Behind the emergency:

clinician perspectives on emergency bowel cancer diagnosis

Bowel Cancer UK
Beating bowel cancer together

Contents

Emergency diagnosis of bowel cancer

Bowel cancer is the UK's second biggest cancer killer, yet it is treatable and curable, especially when diagnosed early. Around 1 in 4 people with bowel cancer* are diagnosed as an emergency, often in A&E, and this figure has stayed stubbornly high for years. For those patients, the consequences are profound: later stage disease, more intensive treatment, and poorer outcomes. Earlier diagnosis saves lives, which is why reducing emergency diagnosis matters so much. Across the sector, there is a growing determination to understand why emergency diagnosis happens and how it can be prevented. Bowel Cancer UK is bringing together clinicians, researchers, policymakers and people affected by bowel cancer to build that understanding and drive action.

Cancer strategies across the four nations prioritise earlier diagnosis, yet emergency diagnosis in bowel cancer has not received the dedicated focus that its persistently high rates warrant. There is a stark gap between national ambition and reality. This report brings together clinician perspectives to identify what is bringing people to crisis point, from missed opportunities to wider system pressures, so that the most effective changes can be made.

Clinicians are realistic that emergency diagnosis will never be entirely eliminated. They are clear that this is happening far too often, but that there is more that can be done to improve the experience and outcomes of those diagnosed this way. The insights in this report extend beyond the emergency setting, touching on how bowel cancer is identified, supported and treated more broadly. Patients deserve that learning to be applied across the whole pathway, and Bowel Cancer UK is committed to ensuring that happens.

1 in 4* people with bowel cancer are diagnosed in an emergency, often in A&E.

Figures reflect variation across UK data sources and years. While the proportion of emergency presentations of bowel cancer varies between nations, and comprehensive data is not available for all four, evidence indicates that around 1 in 4 cases are diagnosed following an emergency presentation (such as A&E).

Building the picture

Understanding emergency bowel cancer diagnosis properly means hearing from more than one perspective. Our report Behind the Emergency brought together the voices of patients and families, setting out the reality of an emergency diagnosis and the journey that led them there. This report is the second part of that work, drawing on the insights of clinicians working across bowel cancer care in the UK.*

A third element, planned for later this year, will bring in researchers and data specialists to add the research layer to what patients and clinicians have told us. Together, the three parts will build the foundation for focused, realistic policy priorities and the changes most likely to make a difference.

The evidence-base is patchy

The 1 in 4 people diagnosed as an emergency tells us how many are affected, but the picture of who is most likely to be diagnosed this way is less clear than might be expected.

Emergency patients tend to present with more advanced disease.[1] Some data also suggests deprivation and ethnic minority status are associated with a higher likelihood of emergency presentation, but the evidence base has limitations, and local patterns can differ significantly from national assumptions.[2] What is clear is that we still do not fully understand the scale, causes or distribution of emergency bowel cancer diagnosis.

> **"Emergency presentations often reflect missed opportunities for an earlier diagnosis rather than a sudden onset of disease."**
>
> **Colorectal Surgeon, England**

To build the insight and evidence for this report, Bowel Cancer UK ran an in-depth qualitative survey receiving 25 responses and conducted 11 semi-structured interviews with clinicians working across the bowel cancer pathway, drawing on participants from across England, Wales and Scotland. Participants spanned primary, secondary and specialist care, including Consultant Colorectal Surgeons, General Surgeons, Oncologists, Gastroenterologists, GPs, Practice Managers and Clinical Nurse Specialists. Responses from Northern Ireland were not received. This report also draws on Bowel Cancer UK's ongoing engagement with healthcare professionals, policy makers and researchers working across the pathway.

1. Golder et al., Determinants of emergency presentation in patients with colorectal cancer: a systematic review and meta-analysis, Scientific Reports, 12, 4366 (2022)
2. Exarchakou et al., What can hospital emergency admissions prior to cancer diagnosis tell us about socio-economic inequalities in cancer diagnosis? Evidence from population-based data in England, British Journal of Cancer, 130 (2024)

Clinician insights

The themes that follow reflect what clinicians across bowel cancer care told us, drawing on their direct experience of seeing and treating patients diagnosed this way. Together they start to build a picture of what needs to change to reduce emergency diagnoses. This includes the challenge of recognising symptoms and reaching diagnosis earlier, the realities of an emergency setting that is rarely ideal, and the incomplete picture of who is most affected and why. They also explore what can be done to improve care for those diagnosed this way.

1: A slow build to crisis

For many people diagnosed with bowel cancer in an emergency, the crisis point is not where the story begins. Clinicians consistently describe a pattern of symptoms or events that preceded the emergency, sometimes by weeks or months.

This mirrors what we heard from many patients. Repeated attempts to seek help, symptoms attributed to other causes, and a slow build towards a sudden crisis. Patients and clinicians tell the same story. That should be a clear signal that this is a systemic problem, not a series of unfortunate individual events. But the journey to that crisis point is not the same for everyone.

Clinicians are clear that the reasons why patients reach crisis point vary. Some patients didn't seek help, others sought help, but symptoms weren't identified as serious, and for another group there was simply no warning before the crisis hit.

Patients themselves have described not always knowing how to talk about what they were experiencing, or whether it was serious enough to pursue. Many accepted the explanations they were given, with symptoms that didn't point clearly in one direction. Patients tell us this played out across multiple consultations, returning again and again, each visit leaving them no closer to a diagnosis. Clinicians recognise this pattern across their caseloads and describe it as not uncommon.

There is a smaller but important group for whom the picture is different. These are patients who did seek help, who had already made contact with services, and who still ended up in A&E. Clinicians describe waiting times so long that patients deteriorate before they are ever seen. For example, a five week wait for a GP appointment, followed by investigation delays, followed in some cases by a 10 month wait for a first diagnostic test. For these patients, the emergency was not the result of not seeking help. It was the result of a system that failed to move quickly enough.

Access to diagnostics, including endoscopy, is described by most clinicians as a long-standing challenge that has not been adequately resolved. Patients have described waiting weeks for scans or facing delays even when investigations were arranged, and clinicians confirm the problem persists. Waiting times for diagnostics can vary significantly, and for some patients they make the difference between an earlier diagnosis and an emergency one.

Understanding why symptoms don't always lead to earlier diagnosis is not straightforward, and it is where the picture becomes more complex.

“Sometimes it's genuinely that until a week or two before, they didn't have any symptoms and they've now suddenly got abdominal pain and they're not going to the toilet. And sometimes, that's genuinely the reason.”

Consultant Nurse, Colorectal Cancer, England

“There's no doubt that some patients present as an emergency because their disease has progressed without giving them the typical warning signs that we'd hope to pick up earlier.”

Consultant Colorectal Surgeon, Scotland

2: Bowel symptoms are genuinely hard to recognise for patients and clinicians

Gastrointestinal symptoms are among the most common reasons people see a GP. This is the clinical reality that sits behind the recognition challenge. Distinguishing bowel cancer from other conditions is one of the biggest challenges clinicians face.

This challenge exists on both sides of the consultation desk. Some patients don't recognise their symptoms as potentially serious, and some might know something is wrong but struggle to get that concern heard. Bowel habits can be personal, embarrassing to discuss, and easy to attribute to something less worrying. Bowel Cancer UK's own work to encourage people with symptoms to contact their GP found that embarrassment and a belief that bowel cancer is inevitably devastating were both barriers to seeking help.

Clinicians, meanwhile, face a genuine clinical difficulty. Blood from the bottom is far more likely to indicate haemorrhoids than cancer, and many bowel symptoms share characteristics with common, less serious conditions - so-called 'mimics'- making it genuinely difficult to know when to escalate. The same symptoms that point clearly to cancer by the time a patient reaches a bowel cancer specialist can look very different in a primary care setting, where a GP is weighing up many possible causes. This clinical challenge is compounded by the pressures GPs are working under. The Royal College of General Practitioner's (RCGP) own recent research into GP workload highlights the scale of hidden demands on general practice that affect capacity to deliver care.[3]

What makes this harder still is that patients don't always find it easy to describe what they're experiencing, and clinicians don't always have enough to go on. For some, describing symptoms in a way that triggers clinical concern is particularly difficult, and while clinicians are trained to unpick this, the conversation doesn't always surface what matters most. For patients, situations like this can feel like not being heard. For clinicians, it reflects the genuine difficulty of knowing when to take things further.

The recognition challenge is compounded by gaps in awareness among patients about what tests exist, and among clinicians about when to use them. Clinicians told us the public are generally unaware that a simple stool test (the symptomatic FIT test) exists as an option for investigating bowel symptoms. It can help identify who needs further investigation, but only if patients know to ask for it or clinicians think to offer it. There is variation in how consistently it is used in primary care, and clinicians are clear that there is more that could be done to make it part of routine practice.

3. Royal College of General Practitioners, Uncovering the GP workload burden: A study of the drivers and costs of unnecessary and hidden workload, December 2025.

> **Sometimes people aren't even sure what their symptoms mean, and that uncertainty alone can make things really confusing.**

Clinical Nurse Specialist Stoma and Colorectal, England

> **Prior to diagnosis, patients may not be aware of the significance of their symptoms, or may attribute them to other causes.**

Consultant Colorectal Surgeon, Scotland

> **I think there are groups of GPs that are not engaging with this as perhaps they should. I think there's also a lot of pressure on primary care. It's easy for me sitting in secondary care...the diversity of conditions you see is just huge, isn't it? So I do completely appreciate how difficult it is when you're a generalist.**

Consultant Nurse, Colorectal Cancer, England

3: Emergency diagnosis: life-changing news in the worst possible setting

For many people, this point of emergency can arrive suddenly, even after a longer period of warning signs. Things can escalate to a point where A&E becomes the only option, often in considerable pain or distress, and surgery may follow within hours or days of admission. Some wake from surgery with a stoma they never had a chance to prepare for. Others learn their diagnosis alone, without family present.

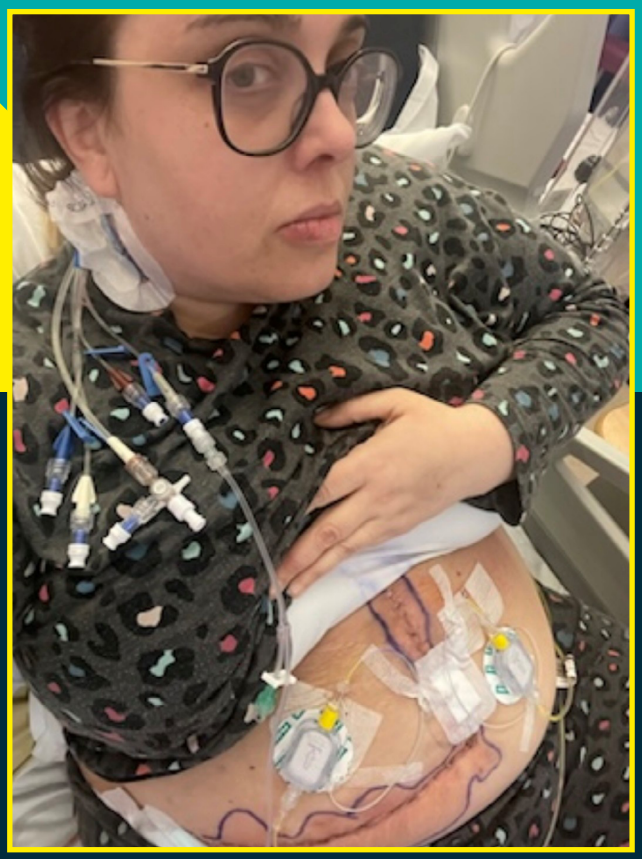
Clinicians working in this environment are doing so under significant pressure, making rapid decisions with incomplete information and limited time. Surgery is often not a planned event, it happens fast, frequently out of hours, and without the full multidisciplinary team input and preparation that a planned pathway would provide. How well the system responds in the days and weeks that follow is where clinicians identify some significant challenges begin.

For patients, this environment can feel disorienting and frightening at an already overwhelming moment. The environment in which all of this unfolds is rarely ideal. From the initial A&E presentation through to days or weeks on a ward, patients can find themselves navigating a system under enormous pressure, and the conditions in which life-changing news is delivered and critical decisions are made are not always what clinicians would choose.

Clinicians tell us that this reflects the reality of a system under significant strain. What follows in the days and weeks after admission reveals how deeply that strain runs across the whole system.

> **"The sudden nature of the diagnosis often means they have less time to process information or understand the next steps in their treatment."**
>
> **Clinical Nurse Specialist Stoma and Colorectal, England**

> **"Nobody wants to be telling people that in A&E. You are often in the middle of a corridor without any real privacy."**
>
> **Colorectal Surgeon, England**



Marie’s story

Diagnosed in January 2024 at just 43 years old, Marie spent over a year experiencing severe bowel issues and dramatic weight loss. "I had numerous doctor visits," Marie recalls, "and it was assumed that I either had IBS, or intolerances, and once in A&E the admin team wrote down that my pain was likely to be due to anxiety!" Because her symptoms overlapped with more common conditions, and her age put her outside the routine screening bracket, her cancer remained hidden.

It wasn't until she reached a breaking point on New Year’s Day, arriving at A&E in tears, that an eventual CT scan finally revealed advanced bowel cancer. "My whole world was ripped apart," she says, remembering the devastating initial prognosis that her condition was inoperable and palliative. Marie’s frightening journey shows just how easily patients can be overlooked until they hit a medical crisis, making it vital that we take their symptoms seriously from the very beginning.

4. After the emergency: gaps in care and communication

Patients have told us that despite the circumstances, the care they received was often excellent. But clinicians are equally clear that excellent clinical care is not always matched by effective communication and coordination, leaving patients and the professionals supporting them without the information they need.

In the days that follow, patients can sometimes find themselves waiting before reaching the team best placed to support them, with the right specialists not always involved from the start. The gaps this creates are not about individual clinician failures. They reflect the structural reality of services that were not designed with this kind of journey in mind.

Patients have described feeling uncertain about what was happening and who was responsible for their care. Clinicians recognise the picture: specialist nursing teams not always informed promptly, GPs unaware their patient has been admitted, oncology teams not always brought in quickly enough. GPs also describe learning their patient has been admitted only by chance, if at all, leaving them unable to offer support at the moment it is most needed.

Getting the right information to the right person at the right time is not always straightforward. When information does arrive, via discharge summaries or referral letters the quality is not always what it needs to be. A letter can arrive and still leave a clinician without the detail they need to support their patient. These are not communication failures in isolation. They reflect how the system as a whole responds, when an emergency diagnosis is made.

There is a further gap that clinicians identify around psychological support. Patients can move from emergency surgery to discharge without a clear plan for their emotional needs, still processing the shock of what has happened. It is a consequence of facing one of the most frightening moments of a person's life, in a setting where the system was never designed to support them through it. For those diagnosed in an emergency, these challenges do not end at discharge. The psychological impact, bowel dysfunction and stoma care that can follow for some patients connect to a broader picture of long-term consequences of bowel cancer treatment that Bowel Cancer UK is also working to address.

> There is a huge gap in communication between services. Different IT systems. Discharge letter taking too long to get to GPs.

Colorectal Nurse Specialist, England

> For the emergency cohort, they go from being well overnight to waking up with a stoma, having been through intensive care. I do not think we provide any psychological support for the trauma of that.

General Surgeon, Wales

> Surgeons who operate on emergency cases frequently fail to pass on all clinical information to the CNS team. It is often our stoma nurse colleagues who communicate a cancer diagnosis to the CNS team.

Colorectal Nurse Specialist, England

5: Who is most likely to be diagnosed this way: a picture still emerging

The question of which groups are most likely to receive an emergency bowel cancer diagnosis sits at the heart of this work. Clinicians bring observations and experience to this question but are clear that the evidence base is limited. Some data suggests that deprivation, ethnicity and age are associated with a higher likelihood of emergency presentation,[4] but clinicians stressed that the picture is incomplete and local patterns can look very different from national assumptions.

Some clinicians point to groups who may be more likely to present as emergencies, including those in deprived areas, rural communities, and those who face language or communication barriers. People experiencing homelessness, mental health challenges or dependency issues are also described as less likely to engage with healthcare until crisis point.

These are clinical observations, and clinicians acknowledge that individual cases can shape perception as much as data. What is consistently described, however, is that practical barriers play a role, including difficulty accessing a GP, long waits, and for those managing financial hardship, health might simply not be the priority.

Clinicians describe a particular and growing concern around younger patients. They are seeing more under-50s with advanced disease than they did a decade ago, with some cases presenting in patients in their 20s and 30s. This group falls outside the age range for routine screening (currently 50-74 in England, Wales and Scotland, with Northern Ireland offering this from 60-74), and clinicians raise the question of whether the current screening age should be reviewed, though the evidence to support a lower screening age is not yet established.

This is a group that demands closer attention, both in terms of understanding why rates are rising and ensuring services are equipped to identify and support them. Older adults are also adversely affected by emergency diagnosis, and addressing it requires focus across the age range.

Clinicians are also clear that local experience does not always match national assumptions, with some describing patients that span all ages, backgrounds and socioeconomic groups, with no clear pattern emerging. Clinicians are consistent on one point: stronger evidence is needed before firm conclusions can be drawn and we need to link up primary and secondary care data.

4. Golder et al., Determinants of emergency presentation in patients with colorectal cancer: a systematic review and meta-analysis, Scientific Reports, 12, 4366 (2022)

> It would be really interesting to know if the data [on younger people] supports that or if that's just my interpretation of it.

Consultant Nurse, Colorectal Cancer, England

> Those not presenting for screening are also the patients most likely to present as an emergency. It tends to be men, patients in deprived areas, and patients in very rural areas.

Consultant Colorectal Surgeon, Scotland

> People from more deprived backgrounds — what they're worried about in their life is how they're going to put the next meal on the table or pay the next rent bill.

Salaried GP / GP Facilitator Cancer Services, Wales

> A lot of the emergencies I see are sadly in younger patients. It is devastating when you get a 23-year-old in with metastatic bowel cancer.

General Surgeon, Wales

6: Toll on clinicians

Patients have described the experience of being diagnosed in A&E as sudden and overwhelming. Clinicians, too, describe a significant professional and emotional burden that is not always spoken about. It comes with delivering difficult news in overcrowded and pressured environments, often without privacy, navigating system pressures, and for many, the weight of recognising that an earlier diagnosis might have been possible. For others, the toll comes simply from delivering devastating news to someone who had little or no warning it was coming.

Many describe frustration, anger and a deep sense of injustice, particularly when a patient's history makes it clear that earlier action might have changed the outcome. This frustration extends beyond individual cases. Clinicians describe the broader reality of working within a system that makes it harder to deliver the care they want to give. For others, it is guilt, a personal sense of responsibility that persists even when the clinical decisions made were entirely appropriate.

Clinicians also describe the difficulty of supporting families who are not just frightened but deeply distressed, struggling to process their feelings at the same time as facing a life-changing diagnosis. Clinicians vary in how they describe this experience, and some speak of emergency diagnosis simply as part of the reality of the work. Equally, some note that a swift emergency diagnosis does at least allow treatment to begin immediately, which matters.

> **A sense of letting down the patients.**
>
> General and Colorectal Surgeon, Wales

> **It's your job, isn't it? So you kind of get on with it, but it is hard. People being diagnosed just after the birth of their children because their symptoms have been dismissed. You just feel so frustrated on their behalf.**
>
> Consultant Nurse, Colorectal Cancer, England

Managing advanced disease where earlier diagnosis might have altered outcomes...as a clinician, you feel that, that impacts on you, that makes you angry, makes you sad, makes you frustrated. When you have a patient that presents with advanced disease and you know there were missed opportunities to diagnose that cancer at an earlier stage, you do get upset with it.

Colorectal Surgeon, England

It can be difficult, especially if there is metastatic disease and care is very complex or palliative. Our patients are getting diagnosed at a younger age and emotionally, mentally and psychologically, this can have a significant effect on us, especially if the patient has a young family.

Colorectal Advanced Nurse Practitioner, Wales

7: Where clinicians see opportunity for change

Two broad threads run through what clinicians tell us: acting earlier to reduce emergency diagnoses, and improving the experience for those who do reach that point. No single change will solve the problem, but together these areas represent a meaningful direction of travel.

7.1 Reducing the number of people who reach emergency diagnosis

Public awareness

Clinicians consistently identify public awareness as a significant gap, and bowel cancer has not had the kind of sustained national campaigns seen for other cancers. Symptoms can be difficult to talk about and hard to describe in ways that trigger clinical concern.

Reaching underserved communities requires going beyond traditional channels into everyday settings like pharmacies and community spaces. Targeted campaigns have shown what is possible, but clinicians are clear that more sustained and widespread activity is needed.[5]

FIT testing

The symptomatic faecal immunochemical test (FIT) is a valuable tool but is not consistently available to all patients who could benefit.[6] Variation in who can request it and on what grounds is limiting its impact, with clinicians pointing to specific examples including networks where only one member of staff is authorised to request it and requests declined on cost grounds.

People affected by bowel cancer are clear that access to FIT is a priority. Bowel Cancer UK's Tell Your GP Instead campaign[7] suggests targeted activity can increase symptomatic FIT use in primary care, and there is a case for exploring whether FIT could be made available through wider settings including community pharmacies. Any expansion should be supported by appropriate diagnostic capacity and clear referral pathways to ensure timely investigation for those who need it.

5. See: DHSC, Help Us Help You: Bowel Cancer Screening, available at: https://campaignresources.dhsc.gov.uk/campaigns/help-us-help-you-cancer/bowel-cancer-screening/; Cancer Prevention Scotland, Bowel screening could save a life, available at: https://www.cps.scot/latest-news/bowel-screening-could-save-a-life; Bowel Cancer UK, Tell Your GP Instead, available at: https://www.bowelcanceruk.org.uk/campaigning/tell-your-gp-instead/

6. Morton et al., Variations in the Use of Faecal Immunochemical Testing (FIT) in Primary Care in England: A Population-Based Cohort of 531,735 FITs from 495,121 Patients Between 2019 and 2023, Clinical Epidemiology, 17 (2025)

7. Bowel Cancer UK, Tell Your GP Instead, available at: https://www.bowelcanceruk.org.uk/campaigning/tell-your-gp-instead/

Supporting GPs and primary care teams

GPs and primary care teams are working under significant pressure, and any support needs to reflect that reality rather than add to it. Clinicians identify a need for better tools and guidance, and question whether awareness of symptoms and available tests extends sufficiently to others who are a patient's first point of contact.

Some steps are being taken. Jess's Rule, an NHS England initiative supported by the RCGP,[8] offers a practical prompt to ensure persistent or escalating symptoms are not overlooked, including in younger patients where cancer may not be the first consideration. There may also be value in exploring whether existing clinical tools are being used as consistently as possible, including those for rectal examination and investigation of anaemia where appropriate.

Bowel cancer in younger adults is a growing concern

Clinicians are clear that this group warrants specific attention. They describe seeing more younger patients presenting with advanced disease than they did a decade ago, and raise concerns that age can act as an implicit barrier to timely investigation, with symptoms sometimes attributed to less serious causes and cancer not on the clinical radar.

For those of working age, an emergency diagnosis brings distinct additional challenges, with the impact on work, family and finances adding a further layer of complexity to an already devastating situation.

7.2 Improving experience and outcomes in an emergency

Getting the right care from the right people

Earlier involvement of specialist teams is consistently identified as one of the most impactful changes that could be made to improve patient experience and outcomes. Clinical Nurse Specialists (CNS) teams are frequently not informed until diagnosis is confirmed, meaning patients can go through some of the most frightening moments of their care without specialist support. Acute Oncology services could act as a valuable bridge to ongoing care, but are not consistently available.

Clinicians raise whether emergency surgery should more consistently be performed by colorectal specialists, noting many operations result in stomas that might have been avoided with specialist input. Ensuring the right people are involved from the start could make a significant difference to patient experience and outcomes.

During and after the emergency

Where clinically possible, 'divert and treat' approaches, which aim to stabilise patients ahead of planned surgery rather than proceeding straight to emergency intervention, could improve outcomes.

There is also evidence that emergency patients arrive with their overall health already compromised, directly restricting treatment options further down the line.

8. NHS England, Jess's Rule: Three strikes and we rethink, 23 September 2025. Available at: https://www.england.nhs.uk/long-read/jesss-rule-three-strikes-and-we-rethink/

Post-discharge coordination is consistently described as a gap. Once surgical teams have discharged a patient, ongoing coordination does not always follow, GPs may not be notified, and rehabilitation services have not been planned, leaving a vacuum of ownership that can follow patients well beyond discharge.

Screening: evidence and reach

The reach and equity of the existing screening programme matters as much as its scope, and clinicians point to significant variation in who engages with it, suggesting this may be connected to patterns of emergency presentation.

A number of clinicians raise the question of whether the current screening age captures everyone who could benefit, noting a pattern of younger patients presenting with more advanced disease, though what age screening should start and for whom are questions that need clearer evidence to answer. Any change would need careful evaluation and investment in diagnostic capacity, and Bowel Cancer UK supports continued review by the UK National Screening Committee as that picture develops.

Diagnostic capacity: an urgent priority

Diagnostic capacity is one of the biggest barriers to reducing emergency bowel cancer diagnosis. Clinicians describe waiting times for diagnostics, including endoscopy, that can be so long that patients already in the system deteriorate before they are seen. Diagnostic capacity also acts as a ceiling on wider progress, meaning expanded screening, more consistent FIT use and better primary care recognition all depend on it being addressed first.

Some steps are being taken, including investment in Community Diagnostic Centres in England, but endoscopy is not yet consistently available across them, and workforce constraints remain a significant challenge. Investment in diagnostic capacity is not optional. It is fundamental to reducing emergency diagnosis.

Psychosocial support: a gap that warrants specific attention

Too many patients reach later stages of care still processing the shock of an emergency diagnosis, having had little or no emotional or psychological support in the interim, and this is not unique to those diagnosed in an emergency.

For those diagnosed in an emergency setting, where the experience is sudden and unplanned, ensuring psychological support is available and consistent is particularly pressing. This support should be protected and consistently available within cancer care, rather than treated as an add-on.

Understanding the problem better: data and learning

A national audit of emergency bowel cancer diagnosis is repeatedly called for to establish how many people are affected, who they are, how they are managed and what outcomes they experience, and to allow emergency diagnosis rates to be used as a meaningful indicator of how well the system is performing.

Clinicians also point to the need for better joined-up data between primary and secondary care, where fragmented systems mean the full picture of a patient's situation is rarely visible in one place.

Shaping change together

Too many people are still reaching crisis point when finding bowel cancer earlier could mean better treatment and better outcomes. The clinician perspectives in this report have helped build a clearer picture of why that happens and where change is needed, adding to what patients and families have already told us.

The next step is to build on those insights with a research and evidence focus, developing the policy priorities most likely to make a difference. Engaging further with clinicians will remain central to that work.

There is more to learn, and there are more voices to hear. If you have insights or evidence that could contribute to this work, whether as a clinician, researcher or someone affected by bowel cancer, we would like to hear from you.

Visit bowelcanceruk.org.uk and contact us at campaigns@bowelcanceruk.org.uk.

Together, we can create a future where bowel cancer is found early - not in an emergency.

Bowel Cancer UK
Beating bowel cancer together

Bowel Cancer UK is the UK's leading bowel cancer charity. We're determined to save lives and improve the quality of life of everyone affected by the disease.

We support and fund targeted research, provide expert information and support to patients and their families, educate the public and professionals about bowel cancer and campaign for early diagnosis and access to best treatment and care.

To donate or find out more visit bowelcanceruk.org.uk

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