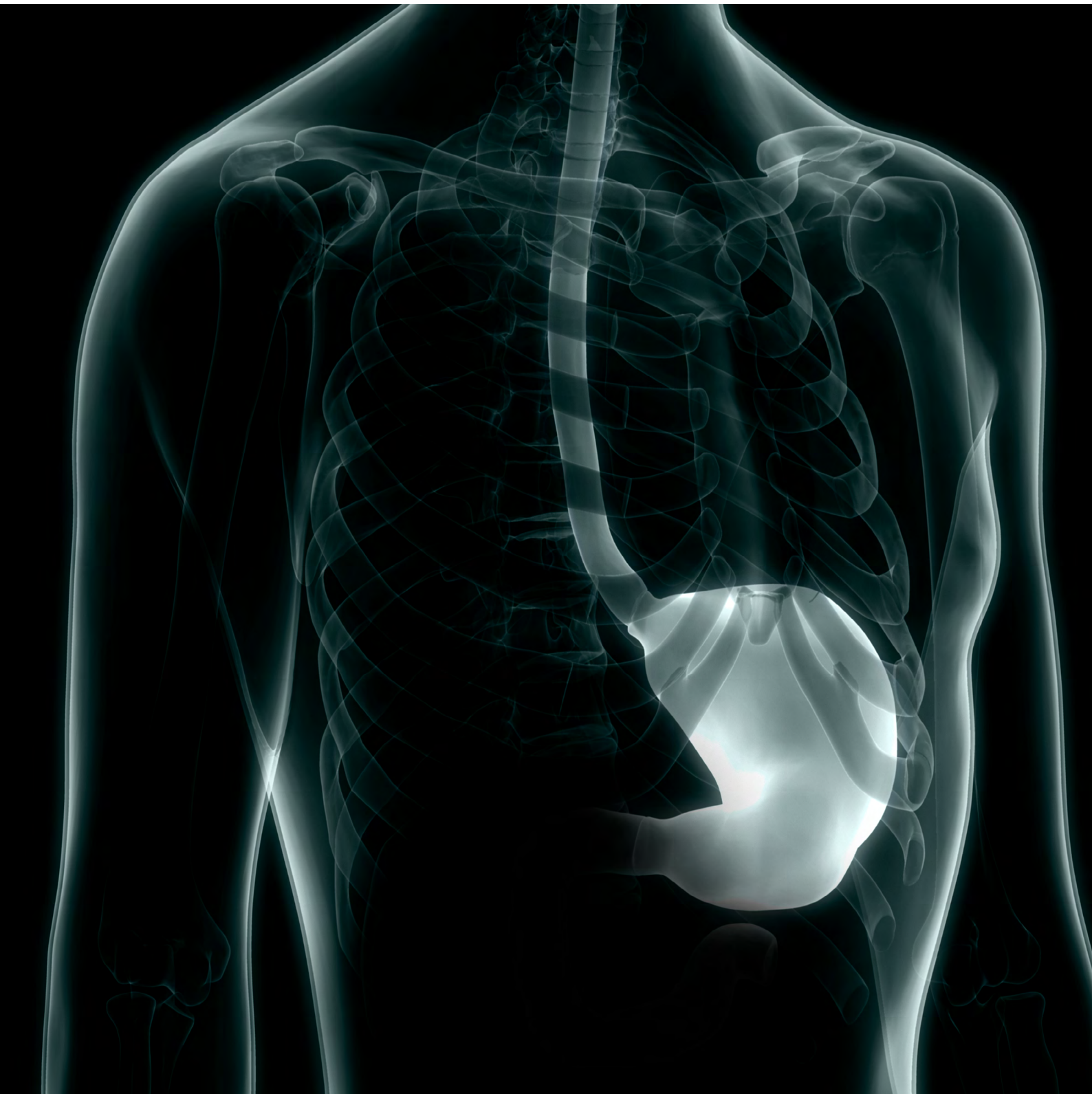
NOGCA
National Oesophago-Gastric Cancer Audit

NATCAN
National Cancer Audit Collaborating Centre

National Oesophago-Gastric Cancer Audit
State of the Nation Report 2026

An audit of care received by people diagnosed with oesophageal or gastric cancer between 1 January 2023 and 31 December 2024 in England and Wales.

Published September 2026



NOGCA

National Oesophago-Gastric Cancer Audit

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Royal College of Surgeons of England
ADVANCING SURGICAL CARE

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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 the Welsh Government as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). NATCAN delivers national audits in bowel, breast (primary and metastatic), kidney, lung, non-Hodgkin lymphoma, oesophago-gastric, ovarian, pancreatic and prostate cancers.

AUGIS
ASSOCIATION OF UPPER GASTROINTESTINAL SURGERY OF GREAT BRITAIN AND IRELAND

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

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British Society of Gastroenterology is the specialty 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 have been provided by patients and collected by the NHS as part of their care and support. For patients diagnosed in England, the data are collated, maintained and quality assured by the National Disease Registration Service (NDRS), which is part of NHS England. Access to the data was facilitated by the NHS England Data Access Request Service.

GIG CYMRU NHS WALES
Perfformiad a Gwella
Performance and Improvement

NHS Wales recently implemented Cancer Dataset Forms with the latest implementation date being January 2025. These have been designed to improve the data capture and reporting capabilities of NHS Wales. This implementation has impacted the data quality within NHS Wales. NHS Wales has committed to continue to submit audit data annually until data submissions are sourced exclusively from the new cancer informatics solution. This will be from 2027 onwards that NHS Wales will be able to supply quarterly data using this new integrated, and more accessible digital platform.

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Contents

1. Introduction 1
2. Infographic 3
3. Recommendations 4
4. Results for England and Wales 6
   - 4.1 Characteristics, stage at diagnosis and emergency presentation of people diagnosed with oesophageal or gastric (OG) cancer 6
   - 4.2 Time from diagnostic endoscopy to disease-targeted treatment 6
   - 4.3 Access to Clinical Nurse Specialists (CNS) 8
   - 4.4 Curative treatment rates 9
   - 4.5 Outcomes of curative surgery 9
   - 4.6 Outcomes of palliative systemic anti-cancer therapy (SACT) 12
   - 4.7 One-year and three-year survival 13
   - 4.8 Change over time 14
5. Commentary 16

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1. Introduction

The National Oesophago-Gastric Cancer Audit (NOGCA) measures the quality and outcomes of care for people diagnosed with oesophageal or gastric cancer in England and Wales. This report focuses on people who had a histological diagnosis of epithelial oesophageal or gastric cancer (OG cancer) between 1 January 2023 and 31 December 2024.

NOGCA's Quality Improvement (QI) Plan sets out five QI goals covering the entire patient care pathway, supported by eight performance indicators mapped to these goals. The aim is to increase the consistency of access to treatments and stimulate improvements in care and outcomes for people with oesophageal or gastric cancer.

In this report, we present the results for our eight key performance indicators (PIs) and set out recommendations to support performance improvement. For this reporting cycle, the set of performance indicators has been updated to reflect changes in data availability and maintain our focus on clinically meaningful measures of care quality. Completeness of pathology data in England remains insufficient to support reliable reporting of pathology-based surgical indicators. These have therefore been replaced with alternative surgical outcome indicators derived from routinely collected data: length of stay greater than 15 days following curative surgery and 30-day readmission rates, which act as proxy measures of postoperative complications and recovery.

Table 1 sets out the eight NOGCA performance indicators and their corresponding reporting periods. Reporting periods vary according to the purpose of each measure and the need to ensure robust and reliable estimates. Most performance indicators use a two-year diagnosis cohort (1 January 2023 to 31 December 2024) to maximise case numbers and improve the stability of estimates. Surgical outcome indicators are reported using a three-year diagnosis cohort (1 January 2022 to 31 December 2024) to provide sufficient volumes for meaningful comparison between surgical centres. Survival measures are reported using earlier diagnosis cohorts to allow sufficient follow-up for complete one-year and three-year survival estimation.

Table 1. NOGCA's performance indicators (PIs) and corresponding reporting periods

Description	England^	Wales#
PI 1: Median time (days) and interquartile range (IQR) from diagnostic endoscopy to first disease-targeted treatment for oesophageal or gastric (OG) cancer	Yes (01/23 – 12/24)	Yes (01/23 – 12/24)
PI 2: Percentage of people with a diagnosis of OG cancer who are seen by a Clinical Nurse Specialist (CNS)	Yes (01/23 – 12/24)	Reported only for people with data recorded in Cancer Dataset Forms
PI 3: Percentage of people who initiated potentially curative treatment (stages 1-3)	Yes (01/23 – 12/24)	Yes (01/23 – 12/24)
PI 4: 90-day survival rate after curative surgery*†	Yes (01/22 – 12/24)	Yes (01/22 – 12/24)
PI 5: Percentage of people with length of stay >15 days following curative surgery*	Yes (01/22 – 12/24)	Yes (01/22 – 12/24)
PI 6: Percentage of people readmitted to hospital within 30 days of discharge following curative surgery*	Yes (01/22 – 12/24)	Yes (01/22 – 12/24)
PI 7: Percentage of people starting palliative systemic anti-cancer therapy (SACT) completing at least four cycles of treatment	Yes (01/23 – 12/24)	Yes (01/23 – 12/24)
PI 8: Percentage of people diagnosed with stage 4 disease dying within 90 days of starting systemic anti-cancer therapy (SACT)	Yes (01/23 – 12/24)	Yes (01/23 – 12/24)

* Risk-adjusted indicator

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

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

† Subject to NOGCA Outlier Policy

Reporting periods differ according to the purpose of each indicator. Two-year diagnosis cohorts are used for most performance indicators to maximise precision, three-year cohorts are used for surgical outcome indicators to ensure sufficient case numbers for provider-level comparisons, and survival measures use earlier diagnosis cohorts to allow adequate follow-up.

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We use data routinely collected by the NHS, using the nationally mandated flow of data from hospitals to the National Disease Registration Service (NDRS) in NHS England and the National Cancer Team, NHS Wales Performance and Improvement.

Please refer to the NOGCA Methodology Supplement for comprehensive details regarding data sources and methodology. Supporting materials, including our Supplementary Report, Glossary, Local Action Plan Template, Outlier Policy, each NHS provider's results for performance indicators and data quality metrics, and our Patient and Public Summary Report are available on the NOGCA State of the Nation report 2026 webpage.

In addition to this annual report, we publish quarterly updates on performance indicator and data quality metrics on the NOGCA Data Dashboard for NHS trusts in England, to be able to track progress alongside local quality improvement initiatives.

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2. Infographic

Summary of results for people diagnosed with oesophageal or gastric (OG) cancer in England and Wales between 1 January 2023 and 31 December 2024

NOGCA
National Oesophago-Gastric Cancer Audit

20,441 people diagnosed with OG cancer in England and Wales between 1 January 2023 and 31 December 2024

E England: 19,161 W Wales: 1,280

Route of diagnosis

E 21%
W 13%

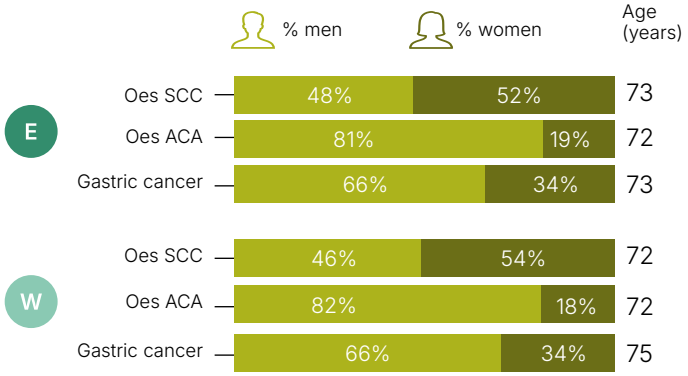
% people diagnosed after emergency admission

Stage at diagnosis

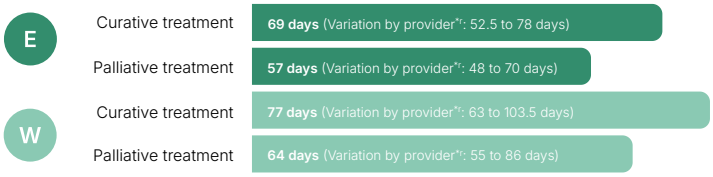
E 45%
W 42%

% people diagnosed with stage 4 disease

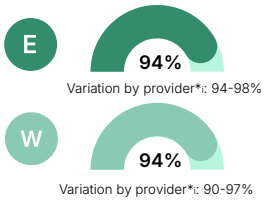
Patient profile at diagnosis



Median time from diagnostic endoscopy to first disease-targeted treatment for OG cancer[a] (PI 1)



% people with a diagnosis of OG cancer who are seen by a Clinical Nurse Specialist[b] (PI 2)

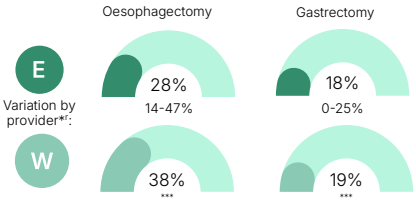


% people diagnosed with stage 1-3 OG cancer (PS 0-1) who initiated potentially curative treatment (PI 3)

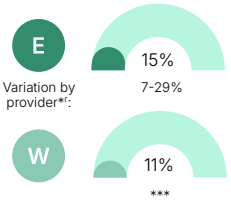
E 67% Variation by provider*†: 55-77%
W 47%**

90-day survival rate after curative surgery[c] (PI 4)

% people with length of stay >15 days following curative surgery[c] (PI 5)



% people readmitted to hospital within 30 days of discharge following curative surgery[c] (PI 6)



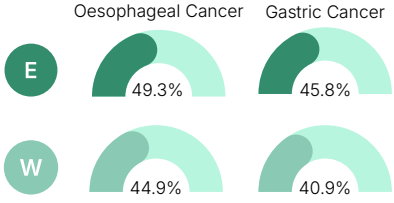
% people starting palliative systemic anti-cancer therapy (SACT) completing at least four cycles of treatment (PI 7)

E 55% Variation by provider*†: 46-64%
W 60% 47-77%

% people diagnosed with stage 4 disease dying within 90 days of starting SACT (PI 8)

E 16.0% Variation by provider*†: 11.8-20.7%
W 14.9% **

One-year survival



Fewer than 10% of people diagnosed with OG cancer at stage 4 survived to three years after diagnosis

National performance across OG cancer indicators in England showed little change between 2021 and 2024. (Change over time is not presented for Wales due to changes in data collection approaches in recent years, making comparisons inappropriate.)

Key
PI: Performance Indicator
PS: Performance Status
OG: Oesophago-Gastric
Oes SCC: Oesophageal squamous cell carcinoma
Oes ACA: Oesophageal adenocarcinoma
Gast. cancer: Gastric (stomach) cancer***

a. 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.
b. Data available for 73% of patients in England and 90% of patients in Wales.
c. 3 years' of data (1 Jan 2022 - 31 Dec 2024) used for surgical outcomes to produce robust statistics; results are the % for people undergoing surgery.

* Variation is the IQR or range across providers;
** Variation data not available for Wales;
*** Data for surgical centres in Wales were not available for this analysis at the time of reporting due to limitations in reliably allocating people to surgical centres - thus variation not reported.

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3. Recommendations

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

Recommendation	Audience	Audit Findings	Quality Improvement (QI) Goal	National Guidance/Standards/Resources
1. Providers to review why people were recorded as not being seen by a Clinical Nurse Specialist (CNS) to identify potential barriers to timely CNS support. All people diagnosed with oesophageal or gastric (OG) cancer to be offered specialist CNS input, ideally within 72 hours of diagnosis.	England: Cancer Alliances working with Integrated Care Boards (ICBs) and NHS trusts Wales: health boards	In England, where data were complete, 94% of people with OG cancer were seen by a Clinical Nurse Specialist (CNS). However, variation was observed between trusts: IQR 94% to 98%. Among the subgroup of people diagnosed in Wales who had their information submitted via the new Cancer Dataset Forms, CDF, 94% of those with complete data had a record of being seen by a CNS (IQR 90% to 97%).	Goal #2: Improve access to Clinical Nurse Specialist (CNS) support and care coordination.	The National Cancer Plan for England: Action 23: Every patient will have a Clinical Nurse Specialist or other named lead to support them through diagnosis and treatment. NHS Wales Cancer Improvement Plan: Every person diagnosed with cancer should have a named Key Worker [...] a role undertaken ordinarily by a Clinical Nurse Specialist
2. Specialist multidisciplinary teams (MDTs) with comparatively low rates of treatment with curative intent among people with stages 1–3 OG cancer to ensure that people are offered appropriate optimisation and prehabilitation strategies, and to consider mechanisms for wider specialist MDT discussion or second-opinion review for people with complex or borderline disease where suitability for curative treatment may be unclear.	England and Wales: Upper Gastrointestinal (UGI) MDTs (specialist and non-specialist)	The overall proportion of people who initiated potentially curative treatment was 34% in England and 25% in Wales. Among people with stages 1–3 disease and a performance status of 0 or 1 at diagnosis, 67% initiated potentially curative treatment in England (range across Cancer Alliances: 55%–77%) and 47% in Wales.	Goal #3: Improve access to potentially curative treatment, where appropriate.	NICE guideline 83: All people with confirmed OG cancer should be reviewed within an MDT that includes an oncologist and radiologist with an interest in OG cancer, and people with non-metastatic disease should additionally be discussed at a specialist OG cancer MDT. Macmillan Cancer Support Prehabilitation for people with cancer clinical and implementation guidelines: prehabilitation should be widely adopted to benefit patients' preparation for and recovery from cancer treatment.
3. Surgical OG cancer centres to undertake a structured review of people with a length of stay (LOS) >15 days following OG resection to identify complications or other factors contributing to delayed discharge, evaluate opportunities for prevention, including timeliness of management, escalation pathways and postoperative decision-making.	England: Cancer Alliances, specialist surgical centres Wales: health boards, specialist surgical centres	Postoperative length of stay exceeding 15 days occurred in 25% of people undergoing curative surgery for OG cancer in England and 33% in Wales. In England, adjusted rates varied across surgical centres, ranging from 11% to 40%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NHS England Theatres, surgery and perioperative care: A clinical and operational improvement guide: compliance with an enhanced recovery bundle is associated with shorter LOS. General Surgery GIRFT Programme Follow-up Report: Mortality and morbidity (M&M) meetings should evolve beyond a traditional focus on deaths and major complications to include routine review of performance data.

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Recommendation	Audience	Audit Findings	Quality Improvement (QI) Goal	National Guidance/Standards/Resources
4. Specialist centres with comparatively high rates of readmission within 30 days of discharge following an OG resection to ensure there is adequate discharge planning within Enhanced Recovery after Surgery (ERAS) pathways, so that people are prepared for recovery at home and can access follow-up nutritional and support services. Centres should also undertake regular local audit and review of readmissions, including root cause analysis of potentially preventable readmissions, to identify opportunities for service improvement and reduce avoidable hospital reattendance.	England and Wales: Specialist surgical centres	Following curative surgery for OG cancer, 15% of people in England and 11% in Wales were readmitted to hospital within 30 days of discharge, requiring an overnight stay. After case-mix adjustment, rates across surgical centres in England ranged from 7% to 29%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NICE guideline 94 Chapter 35 Discharge Planning: 30-day readmission is an important outcome measure linked to discharge processes and transitional care.
5. Optimise decision-making and supportive care for all people being considered for palliative systemic anti-cancer therapy (SACT). • Carry out thorough assessment, counselling, and consideration of specialist palliative care involvement. In older people, 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 should be discussed as an alternative. • Review all deaths within 30 days of palliative SACT through local morbidity and mortality processes to support continuous improvement in treatment decision-making.	England: Cancer Alliances working with Integrated Care Boards (ICBs) and NHS trusts Wales: health boards	Among people with stage 4 OG cancer receiving SACT, 4.2% in England and 4.6% in Wales died within 30 days of starting treatment. Within 90 days of starting treatment, 16.0% of people in England and 14.9% in Wales had died. There was variation between NHS trusts in England for 90-day mortality: IQR 12% to 21%.	Goal #4: Improve short-term outcomes for people receiving treatment for OG cancer.	NCEPOD: all deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting. The UK SACT Board has developed a template for an operational policy and pro forma for reviewing deaths within 30 days of SACT. RCR: Centres should present mortality figures so that departments can put their short-term mortality into context. BGS: Late recognition of end of life in people with frailty can impede patient-centred decisions.

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4. Results for England and Wales

4.1 Characteristics, stage at diagnosis and emergency presentation of people diagnosed with oesophageal or gastric (OG) cancer

Key messages

In England, 45% of patients are diagnosed with stage 4 OG cancer. In Wales, the equivalent figure is 42%.

One in five people diagnosed with OG cancer were diagnosed following an emergency hospital admission (21% in England; 13% in Wales).

Emergency presentation was more common for gastric cancer than for oesophageal cancer.

Table 2 presents the characteristics of the 20,441 people diagnosed with epithelial oesophageal or gastric (OG) cancer in England and Wales between 1 January 2023 and 31 December 2024, including stage at diagnosis and emergency presentation. In England, 45% of people were diagnosed with stage 4 disease, compared with 42% in Wales. Overall, there has been little improvement in rates of advanced-stage diagnosis over the past five years, highlighting the ongoing challenges in achieving earlier diagnosis of OG cancer.

One in five people diagnosed with OG cancer were diagnosed following an emergency hospital admission (21% in England and 13% in Wales). Emergency presentation was more common among older people and those living in more deprived areas. Gastric cancer was also slightly more common among people living in more deprived areas.

4.2 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 83) from diagnostic endoscopy to disease-targeted treatment and 76 days (IQR 49 to 112) in Wales, highlighting delays in this part of the pathway. (Performance Indicator 1).

People undergoing curative treatment for OG cancer faced longer waits to start treatment compared to those receiving palliative treatments. The longest delays were seen in people treated with surgical resection alone, highlighting potential issues in preoperative pathways.

Median waiting times from diagnostic endoscopy to first disease-targeted treatment were 64 days (IQR 49 to 83) in England and 76 days (IQR 49 to 112) in Wales, indicating ongoing delays within this part of the treatment pathway. Waiting times were generally longer among people receiving curative treatment compared with those receiving palliative treatments (Table 3). The longest waits were observed among people undergoing OG surgery without neoadjuvant therapy, suggesting potential delays within preoperative assessment and surgical pathways.

Figure 1 demonstrates substantial variation between Cancer Alliances in England, with median waiting times ranging from 51 to 72 days. Additional analyses showed marked differences according to specific treatment modalities (see our Supplementary Report). Median waiting times ranged from 41 to 110 days for endoscopic treatment, 48 to 97.5 days for surgery, and 48 to 77 days for neoadjuvant therapy prior to surgery across Cancer Alliances. These findings suggest that delays may occur within different parts of the treatment pathway in different regions.

Reducing delays to treatment may help people remain sufficiently fit to receive potentially curative therapy and may improve overall outcomes. The variation observed across Cancer Alliances highlights opportunities to improve pathway efficiency and reduce unwarranted delays in access to treatment.

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Table 2. Characteristics of people diagnosed with OG cancer between 1 January 2023 and 31 December 2024, including stage at diagnosis and emergency presentation, overall and by tumour subtype, England and Wales.

England					Wales				
	Overall	**Oes SCC**	**Oes ACA**	**Gast**		**Overall**	**Oes SCC**	**Oes ACA**	**Gast**
No. of people	**19,161**	**3,430**	**10,059**	**5,042**	**No. of people**	**1,280**	**207**	**719**	**354**
Sex					**Sex**				
Men	71%	48%	81%	66%	Men	72%	46%	82%	66%
Women	29%	52%	19%	34%	Women	28%	54%	18%	34%
Age at diagnosis (years)					**Age at diagnosis (years)**				
<60	16%	14%	15%	19%	<60	13%	14%	13%	10%
60-69	25%	26%	26%	21%	60-69	23%	25%	24%	18%
70-79	36%	35%	38%	31%	70-79	41%	41%	42%	38%
≥80	24%	25%	22%	29%	≥80	24%	20%	20%	34%
Median	73	73	72	73	Median	74	72	72	75
Index of Multiple Deprivation quintile					**Index of Multiple Deprivation quintile**				
1 – most deprived	19%	21%	17%	22%	1 – most deprived	18%	17%	17%	21%
2	19%	20%	18%	21%	2	23%	19%	23%	25%
3	21%	22%	21%	20%	3	22%	20%	24%	20%
4	21%	18%	22%	20%	4	19%	23%	19%	18%
5 – least deprived	20%	19%	21%	17%	5 – least deprived	18%	20%	18%	17%
Unknown (n=0)					Unknown (n=68)				
Ethnicity					**Ethnicity**				
White	93%	93%	97%	87%	White	99%	*	*	*
Asian or Asian British	3%	3%	1%	6%	Asian or Asian British	<1%	*	*	*
Black or Black British	2%	2%	1%	4%	Black or Black British	<1%	*	*	*
Mixed	0%	0%	0%	1%	Mixed	<1%	*	*	*
Other ethnic group	2%	1%	1%	3%	Other ethnic group	<1%	*	*	*
Unknown (n=650)					Unknown (n=672)				
TNM stage at diagnosis					**TNM stage at diagnosis**				
1	8%	4%	6%	14%	1	5%	5%	5%	8%
2	23%	28%	26%	16%	2	12%	19%	10%	13%
3	24%	27%	24%	23%	3	41%	42%	43%	37%
4	45%	42%	44%	47%	4	42%	35%	43%	43%
Unknown (n=2,431)					Unknown (n=186)				
Performance status					**Performance status**				
0 – fully active	42%	40%	45%	40%	0 – fully active	36%	32%	39%	32%
1	34%	37%	33%	34%	1	34%	37%	33%	35%
2	15%	15%	15%	15%	2	17%	22%	15%	16%
3	7%	7%	6%	9%	3	12%	9%	11%	14%
4 – bedbound	1%	1%	1%	1%	4 – bedbound	1%	1%	1%	3%
Unknown (n=3,307)					Unknown (n=86)				
Diagnosis following emergency admission					**Diagnosis following emergency admission**				
Unknown (n=368)	21%	18%	17%	31%	Unknown (n=11)	13%	10%	12%	16%

Notes:
Oes SCC: Oesophageal squamous cell carcinoma; Oes ACA: Oesophageal adenocarcinoma; Gast: Gastric (stomach) cancer
Overall cohort is larger than sum of tumour subgroups as some diagnoses of oesophageal cancer could not be categorised as SCC or ACA.
* Data suppressed due to small cell counts. 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.

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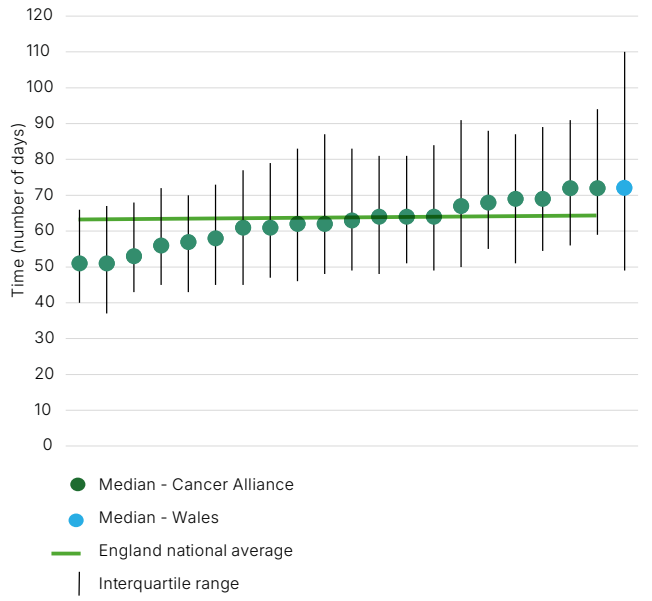
Table 3. Time from diagnostic endoscopy to start of disease-targeted treatment for people diagnosed with oesophageal or gastric (OG) cancer between 1 January 2023 and 31 December 2024 in England and Wales, by type of treatment.

	Median (interquartile range), days	
	By treatment approach	
	Curative	Palliative
England	69 (55 to 87) n=5,502	57 (43 to 77) n=5,290
Median range across Cancer Alliances	52.5 to 78	48 to 70
Wales	77 (54-115) n=262	64 (44 to 105) n=245
Median range across health boards	63 to 103.5	55 to 86

Figure 1. Time from diagnostic endoscopy to first disease-targeted treatment by Cancer Alliance in England and overall for Wales, 2023-2024 diagnoses (unadjusted)



[Wales organisational-level variation available in the NOGCA Data Dashboard.]

4.3 Access to Clinical Nurse Specialists (CNS)

Key messages

Based on available data, the majority of people diagnosed with OG cancer in England (94%) were seen by a CNS around the time of diagnosis. (Performance Indicator 2).

Variation was observed between NHS trusts in England: IQR 94% to 98%, with approximately 15% of trusts reporting that fewer than 90% of people had seen a CNS.

In England, people diagnosed with OG cancer following an emergency admission were less likely to see a CNS, as were people who survived fewer than 30 days after diagnosis.

Based on available data in England, the majority of people diagnosed with OG cancer (94%) were seen by a CNS around the time of diagnosis. However, there was variation between NHS trusts (IQR 94% to 98%), with approximately 15% of trusts reporting that fewer than 90% of people had been seen by a CNS.

People diagnosed following an emergency hospital admission were less likely to have seen a CNS, as were people who survived fewer than 30 days following diagnosis. These findings suggest that some of the most clinically vulnerable people may have less access to specialist support services.

Data completeness for the CNS variable varied across providers, with CNS status missing for 27% of the cohort in England and 71% in Wales. As a result, it is unclear whether these people did not receive CNS input or whether this was not recorded. More complete data would provide a fuller understanding of CNS service provision and access to specialist support across OG cancer services.

Among the 412 people diagnosed in Wales who had their information submitted via the new Cancer Dataset Forms (CDF), 90% had complete information on CNS involvement. Among this subgroup, 94% had a record of being seen by a CNS (IQR across health boards 90% to 97%).

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4.4 Curative treatment rates

Key messages

57% of people in England and 39% of people in Wales with stages 1–3 OG cancer initiated potentially curative treatment. (Performance Indicator 3).

For people with stages 1-3 disease and performance status 0 or 1 at diagnosis, 67% of people in England and 47% of people in Wales initiated potentially curative treatment. (Performance Indicator 3).

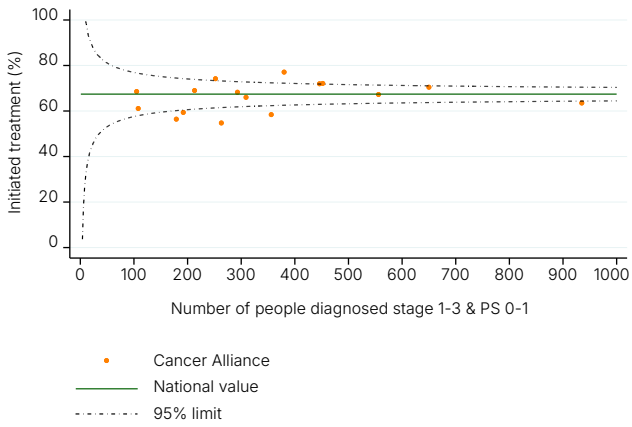
In England, there was substantial variation between Cancer Alliances in the proportion of people receiving curative treatment, ranging from 55% to 77%.

Overall, 34% of people diagnosed with OG cancer in England and 25% in Wales initiated treatment with curative intent. Restricting the analysis to people with stages 1–3 disease, the proportion increased to 57% in England and 39% in Wales. Among those with stages 1–3 disease and good performance status (0–1) at diagnosis, the proportion initiating curative treatment was 67% in England and 47% in Wales.

A key finding from this report is the relatively low proportion of people with potentially curable disease and an appropriate level of fitness who initiated curative treatment. In England, there was substantial variation across Cancer Alliances, ranging from 55% to 77% (Figure 2), which may reflect differences in treatment allocation, thresholds for offering curative treatment, or access to specialist services.

These findings highlight heterogeneity in treatment decision-making and emphasise the need to understand whether differences in curative and palliative treatment rates reflect appropriate clinical judgement and patient factors, or unwarranted variation in access to potentially curative care. In particular, wider specialist MDT discussion or second-opinion review may be beneficial for people with complex or borderline disease where suitability for curative treatment is uncertain, helping to ensure consistent decision-making and equitable access to curative treatment options.

Figure 2. Curative treatment rates for people with stages 1-3 oesophageal or gastric (OG) cancer and performance status (PS) 0 or 1 in England, 2023-2024 diagnoses, by Cancer Alliance* (unadjusted)



* Restricted to Cancer Alliances with minimum 70% completeness of both stage and performance status variables.

A comparison between Welsh health boards and English Cancer Alliances is not presented in Figure 2 as they represent different organisational structures. National results for Wales presented in the accompanying text and tables.

[Wales organisational-level variation available in the NOGCA Data Dashboard.]

4.5 Outcomes of curative surgery

Key messages

Survival rates following curative surgery for OG cancer remain high: 96.7% in England and 94.9% in Wales at 90 days after surgery. No surgical centres were identified as outliers for 90-day postoperative mortality. (Performance Indicator 4).

In England, 25% of people undergoing curative OG cancer surgery have a length of stay of more than 15 days; in Wales, this figure is 33%. There is substantial variation between surgical centres in England (11%–40%). (Performance Indicator 5).

15% of people in England and 11% in Wales who underwent curative surgery for OG cancer had a record of readmission to hospital requiring an overnight stay within 30 days of discharge, with rates varying from 7% to 29% across surgical centres in England. (Performance Indicator 6).

Outcomes of curative surgery are reported over a three-year diagnosis period (1 January 2022 to 31 December 2024) to ensure sufficient case numbers for robust analysis and meaningful comparison between individual surgical centres. Survival following curative surgery for OG cancer remained high, with 90-day survival rates of 96.7% in England and 94.9% in Wales. Both short- and longer-term survival following surgery are presented in Table 4a. No outliers were identified through the implementation of our 90-day postoperative mortality outlier policy.

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Table 4a. 90-day and one-year survival following curative surgery for oesophageal or gastric (OG) cancer (95% CI), diagnoses 2022-2024

	England			Wales		
	Overall	**Oesophagectomy**	**Gastrectomy (Any)**	**Overall**	**Oesophagectomy**	**Gastrectomy (Any)**
90-day survival	96.7% (96.2-97.2%) (n=5,284)	96.3% (95.7-96.9%) (n=3,811)	97.9% (97.0-98.6%) (n=1,473)	94.9% (91.3-97.3%) (n=235)	93.2% (88.4-96.4%) (n=176)	100% (93.9-100%) (n=59)
One-year survival*	84.9% (83.7-86.1%) (n=3,513)	85.0% (83.6-86.4%) (n=2,520)	84.7% (82.3-86.9%) (n=993)	84.5% (77.9-89.7%) (n=161)	82.0% (74.0-88.3%) (n=122)	92.3% (79.1-98.4%) (n=39)

* One-year survival is restricted to people diagnosed between 1 January 2022 and 31 December 2023 to allow complete one-year follow-up.
CI = confidence interval

This report introduces two new performance indicators derived from routinely collected data: length of stay (LOS) greater than 15 days and readmission within 30 days of discharge following surgery. These measures act as proxy indicators of postoperative complications and recovery, providing additional insight into perioperative care quality and discharge processes when interpreted alongside postoperative mortality.

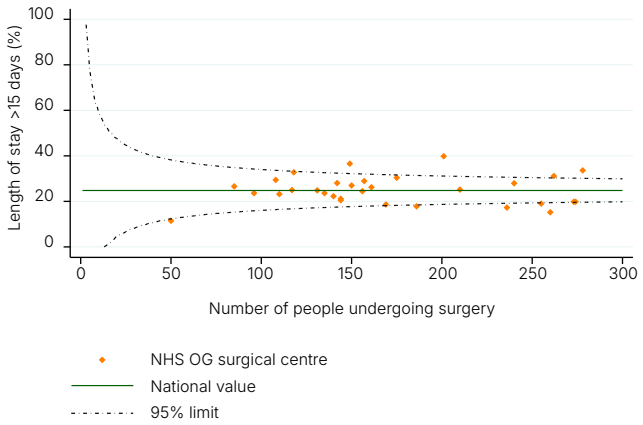
Length of stay after curative surgery for OG cancer

Median LOS stratified by procedure type is shown in Table 4b and was consistent with those reported in previous years, suggesting stable postoperative recovery times across surgical centres.

Length of stay >15 days

In England, 25% of people undergoing curative OG resection had a LOS greater than 15 days, compared with 33% in Wales. LOS greater than 15 days varied across surgical centres in England (Figure 3), with a range from 11% to 40% across centres. Rates were higher following oesophagectomy (28%, range 14%–47%) than gastrectomy (18%, range 0%–25%). Although most centres fell within expected 95% control limits after case-mix adjustment, the observed variation may reflect differences in patient complexity, complication rates, enhanced recovery pathways, discharge planning, and perioperative care processes. However, prolonged LOS may also reflect opportunities to improve perioperative care, complication management, and discharge planning.

Figure 3. Length of stay >15 days after curative surgery for oesophageal or gastric (OG) cancer in England, 2022-2024 diagnoses, by NHS OG surgical centre (case-mix adjusted)



Wales organisational-level data are not presented because people diagnosed in Wales cannot currently be reliably allocated to individual OG surgical centres.

Readmission within 30 days of discharge

In England, 15% of people undergoing curative surgery and 11% in Wales were readmitted to hospital with an overnight stay within 30 days of discharge following surgery. Readmission rates varied across surgical centres in England (Figure 4), with a range from 7%–29%. Readmission rates were similar following oesophagectomy (16%, range 5%–31%) and gastrectomy (14%, range 3%–32%). Most centres fell within expected 95% control limits following adjustment for case-mix. Differences in readmission rates between centres may reflect variation in perioperative pathways, discharge practices, access to specialist follow-up services and patient complexity.

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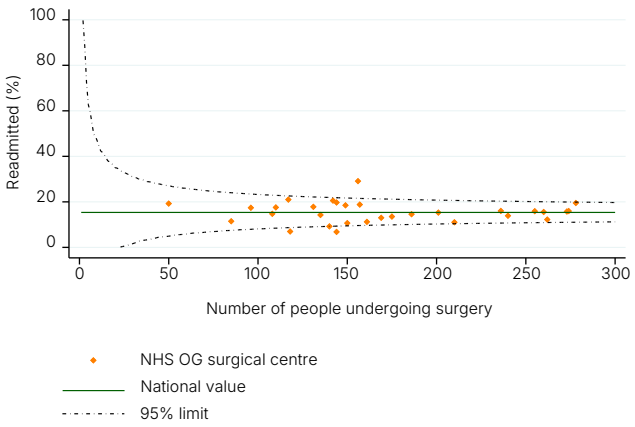
Figure 4. Readmission with overnight stay within 30 days of discharge after curative surgery for oesophageal or gastric (OG) cancer in England, 2022-2024 diagnoses, by NHS OG surgical centre (case-mix adjusted)



Wales organisational-level data are not presented because people diagnosed in Wales cannot currently be reliably allocated to individual OG surgical centres.

Length of stay and readmission rates (Table 4c) should be interpreted alongside other postoperative outcomes, including postoperative mortality, to provide a broader assessment of the quality and safety of perioperative care following OG surgery. While prolonged LOS may reflect postoperative complications or delays in recovery, short hospital stays may increase the risk of early readmission in some settings. Considered together, these indicators provide complementary information on postoperative recovery, complication management, discharge planning, and the effectiveness of enhanced recovery pathways. [Data for surgical centres in Wales were not available for this analysis at the time of reporting due to limitations in reliably allocating people to surgical centres.]

Table 4b. Length of stay (in days) following curative surgery for oesophageal or gastric (OG) cancer, diagnoses 2022-2024

	England			Wales^		
	Oesophagectomy n=3,834	Gastrectomy		Oesophagectomy n=166	Gastrectomy	
		Total n=863	Partial n=615		Total n=41	Partial n=17
Length of stay	11 (8 to 16)	10 (8 to 15)	7 (6 to 11)	13 (10 to 21)	10 (7 to 13)	9 (7 to 15)

^ Length of stay analyses were restricted to people with a valid operation date and discharge/death date.

Table 4c. Surgical Quality Indicators: Length of stay >15 days and readmission within 30 days of discharge following curative surgery for oesophageal or gastric (OG) cancer, diagnoses 2022-2024

	England				Wales^			
	Overall n=5,312	Oesophagectomy n=3,834	Gastrectomy (Any) n=1,478		Overall	Oesophagectomy	Gastrectomy (Any)	
Length of stay >15 days	25%	28%	18%		33% (n=224)	38% (n=167)	19% (n=57)	
Readmission within 30-days	15%	16%	Total 16% (n=863)	Partial 12% (n=615)	11% (n=235)	10% (n=176)	Total 10% (n=41)	Partial 22% (n=18)

^ Length of stay analyses were restricted to people with a valid operation date and discharge/death date.

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4.6 Outcomes of palliative systemic anti-cancer therapy (SACT)

Key messages

Among people who began a NICE-recommended palliative SACT regimen for OG cancer, 55% in England and 60% in Wales completed at least four cycles of treatment. Completion rates varied across SACT-administering NHS trusts in England (IQR 46%–64%) and health boards in Wales (IQR 47%–77%). (Performance Indicator 7).

For people with stage 4 disease receiving SACT, 4.2% in England and 4.6% in Wales died within 30 days of starting treatment. Mortality within 90 days of treatment initiation was 16.0% in England and 14.9% in Wales, with rates varying across SACT-administering NHS trusts in England (IQR 12%–21%). (Performance Indicator 8).

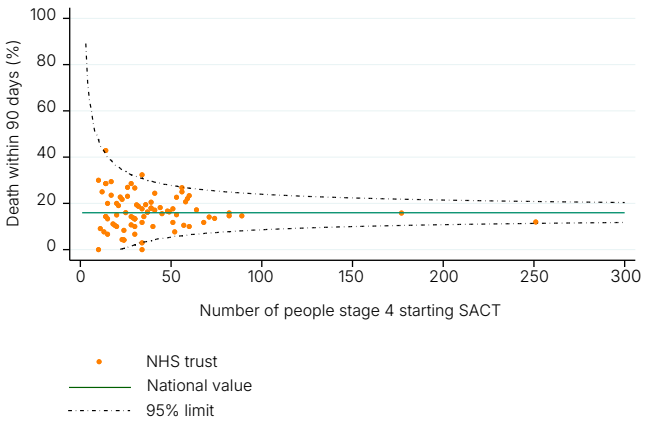
Among people who began a NICE-recommended palliative SACT regimen for OG cancer, 55% in England and 60% in Wales completed at least four cycles of treatment. Variation across SACT-administering NHS trusts in England (IQR 46% to 64%) and health boards in Wales (IQR 47% to 77%) may reflect differences in patient selection, treatment decision-making, delivery of systemic therapy, and access to supportive and palliative care services.

While palliative SACT may provide symptom control and modest survival benefit for selected patients, it is also associated with treatment-related toxicity. For some people with limited physiological reserve, best supportive care may represent the more appropriate management approach.

These findings highlight the importance of careful clinical decision-making and ongoing evaluation of treatment outcomes to ensure that palliative treatment is offered to people most likely to benefit.

Table 5 summarises early mortality following initiation of palliative SACT among people diagnosed with stage 4 OG cancer. In England, 4.2% of people died within 30 days of starting treatment and 16.0% died within 90 days. Corresponding figures in Wales were 4.6% and 14.9%, respectively. Across English SACT-administering NHS trusts, the interquartile range for 90-day mortality was 11.8% to 20.7% (Figure 5), demonstrating variation in outcomes following initiation of palliative treatment.

Figure 5. Death within 90 days of starting systemic anti-cancer therapy (SACT) in England, 2023-2024 diagnoses, by NHS trust of SACT administration (unadjusted)



Equivalent organisation-level analyses are not presented for Wales because SACT services are organised differently from England and, at present, patients cannot be reliably allocated to SACT-administering organisations, and Health Board-level case volumes are too small to support robust funnel plot analysis.

Table 5. 30-day and 90-day mortality after starting systemic anti-cancer therapy (SACT) in people diagnosed with oesophageal or gastric (OG) cancer between 1 January 2023 and 31 December 2024.

	England			Wales		
	Overall (n=3,297)	**Oesophageal** (n=2,409)	**Gastric** (n=888)	**Overall** (n=87)	**Oesophageal** (n=62)	**Gastric** (n=25)
30-day mortality	4.2%	3.9%	4.7%	4.6%	*	*
90-day mortality	16.0%	15.4%	17.6%	14.9%	*	*

* Results not presented due to small cell counts

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4.7 One-year and three-year survival

Key messages

Overall survival following diagnosis of OG cancer remains poor, particularly among people diagnosed with stage 4 disease, where fewer than 10% of people survived to three years after diagnosis.

Survival outcomes were strongly associated with stage at diagnosis. People diagnosed with stage 1 disease had substantially higher one-year and three-year survival than those diagnosed with advanced disease.

Variation in adjusted survival was observed across Cancer Alliances in England; however all organisations fell within expected limits following case-mix adjustment.

Survival analyses use earlier diagnosis cohorts than the performance indicators to allow sufficient follow-up for complete estimation of one-year and three-year survival. These measures are presented as contextual outcomes and are not designated NOGCA Performance Indicators.

Survival declined progressively with advancing stage at diagnosis, as demonstrated in Figure 6. People diagnosed with stage 1 disease had substantially better outcomes than those diagnosed with stage 4 disease, with the steepest decline in survival occurring within the first year after diagnosis for advanced-stage disease. Overall survival remained poor among people diagnosed with stage 4 OG cancer, with fewer than 10% surviving to three years after diagnosis (6.9% in England and 7.8% in Wales).

Survival outcomes were broadly similar between oesophageal and gastric cancer overall, although people diagnosed with gastric cancer had slightly lower one-year and three-year survival. In England, overall survival for oesophageal cancer was 49.3% at one year and 21.7% at three years, compared with 45.8% and 19.3%, respectively, for gastric cancer. Figure 7 demonstrates variation in adjusted survival across Cancer Alliances.

In Wales, overall survival was 44.9% at one year and 25.7% at three years for oesophageal cancer, compared with 40.9% and 20.4% respectively for gastric cancer. Across both tumour sites combined, overall survival in Wales was 44.0% at one year and 24.7% at three years.

Figure 6. Survival following diagnosis of oesophageal cancer (A) and gastric cancer (B) in England and Wales, 2023-2024, by stage at diagnosis

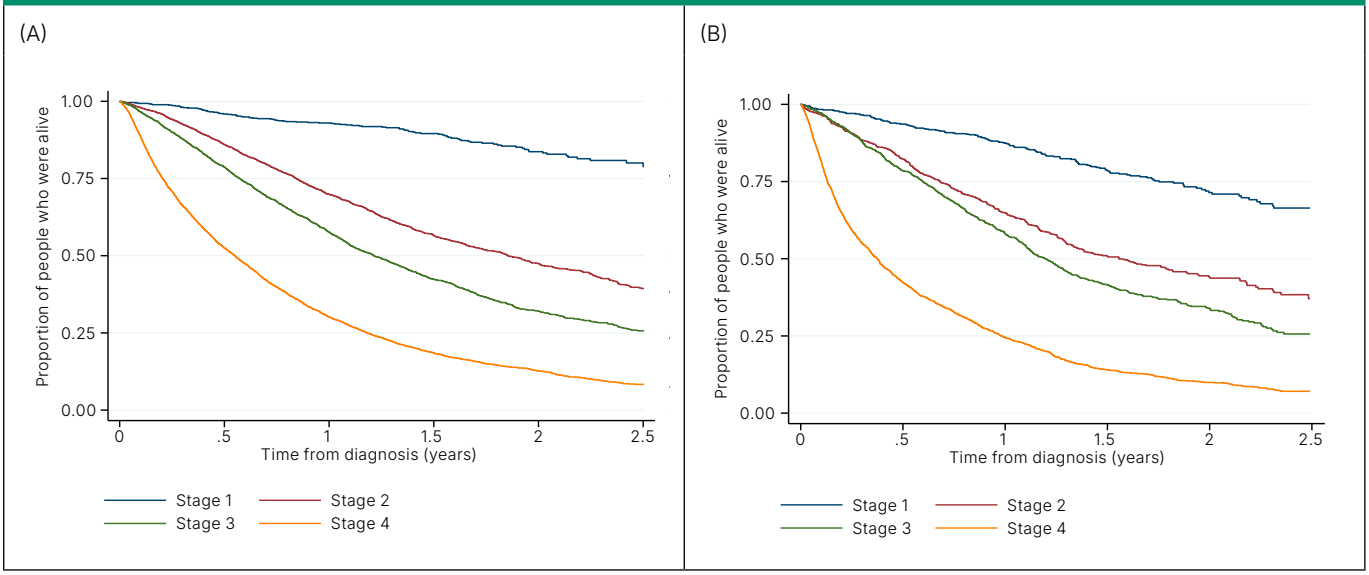

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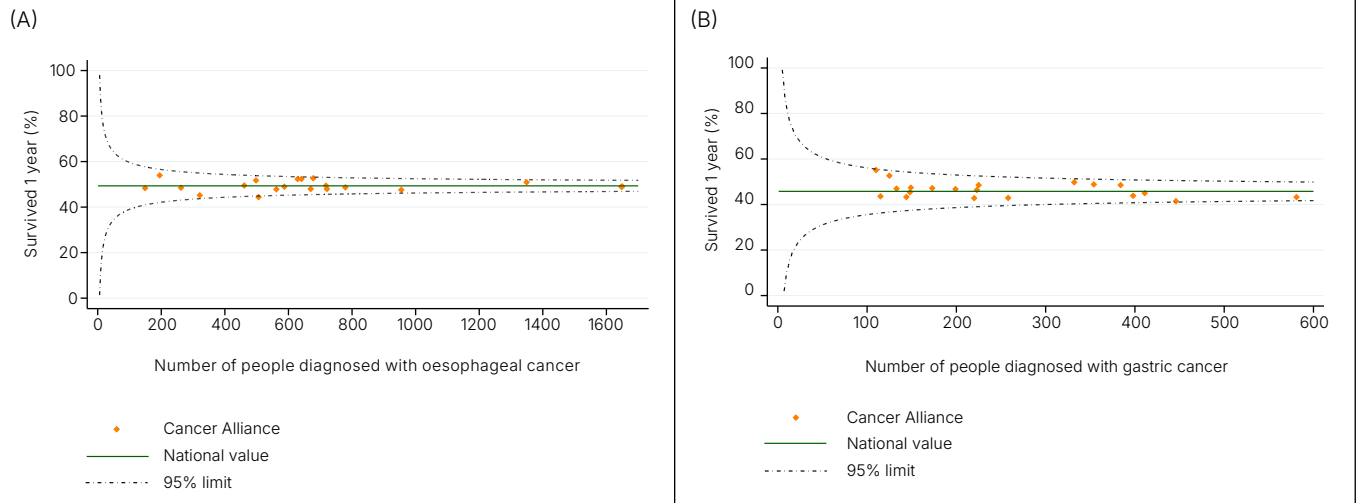
Figure 7. One-year survival following diagnosis of oesophageal cancer (A) and gastric cancer (B) in England, by Cancer Alliance (case-mix adjusted). Restricted to 2022–2023 diagnoses to allow complete one-year follow-up.



Comparison between Welsh health boards and English Cancer Alliances is not presented in Figure 7 as they represent different organisational structures. National results for Wales presented in the accompanying text and tables.

[Wales organisational-level variation available in the NOGCA Data Dashboard.]

4.8 Change over time

Key messages

National performance across OG cancer indicators in England showed little change between 2021 and 2024.

The proportion of people with stages 1–3 OG cancer initiating potentially curative treatment has remained largely unchanged over recent years, highlighting ongoing opportunities to improve access to curative treatment for people with potentially treatable disease.

Figure 8 demonstrates that performance across the reported OG cancer pathway indicators in England remained broadly stable between 2021 and 2024, with little evidence of improvement or deterioration over time. Rates of emergency presentation and stage 4 diagnosis showed minimal change across the four-year period, indicating ongoing challenges in achieving earlier diagnosis of OG cancer.

Access to CNS support remained consistently high among people with recorded data. However, the proportion of people with stages 1–3 disease initiating potentially curative treatment remained largely unchanged over time, despite this group representing people with potentially treatable disease. These findings suggest there remains substantial scope to improve access to curative treatment pathways and ensure that people are offered optimisation and prehabilitation to support curative treatment where appropriate.

Postoperative outcomes following curative surgery, including prolonged length of stay and readmission rates, also showed little variation between years. Similarly, outcomes following palliative SACT remained relatively stable, with little change in the proportion of people completing at least four cycles of treatment or in 90-day mortality following treatment initiation.

Overall, these findings suggest that, despite some year-to-year fluctuation, national performance across the OG cancer pathway has remained largely unchanged over recent years, highlighting ongoing opportunities to improve earlier diagnosis, access to curative treatment, and outcomes for people diagnosed with OG cancer.

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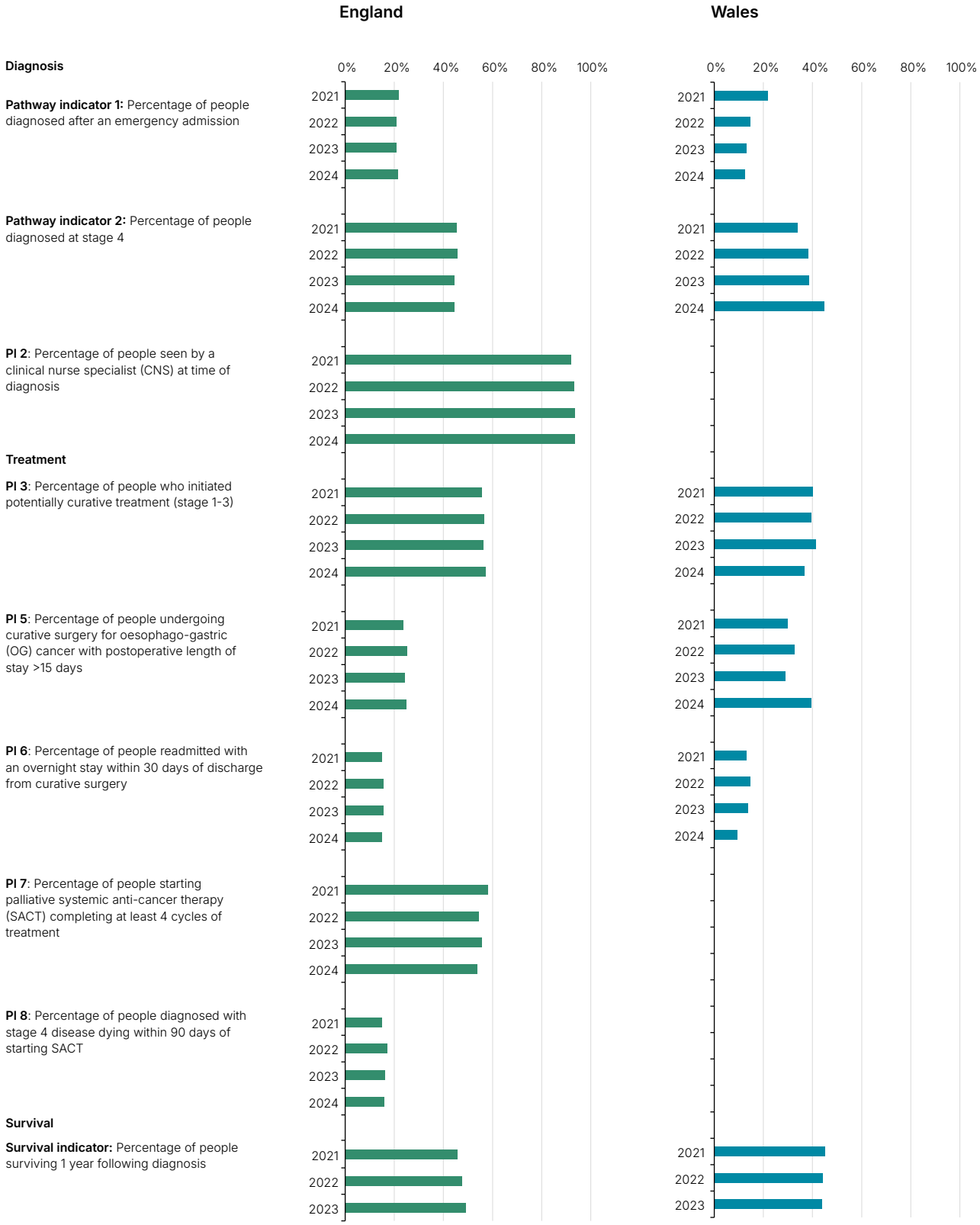
Figure 8. Annual results for selected performance indicators, by year of diagnosis with oesophageal or gastric (OG) cancer, 2021-2024



Note: Data were impacted by the COVID-19 pandemic and so will be atypical to some degree during 2020-21.

CNS results are not presented for Wales because the CNS data item is only available in CDF and comparable data are not available for earlier years.

PI 7 and PI 8 are not presented for Wales because current data are affected by incomplete SACT case ascertainment resulting in small annual case numbers that are not sufficiently robust for year-on-year trend analysis. Survival is presented for diagnoses up to the end of 2023 only, to allow for complete one-year survival estimation.

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5. Commentary

This year's State of the Nation report highlights persistent variation between providers across the oesophago-gastric (OG) cancer pathway in England and Wales. While short-term survival outcomes following curative surgery remain consistently high, there continues to be marked variation in key aspects of care, including stage at diagnosis, access to treatment, and time to treatment. Reducing unwarranted variation is central to improving equity and ensuring that people have access to high-quality care, regardless of where they are treated.

Late presentation remains a major challenge. A substantial proportion of people continue to be diagnosed with advanced disease, with little change over recent years. This reflects both the non-specific symptom profile of OG cancers and variation in diagnostic pathways. There is a need for continued focus on earlier diagnosis, including optimisation of referral pathways, improved risk stratification in primary care, and implementation of streamlined diagnostic models.

Delays between diagnosis and treatment also remain a key concern, with variation observed across organisations and treatment modalities. While national Cancer Waiting Times standards monitor performance against referral-to-treatment targets, NOGCA provides additional insight into the interval from diagnostic endoscopy to disease-targeted treatment and highlights variation by treatment approach and Cancer Alliance in England. This clinically focused view helps identify where delays occur within the OG cancer pathway and where targeted improvement efforts may be needed. Prolonged waits can affect treatment options, patient outcomes, and experience of care. In response, NOGCA launched a targeted Quality Improvement (QI) Intervention in January 2026, focused on reducing time from diagnostic endoscopy to treatment. Bespoke feedback reports were provided to Cancer Alliances in England, presenting their performance in a national context alongside detailed breakdowns at trust level. This approach is intended to support local services in identifying bottlenecks and prioritising improvement actions.

Variation is also evident in treatment allocation. The percentage of people with stages 1–3 disease initiating treatment with curative intent remains relatively low, particularly in Wales, and varies considerably between organisations. Notably, curative treatment rates also remained lower than expected among people with stages 1–3 disease and a performance status of 0 or 1, suggesting that some potentially treatable and relatively fit patients may not always progress to curative treatment pathways. While some differences are likely to reflect variation in case-mix and patient preference, they may also indicate differences in clinical decision-making, access to specialist services, optimisation pathways, and local treatment thresholds. Variation in curative treatment rates should be interpreted alongside other outcomes, reflecting the need to balance access to curative treatment with appropriate patient selection. Understanding the reasons for these differences is therefore essential to ensure equitable access to curative treatment opportunities for all people who are likely to benefit.

National collaboration will be critical to addressing these challenges. The National OG Cancer Day held in Manchester in 2025 brought together clinicians, researchers, and service leaders to share best practice and explore more effective and timely care pathways. In parallel, work is underway through the UKIOG to develop diagnostic bundles aimed at standardising and accelerating diagnostic pathways.

Importantly, identifying what high-performing systems are doing differently is key to translating variation into improvement. This is being addressed through the NIHR-funded TACTIC project, which aims to understand organisational and pathway-level factors associated with better outcomes and more timely care. Insights from this work will be essential in informing scalable, evidence-based improvements across NHS cancer services.

We continue to expand the Audit's role in supporting quality improvement. Through a combination of national reporting, more frequent data via the NOGCA Data Dashboard, and targeted interventions, NOGCA is increasingly focused on enabling services to reduce unwarranted variation and improve outcomes. Continued collaboration between national bodies, Cancer Alliances, and local clinical teams will be essential to drive meaningful and sustained improvement in OG cancer care.

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