National Bowel Cancer Audit: Findings of the 2024 State of the Nation Report Part 1

14th January 2025

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National Bowel Cancer Audit

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Welcome

Chair: Mr Justin Davies,
ACPGBI President

Miss Nicola Fearnhead, NBOCA
Clinical Co-Lead: Surgery

Dr Mike Braun, NBOCA
Clinical Co-Lead: Oncology

Prof Kate Walker, NBOCA
Senior Methodologist

Miss Elaine Burns, Consultant
Colorectal Surgeon

Prof Deena Harji, Consultant
Colorectal Surgeon

Prof Gabrielle Thorpe, Prof of Professional
Development in Health Sciences

Dr Katrina Attwood, NBOCA Patient and
Public Involvement Forum chair

Key Changes in NBOCA

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- NBOCA moved to National Cancer Audit Collaborating Centre (NATCAN) in 2023
- Clinical Audit Platform (CAP) no longer used for data collection
- Replaced by National Cancer Registry, a routinely collected dataset, to reduce burden of data collection
- Data items from CAP system mapped to Cancer Registry data
- Cancer registry links as before to other datasets (HES/PEDW, SACT, RTDS) and new linkage to additional datasets (Somatic Molecular Data Set)

Measuring the quality of care & outcomes for people with bowel cancer (KPIs & context)

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Performance indicator and local target
More than 95% of people seen by Clinical Nurse Specialist
Annual rectal cancer resection volume greater than or equal to 20 cases per centre
<6% adjusted 90-day mortality after all bowel cancer resections
<10% adjusted 30-day unplanned return to theatre after all bowel cancer resections
<15% adjusted 30-day unplanned readmission after all bowel cancer resections
<35% adjusted proportion of people with unclosed diverting ileostomy 18 months after anterior resection
>50% people with Stage 3 colon cancer receiving adjuvant chemotherapy
<33% adjusted proportion of people experiencing severe acute toxicity related to adjuvant chemotherapy for Stage 3 colon cancer
10% to 60% of people with rectal cancer undergoing major resection receiving neo-adjuvant treatmen
>70% adjusted 2-year overall survival rate after bowel cancer resection
More than 70% data completeness of seven items for risk-adjustment in people undergoing major surgery
More than 90% of people with mismatch repair (MMR) immunohistochemistry tested
More than 50% of all bowel cancer resections via a minimally invasive approach (laparoscopic or robotic)

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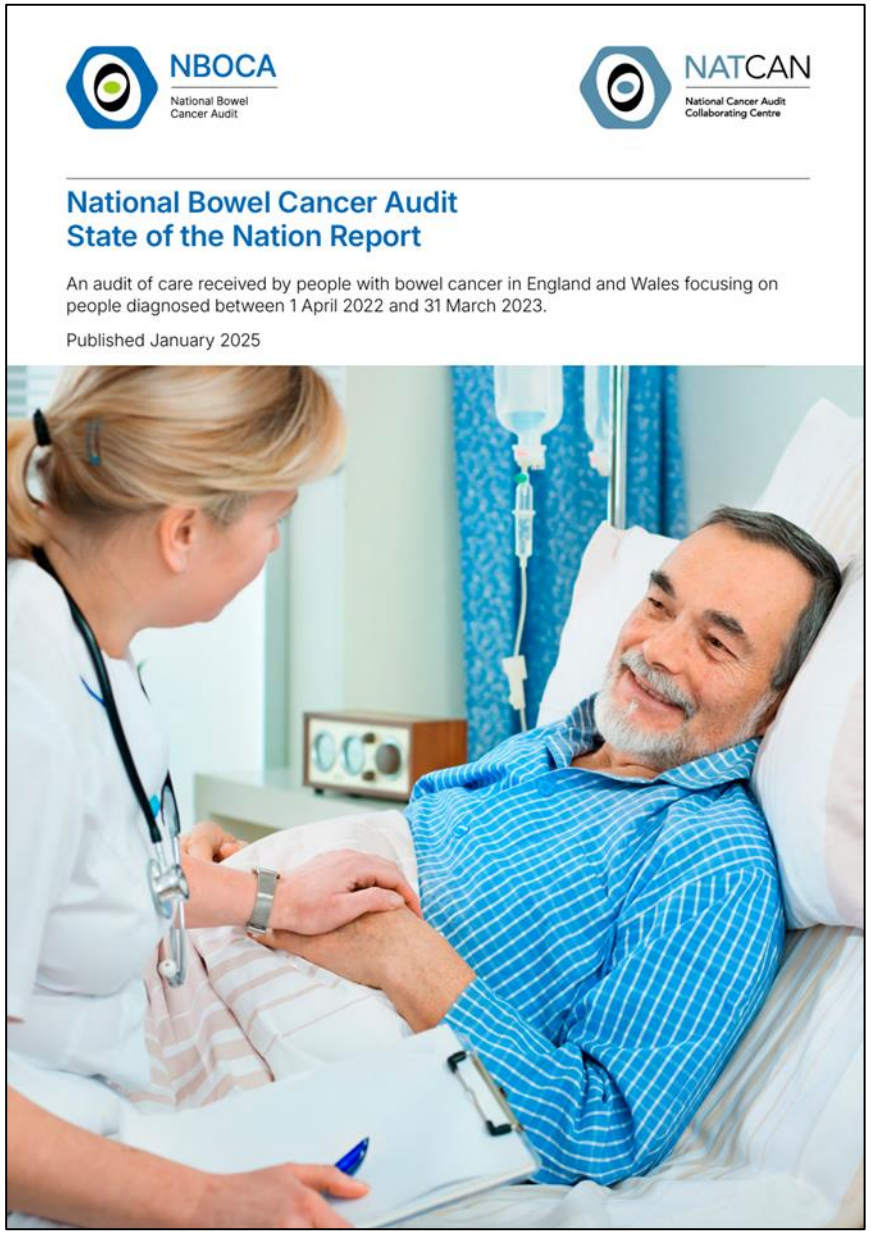

NBOCA 2024
State of the Nation Report
Key Findings

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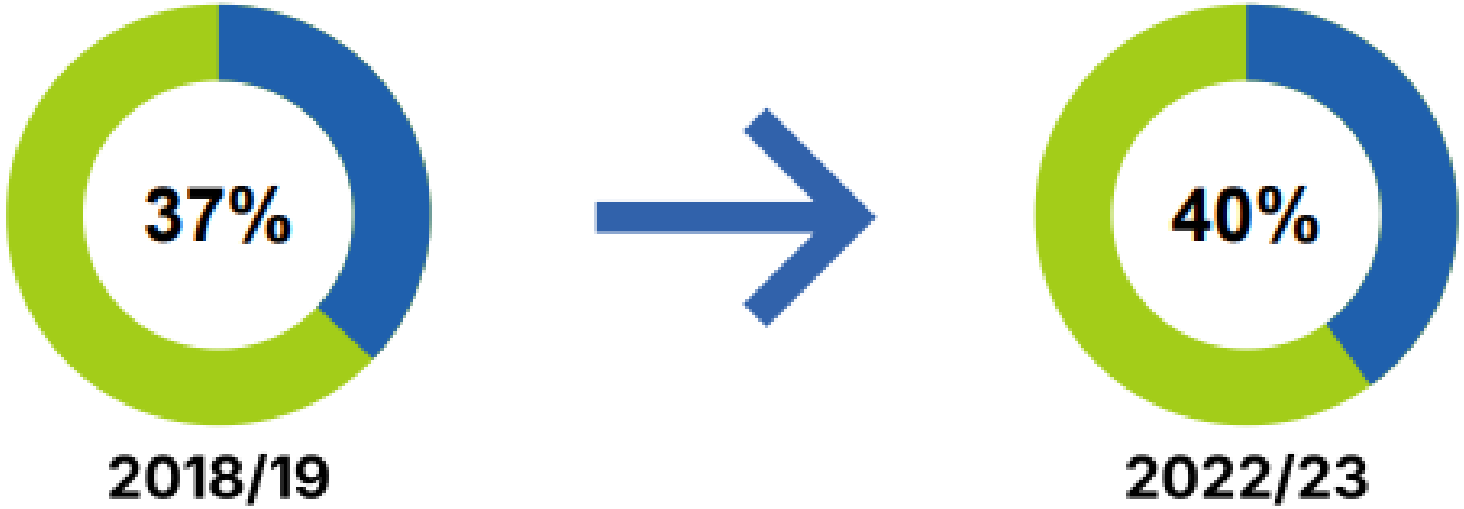
38,604 people

were diagnosed with bowel cancer in England and Wales between 1 April 2022 and 31 March 2023.

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



Bowel Cancer Screening Programme

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Proportion of people in England and Wales aged 50-59 years diagnosed through screening has increased from 4.6% in 2019/20 to 10.8% in 2022/23.

Reflects ongoing expansion in NHS bowel cancer screening to people aged 50 to 74 years in England and 51 to 74 years in Wales.

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Contextual Measure and Local Target
More than 70% data completeness of seven items for risk-adjustment in people undergoing major surgery: 42% of trusts/MDTs


Drop in data completeness with move to Cancer Registry


Reduces ability for risk adjustment (unable to report all risk adjusted outcomes >10 trusts/MDTs)


Expected to improve with increasing utilisation of Cancer Registry by National Cancer Audits


Key Recommendation 1: Providers to improve data completeness of key items in national cancer registration datasets (clinicians working with MDT coordinators and coders)

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

65%

% of people with CNS data available

94%

% of people with CNS data available who were seen by a CNS

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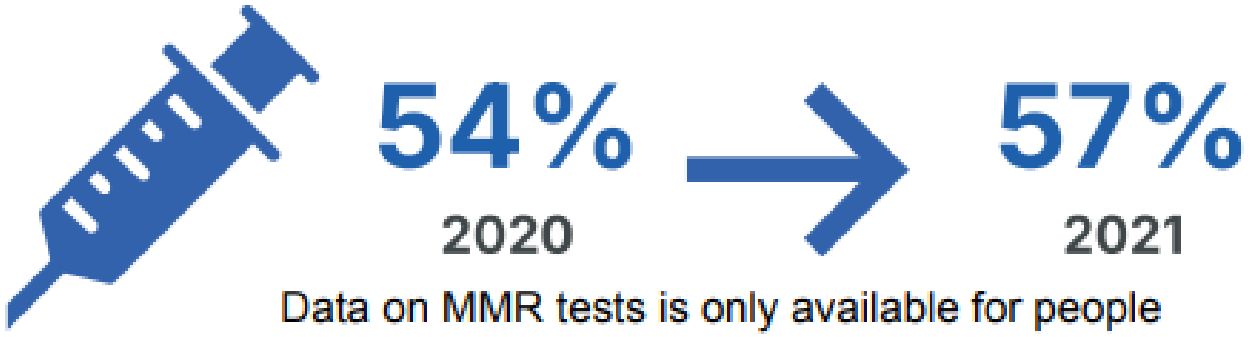
Proportion of people in England with mismatch repair (MMR) immunohistochemistry test



Data on MMR tests is only available for people diagnosed in England until 31 December 2021

Key Recommendation 2: Increase the proportion of people who are offered mismatch repair (MMR) assessment

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Peri-operative care

3.4% 2018/19
to
2.7% 2022/23

% of people who died within 90 days of surgery

8.0% in 2018/19
to
6.7% in 2022/23

% of people with an unplanned 30-day return to theatre after surgery

11% 2018/19
to
11% 2022/23

% of people with an unplanned 30-day readmission after surgery

81%
2022/23

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

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Figure 12. Adjusted 18-month unclosed ileostomy after anterior resection performed between 1 April 2017 and 31 March 2022 at English trust/Welsh MDT level.

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

2017/22

% of people with an unclosed diverting ileostomy 18-months after anterior resection (major rectal cancer operation, year of surgery)

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Key Recommendation 3:

Increase the proportion of people who have their ileostomy closed within 18-months of anterior resection.

Identify system-level (e.g. access to theatre/radiological investigations) and patient-level drivers of delayed ileostomy closure.

Participate and engage with the local and national Quality Improvement initiatives to enable more timely reversal of ileostomy.

QI initiatives should provide a streamlined pathway for timely and safe ileostomy closure with regular feedback on performance to the wider MDT.

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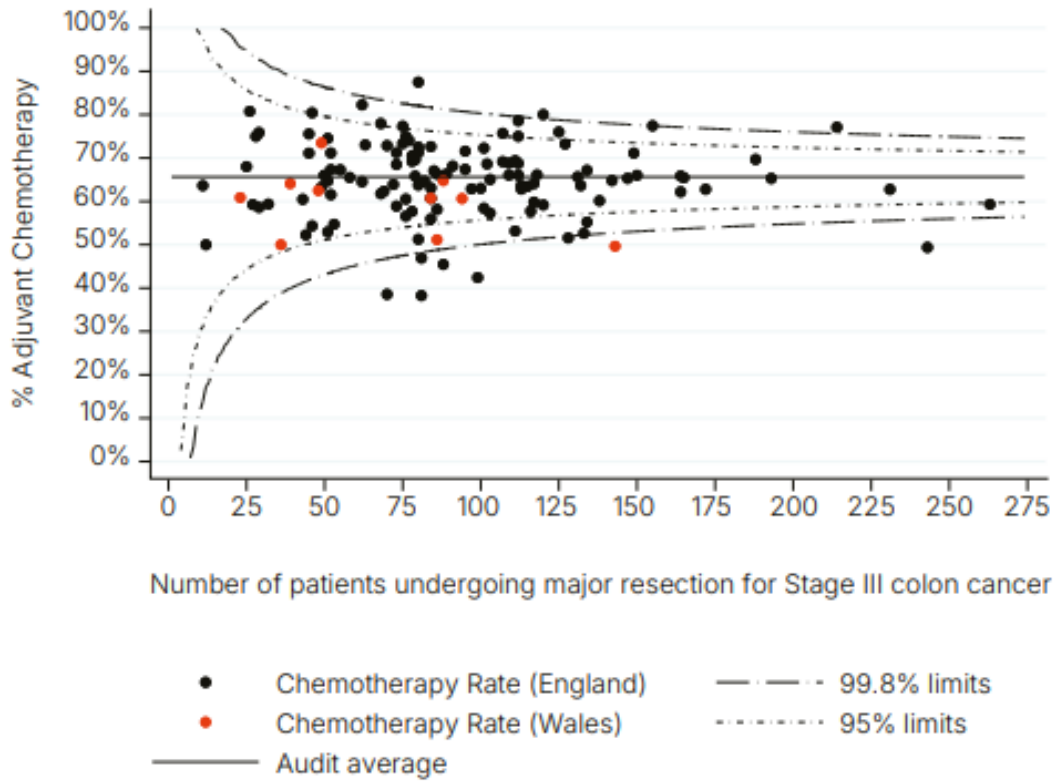
Oncological Management

Figure 14. Adjuvant chemotherapy uptake in people with Stage 3 colon cancer by English NHS trusts/Welsh MDTs with more than ten operations, for people undergoing major resection between 1 April 2020 and 30 November 2022 in England and Wales.



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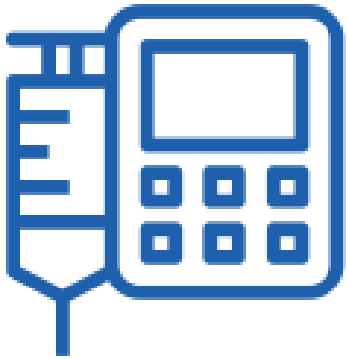

66%

2020/22

% of people who received adjuvant chemotherapy for stage 3 colon cancer (year of surgery)

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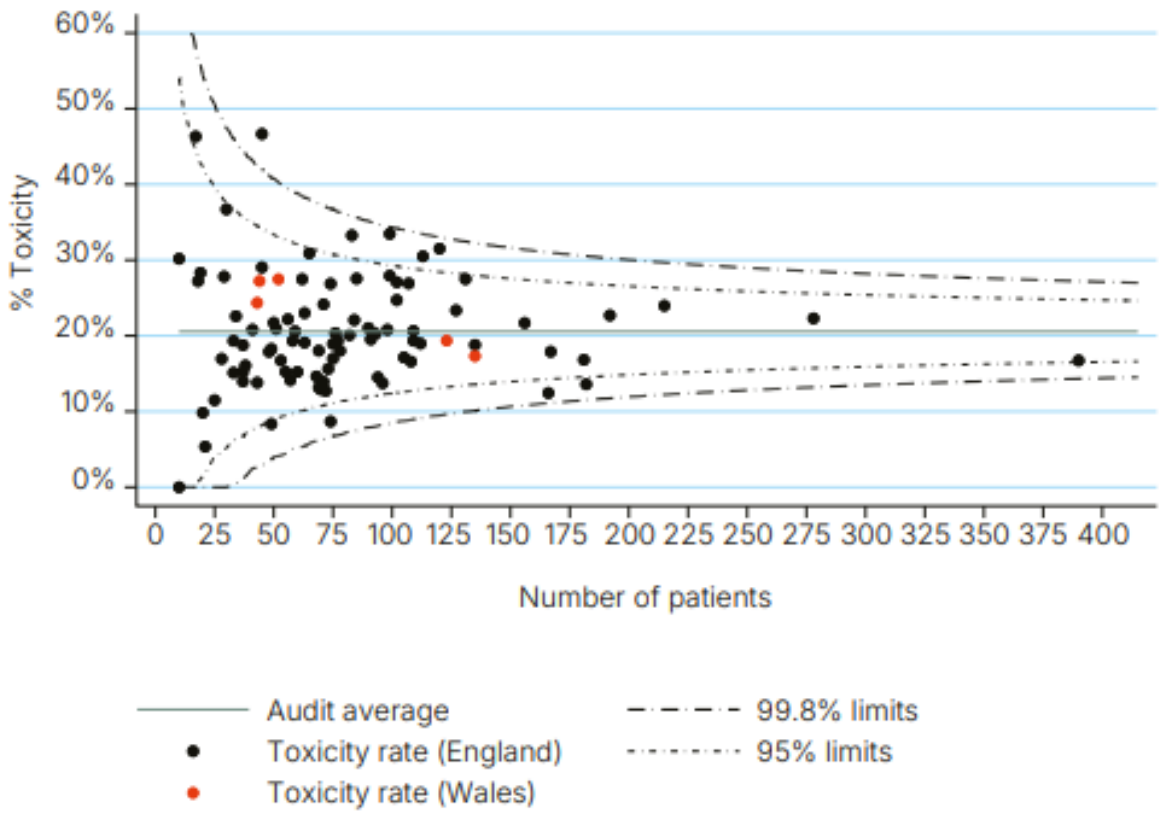
Oncological Management

Figure 15. Adjusted severe acute toxicity for people receiving adjuvant chemotherapy for pathological Stage 3 bowel cancer, by English NHS trusts/Welsh MDTs treating more than ten people after major resection between 1 April 2020 and 30 November 2022.



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

21%

2020/22

% of people who experienced severe acute toxicity after adjuvant chemotherapy (year of surgery)

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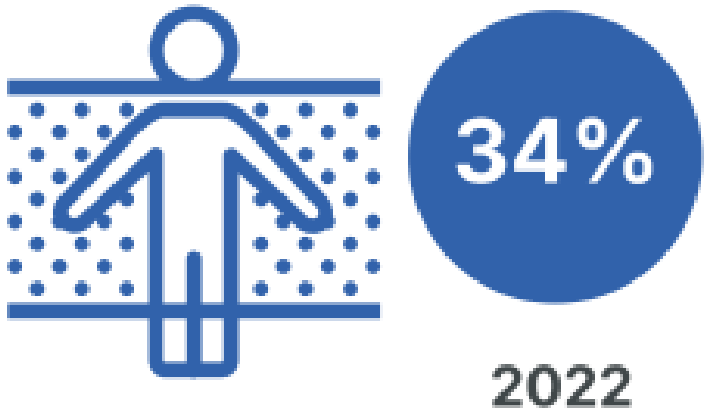
Key Recommendation 4:

Reduce variation between trusts/MDTs in the use of chemotherapy for people with Stage 3 colon cancer to optimise cancer survival while maintaining low levels of acute severe toxicity.

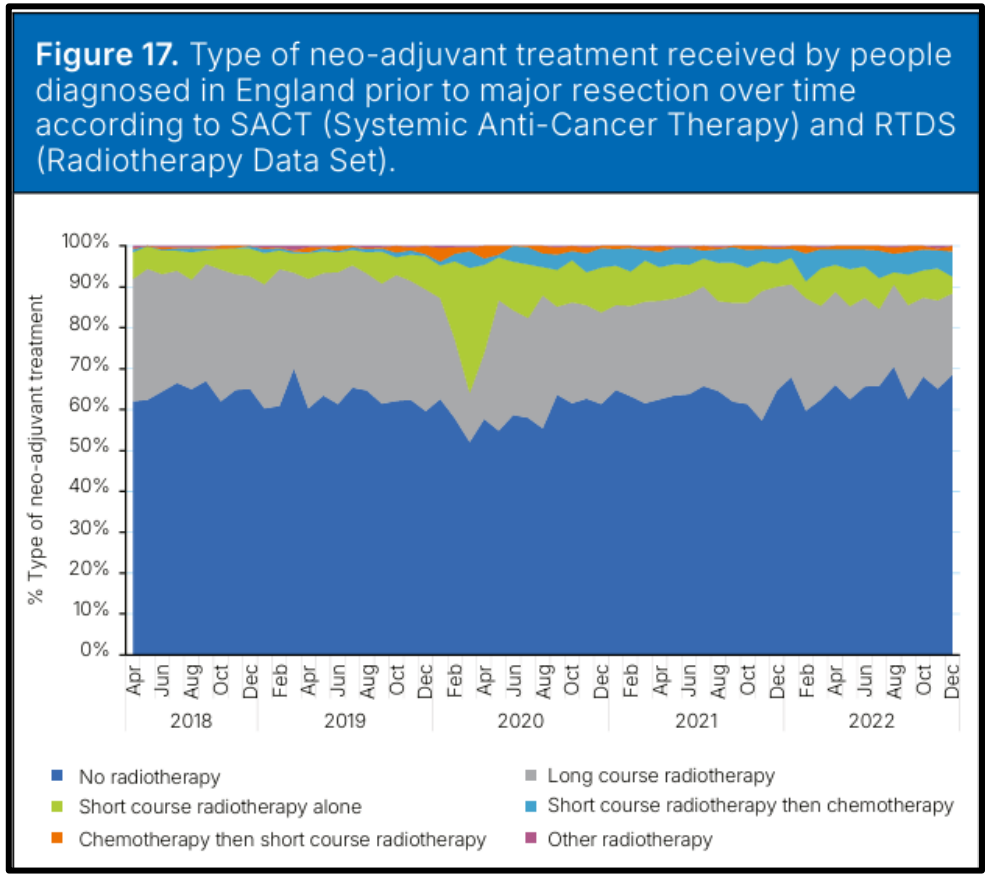
Identify and address barriers to timely access to adjuvant chemotherapy.

Encourage utilisation of appropriate risk stratification tools for severe acute toxicity from chemotherapy including frailty scoring, and integration of geriatric expertise and rehabilitation into shared chemotherapy decision making.

Neoadjuvant Therapy for Rectal Cancer



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



There is considerable variation between trusts/MDTs in use of neo-adjuvant radiotherapy: 0% to 82%

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Key Recommendation 5:

Understand variation in the utilisation of neo-adjuvant radiotherapy for people with rectal cancer to optimise their outcomes.

Cancer Alliances to develop standardised evidence-based neo-adjuvant treatment protocols based on high-quality radiological staging. This will aid decision making and take into account locoregional approaches to neoadjuvant therapy, incorporating organ preservation techniques and participation in clinical trials.

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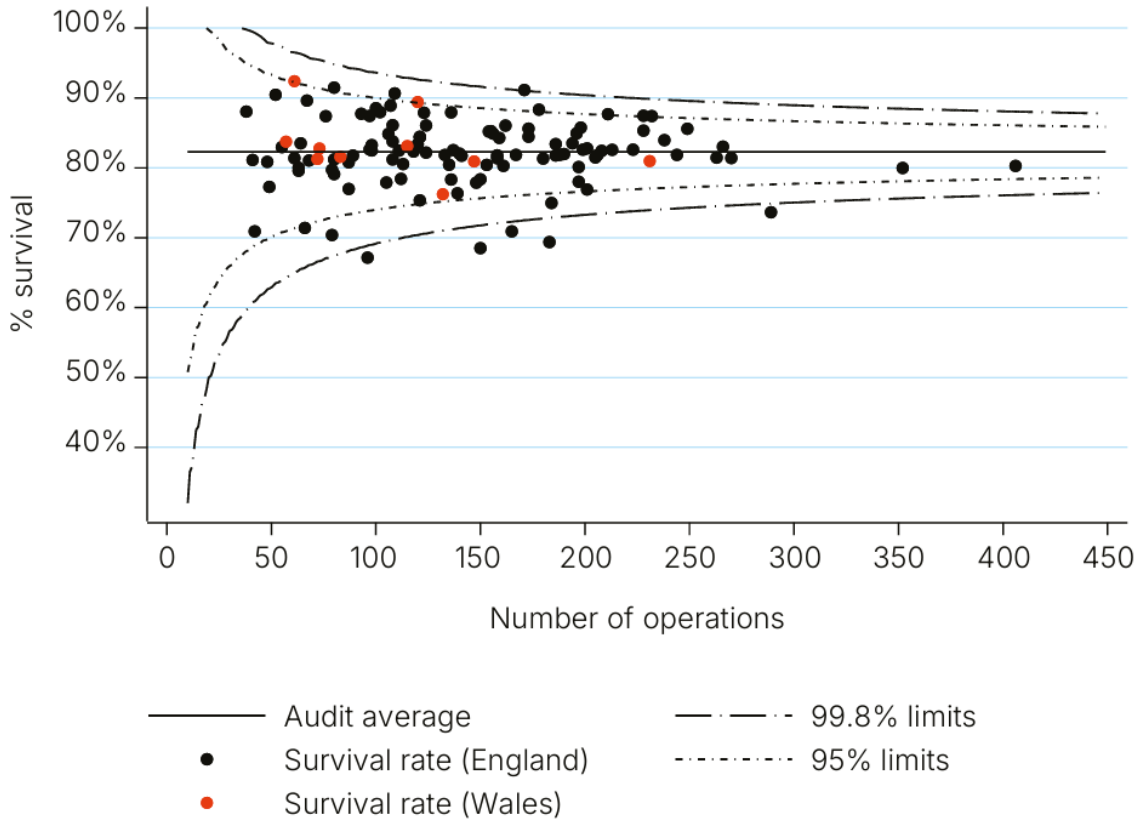
2-Year Survival after Bowel Cancer Resection

Figure 18. Adjusted 2-year survival rate for people who underwent a major resection between 1 April 2020 and 31 March 2021, by English NHS trusts/ Welsh MDTs with more than ten operations. Audit average = 82.3%.



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82%

2020/21

% of people alive 2-years after major colorectal cancer surgery (year of surgery)

Performance Indicators
National and Local Results

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

Performance indicator	National results	Local Target	Percentage of trusts/ MDTs meeting local target
1. Seen by Clinical Nurse Specialist	94%*	>95%	61%*
2. Trust/MDT volume for rectal cancer surgery	N/A**	≥20 per year	81%
3. Adjusted 90-day mortality after major resection	2.7%	<6%	96%
4. Adjusted 30-day unplanned return to theatre after major resection	6.4%	<10%	92%
5. Adjusted 30-day unplanned readmission after major resection[1]	11%	<15%	81%
6. Adjusted 18-month unclosed ileostomy after anterior resection	38%	<35%	41%
7. Stage 3 colon cancer receiving adjuvant chemotherapy	66%	>50%	93%
8. Adjusted severe acute toxicity after adjuvant chemotherapy for colon cancer	21%	<33%	95%
9. People with rectal cancer receiving neo-adjuvant treatment***	34%	10%-60%	89%
10. Adjusted 2-year survival rate after major resection	82%	>70%	97%

NBOCA QI Workshop

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The Association of Coloproctology of Great Britain & Ireland

- Monday 30th June 2025
- Join the discussion on data driven approaches to improve the quality of care for people with bowel cancer

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National Bowel Cancer Audit State of the Nation Report

Summary of findings for the public and patients

Published January 2025

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Panellist Discussion

- Please submit your questions via Q&A function
- Chair will put your questions to the panellists
- NBOCA team on hand to answer queries in Q&A
- No patient identifiable data please

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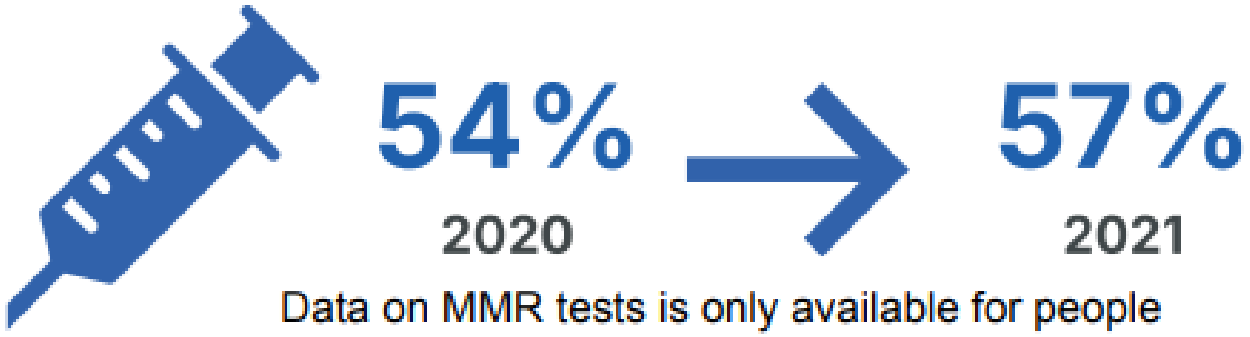

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QI initiatives should provide a streamlined pathway for timely and safe ileostomy closure with regular feedback on performance to the wider MDT.

Quality Improvement in Ileostomy Closure

Close It Quick

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Stepwise Interventions in Patient Pathway

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1. Shared Decision-Making

- Discuss benefits and risks of restoration of bowel continuity
- Explain rationale for diverting ileostomy
- Discuss potential complications of having an ileostomy
- Explore potential risks for poor bowel function after closure
- Assess risk factors for non-closure
- Explain risks of subsequent ileostomy closure
- Preoperative stoma counselling

2. Discharge Diary after Ileostomy Creation

- Book contrast enema
- Schedule outpatient appointment
- Schedule date for closure
- Administrative support
- Strategy for closure if adjuvant chemotherapy

3. Checklist Prior to Ileostomy Closure

- Negative contrast study excluding anastomotic leak
- Date for surgery
- Preoperative consent and information
- Consider preoperative measures to reduce risk of LARS (physiotherapy, biofeedback, distal instillation)

4. Optimisation of Ileostomy Closure

- Timely access to operating lists (ring-fenced slots?)
- Administrative support / tracking
- EUA at time of closure
- Enhanced recovery after surgery (ERAS)
- Probiotics
- Reducing length of stay (23 hour pathway/virtual ward)
- Evidence-based practice (purse-string wound closure, probiotics)

5. Follow-up after Closure

- Functional assessment (nurse-led)
- Access to treatment for LARS
- Colonoscopic surveillance (scheduling)

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Thank you for participating

We look forward to seeing you for Part 2 of this webinar series on 21st January 2025, 17:30-18:30

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