



Prioritisation of unwarranted variations in head & neck cancer

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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 the state. (1) To support this, the nationally recognised Optimal Care Pathways (OCPs) provide a framework for the delivering consistent, safe, high-quality, and evidence-based cancer care. (2) The OCPs aim to ensure that all people diagnosed with cancer receive the best possible care, regardless of where they live or receive treatment. (2)

The *Victorian Integrated Cancer Services (VICS)*, Victoria’s cancer service improvement network, lead initiatives that bring together healthcare providers to strengthen cancer care delivery. There are eight regional ICS and one statewide paediatric ICS. One of their flagship initiatives is the *VICS Optimal Care Summits program*, which examines tumour-specific care, patient experience, and outcome measures against OCP standards and targets. Through these Summits, stakeholders identify data-informed patterns of care, highlight unwarranted variations, set priorities for improvement, and implement targeted quality initiatives. (2)

The Victorian Cancer Plan 2024–2028 identifies the Summits program as a key enabler for reducing variation in clinical practice and outcomes. Using a mixed-methods approach including expert advisory groups, statewide surveys, strategic consultations, and broad stakeholder engagement, the program identifies and resources priority improvement initiatives across Victoria. In 2025, the program focused on head and neck cancer, engaging clinicians, stakeholders, and consumers to identify and prioritise unwarranted variations for action.

Unwarranted variations in cancer care

While some degree of variation in cancer care is expected, and often necessary because treatment decisions should be patient-centred and responsive to individual needs, preferences, and clinical circumstances, not all variation is beneficial. (3,4) Unwarranted variation occurs when differences in care cannot be explained by patient factors and instead reflect inconsistencies in healthcare delivery that may compromise quality, equity, or outcomes. (5) Unwarranted variation is problematic because the structure and processes of care are closely linked to patient outcomes. (6) Identifying and addressing such variation offers opportunities to improve outcomes, patient experience, and system efficiency. (7) Despite its importance, there is no universal framework for identifying unwarranted variation in healthcare.

To address this gap, the VICS Optimal Care Summits program developed a set of criteria in 2022 to guide consistent identification of unwarranted variations in cancer care across Victoria. These criteria, outlined in Table 1, ensure variations are assessed for reliability, significance, alignment

with OCP indicators, impact on outcomes and equity, and feasibility for improvement. Additional criteria apply at repeat Summits, focusing on persistent or worsening variations.

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 by which unwarranted variations in head and neck cancer care were identified, assessed, and prioritised for discussion at the Head and Neck Cancer Summit held in October 2025.

Aim

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

Methodology

Identification of unwarranted variations

The VICS Optimal Care Summits program examined patterns of Victorian head and neck cancer care, experience, and outcomes. Indicators assessing the OCP steps were identified and informed by the previous head and neck cancer summits, VICS Optimal Care Summits team, an expert advisory group of 20 Victorian multidisciplinary head and neck 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 head and neck 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

From August to September 2025, three online Delphi surveys were distributed to members of the expert advisory group and Victorian head and neck 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=20) comprising seasoned leaders in head and neck cancer care and a broader stakeholder group, (n=129) representing key stakeholders in policy and provision of head and neck 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 20 members of the expert working group in early August 2025 to complete the first round of prioritisation of the unwarranted variations. From mid-August to mid-September 2025, a second Delphi survey was developed and circulated to a group of 129 Victorian head and neck cancer stakeholders to gain a broader perspective and further prioritise the unwarranted variations identified. The third and final Delphi survey was sent to the 20 members of the expert working group in mid-September 2025, to identify the top three priority unwarranted variations. Results from all three Delphi surveys were collated and analysed using Microsoft Excel.

Results

Nineteen unwarranted variations in head and neck 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 19 unwarranted variations identified in Victorian head and neck cancer care 2025.

| Ranking | Variation |
|---------|--|
| 1 | LMICS has a lower rate of documented multidisciplinary meeting (MDM) presentation for head and neck cancer patients. The target is 85%, the statewide result is 91% in 2022, but LMICS rates were approximately <50%. |
| 2 | There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for head and neck cancer patients, by ICS. The target is 100%, the statewide result is 42% in 2022. In some ICS the rate is less than 25% (BSWRICS and NEMICS). |
| 3 | Across all ICS, there are low rates of supportive care screening for head and neck cancer patients. The target is 80%, the statewide average is 30% in 2022. |
| 4 | There is variation in documented evidence of communication of treatment plans to GPs for head and neck cancer patients by ICS. The target is 100%, the statewide result is 81% in 2022. |
| 5 | In 2020–2022, the proportion of thyroid cancer patients who had surgery as their first treatment within 6 weeks of diagnosis was significantly lower than the statewide average in WCMICS. |
| 6 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received radiotherapy or admitted chemotherapy as their first treatment within 6 weeks of diagnosis was significantly lower than the statewide average in GICS. |

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| 7 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received adjuvant treatment within 6 weeks of surgery was significantly lower than the statewide average in GICS. |
| 8 | In 2020–2022, the proportion of head and neck cancer patients receiving any treatment within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. |
| 9 | In 2020–2022, the proportion of head and neck cancer patients receiving chemotherapy, radiotherapy or chemoradiation within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. |
| 10 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received their first treatment (admitted systemic therapy) within 6 weeks was significantly lower than the statewide average in GICS. |
| 11 | In 2020–2022, the proportion of head and neck cancer patients who received adjuvant treatment within 6 weeks of surgery was significantly lower than the statewide average in GICS. |
| 12 | There is variation in the 5-year relative survival for patients with head and neck cancer for the period 2018–2022 by ICS of residence. GRICS observed poorer 5-year survival compared to the statewide average. |
| 13 | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a speech pathologist during their admission within 6 months of diagnosis: 27.8% (2017–2019) and 33.4% (2020–2022). GICS is significantly below the statewide average in 2020-2022. |
| 14 | Across all ICS there are low rates of head and neck cancer patients who did not receive surgery within 1 year who have been seen by a speech pathologist during their admission within 6 months of diagnosis: 0.8% (2017–2019) and 1.9% (2020–2022). |
| 15 | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a psychologist during their admission within 6 months of diagnosis: 1.1% (2017–2019) and 2.1% (2020–2022). |
| 16 | Across all ICS, there are low rates of head and neck cancer patients who are seen by a social worker during admission with 3 months of diagnosis; 6.9% (2017–2019) and 6.0% (2020–2022). |
| 17 | Across the state, there is a high proportion of head and neck cancer patients who received systemic therapy 30 days prior to death; 7.2% (2017–2019) and 9.8% (2020–2022). |
| 18 | Across the state, on average only 4.5% of head and neck cancer patients who died between 2018 and 2022 had recorded evidence of an advance care directive. Rates are low across all ICS. |
| 19 | On average only 61.6% of head and neck cancer patients were admitted for palliative care one year prior to death in 2020–2022. |

First Delphi survey

Fifteen participants responded to the first Delphi survey which was sent to the 20 members of the expert advisory group (response rate= 75%). Table 3 shows the 19 unwarranted variations and highlights the top 15 unwarranted variations that were selected by the expert advisory group to be priorities in head and neck 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 timeliness to treatment, access to supportive care screening and presentations at multidisciplinary meetings. Access to palliative care and receipt of systemic therapy prior to death were not prioritised at this stage.

Table 3. Round One Delphi results for Head and Neck Cancer Summit unwarranted variations, 2025.

| Ranking | Variation | Score (n=15) |
|---------|---|-----------------|
| 1 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received radiotherapy or admitted chemotherapy as their first treatment within 6 weeks of diagnosis was significantly lower than the statewide average in GICS. | 57 |
| 2 | In 2020–2022, the proportion of head and neck cancer patients receiving chemotherapy, radiotherapy or chemoradiation within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. | 55 |
| 3 | Across all ICS, there are low rates of supportive care screening for head and neck cancer patients. The target is 80%, the statewide average is 30% in 2022. | 55 |
| 4 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received adjuvant treatment within 6 weeks of surgery was significantly lower than the statewide average in GICS. | 54 |
| 5 | In 2020–2022, the proportion of head and neck cancer patients receiving any treatment within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. | 54 |
| 6 | LMICS has a lower rate of documented multidisciplinary meeting (MDM) presentation for head and neck cancer patients. The target is 85%, the statewide result is 91% in 2022, but LMICS rates were approximately <50%. | 54 |
| 7 | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a speech pathologist during their admission within 6 months of diagnosis: 27.8% (2017–2019) and 33.4% (2020–2022). GICS is significantly below the statewide average in 2020–2022. | 52 |
| 8 | There is variation in the 5-year relative survival for patients with head and neck cancer for the period 2018–2022 by ICS of residence. GRICS observed poorer 5-year survival compared to the statewide average. | 52 |
| 9 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received their first treatment (admitted systemic therapy) within 6 weeks was significantly lower than the statewide average in GICS. | 52 |
| 10 | In 2020–2022, the proportion of head and neck cancer patients who received adjuvant treatment within 6 weeks of surgery was significantly lower than the statewide average in GICS. | 51 |

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| 11 | There is variation in documented evidence of communication of treatment plans to GPs for head and neck cancer patients by ICS. The target is 100%, the statewide result is 81% in 2022. | 51 |
| 12 | There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for head and neck cancer patients, by ICS. The target is 100%, the statewide result is 42% in 2022. In some ICS the rate is less than 25% (BSWRICS and NEMICS). | 49 |
| 13 | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a psychologist during their admission within 6 months of diagnosis: 1.1% (2017–2019) and 2.1% (2020–2022). | 47 |
| 14 | Across the state, on average only 4.5% of head and neck cancer patients who died between 2018 and 2022 had recorded evidence of an advance care directive. Rates are low across all ICS. | 44 |
| 15 | Across all ICS, there are low rates of head and neck cancer patients who are seen by a social worker during admission with 3 months of diagnosis; 6.9% (2017–2019) and 6.0% (2020–2022). | 43 |
| 16 | Across all ICS there are low rates of head and neck cancer patients who did not receive surgery within 1 year who have been seen by a speech pathologist during their admission within 6 months of diagnosis: 0.8% (2017–2019) and 1.9% (2020–2022). | 42 |
| 17 | On average only 61.6% of head and neck cancer patients were admitted for palliative care one year prior to death in 2020–2022. | 38 |
| 18 | Across the state, there is a high proportion of head and neck cancer patients who received systemic therapy 30 days prior to death; 7.2% (2017–2019) and 9.8% (2020–2022). | 37 |
| 19 | In 2020–2022, the proportion of thyroid cancer patients who had surgery as their first treatment within 6 weeks of diagnosis was significantly lower than the statewide average in WCMICS. | 33 |

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

Second Delphi survey

Eighty-seven participants responded to the second Delphi survey which was sent to the 129 read and neck cancer stakeholders across Victoria (response rate=67%). The fifteen 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 timely access to treatment, access to supportive care and speech pathology and communications with general practitioners were

prioritised. Due to the large number of variations related to GICS, the top 15 variations were presented to the expert advisory group as opposed to just the top seven.

Table 4. Round Two Delphi results for Head and Neck Cancer Summit unwarranted variations, 2025.

| Ranking | Previous ranking | Variation | Score (n=87) |
|---------|------------------|---|--------------|
| 1 | 5 | In 2020–2022, the proportion of head and neck cancer patients receiving <i>any treatment</i> within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. | 199 |
| 2 | 7(+5) | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a speech pathologist during their admission within 6 months of diagnosis: 27.8% (2017–2019) and 33.4% (2020–2022). GICS is significantly below the statewide average in 2020–2022. | 198 |
| 3 | 3 | There is variation in documented evidence of communication of treatment plans to GPs for head and neck cancer patients by ICS. The target is 100%, the statewide result is 81% in 2022. *NB two ICS (HRICS and GRICS) were excluded because they had less than 5 patients. | 196 |
| 4 | 2(-2) | In 2020–2022, the proportion of head and neck cancer patients receiving <i>chemotherapy, radiotherapy or chemoradiation</i> within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. | 196 |
| 5 | 10(+5) | In 2020–2022, the proportion of head and neck cancer patients who received <i>adjuvant treatment</i> within 6 weeks of surgery was significantly lower than the statewide average in GICS. | 196 |
| 6 | 6 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received their <i>first treatment (admitted systemic therapy)</i> within 6 weeks was significantly lower than the statewide average in GICS. | 194 |
| 7 | 7 | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received <i>radiotherapy or admitted chemotherapy</i> as their first treatment within 6 weeks of diagnosis was significantly lower than the statewide average in GICS. | 193 |
| 8 | 3(-5) | In 2020–2022, the proportion of head and neck cancer patients (excluding thyroid) who received <i>adjuvant treatment</i> within 6 weeks of surgery was significantly lower than the statewide average in GICS. | 193 |
| 9 | 8(-1) | Across all ICS, there are <i>low rates of supportive care screening for head and neck cancer patients</i> . The target is 80%, the statewide average is 30% in 2022. *NB two ICS (HRICS and GRICS) were excluded because they had fewer than 5 patients. | 187 |
| 10 | 13(+3) | There is variation in the 5-year relative survival for patients with head and neck cancer for the period 2018–2022 by ICS of residence. GRICS observed poorer 5-year survival compared to the statewide average. | 187 |

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| 11 | 6 ⁽⁻⁵⁾ | Across all ICS there are low rates of head and neck cancer patients who received surgery who have been seen by a psychologist during their admission within 6 months of diagnosis: 1.1% (2017–2019) and 2.1% (2020–2022). | 179 |
| 12 | 15 ⁽⁺³⁾ | LMICS has a lower rate of documented multidisciplinary meeting (MDM) presentation for head and neck cancer patients. The target is 85%, the statewide result is 91% in 2022, but LMICS rates were approximately <50%. *NB two ICS (HRICS and GRICS) were excluded because they had less than 5 patients | 178 |
| 13 | 14 ⁽⁺¹⁾ | Across all ICS, there are low rates of head and neck cancer patients who are seen by a social worker during admission with 3 months of diagnosis; 6.9% (2017–2019) and 6.0% (2020–2022). | 178 |
| 14 | 12 ⁽⁻²⁾ | Across the state, on average only 4.5% of head and neck cancer patients who died between 2018 and 2022 had recorded evidence of an advance care directive. Rates are low across all ICS. | 167 |
| 15 | 15 | There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for head and neck cancer patients, by ICS. The target is 100%, the statewide result is 42% in 2022. In some ICS the rate is less than 25% (BSWRICS and NEMICS). *NB two ICS (HRICS and GRICS) were excluded because they had less than 5 patients. | 164 |

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 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 VICS Head and Neck Cancer Summit (response rate=74%). Variations selected related to a range of topics including supportive care, MDM quality and timely access to treatment in the Grampians Integrated Cancer Services (GICS) region.

Due to the results of the second round of the Delphi survey, the expert advisory group recommended grouping several unwarranted variations together to discuss at the summit event. GICS had several treatment related variations, there were multiple variations related to supportive care services, access and screening, and finally variations related MDM outputs. The unwarranted variations were grouped together and were selected as the top three as a result of the Delphi process.

Table 5. Round Three Delphi results for Head and Neck Summit unwarranted variations, 2025.

| Ranking | Variation |
|---------|---|
| 1 | Across the state, head and neck cancer patients do not consistently receive multidisciplinary care, supportive care screening, or timely action to address supportive care needs. |

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|---|--|
| 2 | In 2020–2022, the proportion of head and neck cancer patients receiving any treatment within 6 weeks of diagnosis was significantly lower than the statewide average for GICS. |
| 3 | Across the state, head and neck cancer patients do not consistently benefit from high-quality multidisciplinary meetings, including comprehensive documentation of treatment plans and timely communication with general practitioners. |
| 4 | There is variation in documented evidence of communication of treatment plans to GPs for head and neck cancer patients by ICS. The target is 100%, the statewide result is 81% in 2022. *NB two ICS (HRICS and GRICS) were excluded because they had less than 5 patients |
| 5 | There is variation in the 5-year relative survival for patients with head and neck cancer for the period 2018–2022 by ICS of residence. GRICS observed poorer 5-year survival compared to the statewide average. |
| 6 | Across the state, on average only 4.5% of head and neck cancer patients who died between 2018 and 2022 had recorded evidence of an advance care directive. Rates are low across all ICS. |
| 7 | LMICS has a lower rate of documented multidisciplinary meeting (MDM) presentation for head and neck cancer patients. The target is 85%, the statewide result is 91% in 2022, but LMICS rates were approximately *NB two ICS (HRICS and GRICS) were excluded because they had less than 5 patients. |
| 8 | There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for head and neck cancer patients, by ICS. The target is 100%, the statewide result is 42% in 2022. In some ICS the rate is less than 25% (BSWRICS and NEMICS). *NB 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 head and neck cancer care. The Delphi process identified three priority unwarranted variations in head and neck cancer care for action:

- (1) inconsistent access to multidisciplinary care and supportive care screening,
- (2) delays in timeliness to treatment in the Grampians ICS (GICS), and
- (3) inconsistent quality and documentation of multidisciplinary meetings (MDMs), including communication of treatment plans to general practitioners.

These priorities will form the basis for discussion and action planning at the upcoming VICS Head and Neck Cancer Summit. Addressing them will require both coordinated statewide initiatives and targeted local strategies to reduce variation, improve equity, and strengthen outcomes for people affected by head and neck cancer. The Summit will provide an opportunity for clinicians, services, and consumers to co-design practical solutions and agree on next steps for implementation.

Conclusion

This Delphi survey of the unwarranted variations in head and neck cancer care has identified important findings to inform improvements that can be made in head and neck cancer care in Victoria. A 3-round Delphi survey process was successfully used engaging both head and neck cancer expert advisory group members and head and neck cancer stakeholders to prioritise the top three unwarranted variations for discussion at the VICS Head and Neck Cancer Summit. There was clear preference for unwarranted variations that addressed supportive and multidisciplinary care. There was also great support for improvements in multidisciplinary meeting quality and timely access to treatment. While there were only three unwarranted variations prioritised for the summit event, a statewide Action Register will aim to address all unwarranted variations.

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