Lung Cancer Screening Collaborative Workshop

WESTERN & CENTRAL MELBOURNE INTEGRATED CANCER SERVICE

Prepared by WCMICS Program

WCMICS Lung Cancer Screening Workshop Report

1. Background

On 22 July 2025, the Western and Central Melbourne Integrated Cancer Service (WCMICS) hosted a local Lung Cancer Screening (LCS) Collaborative Workshop to support shared implementation of the National Lung Cancer Screening Program (NLCSP), which commenced nationally on 1 July 2025.

The workshop aimed to foster collaboration, surface local implementation challenges, and identify practical, service-level solutions to support equitable, efficient, and sustainable delivery of the program across participating health services.

Attendees included clinical leaders, general practitioners, Primary Health Networks (PHNs), Aboriginal health service representatives, program leads, and administrators. The workshop was structured around two facilitated discussion rounds. In the first round participants were grouped by clinical discipline; such as primary care, respiratory medicine, radiology, and multidisciplinary teams, to explore role-specific perspectives. In the second round participants were regrouped attendees around key process themes, including referral and eligibility, data infrastructure, workforce capacity, and equity of access, enabling cross-disciplinary insights and shared problem-solving.

This summary report presents a synthesis of these discussions and outlines the key opportunities and actions identified by participants to support local delivery of the National lung cancer screening program.

2. Workshop Insights

The table discussions revealed shared experiences and challenges across services, while also highlighting important variations in referral processes, service readiness, and population access. Key themes included primary care engagement, respiratory medicine pathways, multidisciplinary team coordination, radiology capacity, data infrastructure, workforce sustainability, referral and eligibility processes, and equity of access.

Round 1

Primary Care Engagement

Participants highlighted that general practice engagement with the screening program is currently variable, with many GPs unaware of the program or uncertain about how to identify and refer eligible patients. Some GPs are reluctant to engage due to concerns about workload and financial implications, highlighting the need for appropriate funding or incentives to support their active participation. Others are reluctant to engage due to concerns about workload or face structural barriers such as the absence of nurse-led models or difficulty accessing the National Cancer Screening Register (NCSR). Feedback loops to general practice are also inconsistent, limiting continuity of care.

It was suggested that PHNs be supported to play a central role in GP education by using tailored resources and consistent messaging. The development of a GP-facing referral toolkit and streamlined workflows would assist in building confidence and reducing ambiguity. There was also support for piloting nurse-led coordination within general practices, where resourcing permits.

Respiratory Medicine

Respiratory physicians expressed concern about increasing referral volumes and limited capacity to manage screen-detected nodules. Several services are already experiencing pressure on multidisciplinary team (MDT) meetings, and the addition of low-risk or inappropriate referrals risks further straining these resources. There is also inconsistency in how nodules are managed across services, and some referrals lack sufficient clinical information to support appropriate triage.

Services emphasised the need for clear referral protocols and triage models to prevent unnecessary MDT presentations. There was strong interest in expanding nurse-led triage clinics, similar to models already in place at some sites, and in exploring shared service agreements to distribute diagnostic and procedural workload.

Multidisciplinary Team

Discussion revealed a shared concern that MDTs are not currently resourced to accommodate the anticipated increase in referrals. Participants noted that the referral of all screen-detected nodules to MDTs is neither necessary nor feasible, particularly given the prevalence of low-risk lesions. There was also variation in post-diagnosis follow-up processes, with ambiguity about who holds responsibility for ongoing coordination.

Improved triaging of cases and defined criteria for MDT presentation were seen as immediate priorities. Several services proposed the introduction of local review clinics or virtual case conferencing models to manage lower-risk cases outside the formal MDT structure.

Radiology

Radiology was identified as a key pressure point, with difficulties in accessing external scans, inconsistent reporting formats, and limited capacity for timely follow-up. The lack of interoperability between systems impedes efficient scan sharing, and the reliance on GPs to upload images to the NCSR adds unnecessary complexity. Structured reporting and follow-up recommendations are not consistently used.

Participants proposed the use of shared reading services and artificial intelligence-assisted tools to support reporting and reduce variability. Integration with the NCSR was seen as critical, and some services advocated for centralised reporting hubs to support equity and quality across the region.

Round 2

Data Infrastructure and Monitoring

Data systems were noted to be fragmented, with limited capacity to capture screening activity, monitor patient outcomes, or evaluate performance across services. Manual data entry is common, and there is no shared dashboard or platform to support collective oversight.

There was strong support for establishing a set of core indicators for the LCS program and developing a regional dashboard to enable real-time monitoring. This would require investment in data integration and analytics capabilities, as well as training for staff to use the systems effectively.

Sustainability and Workforce Capacity

Workforce limitations were identified as a major barrier to sustainable implementation. Services reported shortages of specialist nurses, radiologists, and administrative staff, all of whom are critical to the successful delivery of the screening pathway. Some clinicians expressed concern about absorbing additional screening-related tasks without added additional resourcing or protected time.

Suggested solutions included expanding nurse-led roles for triage and navigation, exploring mobile or cross-site workforce models, and developing structured training pathways to support workforce development. There was also discussion around the need for clearer role definitions to support safe delegation and program sustainability.

Referral and Eligibility Processes

Currently, referral processes vary widely between services, with each health service maintaining its own forms and workflows. This lack of standardisation contributes to confusion among referring clinicians and risks inequitable access. Smoking history data, which is central to determining eligibility, is often poorly captured or inconsistently recorded in electronic medical records (EMRs).

Participants proposed developing a regionally agreed referral form and embedding eligibility prompts into EMRs. Improving the consistency of GP referral information and providing administrative support to assist with eligibility assessment were also identified as high-priority actions.

Equity of Access for Priority Populations

Participants acknowledged that the NLCSP risks entrenching existing inequities unless active strategies are implemented to reach culturally and linguistically diverse (CALD), Aboriginal, rural, and low-income populations. Barriers identified included language and cultural differences, low health literacy, distrust of mainstream health services, lack of digital access, and trauma from previous care experiences.

There was a strong call for co-designed, culturally safe communication materials in multiple formats—including translated resources, community radio messaging, and visual or video-based tools. Trusted messengers such as Aboriginal health workers, multicultural community leaders, and peer educators were seen as essential to building trust and supporting engagement. Services also recommended funding local health worker outreach and providing flexibility in eligibility verification for patients without regular GP access.

3. Recommended Actions

The workshop identified several clear next steps to support implementation of the LCS program across WCMICS member services (see **Appendix 1**):

1. **Develop a regionally consistent GP referral toolkit**, including clear eligibility criteria, referral instructions, and supporting education materials.
2. **Support Primary Health Networks to lead GP engagement and communication**, with aligned messaging and locally appropriate outreach strategies.
3. **Establish triage and referral protocols for screen-detected nodules**, including defined criteria for MDT presentation and mechanisms for local review where appropriate.
4. **Strengthen radiology access and reporting infrastructure**, including consideration of shared AI-supported reporting services and streamlined scan-sharing processes.
5. **Create a regional data dashboard and standardised indicator set** to support consistent monitoring of LCS program delivery and equity of access.
6. **Advocate for dedicated workforce resourcing**, including nursing, radiology, and administrative roles required to support screening coordination.
7. **Ensure the LCS program embeds equity from the outset**, through co-designed communication, culturally safe service models, and outreach partnerships with community-led organisations.
8. **Convene a WCMICS referral process working group** to align referral forms, EMR prompts, and smoking history capture across all participating services.

To support implementation of these priorities, a detailed action plan has been developed and is included as **Appendix 2**. This plan consolidates insights from the workshop discussions into a structured set of 14 regionally relevant actions, grouped by implementation horizon and clearly identifying those within WCMICS' remit. The action plan is intended to guide next steps, support role clarity, and enable progress monitoring as local implementation of the NLCSP advances.

4. Conclusion

The WCMICS Lung Cancer Screening Collaborative Forum provided a valuable platform for cross-sector dialogue, surfacing both common challenges and practical opportunities to strengthen for strengthening local implementation of the National Lung Cancer Screening Program. The insights captured across two rounds of structured discussion, first by clinical discipline, then by key

process themes reflect the complexity of delivering an equitable, coordinated, and sustainable screening pathway across a diverse health system.

While readiness varies across services clear progress and a strong commitment to collaboration, continuous learning, and locally tailored solutions are evident. Participants identified clear and actionable priorities, including the need for standardised referral processes, enhanced GP engagement, improved radiology and data infrastructure, investment in workforce capacity, and embedding of equity considerations throughout the pathway.

WCMICS remains well-positioned to continue its convening and coordination role, supporting services to translate these insights into meaningful action and to collectively shape a screening system that is not only effective, but also accessible and responsive to the communities it serves. Ongoing evaluation and adaptation will be essential to sustain gains and address emerging challenges.

Appendix 1: Combined Recommendations

1. Enhance GP Engagement and Standardise Referral Processes
    - Support PHNs to lead GP engagement with aligned messaging and locally tailored outreach.
    - Convene a WCMICS referral process working group to align referral forms, EMR prompts, and smoking history capture across all participating services.

2. Establish Triage Protocols and Optimise Multidisciplinary Team Resources
    - Define referral and triage protocols for screen-detected nodules with clear criteria for MDT presentation.
    - Implement local review clinics or virtual case conferences to manage lower-risk cases outside the formal MDT.
    - Expand nurse-led triage clinics and explore shared service agreements to distribute workload.
    - Clarify roles and responsibilities for post-diagnosis follow-up coordination.

3. Strengthen Radiology Infrastructure and Reporting
    - Improve access to external scans and streamline scan-sharing processes.
    - Promote use of structured reporting formats and follow-up recommendations.
    - Introduce shared AI-assisted reporting services to reduce variability and support timely reporting.
    - Develop centralised reporting hubs and integrate with the National Cancer Screening Register (NCSR) to support quality and equity.

4. Develop Integrated Data Systems for Monitoring and Evaluation
    - Create a regional dashboard and standardised indicator set to monitor program delivery, outcomes, and equity in real time.
    - Provide staff training to maximize effective use of data systems.
    - Reduce manual data entry by improving interoperability between systems.

5. Promote Workforce Sustainability and Capacity Building
    - Expand nurse-led roles for triage, navigation, and screening coordination.
    - Explore mobile or cross-site workforce models to increase flexibility and coverage.
    - Develop structured training pathways and clarify role definitions to support delegation and program longevity.

6. Embed Equity and Community Engagement
    - Co-design culturally safe, translated communication materials in multiple formats.
    - Partner with community-led organisations and trusted messengers to improve outreach and trust among priority populations.
    - Address barriers such as language, cultural differences, health literacy, distrust of mainstream services, and digital access challenges.

Appendix 2: Proposed prioritised Action Plan

Immediate Priorities (0–3 months) Foundational activities to enable safe, consistent program rollout.		
Action	**Description**	**WCMICS Role**
Support development of a standardised referral toolkit for GPs	Co-design a regionally endorsed pack including eligibility criteria, referral templates, and FAQs.	Facilitate and support PHNs and health services where appropriate
Establish triage and referral protocols for screen-detected nodules	Facilitate agreement on triage criteria to avoid unnecessary MDT referral.	Convene clinical leads and MDT reps
Support PHNs to deliver aligned GP engagement and education	Provide messaging, slides, and clinical assets to assist PHNs with rollout.	Enable and support where appropriate
Form a WCMICS referral and eligibility working group	Align referral forms, EMR prompts, and smoking history capture across sites.	Convene and facilitate with clinical leads
Share successful nurse-led triage and nodule models	Document and disseminate exemplar models to support adoption across sites.	Collate, and share across network
Short-to-Medium Term Priorities (3–9 months) Actions to strengthen infrastructure, monitoring, and workforce.		
Action	**Description**	**WCMICS Role**
Define and implement a common data indicator set	Establish shared measures for screening activity, conversion rates, and equity.	Support and facilitate coordination with HS sites

Develop a regional LCS monitoring dashboard	Create or augment a dashboard to track screening metrics across sites.	Partner-led (requires IT/BI support), but WCMICS can scope and advocate
Undertake a regional radiology capability and workflow scan	Identify scan access, structured reporting, and AI-readiness gaps.	Collaborative (led by radiology teams), WCMICS may support data collection
Support workforce planning aligned to LCS demand	Advocate for resource allocation informed by volume modelling.	Service-led, but WCMICS can provide insights and facilitate discussion
Co-design culturally safe education materials and outreach strategies	Partner with CALD, Aboriginal and community orgs to create materials.	WCMICS can lead design coordination and engagement process
Longer-Term Opportunities (9–18 months and ongoing) Broader initiatives for equity, innovation, and sustainability.		
Action	**Description**	**WCMICS Role**
Pilot integrated care pathways across PHNs and health services	Develop shared navigation models for high-risk or underserved patients.	Advocacy and facilitation as appropriate
Explore centralised/shared radiology reading and reporting models	Investigate pooled or AI-assisted services to improve access.	Sector-led; WCMICS can advocate and support planning
Advocate for EMR enhancements	Embed eligibility prompts, smoking data, and auto-upload to NCSR.	Facilitate conversations with digital health leads
Build workforce development pathways	Develop orientation modules and peer networks for program roles.	Coordinate with HS clinical (and education) team