

# Victorian Integrated Cancer Services Colorectal Cancer Action Register 2025



VICCS, November 2025

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## Background

The Victorian Integrated Cancer Services (VICS) Optimal Care Summits program, previously known as the Victorian Tumour Summits, is a leading initiative of the VICS. It is administered and managed by the North Eastern Melbourne Integrated Cancer Service (NEMICS) – one of the 9 Integrated Cancer Services (ICS) that make up the statewide VICS network. The program identifies unwarranted variations in cancer care and outcomes (including clinical practice variation) and provides recommendations for the VICS to address those variations at the state, network, and/or health service level. Lateral work from key stakeholders including the Victorian Department of Health (DH), Cancer Council Victoria (CCV), Victorian Comprehensive Cancer Centre (VCCC) Alliance, Bowel Cancer Australia, and the Multicultural Centre for Women's Health is also considered.

The VICS Optimal Care Summits program involves a mixed-methods strategic consultation approach to agree priorities for reducing variations and improving cancer outcomes throughout Victoria. The methods are overseen by the relevant expert advisory group and delivered by the VICS Optimal Care Summits team and the VICS. Methods are shown in Figure 1 below.

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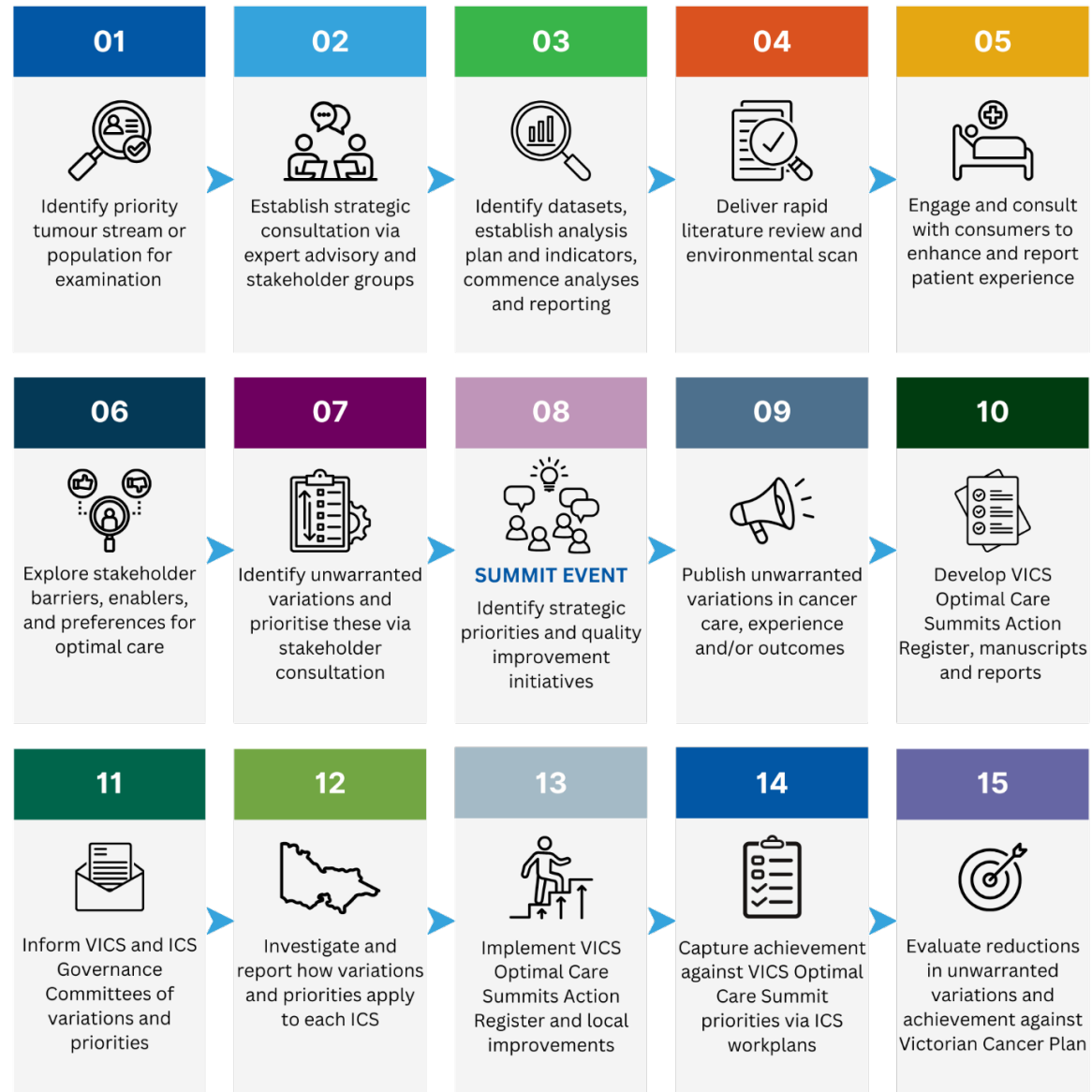


Figure 1: The VICs Optimal Care Summits mixed methods strategic consultation

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## Action register

During 2024 and 2025, the VICS Optimal Care Summits program engaged with colorectal cancer multidisciplinary clinicians, stakeholders, and consumers to participate in various mixed-method strategic consultations to identify unwarranted variations in colorectal cancer care and outcomes across Victoria. The unwarranted variations identified are listed in Table 1.

**Table 1: Unwarranted variations identified in colorectal cancer care and outcomes across Victoria, 2024 and 2025**

Number	Unwarranted variation
1	Age standardised incidence rates of Victorians aged 25–49 years with colorectal cancer have been steadily increasing at an annual rate of 2.6% since 2005. This trend contrasts with the overall decline in colorectal cancer incidence rates among older Victorians over the past four decades.
2	Between 2018 and 2022, Aboriginal Victorians were 74% more likely to be diagnosed with colorectal cancer, compared to other Victorians.
3	Between 2020 and 2022, age-standardised incidence rates of colorectal cancer were higher in regional ICS.
<u>4*</u>	<b>A significantly higher proportion of colorectal cancer patients with early-onset disease (less than 50 years of age) were diagnosed with later stage disease compared with those more than 50 years of age.</b>
5	The proportion of colorectal cancer patients who presented to an emergency department (ED) for emergency surgery increased from 15.2% (2017) to 17.5% (2022). There was a statistically significant trend between 2017 and 2022 ( $p < 0.01$ ).
<u>6*</u>	<b>In Victoria, the waiting time between positive screening and colonoscopy of people aged 50–74 has been increasing since 2019. In 2021, 90% of patients aged 50–74 had a colonoscopy within 136 days after positive screening, which is above the maximum recommended diagnostic interval, 120 days.</b>
<u>7*</u>	<b>Regional ICS have lower rates of documented multidisciplinary meeting (MDM) presentation for colorectal cancer patients. The target is 85%, the statewide result is 74% in 2022, and in some regional ICS rates were below 50%.</b>
8	There is variation in recording of stage in MDM recommendations for colorectal cancer patients between the ICS. The target is 85% and the statewide average in 2022 is 81%.
9	There is variation in documented evidence of Eastern Cooperative Oncology Group (ECOG) Performance Status recorded in an MDM for colorectal cancer patients, by ICS. The target is 100%, the statewide result was 20% in 2017, rising to 43% in 2022. However, in some ICS areas the rate was less than 25% (SMICS and BSWRICS) in 2022.
10	Across all ICS, there are low rates of supportive care screening for colorectal cancer patients. The target is 80%, while the statewide average is 20% (2022).
11	There is variation in documented evidence of communication of treatment plans to GPs for colorectal cancer patients by ICS. The target is 100%; the statewide result is 71% (2022), decreasing from 81% in 2017.

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12	In 2020–2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 1, 2 and 3 colorectal cancer was significantly lower than the statewide average in WCMICS and GRICS.
13	In 2020–2022, the proportion of patients receiving any treatment within 6 weeks of diagnosis for stage 4 colorectal cancer was significantly lower than the statewide average in WCMICS.
14	In 2020–2022, the median time between colonoscopy and first treatment was above the statewide median (22 days) in GRICS (33 days), LMICS (29 days) and HRICS (26 days).
15	The proportion of surgeries with 12 or more lymph nodes examined for stage II and III colon cancer patients in HRICS, LMICS, and GICS showed wider variation from 2017 to 2022, compared to other ICS.
16	On average only 51.1% (2017–19) and 49.4% (2020–22) of CRC patients were seen by a dietitian during admission within 6 months of diagnosis. Rates are low across all ICS.
17	On average only 54.9% (2017–19) and 53.6% (2020–22) of CRC patients were seen by a physiotherapist during admission within 3 months of diagnosis. Rates are low across all ICS.
18	Age-standardised mortality rate of Victorians aged 25–49 years with colorectal cancer early-onset have been increasing at an annual rate of 1.8% annually over the past 17 years, between 2006 and 2023. This trend contrasts with the overall decline in colorectal cancer mortality rates among older Victorians.
19	Between 2018 and 2022, Aboriginal Victorians were 160% more likely to die from colorectal cancer, compared to other Victorians.
20	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from all-cause mortality among colorectal cancer patients by stage and ICS of residence were significantly worse for LMICS (stages 1 and 4 CRC) in 2020–2022, compared to the statewide average.
21	After adjusting for age at diagnosis, sex, socioeconomic status and comorbidities, survival from cancer specific mortality among patients diagnosed in 2020–2022 with stage 2 CRC in GRICS observed poorer survival compared to the statewide average.
22	On average, only 11.6% of stage 4 colorectal cancer patients had recorded evidence of advance care directive in 2020–2022. Rates are low across all ICS.
23	On average, only 47.7% of colorectal patients were admitted for palliative care within 12 months prior to death in 2020–2022.
24	On average, 40% of colorectal cancer patients had an emergency department presentation 30 days prior to death between 2017 and 2022.

\* Three unwarranted variations were prioritised through a 3-step Delphi process and were discussed at the VICS colorectal cancer summit in February 2025 – These are bolded in Table 1 above.

The actions listed in Table 2 were recommended to be prioritised by the VICS, individual Integrated Cancer Services (ICS), and the VICS Optimal Care Summits (OCS) team to address the 3 priority unwarranted variations. These actions may also have direct and indirect impacts across multiple colorectal cancer unwarranted variations, as shown below.

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**Table 2: Recommended action items, owners, and governance to address Victorian colorectal cancer unwarranted variations**

Optimal Care Pathway alignment >			Step 1			Step 2			Step 3			Step 4			Step 5			Step 6			Step 7					
Unwarranted variation identified in Table 1																										
Recommended action	Recomm- ended owners	Recomm- ended governance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1. Create a video highlighting the key variations and outcomes from the colorectal cancer summit, to engage clinicians in supporting changes	OCS, EAG	VICS Managers Group																								
2. Consult with other states to collate information regarding direct and rapid access colonoscopy referrals from primary care	OCS	VICS Managers Group																								
3. Facilitate the uptake of direct/rapid access colonoscopy referrals, as appropriate	ICS	VICS Managers Group						D																		
4. Enhance colonoscopy referral quality by implementing and promoting the use of standardised referral forms	ICS	VICS Managers Group						D																		
5. Disseminate information regarding endoscopy categorisation tool	OCS, ICS	VICS Managers Group						D																		
6. Coordinate the distribution of resources to health services to increase transparency and visibility of colonoscopy waiting lists	ICS	VICS Managers Group						D																		

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Optimal Care Pathway alignment >			Step 1			Step 2			Step 3			Step 4			Step 5		Step 6			Step 7						
Unwarranted variation identified in Table 1																										
Recommended action	Recommend- ed owners	Recommend- ed governance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
7. Support the scale and spread of initiatives from the GICS colonoscopy access project	GICS/ ICS	VICS Managers Group				I	I	D												I	I					
8. Partner with Multicultural Centre for Women's Health to distribute available resources and services to health services and clinicians	ICS, Multicultural Centre for Women's Health	VICS Managers Group	I		I	I																				
9. Collaborate with Multicultural Centre for Women's Health to deliver training to their health educators	ICS, Multicultural Centre for Women's Health	VICS Managers Group	I		I	I																				
10. Collaborate with Bowel Cancer Australia to disseminate information to the workforce to increase awareness of bowel cancer symptoms and early-onset bowel cancer	ICS, Bowel Cancer Australia	VICS Managers Group	D	D	D	D	I																			
11. Work with Bowel Cancer Australia to develop Clinical Practice Guidelines for early-onset colorectal cancer	OCS, EAG, Bowel Cancer Australia	VICS Managers Group	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I	I
12. Work with health services to progress statewide supportive care work and improve supportive care screening and practices	ICS	Individual ICS Governance committees										D						D	D							

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Optimal Care Pathway alignment >			Step 1			Step 2			Step 3			Step 4			Step 5		Step 6			Step 7						
Unwarranted variation identified in Table 1																										
Recommended action	Recommend- ed owners	Recommend- ed governance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
<b>13.</b> Partner with key stakeholders that deliver supportive care and refer to these services as required (such as CCV, Bowel Cancer Australia)	ICS	Individual ICS Governance committees																D	D							
<b>14.</b> Update guidance and information in Health Pathways for general practitioners	OCS	VICS Managers Group																								
<b>15.</b> Engage with Cancer Australia and inform updates to the Colorectal Cancer Optimal Care Pathway (OCP)	OCS	VICS Managers Group																								
<b>16.</b> Progress the statewide VICS multidisciplinary meeting (MDM) quality program	ICS	Individual ICS Governance committees							D	D	D															
<b>17.</b> Investigate and implement registering MDMs as Tier 2, 20.56 clinics to ensure activity is counted and to access NWAU funding.	ICS	Individual ICS Governance committees																								
<b>18.</b> Map location, type, meeting frequency and capacity of colorectal and all MDMs across the state	ICS	VICS Managers Group																								
<b>19.</b> Partner with Safer Care Victoria to explore opportunities to strengthen MDM governance	ICS	VICS Managers Group																								
<b>20.</b> VCCC Alliance to develop and deliver relevant education to stakeholders with support from the VICS Optimal Care Summits team	VCCC/ OCS	VICS Managers Group																								

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Optimal Care Pathway alignment >			Step 1			Step 2			Step 3			Step 4			Step 5			Step 6			Step 7					
Unwarranted variation identified in Table 1																										
Recommended action	Recommend- ed owners	Recommend- ed governance	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
21. Promote the uptake of the VICS/VCCC Optimal Cancer Care for Aboriginal and Torres Strait Islander People Learning Program	ICS/ VCCC	VICS Managers Group			D								I	I	I						D					
22. Facilitate training between the ICS and Victorian Cancer Registry to strengthen ICS understanding of how to use and interpret available data	OCS/ ICS/ VCR	VICS Managers Group	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM	PM

D = Direct impact, I = Indirect impact, PM = Performance monitoring

CCV = Cancer Council Victoria, ICS = Integrated Cancer Services, OCS = VICS Optimal Care Summits team, EAG = expert advisory group, VCCC= Victorian Comprehensive Cancer Centre Alliance, VCR = Victorian Cancer Registry

In addition to work being completed by the VICS, other key cancer stakeholders have lateral work occurring that may have both direct and indirect impacts on the Victorian colorectal cancer unwarranted variations identified above. Lateral work may influence the development of specific projects and activities of the VICS. Key stakeholders including Cancer Council Victoria (CCV), Bowel Cancer Australia, McGrath Foundation, Victorian Comprehensive Cancer Centre (VCCC) Alliance, and the Multicultural Centre for Women’s Health have been consulted and the lateral work they may undertake is listed in Table 3.

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**Table 3: Lateral work occurring to address Victorian colorectal cancer unwarranted variations**

Optimal Care Pathway alignment >		Step 1			Step 2			Step 3			Step 4			Step 5			Step 6			Step 7					
Unwarranted variation identified in Table 1																									
Activity	Lead Organisation	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Advocate for systems, practices, policy and regulatory reform to address cancer risk factors, to improve the experience of navigating cancer and ensure optimal care	CCV																								
Advocate for the improvement of capture of cancer stage, progressing and recurrence data	CCV																								
Provide education resources for people with cancer (including relevant written information, My Cancer Guide) and support through the Cancer Information Support Service (13 11 20) to assist people with practical, financial, and emotional support and help with navigation of and access to available supportive care services	CCV																								
Provide practical legal support services to Victorians with advanced cancer	CCV																								
Expand model of care to include all cancers	McGrath Foundation																								
Deliver health education and support to refugee and migrant women across Victoria	Multicultural Centre for Women's Health																								
Provide advocacy, research, patient support services, awareness, and education to support people with bowel cancer and their families	Bowel Cancer Australia																								

D = Direct impact, I = Indirect impact, CCV = Cancer Council Victoria

For more information on the VICS, see [www.vics.org.au](http://www.vics.org.au)

