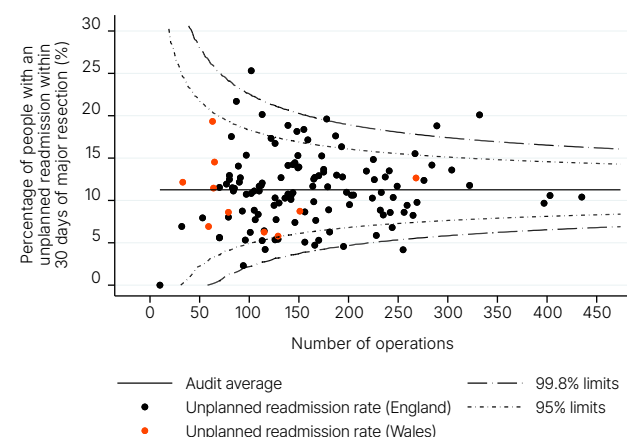


Figure 8. Unplanned readmission within 30 days of major resection for all people who underwent major resection between 1 January 2020 and 31 December 2024 in England and Wales.



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

Figure 9. Adjusted 30-day unplanned readmission for all people who underwent major resection in 2024, by NHS trusts/MDTs with more than ten resections (N = 20,459) in England and Wales.



Approximately half of all people diagnosed with rectal cancer in 2024 underwent surgical resection ([Supplementary Table 5](#)). Among people undergoing rectal cancer resection, the distribution of procedure type has remained stable over recent years ([Supplementary Table 6](#)). Focusing on people who underwent anterior resection, over half had a diverting ileostomy formed, with the proportion falling slightly from 57% in 2021/22 to 53% in 2023/24 ([Supplementary Table 7](#)).

Key message

Approximately one-third of people have an unclosed diverting ileostomy 18 months after anterior resection. Although performance has improved, fewer than 40% of NHS trusts/MDTs met the local target.

Performance Indicator and Local Target 6

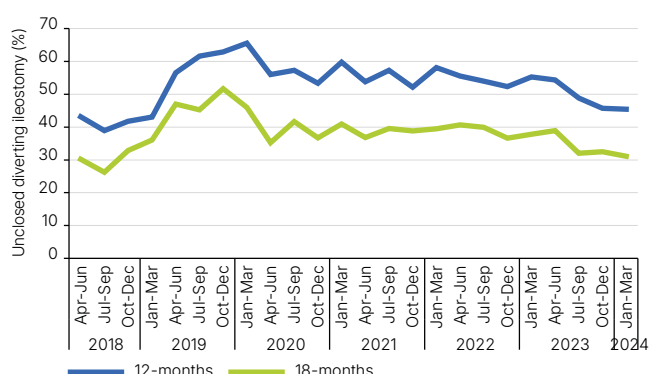
<35% of people with unclosed diverting ileostomy 18 months after anterior resection (adjusted): 37% of NHS trusts/MDTs

For people undergoing anterior resection with a diverting ileostomy between April 2019 and March 2020, the proportion with unclosed ileostomy at 18 months increased substantially to 48%, reflecting the impact of the COVID-19 pandemic (Figure 10). Since then, the proportion with unclosed ileostomy at 18 months has begun to approach pre-pandemic levels (34% unclosed amongst people undergoing surgery in 2023/24). In patients undergoing surgery in 2023/24, 49% had an unclosed ileostomy at 12 months.

For people who underwent anterior resection with a diverting ileostomy between 1 April 2019 and 31 March 2024, nine NHS trusts/MDTs were above the 99.8% funnel limit and are subject to our [NBOCA Outlier Policy](#). Substantial between-unit variation remained, ranging from 13% to 83% (IQR 30%-68%) (Figure 11). Stoma closure pathways are often not standardised, and administrative factors, including waiting-list pressures from other urgent procedures, may affect the prioritisation of reversal. Six NHS trusts/MDTs were below the lower 99.8% funnel limit, indicating exceptional performance and opportunity to identify best practice.

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, reduce variation, and improve patient care and experience. Close It Quick aims to bring forward temporary ileostomy closure to between 6 and 12 months after resection to minimise harms and complete the patient's cancer treatment.

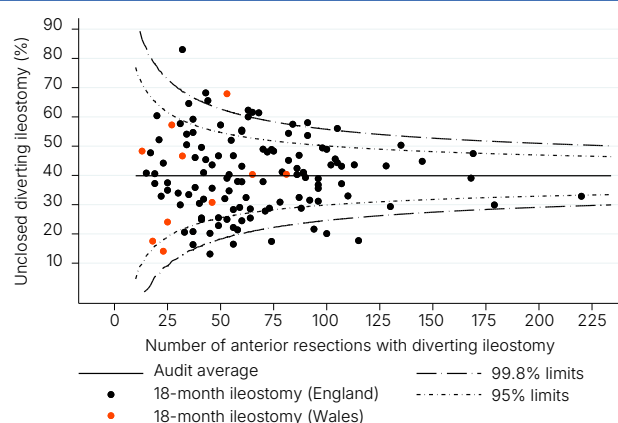
Figure 10. Unclosed ileostomy at 12 and 18 months for people who underwent anterior resection* between 1 April 2018 and 31 March 2024, in England and Wales.



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

*with ileostomy formation within 30 days of procedure

Figure 11. Adjusted 18-month unclosed ileostomy for people who underwent anterior resection between 1 April 2019 and 31 March 2024 at NHS trust/MDT-level (N = 8,311), in England and Wales.



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

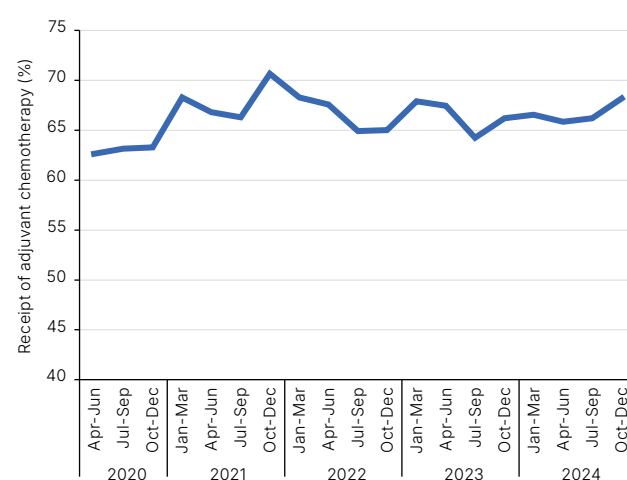
Considerable variation remains between NHS trusts/MDTs in the use of adjuvant chemotherapy for stage 3 colon cancer and neo-adjuvant therapy for rectal cancer.

Performance Indicator and Local Target 7

>55% people with stage 3 colon cancer receiving adjuvant chemotherapy: 92% of NHS trusts/MDTs

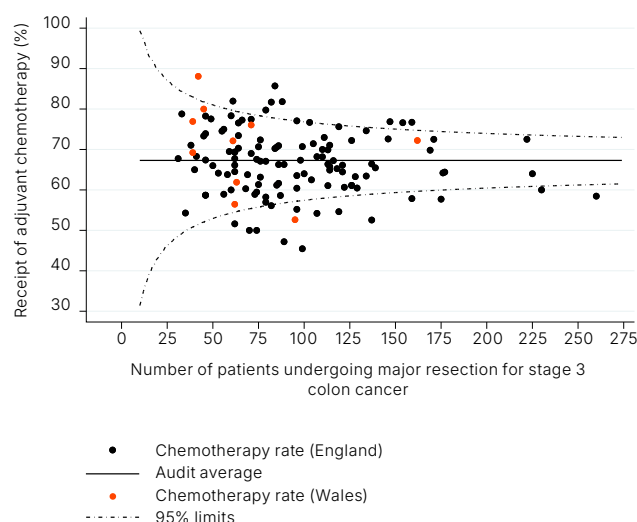
The proportion of people with stage 3 colon cancer receiving adjuvant chemotherapy remained stable at 68% in 2021 and 67% in 2024 (Figure 12). Between-unit variation persists, with uptake ranging from 45% to 88% (IQR 61%-73%) (Figure 13). Given emerging evidence of the benefits of neo-adjuvant chemotherapy, NBOCA is developing methodology to track this practice, but results are not reported due to small numbers.

Figure 12. Receipt of adjuvant chemotherapy following major resection for people with pathological stage 3 colon cancer between 1 April 2020 and 31 December 2024, by date of surgery, England and Wales.



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

Figure 13. Adjuvant chemotherapy uptake in people with stage 3 colon cancer by NHS trusts/MDTs with more than ten resections, for people undergoing major resection between 1 April 2022 and 31 December 2024 (N = 11,910), England and Wales.



Performance Indicator and Local Target 8

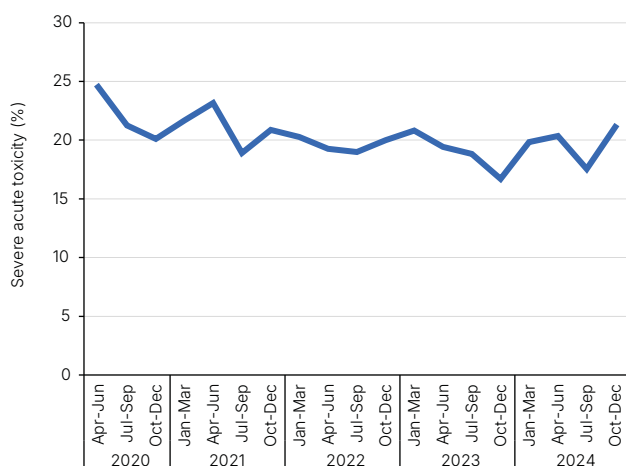
<30% of people experiencing severe acute toxicity related to adjuvant chemotherapy for stage 3 colon cancer (adjusted): 94% of NHS trusts/MDTs

Performance Indicator and Local Target 9

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

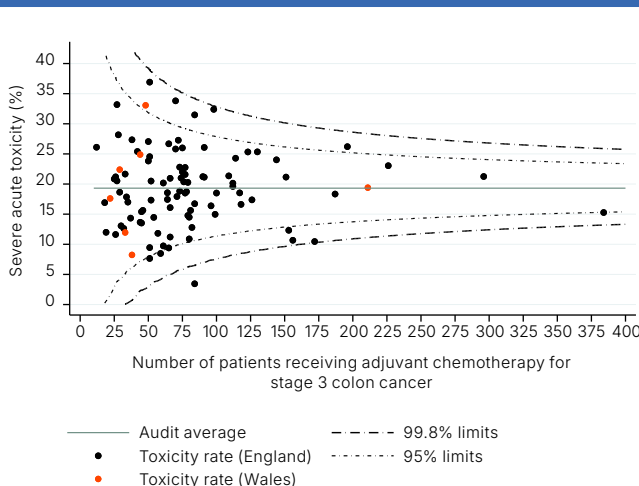
The proportion of people who required overnight hospital admission for [severe acute toxicity](#) related to adjuvant chemotherapy remained stable at 19% in 2024 (Figure 14). Risk-adjusted toxicity varied between NHS trusts/MDTs, ranging from 3% to 37% (IQR 15%-23%) (Figure 15).

Figure 14. Severe acute toxicity for people receiving adjuvant chemotherapy for pathological stage 3 bowel cancer, by date of surgery, 1 April 2020 to 31 December 2024, England and Wales.



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

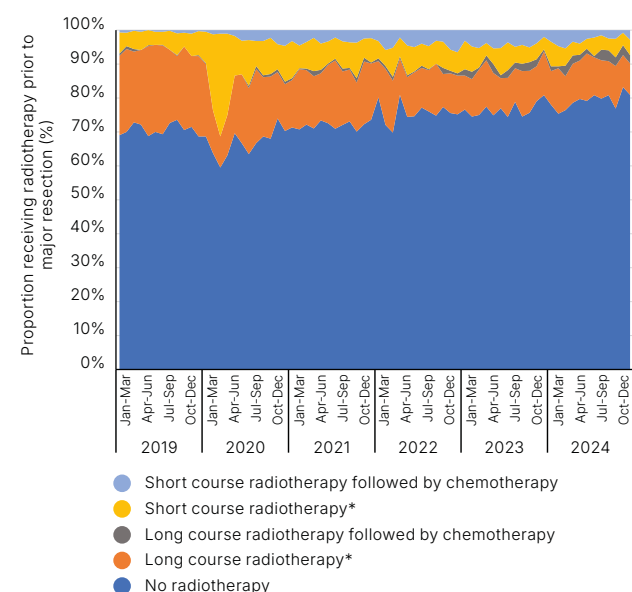
Figure 15. Adjusted severe acute toxicity for people receiving adjuvant chemotherapy for pathological stage 3 bowel cancer after major resection between 1 April 2022 and 31 December 2024 (N = 7,841), England and Wales.



Among all people who underwent rectal cancer resection in 2024, 27% received neo-adjuvant radiotherapy (34% in 2021). There continues to be considerable variation between NHS trusts/MDTs in the use and treatment protocols of neo-adjuvant radiotherapy from 0% to 84% (IQR 19%-39%). These represent a heterogeneous group in terms of tumour and patient factors, with a multitude of treatment options, therefore a range is used for the local target. In those who underwent a major resection within nine months of diagnosis, the proportion on a "straight to surgery" pathway (ie no neo-adjuvant radiotherapy) increased from approximately 70% in 2019 to 79% in 2024 (Figure 16). However, the overall proportion of those with a rectal cancer diagnosis who received neo-adjuvant radiotherapy has changed very little with around 34% receiving neo-adjuvant radiotherapy in 2019 and around 32% in 2024. This combination suggests that there may be an increasing number of patients undergoing a delay in surgery or no surgery after neo-adjuvant treatment with the aim of preserving the rectum. [Supplementary Table 8](#) provides a breakdown of characteristics for people diagnosed with rectal cancer in England

During the first wave of the COVID-19 pandemic in 2020, there was a temporary reduction in the use of neo-adjuvant long-course chemoradiotherapy (LCCRT), and an increase in the use of short-course radiotherapy (SCRT) for people with rectal cancer undergoing major resection. This trend has not fully reversed by 2024: 23.2% of those diagnosed with stage 1-3 rectal cancer received LCCRT compared to 26.3% in 2019 (12.8% and 9.8% for SCRT). However, a proportion of this neo-adjuvant radiotherapy is now given together with chemotherapy within a total neo-adjuvant therapy (TNT) regimen. (Caution is important when interpreting the proportion receiving surgery, radiotherapy or SACT in 2024 as it may be underestimated due to a shorter follow-up period.)

Figure 16. Type of neo-adjuvant treatment received by people* with rectal cancer prior to a rectal cancer resection, over time (England only)**.



*Includes patients with evidence of Systemic Anti-Cancer Therapy (SACT) receipt prior to radiotherapy
 **Wales data not included due to differences in data collection.
 Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

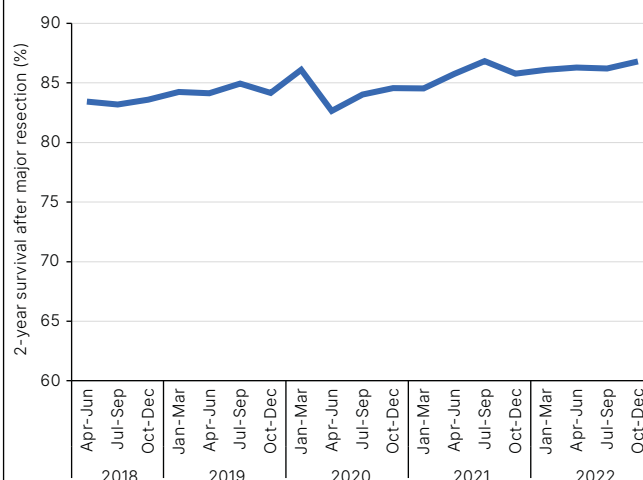
Initial work to capture the use of TNT has been incorporated into this description of neo-adjuvant therapy in rectal cancer. This will be refined and used to evaluate TNT utilisation by rectal cancer stage and geography. Methodology is also being developed to identify people with rectal cancer who start neo-adjuvant treatment but do not undergo major resection after achieving a clinical complete response. This aims to support the evaluation of organ-preservation strategies.

Performance Indicator and Local Target 10

>80% adjusted two-year overall survival rate after bowel cancer resection: 86% of NHS trusts/MDTs

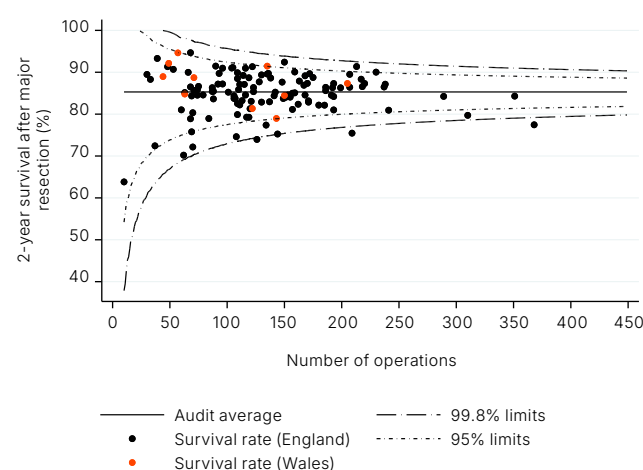
Two-year overall survival after major resection has improved gradually in recent years, from 84.4% for people with bowel cancer undergoing surgery in 2019 to 86.4% for those undergoing surgery in 2022 (Figure 17). This improvement likely reflects continued progress in peri-operative care, oncological treatment, and multidisciplinary decision-making. Among patients who underwent major resection between 1 April 2022 and 31 December 2022, three NHS trusts/MDTs had risk-adjusted two-year survival below the 99.8% funnel limit (Figure 18) and are subject to the [NBOCA Outlier Policy](#). [Supplementary Figure 7](#) demonstrates variation in adjusted two-year cancer-specific survival.

Figure 17. Two-year survival for people who underwent a major resection, by date of surgery, 1 April 2018 to 31 December 2022, England and Wales.



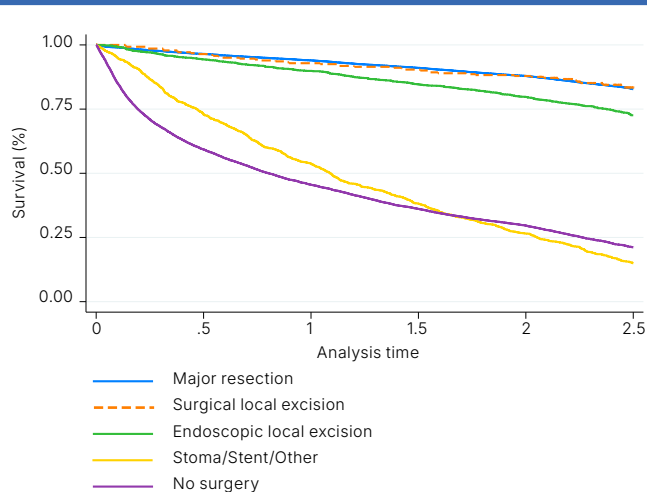
Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-2021.

Figure 18. Adjusted two-year survival rate for people who underwent a major resection between 1 April 2022 and 31 December 2022, by NHS trusts/MDTs with more than ten resections (N = 16,838), England and Wales.



Among people with bowel cancer diagnosed between 1 April 2022 and 31 December 2022, observed two-year overall survival from diagnosis varied by treatment strategy: 88% for people who had major resection or surgical local excision, 80% for those who had endoscopic local excision, 30% for those not undergoing surgery, and 27% for those managed with a stoma or stent without major resection (Figure 19). The poorest survival was observed among those not undergoing surgery, while people with bowel cancer managed with a stoma or stent followed a similar trajectory.

Figure 19. Kaplan-Meier plot of overall survival for people with bowel cancer diagnosed in England and Wales between 1 April 2022 and 31 December 2022, by treatment strategy (N = 29,482*).



* 74 people with bowel cancer diagnosed in Wales who had a local excision are excluded as type of local excision could not be determined from available codes in the data

5. Commentary

The 2026 State of the Nation report highlights continued progress in several areas of bowel cancer care, alongside persistent variation in practice and outcomes. This year NBOCA has reported delays to treatment in secondary care for the first time. Following a cancer diagnosis, treatment decisions for all people with bowel cancer, regardless of referral route, should be timely. However, people diagnosed following a routine GP referral waited over a week longer for a treatment decision in secondary care than those referred through the urgent suspected cancer pathway. This highlights the need to optimise secondary care pathways, including access to radiological investigations, patient tracking and MDT processes.

Peri-operative outcomes remain encouraging. Post-operative mortality remains low, and two-year overall survival after major resection has improved in recent years, rising gradually to 86.4% for people undergoing surgery in 2022. This is likely to reflect improvements in care across the whole pathway, including peri-operative care, oncological treatment and multidisciplinary decision-making. However, the gap between elective and emergency surgery has not narrowed, with 90-day mortality six times higher after emergency resection. Greater focus is needed on improving outcomes in this high-risk group, including earlier diagnosis, pre-operative optimisation where possible, timely recognition and management of complications, and further evaluation of bridging strategies that may enable selected patients to undergo planned rather than emergency resection.

Timely ileostomy closure after rectal cancer surgery remains a key priority. Although outcomes are now approaching pre-pandemic levels, only one third of NHS trusts/MDTs meet the local target of fewer than 35% of people with an unclosed diverting ileostomy 18 months after anterior resection, with persistent between-unit variation. NBOCA has launched a pilot national quality improvement initiative [Close It Quick](#), in collaboration with the Royal College of Surgeons of England and ACPGBI, to facilitate teams and identify and address barriers to timely closure.

Variation in rectal cancer management also persists with rates of neo-adjuvant radiotherapy ranging from 0% to 84% across providers. This variation is likely to be multifactorial reflecting differences in case mix, quality of radiological staging, MDT decision-making, and access to organ preservation strategies. NBOCA calls for the development of consensus-driven evidence-based guidance for rectal cancer management, informed by high-quality pre-operative staging, standardised radiology reporting, equitable access to organ preservation strategies, and shared decision-making with patients.

Utilisation of chemotherapy for stage 3 colon cancer remains an important area for quality improvement. While overall utilisation has remained stable over time, wide variation between providers persists with one in ten providers below the 55% 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.

Data completeness has improved, reducing the number of providers excluded from reporting. Continued collaboration between clinical teams, clinical coders and data teams is needed to improve the completeness and accuracy of key data items and ensure that all providers can be included in future reporting.

Future directions.

NBOCA continues to develop performance indicators set out in its [Quality Improvement Plan](#), with a particular focus on the management of stage 4 disease and end-of-life care. NBOCA also plans to develop new methodology. For example, monitoring the uptake of organ preservation strategies for rectal cancer, incorporating [cancer recurrence](#) into long-term outcome reporting, assessing equitable access to clinical trials, and monitoring rates of post-CT colonography and post colonoscopy colorectal cancers. National primary care data, such as OpenSAFELY in England, is now becoming a reality, which may in the future bring opportunities to better understand patient pathways before and after a bowel cancer diagnosis. Emerging biomarkers, including circulating tumour DNA are also becoming increasingly important in bowel cancer care, with potential roles in risk stratification, detection of minimal residual disease, and tailoring surveillance after treatment. NBOCA will continue to monitor these developments in partnership with professional bodies, focusing on how emerging data sources and technologies can support clinically meaningful audit, quality improvement, and better outcomes for people with bowel cancer.