



Victorian Optimal Care
Summits:

Head and Neck Cancer Barriers, Enablers, and Preferences Survey

Summary of Findings

July 2025



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Acknowledgements

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

Abbreviation	Definition
CALD	Culturally and Linguistically Diverse
EMR	Electronic Medical Record
ERAS	Enhanced Recovery After Surgery
ICS	Integrated Cancer Services
MDT	Multidisciplinary teams
OCP	Optimal Care Pathways
VICS	Victorian Integrated Cancer Services
VSP	Virtual Surgical Planning

Background

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 Victoria's health services provide care and support to people affected by cancer. There are eight geographical Integrated Cancer Services (ICS) and one statewide paediatric ICS. The VICS drive implementation of the Victorian Cancer Plan and the Optimal Care Pathways.

The 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 Optimal Care Pathways (1). The Victorian Cancer Plan 2024-2028 (2) defines the program as an enabler for reducing variations in clinical practice and cancer outcomes. It aims to identify data informed patterns of cancer care and outcomes, variations in care, agree 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 working 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.

The evidence-to-practice gap remains a healthcare challenge especially in complex settings like cancer services (3). The Optimal Care Pathways are a framework for evidence-based, consistent, safe, high-quality care for people with cancer (1). However, gaps exist across cancer services in implementing these pathways. In mid-late 2025, the VICS Optimal Care Summits program will explore unwarranted variations in head and neck cancer through a consultation and summit event. An important aspect of determining unwarranted variations is to explore the barriers, enablers, and preferences of key stakeholders to providing optimal care for people with head and neck cancer and their families. Barriers and enablers can be defined as any factor that can negatively or positively impact optimal cancer care respectively (4). Preference of care is defined as a statement indicating the importance of a specific aspect of clinical behaviours of care providers (5).

Aim

To understand the barriers, enablers, and preferences of multidisciplinary stakeholders to providing optimal care to people with head and neck cancer in Victoria.

Methodology

An online survey (see Appendix 1) was developed by the VICS Optimal Care Summits team in collaboration with an expert advisory group comprising of 20 multidisciplinary head and neck cancer stakeholders representing each of Victoria's Integrated Cancer Services (ICS). The survey required respondents to select perceived unwarranted variations in head and neck cancer care for their ICS region and describe via free text fields the barriers, enablers, and preferences for optimal head and neck cancer care. The survey was piloted and then distributed to a key stakeholder list of 140 head and neck cancer multidisciplinary clinicians and stakeholders. The survey was open for 6 weeks between April and June 2025. Participation was voluntary and results were collated and analysed using Microsoft Excel and Google AI Studio software. Qualitative responses were coded using semantic and latent codes and themes were identified.

Findings

A total of 58 head and neck cancer multidisciplinary stakeholders participated in the survey, with a response rate of 41%. Table 1 demonstrates that there was an almost even split of responses, where half of respondents (50%, n=29) are from metropolitan ICS. Just under half of the respondents (45%, n=26) were from regional ICS and a small percentage were involved in state-wide work (5%, n=3).

Table 1. Demographics of head and neck stakeholder survey respondents

Name of Integrated Cancer Service (ICS)	Number of responses
Metropolitan Integrated Cancer Services	
Western & Central Melbourne (WCMICS)	13
North Eastern Melbourne (NEMICS)	7
Southern Melbourne (SMICS)	7
Regional Integrated Cancer Services	
Hume (HRICS)	11
Loddon–Mallee (LMICS)	8
Grampians (GICS)	6
Barwon South Western (BSWRICS)	2
Gippsland (GRICS)	1
My work applies statewide	3
Grand Total	58

As seen in Table 2, most respondents were medical (40%, n=23). There was also significant representation from allied health staff (34%, n=20) and nurses/ care coordinators (19%, n=11). Those who responded as 'other' (7%, n=4) included those in management and/ or leadership roles.

Table 2. Occupation of head and neck cancer survey respondents

Occupation of head and neck cancer survey respondents	Number of respondents (percentage)
Medical	23 (40%)
Allied health	20 (34%)
Nurses/ care coordinators	11 (19%)
Other	4 (7%)
Total	58 (100%)

Survey respondents were asked to select the unwarranted variations that they believed existed in providing optimal care to head and neck cancer patients. Respondents were able to select multiple responses.

As shown in Figure 1, most respondents (57%, n=33) felt that limited access to survivorship care, was a key unwarranted variation to people with head and neck cancer in Victoria. In addition, delayed access to diagnostic procedures/ tests (57%, n=33) and limited access to supportive care

services (55%, n=32) were also perceived to be the amongst the most prevalent unwarranted variations.

Other key unwarranted variations were delays in access to surgery (47%, n=27), delays in diagnosis (47%, n=27), limited presentation and communication at multidisciplinary meetings (26%, n=15), delays in access treatment (24%, n=14), limited access to clinical trials (22%, n=13), and decreased access to multidisciplinary meeting discussions (21%, n=12),

Variation also exists between the perceived unwarranted variations amongst metropolitan and regional ICS. For example, access to clinical trials and emergency medicine was seen as a limitation in regional ICS but much less recognised in metropolitan ICS.

Survey respondents were asked to estimate their patients' level of access to supportive care and survivorship services for head and neck cancer, as shown in Figure 2. Services reported to have high levels of access, defined as being available to more than 75% of patients, included dietetics (88%), palliative care (88%), speech pathology (84%), and pain management (72%). In contrast, services with low reported access, defined as less than 50% of patients having access to them , included prosthodontics (84%), financial support services (74%), prosthetics (71%), and lymphedema services (64%).

Barriers

Metropolitan Integrated Cancer Services

The analysis of qualitative survey responses from metropolitan ICS (n=29) identified several key themes in relation to barriers to optimal head and neck cancer care and indicated the cancer system is under immense strain, struggling to provide consistent, holistic, and timely care.

1. Systemic under resourcing

A key issue identified by respondents is the systemic under-resourcing of the cancer services system. Respondents described the cancer services system struggling to meet patient demand due to shortages in staffing, funding, and infrastructure. These include insufficient hospital beds, which directly contributes to treatment delays, and scarcity of specialist staff such as head and neck medical staff and trained lymphoedema therapists. Respondents noted that budget restraints limit the benefits of multidisciplinary meetings (MDMs), while a lack of clinic space and up-to-date equipment further hampers the delivery of quality care.

Theatre access is the key difficulty. We have long waitlist for conditions which as ameloblastoma, and management of complications due to HNC treatment such as ORN (with or without pathological fracture), revision surgery to improve speech and swallowing and mouth opening post initial resection and reconstruction, dental prosthesis. We need to be able to have resources to deal with the issues that arises from the initial treatment as quality of life in survivorship state is just as important. Head and Neck cancer stakeholder

2. A fragmented and poorly coordinated patient journey

Respondents identified a disjointed and inefficient patient journey which is demonstrated by poor coordination between services. This fragmentation contributes to significant delays at multiple stages, from initial GP referrals to securing diagnostic tests and follow-up scans. Respondents

Figure 1. Stakeholder perceived unwarranted variations to head and neck cancer care in Victoria

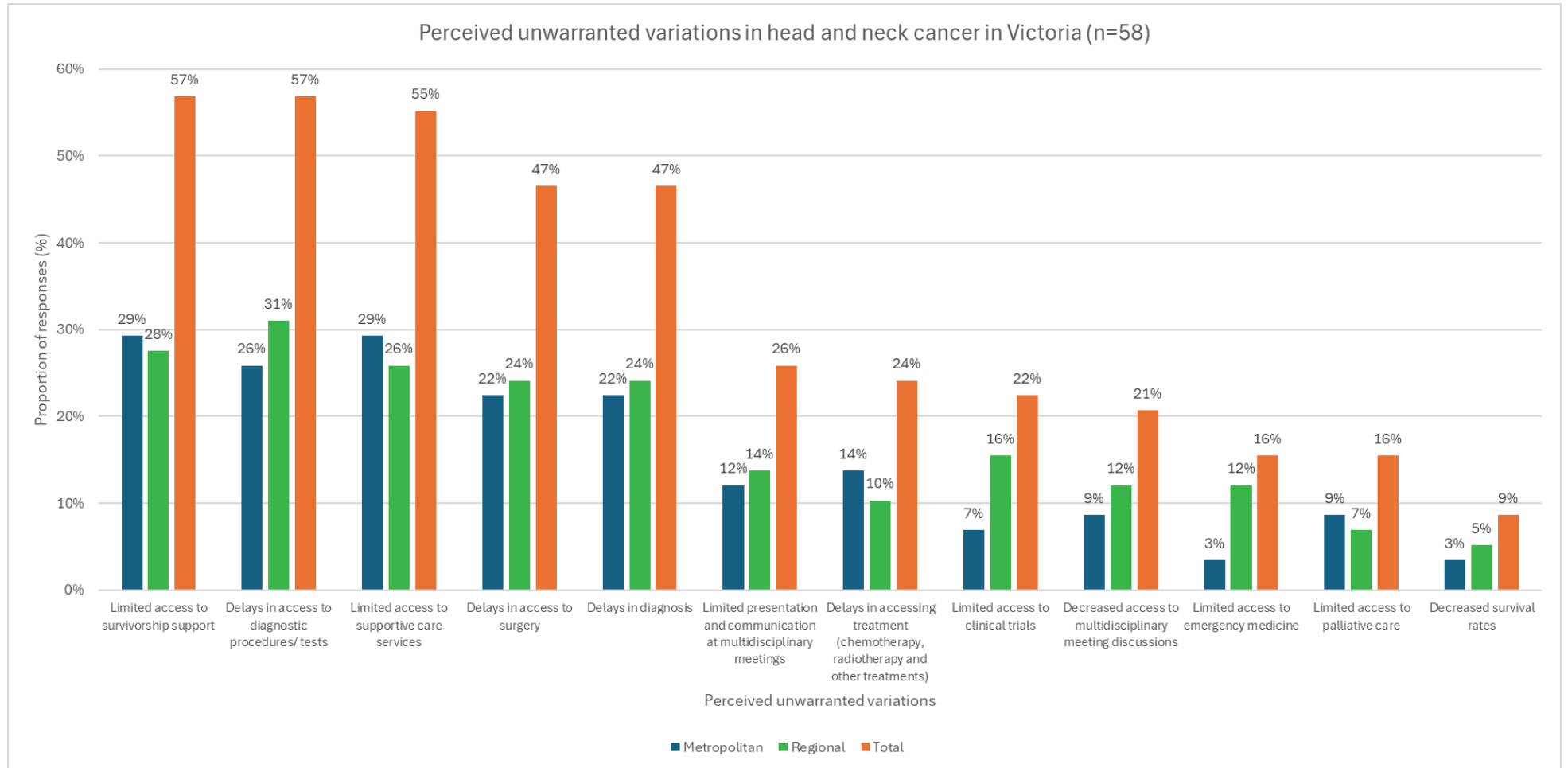
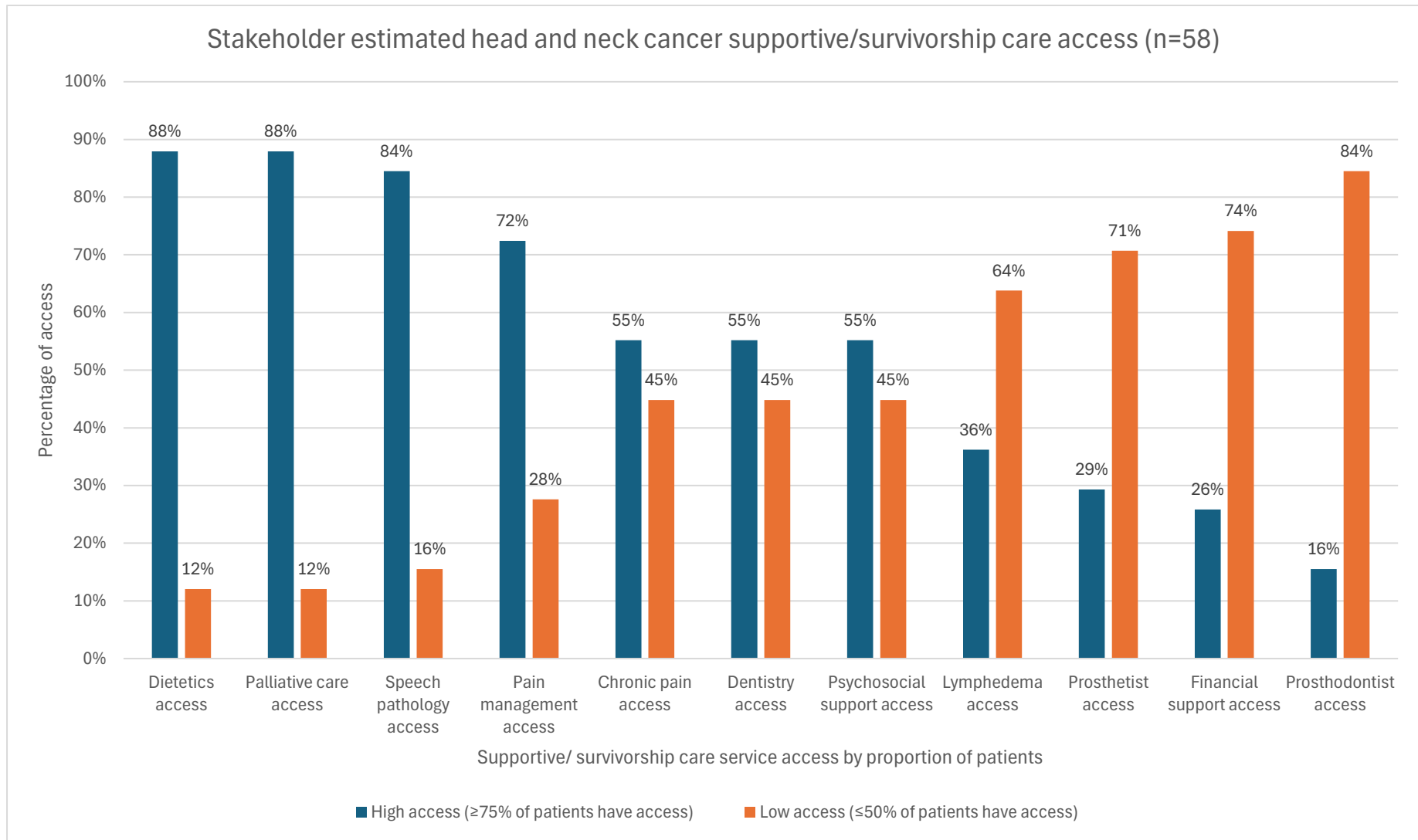


Figure 2. Stakeholder estimated head and neck cancer supportive/survivorship care access in Victoria



described the frustration of patients needing to attend multiple, separate appointments and navigating a system where different services offer varying levels of care.

Several systemic failures were identified for this disorganisation. A frequently mentioned concern by respondents was the lack of a statewide Electronic Medical Record (EMR) to ensure seamless information sharing. Respondents also pointed to the absence of dedicated clinical coordinators and booking planners to help patients navigate the system. The constant rotation of junior medical staff was reported as a major issue, leading to knowledge gaps.

3. Inequitable access and a lack of patient-centred design

Respondents identified the significant inequities in access which create major barriers for patients based on their geography and socioeconomic status. Respondents repeatedly highlighted the disadvantages faced by rural and regional patients, who are required to travel long distances for specialised care. This tension between centralising expertise and ensuring local access means that care is often physically and financially out of reach for many. Barriers such as late referrals, low health literacy, transport challenges, and social isolation were all cited as factors that prevent timely access to care. Even within metropolitan areas, respondents noted that access to specialists for appropriate diagnostic testing remains limited.

4. Deficiencies in proactive and holistic care

A recurring theme identified by respondents was the system's reactive focus on treating disease rather than providing proactive, holistic care that addresses the whole person. Respondents felt this was most evident in delayed diagnoses, which they attributed to poor GP knowledge of symptoms and referral pathways and further exacerbated by a lack of public health education.

Beyond the primary diagnosis, respondents described a critical lack of dedicated supportive care including inadequate pain management and insufficient social work and psychology support for outpatients. Respondents emphasised that many patients present with complex health and socioeconomic issues that the current system fails to address, leaving individuals vulnerable such as elderly or co-morbid patients who may not be able to self-advocate.

5. The neglect of survivorship care

Respondents described the period after active treatment as a 'forgotten phase', where patients face unacceptable delays for crucial follow-up care. Respondents reported staggeringly long waits for oncological surveillance scans and essential reconstructive services. For example, a patient might wait four to five years after radiotherapy to access publicly funded dental care. Similarly, respondents reported that delays in major reconstructive surgery for swallowing and speech are so prolonged that they cause immense hardship and further complications.

'Navigating of systems [is] difficult for people to find what they need when their primary system does not include it, and re-accessing services as their life goals change once they are out of the system but may need further support to return to work'

6. The unacknowledged cost of treatment

Metropolitan respondents reported that the system fails to account for the true cost of treatment, which extends beyond clinical fees. They highlighted the immense hidden costs of financial, emotional, and time-related burdens placed on patients and their families. Systemic inefficiencies, chronic delays, and the financial burden associated with travel for regional patients were all identified as major contributors to this unacknowledged cost, adding significant stress and hardship to an already difficult patient journey.

'These patients are often elderly, co-morbid and have poorer health literacy than some other cancer groups (eg. breast). They do not advocate for their and others' rights sufficiently.'

Regional Integrated Cancer Services

The analysis of qualitative survey responses from regional ICS (n=26) identified several themes that were reported as barriers to optimal head and neck cancer care in Victoria. Core themes are similar to metropolitan ICS and are centred around equitable access to regional services.

1. Lack of local services and under resourcing

Regional respondents report on the system's lack of specialised local services. The respondents noted the inadequately funded allied health positions across the entire care pathway which leave patients without the necessary support. In some regional areas, respondents noted a complete absence of public head and neck clinics and a limited access to local facilities. This forces patients to travel to metropolitan centres for care and is further compounded by the difficulty of retaining staff with specialist expertise in regional areas, leading to critical gaps in biopsies, radiology, and emergency care which in turn causes significant delays in diagnosis and surgery.

Difficulties with staff retention in regional Victoria impacting ability to provide specialist skillsets (in speech pathology this pertains to dysphagia in post operative surgical management, laryngectomy, tracheostomy and flexible endoscopic evaluation of swallowing). This results in constant attempts to keep upskilling staff and reduces time available for service development initiatives or research. Head and Neck cancer stakeholder

2. A fragmented patient journey

Similar to metropolitan ICS responses, regional stakeholders also reported on the lack of supportive links between treatment phases with limited to no dedicated case coordination to guide patients through diagnosis, treatment, and survivorship. This fragmentation is caused by siloed services, poor communication between providers, and the use of different EMR systems that are unable to communicate with each other. Respondents highlighted how scattered appointments for patients throughout the week increases travel burdens and reduces the opportunity for collaborative discussion among care teams, making the pre-treatment pathway feel complex and daunting.

3. Regional inequity and lack of patient centred care

Significant disparities in patient access to care was a major theme identified by regional respondents. It was described by respondents as mostly driven by geographical differences, inconsistency of policies, and a system that is not designed around patient needs. Respondents pointed to inconsistent travel assistance schemes between states which create inequity for patients in border communities. Access to allied health was also described as 'a lottery' and varied widely depending on the specific health service. Rural patients were identified to be disadvantaged, faced long-distance travel and were reported to have poorer access to transport support, making them less likely to complete treatment.

Respondents also reported that the system frequently fails to treat the whole person, neglecting crucial psychosocial support and practical care needs. Accessing local allied health support, such as lymphoedema management, was reported to involve long wait times and limited availability, leaving patients without coordinated care precisely when they need to manage the long-term effects of their treatment.

Similar to metropolitan ICS, regional respondents emphasised that the system fails to acknowledge the significant hidden costs such as out-of-pocket costs for specialist appointments, travel expenses, and time off work. This burden is so significant that regional patients are often reluctant or financially unable to travel for necessary care.

'Patients with rural postcodes have poorer access to transport support for radiotherapy, chemotherapy and sometimes post-op review appointments. These group of patients are less likely to agree to treatment and complete the full course of treatment.'

Statewide

Respondents who identified themselves as working statewide (n=3) observed barriers to head and neck cancer treatment which centred on systemic failures related to the unacknowledged burden of treatment, inequitable access, and a fragmented patient journey.

1. Recognising the full burden of treatment

Statewide respondents similarly identified that the health system fails to account for the significant and often uncommunicated financial and psychological costs placed on patients, which directly impacts their ability to receive optimal care. Respondents pointed out that significant out-of-pocket costs exist at every stage of the care pathway including treatment and supportive care such as dietetics, transport, dental, and psychological support. This financial burden becomes a major source of stress and worry, creating a direct barrier to accessing care.

Respondents noted that financial distress can lead to poor treatment outcomes and even early mortality if patients are forced to abandon expensive treatments, delay and/or avoid seeking care. This problem was reported to be exacerbated as health professionals do not routinely explain the costs of services upfront, preventing patients from making fully informed decisions about their care.

2. Inequitable access to care

Statewide respondents also stressed that systemic challenges in the healthcare system disproportionately affect priority populations which creates inequity. Respondents identified that barriers to care are more severe for Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, those in regional and rural areas, and low-income households. The financial burden is often higher and more impactful for younger, socioeconomically disadvantaged, and regional populations. This is compounded by poor access to experienced medical staff for diagnosis and treatment in regional areas, which leads to critical delays in care.

For people with head and neck cancer, there are many challenges which create barriers to receiving optimal cancer care, including navigation challenges, gaps in access to supportive care services, and increased financial distress and out-of-pocket costs. These challenges disproportionately affect priority populations including Aboriginal and Torres Strait Islander communities, culturally and linguistically diverse communities, regional and rural communities, and low-income households. It is essential to address these inequities across the optimal care pathway to improve outcomes and reduce the severity of head and neck cancer burden for all people across the state. Financial costs is a key barrier we've highlighted and expanded on below. Head and neck cancer stakeholder

3. A fragmented patient journey & inconsistent care

Statewide respondents described the patient's path through the system as disjointed, with inconsistent referral practices that prevent access to the most appropriate specialist care. They provided a key example, noting that not all patients are offered access to a specialist plastic surgeon for reconstruction. Respondents stressed that these inconsistent referral practices mean patients are often not sent to the provider with the greatest expertise, a failure that is detrimental to achieving the best patient outcomes, especially for those requiring complex reconstruction.

Enablers

Metropolitan Integrated Cancer Services

Several key themes specific to enablers for metropolitan ICS (n=29) emerged from the survey responses. Metropolitan themes focused on the importance of a patient-centred healthcare system enabled by a collaborative and well-resourced workforce.

1. Dedicated resources & staffing

Metropolitan respondents emphasise that the foundation of a successful healthcare system requires the availability of dedicated resources and a committed workforce. Adequate funding for essential supplies and equipment, sufficient staffing levels to meet patient demand and qualified, experienced, and dedicated multidisciplinary team members are essential in enabling quality head and neck cancer care.

2. Integrated pathways & coordinated navigation

Respondents identified that an efficient patient journey is an enabler of optimal care. This is developed through well-defined systems and dedicated navigators who can be a single point of contact. Clinical nurse consultants or care coordinators are essential for guiding patients through the complex treatment pathway. Respondents also highlighted the importance of clear, automatic referral pathways to critical services like dietetics and speech pathology from diagnosis. Furthermore, respondents emphasised that strong, collaborative links between regional and metropolitan centres are crucial for ensuring seamless transition of care.

Broadly, to address the issue of health services relying on referrals only, an enabler would be to implement automatic, systemised processes i.e., all patients having radical chemo/radiotherapy will see a dietitian pre-treatment (or week 1 at the latest) and this should be set as usual standard of care (which is what evidence-based guidelines already tell us). This should apply for some other disciplines as well e.g., speech pathology. Head and neck cancer stakeholder

3. Equitable & patient-centred access

Metropolitan respondents highlighted that high-quality care is achieved when services are accessible and designed around the holistic needs of head and neck cancer patients. This includes providing easy access to a full suite of supportive care, including specialised allied health, dental services, psychosocial support, and financial counselling. Respondents stressed the importance of delivering this care as close to the patient's home as possible to reduce the travel and financial burden. A key enabler identified was the empowerment of patients through education and advocacy, particularly for vulnerable individuals navigating this challenging diagnosis.

Having a pathway for people having needs and options which they can choose from - e.g. hospital may not have lymphedema service, that's okay, but where do the patients all go to get good lymphedema therapy or acute hospitals do not have time to rehab speech outcomes, so who in the community can they refer to. Head and neck cancer stakeholder

4. Proactive, timely & holistic care

Metropolitan respondents noted that proactive care as opposed to reactive and focusing on early and comprehensive intervention is a significant enabler of optimal head and neck cancer care. This is enabled by measures such as prehabilitation and preparing patients for treatment, early and integrated involvement of allied health, and timely access to diagnostics. Respondents also acknowledged the importance of early identification and referral to palliative care.

5. Structured survivorship & post-treatment support

Respondents emphasised that supporting head and neck cancer patients beyond their initial treatment is a critical enabler of survivorship outcomes. Respondents identified structured, evidence-based survivorship programs as essential which includes initiatives like dietitian-led clinics to manage the long-term impacts on swallowing and nutrition. A key success factor is establishing a safe and supported transition from the acute hospital setting to community-based care, ensuring patients continue to receive the specialised support they need.

6. Effective team collaboration & strong leadership

Metropolitan respondents identified a positive and collaborative team culture as the foundation of excellent patient care. This is fostered by strong clinical leadership and a dedicated head and neck multidisciplinary team (MDT) that works cohesively. Respondents observed that genuine multidisciplinary input in complex treatment planning, along with the presence of clinical champions directly translates to a better and safer experience for head and neck cancer patients.

Regional Integrated Cancer Services

Regional respondents (n=26) reported that key enablers for optimal head and neck cancer care is a system that provides consistent, specialised, and supportive care.

1. A skilled and stable workforce with clinical expertise

Regional respondents stressed that high-quality head and neck cancer care is fundamentally dependent on a workforce with specialised knowledge. They noted this is enabled by having experienced clinicians and multi-disciplinary team with expertise in head and neck oncology. The presence of professional champions who advocate for patients, alongside a stable, collaborative and experienced regional workforce was identified as crucial for ensuring consistent and excellent care delivery.

Champions of the head and neck space both medical and allied health professionals who advocate for patients and have set up internal systems to provide best care for H&N patients within the limited resources we have. E.g., regular MDMs, patient review meetings of currently on treatment patients. Head and neck cancer stakeholder

2. Dedicated navigation and patient-centred guidance

Similar to metropolitan respondents, regional respondents identified that a significant enabler is when patients are efficiently and effectively guided through the complex treatment pathway by dedicated personnel. Nurse coordinators and cancer care coordinators who are able to provide timely and appropriate navigation to serve as a consistent point of contact also enables patients to feel holistically supported and are able to understand their care plan, which is vital in a journey as intensive as head and neck cancer treatment.

3. Geographic accessibility and practical support

Respondents emphasised that effective care requires overcoming the hidden costs of treatment and recovery placed on patients. Respondents identified that this is enabled by providing local access to treatment, surgery, and radiotherapy whenever possible which reduces the need for lengthy and disruptive travel to metropolitan centres. For those who must travel, systems that provide

accommodation and support for transport costs, such as the Victorian Patients Transport Assistance Scheme (VPTAS), were cited as crucial enablers of equitable access.

4. Integrated teamwork and seamless communication

A cohesive and communicative team was identified by regional respondents as a foundation of effective multidisciplinary care for head and neck cancer. This is enabled by strong working relationships within the head and neck team, well-led and engaged MDMs, and systems like shared medical records that ensure all clinicians are fully informed. Respondents particularly highlighted the role of specialist coordinators who facilitate communication between regional and metropolitan services, viewing them as vital for bridging information gaps and increasing efficiency of care.

'Effective multidisciplinary discussions and effective coordination of care delivery, at times if the different specialties do not effectively communicate, this can interrupt the delivery of care as one speciality completes their work, but the next subsequent care team are not aware.'

5. Comprehensive and accessible supportive care

Regional respondents noted that holistic care is only possible with access to a full range of supportive care services. For head and neck cancer patients, this specifically includes a strong and integrated allied health presence including speech pathology, dietetics, and lymphoedema management being essential and further enhanced with social work and access to financial and psychosocial assistance. They also pointed to comprehensive discharge planning as a critical enabler, ensuring that complex care needs are safely managed even after the patient leaves the hospital.

6. Streamlined systems and referral pathways

Regional respondents identified that an efficient patient journey is facilitated by clear and accessible system pathways. This is enabled by processes that allow for early referrals and timely access to diagnostics, which is critical for head and neck cancer outcomes. Respondents highlighted the value of open referral systems, where anyone can refer to the MDT, and established corridors between regional and metropolitan services. Respondents concluded that these streamlined systems are essential for ensuring patients move smoothly optimal care pathway without unnecessary and potentially harmful delays.

Multidisciplinary meetings & streamlined medical record access to ensure all clinicians (medical, allied health etc) have access to the information needed to stay informed about patient care/progress/issues and then in turn provide safe, timely, specific and evidence-based patient care. Head and neck cancer stakeholder

Statewide

Statewide respondents (n=3) highlight that key enablers for optimal head and neck cancer care include a framework that prioritises expert guidance, comprehensive support, accessible multidisciplinary teams, and patient empowerment.

1. Dedicated system navigation

Statewide respondents highlight that providing patients and their carers with dedicated system navigation is essential. The role of a consistent, patient-centred guide, such as a clinical nurse specialist to support patients in navigating the complex treatment and recovery pathway. This dedicated support was seen as crucial for overcoming systemic barriers, ensuring timely access to both health and psychosocial care, and ultimately improving clinical outcomes and quality of life.

2. Accessible, expert multidisciplinary teams

Similarly to metropolitan and regional respondents, ensuring all patients have access to a well-functioning MDT and MDMs was seen as a significant contributor to enablers in head and neck cancer care. Statewide respondents stressed the importance of enabling equitable geographic

access to core clinical services and ensuring that regional differences does not determine quality of care. Furthermore, respondents noted the importance of ongoing training for staff, particularly in crucial tasks like the early detection of head and neck cancers.

'Geographical location [and] access to a variety of services in metro areas'

3. Empowered patients and carers

Statewide respondents identified the empowerment of patients and their carers as a crucial enabler to optimal care. This is achieved by providing patients and carers with understandable and relevant information about both the emotional and physical aspects of their head and neck cancer treatment. This support not only helps them overcome barriers to care but also empowers them with the confidence and knowledge to self-manage their own wellbeing throughout their journey.

Mechanisms for change

Across metropolitan, regional, and statewide stakeholders, several interrelated mechanisms for change were identified to improve the quality, accessibility, and coordination of head and neck cancer care. These mechanisms reflect a shared vision for a more integrated, equitable, and patient-centred system, underpinned by strategic investment, structural reform, and evidence-informed planning.

1. Address systemic under-resourcing through strategic investment

A consistent theme across all levels was the need to address entrenched under-resourcing in head and neck cancer care. Respondents called for targeted investment in both workforce and infrastructure, including the expansion of specialist roles such as clinical nurse consultants, allied health professionals (e.g., dietitians, speech pathologists, psychologists), and pain management services. Dedicated funding for essential supportive care services such as lymphoedema therapy, dental care, prosthetics, and facial prosthetics was emphasised as vital for improving survivorship and rehabilitation outcomes. This also includes investment in modern equipment and expanded physical infrastructure to meet growing patient demand.

2. Strengthen and systematise care pathways

Stakeholders highlighted the need for more efficient, standardised, and proactive care pathways that reduce fragmentation and ensure timely access to diagnostic, treatment, and supportive care services. Mechanisms proposed include implementing automatic referrals to key services at diagnosis, embedding prehabilitation into standard care, and separating theatre lists to better accommodate follow-up care. Formalising statewide referral pathways and integrating supportive care from the outset were identified as key to improving coordination and consistency.

3. Evolve the model-of-care to be holistic and patient-centred

There was a strong call to shift the focus of care from tumour-centric treatment to holistic, person-centred models that acknowledge the psychological, financial, social, and cultural dimensions of living with head and neck cancer. Respondents emphasised integrating psychosocial support, dental and prosthetic planning, and pain management into routine care. Particular attention was given to vulnerable groups such as older adults and culturally and linguistically diverse patients. Embedding culturally safe practices and improving informed financial consent processes were seen as essential to empowering patients and promoting equity.

4. Expand and enhance the multidisciplinary team

The complexity of head and neck cancer care necessitates a broadened and consistently integrated multidisciplinary team. Respondents advocated for the formal inclusion of allied health professionals and the consistent valuing of their expertise in treatment planning. Improved team dynamics, collaborative culture, and decentralisation of services to enhance geographic accessibility were identified as mechanisms to improve multidisciplinary team function and reduce inequity between metropolitan and regional settings.

5. Improve access and bridge regional-metro gaps

Regional equity was a critical concern, with respondents identifying the need to improve access to specialised services, diagnostics, and follow-up care for patients outside major centres. Mechanisms included forming formal partnerships between metropolitan and regional providers, increasing outreach services, and providing practical supports such as transport and accommodation. Strengthening primary care capacity through targeted training for GPs and dentists was also proposed to improve early detection and ongoing management, particularly in underserved areas.

6. Foster integration, collaboration, and knowledge sharing

Improved integration of services and information systems was seen as fundamental to enhancing coordination and reducing errors. Respondents called for investment in interoperable electronic medical records accessible to all members of the multidisciplinary team, as well as mechanisms to support knowledge transfer and collaboration across institutions and regions. Continuous professional development and cross-sector engagement were seen as crucial to delivering consistent, evidence-based care.

7. Embed evidence-based, data-driven planning

Across all levels, there was a clear recognition of the need for the system to become more adaptive and learning-focused. This includes embedding research into clinical practice, improving the collection of functional and patient-reported outcome measures, and building robust statewide datasets to inform service planning and quality improvement. Respondents advocated for using data not only to monitor performance but to design interventions that are directly responsive to patient needs and experiences.

Changes in head and neck cancer care

Respondents identified some key changes to head and neck cancer care provision across the last 5 years. These are listed below.

The rise of immunotherapy and targeted therapies

Respondents identified that the most significant change is the rapidly evolving role of immunotherapy. It is increasingly used as a standard treatment for recurrent, metastatic, or advanced disease and as a neoadjuvant/adjuvant therapy. This is fundamentally changing treatment paradigms and improving outcomes for head and neck cancer patients.

Surgical advancement and precision

Surgical techniques have advanced significantly. There is a wider acceptance of less aggressive, minimally invasive approaches like robotic surgery. Precision is being enhanced through technology like Virtual Surgical Planning (VSP) and patient-specific implants. Crucially, there is a growing emphasis on collaborative, high-quality reconstruction and providing this expertise regionally to reduce patient travel.

Optimised systemic and radiation therapies

Alongside immunotherapy, respondents note that there is a shift in how traditional therapies are used. This includes an increased use of induction and neoadjuvant therapies before curative treatment, as well as improved and updated radiotherapy techniques and systemic therapy protocols. Better supportive care also enables the use of less toxic regimens which in turn improves patient tolerance.

Growing emphasis on prehabilitation and survivorship

Respondents report that there is an increased awareness and integration of services that support the patient before and after treatment. This includes the implementation of prehabilitation and Enhanced Recovery After Surgery (ERAS) programs. While funding remains a challenge, there is a

stronger focus on survivorship, addressing long-term needs like improved dental rehabilitation for oral cancer patients.

Enhanced multidisciplinary management

The effectiveness of the MDT itself has seen dramatic improvement. Respondents note that management has improved clinical practice indicating a more cohesive and effective collaboration between specialties. This stronger teamwork underpins and enables the successful implementation of the other clinical advancements.

Conclusion

This survey of Victorian multidisciplinary head and neck cancer stakeholders has identified important findings to inform the VICS Head and Neck Cancer Optimal Care Summit. Persistent barriers, including a fragmented patient journey, inequitable access to care, systemic under resourcing, and burden of treatment, were highlighted across metropolitan, regional, and statewide cancer services. These challenges contribute to unwarranted variations in care, particularly in access to supportive care, delays in diagnosis and treatment, and patient centred care.

Conversely, key enablers were identified, including improved system coordination and navigation, a well-resourced and collaborative workforce, and comprehensive and holistic support for patients. A critical strategy to reducing variations in care is the strengthening of referral pathways through streamlined systems ensure timely and equitable access to screening and diagnostic services.

To drive meaningful improvements, stakeholders highlighted the need for strategic investments in physical structures and resources, development of the multidisciplinary workforce and evolving current models of care, prioritising supportive care and survivorship services to improve patient outcomes and utilising data and digital health for continuous improvement and to enhance patient outcomes.

By addressing the identified barriers and leveraging the enablers, meaningful improvements in care quality can be achieved, ensuring that all people with head and neck cancer in Victoria, regardless of location, receive consistent and optimal care.

References

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Appendix 1

Barriers, Enablers and Preferences Survey Questions

1. Full name					
2. Please select all your relevant positions					
3. Please list all the organisations you currently work at					
4. Email address					
5. In which Integrated Cancer Services (ICS) region do you do most of your work?					
6. Do your patients have access to these services? (via a 5 point scale)					
	No patients have access	Around 25% of patients have access	Around 50% of patients have access	Around 75% of patients have access	All patients have access
Chronic pain access					
Prosthetist access					
Prosthodontist access					
Dentistry access					
Dietetics access					
Financial support access					
Lymphedema access					
Pain management access					
Palliative care access					
Psychosocial support access					
Speech pathology access					
7. What service(s) don't you have access to that you would like to be prioritised					
8. What unwarranted variation(s) do you believe exist that are specific to providing optimal care to people with head and neck cancer?					
9. What do you believe are the barriers to people with head and neck cancer receiving optimal care? Please explain why these are barriers.					
10. What do you believe are the enablers to people with head and neck cancer receiving optimal care? Please explain why these are facilitators.					
11. What levers (or mechanisms for changes) for how care is provided to people with head and neck cancer can be improved? This may include cancer service improvements that are required in your health service, region or the state.					

12. Have there been in changes in head and neck cancer care over the last five years?
13. Are you aware of any projects or initiatives undertaken since 2017 relating to the care or support for people with head and neck cancer in Victoria?
14. Please name and provide a brief description of the project or initiative.
15. Are the results of the work now publicly available?
16. When are results expected to be available?
17. Can you provide or direct us to any information about the project or initiative?
18. Please list the best contact person who can provide more information and their contact details, if known.
19. Would you be interested in a telephone discussion with a member of the VICS Optimal Care Summits team to clarify or provide any further information regarding optimal care for people with head and neck cancer in Victoria?