NOGCA

National Oesophago-Gastric
Cancer Audit

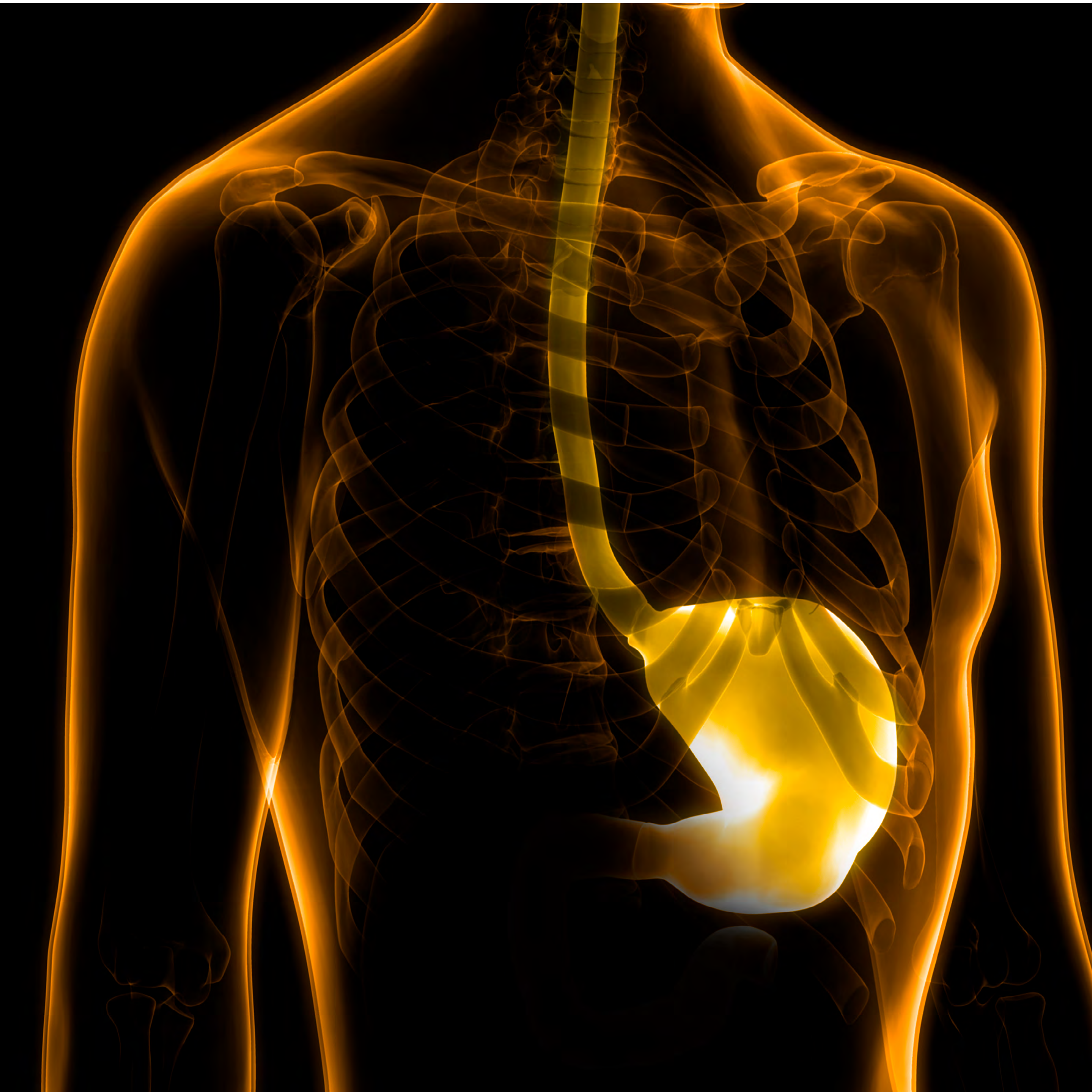
NATCAN

National Cancer Audit
Collaborating Centre

National Oesophago-Gastric Cancer Audit State of the Nation Report September 2025

An audit of care received by people diagnosed with oesophageal or gastric cancer between 1 January 2022 and 31 December 2023 in England and Wales.

Published September 2025



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Royal College
of Surgeons
of England
ADVANCING SURGICAL CARE

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

HQIP
Healthcare Quality
Improvement Partnership

The National Cancer Audit Collaborating Centre (NATCAN) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) and funded by NHS England and 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.

AUGIS
ASSOCIATION OF UPPER GASTROINTESTINAL
SURGERY OF GREAT BRITAIN AND IRELAND

The Association of Upper Gastrointestinal Surgery of Great Britain and Ireland is the speciality society that represents upper gastrointestinal surgeons. It is one of the key partners leading the Audit. Registered Charity no: 1093090

bsg BRITISH SOCIETY OF
GASTROENTEROLOGY

British Society of Gastroenterology is the speciality society of gastroenterologists. It is one of the key partners leading the Audit. Registered Charity no: 1149074

The Royal College of Radiologists

The Royal College of Radiologists is the professional body for clinical radiologists and clinical oncologists. It is one of the key partners leading the Audit. Registered Charity no: 211540

NDRS
NATIONAL DISEASE REGISTRATION SERVICE

This work uses data that has been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data is collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.

GIG CYMRU NHS WALES
Rhwydwaith Canser Cymru
Wales Cancer Network

NHS Wales is implementing a new cancer informatics system. As a result, the quality and completeness of data from Wales is likely to have been impacted due to implementation of this new system across multiple NHS organisations (Health Boards), which has resulted in data being supplied by both old and new systems. Additionally, and reflecting the uncertainty of data quality, the data submitted to the audit may not have undergone routine clinical validation prior to submission to the Wales Cancer Network (WCN), Public Health Wales.

Contents

1. Introduction

The National Oesophago-Gastric Cancer Audit (NOGCA) is part of the National Cancer Audit Collaborating Network (NATCAN), a programme commissioned within the National Clinical Audit and Patient Outcomes Programme (NCAPOP) by the Healthcare Quality Improvement Partnership (HQIP). NOGCA evaluates the quality of care received by people diagnosed with oesophageal or gastric cancer in England and Wales, with the overarching aim of supporting NHS trusts/health boards, Cancer Alliances, and policymakers to improve outcomes.

This 2025 State of the Nation report is the second annual national report produced using routine national cancer data[1]. It includes people who had a histological diagnosis of epithelial oesophageal or gastric cancer (OG cancer) between 1 January 2022 and 31 December 2023. While a previous report was published in January 2025 covering the period 1 April 2021 to 31 March 2023, this report aligns with the calendar year to be consistent with other NATCAN audits and to support clearer year-on-year comparisons across the cancer audit portfolio. A two-year reporting window ensures adequate patient numbers for robust organisation-level analysis. Surgical outcomes are reported over three years (1 January 2021 - 31 December 2023) for the same reason, with a longer time period as only a subset of people have surgery. Although the data presented in this report relates to treatment up to the end of 2023, it is being published in September 2025 to allow sufficient follow-up time for the full care pathway to be captured, including definitive treatment and short-term outcomes. This is particularly important in OG cancer, where treatment pathways can span many months, and sufficient time is needed to ensure that key quality indicators, such as post-operative outcomes and completion of multi-modality treatment, are accurately recorded and reported. Organisation-level results are typically based on the people diagnosed at each NHS trust/health board (see supplementary tables). Surgical indicators are reported for the 32 specialist surgical centres in England and two centres in Wales. Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2021.

Since 2024, the Audit has derived its performance indicators (see Table 1) using information that is routinely collected by the NHS as part of the care and support given to people diagnosed with oesophageal or gastric cancer, rather than data collected specifically for the Audit.[2] For people diagnosed or treated in England, the data are collated, maintained and quality assured by NHS England's National Disease Registration Service (NDRS). For people diagnosed or treated in Wales, data are provided by Wales Cancer Network (WCN)[3], using the Cancer Network Information System Cymru (CaNISC) or Cancer Dataset Form (CDF).

To further support quality improvement activities, NOGCA also publishes quarterly dashboards that include a subset of performance indicators for England (available here); these provide more frequent updates that enable monitoring of performance and quality improvement initiatives.

For full details of the data and methods used within this report, please see the NOGCA Methodology Supplement.

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[1] Timeliness of cancer registration data releases from the National Disease Registration Service

[2] The audits in NATCAN do not 'collect' clinical data. The cancer audits utilise the nationally mandated flows of data from hospitals to the National Disease Registration Service (NDRS) in NHS England and the Wales Cancer Network in Public Health Wales, thereby minimising the burden of data collection on provider teams.

[3] NHS Wales is part way through a cancer informatics implementation programme which is designed to improve the data capture and reporting capabilities of NHS Wales. This ongoing implementation is impacting the data quality within NHS Wales in the short term with multiple systems being used and different implementation dates across cancer sites and organisations resulting in a complex data landscape. 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 2026 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

Table 1. *Performance Indicators Included

	England^	**Wales#**
PI1: Percentage of people with a diagnosis of OG cancer who are diagnosed after an emergency admission	Yes (01/22 – 12/23)	Yes (01/22 – 12/23)
PI2: Percentage of people with a diagnosis of OG cancer who are diagnosed at stage 4 or with unknown stage	Yes (01/22 – 12/23)	Yes (01/22 – 12/23)
PI3: Median time (days) and IQR from diagnostic endoscopy to first disease-targeted treatment for OG cancer	Yes (01/22 – 12/23)	Yes (01/22 – 12/23)
PI4: Percentage of people with a diagnosis of OG cancer who are seen by a Clinical Nurse Specialist (CNS)	Yes (01/22 – 12/23)	No (data unavailable)
PI5: Percentage of people undergoing curative surgical resection for OG cancer who had adequate lymph nodes examined after surgery	No (data not complete)	Yes (01/21 – 12/23)
PI6: Percentage of people undergoing curative surgical resection for OG cancer who had positive surgical resection margin rates (risk adjusted)	No (data not complete)	Yes (01/21 – 12/23)
PI7: 90-day survival rate after curative surgery (unadjusted)	Yes (01/21 – 12/23)	Yes (01/21 – 12/23)
PI8: 1-year survival rate after curative surgery (unadjusted)	Yes (01/21 – 12/22)	Yes (01/21 – 12/23)
PI9: Percentage of people starting palliative systemic anti-cancer therapy (SACT) completing at least 4 cycles of treatment	Yes (01/22 – 12/23)	No (data not complete)
PI10: Percentage of people diagnosed with stage 4 disease dying within 90 days of starting systemic anti-cancer therapy (SACT)	Yes (01/22 – 12/23)	No (data not complete)

*See methodology supplement for the exact definitions of each performance indicator
^England data: Rapid Cancer Registration Dataset (RCRD)
#Welsh data: Cancer Network Information System Cymru (CaNISC)

Additional materials that accompany this report include:

- A methodology supplement with details about the Audit's data sources and methods
- Supplementary results including changes in performance indicators over time
- An online glossary that explains technical terms used in this report
- Information about the outlier process
- Resources to support local monitoring of practice and quality improvement, such as provider-level results on the Data Dashboard and downloadable reports and a local action plan template
- A summary of this report for people living with OG cancer and for the public is available on the Audit webpages.

2. Infographic

NOGCA

National Oesophago-Gastric Cancer Audit

Summary of results for people diagnosed with oesophageal or gastric (OG) cancer in England and Wales between 1 Jan 2022 and 31 Dec 2023

20,582

people diagnosed with OG cancer

E England: 19,243

W Wales: 1,339

Emergency admission & stage 4 diagnoses

E 21%

W 14%

People diagnosed after emergency admission

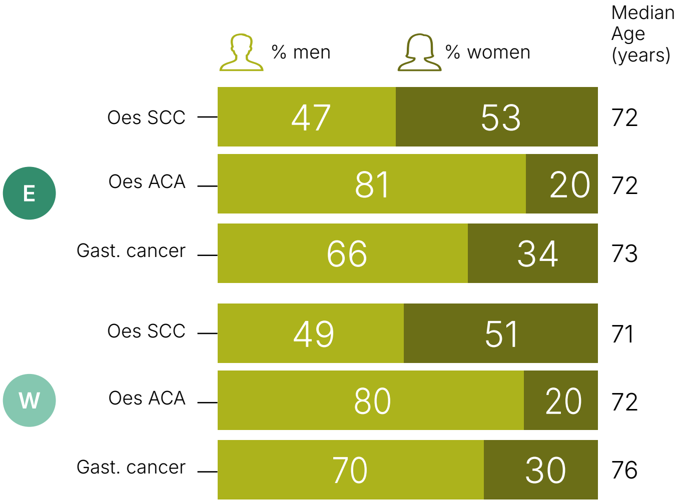
E 38%

W 32%

People diagnosed with stage 4 disease

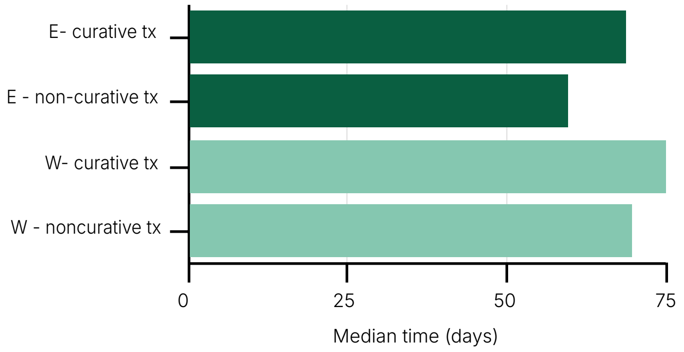
People aged 80 years and over had the highest rates of diagnosis via emergency admission

Patient profile at diagnosis



Waiting times

Time from diagnostic endoscopy to start of disease-targeted treatment*



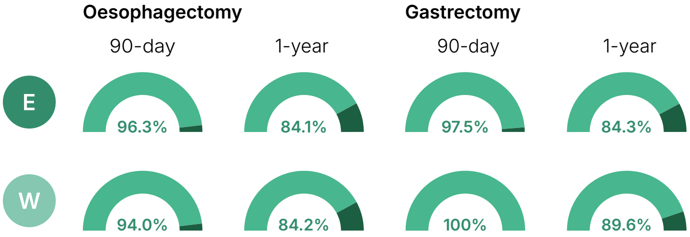
Curative treatment & outcomes

E 53%

W 31%

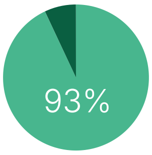
% people diagnosed at stage 1-3 treated receiving curative treatment

Survival following surgical resection**



Access to CNS

Where data were complete***, 93% of people in England were seen by a CNS****



People diagnosed by emergency admission, and those with survival of less than 90 days after diagnosis, were less likely to see a CNS

Non-curative treatment & outcomes

% people diagnosed at stage 4 treated with SACT and/or radiotherapy

E 56% W 37%

4.3% died within 30 days of starting SACT in England*****

16.7% died within 90 days of starting SACT in England*****

CNS: Clinical Nurse Specialist
Gast. cancer: Gastric (stomach) cancer
OG: Oesophago-Gastric
Oes SCC: Oesophageal squamous cell carcinoma
Oes ACA: Oesophageal adenocarcinoma
tx: Treatment
SACT: Systemic Anti-Cancer Therapy

* Waiting times measured from date of first endoscopy within 30 days of date of diagnosis and date of first disease-targeted treatment of EMR/ESD, surgery, radiotherapy, or SACT.

** 3 years' of data (1 Jan 2021 - 31 Dec 2023) used for surgical outcomes to ensure enough procedures to produce robust statistics; results are the % for people undergoing surgery.

*** Data available for only 63% of patients.

**** CNS data not available for Wales.

***** Outcomes of palliative chemotherapy are not reported for Wales due to known issues with oncology data.

3. Recommendations

Recommendations developed in collaboration with NOGCA Clinical Reference Group and based on key findings in this report.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
Clinical Recommendations				
1. Expand the use of approaches to improve early diagnosis in community settings, including: – Explore strategies to improve engagement with their local populations and address identified hotspots of emergency cancer presentation. – Case reviews of emergency presentation or late-stage diagnosis by referring hospitals to identify potential missed opportunities and share learning with primary care partners to support earlier diagnosis in the future.	England: NHS England, Cancer Alliances working with NHS trusts Wales: Wales Cancer Network, health boards Primary care organisations	1 in 5 people (21% in England, 14% in Wales) with OG cancer were diagnosed following an emergency hospital admission. For gastric cancer this figure was higher: 30% in England and 21% in Wales. People aged 80 years and over had the highest rates of diagnosis via emergency admission. Over one third of all people included in the Audit were diagnosed with either stage 4 OG cancer (38% in England, 32% in Wales) or unknown stage (16% in England, 16% in Wales).	Goal #1: Reduce rates of emergency and late-stage diagnosis of OG cancer.	NHS Long Term Plan: the proportion of cancers diagnosed at stages 1 and 2 will rise to three-quarters of cancer patients (2028). Wales Cancer Network, A Cancer Improvement Plan for NHS Wales: reducing emergency presentation and first presentation with advanced disease.
2. Explore opportunities to streamline diagnostic and decision-making pathways. This includes considering implementation of new models of care that reduce delays and support timely initiation of treatment for people with OG cancer.	England: Cancer Alliances working with NHS trusts Wales: health boards	The median time between diagnostic endoscopy and initiation of disease-targeted treatment for people with OG cancer was 64 days (interquartile range (IQR) 49 to 84 days) in England and 72 days (IQR 51 to 104) in Wales. Wait times were longer for people undergoing curative treatment (69 days, IQR 55 to 88 days in England; 75 days, IQR 55 to 107.5 days in Wales) vs. non-curative treatment (60 days, IQR 45 to 79 days in England; 70 days, IQR 49 to 100 days in Wales). Wait times were longest for people whose primary treatment was surgical resection without neoadjuvant chemotherapy or radiotherapy, with a median of 78 days (IQR 52 to 107 days) in England.	Goal #2: Improve timely access to staging investigations to reduce delays between diagnostic endoscopy and the start of disease-targeted treatment.	No national guidance set. Recommendation identified as a priority by NOGCA Clinical Reference Group.

Recommendation	Audience	Audit Findings	Quality Improvement Goal	National Guidance/Standards/Resources
3. Carry out thorough assessment and counselling for all people being considered for palliative systemic anti-cancer therapy (SACT) to ensure treatment decisions are based on a clear understanding of potential risks and benefits. In older populations, use formalised fitness assessments, such as the Clinical Frailty Scale. Where there is a high risk of early mortality (within 90 days), best supportive care to be discussed as an alternative. To support continuous improvement in decision-making, all people who die within 30-days of receiving palliative SACT to be reviewed through local morbidity and mortality processes.	England: Cancer Alliances working with NHS trusts Wales: health boards	In England, 4.3% of people with stage 4 OG cancer receiving systemic anti-cancer therapy (SACT) died within 30 days, and 16.7% of people died within 90 days of starting treatment. There was considerable variation between NHS trusts in England, with a median 90-day mortality rate of 16.7% (IQR 12.3% to 21.7%) and a range from 0% up to a maximum of 50%. Data not reported for Wales.	Goal #5: Improve completion and reduce complications of palliative chemotherapy for people with OG cancer.	NCEPOD: all deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting.
4. All people diagnosed with OG cancer to have timely access to a Clinical Nurse Specialist (CNS) ideally within 72 hours of diagnosis. NHS organisations to review CNS provision where data show low levels of CNS contact and take steps to address workforce or service gaps. Accurate recording of CNS involvement to be prioritised in clinical data systems to support ongoing monitoring and improvement.	England: Integrated Care Boards (ICBs) working with NHS trusts Wales: health boards	In England, where data were complete, 93% of people with OG cancer were seen by a CNS. However, overall data completeness for CNS review was limited (68%), with information about CNS involvement missing for a third of people. In four-fifths of NHS trusts in England, >=90% of people were seen by a CNS; however, in seven NHS trusts this figure was <80%. People diagnosed by emergency admission in England were less likely to see a CNS, as were people with survival of less than 90 days after diagnosis. *Data not reported for Wales.*	Goal #3: Increase the percentage of people with OG cancer who have access to a clinical nurse specialist (CNS).	NHS England Cancer Programme: All people with OG cancer should have access to a CNS or other support worker.
Data Quality Recommendation				
5. Ensure there is a national and local level focus on improving the capture and availability of pathology data in routine datasets in England, to enable reporting of key cancer outcomes	England: NHS England, NHS trust pathology laboratories	There are poor levels of completeness of pathology data in national cancer datasets (England), which limits the reporting of surgical-pathology indicators for OG cancer. Data on excision margin were only available for three out of 32 OG surgical centres in England; some data on lymph node yield were available from all OG surgical centres but had high levels of data missing.	Goal #4: Improve the quality and consistency of pathology data flows to enable robust national assessment and benchmarking of surgical performance.	AUGIS The provision of services for specialist OG surgery (2024): ≥15 lymph nodes removed and examined. AUGIS The provision of services for specialist OG surgery (2024): Longitudinal resection margin positivity rate for oesophagectomies <5%

4. Results for England and Wales

4.1 Data completeness

Key messages:

- Data items relating to patient and tumour characteristics generally had good levels of completeness in national cancer datasets for England and Wales.
- The quality of audit findings is directly dependent on the completeness and format of data submitted.
- Margin status and lymph node yield (Performance Indicators 5 and 6, Table 1) are critical surgical quality indicators, but little data are available on these pathology outcomes in England. National and local action is needed to improve the flow of pathology data from English NHS trusts to the National Disease Registration Service.

Completeness of disease stage at diagnosis and performance status[4] was 84% and 80% respectively, for people diagnosed in England, but many NHS trusts had levels of completeness below the Audit's 90% target on these data items (out of 119 diagnosing NHS trusts, 76 and 69 NHS trusts had levels of completeness below 90% for stage and performance status, respectively). Completeness ranged across NHS trusts from 47% to 99% for disease stage and from 5% to 100% for performance status. For people diagnosed in Wales, completeness of information on stage at diagnosis was similar to England (84%) but completeness of performance status was higher (96%). Disease stage and performance status are essential variables for sub-group analyses and risk-adjustment of performance indicators. A list of key COSD data items can be found on the NOGCA website.

The completeness of some data items affects the reliability of specific performance indicators. The completeness of data about Clinical Nurse Specialist (CNS) involvement was 68% overall for people diagnosed in England (performance indicator 4) with values ranging from 5% to 94%. Data on pathology outcomes after surgical resections were missing for the majority of people treated in England: data items on nodes excised and nodes examined were available for less than half of surgical resection procedures, while information on excision margins was available from only three NHS specialist centres due to the format in which they submit pathology reports to National Disease Registration Service (NDRS). Information on CNS involvement is not available for Wales at this time.

Pathology data were complete for over 98% of people who underwent a gastrectomy and 84% of people who had an oesophagectomy in Wales, however the lack of surgical pathology data for people treated in England is a concern. Pathological outcomes such as resection margin status and lymph node yield are critical indicators of surgical performance. Without reliable pathology data it is not possible to provide a comprehensive picture of surgical quality. The Audit uses pathology data submitted via the Cancer Outcomes and Services Dataset – Pathology (COSD-Pathology) to the NDRS. However, in many cases, data are not submitted in the correct XML format or are embedded in free-text fields of pathology reports, which cannot be easily processed. The NDRS has limited capacity to extract information manually from these unstructured and unformatted submissions, resulting in key data items being unavailable.

NOGCA will continue to work with the NDRS, NHS England and the Cancer Alliances on this issue and advocate for the improvements needed to support reporting of surgical pathology outcomes.

4.2 Characteristics of people diagnosed with oesophageal or gastric (OG) cancer

Key messages:

- Over one third of all people included in the Audit were diagnosed with either stage 4 (38% in England, 32% in Wales) or unknown stage (16% in England, 16% in Wales) OG cancer. (Performance Indicator 2).
- There has been no reduction in the percentage of people diagnosed with advanced disease in the last five years.

Table 2 presents the characteristics of the 20,582 people diagnosed with epithelial oesophago-gastric (OG) cancer in England and Wales between 1 January 2022 and 31 December 2023. The majority of people (71%) had oesophageal tumours. OG cancer was more commonly diagnosed in men, accounting for 70% of cases in England and 73% in Wales. The split by sex varied by cancer subtype: oesophageal adenocarcinoma had a higher proportion of men (81% in England and 80% in Wales), whereas oesophageal squamous cell carcinoma was more evenly split between men and women (47% men in England, 49% men in Wales).

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[4] Performance status – a classification system to describe a person's functional status whilst performing routine activities of daily living. Scores range from 0 (fully active with no restrictions) to 5 (dead).

The median age at diagnosis was 72 years in England and 73 years in Wales, with approximately one-quarter of people diagnosed aged 80 or over in both countries. A significant proportion of people with OG cancer presented with advanced disease: 38% of people in England and 32% in Wales were diagnosed with stage 4 cancer, and a further 16% in both countries had no stage recorded. An analysis of the survival times by stage suggests that people with missing stage values were likely to be stage 3 or 4. There has been no reduction in the percentage of people diagnosed with stage 4 disease in the last five years.

Among people with known performance status (PS), the majority (76% in England; 70% in Wales) were fully active or active. PS was unknown for 20% in England and 4% in Wales. Ethnicity data was well completed in England, where 93% of people with OG cancer were recorded as White. Data on ethnicity was missing for 57% of people in Wales.

Socioeconomic status, as measured by the Index of Multiple Deprivation (IMD), was relatively evenly distributed across quintiles. IMD was complete for 100% of cases in England but unknown for 42% of cases in Wales. However, gastric cancer appeared slightly more common among people from more deprived areas. These findings reflect the varied demographic and clinical profiles of people diagnosed with OG cancer and underscore the importance of high-quality data collection to support targeted improvements in care.distributed across quintiles. However, gastric cancer appeared slightly more common among people from more deprived areas. These findings reflect the varied demographic and clinical profiles of people diagnosed with OG cancer and underscore the importance of high-quality data collection to support targeted improvements in care.

Table 2. Characteristics of people diagnosed with OG cancer between 1 January 2022 and 31 December 2023 by main subtypes, England and Wales

England					Wales				
	Overall	**Oes SCC**	**Oes ACA**	**Gast**		**Overall**	**Oes SCC**	**Oes ACA**	**Gast**
No. of people	**19,243**	**3,389**	**10,048**	**5,173**	**No. of people**	**1,339**	**225**	**828**	**279**
Sex					Sex				
Men	**70%**	47%	81%	66%	Men	**73%**	49%	80%	70%
Women	**30%**	53%	20%	34%	Women	**27%**	51%	20%	30%
Unknown (n=0)					Unknown (n=1)				
Age at diagnosis (years)					**Age at diagnosis (years)**				
<60	**16%**	14%	15%	18%	<60	**12%**	11%	13%	12%
60-69	**25%**	27%	26%	22%	60-69	**25%**	28%	26%	17%
70-79	**36%**	34%	38%	32%	70-79	**40%**	41%	40%	38%
≥80	**24%**	25%	21%	28%	≥80	**23%**	20%	21%	33%
Unknown (n=0)					Unknown (n=3)				
Median age at diagnosis (years)		72	72	73	**Median age at diagnosis (years)**		71	72	76
Index of Multiple Deprivation quintile					**Index of Multiple Deprivation quintile**				
1 – most deprived	**20%**	21%	17%	23%	1 – most deprived	**20%**	13%	20%	26%
2	**20%**	20%	19%	21%	2	**22%**	24%	21%	21%
3	**21%**	21%	21%	19%	3	**21%**	22%	21%	19%
4	**21%**	19%	22%	20%	4	**19%**	22%	19%	18%
5 – least deprived	**19%**	19%	20%	17%	5 – least deprived	**18%**	18%	19%	16%
Unknown (n=0)					Unknown (n=557)				
TNM Stage at diagnosis					**TNM Stage at diagnosis**				
1	**6%**	3%	5%	10%	1	**3%**	*	*	*
2	**19%**	23%	21%	13%	2	**12%**	*	*	*
3	**21%**	21%	22%	19%	3	**37%**	38%	42%	23%
4	**38%**	35%	38%	38%	4	**32%**	19%	35%	35%
Unknown	**16%**	17%	13%	19%	Unknown	**16%**	19%	15%	18%
Performance status					**Performance status**				
0 – fully active	**42%**	39%	44%	39%	0 – fully active	**36%**	31%	39%	31%
1	**34%**	35%	33%	34%	1	**34%**	34%	33%	36%
2	**16%**	17%	15%	17%	2	**17%**	21%	17%	16%
3	**8%**	8%	7%	9%	3	**11%**	11%	10%	14%
4 - bedbound	**1%**	1%	1%	2%	4 – bedbound	**2%**	2%	1%	3%
Unknown (n=3789)					Unknown (n=57)				

Note: Oes SCC – oesophageal squamous cell carcinoma; Oes ACA – oesophageal adenocarcinoma; Gast – gastric;

* - data suppressed due to small cell counts.

Overall cohort is larger than sum of each tumour subgroup as some diagnoses of oesophageal cancer could not be categorised as SCC or ACA.

Column percentages may not add up to 100% due to rounding.

For further details about the definitions of characteristics, please refer to the Audit's methodology supplement and glossary.

4.3 Diagnosis after emergency admission

Key messages:

- One in five people diagnosed with OG cancer were diagnosed following an emergency hospital admission (21% in England; 14% in Wales). (Performance Indicator 1).
- Among people with gastric cancer, the proportion diagnosed via emergency admission was high (30% in England, 21% in Wales) compared to oesophageal cancer (18% in England, 12% in Wales).

In England, the likelihood of being diagnosed with OG cancer via emergency admission was related to both older age and higher socioeconomic deprivation. People aged 80 years and over had the highest rates of diagnosis after emergency admission (29%), with people diagnosed aged 60-69 years having the lowest (17%). In terms of socioeconomic deprivation, 24% of individuals living in the most deprived areas were diagnosed via emergency admission, compared to 18% in the least deprived areas. There was variation across NHS trusts in England, with a median emergency diagnosis rate of 21% and an interquartile range (IQR) of 18% to 24% across 118 NHS trusts.

In Wales, a similar pattern was observed: 20% of people aged 80 and over were diagnosed after an emergency admission compared to 14% of those aged 60–69; 20% of people living in the most deprived areas were diagnosed via an emergency route compared to 9% of those in the least deprived areas.

Overall rates of diagnosis following an emergency admission have not improved over the last five years.

4.4 Time from diagnostic endoscopy to disease-targeted treatment

Key messages:

- People with OG cancer in England waited a median of 64 days (IQR 49 to 84) from diagnostic endoscopy to disease-targeted treatment and 72 days (IQR 51 to 104) in Wales, highlighting delays in this part of the pathway. (Performance Indicator 3).
- People undergoing curative treatment for OG cancer faced longer waits to start treatment compared to those receiving non-curative care. The longest delays were seen in people treated with surgical resection alone, highlighting potential issues in preoperative pathways.

In this State of the Nation report, we have updated how timelines through the diagnostic and staging pathway are calculated to ensure the figures complement the metrics published through the Cancer Waiting Times (CWT) Monitoring Dataset. Our focus is on capturing the part of the patient pathway after referral, which is most relevant to secondary care cancer services. For the majority of people in the Audit cohort, a gastroscopy was performed within 30 days of the date of diagnosis. In most cases, this procedure will represent the point at which the cancer is first detected and subsequently confirmed on biopsy. We therefore designated this as the “diagnostic endoscopy” and starting point for the calculation of the diagnostic and staging pathway waiting times. We then measured the time interval from this diagnostic endoscopy to the first disease-targeted treatment, defined as endotherapy (endoscopic mucosal resection (EMR) and endoscopic submucosal dissection (ESD)), surgery, neo-adjuvant chemotherapy, definitive chemoradiotherapy, or palliative systemic anti-cancer therapy (SACT)/radiotherapy (RT). This approach differs from the CWT methodology, which “stops the clock” for treatment-enabling interventions, such as stent insertion, and considers the use of supportive care drugs as first definitive treatment when a patient is receiving palliative care only and no active treatment is planned.

People diagnosed with OG cancer in England wait a median of 64 days (IQR 49 to 84) from diagnostic endoscopy to the start of disease-targeted treatment. In Wales, the median time was 72 days (IQR 51 to 104).

Table 3 provides more detail on the patterns of waits by treatment type. Wait times were longer for those receiving curative treatment, with the longest delays observed in people undergoing surgical resection without neoadjuvant chemotherapy or radiotherapy.

Table 3. Time from diagnostic endoscopy to start of disease-targeted treatment for people diagnosed with OG cancer between 1 January 2022 and 31 December 2023 in England and Wales, by type of treatment

	Median (interquartile range), days					
	By treatment type		**By primary treatment modality**			
	Curative	**Non-curative**	**Surgery only**	**Surgery + chemo/RT**	**EMR/ESD**	**Chemo / RT only**
England	69 (55 to 88) n=4,944	60 (45 to 79) n=5,587	78 (52 to 107) n=530	67 (54 to 81) n=2,531	70 (47 to 101) n=487	62 (47 to 83) n=6,983
Range across Trust of diagnosis**	49 to 102	27 to 103	41 to 132	39.5 to 100.5	25 to 153	29 to 101
Wales	75 (55 to 107.5) n=224	70 (49 to 100) n=322	*	68 (56 to 92) n=101	*	70 (51 to 98) n=372
Range across health boards	56.5 to 145	57 to 93.5	*	*	*	60 to 90.5

* Results not presented due to small numbers of people receiving these treatment types at national or organisation level

** Required minimum of 5 diagnoses at NHS trust of diagnosis with endoscopy and treatment to be included in analyses on range

4.5 Access to Clinical Nurse Specialists (CNS)

Key messages:

- Based on available data, the majority of people diagnosed with OG cancer in England (93%) were seen by a CNS around the time of diagnosis. (Performance Indicator 4).
- People diagnosed with OG cancer following an emergency admission were less likely to see a CNS, as were people who survived fewer than 90 days after diagnosis.

In England, among people with complete Clinical Nurse Specialist (CNS) data (n=13,043), 93% had a recorded consultation with a CNS around the time of diagnosis. This varied by (i) route to diagnosis: 88% of people diagnosed following an emergency admission had a consultation with a CNS (vs 94% for other routes) and (ii) survival: 88% of people who died within 90 days of diagnosis had a consultation with a CNS (vs 95% of people alive at 90 days). However, data completeness was poor: 37% of people diagnosed with OG cancer were missing data on CNS involvement. [Data on "Seen by a CNS" are not available for Wales at this time.]

4.6 Disease-targeted treatments

Key messages:

- Overall, 53% of people in England and 31% of people in Wales with stage 1–3 OG cancer received curative treatment within nine months of diagnosis.
- Receipt of both curative and palliative treatments was strongly associated with patient fitness, emphasising the need for accurate recording of performance status to assess treatment decisions and service planning.

Table 4 summarises the percentage of people who received disease-targeted treatments within nine months of diagnosis in England and Wales, by stage at diagnosis.

Curative treatments included EMR/ESD, resection surgery (with or without neoadjuvant chemotherapy), and definitive chemoradiotherapy. Receipt of curative treatment was strongly associated with patient fitness, measured by performance status (PS). Fitter people were substantially more likely to receive curative treatment. Overall, 53% of patients with stage 1-3 in England receive curative treatment, however there is variation between NHS trusts (IQR 45% to 90%).

For people diagnosed with stage 4 OG cancer, 56% in England and 37% in Wales received systemic anti-cancer therapy (SACT) and/or radiotherapy (RT). In England there was variation across NHS trusts (IQR 48% to 65%).Treatment rates were closely linked to PS: In England, 75% of people with stage 4 disease and PS 0 received palliative SACT/RT, compared with 10% of those with PS 3 or 4. A similar pattern was seen in Wales, where 55% of people with PS 0 received SACT, compared to 12% with PS 3 or 4.

Table 4. Percentage of people diagnosed with OG cancer between 1 January 2022 and 31 December 2023 who received disease-targeted treatments within nine months of diagnosis, by stage at diagnosis and cancer subtype, England and Wales

	England				**Wales***			
	All[Ł]	**Oes SCC**	**Oes ACA**	**Gast**	**All**	**Oes SCC**	**Oes ACA**	**Gast**
Stage 1-3								
No. of people	**8,912**	1,621	4,832	2,203	**692**	139	420	129
Surgery only	**5%**	2%	4%	13%	**7%**	1%	8%	12%
Surgery plus systemic anti-cancer therapy and/or radiotherapy	**26%**	11%	31%	27%	**16%**	5%	20%	15%
Definitive chemoradiotherapy	**14%**	34%	13%	2%	**7%**	9%	9%	0%
EMR/ESD	**7%**	3%	9%	5%	**1%**	0%	2%	1%
Overall curative treatment	**53%**	50%	56%	47%	**31%**	15%	38%	27%
Overall receiving treatment (irrespective of intent)	**76%**	74%	79%	72%	**60%**	53%	65%	55%
Stage 4								
No. of people	**7,289**	1,187	3,863	1,968	**430**	43	286	99
Systemic anti-cancer therapy and/or radiotherapy	**56%**	59%	59%	49%	**37%**	40%	40%	30%

[Ł] Overall cohort is larger than sum of each tumour subgroup as some diagnoses of oesophageal cancer could not be categorised as SCC or ACA;
*- data suppressed due to small cell counts or to prevent disclosure of small cell counts.

4.7 Outcomes of curative surgery

Key messages:

- Survival rates following curative surgery for OG cancer remain high: 96.6% in England and 95.6% in Wales at 90 days after resection surgery (Performance Indicator 7), and 84.2% in England and 85.7% in Wales at one year. (Performance Indicator 8).
- Poor completeness of pathology data in England limits the ability to assess surgical quality and benchmark performance nationally.

Outcomes of curative surgery are reported over a three-year period (1 January 2021 to 31 December 2023) to ensure sufficient case numbers for robust analysis at the level of individual organisations.

During this period, 5,202 people diagnosed with OG cancer in England underwent major surgical resection with curative intent - comprising 3,716 people undergoing oesophagectomy and 1,486 people undergoing gastrectomy. In Wales, 251 major resections were recorded, including 184 people undergoing oesophagectomy and 67 people undergoing gastrectomy.

Both short-term and longer-term survival rates following curative surgery were high (see Table 5). One-year survival was 84.2% in England and 85.7% in Wales.

Both 90-day survival and 1-year survival following surgery are subject to the Audit's outlier process. There were no outliers identified. For further information please refer to the supplementary materials.

Among those in Wales who had resection surgery, 79% had at least 15 lymph nodes removed and examined, meeting the standard recommended by the Association of Upper Gastrointestinal Surgery of Great Britain and Ireland (AUGIS). Information on positive resection margins has not been reported, due to low numbers when analysed by type of procedure.

For this audit period, data on excision margins were only available from three of the 32 OG surgical centres in England: Leeds, Oxford, and Lancashire. This significant data gap limits our ability to report on one of the key indicators of surgical quality. Some data on lymph nodes excised were available from all surgical centres; however, this information was often incomplete with high levels of data missing (missing for >40% of surgical resections).

Length of stay

The median length of stay following oesophagectomy in England was 11 days (IQR 8 to 16 days), and 13 days (IQR 10 to 19 days) in Wales. For people undergoing gastrectomy, the median length of stay was 9 days (IQR 7 to 13 days) in both England and Wales. These figures are consistent with those reported in previous years, suggesting stable post-operative recovery times across surgical centres.

Table 5. 90-day and 1-year survival rates and surgical pathology outcomes (95% CI[i]) after surgery with curative intent among people diagnosed with OG cancer between 1 January 2021 and 31 December 2023, England and Wales

	England			**Wales**		
	Oesophagectomy (n=3,701)	**Gastrectomy (n=1,481)**	**Overall (n=5,182)****	**Oesophagectomy (n=184)**	**Gastrectomy (n=67)**	**Overall (n=251)**
Survival rate % (95% CI)						
90-day	96.3% (95.6% to 96.9%)	97.5% (96.6% to 98.2%)	96.6% (96.1% to 97.1%)	94.0% (90.6% to 97.4%)	100%	95.6% (92.3% to 97.8%)
1 year*	84.1% (82.6% to 85.5%)	84.3% (81.9% to 86.6%)	84.2% (82.9% to 85.4%)	84.2% (79.0% to 89.5%)	89.6% (82.2% to 96.9%)	85.7% (80.7% to 89.7%)
Surgical pathology indicators						
≥15 lymph nodes examined	Not available***	Not available***	Not available***	78.1% (71.4% to 83.9%)	81.8% (70.4% to 90.2%)	79.1% (73.5% to 84.0%)

*Calculated for people diagnosed between 1 January 2021 and 31 December 2022 to ensure sufficient follow-up. [i]CI: confidence interval. NOTE: Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-21.

** The total number of surgeries are lower in the 90-day survival analysis as some patients diagnosed in calendar year 2023 had not yet reached 90 days post-surgery at the time of data extraction and were therefore censored (n = 20).

*** This information was often incomplete with high levels of data missing for >40% of surgical resections.

4.8 Outcomes of palliative systemic anti-cancer therapy (SACT)/radiotherapy (RT)

Key messages:

- Among people who began a NICE-recommended palliative SACT regimen for OG cancer in England, 55% completed at least four cycles of treatment. (Performance Indicator 9).
- 4.3% of people with stage 4 disease undergoing SACT/RT in England died within 30 days of starting treatment.
- 16.7% of people with stage 4 disease undergoing SACT/RT in England died within 90 days of starting treatment. (Performance Indicator 10).
- Careful clinical decision-making and ongoing evaluation of treatment outcomes is essential to ensure that palliative SACT is offered to people who are most likely to benefit.

Between 1 January 2022 and 31 December 2023, among people diagnosed at any stage in England who began a NICE-recommended palliative SACT regimen, 55% completed at least four cycles. However, there was substantial variation in treatment completion rates across NHS trusts (IQR 47%-63%), highlighting potential differences in patient selection, treatment protocols, or access to best supportive care.

Table 6 presents 30-day and 90-day mortality rates following the start of SACT among people diagnosed with stage 4 OG cancer. These measures are important indicators of whether people are being appropriately selected for treatment. While SACT may offer symptom relief and modest survival benefits, the treatments can have significant side effects. For people approaching the end of life, best supportive care may be more appropriate and aligned with a person's goals and preferences for quality of life.

In Wales, 121 people diagnosed with OG cancer were recorded as having received palliative chemotherapy. However, this is likely to underestimate the true number of people treated, due to known data quality issues following the implementation of a new cancer information system in Wales in 2022. Additionally, for most people with a recorded palliative chemotherapy episode, key details such as the treatment regimen, number of cycles, and treatment completion were not available. As a result, indicators related to palliative SACT could not be reliably reported for Wales in this audit cycle.

Table 6. 30-day and 90-day mortality after starting systemic anti-cancer treatment (SACT) in people diagnosed with OG cancer between 1 January 2022 and 31 December 2023, England only

	Oesophageal (n=2,260)	Gastric (n=838)	Overall (n=3,098)
30-day mortality	2.4%	4.5%	4.3%
90-day mortality	16.3%	17.8%	16.7%

4.9 High grade dysplasia

Since the previous State of the Nation Report published January 2025, NATCAN arranged for NOGCA's Rapid Cancer Registration data to include people diagnosed with oesophageal (D00.1) and gastric (D00.2) carcinoma in situ. High grade dysplasia (HGD) cases are allocated these codes when notified to NDRS. In 2022 and 2023, 245 and 210 cases, respectively, were identified with a D00.1 or D00.2 code, fewer than expected, likely due to local data collection practices. Only two NHS Trusts reported more than 40 patients over the two years. However, this sample may provide insight into treatment patterns for HGD.

Over the last decade, endoscopic techniques (EMR/ESD) have increasingly replaced major surgical resection for early tumours. Table 7 describes the use of resection procedures for people diagnosed with HGD and stage 1 OG cancer. Among people diagnosed in 2022-23 who had a procedure recorded in the data, initial management for HGD was most commonly with EMR/ESD, with a small proportion having surgery. Among the people who had an EMR/ESD, a small proportion went on to have a surgical resection. Among people diagnosed with stage 1 OG cancer, the ratio of EMR/ESD to surgery is more even.

Table 7. Management of people diagnosed with high grade dysplasia and stage 1 OG cancer between 1 January 2022 and 31 December 2023, England only

	No. of patients	Primary treatment			
		% Patients who did not have a procedure recorded	% Patients who had EMR/ESD	% Patients who had major surgical resection	% Patients with surgical resection after EMR/ESD
HGD	455	70%	27%	4%	3%
Stage 1 OG cancer	1317	31%	41%	27%	15%
Stage 1 OG cancer figures by age at diagnosis (years)					
<60	158	22%	30%	47%	25%
60-69	295	19%	47%	33%	21%
70-79	415	28%	46%	26%	13%
≥80	269	55%	33%	11%	3%

5. Commentary

This year's second State of the Nation report highlights both the strengths and the ongoing challenges facing oesophago-gastric (OG) cancer services in England and Wales. For people who have surgery with curative intent, rates of survival remain at a consistently high standard. 90-day and 1-year post operative survival is subject to our outlier process and no outliers have been identified. However, in other areas, figures show that specific aspects of the care pathway remain a concern and there has been little progress in tackling these issues.

The proportion of people diagnosed with stage 4 disease remains high, with more than 1 in 3 presenting with advanced cancer, similar to those reported five years ago. This may reflect the non-specific symptoms of OG cancers. We encourage Cancer Alliances to monitor rates of late-stage diagnoses and coordinate multidisciplinary review across services involved in the diagnostic pathway to identify opportunities for earlier detection. Innovations may include the implementation of single queue diagnostic models, use of risk stratification tools in primary care, and rapid diagnostic centres.

Looking ahead, emerging technologies such as the capsule sponge and breath testing could offer opportunities to reduce the number of people diagnosed with late-stage disease. By detecting premalignant conditions or enabling earlier diagnosis, these innovations may support the development of targeted screening strategies for individuals at higher risk.

We also continue to see delays along the diagnostic and treatment pathway. Long delays can affect decision options, recovery, and people's emotional wellbeing at a time of profound uncertainty. Reducing delays remains a shared priority at all levels of the NHS but achieving target times will require better coordination across services, local innovation to streamline diagnostic pathways, and a continued focus on improving patient flow.

NOGCA's shift to using routine data has brought significant benefits by reducing the burden on frontline clinical teams and increasing case ascertainment across England and Wales. However, it has introduced new challenges, most notably in relation to the lack of pathology data for people treated in England. Key metrics such as margin status and lymph node yield are essential for assessing surgical quality and benchmarking performance. Resolving this issue will require coordinated leadership at national and local levels, and investment in digital infrastructure. Pathology departments must be supported to submit structured data to the NDRS in line with COSD-Pathology guidance to ensure these vital data are available for quality assurance and improvement.

Clinical Nurse Specialists play a pivotal role for people living with OG cancer, helping them navigate the complex care pathway, manage symptoms, and access appropriate support. However, due to data quality issues, it is difficult to draw firm conclusions about what proportion of people are seen by a CNS around the time of diagnosis. Consequently, it is not possible to conclude whether service coverage is sufficient or to identify where investment and support are most urgently needed to improve patient care.

The focus of the Audit is evolving from an emphasis on quality assurance to quality improvement. We have published a national Quality Improvement (QI) Plan (due to be reviewed in October 2025), and later this year will launch our targeted QI intervention to support improvement in key areas of OG cancer care. The rollout of the NOGCA Quarterly Data Dashboard has also been a major step forward, giving NHS trusts and Cancer Alliances in England (and in due course for Wales) access to more real-time data to inform local improvement work.