



Victorian Optimal Care
Summits:

Prioritisation of Unwarranted Variations in Colorectal Cancer

February 2025



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The Victorian Integrated Cancer Services (VICS) are Victoria's cancer services improvement network. They build relationships between healthcare providers and other cancer care stakeholders to develop, implement and evaluate initiatives that improve the way our member health services provide care and support people affected by cancer. The VICS Optimal Care Summits program is an initiative of the VICS and administered by the North Eastern Melbourne Integrated Cancer Service (NEMICS). The VICS are supported by the Victorian Government. For more information, see www.vics.org.au/.

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List of Acronyms

Acronym	Definition
ALIC	Analysis of Linked Information in Cancer
ICS	Integrated Cancer Services
MDM	Multidisciplinary meetings
MDT	Multidisciplinary team
OCP	Optimal Care Pathways
VICS	Victorian Integrated Cancer Services

Background

The Victorian Cancer Plan 2024-2028 highlights the importance of reducing variation in cancer care experience and outcomes across Victoria. (1) The cancer Optimal Care Pathways (OCPs) are nationally recognised frameworks for the delivery of consistent, safe, high-quality, and evidence-based care for people with cancer. (2) The OCPs aim to improve patient outcomes through promoting quality cancer care and ensuring that all people diagnosed with cancer receive the best care, irrespective of where they live or receive cancer treatment.

The Victorian Integrated Cancer Services (VICS) Optimal Care Summits program is an initiative of the VICS which involves the examination of tumour-specific cancer care, experience and outcomes measures against the standards and targets set out in the OCPs. (2) The VICS are Victoria's cancer service improvement network. They build relationships between healthcare providers to develop, implement and evaluate initiatives that improve the way Victoria's health services provide care and support to people affected by cancer. There are eight geographical ICS and one statewide paediatric ICS.

The Victorian Cancer Plan 2024-2028 defines the program as an enabler for reducing variations in clinical practice and cancer outcomes. (2) The VICS Optimal Care Summits program aims to identify data informed patterns of cancer care and outcomes, variations in care, agree to priorities for reducing unwarranted variations, and deliver quality improvement initiatives to reduce prioritised variations.

The program involves a mixed-methods strategic consultation approach including tumour-specific expert advisory groups, strategic consultations, statewide surveys, and relevant stakeholder engagement throughout Victoria. The consultation identifies priority improvement initiatives that are resourced by the VICS and other cancer organisations.

In 2025, the Optimal Care Summits program engaged with colorectal cancer clinicians, stakeholders and consumers to participate in various mixed-method strategic consultations to identify unwarranted variations in colorectal cancer across Victoria.

Unwarranted variations in cancer care

To some extent, variation in cancer treatment is essential as each patient is unique and will require patient-centred care, shared decision making, and unique personal circumstances and environmental conditions will produce different treatment pathways. (3) The decision-making by medical professionals, guided by their experiences, will also contribute to variation. (4) However,

unwarranted variation is a quality and safety problem in health care delivery, especially where the variation does not contribute to better health outcomes. (5)

Unwarranted variations can be defined as the variation in the utilisation of health services that cannot be explained by differences in patient illness or patient preferences and therefore, provide an opportunity to improve the quality and equity of clinical care. (5) Structure and process in health care delivery has an interdependent relationship on health outcomes (6). Therefore, identifying and addressing unwarranted variation can help improve health outcomes, system efficiency, and quality (7). There is no framework however, that examines how an unwarranted variation is identified in health care.

In 2022, the VICS Optimal Care Summits program recommended a set of criteria to be implemented to consistently identify unwarranted variations in cancer care across Victoria. These are listed in Table 1.

Table 1. Criteria for identifying unwarranted variations in cancer care across Victoria

All Summits	1. The data identifying a variation is reliable and the variation is unwarranted (any data limitations have been identified).
	2. The variation is statistically significant.
	3. There is variation from the OCP performance indicators e.g., time to referral, treatment etc.
	4. The variation is unacceptable and negatively impacts patient outcomes and/or experience.
	5. The variation demonstrates inequitable access to services and/or treatment impacting patient outcomes and/or experience.
	6. Multidisciplinary clinicians, cancer services, and/or Integrated Cancer Services (ICS) have influence and capability to undertake cancer services improvement activities to reduce the variation.
Repeat Summits	7. There is no improvement to a prioritised unwarranted variation and/or recommendation from the previous summit.
	8. There are poorer outcomes and/or experience since the last Summit.

This report examines the process of how unwarranted variations in colorectal cancer were identified and then prioritised by stakeholders for discussion at a colorectal summit held in February 2025.

Aim

To identify, examine and prioritise unwarranted variations in colorectal cancer care across Victoria to promote optimal care.

Methodology

Identification of unwarranted variations

The VICS Optimal Care Summits program examined patterns of Victorian colorectal cancer care, experience, and outcomes. Indicators assessing the OCP steps were identified and informed by the previous colorectal cancer summits, VICS Optimal Care Summits team, an expert advisory group of 18 Victorian multidisciplinary colorectal cancer stakeholders, and the Analysis of Linked Information in Cancer (ALIC) data unit of the Victorian Department of Health.

Data analysis examining the endorsed OCP related indicators was completed by the ALIC team. A range of linked cancer datasets were accessed and analysed for colorectal cancer indicators. These included the Victorian Admitted Episode Dataset (VAED), Victorian Cancer Registry (VCR) dataset, Victorian Emergency Management Dataset (VEMD), Victorian Radiotherapy Minimum Dataset (VRMD), Notifiable infectious diseases – Public Health Event (PHESS), Statewide Cancer Indicator Platform (SCIP) and Cancer Service Performance Indicators (CPSI). Statistical methods were used to systematically identify potential unwarranted variations.

Data and indicators were then reviewed against the criteria for identifying unwarranted variations (see Table 1) and unwarranted variations of statistical significance identified. These were then cross-checked by members of the ALIC team and analysed in the context of clinical significance by the expert advisory group.

Delphi Survey development

In January 2025, three online Delphi surveys were distributed to members of the expert advisory group and Victorian colorectal cancer key stakeholders. Modifications to a typical Delphi study were required due to resource and time constraints. Two expert panels were engaged: an expert advisory group (n=18) comprising seasoned leaders in colorectal cancer care and a broader stakeholder group, (n=221) representing key stakeholders in policy and provision of colorectal cancer care in Victoria. Unlike traditional Delphi methods relying on set agreement percentages, consensus here was guided by expert insights and mixed-method strategies for identifying priorities. The surveys were piloted and reviewed by clinical experts. All three surveys were administered using Qualtrics. Participation was voluntary and responses were anonymised to remove the effects of status and group pressure biases that can arise during the discussion of results.

The first Delphi survey was sent out to the 18 members of the expert working group in mid-January 2025 to complete the first round of prioritisation of the unwarranted variations. In late-January to early-February 2025, a second Delphi survey was developed and circulated to a group of 221 Victorian colorectal cancer stakeholders to gain a broader perspective and further prioritise the unwarranted variations identified. The third and final Delphi survey was sent to the 18 members of the expert working group in early February 2025, to identify the top three priority unwarranted variations. Results from all three Delphi surveys were collated and analysed using Microsoft Excel.

Results

Twenty-four unwarranted variations in colorectal cancer care across Victoria were identified from the data analysis and consultations with the expert advisory group. These are listed in Table 2.

Table 2. All 24 unwarranted variations identified in Victorian colorectal cancer care 2025.

Ranking	Variation
1	In Victoria, the waiting time between positive screening and colonoscopy of people aged 50-74 has been increasing since 2019. In 2021, 90% of patients aged 50-74 had a colonoscopy within 136 days after positive screening, which is above the maximum recommended diagnostic interval, 120 days.
2	A significantly higher proportion of colorectal cancer patients with early onset disease (<50 years of age) were diagnosed with later stage disease compared with those >50 years of age.
3	Regional ICS have lower rates of documented multidisciplinary meeting (MDM) presentation for colorectal cancer patients. The target is 85%, the statewide result is 74% in 2022, and in some regional ICS rates were <50%.

4	Age standardised incidence rates of Victorians aged 25-49 years with colorectal cancer have been steadily increasing at an annual rate of 2.6% since 2005. This trend contrasts with the overall decline in colorectal cancer incidence rates among older Victorians over the past four decades.
5	Between 2018-2022, Aboriginal Victorians were 160% more likely to die from colorectal cancer, compared to other Victorians.
6	Between 2020-2022, age standardised incidence rates of colorectal cancer were higher in regional ICS.
7	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 1, 2 and 3 colorectal cancer was significantly lower than the statewide average in WCMICS and GRICS.
8	Age-standardised mortality rate of Victorians aged 25-49 years with colorectal cancer early-onset have been increasing at an annual rate of 1.8% annually over the past 17 years, between 2006 and 2023. This trend contrasts with the overall decline in colorectal cancer mortality rates among older Victorians.
9	Between 2018-2022, Aboriginal Victorians were 74% more likely to be diagnosed with colorectal cancer, compared to other Victorians.
10	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 4 colorectal cancer was significantly lower than the statewide average in WCMICS.
11	On average, only 11.6% of stage 4 colorectal cancer patients had recorded evidence of advance care directive in 2020-2022. Rates are low across all ICS.
12	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from cancer specific mortality among patients diagnosed in 2020–2022 with stage 2 colorectal cancer in GRICS observed poorer survival compared to the statewide average.
13	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from all-cause mortality among colorectal cancer patients by stage and ICS of residence were significantly worse for LMICS (stages 1 and 4 colorectal cancer) in the second time period (2020-2022) compared to the statewide average.
14	There is variation in documented evidence of communication of treatment plans to GPs for colorectal cancer patients by ICS. The target is 100%, the statewide result is 71% (2022) decreasing from 81% in 2017.
15	In 2020-2022, the median time between colonoscopy and first treatment was above the statewide median (22 days) in GRICS (33 days), LMICS (29 days) and HRICS (26 days).
16	Across all ICS, there are low rates of supportive care screening for colorectal cancer patients. The target is 80%, the statewide average is 20% (2022).
17	On average only 51.1% (2017-19) and 49.4% (2020-22) of colorectal cancer patients were seen by a dietitian during admission within 6 months of diagnosis. Rates are low across all ICS.
18	On average, 40% of colorectal cancer patients had an emergency department presentation 30 days prior to death between 2017-2022.
19	The proportion of colorectal cancer patients who presented to an emergency department (ED) for emergency surgery increased from 15.2% (2017) to 17.5% (2022). There was a statistically significant trend between 2017 to 2022 ($p < 0.01$).
20	There is variation in recording of stage in MDM recommendations for colorectal cancer patients between the ICS. The target is 85% and the statewide average in 2022 is 81%.
21	On average, only 47.7% of colorectal patients were admitted for palliative care within 12 months prior to death in 2020-2022.

22	On average only 54.9% (2017-19) and 53.6% (2020-22) of colorectal cancer patients were seen by a physiotherapist during admission within 3 months of diagnosis. Rates are low across all ICS.
23	There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for colorectal cancer patients, by ICS. The target is 100%, the statewide result was 20% in 2017 rising to 43% in 2022. However, in some ICS the rate is less than 25% (SMICS and BSWRICS) in 2022.
24	The proportion of surgeries with 12 or more lymph nodes examined for stage II and III colon cancer patients in HRICS, LMICS, and GICS showed wider variation from 2017 to 2022 compared to other ICS.

First Delphi survey

Fifteen participants responded to the first Delphi survey which was sent to the 18 members of the expert advisory group (response rate= 83%). Table 3 shows the twenty-four unwarranted variations and highlights the top sixteen unwarranted variations that were selected by the expert advisory group to be priorities in colorectal cancer. The score was generated by using a five-point Likert scale with participants identifying unwarranted variations from not at all important to very important.

As seen in Table 3, a strong priority was identified for those variations that affect early-onset colorectal cancer patients, Aboriginal Victorians, and survival disparities. Access to physiotherapy and documentation of Eastern Cooperative Oncology Group (ECOG) performance status were not seen as high priorities by the expert advisory group. In addition, difficulties in accessing accurate palliative care data also meant that the expert advisory group deprioritised this unwarranted variation.

Table 3. Round One Delphi results for Colorectal Cancer Summit unwarranted variations, 2025.

Ranking	Variation	Score (n=15)
1	A significantly higher proportion of colorectal cancer patients with early onset disease (<50 years of age) were diagnosed with later stage disease compared with those >50 years of age.	67
2	Age-standardised mortality rate of Victorians aged 25-49 years with colorectal cancer early-onset have been increasing at an annual rate of 1.8% annually over the past 17 years, between 2006 and 2023. This trend contrasts with the overall decline in colorectal cancer mortality rates among older Victorians.	67
3	Age standardised incidence rates of Victorians aged 25-49 years with colorectal cancer have been steadily increasing at an annual rate of 2.6% since 2005. This trend contrasts with the overall decline in colorectal cancer incidence rates among older Victorians over the past four decades.	66
4	Care after initial treatment and recovery - Between 2018-2022, Aboriginal Victorians were 160% more likely to die from colorectal cancer, compared to other Victorians.	66

5	Care after initial treatment and recovery - After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from all-cause mortality among colorectal cancer patients by stage and ICS of residence were significantly worse for LMICS (stages 1 and 4 colorectal cancer) in the second time period (2020-2022) compared to the statewide average.	65
6	Diagnosis, staging and treatment planning - In Victoria, the waiting time between positive screening and colonoscopy of people aged 50-74 has been increasing since 2019. In 2021, 90% of patients aged 50-74 had a colonoscopy within 136 days after positive screening, which is above the maximum recommended diagnostic interval, 120 days.	63
7	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 1, 2 and 3 colorectal cancer was significantly lower than the statewide average in WCMICS and GRICS.	63
8	Between 2018-2022, Aboriginal Victorians were 74% more likely to be diagnosed with colorectal cancer, compared to other Victorians.	61
9	Between 2020-2022, age standardised incidence rates of colorectal cancer were higher in regional ICS.	58
10	Care after initial treatment and recovery - After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from cancer specific mortality among patients diagnosed in 2020–2022 with stage 2 colorectal cancer in GRICS observed poorer survival compared to the statewide average.	58
11	Diagnosis, staging and treatment planning - There is variation in documented evidence of communication of treatment plans to GPs for colorectal cancer patients by ICS. The target is 100%, the statewide result is 71% (2022) decreasing from 81% in 2017.	57
12	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 4 colorectal cancer was significantly lower than the statewide average in WCMICS.	57
13	Diagnosis, staging and treatment planning - Regional ICS have lower rates of documented multidisciplinary meeting (MDM) presentation for colorectal cancer patients. The target is 85%, the statewide result is 74% in 2022, and in some regional ICS rates were <50%.	56
14	End of life care - On average, only 11.6% of stage 4 colorectal cancer patients had recorded evidence of advance care directive in 2020-2022. Rates are low across all ICS.	53
15	In 2020-2022, the median time between colonoscopy and first treatment was above the statewide median (22 days) in GRICS (33 days), LMICS (29 days) and HRICS (26 days).	51
16	Across all ICS, there are low rates of supportive care screening for colorectal cancer patients. The target is 80%, the statewide average is 20% (2022).	50

17	On average only 51.1% (2017-19) and 49.4% (2020-22) of colorectal cancer patients were seen by a dietitian during admission within 6 months of diagnosis. Rates are low across all ICS.	50
18	On average, 40% of colorectal cancer patients had an emergency department presentation 30 days prior to death between 2017-2022.	49
19	The proportion of colorectal cancer patients who presented to an emergency department (ED) for emergency surgery increased from 15.2% (2017) to 17.5% (2022). There was a statistically significant trend between 2017 to 2022 ($p < 0.01$).	48
20	There is variation in recording of stage in MDM recommendations for colorectal cancer patients between the ICS. The target is 85% and the statewide average in 2022 is 81%.	47
21	On average, only 47.7% of colorectal patients were admitted for palliative care within 12 months prior to death in 2020-2022.	43
22	On average only 54.9% (2017-19) and 53.6% (2020-22) of colorectal cancer patients were seen by a physiotherapist during admission within 3 months of diagnosis. Rates are low across all ICS.	42
23	There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for colorectal cancer patients, by ICS. The target is 100%, the statewide result was 20% in 2017 rising to 43% in 2022. However, in some ICS the rate is less than 25% (SMICS and BSWRICS) in 2022.	41
24	*The proportion of surgeries with 12 or more lymph nodes examined for stage II and III colon cancer patients in HRICS, LMICS, and GICS showed wider variation from 2017 to 2022 compared to other ICS.	N/A

Note: Unwarranted variations highlighted in green indicates which variations were prioritised for the round and for consideration at the next Delphi stage.

*This unwarranted variation was identified at a later stage and was not available in the surveys and therefore not prioritised.

Second Delphi survey

Eighty-seven participants responded to the second Delphi survey which was sent to the 221 colorectal cancer stakeholders across Victoria (response rate=39%). The fifteen variations sent in the Delphi survey and the top ten prioritised are depicted in Table 4.

Similar trends to the first Delphi survey were seen, where survival and outcomes for colorectal patients with early-onset disease were prioritised. Variations relating to time to first treatment, documented evidence of communication with general practitioners, and poorer survival in some areas of the state were not considered to be high priority by colorectal cancer stakeholders.

Table 4. Round Two Delphi results for Colorectal Cancer Summit unwarranted variations, 2025.

Ranking	Previous ranking	Variation	Score (n=87)
1	1	A significantly higher proportion of colorectal cancer patients with early onset disease (<50 years of age) were diagnosed with later stage disease compared with those >50 years of age.	403
2	3 ⁽⁺¹⁾	Age standardised incidence rates of Victorians aged 25-49 years with colorectal cancer have been steadily increasing at an annual rate of 2.6% since 2005. This trend contrasts with the overall decline in colorectal cancer incidence rates among older Victorians over the past four decades.	391
3	2 ⁽⁻¹⁾	Care after initial treatment and recovery - Age-standardised mortality rate of Victorians aged 25-49 years with colorectal cancer early-onset have been increasing at an annual rate of 1.8% annually over the past 17 years, between 2006 and 2023. This trend contrasts with the overall decline in colorectal cancer mortality rates among older Victorians.	386
4	4	Care after initial treatment and recovery - Between 2018-2022, Aboriginal Victorians were 160% more likely to die from colorectal cancer, compared to other Victorians.	379
5	6 ⁽⁺¹⁾	In Victoria, the waiting time between positive screening and colonoscopy of people aged 50-74 has been increasing since 2019. In 2021, 90% of patients aged 50-74 had a colonoscopy within 136 days after positive screening, which is above the maximum recommended diagnostic interval, 120 days.	375
6	8 ⁽⁺²⁾	Between 2018-2022, Aboriginal Victorians were 74% more likely to be diagnosed with colorectal cancer, compared to other Victorians.	370
7	9 ⁽⁺²⁾	Between 2020-2022, age standardised incidence rates of colorectal cancer were higher in regional ICS.	361
8	7 ⁽⁻¹⁾	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 1, 2 and 3 colorectal cancer was significantly lower than the statewide average in WCMICS and GRICS.	353
9	12 ⁽⁺³⁾	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 4 colorectal cancer was significantly lower than the statewide average in WCMICS.	341
10	13 ⁽⁺³⁾	Regional ICS have lower rates of documented multidisciplinary meeting (MDM) presentation for colorectal cancer patients. The target is 85%, the statewide result is 74% in 2022, and in some regional ICS rates were <50%.	339
11	14 ⁽⁺³⁾	On average, only 11.6% of stage 4 colorectal cancer patients had recorded evidence of advance care directive in 2020-2022. Rates are low across all ICS.	338
12	10 ⁽⁻²⁾	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from cancer specific mortality among patients diagnosed in 2020–2022 with stage 2 colorectal cancer in GRICS observed poorer survival compared to the statewide average.	336

13	5 ⁽⁻⁸⁾	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from all-cause mortality among colorectal cancer patients by stage and ICS of residence were significantly worse for LMICS (stages 1 and 4 colorectal cancer) in the second time period (2020-2022) compared to the statewide average.	335
14	11 ⁽⁻³⁾	There is variation in documented evidence of communication of treatment plans to GPs for colorectal cancer patients by ICS. The target is 100%, the statewide result is 71% (2022) decreasing from 81% in 2017.	326
15	15	In 2020-2022, the median time between colonoscopy and first treatment was above the statewide median (22 days) in GRICS (33 days), LMICS (29 days) and HRICS (26 days).	326

Note: Unwarranted variations highlighted in green indicates which variations were prioritised for the round and for consideration at the next Delphi stage.

Third Delphi survey

Table 5 summarises the top ten unwarranted variations that were included in the Delphi survey and indicates the top three selected by the expert advisory group to be prioritised and discussed at the colorectal cancer summit (response rate=69%). Variations selected related to a range of topics including access to colonoscopy, diagnosis of early-onset colorectal cancer, and regional multidisciplinary meeting rates.

Table 5. Round Three Delphi results for Colorectal Summit unwarranted variations, 2025.

Ranking	Previous ranking	Variation
1	5 ⁽⁺⁴⁾	In Victoria, the waiting time between positive screening and colonoscopy of people aged 50-74 has been increasing since 2019. In 2021, 90% of patients aged 50-74 had a colonoscopy within 136 days after positive screening, which is above the maximum recommended diagnostic interval, 120 days.
2	1 ⁽⁻¹⁾	A significantly higher proportion of colorectal cancer patients with early onset disease (<50 years of age) were diagnosed with later stage disease compared with those >50 years of age.
3	10 ⁽⁺⁷⁾	Regional ICS have lower rates of documented multidisciplinary meeting (MDM) presentation for colorectal cancer patients. The target is 85%, the statewide result is 74% in 2022, and in some regional ICS rates were <50%.
4	2 ⁽⁻²⁾	Age standardised incidence rates of Victorians aged 25-49 years with colorectal cancer have been steadily increasing at an annual rate of 2.6% since 2005. This trend contrasts with the overall decline in colorectal cancer incidence rates among older Victorians over the past four decades.
5	4 ⁽⁺¹⁾	Between 2018-2022, Aboriginal Victorians were 160% more likely to die from colorectal cancer, compared to other Victorians.
6	7 ⁽⁺¹⁾	Between 2020-2022, age standardised incidence rates of colorectal cancer were higher in regional ICS.

7	8 ⁽⁺¹⁾	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 1, 2 and 3 colorectal cancer was significantly lower than the statewide average in WCMICS and GRICS.
8	3 ⁽⁻⁵⁾	Age-standardised mortality rate of Victorians aged 25-49 years with colorectal cancer early-onset have been increasing at an annual rate of 1.8% annually over the past 17 years, between 2006 and 2023. This trend contrasts with the overall decline in colorectal cancer mortality rates among older Victorians.
9	6 ⁽⁺¹⁾	Between 2018-2022, Aboriginal Victorians were 74% more likely to be diagnosed with colorectal cancer, compared to other Victorians.
10	9 ⁽⁻¹⁾	In 2020- 2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 4 colorectal cancer was significantly lower than the statewide average in WCMICS.

Recommendations

Results highlight that a three round, anonymous, online Delphi survey process can be successful in prioritising unwarranted variations in colorectal cancer care. The engagement of a variety of multidisciplinary stakeholders including both members of the expert advisory group and key colorectal cancer stakeholders from across Victoria can assist in identifying unwarranted variations of clinical significance and to be addressed by improvement initiatives. Increasing stakeholder engagement and ensuring that future Delphi surveys identify the respondent's position and region of work will be crucial to further interpreting results and guiding decisions on priorities.

One variation regarding lymph node examinations for stage II and III colorectal cancer patients was not included in the Delphi surveys and therefore has not been prioritised.

Conclusion

This Delphi survey of the unwarranted variations in colorectal cancer care has identified important findings to inform improvements that can be made in colorectal cancer care in Victoria. A three round Delphi survey process was successfully used engaging both colorectal cancer expert advisory group members and colorectal cancer stakeholders to prioritise the top three unwarranted variations for discussion at the VICS Colorectal Cancer Summit. There was clear preference for unwarranted variations that addressed early-onset colorectal cancer. There was also great support for improvements in access to colonoscopy and multidisciplinary meetings. While there were only three unwarranted variations prioritised for the summit event, all unwarranted variations will be addressed in the development of a statewide Action Register by the VICS Optimal Care Summits team.

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