

# National Oesophago-Gastric Cancer Audit

## State of the Nation Report

An audit of the  
care received by  
people with  
oesophago-  
gastric cancer in  
England and  
Wales

1 April 2020 – 31 March  
2022



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**Commissioned by the Healthcare Quality Improvement Partnership**

The National Audit of oesophago-gastric cancer (NOGCA) is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (NCAPOP). HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that clinical audit, outcome review programmes and registries have on healthcare quality in England and Wales. HQIP holds the contract to commission, manage, and develop the National Clinical Audit and Patient Outcomes Programme (NCAPOP), comprising around 40 projects covering care provided to people with a wide range of medical, surgical and mental health conditions. The programme is funded by NHS England, the Welsh Government and, with some individual projects, other devolved administrations and crown dependencies [www.hqip.org.uk/national-programmes](http://www.hqip.org.uk/national-programmes)

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## Recommendations, key findings and national guidance

Recommendation	Practical actions / resources	Key findings (2020-22) & change since last audit	National guidance / standards	Target audience
1. Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene, and reduce high and variable rates of diagnosis following emergency admission and late stage diagnosis	Characterise patients diagnosed after emergency admission (e.g. histology type, tumour site, appointments / referral history) to help inform appropriate action; review the region's patient pathways from primary care to diagnosis and identify opportunities for intervention in the community, primary and secondary care	● 13% of patients were diagnosed following an emergency admission; there is marked regional variation in rates of diagnosis following an emergency admission	<a href="#">NHS Long Term Plan</a> : the proportion of cancers diagnosed at stages 1 & 2 will rise to three-quarters of cancer patients (2028).  <a href="#">Wales Cancer Network, A Cancer Improvement Plan for NHS Wales</a> : reducing emergency presentation and 1 <sup>st</sup> presentation with advanced disease	Cancer Pathway Boards / Cancer Alliances / Welsh Health Boards / Wales Cancer Network
2. Review oesophago-gastric (OG) cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment	Best practice – diagnostic and post-diagnostic pathways: 1. <a href="#">NHS England's GIRFT and Cancer programmes, Best Practice Timed Diagnostic Cancer pathways</a> 2. <a href="#">Wales Cancer Network, A Cancer Improvement Plan for NHS Wales</a>	● Two-thirds (65.4%) of urgent GP referrals waited longer than the target 62 days from referral (or Point of Suspicion in Wales) to first treatment	<a href="#">NHS England</a> : ≥85% patients begin treatment within 62 days of urgent GP referral.  <a href="#">NHS Wales</a> : ≥75% patients begin treatment within 62 days of suspected cancer.	Cancer Pathway Boards / Cancer Alliances / Welsh Health Boards / Wales Cancer Network
3. Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate	Focus on patients who only had one round of chemotherapy or who died within 90 days of starting treatment	● 61.1% of patients completed palliative chemotherapy  ● 8.0% of patients died within 30 days of starting palliative chemotherapy; 15.7% died within 90 days	<a href="#">NCEPOD</a> : all deaths within 30 days of SACT should be considered at a morbidity and mortality or a clinical governance meeting.	Cancer Pathway Boards / Cancer Alliances / Welsh Health Boards / Wales Cancer Network
4. Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input	Resources: <a href="#">NICE: Oesophago-gastric cancer: assessment and management in adults, section 1.6 Nutritional support</a>  <a href="#">NHS England: Service Specification for oesophageal and gastric cancer</a>	● * 50.5% of patients with OG cancer received support from a specialist OG dietitian between diagnosis and treatment (76.2% received any dietetic support)	<a href="#">NICE</a> : All patients undergoing curative treatment should be offered specialist dietetic support. For people receiving palliative care, consider specialist dietetic support.	Cancer Pathway Boards / Cancer Alliances / Welsh Health Boards / Wales Cancer Network
5. In Cancer Alliances with low rates of active treatment for high-grade dysplasia (HGD), review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy	Resources: See national guidance / standards references	● In England, 80% of patients had a plan for active treatment; however, by Cancer Alliance this ranged from 33% - 100%	<a href="#">BSG guidelines on diagnosis &amp; management of Barrett's oesophagus</a>  <a href="#">NICE: Barrett's oesophagus and stage 1 oesophageal adenocarcinoma</a>	Cancer Alliances

Change since last audit period (2019-21): ● worse, ● no change; \*Compared to the 2019-20 audit period


# NOGCA | National Oesophago-Gastric Cancer Audit


## State of the Nation Report

**19,865**

records of patients diagnosed with OG cancer in England and Wales between 2020-2022 were submitted to the Audit

### Routes to diagnosis

**13%**  of patients were diagnosed after emergency admission

**44%**  of patients had Stage 4 cancer at diagnosis (up from 37% in 2012/13)

### Treatments & outcomes

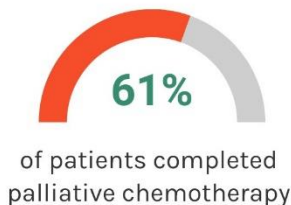
**37%** of patients had a treatment plan with curative intent

#### Surgical outcomes

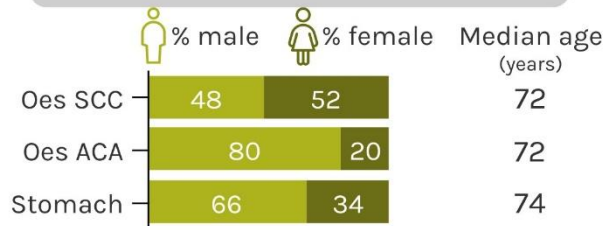
	Oesophagectomy	Gastrectomy
90-day mortality*	<b>3.0%</b>	<b>2.5%</b>
+ longitudinal margins*	<b>4.9%</b>	<b>9.8%</b>

	1 year	2 year	3 year
% of patients alive after surgery**	<b>85.3</b>	<b>71.4</b>	<b>62.7</b>

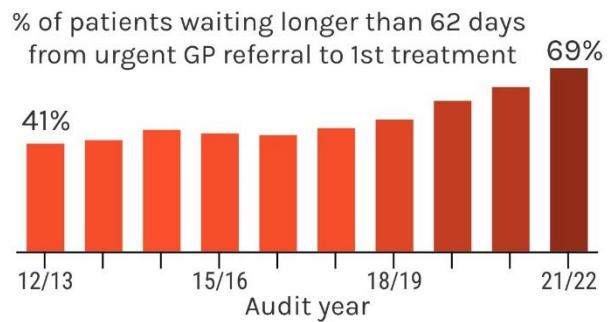
#### Non-curative treatments




### Patient profile at diagnosis



### Waiting times





### Nutritional support


**76%**  of patients received dietetic support between diagnosis and treatment


**93%** of patients had ongoing nutritional management following curative surgery

### High grade dysplasia

 **92%** of people had diagnosis confirmed by 2<sup>nd</sup> pathologist

 **91%** of people had their treatment plan agreed at an upper GI MDT meeting

 **80%** of patients had a plan for active treatment

 **98%** of active treatment plans involved endoscopy

Arrows indicate increase compared to first years of audit (2012-2014)<sup>^</sup>

**BSC:** Best supportive care  
**OG:** Oesophago-Gastric  
**Oes SCC:** Oesophageal squamous cell carcinoma  
**Oes ACA:** Oesophageal adenocarcinoma

\*3 years' of data (2019-22) used for surgical outcomes to ensure enough procedures to produce robust statistics; results are the % of patients undergoing surgery  
 \*\*Analysis of patients diagnosed between 2017-22  
<sup>^</sup>Compared to 2012-2014 cohort to highlight changes over 10 years of HGD data collection

## Introduction

The National Oesophago-Gastric Cancer Audit (NOGCA) aims to evaluate the quality of care received by people diagnosed with oesophago-gastric (OG) cancer in England and Wales. It describes patterns of care and outcomes, highlights regional variations, and helps NHS cancer services to identify areas where they can improve. The Audit also examines the care received by people diagnosed with oesophageal high-grade dysplasia (HGD) in England, due to the risk of progression to cancer if HGD is left untreated. Further information on the background, scope, and objectives of the audit can be found at [www.nogca.org.uk](http://www.nogca.org.uk).

NOGCA uses patient information uploaded to the Audit's data collection system, from NHS acute trusts in England and NHS Wales Executive in Wales. The Audit dataset is linked to several other national datasets. This report focuses on people diagnosed over a two-year period from 1 April 2020 to 31 March 2022 (except for surgical outcomes, which are reported for a three-year period from 1 April 2019 – 31 March 2022), to ensure enough people are included to enable analysis of subgroups according to tumour, patient and treatment characteristics. More information on the Audit's methods and data sources can be found in the online [Methods Supplement](#).

## Characteristics of people diagnosed with OG cancer

Records were submitted for 19,865 people diagnosed with OG cancer between 1 April 2020 and 31 March 2022, including 18,627 people diagnosed at 123 NHS trusts in England and 1,238 diagnosed at six health boards in Wales.

OG cancer predominantly affects older people and occurs more frequently in men than in women, though there is variation by tumour type (Table 1 and [Supplementary Figures](#)). Stomach cancer as a proportion of all OG cancers continues to decline, accounting for 25.1% of all cases diagnosed in 2021/22 compared to 33.8% in 2012/13.

*National goal (England, NHS Long Term Plan): By 2028, the proportion of cancers diagnosed at stages 1 and 2 will rise to three-quarters of cancer patients.*

Over two-fifths of people in the Audit (44%) were diagnosed with stage 4 (metastatic) disease, an increase from 37% in 2012/13.

**Table 1: Characteristics of people diagnosed with OG cancer by tumour type, 2020-2022**

	Oes SCC	Oes ACA	Stomach
Male (%)	48.0%	80.2%	66.3%
Median age (yrs)	72	72	74
Age group			
<60	14.7%	16.2%	17.7%
60-69	26.4%	25.4%	19.4%
70-79	34.8%	36.6%	32.3%
≥80	24.1%	21.8%	30.6%
Clinical stage (pre-treatment)			
Stage 0/1	2.7%	4.4%	10.8%
Stage 2	26.5%	8.3%	17.4%
Stage 3	38.7%	40.1%	26.6%
Stage 4	32.1%	47.2%	45.2%
Missing	533	1,515	892
Total	3,646	11,192	5,027

KEY: Oes – oesophageal; SCC – squamous cell carcinoma; ACA – adenocarcinoma

## Routes to diagnosis

**KEY MESSAGE:** The percentage of patients with OG cancer who are diagnosed with stage 4 (metastatic) disease has increased since the audit began, from 37% in 2012/13 to 44% in the most recent audit period. Rates of diagnosis following an emergency admission have not improved and continue to show substantial regional variation.



**Recommendation 1:** Cancer Alliances and Wales Cancer Network should review patient pathways in their region to identify opportunities to intervene, and reduce high and variable rates of diagnosis following emergency admission and late stage diagnosis.

Overall, 13.1% of patients with OG cancer were diagnosed following an emergency admission. This figure was 10.5% among those diagnosed with oesophageal cancer, and 20.8% among those with stomach cancer. The risk of diagnosis via emergency admission was strongly associated with age, with 18.7% of those aged ≥80 years diagnosed after an emergency admission, compared to 11.4% of patients aged 70-79 and 10.3% of those aged 60-69 ( $p < 0.001$ ).

The proportions also differ among areas with different levels of social deprivation. 14.2% of people with OG cancer living in the most socially deprived areas were diagnosed after an emergency admission, compared to 12.0% of those in the least deprived areas ( $p=0.007$ ).

There continues to be regional variation in rates of emergency diagnosis. This persists after adjusting for patient characteristics (see [Supplementary Figures](#)).

## Staging investigations

*Guidance (NICE): All patients diagnosed with OG cancer should have an initial CT. PET-CT scans should be offered to patients with oesophageal and oesophago-gastric junctional (GOJ) tumours that are suitable for curative treatment (except for T1a tumours).*

In the 2020-22 Audit cohort, 94.0% of all people with OG cancer were reported to have had a CT scan. Among those with oesophageal and GOJ cancer who had a curative treatment plan (excluding those with T1a tumours), 70.8% were recorded to have PET-CT, although there was substantial variation across Cancer Alliances / Welsh regions (range 40.2% to 97.4%). These results are based on data from only 109 organisations (out of 129) that reported staging investigations for at least 80% of patients.

## Treatment planning

Treatment options for people with OG cancer depend on several factors, including clinical stage, patient fitness and patient preferences. Overall, 37.2% of people with OG cancer had a treatment plan with curative intent, with some variation by tumour type (Table 2).

Among patients without distant metastatic disease (stage 1-3), 58.4% had a plan for curative treatment. Curative treatment was less common among the oldest patients and those living in the most deprived areas, even after adjusting for clinical stage, tumour site, presence of comorbidities, performance status and sex. For patients with a plan for non-curative treatment, oncological therapy (chemotherapy or radiotherapy) was planned for 53.5%. Other planned palliative treatments were endoscopic / radiological therapies (14.6%), surgery (6.1%), and best supportive care (25.8%).

**Table 2: Percentage of patients with OG cancer with curative treatment plans, 2020-2022**

Treatment plan	Oes SCC	Oes ACA Upper/Mid	Oes ACA Lower (w SI,SII)	Stomach (w SIII)	Total
Total patients	3,646	1,622	9,570	5,027	19,865
Curative intent	38.7%	34.3%	40.1%	31.7%	37.2%
By clinical stage					
0/1	81.0%	91.4%	95.4%	69.8%	81.9%
2	58.6%	58.9%	66.1%	52.6%	59.0%
3	46.3%	48.8%	59.4%	51.2%	54.5%
4	14.2%	14.7%	16.3%	4.3%	12.8%
(missing data)	533	303	1,212	892	2,940

KEY: Oes – oesophageal, SCC – squamous cell carcinoma, ACA – adenocarcinoma, SI, SII, SIII - Siewert classification of the gastro-oesophageal junction (GOJ) [Siewert et al 1996]. See glossary for details:

[www.nogca.org.uk/content/uploads/2024/01/1e\\_REF437\\_NOGCA-SoN-report-S4-Glossary\\_DRAFT2.0.pdf](http://www.nogca.org.uk/content/uploads/2024/01/1e_REF437_NOGCA-SoN-report-S4-Glossary_DRAFT2.0.pdf)

## Waiting times along the care pathway

**KEY MESSAGE:** The percentage of patients with OG cancer waiting more than the target 62 days from urgent GP referral to first treatment has increased since the audit began, from 41% in 2012/13 to 65% in the most recent audit cohort. This figure does not meet the national targets in either England (15%) or Wales (25%, for all suspected cancers).



**Recommendation 2:** Review OG cancer care pathways against best practice guidance to identify ways to reduce the proportion of patients with OG cancer waiting more than 62 days from urgent referral to first treatment.

*National targets (NHS): In England, ≥85% patients begin treatment within 62 days of urgent GP referral; in Wales, ≥75% patients begin treatment within 62 days of suspected cancer.*

Patterns of waiting times can be seen in Table 3. Two-thirds (65.4%) of people with OG cancer diagnosed following urgent GP referral waited longer than the target 62 days from referral to first treatment. This figure has increased since the audit began (Figure 1). The percentage of all patients who waited more than 104 days from referral to first treatment (all routes to diagnosis) was 18.7%.

**Table 3: Waiting times along the care pathway for people diagnosed with OG cancer, 2020-2022**

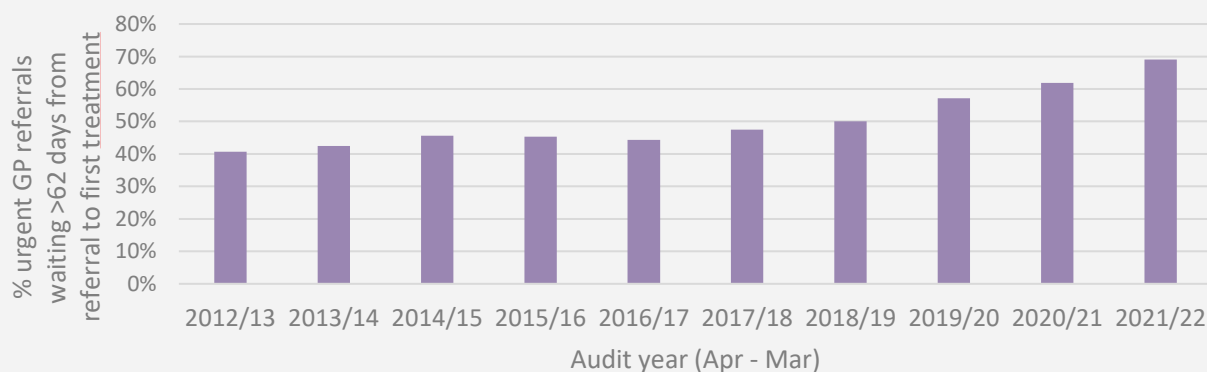
Referral route	Time in days from...			
	Referral to diagnosis		Referral to 1st treatment	
	Median	IQR	Median	IQR
GP referral: urgent/2WW	20	13 to 33	74	57 to 96
GP referral: routine	27	8 to 65	90	61 to 131
After emerg. admission	7	3 to 15	50	26 to 78
Other consultant referral	9	2 to 23	71	50 to 99

Treatment intent	Diagnosis to treatment plan		Diagnosis to 1st treatment		Referral to 1st treatment	
	Median	IQR	Median	IQR	Median	IQR
Curative: surgery only	28	11 to 49	67.5	46 to 96	96	68 to 134
Curative: definitive/neoadj. oncology	27	14 to 40	57	44 to 72	78	62 to 96
Palliative: oncology	14	6 to 29	46	33 to 65	67	51 to 92
Palliative: ERPT	7	1 to 15	15	8 to 30	36	22 to 56

KEY: 2WW – Two week wait. ERPT – Endoscopic / radiologic palliative therapy. IQR – Interquartile range. Neoadj - neoadjuvant

**Figure 1. Percentage of people with OG cancer waiting more than 62 days from urgent GP referral to first treatment**





## Curative surgery

Outcomes of curative surgery are reported for a three-year period to ensure that enough procedures are included in the analysis to produce robust statistics for individual organisations. For patients with OG cancer diagnosed between April 2019 and March 2022, 5,688 surgical records were submitted. Of these, 95.9% were recorded as curative oesophagectomy or gastrectomy.

### Short-term outcomes of surgery

*Outcome standards (AUGIS): For both oesophageal and gastric resections, the median number of nodes harvested should be 15 or more and the target for resection margin positivity is <5%.*

The short-term outcomes of curative surgery in patients with OG cancer in the 2019-2022 surgical cohort are summarised in Table 4. The overall positive longitudinal margin rate of 9.8% for gastrectomy exceeded the 5% target set by AUGIS. The overall rate of positive longitudinal margins for oesophagectomy was within the 5% target. The organisational values for the circumferential margin and lymph node indicators continued to show large variation (see online [Data Tables](#)).

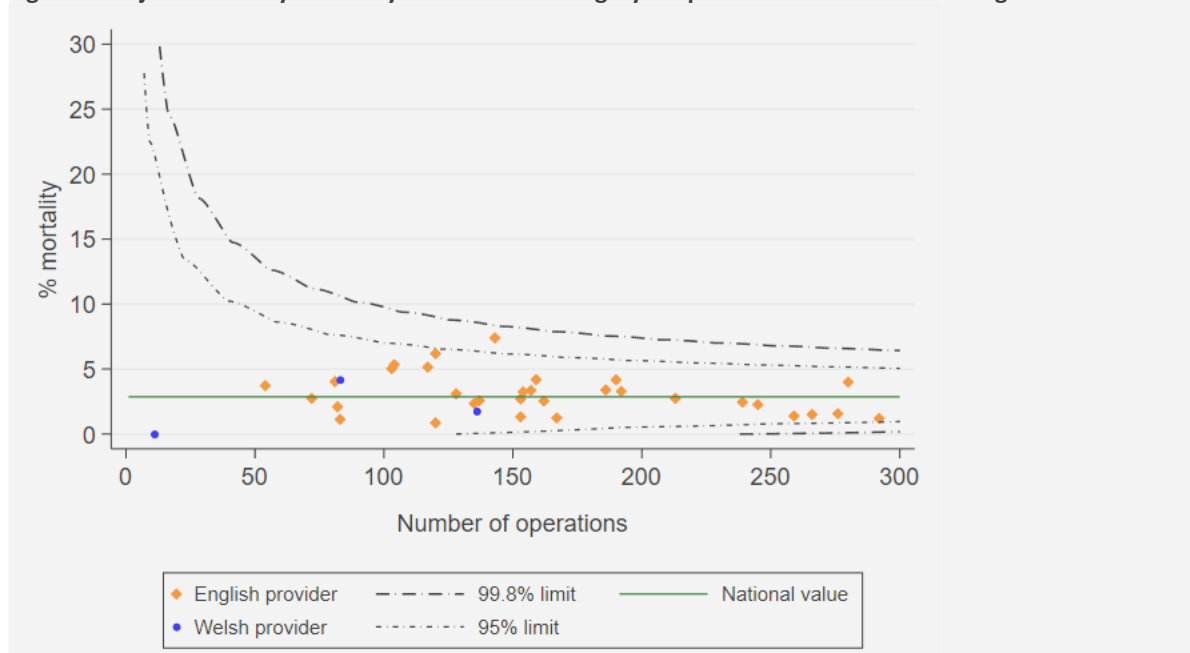
**Table 4: Postoperative outcomes after curative surgery for patients with OG cancer, 2019-2022**

	Oesophagectomy (n=3,733)	Gastrectomy (n=1,720)	Overall (n=5,453)
30-day mortality (95% CI)	1.4% (1.0 to 1.8)	1.6% (1.0 to 2.2)	1.5% (1.2 to 1.8)
90-day mortality (95% CI)	3.0% (2.5 to 3.6)	2.5% (1.8 to 3.2)	2.9% (2.4 to 3.3)
Median length of stay, days (IQR)	11 (9 to 16)	8 (7 to 12)	10 (8 to 15)
<i>Pathology indicators</i>			
Nodes examined ≥15	91.7% (90.8 to 92.6)	86.4% (84.7 to 88.1)	90.1% (89.2 to 90.9)
Positive longitudinal margins	4.9% ( 4.2 to 5.6)	9.8% ( 8.4 to 11.4)	6.4% ( 5.8 to 7.1)
Positive circumferential margins*	21.5% (20.1 to 23.0)	n/a	n/a

\*Excludes NHS organisations that reported 0% positive circumferential margins. Circumferential resection margins are examined after oesophagectomy and are not applicable to gastrectomy. CI – confidence interval; IQR – interquartile range

All OG cancer surgical centres had adjusted 90-day mortality rates within the expected range (99.8% control limits) (Figure 2).

**Figure 2: Adjusted 90-day mortality after curative surgery for patients with OG cancer diagnosed 2019-2022**



## Enhanced recovery after surgery (ERAS)

*Guidance (AUGIS): All OG cancer units that perform surgical resections should have an ERAS programme in place for patients who have an oesophagectomy or gastrectomy.*

In the 2019-2022 surgical cohort (n=4,852 with information on ERAS), 64.5% of patients with OG cancer were reported to have followed an ERAS pathway after curative surgery. The majority of ERAS protocols (80.3%) involved daily documentation in medical notes, and 91.4% of patients on an ERAS pathway completed the protocol.

## Longer term outcomes after surgery

85.3% of patients who underwent curative surgery were still alive after one year, while 62.7% survived at least three years after surgery (Table 5).

**Table 5: Percentage of patients diagnosed with OG cancer surviving up to 3 years after curative surgery, 2017-2022**

Time after surgery	% alive (95% CI)
1 year	85.3 (84.3 to 86.2)
2 years	71.4 (70.1 to 72.8)
3 years	62.7 (61.0 to 64.3)

KEY: CI – confidence interval

## Non-curative treatment

**KEY MESSAGE:** Rates of completion for palliative radiotherapy are high across all OG tumour types (98% overall), but remain comparatively low for palliative chemotherapy (61%).



**Recommendation 3:** Explore reasons for non-completion of palliative chemotherapy regimens, including review of patients with OG cancer who died within 90 days of starting treatment, and review patient selection for palliative chemotherapy where appropriate.

Two-thirds of patients with OG cancer who received palliative oncology had chemotherapy (Table 6). Radiotherapy was used less frequently, and use of immunotherapy continued to be rare. Completion rates for palliative radiotherapy were high across all tumour types (97.5% overall). The proportion of patients with OG cancer completing palliative chemotherapy was comparatively low, at 61.1% over the same period.

In the 2020-22 cohort, 8.0% of patients with OG cancer receiving palliative chemotherapy (95% CI 6.2 to 10.1) died within 30 days of starting treatment, and 15.7% of patients with OG cancer (95% CI 14.4 to 17.0) died within 90 days.

**Table 6. Palliative oncological treatment received by patients with OG cancer by tumour type, 2020-2022**

	Oes SCC	Oes ACA Upper/Mid	Oes ACA Lower (w SI,SII)	Stomach (w SIII)	All
Chemotherapy	412 (47%)	246 (67%)	1,569 (70%)	817 (75%)	3,044 (67%)
Radiotherapy	380 (44%)	101 (27%)	565 (25%)	232 (21%)	1,278 (28%)
Chemo-radiotherapy	74 ( 8%)	20 ( 5%)	90 ( 4%)	20 ( 2%)	204 ( 4%)
Immunotherapy (+/- CT/RT)	<10 ( 1%)	<10 ( 1%)	16 ( 1%)	16 ( 1%)	42 ( 1%)
% completed chemotherapy	53.8%	61.7%	63.0%	61.1%	61.1%
% completed radiotherapy	96.0%	97.7%	97.9%	99.0%	97.5%

KEY: Oes – oesophageal, SCC – squamous cell carcinoma, ACA – adenocarcinoma, SI, SII, SIII – Siewert classification of the gastro-oesophageal junction (GOJ) [Siewert et al 1996], CT/RT – Chemotherapy/radiotherapy. See glossary for details: [www.nogca.org.uk/content/uploads/2024/01/1e\\_REF437\\_NOGCA-SoN-report-S4-Glossary\\_DRAFT2.0.pdf](http://www.nogca.org.uk/content/uploads/2024/01/1e_REF437_NOGCA-SoN-report-S4-Glossary_DRAFT2.0.pdf)

## Nutritional support

**KEY MESSAGE:** Information on nutritional management is available for only around half of all patients diagnosed with OG cancer. Among those patients for whom the audit has information, three-quarters are reported to receive dietetic support before treatment, but only half are seen by a specialist dietitian.



**Recommendation 4:** Given the often profound impact of OG cancer on patients' nutritional status, Cancer Alliances and Wales Cancer Network should review specialist dietetic provision across their region, and ensure OG cancer units are resourced according to national specifications to ensure that all patients have access to appropriate dietetic input.

*Guidance (NICE): All patients undergoing curative treatment should be offered specialist dietetic support before, during, and after treatment. For people receiving palliative care, tailored specialist dietetic support should be considered.*

Information about the involvement of dietitians between the time when patients were diagnosed with OG cancer and started treatment was submitted for 50.4% (n=10,009) of patients in the 2020-22 audit cohort. Of these patients with OG cancer:

- 76.2% received dietetic support:
  - 50.5% from a specialist OG dietitian
  - 13.5% from a general dietitian
  - 12.2% from a dietitian (unspecified)
- 23.8% were not seen by a dietitian, either because a dietitian was not available (2.1%) or one was not required (21.7%).

Information on postoperative nutritional management had been supplied by OG cancer units for around half of the 3,523 patients in the 2019-22 cohort who underwent curative surgery: 52.7% of patients had data submitted about nutritional management during their surgical admission and 52.5% had data submitted about dietetic management on discharge. Among these patients:

- 70.3% of patients undergoing curative oesophagectomy had enteral or parenteral nutrition during their surgical admission, including 54.4% via a jejunostomy.
- 89.2% of patients undergoing gastrectomy had some form of nutritional management during the surgical admission, including 56.9% in the form of oral nutrition.
- 91.6% of all patients were assessed postoperatively and advised by a specialist OG dietitian. A further 7.7% were seen by a general or unspecified dietitian. Only 0.7% of patients had no contact with a dietitian.
- 92.5% of patients undergoing surgery had ongoing nutritional management on discharge, mainly in the form of oral nutrition (62.9%) or jejunostomy feeding (26.3%).

## High-grade dysplasia

This is the final year that NOGCA will report on people with oesophageal high-grade dysplasia (HGD) from the point of diagnosis until the end of initial treatment (see explanation in [Changes to NOGCA](#) section). This report focuses on people diagnosed with HGD between April 2020 and March 2022 (2020-22), and highlights changes seen over 10 years of data collection. Data were analysed for 2-year audit periods, to ensure that sample sizes were sufficiently large to produce robust statistics.

Data were submitted for 489 people diagnosed with HGD in 2020-22. The number of records and the number of trusts submitting data decreased over time (Figure 3). Trusts noted that data on people with HGD is difficult to collect, in particular coordinating data collection with different organisations along the care pathway (see [NOGCA user survey](#)). This may partly explain the decrease in submissions over time. In this section, changes over time are reported for all records, with sensitivity analysis including only records from the subset of trusts that submitted data in every audit period since 2012 (see [Methods Supplement](#) for further details).

**Figure 3: Records of people with HGD submitted and number of trusts submitting data to NOGCA, 2012-2022**



### HGD diagnosis

For the period 2020-22, the median age of people at diagnosis with HGD was 71 (IQR: 64-78) and 77% of people diagnosed were men. Referrals for HGD assessment and diagnosis were split via Barrett's surveillance (55%) and symptomatic referral from a GP (45%). The proportion of people diagnosed with HGD via Barrett's surveillance increased over the audit, from 45% in 2012-14.

*Guidance (BSG): All cases of suspected HGD should be confirmed by two gastrointestinal (GI) pathologists.*

The proportion of people who had their original diagnosis confirmed by a second pathologist increased in every audit period, from 83% in 2012-14 to 92% in 2020-22. A previous finding that older age groups were less likely to have their diagnosis confirmed by a second pathologist was not found in the most recent period of 2020-22: 92% of people <60 years of age and 95% of people 80+ years of age had their original diagnosis confirmed. There was no evidence of differences by sex or deprivation.

### HGD treatment planning

*Guidance (BSG): All patients with HGD for whom therapy is considered should be discussed by a specialist OG cancer multidisciplinary team (MDT).*

The proportion of patients with HGD with a treatment plan agreed at an upper GI MDT meeting increased from 87% in 2012-14 to 91% in 2020-22. Overall, older patients were less likely to have their treatment plan agreed at an upper GI MDT meeting than younger patients: 88% of patients ≥80 years of age versus 92% of patients <60 years of age (p-value=0.02). There was no evidence of differences by sex or deprivation.

### HGD primary treatment modality

**KEY MESSAGE:** The proportion of patients with HGD with an active treatment plan increased over the audit period. In 2020-22, 80% of patients diagnosed with HGD had a plan for active treatment; however, there was large variation in the proportion of patients with an active treatment plan by Cancer Alliance, ranging from 33% to 100%.



**Recommendation 5:** In Cancer Alliances with low rates of active treatment for HGD, review reasons for non-treatment and determine if more patients with HGD could be eligible for endoscopic therapy.

Data completeness on primary treatment modality was high for the 2020-22 period (445/489 patients had information available). 80% of patients with HGD had a plan for active treatment and 12% had a plan for surveillance. Over the entire audit period, the proportion of patients with HGD with an active treatment plan increased (Table 7). This was also observed in sensitivity analysis.

There was variation in the proportion of patients with HGD with an active treatment plan by Cancer Alliance, ranging from 33% to 100% (see online [Data Tables](#)). There was some evidence that patients with HGD  $\geq 80$  years were less likely to have an active treatment plan versus those  $< 60$  years: odds ratio 0.42 (95% CI 0.19 to 0.93),  $p=0.033$ .

*Guidance (BSG): Endoscopic treatment of HGD is preferred over oesophagectomy or surveillance.*

The use of endoscopic procedures as active treatment increased from 84% in 2012-14 to 98% in 2020-22. A similar trend was observed in the sensitivity analysis. In 2020-22, the breakdown of active treatments was: 72% endoscopic resection, 22% radiofrequency ablation, 4% argon plasma coagulation, and  $< 2\%$  oesophagectomy and other treatment.

**Table 7: Treatment plan for patients with HGD, 2012-22**

Audit year	Records	HGD treatment plan (%)		
		Active	Surv	No plan
2012-14	933	72.2%	22.1%	5.7%
2014-16	775	77.9%	12.5%	9.6%
2016-18	799	78.0%	12.9%	9.1%
2018-20	587	83.1%	10.9%	6.0%
2020-22	445	79.6%	11.7%	8.8%
<b>Total</b>	<b>3539</b>	<b>77.5%</b>	<b>14.8%</b>	<b>7.7%</b>

KEY: Surv - surveillance

## HGD outcomes after endoscopic procedures

There was a decrease in the number of trusts submitting data on endoscopic procedures over time (61 in 2012-14 vs. 37 in 2020-22). In 2020-22, 92% of endoscopic procedures were done at specialist surgical centres. In sensitivity analysis, the proportion of endoscopic procedures performed at surgical centres was consistent: 91% in 2012-14 and 93% in 2020-22.

Information on resection margins was collected for patients with HGD undergoing endoscopic procedures; however, 60% of records had either missing information or “not known” entered. Excluding these, of patients undergoing endoscopic procedures in 2020-22: 26% (36/139) had a positive lateral resection margin and 17% (26/156) had a positive deep resection margin.

## HGD summary

Since 2012, improvements in the care of people with HGD have been observed in various aspects of the care pathway: today, higher proportions of people with HGD have their diagnosis confirmed by a second pathologist, have a treatment plan agreed at an upper GI MDT, have a plan for active treatment, and undergo endoscopic treatments.

## Changes to NOGCA

In June 2023, NOGCA moved into the [National Cancer Audit Collaborating Centre \(NATCAN\)](#), which is responsible for delivering all ten national cancer audits within the National Clinical Audit and Patient Outcomes Programme ([NCAPOP](#)).

NATCAN audits are designed to use cancer data that is already collected routinely by hospitals, rather than collecting their own core datasets. Consequently, from 2024, NOGCA will report on clinical practice and patient outcomes using existing national cancer datasets only. Advantages of this approach include: a reduced burden of data collection on hospital staff, the ability to provide more timely information using the English rapid cancer registration data, and more complete case ascertainment. However, information on HGD, nutrition, and ERAS will not be available. Furthermore, while the audit will continue to publish similar metrics, the information will not be directly comparable to the values previously produced from bespoke Audit data.

Key priorities for NOGCA in 2024 include:

- Identification of a new “minimum dataset” for the audit, reflecting the changes in data flows.
- Development of a new healthcare improvement strategy to identify quality improvement (QI) goals, activities and resources.
- Development of new online dashboards to provide timely information on key indicators.
- Continued stakeholder engagement to develop the audit, including the audit’s Clinical Reference Group, Patient and Public Involvement Forum, and national organisations such as United Kingdom and Ireland Oesophagogastric Cancer Group (UKIOG).