



Victorian Optimal Care
Summits:

Colorectal Cancer
Barriers, Enablers, and
Preferences Survey

Summary of Findings

March 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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This material *Victorian Integrated Cancer Services Optimal Care Summits Colorectal Cancer Barriers, Enablers and Preferences Survey* has been prepared by NEMICS and the VICS Optimal Care Summits program to inform and guide activities related to cancer service improvement within Victoria. The material and data are intended for Victorian Integrated Cancer Services (VICS) member organisations and health professionals to promote cancer services quality improvement within their health organisations.

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List of Acronyms

Abbreviation	Definition
CALD	Culturally and Linguistically Diverse
ICS	Integrated Cancer Services
MDM	Multidisciplinary meetings
OCP	Optimal Care Pathways
VICS	Victorian Integrated Cancer Services

Background

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 Optimal Care Pathways (1). The Victorian Cancer Plan 2020-2024 (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 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 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 2024, the VICS Optimal Care Summits program will explore unwarranted variations in colorectal 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 colorectal 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 colorectal 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 18 multidisciplinary colorectal cancer stakeholders representing each of Victoria's Integrated Cancer Services (ICS). The survey required respondents to select perceived unwarranted variations in colorectal cancer care for their ICS region and describe via free text fields the barriers, enablers, and preferences for optimal colorectal cancer care. The survey was piloted and then distributed to a key stakeholder list of 320 colorectal cancer multidisciplinary clinicians and stakeholders. The survey was open for 6 weeks between November and December 2024. Participation was voluntary and results were collated and analysed using Microsoft Excel.

Findings

A total of 54 colorectal cancer stakeholders participated in the survey, with a response rate of 17%. Table 1 demonstrates that the majority of responses were from metropolitan ICS making up almost two-thirds of participants (57%, n=31). More than one third (37%, n=23) of participants were from regional ICS and a small percentage were involved in state-wide work (6%, n=3).

Table 1. Demographics of colorectal stakeholder survey participants

Name of Integrated Cancer Service (ICS)	Number
Metropolitan Integrated Cancer Services	
North Eastern Melbourne (NEMICS)	12
Western & Central Melbourne (WCMICS)	10
Southern Melbourne (SMICS)	9
Regional Integrated Cancer Services	
Loddon–Mallee (LMICS)	8
Hume (HRICS)	6
Barwon South Western (BSWRICS)	4
My work applies statewide	3
Grampians (GICS)	2
Gippsland (GRICS)	0
Grand Total	54

As seen in Table 2, half of respondents were medical (50%, n=27). There was also representation from nurses/ care coordinators (16%, n=9), stomal therapists (9%, n=5), allied health (6%, n=3), and general practitioners (4%, n=2). Those who responded as ‘other’ included those in management and/ or leadership roles.

Table 2. Occupation of colorectal cancer survey respondents

Occupation of colorectal cancer survey respondents	Number (percentage)
Medical	27 (50%)
Nurses/ care coordinators	9 (16%)
Other	8 (15%)
Stomal therapists	5 (9%)
Allied health professional	3 (6%)
General Practitioner	2 (4%)
Total	54 (100%)

Survey respondents were asked to select the unwarranted variations that they believed existed in providing optimal care to colorectal cancer patients as show in Figure 1. Respondents were able to select multiple responses. Two-thirds of respondents (67%, n=36) felt that delays in access to colonoscopy was a key unwarranted variation to people with colorectal cancer in Victoria. In addition, limited access to supportive care (56%, n=30) and delays in diagnosis (46%, n=25) were also perceived to be the amongst the most prevalent unwarranted variations. Other key unwarranted variations were delays in access to surgery (22%, n=12), limited access to clinical trials (22%, n=12), other, which includes geriatric assessment and GP access (22%, n=12), access to multidisciplinary meetings (MDMs) (19%, n=10) and bowel screening (19%, n=10).

Variation also exists between the perceived unwarranted variations amongst metropolitan and regional ICS. For example, access to supportive care services and MDM presentation was seen as a limitation in metropolitan ICS but much less recognised in regional ICS. In contrast, for regional

ICS, delays in access to surgery was highlighted. This may be attributed to the availability of services across the ICS.

Barriers

Metropolitan Integrated Cancer Services

Our analysis of survey responses from metropolitan ICS (n=31) identified several key themes across all metropolitan ICS that were presented as barriers to optimal colorectal cancer.

The most significant issue reported by metropolitan ICS stakeholders was delayed access to diagnosis for colorectal cancer patients. This includes limited access to colonoscopy and endoscopy, clinics and gastroenterology. This was reported to lead to long wait times for diagnostic services and patients potentially presenting with more advanced disease.

Another key barrier identified were workforce and resource/equipment issues. This included a shortage of stomal nurses, allied health, nurse coordinators to support and facilitate multidisciplinary care and outpatient pathways. This was reported to result in limited access to supportive care and survivorship services for people with colorectal cancer.

System related issues are another key barrier reported by metropolitan ICS to impact of the care provided to people with colorectal cancer. This included a lack of systemic surveillance, limited administrative support for clinicians and informal referral pathways between hospitals and regions.

Regional Integrated Cancer Services

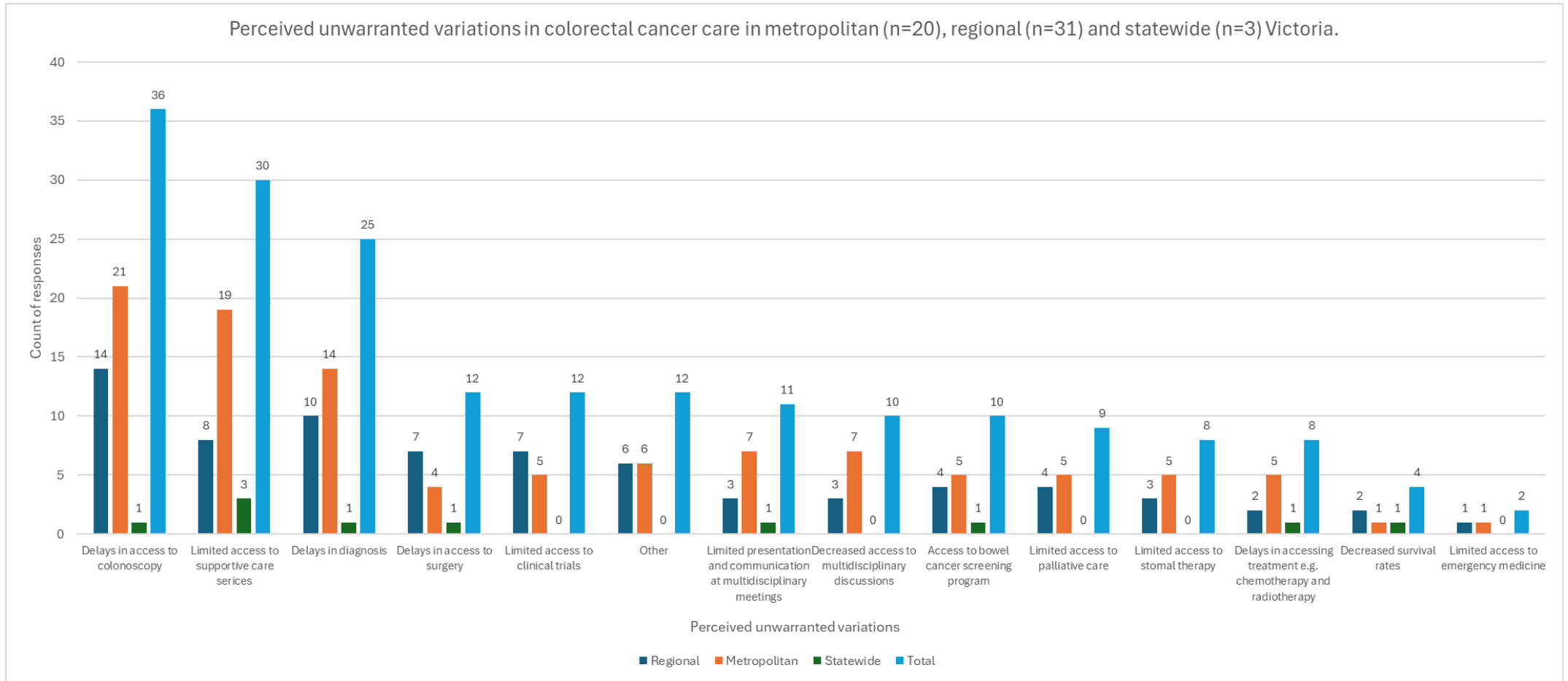
Our analysis of survey responses from regional ICS (n=17) identified several themes that were reported as barriers to optimal colorectal cancer care. They included: diagnostic delays, access and equity of care, system coordination, geographical challenges, and workforce and resource/equipment shortages.

Similar to metropolitan ICS, there was a strong theme of delays to diagnostic services by respondents from regional ICS. This included lack of access to colonoscopy and endoscopy, GP services, imaging and pathology.

The respondents identified health literacy and access to resources as key barriers to optimal care. This included community and GP awareness of colorectal cancer symptoms. Furthermore, patient challenges such as travel time, financial constraints, stigma of colorectal cancer and poor health literacy were reported as factors impacting on patients being able to present to primary care for symptom investigation.

Workforce shortages in stomal therapy, allied health services, navigators and nursing were reported to have limited availability. Regional ICS also reported barriers related to system coordination which included follow ups to bowel screening not being supported by systems and processes, limited referral pathways to rehabilitation, and variation in the quality of pathology reporting result in system delays.

Figure 1. Stakeholder perceived unwarranted variations to colorectal cancer care in Victoria



Statewide

Respondents who identified themselves as working statewide (n=3) observed barriers to colorectal cancer treatment including lack of surgeons, out of pocket costs and financial distress, colonoscopy wait times, and low awareness of lynch syndrome. Financial challenges were reported to include access to private services, supportive and survivorship services. This was also reported to disproportionately impact on younger patients who were reported to be more at risk of financial burden with travel, work and childcare needs. Respondents identified lynch syndrome to be under diagnosed with a significant number of carriers unaware of their increased risk of colorectal cancer.

Enablers

Metropolitan Integrated Cancer Services

Three key themes specific to enablers for metropolitan ICS (n=34) emerged from the survey responses. The themes included clinical trials and genetic assessment, access to supportive care and system coordination. Access to services such as clinical trials and genetic assessment were identified as key in optimising care. These were reported to be essential to enable colorectal cancer patients to access appropriate treatment options and care. In addition, system coordination that enables access to and sharing of timely information was reported to allow patients to be seen and treated quicker. This also included improved sharing of new research, evidence and recommendations for optimal care.

An enabler identified by metropolitan ICS respondents included the availability of supportive care services. Access to local multidisciplinary workforce and supportive care providers such as psychological support, dietetics, social work, and financial support were reported as key to address colorectal cancer patients supportive care needs. In conjunction with this, supporting patient care through access to educational resources, CALD translation services, telehealth and the utilisation of navigators were identified to be key enablers in optimising colorectal cancer care and experience.

Key personnel like coordinators and navigators, stoma nurses and clinical nurse consultants were reported as enabling access to optimal care. In addition, having appropriate equipment like access to MDMs, screening tools and pathology services were also reported as key facilitators.

Regional Integrated Cancer Services

Key themes specific to enablers for regional ICS (n=20) distilled from the survey responses included system coordination and referral pathways, workforce and navigation, and care closer to home.

Respondents attribute good system coordination as an enabler to optimal care. This was reported to involve the potential utilisation of private MDMs, ensuring all patients are presented at an MDM, streamlining MDM processes, and conducting adequate geriatric assessments. Regional ICS also highlight the need for clearer referral pathways and access to Health Pathways was also identified as a vital service to enable GPs to navigate the system.

Availability both workforce personnel and equipment were reported as important. This included access to nursing staff and allied health to provide supportive care, care coordinators, community palliative care services, oncologists and stomal therapy nurses. The importance of facilitating care closer to home was reported to optimise cancer care for people with colorectal cancer.

Statewide

Statewide respondents (n=3) reported that key enablers for optimal colorectal cancer care included more access to diagnostic and screening programs, hospital and surgical teams and timely care. Statewide respondents also highlight the importance of supporting patients and their families with

financial and travel assistance, supportive care screening, emotional and mental health support, and navigation, and the raising awareness of the National Bowel Cancer Screening Program.

Mechanisms for change

Metropolitan Integrated Cancer Services

When asked about the levers and mechanisms for change to improve colorectal cancer care, metropolitan ICS respondents (n=30) reported several ideas relating to diagnostic access, system coordination and workforce.

A significant mechanism for change reported by metropolitan ICS was to enhance access to diagnostic services. It was reported that there is significant demand to expand colonoscopy services and fund the increasing need for more screening, especially as the new bowel screening age is lowered.

Recommendations for system coordination included greater support for shared care with the GP for surveillance, redesigning the clinical nurse consultant role to minimise duplication and maximise efficiency and implementation of a nurse led telehealth service, departmental notification for hospital complaints and compliments as well as a public dashboard of colonoscopy wait times.

Metropolitan ICS respondents also felt that having more nurse coordinators and stoma specialists, perioperative physicians and administrative support would assist in providing optimal care. They also felt there was an opportunity to facilitate education for all medical staff.

Regional Integrated Cancer Services

Regional respondents (n=19) reported improvements for system coordination, workforce and diagnostic access. There were suggestions to streamline referral pathways, modify Medicare Benefits Schedule (MBS) time constraints, promote screening in line with National Bowel Cancer Screening Program recommendations, collaborate with private health services and provide greater administrative support for MDMs.

Another key mechanism for change reported by regional respondents was to focus on developing and supporting the workforce. Access to nurses, navigators and consultants with a strong focus regional colorectal care was reported to support patients with their treatment and supportive care needs. Raising GP knowledge and awareness of screening kits and utilising tools such as Provider Digital Access (PRODA) to ensure patients are undergoing active surveillance.

In addition, facilitating increased health literacy and community awareness of colorectal cancer, symptoms and screening programs were identified as key mechanisms for change to improve colorectal cancer outcomes.

Statewide

On a statewide level, respondents underscored the significance of access to health literacy and understanding where support might be available. This includes the Victorian Patient Transport Assistance Scheme (VPTAS) and to ensure patients are provided with informed financial consent regarding costs of cancer care. Access to regular screening to supportive care and improved data collection were reported to address unmet needs and early access to supportive care needs which patients and their families can be referred to.

Conclusion

This survey of multidisciplinary colorectal cancer stakeholders has identified important findings to inform the VICS Colorectal Cancer Summit. Persistent barriers, including delays in access to

diagnostic services such as colonoscopy, workforce shortages, and systemic inefficiencies, were highlighted across metropolitan, regional, and statewide cancer services. These challenges contribute to unwarranted variations in care, particularly in access to supportive care, multidisciplinary meetings, and surgical interventions.

Conversely, key enablers were identified, including improved system coordination, enhanced access to supportive care services, and the expansion of clinical trial participation and genetic assessment. Workforce development, particularly the expansion of nursing roles such as coordinators and stoma specialists, was seen as pivotal in addressing gaps in care. Strengthening referral pathways and ensuring timely and equitable access to screening and diagnostic services emerged as critical strategies for reducing variations in care.

To drive meaningful improvements, stakeholders highlighted the need for strategic investments in diagnostic capacity, workforce development, and system integration. Additionally, targeted efforts to improve health literacy, facilitate access to financial support, and integrate digital health solutions could further 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 colorectal cancer, regardless of location, receive consistent and optimal care.

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Appendix 1

Barriers, Enablers and Preferences Survey Questions

1. Full name and title (optional)
2. Position(s) and organisation(s)
3. Email address
4. In which Integrated Cancer Services (ICS) region do you do most of your work?
5. What services does your organisation provide colorectal cancer patients?
6. What unwarranted variation(s) do you believe exists that are specific to providing optimal care to people with colorectal cancer?
7. What do you believe are the barriers to people with colorectal cancer receiving optimal care? Please explain why these are barriers.
8. What do you believe are the facilitators to people with colorectal cancer receiving optimal care? Please explain why these are facilitators.
9. What levers (or mechanisms for changes) for how care is provided to people with colorectal cancer can be improved? This may include cancer service improvements that are required in your health service, region or the state.
10. Would you be interested in a telephone discussion with a member of the VICS Optimal Care Summits team to clarify any of your findings and preferences?
11. If you responded 'yes' to question 10, please can you provide a contact number.