NOGCA
National Oesophago-Gastric Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

Foreword

It is a privilege to write this foreword for the National Oesophago-Gastric Cancer Audit (NOGCA) State of the Nation Report 2026. This report offers an important and comprehensive picture of the care received by 20,441 people diagnosed with oesophageal or gastric cancer in England and Wales between 2023 and 2024. It highlights areas of real achievement, while also showing clearly where we must focus our efforts to ensure that every patient has timely, equitable access to the best possible care.

There are encouraging findings. Outcomes following curative surgery remain strong, with 90-day survival of 96.7% in England and 94.9% in Wales. These results reflect the skill, dedication and close multidisciplinary working of surgical, anaesthetic, oncology, gastroenterology, radiology, pathology, nursing and wider support teams across the country. The majority of people with complete data also had contact with a Clinical Nurse Specialist around the time of diagnosis- an essential component of the care and support patients and their families need throughout an often difficult pathway.

Yet this report also reminds us that good outcomes are not experienced equally by all patients. Too many people continue to present with advanced disease: 45% in England and 42% in Wales were diagnosed with stage 4 cancer. One in five people in England were diagnosed following an emergency admission. Earlier diagnosis must therefore remain a shared priority, through improved awareness, effective referral pathways, prompt access to diagnostic tests and better use of risk stratification.

Timeliness matters throughout the pathway. The median interval from diagnostic endoscopy to first disease-targeted treatment was 64 days in England and 76 days in Wales, with substantial variation between Cancer Alliances and across treatment modalities. Behind these figures are patients and families living with uncertainty at a pivotal point in their care. Delays may also affect fitness for treatment and the range of options that remain available. Understanding where bottlenecks occur- and learning from services that achieve timely, well-coordinated pathways- must be central to improvement work.

The introduction of two new performance indicators- prolonged length of stay following curative surgery and readmission within 30 days of discharge is particularly welcome. These measures give a fuller picture of recovery after surgery, complementing the strong short-term survival outcomes. In England, 25% of patients had a stay of more than 15 days, with adjusted rates ranging from 11% to 40% between surgical centres; the equivalent figure in Wales was 33%. Readmission rates also varied, from 7% to 29% across English surgical centres, with 15% of patients in England and 11% in Wales readmitted overnight within 30 days. These indicators must be considered alongside case-mix and mortality, but they offer an important opportunity to examine enhanced-recovery pathways, early recognition and management of complications, discharge planning, and access to nutritional and specialist follow-up support. Learning from teams achieving good outcomes in both measures can help ensure that more patients experience a safe, timely and well-supported recovery.

Perhaps the most important challenge highlighted by this report is variation in the proportion of patients who progress to a potentially curative treatment pathway. Among people with stage 1–3 disease, 57% in England and 39% in Wales initiated treatment with curative intent. For those with stage 1–3 disease and a performance status of 0 or 1, the

proportions were 67% and 47% respectively. In England, rates across Cancer Alliances ranged from 55% to 77%.

These figures must be interpreted carefully. Decisions about curative treatment are rightly individualised, taking account of tumour factors, co-morbidity, frailty, patient preference and the likely balance of benefit and risk. Nevertheless, variation of this scale should prompt us to ask searching questions. Are all patients being discussed in the appropriate specialist multidisciplinary setting? Are optimisation, prehabilitation and nutritional support available early enough? Do patients with complex or borderline disease have consistent access to wider specialist discussion or a second opinion? And are we doing enough to ensure that a patient's place of residence does not influence their opportunity to receive potentially curative treatment?

As a surgical representative on the NOGCA committee, I am particularly encouraged by the Audit's increasing ability to use data not simply to describe care, but to support improvement. The new measures of prolonged length of stay and readmission after surgery provide valuable insight into recovery, perioperative care and discharge planning. Variation between surgical centres should be viewed as an opportunity to understand what high-performing teams do well and to spread effective practice- not as a reason for complacency or blame.

This is also an area in which collaboration will be crucial. As Co-Founder and Trustee of UKIOG, I see the value of bringing clinicians, researchers, patients, charities and service leaders together to develop practical solutions. Work to standardise and accelerate diagnostic pathways, alongside NOGCA's targeted quality-improvement activity and more frequent reporting through the Data Dashboard, provides an important platform for shared learning and sustained progress.

The findings in this report are a testament to the commitment of everyone involved in oesophago-gastric cancer care. They should give us confidence in what can be achieved, while challenging us to reduce unwarranted variation and ensure that every patient can benefit from timely diagnosis, expert multidisciplinary care and appropriate treatment. I thank the NOGCA team, its clinical leads, the contributing organisations, and the many healthcare professionals whose data, commitment and care make this work possible.

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