



Victorian Optimal care
Summits:

Prioritisation of Unwarranted Variations in Endometrial Cancer

November 2024



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Table of Contents

Table of Contents	3
List of Acronyms	4
Background.....	4
Aim.....	5
Methodology	5
Results.....	6
Recommendations.....	13
Conclusion	13
References	14

List of Acronyms

Acronym	Definition
ALIC	Analysis of Linked Information in Cancer
EC	Endometrial 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, as well as priority initiatives that are resourced by the VICS and other cancer organisations.

In 2024, the Optimal Care Summits program engaged with endometrial cancer clinicians, stakeholders and consumers to participate in various mixed-method strategic consultations to identify unwarranted variations in endometrial 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.

The 2022 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 endometrial cancer were identified and then prioritised for discussion by stakeholders at an EC summit held in November 2024.

Aim

To identify unwarranted variations in endometrial cancer across Victoria and achieve consensus on which should be prioritised for action to provide optimal care.

Methodology

Identification of unwarranted variations

The VICS Optimal Care Summits team, along with a panel of 24 multidisciplinary endometrial cancer stakeholders from across the state and the Analysis of Linked Information in Cancer (ALIC) data unit of the Victorian Department of Health, identified and discussed various indicators in endometrial cancer care across Victoria.

Key indicators were decided on and data analysis was completed by the ALIC team. A range of linked cancer datasets were accessed and analysed for endometrial 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).

Data was then reviewed by the VICS Optimal Care Summits team, and the criteria (see Table 1) was applied to determine any unwarranted variations. These were then cross-checked by members of the ALIC team and analysed in the context of clinical significance by the 24 multidisciplinary EC cancer stakeholders.

Delphi Survey development

In October 2024, the VICS Optimal Care Summits team developed three online Delphi surveys to distribute to members of the expert advisory group and endometrial cancer key stakeholders. The team considered some modifications to a typical Delphi study due to resource and time constraints. Two expert panels were engaged: an expert advisory group (n=24) comprising seasoned leaders in endometrial cancer care and a broader stakeholder group, (n=139) representing key stakeholders in policy and provision of endometrial 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 24 members of the expert working group in early October 2024 to complete the first round of prioritisation of the unwarranted variations. In mid-October 2024, a second Delphi survey was developed and circulated to a group of 139 endometrial cancer stakeholders to gain a broader perspective and further prioritise the unwarranted variations identified. The third and final Delphi survey was sent to the 24 members of the expert working group in late October 2024, to identify the top three priority unwarranted variations. Results from all three Delphi surveys were collated and analysed using Microsoft Excel.

Results

Twenty-two unwarranted variations in endometrial 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 23 unwarranted variations identified in Victorian endometrial cancer care 2024.

Ranking	Variation
1	*Across all ICS, there are low rates of supportive care screening for endometrial cancer patients. The target is 80%, the statewide result is 22% and most ICS have rates <25%.
2	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours, ranging from 26-56 days in 2018-2022.
3	After adjusting for age at diagnosis and comorbidities, both survival from all-cause mortality and cancer-specific mortality among endometrial cancer patients with high

	grade tumours was significantly worse than the statewide average in LMICS between 2018-2022.
4	The proportion of endometrial cancer patients over the age of 50 with high grade tumours who received surgery within 6 weeks of diagnosis significantly decreased from 71.8% (2013-17) to 65.4% (2018-2022). One ICS, GRICS was also below the statewide average in 2018-2022.
5	Care after initial treatment and recovery - After adjusting for age at diagnosis and comorbidities, survival from all-cause mortality among patients diagnosed in 2018-22 with high grade tumours in BSWRICS was significantly worse than that observed among patients diagnosed in 2013-17.
6	*Regional ICS have lower rates of documented MDM presentation for endometrial cancer patients. The target is 85%, the statewide result is 81% and in some regional ICS rates were <50%.
7	*There is variation in documented evidence of communication of treatment plans to GPs for endometrial cancer patients by ICS. The target is 100%, the statewide result is 77%.
8	The median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours increased from 27 days (2013-17) to 30 days (2018-2022).
9	*There is variation in recording of stage in multidisciplinary meeting (MDM) recommendations for endometrial cancer patients between the ICS with SMICS and WCMICS below the DH target of 85%.
10	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with low grade tumours, ranging from 24-47 days in 2018-2022.
11	The proportion of endometrial cancer patients with low grade tumours and were over the age of 50 who received surgery within 6 weeks of diagnosis significantly decreased from 69.7% (2013-17) to 62.1% (2018-2022). Several ICS were also below the statewide average in 2018-2022 (LMICS, HRICS and WCMICS).
12	There is a significantly higher percentage of patients from LMICS who presented to ED 28 days prior to a diagnosis of endometrial cancer, compared to the statewide average.
13	The statewide average for patients admitted 30 days prior to death was 33.2% (2013-17), increasing to 41.2% (2018-22). GRICS was significantly above the statewide average in 2018-22 with approximately 75% of patients presenting to ED.
14	Statewide, only 10% of EC patients who died had recorded evidence of an advance care directive. Rates are low across all ICS.
15	*There is variation in documented evidence of ECOG recorded in an MDM for endometrial cancer patients by ICS. The target is 100%, the statewide result is 62%, and in some ICS the rate is less than 25% (WCMICS and BSWRICS).
16	On average, only 5.2% of endometrial cancer patients were seen by a dietitian during admission within 3 months of diagnosis in 2018-22. Rates are low across all ICS. GRICS is significantly below the statewide average.
17	The proportion of patients who presented to an emergency department (ED) within 28 days prior to diagnosis of endometrial cancer increased from 7.4% (2013-2017) to 9.7% (2018-2022).
18	Across all ICS, there are low and decreasing rates of referrals to a physiotherapist within 3 months of diagnosis for endometrial cancer patients with the statewide average decreasing from 63.7% (2013-2017) to 49.7% (2018-2022). NEMICS was significantly below the statewide average in both time periods.
19	Only 10 endometrial cancer patients were seen by a psychologist during admission within 3 months of diagnosis across the past 10 years in Victoria.

20	Across all ICS, there are low and decreasing rates of referrals to a social worker during admission within 3 months of diagnosis for endometrial cancer patients with the statewide average decreasing from 23.6% (2013-2017) to 15.8% (2018-2022). SMICS and GICS were significantly below the statewide average in 2018-2022.
21	There is variation between the ICS for length of stay after a hysterectomy. In 2018-22, the proportion of patients who had a shorter length of stay than the statewide median (3 days) is significantly lower in SMICS.
22	The median number of days from diagnosis to any treatment for endometrial cancer patients with low grade tumours increased from 28 days (2013-17) to 30 days (2018-22).

* Two ICS (HRICS and GRICS) were excluded because they had less than 5 patients.

First Delphi survey

Ten participants responded to the first Delphi survey which was sent to the 24 members of the expert advisory group (response rate= 42%). Table 3 shows the twenty-three unwarranted variations and highlights the top sixteen unwarranted variations that were selected by the expert advisory group to be priorities in endometrial 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 directly impact survival e.g. survival from all-cause mortality, time from diagnosis to any treatment, overall survival, and metropolitan versus regional survival differences. Access to social work and physiotherapy, emergency related variations and length of stay were not considered for higher prioritisation by the expert advisory group.

Table 3. Round One Delphi results for Endometrial Cancer Summit unwarranted variations, 2024.

Ranking	Variation	Score (n=10)
1	The proportion of endometrial cancer patients with high grade tumours who received surgery within 6 weeks of diagnosis significantly decreased from 71.9% (2013-17) to 65.3% (2018-2022). One ICS, GRICS was also below the statewide average in 2018-2022.	47
2	*Across all ICS, there are low rates of supportive care screening for endometrial cancer patients. The target is 80%, the statewide result is 22% and most ICS have rates <25%.	45
3	After adjusting for age at diagnosis and comorbidities, survival from all-cause mortality among patients diagnosed in 2018-22 with high grade tumours in BSWRICS was significantly worse than that observed among patients diagnosed in 2013-17	44
4	*Regional ICS have lower rates of documented MDM presentation for endometrial cancer patients. The target is 85%, the statewide result is 81% and in some regional ICS rates were <50%.	43

5	After adjusting for age at diagnosis and comorbidities, both survival from all-cause mortality and cancer-specific mortality among endometrial cancer patients with high grade tumours was significantly worse than the statewide average in LMICS between 2018-2022.	43
6	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours, ranging from 26-56 days in 2018-2022.	42
7	*There is variation in documented evidence of communication of treatment plans to GPs for endometrial cancer patients by ICS. The target is 100%, the statewide result is 77%.	40
8	The proportion of endometrial cancer patients with low grade tumours and were over the age of 50 who received surgery within 6 weeks of diagnosis significantly decreased from 69.8% (2013-17) to 62.2% (2018-2022). Several ICS were also below the statewide average in 2018-2022 (LMICS, HRICS and WCMICS).	40
9	The statewide average for patients admitted 30 days prior to death was 33.2% (2013-17), increasing to 41.2% (2018-22). GRICS was significantly above the statewide average in 2018-22 with approximately 75% of patients presenting to ED. 5/9/24 19/9/2024	40
10	*There is variation in recording of stage in multidisciplinary meeting (MDM) recommendations for endometrial cancer patients between the ICS with SMICS and WCMICS below the DH target of 85%.	39
11	*There is variation in documented evidence of ECOG recorded in an MDM for endometrial cancer patients by ICS. The target is 100%, the statewide result is 62%, and in some ICS the rate is less than 25% (WCMICS and BSWRICS).	37
12	The median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours increased from 27 days (2013-17) to 30 days (2018-2022).	36
13	On average, only 5.2% of endometrial cancer patients were seen by a dietitian during admission within 3 months of diagnosis in 2018-22. Rates are low across all ICS. GRICS is significantly below the statewide average.	36
14	Across all ICS, only 10% of EC patients who died had recorded evidence of an advance care directive. Rates are low across all ICS. 5/9/24 19/9/2024	35
15	OCP Step Four - Treatment - There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with low grade tumours, ranging from 24-47 days in 2018-2022.	34
16	The proportion of patients who presented to an emergency department (ED) within 28 days prior to diagnosis of endometrial cancer increased from 7.4% (2013-2017) to 9.7% (2018-2022).	33

17	Across all ICS, there are low and decreasing rates of referrals to a physiotherapist within 3 months of diagnosis for endometrial cancer patients with the statewide average decreasing from 63.7% (2013-2017) to 49.7% (2018-2022). NEMICS was significantly below the statewide average in both time periods.	33
18	Only 10 endometrial cancer patients were seen by a psychologist during admission within 3 months of diagnosis across the past 10 years in Victoria.	33
19	Across all ICS, there are low and decreasing rates of referrals to a social worker during admission within 3 months of diagnosis for endometrial cancer patients with the statewide average decreasing from 23.6% (2013-2017) to 15.8% (2018-2022). SMICS and GICS were significantly below the statewide average in 2018-2022.	31
20	There is variation between the ICS for length of stay after a hysterectomy. In 2018-22, the proportion of patients who had a shorter length of stay than the statewide median (3 days) is significantly lower in SMICS.	27
21	The median number of days from diagnosis to any treatment for endometrial cancer patients with low grade tumours increased from 28 days (2013-17) to 30 days (2018-22).	26
22	**There is a significantly higher percentage of patients from LMICS who presented to ED 28 days prior to a diagnosis of endometrial cancer, compared to the statewide average.	n/a

* Two ICS (HRICS and GRICS) were excluded because they had less than 5 patients.

** Variations that were not included in the first Delphi survey.

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

Second Delphi survey

Forty-two participants responded to the second Delphi survey which was sent to the 139 endometrial cancer stakeholders across Victoria (response rate=19.4%). The sixteen variations sent in the Delphi survey and the top seven prioritised are depicted in Table 4.

Similar trends to the first Delphi survey were seen, where survival outcomes were prioritised. The top four unwarranted variations prioritised by the expert advisory group were also prioritised to be addressed by the broader endometrial stakeholders. Variations relating to emergency department admissions, evidence of an advance care directive and delays to treatment for patients diagnosed with low grade endometrial cancer were not considered to be a high priority by endometrial cancer stakeholders.

Table 4. Round Two Delphi results for Endometrial Cancer Summit unwarranted variations, 2024.

Ranking	Previous ranking	Variation	Score (n=27)
1	4 ⁽⁺³⁾	*Regional ICS have lower rates of documented MDM presentation for endometrial cancer patients. The target is 85%, the statewide result is 81% and in some regional ICS rates were <50%.	114
2	2	*Across all ICS, there are low rates of supportive care screening for endometrial cancer patients. The target is 80%, the statewide result is 22% and most ICS have rates <25%.	111
3	3	After adjusting for age at diagnosis and comorbidities, survival from all-cause mortality among patients diagnosed in 2018-22 with high grade tumours in BSWRICS was significantly worse than that observed among patients diagnosed in 2013-17.	111
4	4	After adjusting for age at diagnosis and comorbidities, both survival from all-cause mortality and cancer-specific mortality among endometrial cancer patients with high grade tumours was significantly worse than the statewide average in LMICS between 2018-2022.	110
5	6 ⁽⁺¹⁾	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours, ranging from 26-56 days in 2018-2022.	109
6	7 ⁽⁺¹⁾	*There is variation in documented evidence of communication of treatment plans to GPs for endometrial cancer patients by ICS. The target is 100%, the statewide result is 77%.	108
7	8 ⁽⁺¹⁾	The proportion of endometrial cancer patients over the age of 50 with high grade tumours who received surgery within 6 weeks of diagnosis significantly decreased from 71.8% (2013-17) to 65.4% (2018-2022). One ICS, GRICS was also below the statewide average in 2018-2022.	107
8	12 ⁽⁺⁴⁾	The median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours increased from 27 days (2013-17) to 30 days (2018-2022).	106
9	10 ⁽⁺¹⁾	*There is variation in recording of stage in multidisciplinary meeting (MDM) recommendations for endometrial cancer patients between the ICS with SMICS and WCMICS below the DH target of 85%.	102
10	8 ⁽⁻²⁾	The proportion of endometrial cancer patients with low grade tumours and were over the age of 50 who received surgery within 6 weeks of diagnosis significantly decreased from 69.7% (2013-17) to 62.1% (2018-2022). Several ICS were also below the statewide average in 2018-2022 (LMICS, HRICS and WCMICS).	102
11	15 ⁽⁺⁴⁾	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with low grade tumours, ranging from 24-47 days in 2018-2022.	101
12	NA	There is a significantly higher percentage of patients from LMICS who presented to ED 28 days prior to a diagnosis of endometrial cancer, compared to the statewide average.	96

13	9 ⁽⁻⁴⁾	The statewide average for patients admitted 30 days prior to death was 33.2% (2013-17), increasing to 41.2% (2018-22). GRICS was significantly above the statewide average in 2018-22 with approximately 75% of patients presenting to ED.	96
14	11 ⁽⁻³⁾	*There is variation in documented evidence of ECOG recorded in an MDM for endometrial cancer patients by ICS. The target is 100%, the statewide result is 62%, and in some ICS the rate is less than 25% (WCMICS and BSWRICS).	92
15	14 ⁽⁻¹⁾	Statewide, only 10% of EC patients who died had recorded evidence of an advance care directive. Rates are low across all ICS.	91
16	13 ⁽⁻³⁾	On average, only 5.2% of endometrial cancer patients were seen by a dietitian during admission within 3 months of diagnosis in 2018-22. Rates are low across all ICS. GRICS is significantly below the statewide average.	90

* Two ICS (HRICS and GRICS) were excluded because they had less than 5 patients.

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

Third Delphi survey

Twelve participants responded to the third and final Delphi survey which was sent to the 24 members of the expert advisory group (response rate= 50%). Table 5 summarises the top seven 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 endometrial cancer summit. Variations selected related to a range of topics including supportive care, treatment delays and survival.

Table 5. Round Three Delphi results for EC Summit unwarranted variations, 2024.

Ranking	Previous ranking	Variation
1	1 ⁽⁺¹⁾	*Across all ICS, there are low rates of supportive care screening for endometrial cancer patients. The target is 80%, the statewide result is 22% and most ICS have rates <25%.
2	2 ⁽⁺³⁾	There is variation between the ICS in the median number of days from diagnosis to any treatment for endometrial cancer patients with high grade tumours, ranging from 26-56 days in 2018-2022.
3	3 ⁽⁺¹⁾	After adjusting for age at diagnosis and comorbidities, both survival from all-cause mortality and cancer-specific mortality among endometrial cancer patients with high grade tumours was significantly worse than the statewide average in LMICS between 2018-2022.
4	4 ⁽⁺³⁾	The proportion of endometrial cancer patients over the age of 50 with high grade tumours who received surgery within 6 weeks of diagnosis significantly decreased from 71.8% (2013-17) to 65.4% (2018-2022). One ICS, GRICS was also below the statewide average in 2018-2022.
5	5 ⁽⁻²⁾	After adjusting for age at diagnosis and comorbidities, survival from all-cause mortality among patients diagnosed in 2018-22 with high grade tumours in BSWRICS was significantly worse than that observed among patients diagnosed in 2013-17.

6	6 ⁽⁻⁵⁾	*Regional ICS have lower rates of documented MDM presentation for endometrial cancer patients. The target is 85%, the statewide result is 81% and in some regional ICS rates were <50%.
7	7 ⁽⁻¹⁾	*There is variation in documented evidence of communication of treatment plans to GPs for endometrial cancer patients by ICS. The target is 100%, the statewide result is 77%.

* Two ICS (HRICS and GRICS) were excluded because they had less than 5 patients.

Recommendations

Results highlight that a three round, anonymous, online Delphi survey process can be successful in prioritising unwarranted variations in endometrial cancer care. The engagement of a variety of multidisciplinary stakeholders including both members of the expert advisory group and key endometrial cancer stakeholders from across the state can assist in identifying unwarranted variations of clinical significance and to be addressed by improvement initiatives. Limitations however include the absence of consumer feedback, potentially overlooking important consumer priorities and hindering the understanding of how to enhance endometrial cancer care further. 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.

Conclusion

This Delphi survey of the unwarranted variations in endometrial cancer care has identified important findings to inform improvements that can be made in endometrial cancer care in Victoria. A three round Delphi survey process was successfully used engaging both endometrial cancer expert advisory group members and endometrial cancer stakeholders to prioritise the top three unwarranted variations for discussion at the endometrial cancer summit. There was clear preference for unwarranted variations that directly impacted survival across all stages. There was also great support for improvements in supportive care and access to treatment. While there were only three unwarranted variations prioritised at a 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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