Final Report

Advancing Equitable, Patient-Centred Care at Peter Mac

Developing a Diversity, Equity and Inclusion Action Plan

Kate Ioannou

October 2026

VICS Western & Central Melbourne Integrated Cancer Service
Our Partners: Mercy Health, Peter Mac, the women's, Western Health, The Royal Melbourne Hospital, The Royal Victorian Eye and Ear Hospital, St Vincent's Hospital
The Victorian Integrated Cancer Services are supported by the Victorian State Government

Overview

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Commencement date:	April 2026
Completion date:	September 2026
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Acknowledgements:

WCMICS respectfully acknowledges Australia's Aboriginal and Torres Strait Islander communities pay respects to their Elders past and present. WCMICS is committed to honouring Aboriginal and Torres Strait Islander peoples as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely.

We gratefully acknowledge the contributions of people with lived experience, carers, healthcare professionals, service providers and other stakeholders who participated in this project. We thank them for sharing their expertise, insights and experiences, which have helped shape the findings and recommendations presented in this report.

Recommended citation:

Ioannou, K. 2026. *Advancing Equitable, Patient-Centred Care Across Cancer Pathways*. Western and Central Melbourne Integrated Cancer Service (WCMICS), Melbourne, Australia.

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Generative AI was used to support aspects of the analysis conducted in the project and preparation of this report. No new concepts, findings or recommendations were generated through the use of AI tools.

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Abbreviations

Abbreviation	Term
AI	Artificial Intelligence
COSA	Clinical Oncology Society of Australia
DEI	Diversity, Equity and Inclusion
EFT	Equivalent Full-Time
GP	General Practitioner
IAP2	International Association for Public Participation
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual and Other Sexually or Gender Diverse People (LGBTI+ where a source uses that term)
M&E	Monitoring and Evaluation
NSW	New South Wales
PBS	Pharmaceutical Benefits Scheme
PCXS	Patient and Carer Experience Strategy
Peter Mac	Peter MacCallum Cancer Centre
RACI	Responsible, Accountable, Consulted, Informed
VCCC Alliance	Victorian Comprehensive Cancer Centre Alliance
VHES	Victorian Healthcare Experience Survey
WCMICS	Western and Central Melbourne Integrated Cancer Service

Project Summary

Context and Aim

Significant inequities in cancer outcomes persist across population groups in Australia due to a range of social, cultural, economic and structural determinants of health. Addressing these inequities requires equitable, culturally responsive and accessible cancer care that meets the diverse needs of all people throughout the cancer care continuum.

Peter MacCallum Cancer Centre's (Peter Mac's) Patient and Carer Experience Strategy applies an equity lens to all of its goals, but its three equity objectives, on navigation, communication and access to wellbeing and support services, had no agreed actions. This project aimed to translate that equity intent into a practical, co-designed Diversity, Equity and Inclusion (DEI) Action Plan, with governance and measurement, ready for Peter Mac to implement as business as usual by September 2026.

What Was Done

Between April and September 2026, Western and Central Melbourne Integrated Cancer Service (WCMICS) was engaged by Peter Mac to lead the development of a DEI Action Plan, with an Implementation Plan, equity measures and a governance structure. Overseen by a working group, the project team first prioritised the 12 priority populations in the Victorian Cancer Plan. It then held three Think Tanks with 11 consumers, joined in the second by 21 subject-matter experts. What participants shared informed the Action Plan, the Implementation Plan and the equity measures.

Key Results

- A criteria-based matrix identified three initial priority population groups: people experiencing socioeconomic disadvantage or financial toxicity, people experiencing emotional or psychological distress, and people from regional and rural communities. Each received the highest overall score under the six-criterion assessment.
- Analysis of the Think Tanks produced 139 themes. Seven areas of concern were shared by every group, including care with no single point of contact and a sudden loss of contact when treatment ends.
- The DEI Action Plan sets out 15 strategic actions. Thirteen trace to actions that consumers prioritised and two were added by the project team from the findings. Peter Mac and WCMICS have endorsed the plan.
- The Implementation Plan breaks the actions into 60 outputs and 164 activities, supported by 30 equity measures and a reporting line through existing Strategy governance.

Impact and Value

- Peter Mac has an agreed, evidence-informed starting point for its equity work and a documented reason for starting there.
- Every output states whether it is resourced: 15 are, 23 are partly resourced and 22 need new funding or a business case.
- The measure set shows that only one of the three groups, people from regional and rural communities, can currently be identified in Peter Mac data, and sets out how to close that data equity gap.
- The method can be reused for other priority populations and by other health services.
- The project produced a DEI action and implementation plans, not changes in care. No change in patient or carer experience has been measured.

Next Steps

The next steps for Peter Mac are to confirm action owners, convene the DEI Implementation Group, begin with the resourced outputs and take baseline measurements.

Main Messages

- **Three priority populations emerged as the initial focus for equity action.** People experiencing socioeconomic disadvantage or financial toxicity, people experiencing emotional or psychological distress, and people living from regional and rural communities.
- **The same barriers were heard across groups.** People struggled to know who to contact, received information that was late or not in a usable format, and often had to find support themselves.
- **The project translated consumer and stakeholder input into action.** A 15-action DEI Action Plan, with 60 implementation outputs and 30 equity measures were developed, endorsed and handed over to Peter Mac's Patient Experience and Wellbeing Team.
- **This is a starting point, not an endpoint.** The prioritisation approach provides a structured way to extend equity work to the remaining priority populations over time.

Project Report

Section 1: Introduction

1.1 Problem Statement

Peter Mac has a strong organisational commitment to person-centred care, and its Patient and Carer Experience Strategy (PCXS) applies an equity lens to every goal.[1] Despite this, unwarranted variation in access and experience across the cancer care continuum continues for some consumers. This mirrors inequities recognised across Victoria and nationally, where cancer outcomes and experiences differ for priority populations and across social circumstances.[2,3] At the start of this project, DEI principles were not consistently embedded in practice, measures or governance, and there was no agreed plan for the Strategy's three equity objectives.

1.2 Background

Peter Mac is a public cancer treatment, research and education centre with six patient-facing campuses across Victoria. In 2025-26 it cared for 47,823 patients: 52% were aged 65 years or older, 31% were born overseas, 27% lived outside metropolitan Melbourne and 0.9% identified as Aboriginal or Torres Strait Islander.[1]

The PCXS, launched in 2026, has three priority areas: navigating your cancer pathway; patient communication and personalising information; and supports and services for your care. One objective in each area is directed at priority population groups: objective 1.2 (strengthen navigation), objective 2.4 (provide more support for patients who need assistance communicating) and objective 3.2 (connect priority population groups with the wellbeing and support services they need). In developing its implementation plan, Peter Mac committed to priority population assessments and journey mapping to identify targeted actions.[1] Consumer feedback gathered for the Strategy pointed to the same three areas: difficulty navigating care, variable communication and inconsistent awareness of wellbeing supports.

State and national policy sets the same expectation. The Victorian Cancer Plan names 12 priority populations and aims for equitable outcomes for all Victorians.[2] The Australian Cancer Plan asks services to take an intersectional approach to priority population groups and makes consumer navigation, communication and supportive care priorities for action.[3] The Parkville Precinct Strategic Cancer Service Plan prioritises equity of access, particularly for remote and priority populations,[4] and Peter Mac's organisational strategy names achieving health equity among its intended outcomes.[5] Peter Mac's Disability Accessibility Plan already sets actions for people with disability.[6]

In response to this need, the Peter Mac Patient Experience and Wellbeing team engaged WCMICS to undertake this work; providing project management to support delivery of the six-month project.

The project used the VCCC Alliance Cancer Equity Framework as its guide.[7] The framework distinguishes equity from equality. Equity means recognising that people have different needs and removing unfair and avoidable barriers; it does not mean giving everyone the same response. The framework sets out three domains of action: assessing inequities, addressing inequities and striving for equity. It also asks organisations to recognise intersectionality: a person can belong to more than one priority group, and the effects can compound.

1.3 Aim Statement

To translate the equity intent of the Patient and Carer Experience Strategy into a practical, co-designed Diversity, Equity and Inclusion Action Plan with clearly defined measures and metrics to monitor progress, ready for Peter Mac implementation as business as usual by September 2026.

The project plan set five objectives:

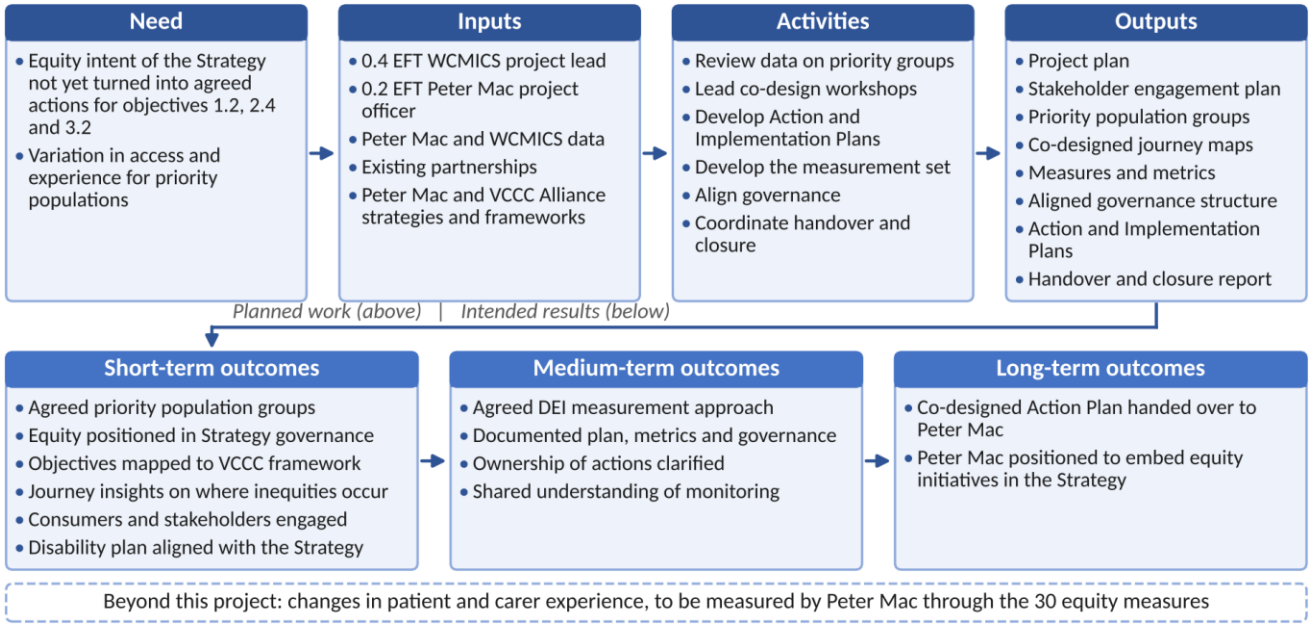
- review existing data to identify and understand priority population groups for patients and carers at Peter Mac
- co-design patient journey maps to understand barriers and enablers to care for priority population groups
- co-design a DEI Action Plan and Implementation Plan aligned to the VCCC Alliance Cancer Equity Framework
- develop a co-designed DEI measurement set to monitor progress
- align DEI governance with PCXS governance and monitoring.

Section 2: Project Design and Approach

2.1 Change Initiative

This was a development project. It set out to produce an agreed plan and the arrangements to govern and measure it. It did not set out to change care directly, and implementing the actions was out of scope. Figure 1 summarises the program logic agreed at the start of the project; Appendix A gives it in full.

Figure 1. *Program logic for the project (summary)*



EFT = equivalent full-time.

All three outcome levels in the program logic describe the state of the plan, not changes for patients and carers. The long-term outcomes are a completed handover and Peter Mac being positioned to embed equity in the Strategy. Changes in patient and carer experience sit beyond the project and are to be measured through the equity measures described in Section 6.2. This report therefore presents the project's outputs as its results.

2.2 Scope

Table 1 sets out the scope agreed in the project plan.

Table 1. *Project scope, as set in the project plan*

In scope	Out of scope
• Peter Mac patients and carers, across all six campuses • Internal Peter Mac documents and datasets, supplemented by data accessible to WCMICS • A patient and carer focused DEI Action Plan shaped by PCXS objectives 1.2, 2.4 and 3.2 • Alignment with existing frameworks, including the VCCC Alliance Cancer Equity Framework • Patient journey maps developed from existing datasets and desktop analysis • Delivery within six months	• Implementation of the actions, including workforce training • External datasets or benchmarking • Journey mapping that requires stakeholder consultation or primary data collection • Changes to clinical care pathways or direct service delivery • Policy, resourcing or budget decisions • Formal evaluation and outcome measurement • Monitoring after delivery of the Action Plan

2.3 Assumptions

- No ethics application was required, because the work was a quality improvement activity.
- Equity concepts, including intersectionality, were understood across the project team and stakeholders.
- Peter Mac could provide timely access to data, and the data would be sufficient to identify priority populations.
- Consumers would be available and able to take part without consultation fatigue.
- Peter Mac governance bodies would review and endorse outputs within planned timeframes.
- The allocated project officer time was sufficient, and Peter Mac would have the capability and resources to implement the plan after handover.

2.4 Governance

Project governance followed the governance of the PCXS. The accountable executive was Peter Mac's Chief Medical Officer and the project sponsor was the Director, Patient Experience and Wellbeing. A working group met weekly and made day-to-day decisions. It comprised the WCMICS project lead, Peter Mac's Manager, Patient Experience, and a Peter Mac diversity and inclusion project officer, with subject-matter experts joining as needed. WCMICS provided the project lead in kind and endorsed the project plan on 9 April 2026. Peter Mac's Community Advisory Committee received project updates on 27 May and 27 August 2026. All project outputs were endorsed by Peter Mac and WCMICS before handover.

2.5 Stakeholder Management

A stakeholder matrix was prepared in April and May 2026 using the IAP2 Spectrum of Public Participation.[8] It listed more than 60 people and organisations by interest, influence and planned level of engagement, from inform to empower. They included Peter Mac service leaders and clinicians, data specialists from Peter Mac and WCMICS, and external community and sector organisations with expertise in the priority populations. Stakeholders were engaged in three ways. Twelve subject-matter experts helped define each population in data during Phase 1. Twenty-one internal and external subject-matter experts worked alongside consumers in Think Tank 2, and five Peter Mac clinicians at the Bendigo campus completed the same activities in a separate session. Stakeholders also reviewed the draft Action Plan. Consumers were recruited through Peter Mac's Consumer Register (Section 3.1).

2.6 Financial Acquittal

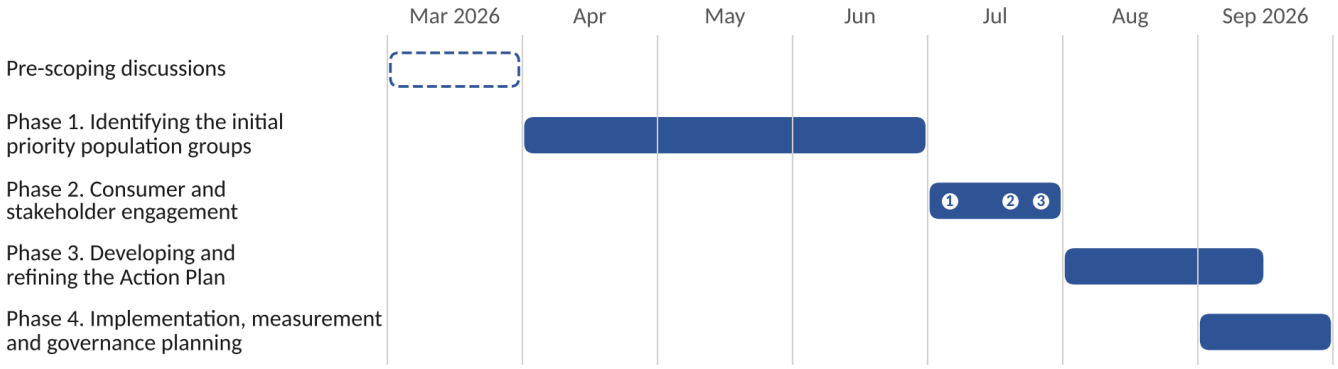
The project had no allocated budget. It was delivered with in-kind staff time: a WCMICS project lead at 0.4 EFT and a Peter Mac project officer at 0.2 EFT, as set out in the program logic.

Section 3: Implementation

3.1 Key Activities and Inputs

The project ran in four phases over six months, after pre-scoping discussions in March 2026 (Figure 2). Its inputs were the in-kind staff time described above, Peter Mac and WCMICS data, Peter Mac's Consumer Register, the time of consumers and subject-matter experts, and existing strategies and frameworks.

Figure 2. *Project phases and timeline, March to September 2026*



Circles 1 to 3 mark the Think Tanks (6, 20 and 27 July). Written feedback on the draft Action Plan was received from 27 August to 1 September. Handover to Peter Mac was at the end of September.

Phase 1: Identifying The Initial Priority Population Groups (April to June 2026)

A structured process was needed because the Victorian Cancer Plan names 12 priority populations[2] and a six-month project could not design meaningful actions with all of them at once. Choosing by population size alone was not appropriate. Size says nothing about how severe an inequity is or whether services already respond to it, and it would have directed effort to the largest groups while overlooking smaller populations with serious unmet needs.

The working group assembled four sources of evidence for each of the 12 populations:

- **Population data.** Unique Peter Mac patient counts for 2025–26, extracted on 18 May 2026 (44,948 patients), using definitions agreed with 12 subject-matter experts. Three populations could not be identified within Peter Mac data and were therefore estimated using published sources provided by subject matter experts from the respective priority populations (Appendix B).
- **Rapid literature review** of Australian, cancer-specific evidence on barriers, experience and outcomes.
- **Environmental scan** of about 110 existing Peter Mac services and initiatives, drawn from a desktop review and a structured walk-through of frontline services, each mapped to the populations it serves.
- **Strategic alignment mapping** of the three PCXS objectives against five state, national, precinct and organisational plans.

The evidence was brought together in a criteria-based prioritisation matrix. The project team scored each population from 1 (low) to 3 (high) on six criteria (Table 2). The criteria carried equal weight and the overall score was the mean of the six criteria. The matrix was used to make the basis for prioritisation explicit and consistent across the 12 populations. Scores were judgement-based and were not intended to represent a statistically derived measure of need. Two criteria were scored inversely, so that populations with fewer existing responses, and less risk of duplicating other work, scored higher. Populations were then grouped into three tiers that describe the kind of organisational response needed.

Table 2. *The six prioritisation criteria*

Criterion	What was assessed	Scoring
Scale	Size of the population group at Peter Mac	Larger scores higher
Severity	Degree of inequity and its effect on outcomes and experience	More severe scores higher
System gap	Extent of structural or system-level failure to meet need	Larger gap scores higher
System maturity	Level of existing response at Peter Mac	Inverse: less mature scores higher
Alignment	Fit with PCXS objectives 1.2, 2.4 and 3.2	Stronger fit scores higher
Duplication risk	Overlap with existing initiatives	Inverse: less overlap scores higher

Each criterion was scored 1, 2 or 3.

Each population was scored separately, so the matrix does not capture intersectionality. The working group addressed this in the next phase by recruiting consumers on the basis of lived experience, not experience of a single group, and by analysing findings across population groups. Carers were considered alongside patients. Data from Peter Mac's Carer Support Program (about 461 carers, 2021 to 2026) were too incomplete to define carer priority groups, so the working group aligned carers with the patient groups and invited carers into the engagement.

Phase 2: Consumer and Stakeholder Engagement (July 2026)

Phase 2 used Think Tanks: facilitated workshops that bring together people with lived experience and people with professional expertise to develop ideas and suggest actions. The purpose was to understand how people in the three groups, and their carers, experience cancer care at Peter Mac, and to identify practical ways to reduce avoidable barriers. The design was informed by Experience-Based Co-Design principles[9] and drew on the NSW Agency for Clinical Innovation co-design toolkit.[10]

Consumers were recruited through an expression of interest in Peter Mac's Consumer Register newsletter in June 2026, followed by purposive follow-up through existing relationships to reach people with relevant lived experience. Eleven consumers took part: nine patients and two carers. Participants spoke from their own experience and were not asked to represent a population group. Several identified with more than one of the three groups.

Each Think Tank was scheduled for 75 minutes, in person at Parkville and online, with pre-reading sent in advance (Table 3). The four pathway stages used in Think Tank 1 were adapted from the Optimal Care Pathways.[11] The project team recorded the discussions in structured notes.

Table 3. *Engagement stages and participation*

Stage	Who took part	What they did
Think Tank 1 *6 July*	11 consumers (9 patients, 2 carers)	Described their experience at four stages: referral, diagnosis and treatment planning, treatment, and after treatment. At each stage: what mattered most, what worked well, what made things harder and how they felt.
Think Tank 2 *20 July*	10 consumers with 21 subject-matter experts from Peter Mac and external organisations	Worked in three groups, one for each priority population. Identified barriers to navigation, communication, and supports and services, then the outcomes wanted, actions, and what would make the actions work.
Bendigo Session *21 July*	5 Peter Mac clinicians at the Bendigo campus	Completed the Think Tank 2 activities for regional and rural patients and carers.
Think Tank 3 *27 July*	8 consumers	Rated 10 draft actions for impact and effort, and began to define steps, signs of progress and accountability for each.
Draft Review, *27 August - 1 September*	5 consumers and 4 Peter Mac staff gave written feedback	Reviewed the draft Action Plan. Twenty-six feedback items were logged.

The project team analysed the notes thematically, informed by Braun and Clarke's approach.[12] Comments were sorted by the three PCXS focus areas and then into four categories: values, barriers, enablers and implementation considerations. Three reviewers each analysed one population's data using a shared framework and a common Microsoft Copilot prompt, and the team reviewed all themes together. For this report, each example of evidence behind the themes was traced back to the session notes to confirm its source (Appendices D and E).

Phase 3: Developing and Refining the Action Plan (August to Mid-September 2026)

The project team consolidated the barriers and proposals from Think Tanks 1 and 2 into 10 draft actions, which consumers prioritised in Think Tank 3. The team then developed these, together with the themes, into strategic actions under the three PCXS objectives and aligned them with the three domains of the VCCC Alliance framework. A draft was circulated for written feedback in late August. Each of the 26 feedback items was logged with the response made. The main changes were plain-language rewriting of every action, naming carers wherever an action applies to them, limiting commitments to what Peter Mac controls, and replacing 'cancer journey' with 'cancer experience' after feedback that many patients dislike the term.

Phase 4: Implementation, Measurement and Governance Planning (September 2026)

The Implementation Plan was built as a program logic. Each strategic action was broken into outputs, defined as a specific thing that will exist when the work is done, and each output into single-step activities. Every output was given a resourcing status and linked to related work already under way at Peter Mac, using a register of 110 current, planned and proposed initiatives drawn from the environmental scan, the PCXS implementation plan and the Disability Accessibility Plan. The measure set gives each action two equity outcome measures built on data sources Peter Mac already has. Governance was aligned to the existing PCXS reporting line, and no separate DEI reporting route was created.

3.2 Key Milestones

Table 4 compares planned and delivered milestones.

Table 4. *Key milestones, planned and delivered*

Milestone	Planned	Delivered
Project kick-off; project plan endorsed by WCMICS	Week 2	6 April and 9 April 2026
Stakeholder engagement matrix and plan	Week 4	April to May 2026
Priority populations identified	Week 6	June 2026
Think Tanks 1, 2 and 3	Weeks 7 to 15	6, 20 and 27 July 2026
Patient journey maps	Week 15	Not produced (Section 3.4)
Draft Action Plan circulated and written feedback received	Not specified	27 August to 1 September 2026
Measures and metrics	Week 14	September 2026
Governance structure aligned to the PCXS	Week 16	September 2026
Action Plan and Implementation Plan endorsed	Week 24	September 2026
Handover to Peter Mac	Week 24	End of September 2026

Week 1 began on 6 April 2026.

3.3 Deliverables

Table 5 lists the project's deliverables and where each can be found.

Table 5. *Project deliverables*

Output or deliverable	Appendix reference
Program logic	A
Priority population prioritisation report and matrix	B and C
Think Tank Findings Report (thematic analysis)	D and E
Evidence-to-action analysis prepared for this report	F
DEI Action Plan (15 strategic actions)	G
DEI Implementation Plan (60 outputs, 164 activities)	H (summary)
DEI Measures and Metrics (30 measures)	I
DEI Governance Structure	J
Project plan, stakeholder engagement matrix and plan, and risk register	Not appended (internal documents)

3.4 Adaptations and Changes

- **Prioritisation method.** The working group first rated need as high, medium or low from a narrative summary. It replaced this with the scored matrix to make the reasoning explicit. The change moved the priority population milestone from mid-May to June.
- **Journey maps.** The plan called for a co-designed journey map for each priority group. Journey mapping was done as a facilitated discussion in Think Tank 1 and analysed thematically. Visual maps were not produced and were left for Peter Mac to complete after the project.
- **External data estimates.** External datasets were out of scope, but published national estimates were used for three populations that Peter Mac data could not identify.
- **Carers.** The plan was to define carer priority populations separately. Because carer data were incomplete, carers were aligned with the patient groups.
- **Names of the groups.** 'People with mental health issues', the Victorian Cancer Plan term used in prioritisation, became 'people experiencing emotional or psychological distress', consistent with the measure used to estimate the population. 'Or financial toxicity' was added to socioeconomic disadvantage. Financial toxicity is the negative patient-level impact of the cost of cancer.[13]
- **Measures.** An earlier, larger measure set was replaced by 30 equity outcome measures with targets set from a baseline. Process and balancing measures will be set by each team that implements an action.
- **Additional session.** A separate session with clinicians at the Bendigo campus was held to strengthen regional input.

3.5 Issues Encountered

Table 6 summarises the main issues and how they were managed.

Table 6. *Issues encountered and how they were managed*

Issue encountered	Management strategies	Outcome
Peter Mac data could not identify some populations	Definitions agreed with subject-matter experts and data analysts; published estimates used; limits documented	All 12 populations assessed; three on published estimates
Limited time in sessions	Three sessions of about 75 minutes, with pre-reading; written feedback round added	Think Tank 3 recorded implementation detail for five of the 10 draft actions and one step for a sixth; the project team developed the rest
Low carer participation	Carers invited throughout; individual interviews offered	Two carers took part; carers are named across the plan; limitation recorded
Stakeholder availability	Early invitations; separate Bendigo session; written feedback option	21 experts joined Think Tank 2; some invited external organisations could not take part in the timeframe
Uncertain resourcing for implementation	Resourcing status recorded for every output; funding needs listed in one place	22 outputs identified as needing new funding or a business case
Delay in Phase 1 from the change of method	Later phases compressed; measurement and governance work run alongside drafting	Handover achieved at the end of September 2026

Section 4: Results

4.1 Outcome Measures

The project's results are its outputs. They are reported here by phase, followed by the three outcome measures from the project plan (Table 9).

Phase 1 Result: Three Initial Priority Population Groups

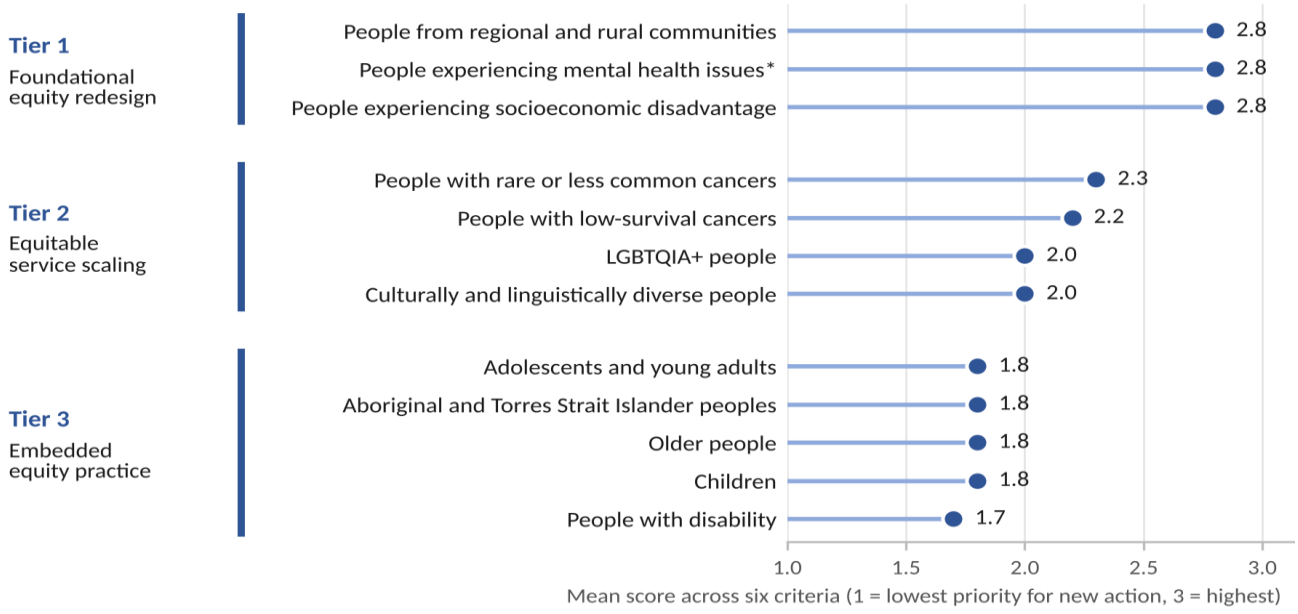
Three populations received the highest overall score under the six-criterion assessment (2.8) (Figure 3; full matrix in Appendix C). All three scored 3 for severity, system gap, alignment with the PCXS objectives and low duplication risk.

The tiers describe the kind of response needed:

- **Tier 1, foundational equity redesign** (three populations): significant inequity with limited or fragmented responses. New work is needed on how care is designed and coordinated.
- **Tier 2, equitable service scaling** (four populations): meaningful inequities that existing services partly address. Targeted improvement and scaling are needed.
- **Tier 3, embedded equity practice** (five populations): populations with established programs, roles or governance. DEI effort is best integrated within those structures, not set up alongside them. Tier 3 does not indicate lower priority or lower levels of inequity; rather, it reflects the type of organisational response indicated by the existing system response.

The tiers reflect the current system response, not the importance of any population. Aboriginal and Torres Strait Islander peoples, for example, scored 3 for both severity of inequity and alignment. They sit in Tier 3 because dedicated roles, programs and strategies already exist. The recommended response is therefore to embed and strengthen equity within this existing work, rather than create a parallel response. The three Tier 1 populations became the initial focus of the Action Plan, where they are named, people experiencing socioeconomic disadvantage or financial toxicity, people experiencing emotional or psychological distress, and people from regional and rural communities. Carers are named throughout the plan as a group whose needs cut across all three.

Figure 3. *Prioritisation scores for the 12 priority populations, by tier*



Population names are those used at the prioritisation stage. *Named 'people experiencing emotional or psychological distress' in the Action Plan.

Phase 2 Result: What Think Tank Participants Said

The thematic analysis produced 139 themes: 46 for socioeconomic disadvantage or financial toxicity, 33 for emotional or psychological distress, 25 for regional and rural communities and 35 for carers. For this report the themes were grouped into 22 concept areas. Seven appeared in all four groups.

Participants' words, as recorded in the Think Tank 1 notes, illustrate the shared findings:

> *"Felt like a **chasm** after that last appointment. It was like a **deathly silence**."* —
> Patient, regional and rural community
>
> *"Had to **take responsibility to find the supports** available."* —
> Patient experiencing socioeconomic disadvantage or financial toxicity
>
> *"I did not have enough information at the time and was **in a complete void.**"* —
> Patient experiencing socioeconomic disadvantage or financial toxicity
>
> *"Oncologists need **to ask at every appointment** how you are doing psychologically"* —
> Patient experiencing emotional or psychological distress
>
> *"**Nobody warned me** about the brain fog"* —
> Patient experiencing emotional or psychological distress
>
> *"**I felt like a ghost** in the room"* —
> Carer

Not all findings came from consumers. Of the 139 themes, 97 include evidence recorded in a consumer-only session. Twenty-six rest only on Think Tank 2, where the notes did not separate consumer from expert contributions, and six regional and rural themes rest only on the Bendigo clinician session. Ten carer themes draw on an interview record that was not available for this review. Appendix E lists every theme with its source. Table 7 sets the shared findings beside those that were more specific to one group.

Table 7. *Shared and group-specific findings from the Think Tanks*

Focus area	Shared across the groups	More specific to one group
Navigation	• No single point of contact when care spans teams or hospitals • Little preparation for what comes next • Contact stops abruptly when treatment ends	• Regional and rural: travel for tests that are available locally; appointment times that ignore travel; weather and transport disruption (raised by clinicians) • Socioeconomic: income support systems too slow for the pace of treatment
Communication	• Information arrives late, is generic or comes in one format only • Being heard and respected matters as much as content	• Psychological distress: cognitive effects of treatment not explained; physical symptoms attributed to mental health; information hard to absorb at diagnosis • Carers: not included in conversations or asked about their own wellbeing
Supports and services	• Supports exist but people find them by chance • Peer and community connection is valued • Help arrives after a crisis, not before (three groups)	• Socioeconomic: costs of parking, travel, childcare and medicines; eligibility rules that exclude people with cancer • Distress: inconsistent access to cancer-specific psychological support • Regional and rural: fewer local supports • Carers: no structured support for the caring role

Phase 3 Result: The DEI Action Plan

The DEI Action Plan contains 15 strategic actions, five under each PCXS objective (Table 8; full plan in Appendix G). Each action states what it means in plain language, who it is for, when accountability will be established and how it will be measured.

Table 8. *The 15 strategic actions and their origin*

ID	Strategic action	Priority population	Origin
N1	Provide an equity-focused cancer navigation model	All three groups	Consumer-prioritised (central point of contact)
N2	Provide inclusive, tailored navigation support	All three groups	Consumer-prioritised (orientation program)
N3	Reduce barriers to equitable care pathways	All three groups	Consumer-prioritised (appointment access and digital inclusion)
N4	Expand equitable regional access and care closer to home	Regional and rural; socioeconomic	Consumer-prioritised (regional patient support)
N5	Strengthen equitable care transitions and shared care	All three groups	Consumer-prioritised (planned transition); detail by project team
C1	Deliver accessible, personalised and inclusive information	All three groups	Consumer-prioritised (staged information packs)
C2	Build an equity-responsive communication workforce	All three groups	Consumer-prioritised (equity-capable workforce); detail by project team
C3	Include carers and families in equitable communication	All three groups	Added by project team from carer themes
C4	Provide inclusive communication for people experiencing emotional or psychological distress	Emotional or psychological distress	Added by project team from distress themes
C5	Use equity data and co-design to improve communication	All three groups	Part consumer-prioritised (feedback loop); mainly project team
S1	Embed equitable, proactive supportive care screening	All three groups	Consumer-prioritised (proactive psychosocial and practical support)
S2	Identify and respond early to financial toxicity	Socioeconomic; regional and rural	Consumer-prioritised (proactive financial support)
S3	Reduce inequitable financial barriers to cancer care	Socioeconomic; regional and rural	Part consumer-prioritised (financial support); developed from themes
S4	Expand inclusive mental health, peer and carer support	Emotional or psychological distress	Consumer-prioritised (peer support) with psychological support themes
S5	Strengthen equitable connections to community supports	All three groups	Consumer-prioritised (community supports); detail by project team

N = objective 1.2, navigation; C = objective 2.4, communication; S = objective 3.2, supports and services.

Thirteen of the 15 actions trace to one of the 10 actions consumers prioritised in Think Tank 3. Three of those 10 were each divided into two strategic actions: orientation and information (N2 and C1), financial support (S2 and S3), and workforce and feedback (C2 and C5). Two actions, on including carers and families (C3) and on communication for people experiencing emotional or psychological distress (C4), were added by the project team from the themes. Of the 139 themes, 133 map to a strategic action. Three reported barriers have no direct action: seeing a different clinician at each visit, access to a service being blocked when a patient is admitted under a partner hospital, and inpatient meal portions (Appendix F). Figure 4 summarises the path from evidence to action.

Figure 4. *The evidence-to-action pathway*

Consumer-only steps: Think Tanks 1 and 3. Mixed step: Think Tank 2. Project team steps: thematic analysis, strategic actions, outputs and measures.

Phase 4 Result: Implementation Plan, Measures and Governance

Implementation Plan. The 15 actions break down into 60 outputs and 164 activities (Appendix H). Twenty-five outputs trace to a specific participant suggestion, 25 were designed by the project team in response to a documented barrier, and 10 are implementation steps such as baseline mapping. Resourcing status was recorded for every output: 15 are resourced, 23 are partly resourced, 18 need new funding and four need a business case. Fifty-three outputs build on existing or planned work. Seven have nothing to build on: navigation response standards, a regional disruption plan, a shared-care handover standard, a consent-based protocol for recording mental health history, clinical prompts to guard against diagnostic overshadowing, a financial toxicity screen, and cost information before treatment decisions.

Measures. The measure set has 30 equity outcome measures, two for each action (Appendix I). Each compares a priority group with all patients. Targets are set as an improvement from a measured baseline, most often closing the gap by half within 24 months. Only one of the three groups, people from regional and rural communities, can be identified in Peter Mac data now. The other two cannot be identified until the screening outputs (S1.3 and S2.2) are delivered.

Governance. The governance structure names an objective executive for each objective and proposes an action owner and a delivery lead for each action, by position. Reporting runs through the existing PCXS line to the Community Advisory Committee and the Executive Quality and Safety Committee (Appendix J).

Table 9. *Outcome measures*

Measure	Baseline	Target	Result	Descriptive summary
DEI Action Plan co-designed, complete and ready for handover	No DEI Action Plan	100% complete and endorsed	Complete and endorsed	Met. Endorsed by Peter Mac and WCMICS and handed over at the end of September 2026.
Priority populations defined and agreed (populations agreed / populations identified)	No agreed definitions	100%	12 of 12 (100%)	Met. All 12 defined and assessed; three selected as the initial focus. Three definitions rely on published estimates.
Journey maps completed (maps completed / maps planned)	0	100%	0 of 3 (0%)	Not met. Journey discussions and thematic analysis were completed for the three groups and carers; visual maps were not produced and have been left with the Patient Experience and Wellbeing team to produce.

4.2 Process Measures

Table 10 reports the four process measures from the project plan.

Table 10. *Process measures*

Measure	Baseline	Target	Result	Descriptive summary
Planned deliverables produced (produced / planned)	0	100% within timeframe	8 of 9 (89%)	Journey maps were not produced.
Stakeholder engagement sessions delivered (delivered / planned)	0	100%	3 of 3 (100%)	All three Think Tanks were delivered. A clinician session and individual interviews were added.
Completeness of data review (datasets reviewed / datasets identified)	0	100%	2 of 2 (100%)	Peter Mac activity data and WCMICS admitted-patient data were reviewed. Three populations could not be identified in either.
Actions aligned to PCXS objectives (aligned / total)	0	100%	15 of 15 (100%)	Five actions sit under each of objectives 1.2, 2.4 and 3.2.

4.3 Balancing Measures

Table 11 reports the balancing measure.

Table 11. *Balancing measure*

Measure	Baseline	Target	Result	Descriptive summary
Stakeholder consultation fatigue (missed sessions or complaints / planned sessions)	Not applicable	10% or fewer missed sessions, or minimal negative feedback	0 of 3 sessions missed	Consumer attendance was 11, 10 and 8 of 11 across the three Think Tanks. Think Tank evaluation survey results were positive.

Section 5: Discussion

5.1 Summary of Key Findings

The approach suited the problem. The project began with a broad commitment, 12 possible populations and six months. Working in sequence, deciding where to start, then listening, then designing, then planning delivery, meant each phase narrowed the next. Prioritising first gave the engagement a clear focus. Ending with resourcing and measurement meant the plan was tested against what Peter Mac can deliver and observe.

The prioritisation matrix strengthened the consistency and transparency of the prioritisation process. Multi-criteria approaches are useful in health priority setting because decisions of this kind involve several considerations that cannot be reduced to one number.[14] Here the matrix changed the order of priority. Ranked by size alone, older people (53% of patients) would come first and people experiencing socioeconomic disadvantage (17%) seventh of 12. Considering severity, system gap and existing response moved attention towards groups for whom the system currently does least. The matrix does not remove judgement. Scores were assigned by the project team on a three-point scale, the criteria were equally weighted, and a single point on one criterion separates the lowest Tier 2 score from the highest Tier 3 score. Its contribution is that the reasoning can be read, questioned and transferred to other health services.

The project benefited from a mixed-methods approach to understanding current state. Activity data showed how many people were affected, but could not see three of the 12 populations at all. Published evidence established that inequities exist and how severe they are, including the legal and financial effects of cancer on work, income and housing for patients and carers.[15] The environmental scan showed what Peter Mac already does. Only lived experience showed how barriers are met in practice, such as learning about a support service by chance or being left without contact after the last appointment. No single evidence source would have produced the Action Plan.

The Think Tanks shaped the action plan. The link is direct for most actions. Thirteen of 15 come from actions consumers prioritised, and 25 outputs match a specific suggestion, including a single contact route with the option to speak to a person, a check-in call about a week after treatment ends, and wellbeing checks made as routinely as vital signs. The engagement is best described as informed by co-design principles, not as full co-design. Consumers identified problems, proposed and prioritised actions and reviewed a draft, which corresponds to the 'involve' and 'collaborate' levels of the IAP2 spectrum.[8] The project team wrote the final actions, the outputs and the measures, and decisions rested with the working group and sponsor.

Intersectionality showed in the findings more clearly than in the method. Scoring populations one at a time treats them as separate, but participants did not describe themselves that way. Several identified with more than one group, cost, distance and distress were described as compounding one another, and seven of the 22 concept areas were shared by every group. Ten of the 15 actions are directed at all three groups together, which fits how people described their experience and action in the shared areas may benefit people outside the three groups, although that has not been tested.

The method is transferable. Its components are a criteria-based matrix, short structured workshops with consumers and staff, an implementation plan written as outputs with a resourcing status, and measures set from a baseline. None depends on Peter Mac's size or specialty. Other health services would need to apply their own data and consumers; the scores and themes reported here are specific to Peter Mac.

The initial focus is a starting point, not an exclusion. A consumer said at the first Think Tank that naming three groups can make it seem as if the others do not exist. The tier model is the project's answer. It gives every population a recommended response, and the Tier 2 and Tier 3 populations remain priorities, to be addressed by scaling existing services and embedding equity in established programs. Placing the Action Plan under the PCXS ensures equity is reported through the Strategy's own governance, so it is treated as part of patient experience and not as a separate program.

5.2 Achievement of Project Aim

Project aim: To translate the equity intent of the Patient and Carer Experience Strategy into a practical, co-designed Diversity, Equity and Inclusion Action Plan with clearly defined measures and metrics to monitor progress, ready for Peter Mac implementation as business as usual by September 2026.

Achievement met: Met.

Key factors influencing achievement:

- The Action Plan, Implementation Plan, measure set and governance structure were completed, endorsed and handed over by the end of September 2026.
- A dedicated WCMICS project lead and a weekly working group kept decisions moving within a six-month timeframe.
- Early agreement on three priority groups gave the engagement a clear focus.
- The objective to co-design patient journey maps was partially met. Journey discussions and analysis were completed, but maps were not produced.
- 'Co-designed' is qualified. Consumers shaped and prioritised the actions, and the project team completed the detail.

5.3 Assessment of Value

No financial analysis was undertaken, because the project had no budget and produced plans, not service changes. Its value is qualitative. For about 0.6 EFT over six months, Peter Mac received an endorsed plan for three PCXS objectives that had no actions, with resourcing needs identified before commitments were made. The register of 110 existing and planned initiatives reduces the risk of duplicating work. The measure design avoids reporting equity results that the data cannot yet support.

5.4 Challenges and Limitations

- **Participation was small and not representative.** Eleven consumers took part, including two carers and four people from regional or rural communities. All were members of Peter Mac's Consumer Register and may be more engaged and confident than other patients. The findings describe these participants' experiences and should not be read as the views of whole populations. People who face the greatest barriers to taking part, including people who need an interpreter, are the least likely to have been heard.
- **Sessions were short.** Three sessions of about 75 minutes limited depth and Think Tank 3 did not complete implementation detail for all 10 draft actions.
- **Contributions cannot always be attributed.** Think Tank 2 notes do not separate consumer from expert input, and transcripts were not available for this review.
- **Prioritisation rested on judgement and incomplete data.** Three populations were sized from published estimates. Socioeconomic disadvantage was measured by area, not by person. Scoring thresholds were not written down, scores were assigned by the project team, and each population was scored separately.
- **AI tools supported the analysis.** Microsoft Copilot was used to support coding, with reviewer judgement applied to all themes (Appendix K).

5.5 Lessons Learned

- **Direct engagement shows what routine data cannot.** Consumers described navigation, communication and support barriers that do not appear in activity data.
- **Settle the prioritisation method before collecting evidence.** Changes to the approach during Phase 1 resulted in approximately a one-month delay, reducing preparation time for the Think Tanks and subsequently delaying Think Tank delivery
- **Be clear about the difference between co-design and consultation, and plan time accordingly.** Longer sessions, planned as a series from the outset, would let consumers complete the design of actions.
- **Recruit carers deliberately.** A general expression of interest reached few carers.
- **Write actions as outputs with a resourcing status.** Reviewers asked what could actually be delivered. Recording resourcing made the plan more credible and focused the funding discussion.
- **Phase equity work, and work in partnership.** Addressing all populations at once would have diluted effort. Input from consumers, clinicians, operational staff and external organisations

Section 6: Future directions

6.1 Sustainability Planning

The WCMICS Change Readiness and Sustainability Assessment was not completed for this project, so scores are not reported. Sustainability rests instead on four design choices:

- The Action Plan sits under the PCXS and reports through its governance. It does not rely on a separate program.
- Each action has a proposed owner identified by position, so responsibility does not depend on individuals.
- Fifty-three of the 60 outputs build on work already under way or planned.
- Resourcing gaps are documented, so funding decisions can be made before work begins.

The main risks to sustainability are the 22 outputs without confirmed funding, and the time-limited funding of some existing services that the outputs build on.

6.2 Monitoring and Evaluation Plan

Monitoring begins with baselines. For most measures, a baseline is set over the first two quarters, and each priority group is then reported beside the figure for all patients. Year one is a baseline year. The measures draw on five existing sources: real-time patient feedback, the Victorian Healthcare Experience Survey, compliments and complaints, demographic and activity data, and service records. Three safeguards are built in: results based on fewer than 10 people are not reported, complaint measures are read alongside experience measures, because complaints can rise when people feel safer to complain and one measure checks whether the people giving feedback reflect the people Peter Mac treats.

Regional and rural status will be derived from residential locality using the Modified Monash Model.[16] For the other two groups, the measure set proposes validated screening: a financial toxicity screen consistent with the Clinical Oncology Society of Australia (COSA) roadmap,[17] and distress screening with a defined referral threshold. Until these are in place, area-level and service-use indicators will be reported and labelled as such.

Figure 5. *Governance and monitoring cycle for the DEI Action Plan*

Figure 5 shows the reporting line and the monitoring cycle. Any measure where a priority group sits 10 or more percentage points below all patients is listed in a six-monthly equity gap report, with a named owner and a date. Members of the Consumer Register and the Community Advisory Committee, including people from all three groups, have a defined role in testing whether changes work. Each action that proceeds as a project will also set its own process and balancing measures.

6.3 Recommendations

For Peter Mac

1. Confirm an owner for each action and convene the DEI Implementation Group, starting with the 15 resourced outputs.
2. Take baseline measurements before any service change, and build regional and rural identification into routine reporting first.
3. Give priority to the outputs that make the other two groups identifiable: supportive care screening (S1.3), the financial toxicity screen (S2.2) and the consent-based protocol for mental health information (C4.1).
4. Decide the status of the 22 outputs that need new funding or a business case as a commitment, aspiration or deferral.
5. Complete the patient journey maps from the Think Tank material and use them to brief action owners.
6. Continue co-design within each action, with longer sessions, separate recruitment of carers, and methods that reach people outside the Consumer Register, including people who need an interpreter.
7. Refer the three barriers without an action (clinician continuity, service access across precinct partners and inpatient meals) to the relevant Peter Mac or precinct forum.
8. Review the prioritisation at agreed intervals and extend the approach to Tier 2 and Tier 3 populations, working through established programs and with the communities concerned.

For WCMICS

1. Share the method and tools with member health services and other Integrated Cancer Services.

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Appendices

Appendix A: Program Logic

The program logic was agreed at the start of the project and is reproduced from the project source, with abbreviations written in full (Table A1). Changes made during delivery are described in Section 3.4.

Table A1. *Program logic*

Element	Content
Inputs	• 0.4 EFT WCMICS project officer • 0.2 EFT Peter Mac project officer • Existing Peter Mac and WCMICS partnerships • Relevant Peter Mac and VCCC Alliance strategies and frameworks • Relevant Peter Mac and WCMICS data
Activities	• Review existing data to identify and understand priority population groups at Peter Mac • Lead and facilitate co-design workshops • Develop the DEI Action Framework and Implementation Plan • Establish and implement the stakeholder engagement strategy • Develop a co-designed, defined DEI measurement set • Align the DEI governance structure to existing governance structures • Coordinate implementation, transition to business as usual and project closure
Outputs	• Project plan • Stakeholder engagement matrix and plan • Documented Peter Mac priority population groups for the focus of the DEI Action Plan • Co-designed patient journey maps highlighting barriers, enablers and experiences, aligned to the Optimal Care Pathways • Defined DEI measures and metrics • DEI governance aligned to the PCXS structure • DEI Action Plan (including framework and implementation plan) • Handover pack and project closure report
Short-term outcomes	• Agreed and documented definition of priority population groups for PCXS-related DEI focus • Equity is positioned within PCXS governance • Regular reporting to working groups and the Community Advisory Committee • The three core objectives for the DEI Action Plan within the PCXS are mapped to the VCCC Alliance Cancer Equity Framework • Patient journey maps inform where inequities occur along the cancer care continuum for priority populations at Peter Mac • Consumers and key stakeholders are meaningfully engaged and informed through structured governance and reporting pathways • Alignment of the Disability Accessibility Plan with the PCXS
Medium-term outcomes	• The PCXS has an agreed DEI measurement approach • DEI Action Plan (including framework and implementation plan) • Ownership of actions and monitoring responsibilities clarified • Shared understanding of governance and monitoring approach • Documented DEI metrics and governance framework • Documented DEI measures and sustainable metrics
Long-term outcomes	• Co-designed DEI Action Plan, aligned with the VCCC Alliance Cancer Equity Framework, formally handed over to Peter Mac • Peter Mac positioned to embed equity initiatives in the PCXS

Appendix B: Prioritisation Method, Definitions and Data

Four sources of evidence were assembled for each of the 12 priority populations in the Victorian Cancer Plan.[2]

- **Population data.** Unique patient counts for 2025–26 were extracted from Peter Mac's data analytics system on 18 May 2026 (44,948 patients). Definitions followed established policy definitions where these exist and were otherwise agreed with 12 subject-matter experts. WCMICS admitted-patient data were also reviewed. Where Peter Mac data could not identify a population, a published national estimate was applied (Table B1).
- **Rapid literature review.** Australian, cancer-specific peer-reviewed and grey literature on barriers, experience and outcomes was summarised for each population, informing the severity and system gap scores.
- **Environmental scan.** About 110 existing services, programs and initiatives were identified through a desktop review and a structured walk-through of frontline services led by Peter Mac's patient experience team. Each was mapped to the populations it serves, informing the system maturity and duplication risk scores.
- **Strategic alignment mapping.** PCXS objectives 1.2, 2.4 and 3.2 were mapped against the VCCC Alliance framework,[7] the Victorian[2] and Australian[3] cancer plans, the Parkville precinct plan[4] and the Disability Accessibility Plan,[6] informing the alignment score.

Table B1. *Definitions and size of the 12 priority populations*

Priority population	Definition used	Share of patients	Basis
Older people	Aged 65 years or older, or 50 years or older for Aboriginal and Torres Strait Islander people	53%	Counted
People experiencing mental health issues	Published estimate that about 35% of people diagnosed with cancer experience clinically significant psychological distress[18]	35%	Estimate
People with rare or less common cancers	Australian Institute of Health and Welfare definitions of rare and less common cancers[19]	28%	Counted
People from regional and rural communities	Residence in a local government area classified as non-metropolitan[20]	27%	Counted
Culturally and linguistically diverse people	Born in a country where English is not the main language	24%	Counted
People with disability	Published estimate that 21.4% of Australians have disability, as cited in the Disability Accessibility Plan[6]	21%	Estimate
People experiencing socioeconomic disadvantage	Residence in a local government area in the most disadvantaged 20% on a Socio-Economic Indexes for Areas index[21]	17%	Counted (area level)
LGBTQIA+ people	Published estimate that 4.5% of Australians aged 16 years and over are LGBTI+[22]	4.5%	Estimate
People with low-survival cancers	Cancers with the lowest five-year survival, as identified in the Victorian Cancer Plan[2]	2.8%	Counted
Adolescents and young adults	Aged 15 to 25 years	2%	Counted
Children	Aged 18 years or younger	1.5%	Counted
Aboriginal and Torres Strait Islander peoples	Patients who identify as Aboriginal and/or Torres Strait Islander	0.9%	Counted

Limits of the population data. Three populations (mental health issues, disability and LGBTQIA+ people) are not reliably recorded in routine data, so national estimates were applied. These show likely scale, not the number of Peter Mac patients. Socioeconomic disadvantage was measured by area of residence, which does not identify individuals or capture financial toxicity caused by cancer. Project documents refer to two different area indexes, and the count behind the 17% figure could not be traced.

Appendix C: Prioritisation Matrix and Tiers

The project team scored each population using an equally weighted multi-criteria matrix: scale, inequity severity, system gap, system maturity (inverse), strategic alignment and duplication risk (inverse). Each criterion was scored from 1 to 3 based on the evidence in Appendix B. The overall score is the mean of the six criteria. For the two inverse criteria, a higher score means a less mature existing response or a lower risk of duplication. The thresholds used to convert evidence into a score of 1, 2 or 3 were not documented. Table C1 gives the scores and Table C2 describes the tiers.

Table C1. *Weighted prioritisation matrix*

Priority population	Scale	Severity	System gap	System maturity (inverse)	Alignment	Duplication risk (inverse)	Score	Tier
People from regional and rural communities	3	3	3	2	3	3	2.8	1
People experiencing mental health issues	3	3	3	2	3	3	2.8	1
People experiencing socioeconomic disadvantage	2	3	3	3	3	3	2.8	1
People with rare or less common cancers	3	2	2	2	2	3	2.3	2
People with low-survival cancers	1	3	2	2	2	3	2.2	2
LGBTQIA+ people	1	2	2	2	2	3	2.0	2
Culturally and linguistically diverse people	2	2	2	2	2	2	2.0	2
Adolescents and young adults	1	2	2	2	2	2	1.8	3
Aboriginal and Torres Strait Islander peoples	1	3	2	1	3	1	1.8	3
Older people	3	2	1	1	2	2	1.8	3
Children	1	2	2	2	1	3	1.8	3
People with disability	2	2	2	1	2	1	1.7	3

Table C2. *Prioritisation tiers*

Tier	Populations	What the scores showed	Recommended response
1. Foundational equity redesign	• People from regional and rural communities • People experiencing mental health issues • People experiencing socioeconomic disadvantage	High severity, significant system gaps, strong alignment with the PCXS objectives and little overlap with existing initiatives. Existing responses are limited or fragmented.	Address underlying system barriers and redesign how care is designed, coordinated and accessed. Initial focus of the DEI Action Plan.
2. Equitable service scaling	• People with rare or less common cancers • People with low-survival cancers • LGBTQIA+ people • Culturally and linguistically diverse people	Meaningful inequities in specific areas. Existing services partly address need but are inconsistently applied or limited in reach.	Strengthen and scale existing services and close targeted gaps, building on current capability.
3. Embedded equity practice	• Adolescents and young adults • Aboriginal and Torres Strait Islander peoples • Older people • Children • People with disability	Established programs, roles, governance or strategies exist. Severity remains moderate to high for some groups, particularly Aboriginal and Torres Strait Islander peoples.	Integrate DEI within existing strategies and governance, and continue to improve them. Avoid separate initiatives that could fragment effort.

Appendix D: Engagement Method and Participation

Approach

Engagement and co-design were informed by Experience-Based Co-Design principles[9] and the NSW Agency for Clinical Innovation co-design toolkit.[10] The work was a quality improvement activity and did not require ethics review. The information pack told participants how their information would be used and that all reporting would be de-identified.

Recruitment

An expression of interest was sent through Peter Mac's Consumer Register newsletter on 17 June 2026 and closed on 24 June 2026. Purposive follow-up through existing relationships was used to reach people with lived experience relevant to the three priority groups, including carers. All 11 consumers who took part were members of the Consumer Register. Subject-matter experts included Peter Mac staff and representatives of external organisations.

Sessions

The three Think Tanks were held on 6, 20 and 27 July 2026. Each was advertised for 12:00 pm to 1:15 pm and could be attended in person at Parkville or online. An information pack with pre-reading and the questions to be asked was sent in advance. Some participants also gave their account in individual interviews. A separate session with five clinicians at Peter Mac's Bendigo campus worked through the Think Tank 2 activities for regional and rural patients and carers. Table D1 shows consumer participation.

Table D1. *Consumer participation by session and priority group*

Session	Consumers	Socioeconomic disadvantage or financial toxicity	Emotional or psychological distress	Regional and rural communities	Other participants
Think Tank 1 (6 July)	11 (9 patients, 2 carers)	7 patients	6 patients, 2 carers	4 patients	None
Think Tank 2 (20 July)	10 (8 patients, 2 carers)	5 patients	6 patients, 2 carers	3 patients	21 subject-matter experts
Think Tank 3 (27 July)	8 (7 patients, 1 carer)	4 patients	5 patients, 1 carer	3 patients	None

Recording and Analysis

The project team recorded discussions in structured notes. Transcripts were not available for all Think Tank data. The notes were analysed thematically, informed by Braun and Clarke's approach.[12] Comments were sorted by the three PCXS focus areas (navigation, communication, and supports and services) and into four categories (values, barriers, enablers and implementation considerations). Three reviewers each analysed one population's data using a shared framework and a common Microsoft Copilot prompt. The team then reviewed all themes together. Carer comments were analysed as a fourth group.

Appendix E: Think Tank Findings by Group and Focus Area

This appendix lists the 139 themes from the thematic analysis, in the wording of the Think Tank Findings Report, with one table for each group (Table E1, Table E2, Table E3 and Table E4). The last two columns were added for this report. 'Source' shows where the supporting evidence was recorded. 'Action' shows the strategic action that most directly responds to the theme (Appendix F). Consistent with the Action Plan, 'journey' has been replaced with 'experience' where it described a person's cancer care. Theme IDs show the group (SES, socioeconomic disadvantage or financial toxicity; DIS, emotional or psychological distress; RR, regional and rural communities; CAR, carers), the focus area (N, C or S) and the category.

Source codes. C: includes evidence from a consumer-only session. M: Think Tank 2 only, where consumer and expert contributions were not separated. S: Bendigo clinician session only. N: source record not reviewed.

Category codes. V: value. B: barrier. E: enabler. I: implementation consideration.

Table E1. *Themes: people experiencing socioeconomic disadvantage or financial toxicity (46 themes)*

ID	Focus area	Cat.	Theme	Source	Action
SES-N-V1	Navigation	V	**Being Heard and Taken Seriously on Time.** Participants valued early recognition of concerns and prompt referral into specialist cancer services.	C	None
SES-N-V2	Navigation	V	**Maintaining Community and Family Connection.** Participants viewed cancer as affecting whole support networks and valued maintaining connection with communities and carers throughout care.	C	S5
SES-N-B1	Navigation	B	**Fragmented Navigation and Care Coordination.** Across diagnosis and treatment, participants described delays, inconsistent referral pathways and difficulties accessing psychosocial and allied health supports. Navigation often depended on clinician knowledge, patient self-advocacy and chance rather than a coordinated pathway.	C	N1
SES-N-B2	Navigation	B	**Lack of Continuity and Trusted Relationships.** During treatment, continuity of care was highly valued. Frequent changes in providers disrupted trust, relationship-building and confidence in care.	C	(S4)
SES-N-B3	Navigation	B	**Poor Preparation and Uncertainty Across the Pathway.** Participants described uncertainty at referral, diagnosis and treatment commencement. Lack of anticipatory guidance increased anxiety and reduced preparedness for managing treatment demands.	C	N2
SES-N-B4	Navigation	B	**Access Difficulties Related to Appointment Burden.** The logistical complexity of treatment schedules created substantial burden, particularly for those balancing travel, employment and competing responsibilities.	C	N3

ID	Focus area	Cat.	Theme	Source	Action
SES-N-B5	Navigation	B	**Financial Circumstances Limit Capacity to Navigate Care.** Financial insecurity reduced capacity to engage with recommended services and adapt daily life around cancer care. Resource constraints affected both treatment engagement and wellbeing.	C	S2
SES-N-B6	Navigation	B	**Health Literacy and System Literacy Create Navigation Inequities.** Participants experiencing socioeconomic disadvantage reported reduced confidence and ability to navigate complex healthcare systems, advocate for referrals and engage with participation opportunities.	C	N2
SES-N-B7	Navigation	B	**Structural Systems Are Not Designed for Cancer-Related Financial Hardship.** Participants described social support systems as poorly aligned to the rapid and fluctuating nature of cancer treatment, creating additional hardship at critical points in the pathway.	C	S3
SES-N-E1	Navigation	E	**Timely Psychosocial Support Reduces Distress.** Psychological support and normalisation of treatment experiences improved confidence and reduced uncertainty during treatment.	C	S4
SES-N-E2	Navigation	E	**Flexible Models of Care Improve Access.** Flexible delivery models reduced travel burden and improved access to care.	C	N4
SES-N-E3	Navigation	E	**Community-Based Advocacy and Practical Assistance Fill System Gaps.** Participants frequently relied on community organisations and informal supports when mainstream systems were inaccessible.	C	S5
SES-N-E4	Navigation	E	**Financial Entitlements Enable Treatment Participation.** Access to Medicare, PBS subsidies and employment leave entitlements substantially reduced barriers to treatment engagement.	C	S3
SES-N-E5	Navigation	E	**Preparedness Through Information.** Preparation and orientation around what to expect with the cancer experience, and how to access available services improved consumer experience.	C	N2
SES-N-I1	Navigation	I	**Meet People Where They Are.** Future initiatives should include proactive outreach and flexible support models for people unable to access mainstream financial and social supports.	C	S1
SES-C-V1	Communication	V	**Information That Supports Preparedness.** Participants valued practical information that helped them anticipate treatment and survivorship challenges.	C	C1
SES-C-V2	Communication	V	**Respectful and Responsive Communication.** Patients valued appointments that provided time for discussion, clarification and shared decision-making.	C	C2

ID	Focus area	Cat.	Theme	Source	Action
SES-C-V3	Communication	V	**Accessible and Actionable Information.** Participants valued feeling prepared through provision of accessible educational resources.	C	C1
SES-C-V4	Communication	V	**Post Treatment Information Needs.** Participants valued resources and information around survivorship preparation.	C	N5
SES-C-B1	Communication	B	**Information Gaps Create Anxiety Across the Care Experience.** Participants reported uncertainty during diagnosis, treatment and survivorship when information was absent, delayed or poorly timed.	C	C1
SES-C-B2	Communication	B	**Post-Treatment Communication Gap.** Transition to survivorship was characterised by reduced communication and support, leaving patients feeling disconnected from care.	C	N5
SES-C-B3	Communication	B	**Need for Personalised Information.** Patients wanted tailored, practical and stage-specific information rather than broad generic resources.	M	C1
SES-C-B4	Communication	B	**Cognitive and Emotional Impacts of Communication.** The cognitive and emotional impact of diagnosis and treatment can affect patients' ability to comprehend, process and retain the information communicated to them.	C	C1
SES-C-B5	Communication	B	**Resource Barriers to Self-Advocacy.** Resource limitations reduced ability to seek information, ask questions and navigate available supports.	M	S1
SES-C-B6	Communication	B	**Health Literacy Intersects with Financial and Cultural Barriers.** Socioeconomic disadvantage compounded communication barriers where language, health literacy and cultural factors were also present.	M	C1
SES-C-E1	Communication	E	**Trusted Clinical Relationships Support Information Sharing.** Trusting clinician relationships enabled tailored communication and improved understanding.	C	C2
SES-C-E2	Communication	E	**Digital Literacy Supports Engagement.** Patients with strong digital skills were better able to access information and communicate throughout their care experience.	C	N3
SES-C-E3	Communication	E	**Communication Support Tools.** Open communication channels allow family networks to stay connected and are deemed as an enabler throughout the cancer experience.	C	C3
SES-C-I1	Communication	I	**Structured and Diverse Information Formats.** Multimodal resources including video, visual and plain-language content are required to meet diverse communication needs.	C	C1
SES-S-V1	Supports and services	V	**Early Access to Financial Support Information.** Participants wanted financial support discussions integrated into routine cancer care.	C	S2

ID	Focus area	Cat.	Theme	Source	Action
SES-S-V2	Supports and services	V	**Family Stability During Treatment.** Maintaining family functioning and caregiving arrangements was a central concern throughout treatment.	C	S3
SES-S-V3	Supports and services	V	**Trust and Safety in Service Delivery.** Patients value services that feel safe, trustworthy, and non-judgmental, particularly where stigma and experiences of historical or systemic harm may influence willingness to seek and engage with care.	M	C2
SES-S-B1	Supports and services	B	**Limited Awareness and Navigation of Support Services.** Participants often learned about services late in their cancer experience, reducing opportunities for early intervention.	M	S5
SES-S-B2	Supports and services	B	**Non-Clinical Supports Are Difficult to Access.** Support systems were frequently reactive rather than preventative, resulting in delayed assistance.	M	S1
SES-S-B3	Supports and services	B	**Carer Support Needs Are Unmet.** Carers required information and support to fulfil care roles and maintain wellbeing.	M	C3
SES-S-B4	Supports and services	B	**Barriers to Engaging with Support.** Treatment demands and cognitive overload, alongside stigma and discomfort around seeking assistance can limit patients' capacity and willingness to engage with available supports.	M	S1
SES-S-B5	Supports and services	B	**Financial Toxicity Shapes Access to Care.** Financial hardship directly influenced treatment options, service access and perceived equity of care.	C	S3
SES-S-B6	Supports and services	B	**Eligibility Systems Exclude People Affected by Cancer.** Participants described systemic gaps where eligibility frameworks did not reflect the realities of cancer-related disability and income disruption.	M	S3
SES-S-B7	Supports and services	B	**Visa Status and Medicare Eligibility Create Extreme Vulnerability.** For some participants, socioeconomic disadvantage intersected with migration status, creating profound barriers to treatment, medications and support.	C	S3
SES-S-B8	Supports and services	B	**Daily Living Costs and Support Needs Become Cancer Care Barriers.** Participants described transport, childcare, accommodation and living expenses as significant determinants of access to treatment.	C	S3
SES-S-B9	Supports and services	B	**Barriers to Proactive and Accessible Support.** Gaps in proactive support and unequal access to the time, technology and resources needed to navigate services can leave patients without assistance until they reach a crisis point.	M	S1
SES-S-E1	Supports and services	E	**Practical Social Support Improves Stability.** Housing and practical support reduced stress and improved capacity to engage in treatment.	C	S1

ID	Focus area	Cat.	Theme	Source	Action
SES-S-E2	Supports and services	E	**Peer and Community Support Reduce Isolation.** Peer connection helped address emotional and practical support needs not met through clinical care alone.	C	S4
SES-S-E3	Supports and services	E	**Targeted Charitable Supports Fill Critical Gaps.** Philanthropic and community organisations played a critical role where public systems could not meet needs.	C	S3
SES-S-E4	Supports and services	E	**Enabling Holistic and Proactive Support.** Access to timely financial assistance, recovery-focused services and early intervention can reduce barriers and provide patients with practical and holistic support throughout their care experience.	M	S1
SES-S-I1	Supports and services	I	**Shift From Reactive to Proactive Support Identification.** Participants consistently advocated for earlier identification of support needs and proactive connection to services before crisis points emerge.	M	S1

Table E2. *Themes: people experiencing emotional or psychological distress (33 themes)*

ID	Focus area	Cat.	Theme	Source	Action
DIS-N-V1	Navigation	V	**Safety and trust.** Participants valued security, confidence and trust from the earliest point of referral.	C	C4
DIS-N-V2	Navigation	V	**Psychological sensitivity from clinicians.** Psychological sensitivity to the impact of cancer was perceived as very important.	C	C4
DIS-N-B1	Navigation	B	**Uncertainty during referral and transitions.** Participants described uncertainty at referral and following treatment as distressing periods. Anxiety was heightened when communication, appointment scheduling, long wait times and future care arrangements lacked clarity.	C	N1
DIS-N-B2	Navigation	B	**Difficult access to information and navigation support.** Consumers reported difficulty accessing information and navigation supports early in the patient pathway, leading to increased reliance on self-navigation.	C	N2
DIS-N-B3	Navigation	B	**Psychological symptoms are insufficiently anticipated and normalised.** Participants experiencing psychological distress reported limited preparation for cognitive and emotional side effects. Distress was amplified when symptoms were unexpected and poorly explained.	C	C4

ID	Focus area	Cat.	Theme	Source	Action
DIS-N-B4	Navigation	B	**Mental distress driven by uncertainty and lack of psychological support.** A distinct need of this priority population was support to manage uncertainty, fear and emotional burden throughout the patient experience and during treatment. This was heightened following treatment where expectations to recovery do not match the reality for self and others.	C	S4
DIS-N-E1	Navigation	E	**Timely care and rapid progression through the system.** Timely commencement of treatment reduced distress and increased confidence in care.	C	N1
DIS-N-E2	Navigation	E	**Trusted clinical relationships.** Strong therapeutic relationships enhanced confidence and engagement in care.	C	C2
DIS-N-I1	Navigation	I	**Proactive information delivery in multiple formats.** Information should be repeated and accessible during periods of distress when information processing may be challenging.	M	N2
DIS-N-I2	Navigation	I	**Peer connection and psychosocial support.** Lived experience networks may reduce isolation and support emotional adjustment.	C	S4
DIS-N-I3	Navigation	I	**Routine psychological check-ins during treatment.** Participants perceived psychological screening as a core component of cancer care rather than an optional service.	C	S1
DIS-C-V1	Communication	V	**Emotional support, understanding and being heard.** Participants valued relational communication that acknowledged emotional needs alongside clinical information.	C	C4
DIS-C-B1	Communication	B	**Information overload and reduced comprehension.** Communication frequently occurred during periods of emotional overload, limiting information retention.	C	C1
DIS-C-B2	Communication	B	**Communication is not sufficiently personalised.** Patients reported variable communication experiences depending on individual clinicians. Participants spoke of a lack of multi-modal materials and need for interpreter support at initial appointments.	M	C1
DIS-C-B3	Communication	B	**Carers not provided tailored information or support.** Patients reported that carers lacked tailored information and were excluded from important communication materials.	M	C3
DIS-C-B4	Communication	B	**Diagnostic overshadowing, mental health stigma and system-wide continuity of care.** Mental health labels were perceived as creating barriers to timely assessment and care. Limited sharing of information across healthcare systems lead to less personalised information, treatment and support.	M	C4

ID	Focus area	Cat.	Theme	Source	Action
DIS-C-B5	Communication	B	**Cognitive effects of treatment are poorly explained.** Lack of communication regarding cognitive side effects contributed to fear, confusion and uncertainty. Participants expressed uncertainty about cognitive recovery and future functioning.	C	C4
DIS-C-E1	Communication	E	**Being heard and respected.** Active listening strengthened patient confidence and engagement.	C	C2
DIS-C-E2	Communication	E	**Written information on treatment and medication.** Participants reported information sheets on treatment schedule and medication to be useful.	C	C1
DIS-C-E3	Communication	E	**Empathetic communication.** Empathy reduced emotional burden and fostered psychological safety.	C	C2
DIS-C-E4	Communication	E	**Peer connection supports mental wellbeing.** Peer support functioned as both an information source and emotional coping strategy.	C	S4
DIS-C-I1	Communication	I	**Accessible, multilingual and multimodal communication.** Information should be delivered in multiple formats to accommodate emotional distress, literacy and communication needs. This should include multilingual and take-home resources, access to interpreters, and greater awareness of Peter Mac and available support services through multimodal information delivery. It should also include making patients explicitly aware of their main contact person at Peter Mac.	M	C1
DIS-C-I2	Communication	I	**Carer-inclusive communication.** Carers require dedicated information and emotional support to fulfil caregiving roles safely.	M	C3
DIS-S-V1	Supports and services	V	**Emotional recovery and restoring normality.** Participants valued support that facilitated psychological adjustment and re-engagement with life roles.	C	N5
DIS-S-B1	Supports and services	B	**Low visibility of support services.** Many participants described discovering support services accidentally rather than through systematic referral or signposting pathways.	C	S5
DIS-S-B2	Supports and services	B	**Fragmented support and care coordination.** Inconsistent continuity of care undermined confidence in support systems. This included fragmented care coordination and communication between health services such as hospitals, GP's and allied health services, and signposting between services.	C	N5

ID	Focus area	Cat.	Theme	Source	Action
DIS-S-B3	Supports and services	B	**Inconsistent access to specialised cancer mental health support.** Participants sought specialised and consistent psychological care that reflected the unique emotional consequences of cancer. This could be to help manage anxiety about self-management of treatment, indvidualised psychosocial needs, or the existential impacts of cancer.	C	S4
DIS-S-B4	Supports and services	B	**Mental health information sharing is fragmented.** Poor information continuity created risks for coordinated psychosocial care.	M	C4
DIS-S-B5	Supports and services	B	**Support services do not always address intersecting identities.** Participants highlighted a need for support options responsive to multiple overlapping identities and experiences.	M	S4
DIS-S-E1	Supports and services	E	**Follow-up and recovery supports.** Structured follow-up and allied health supports helped people rebuild confidence after treatment.	C	N5
DIS-S-E2	Supports and services	E	**Access to specialised oncology mental health care.** Psychological support was perceived as most effective when delivered by clinicians with cancer-specific expertise.	M	S4
DIS-S-I1	Supports and services	I	**Proactive psychosocial referrals.** Psychosocial services should be embedded and routinely offered rather than requiring self-advocacy. Improvements in information sharing of mental health history between GPs and healthcare organisations, noting confidentiality, patient autonomy and continuity of care.	M	S1
DIS-S-I2	Supports and services	I	**Community and peer-based support pathways and awareness.** Community-based psychoeducation and peer networks may extend support beyond hospital settings.	C	S5

Table E3. *Themes: people from regional and rural communities (25 themes)*

ID	Focus area	Cat.	Theme	Source	Action
RR-N-V1	Navigation	V	**Confidence Through Clear Planning.** Patients valued certainty, transparency and advance planning to support decision-making and personal logistics.	C	N2
RR-N-V2	Navigation	V	**Recognition of Regional Realities.** Participants valued care models that recognised the practical realities of living outside metropolitan Melbourne.	M	N4

ID	Focus area	Cat.	Theme	Source	Action
RR-N-B1	Navigation	B	**Navigating Complex and Fragmented Systems.** Participants described navigation burden occurring when care was delivered across multiple organisations without a consistent contact person. This challenge was most pronounced during diagnosis and treatment where coordination demands were highest.	C	N1
RR-N-B2	Navigation	B	**Geographic Inequity in Accessing Cancer Care.** Travel requirements created substantial time, financial and logistical burdens. This theme was unique to regional and rural participants because specialist care, diagnostics and treatment frequently required travel to metropolitan centres.	C	N4
RR-N-B3	Navigation	B	**Rural Vulnerability to Environmental and Transport Disruption.** Environmental events emerged as a distinctly rural barrier, increasing risks of missed appointments and treatment delays.	S	N4
RR-N-E1	Navigation	E	**Coordinated Care Pathways.** Dedicated navigation roles reduced complexity and improved confidence during treatment.	M	N1
RR-N-E2	Navigation	E	**Care Closer to Home.** Access to local treatment and investigations reduced travel burden and improved the overall experience of care.	C	N4
RR-N-I1	Navigation	I	**Rural-Focused Service Design.** Navigation initiatives should be designed specifically for large rural catchments rather than assuming metropolitan service models are appropriate.	S	N4
RR-N-I2	Navigation	I	**Rural-Friendly Scheduling.** Appointment systems should account for travel distance, accommodation needs and transport constraints.	C	N3
RR-C-V1	Communication	V	**Respectful Partnership.** Participants valued relationships where clinicians listened, responded to concerns and created opportunities for questions.	C	C2
RR-C-V2	Communication	V	**Hope and Honesty.** Patients sought honest communication that balanced realism with reassurance.	C	C2
RR-C-B1	Communication	B	**Information Gaps Create Anxiety.** Delays, uncertainty and difficulty accessing information increased distress during referral and diagnosis.	C	C1
RR-C-B2	Communication	B	**Digital Exclusion and Information Access.** Reliance on digital information channels may inadvertently disadvantage some regional consumers.	S	N3
RR-C-E1	Communication	E	**Information That Enables Planning.** Communication was most valued when it enabled practical planning around work, travel and family responsibilities.	C	C1

ID	Focus area	Cat.	Theme	Source	Action
RR-C-E2	Communication	E	**Accessible and Tailored Information.** Providing information in multiple formats improved understanding and supported recall.	C	C1
RR-C-I1	Communication	I	**Multi-Channel Information Delivery.** Resources should be available through both digital and non-digital channels.	S	C1
RR-C-I2	Communication	I	**Structured Information Supports.** Information resources should be co-designed with consumers and aligned with needs at each stage.	M	N2
RR-S-V1	Supports and services	V	**Holistic Support.** Support was conceptualised broadly and included emotional, practical, transportation and carer-related needs.	C	S1
RR-S-B1	Supports and services	B	**Invisible or Poorly Promoted Supports.** Many participants reported support services existed but were not introduced at the time they were needed.	C	S5
RR-S-B2	Supports and services	B	**Rural Travel and Accommodation Hardship.** Travel-related costs created significant inequities for regional patients accessing metropolitan cancer care.	S	N4
RR-S-B3	Supports and services	B	**Reduced Availability of Local Support Services.** Regional participants described fewer available support services compared with metropolitan settings.	S	S5
RR-S-E1	Supports and services	E	**Connecting Patients to Supports.** Navigation support assisted patients to identify and access available community resources.	M	S5
RR-S-E2	Supports and services	E	**Local Community-Based Supports.** Community-based programs reduced isolation and strengthened support beyond the hospital setting.	C	S5
RR-S-I1	Supports and services	I	**Proactive Survivorship Outreach.** Participants identified a service gap immediately after treatment completion and preferred proactive follow-up.	C	N5
RR-S-I2	Supports and services	I	**Statewide Support Navigation.** A statewide navigation approach may help regional consumers identify appropriate supports regardless of location.	C	S5

Table E4. *Themes: carers (35 themes)*

ID	Focus area	Cat.	Theme	Source	Action
CAR-N-V1	Navigation	V	**Timely and Coordinated Commencement of Care.** Carers valued clarity, certainty and forward momentum. Knowing the treatment plan and seeing action occur promptly reduced anxiety and increased confidence in care.	C	N1

ID	Focus area	Cat.	Theme	Source	Action
CAR-N-B1	Navigation	B	**Delays and Fragmentation Across the Pathway.** Across diagnosis, treatment planning and treatment phases, carers described fragmented systems, inconsistent teams and poor continuity. These navigation burdens frequently shifted coordination responsibilities onto carers rather than health service, especially outside eligibility cut-off points.	C	N1
CAR-N-B2	Navigation	B	**Transitional Support Gaps After Treatment.** Difficulties did not end when active treatment ceased. Carers reported continuing challenges after treatment, suggesting a need for stronger follow-up navigation and transition support.	C	N5
CAR-N-B3	Navigation	B	**Emotional Burden of the Caregiving Pathway.** Carers described navigation challenges as emotionally taxing, particularly during referral, waiting periods and treatment changes. Anxiety and repeated exposure to uncertainty contributed to cumulative distress throughout the pathway.	C	S4
CAR-N-B4	Navigation	B	**Carer Invisibility Within the Cancer Pathway.** A distinctly carer-specific issue was feeling excluded from a process they were expected to support. Carers frequently perceived themselves as observers rather than recognised partners in care and decision-making.	C	C3
CAR-N-B5	Navigation	B	**Navigation Challenges for Rural and Regional Carers.** Regional carers experienced additional logistical burdens associated with travel, accommodation and service access. These challenges compounded the complexity of supporting treatment participation.	N	N4
CAR-N-E1	Navigation	E	**Timely and Coordinated Commencement of Care.** Rapid progression from referral to diagnosis and treatment provided reassurance and reduced uncertainty. Timeliness was consistently associated with confidence in the pathway.	C	N1
CAR-N-E2	Navigation	E	**Navigation and Care Coordination Support.** Dedicated navigation and coordination roles reduced burden on carers and provided practical support during complex or unexpected treatment events.	N	N1
CAR-N-E3	Navigation	E	**Flexible Models That Reduce Burden.** Flexible treatment delivery models reduced travel, disruption and caregiving burden, particularly when treatment demands were intensive.	C	N4
CAR-N-E4	Navigation	E	**Guided Support During Crisis Points.** Carers particularly valued trusted clinical staff who helped them navigate high-stress transition points and rapidly changing circumstances.	N	N1

ID	Focus area	Cat.	Theme	Source	Action
CAR-C-V1	Communication	V	**Recognition of Carers as Care Partners.** Carers placed importance on being recognised as partners in care who require information, involvement and acknowledgement throughout the cancer pathway. Recognition was viewed as essential to their ability to support the patient effectively.	C	C3
CAR-C-B1	Communication	B	**Communication Does Not Routinely Recognise Carer Wellbeing.** During treatment, communication was primarily focused on the patient's clinical needs. Carers reported that their own wellbeing was rarely explored, despite the emotional demands of the caregiving role.	C	C3
CAR-C-B2	Communication	B	**Lack of Financial Wellbeing & Workplace Support and Advice.** Financial impacts should be addressed proactively through accessible information, education resources and referral pathways to financial, legal and employment supports.	N	S2
CAR-C-B3	Communication	B	**Carers Excluded from Conversations and Decision-Making.** Across referral and diagnosis/treatment planning phases, carers described feeling peripheral to important conversations. Experiences of not being acknowledged, encouraged to contribute, or actively included created a sense of invisibility despite their central caregiving role. This was the dominant communication issue unique to carers.	C	C3
CAR-C-E1	Communication	E	**Accessible and Responsive Communication.** Carers valued being able to ask questions and receive timely, consistent responses. Accessible communication from clinicians increased confidence and reduced uncertainty during treatment.	C	C2
CAR-C-E2	Communication	E	**Responsive and Reliable Information Systems.** Carers valued digital information systems that were responsive to problems and quickly corrected inaccuracies or omissions. Timely resolution helped maintain trust in information sources.	N	(N3)
CAR-C-E3	Communication	E	**Communication That Recognises Carers as Care Partners.** Carers valued communication approaches that recognised partners as active participants in the cancer experience. Recognition was not sought as a separate service user category but as an integral part of the patient's support system.	C	C3
CAR-S-V1	Supports and services	V	**Accessible Psychological Support for Patients and Carers Throughout the Pathway.** Psychological support was consistently valued from diagnosis through treatment, particularly during periods of uncertainty, waiting and adjustment.	C	S4

ID	Focus area	Cat.	Theme	Source	Action
CAR-S-V2	Supports and services	V	**Early Access to Support Information.** Carers valued receiving information about available services early in the cancer experience so they could access support proactively rather than discovering it by chance.	C	S5
CAR-S-V3	Supports and services	V	**Practical Support Needs Are Important to Care.** Practical aspects of care, including nutrition and day-to-day support needs, were considered important components of the overall treatment experience.	C	None
CAR-S-V4	Supports and services	V	**Support Tailored to Carers' Needs.** Carers valued recognition that they have distinct support requirements that differ from those of patients and require targeted responses.	C	S4
CAR-S-B1	Supports and services	B	**Information and Preparedness Gaps Across the Care Experience.** Carers reported needing clearer guidance about what to expect throughout the cancer experience. Uncertainty during waiting periods increased anxiety and highlighted the importance of timely, practical information. Knowing how and where to access available psychological support services would help carers engage with wellbeing supports and reduced barriers to care.	N	C3
CAR-S-B2	Supports and services	B	**Service Access Restricted by Organisational Boundaries.** Support services were not always accessible across organisational boundaries. Variability in service availability created inequities in access to wellbeing supports.	C	(S5)
CAR-S-B3	Supports and services	B	**Practical Support Needs Are Not Always Addressed.** Practical needs such as nutrition formed an important part of the treatment experience. When these needs were unmet, additional responsibility was transferred to carers.	C	None
CAR-S-B4	Supports and services	B	**Transition and Survivorship Support Gaps.** The transition from inpatient care to home created uncertainty and reduced feelings of security. Additional post-discharge support may be needed to assist carers during this adjustment period.	C	N5
CAR-S-B5	Supports and services	B	**Emotional and Practical Burden of Caregiving.** A uniquely carer-specific issue was the cumulative emotional, practical and relational burden associated with ongoing caregiving responsibilities. Carers described sustained exposure to stress, trauma and disruption to daily life.	C	S4
CAR-S-B6	Supports and services	B	**Lack of Structured Support for Carers.** Carers reported limited support targeted specifically to their role, particularly after treatment. The absence of structured guidance contributed to feelings of isolation and uncertainty.	C	S4

ID	Focus area	Cat.	Theme	Source	Action
CAR-S-E1	Supports and services	E	**Effective and Accessible Psychological Support.** Psychological support was highly valued when it was practical, accessible and focused on managing immediate challenges associated with treatment and caregiving.	C	S4
CAR-S-E2	Supports and services	E	**Coping Skills and Self-Management Supports.** Carers valued practical coping techniques that helped them manage anxiety and emotional demands throughout treatment.	N	S4
CAR-S-I1	Supports and services	I	**Financial Wellbeing Support and Advice.** Financial impacts should be addressed proactively through accessible information, education resources and referral pathways to financial, legal and employment supports.	N	S2
CAR-S-I2	Supports and services	I	**Flexible and Accessible Wellbeing Resources.** Flexible, self-directed resources were viewed as an effective way to provide support outside clinical encounters and accommodate differing information and support preferences.	C	S4
CAR-S-I3	Supports and services	I	**Accessible Psychological Support Throughout the Pathway.** Psychological care should be embedded across the pathway, including inpatient settings, post surgery, and dedicated supports for carers.	C	S4
CAR-S-I4	Supports and services	I	**Tailored Supports for Regional and Rural Carers.** Support initiatives should recognise the different experiences of regional and rural carers and incorporate practical solutions that enhance wellbeing while away from home.	N	N2
CAR-S-I5	Supports and services	I	**Peer Connection and Carer Wellbeing Supports.** Peer-based initiatives may help reduce isolation, normalise experiences and strengthen wellbeing during intensive caregiving periods.	N	S4
CAR-S-I6	Supports and services	I	**Increase Support Tailored to Carers' Needs.** Carers emphasised the importance of supports that specifically recognised and responded to their own emotional and wellbeing needs rather than focusing exclusively on the patient.	C	S4

Appendix F: Evidence-to-Action Matrix

This appendix shows how the Think Tank findings connect to the 15 strategic actions. The mapping was prepared for this report from the session notes, the themes and the Action Plan. Table F1 shows which concept areas appeared in which groups, Table F2 shows where each strategic action came from and how well it is supported, and Table F3 lists matters raised that the plan does not directly address.

Table F1. *The 22 concept areas and the groups in which each appeared*

Concept area	Socioeconomic disadvantage or financial toxicity	Emotional or psychological distress	Regional and rural communities	Carers	Groups
Fragmented care and no single point of contact	Yes	Yes	Yes	Yes	4
Preparation, orientation and knowing what to expect	Yes	Yes	Yes	Yes	4
Transition and follow-up after treatment	Yes	Yes	Yes	Yes	4
Personalised, accessible and multi-format information	Yes	Yes	Yes	Yes	4
Respectful, empathetic communication and being heard	Yes	Yes	Yes	Yes	4
Awareness and visibility of support services	Yes	Yes	Yes	Yes	4
Peer and community support	Yes	Yes	Yes	Yes	4
Timeliness, delays and uncertainty while waiting	Yes	Yes	–	Yes	3
Carer recognition, inclusion and support	Yes	Yes	–	Yes	3
Proactive identification of needs	Yes	Yes	Yes	–	3
Access to psychological and mental health support	Yes	Yes	–	Yes	3
Distance, travel and care closer to home	Yes	–	Yes	Yes	3
Appointment burden and scheduling	Yes	–	Yes	–	2
Continuity and trusted clinical relationships	Yes	Yes	–	–	2
Information gaps and timing	Yes	–	Yes	–	2
Cognitive and emotional load affecting understanding	Yes	Yes	–	–	2
Financial costs and financial support	Yes	–	–	Yes	2
Health, system and digital literacy and self-advocacy	Yes	–	Yes	–	2
Stigma, safety, diagnostic overshadowing and intersecting identities	Yes	Yes	–	–	2
Practical and family needs	Yes	–	–	Yes	2
Eligibility rules and structural systems	Yes	–	–	–	1
Organisational boundaries between services	–	–	–	Yes	1

Table F2. *Origin of and support for each strategic action*

Action	Draft action rated by consumers in Think Tank 3	Themes linked	Support	How the strategic action was developed
N1	Action 1: Establish a central point of contact for common concerns (high impact, lower effort)	10 (SES 1, Distress 2, Regional 2, Carers 5)	Strong	Carries forward Think Tank 3 action 1. The project team widened a single contact point into a navigation model with defined roles, one contact route and response standards.
N2	Action 2: Develop an orientation program and staged information packs (high impact, higher effort)	8 (SES 3, Distress 2, Regional 2, Carers 1)	Strong	Carries forward the orientation half of Think Tank 3 action 2. The six orientation checkpoints and the regional pack were specified by the project team.
N3	Action 3: Improve appointment access and digital inclusion (high impact, higher effort)	4 (SES 2, Regional 2)	Moderate	Carries forward Think Tank 3 action 3. The equity check before major changes was added by the project team, drawing on the health equity impact assessment approach in the VCCC Alliance framework.
N4	Action 4: Develop practical regional patient support (high impact, higher effort)	9 (SES 1, Regional 6, Carers 2)	Moderate	Carries forward Think Tank 3 action 4. The disruption plan and several travel-cost items come from the Bendigo clinician session, not from consumers.
N5	Action 8: Establish a planned transition into follow-up and ongoing care (high impact, lower effort) Action 7: Strengthen community supports and primary care connections (high impact, higher effort)	8 (SES 2, Distress 3, Regional 1, Carers 2)	Strong	Think Tank 3 prioritised a planned transition (action 8) but recorded no implementation detail. The handover standard, transition plan and referral arrangements were specified by the project team from the transition themes.
C1	Action 2: Develop an orientation program and staged information packs (high impact, higher effort)	15 (SES 7, Distress 4, Regional 4)	Strong	Carries forward the information half of Think Tank 3 action 2 as a separate communication action.
C2	Action 10: Build an equity-capable workforce and feedback loop (high impact, higher effort)	9 (SES 3, Distress 3, Regional 2, Carers 1)	Moderate	Carries forward the workforce half of Think Tank 3 action 10. No implementation detail was recorded in Think Tank 3; the capability framework, training and evaluation outputs were specified by the project team.
C3	None of the 10 Think Tank 3 actions	10 (SES 2, Distress 2, Carers 6)	Moderate	Not one of the 10 Think Tank 3 actions. Developed by the project team from carer themes that recur

Action	Draft action rated by consumers in Think Tank 3	Themes linked	Support	How the strategic action was developed
				across all four groups, with related participant suggestions for information for family and friends.
C4	None of the 10 Think Tank 3 actions	7 (Distress 7)	Moderate (population-specific)	Not one of the 10 Think Tank 3 actions. Developed by the project team from the emotional or psychological distress themes on diagnostic overshadowing, stigma, unexplained cognitive effects and information sharing.
C5	Action 10: Build an equity-capable workforce and feedback loop (high impact, higher effort)	0	Limited	Takes the "feedback loop" from Think Tank 3 action 10. The equity dataset, dashboard and advisory group were specified by the project team, drawing on the data equity principle in the VCCC Alliance framework.
S1	Action 6: Embed proactive psychosocial and practical support (high impact, lower effort)	11 (SES 8, Distress 2, Regional 1)	Strong	Carries forward Think Tank 3 action 6. The five screening points and the referral handover process were specified by the project team.
S2	Action 5: Establish proactive financial support (high impact, lower effort)	4 (SES 2, Carers 2)	Moderate	Carries forward the early-identification half of Think Tank 3 action 5.
S3	Action 5: Establish proactive financial support (high impact, lower effort)	8 (SES 8)	Moderate (population-specific)	Takes the partnership and advocacy steps from Think Tank 3 action 5. The cost information and hardship response outputs were developed by the project team from the eligibility, visa and cost themes.
S4	Action 9: Expand peer support (lower broad impact, lower effort) Action 6: Embed proactive psychosocial and practical support (high impact, lower effort)	19 (SES 2, Distress 6, Carers 11)	Strong	Combines Think Tank 3 action 9 (peer support) with the psychological support themes. Consumers rated peer support as lower broad impact; the action is wider than peer support.
S5	Action 7: Strengthen community supports and primary care connections (high impact, higher effort)	11 (SES 3, Distress 2, Regional 5, Carers 1)	Strong	Think Tank 3 prioritised community supports and primary care connections (action 7) but recorded no implementation detail. The service map, directory, promotion plan and site review were specified by the project team.

Table F3. *Matters raised that the Action Plan does not directly address*

Matter raised	Where it was raised	How the Action Plan responds
Seeing a different clinician at each visit	Theme SES-N-B2	Partly. Output S4.2 covers continuity for mental health support only.
Access to a service blocked because the patient was admitted under a partner hospital	Theme CAR-S-B2	Partly. Output S5.4 reviews differences between Peter Mac sites, not between organisations.
Inpatient meal choice and portions	Themes CAR-S-V3 and CAR-S-B3; also raised in Think Tank 2	Not addressed.
Recognition of concerns by a general practitioner before referral	Theme SES-N-V1	Outside the services Peter Mac delivers.
Education for general practitioners about cancer care and coordination	Think Tank 2 and the Bendigo session	Partly, through the shared-care handover standard (N5.2). No output addresses education.
Cost of imaging before referral	Think Tank 2	Not addressed. Outside Peter Mac services.
Awareness of clinical trials	Think Tank 2	Not addressed.
People with rare cancers who have no dedicated support organisation	Think Tank 1	Partly, through peer support (S4.4).
Seasonal workers and people from refugee backgrounds in regional areas	Bendigo session	Not addressed specifically.
Older regional patients with less capacity to self-advocate	Bendigo session	Partly, through N2 and N3. Not addressed specifically.
Parking close to the treatment entrance at the Bendigo campus	Bendigo session	Not addressed.
Use of artificial intelligence or chatbots for navigation	Think Tanks 2 and 3; consumers held mixed views	Not adopted. Output N1.3 keeps the option to speak to a person.

Appendix G: DEI Action Plan

The DEI Action Plan is reproduced below from the version dated September 2026. The cover and contents pages are omitted and the layout has been adapted. Where the plan refers to the 'Consumer Advisory Committee', this is Peter Mac's Community Advisory Committee. Peter Mac is preparing the plan for wider publication, and the published version may differ in presentation.

About this Action Plan

Peter Mac's Patient and Carer Experience Strategy sets out the direction and commitment to improve the experiences of patients, carers and families across the cancer experience.

This Diversity, Equity and Inclusion Action Plan sits under and supports the delivery of the Strategy. It aims to translate the Strategy's equity intent into sustainable, practical actions that reduce avoidable barriers and improve care for Peter Mac's priority population groups.

The Action Plan focuses on three objectives from the Patient and Carer Experience Strategy:

- Strengthening equitable and inclusive navigation
- Delivering equitable and inclusive communication
- Improving equitable access to wellbeing and support services.

Through these areas, the Plan recognises that people have different needs, circumstances and experiences, and that providing the same response to everyone will not always achieve equitable outcomes. It sets out the commitments Peter Mac will progress to make care more inclusive, accessible and responsive, while embedding equity into everyday practice and ongoing improvement.

How this Plan relates to the other DEI documents

This Action Plan states what Peter Mac commits to. Three companion documents say how it will be delivered, measured and governed. The wording of every strategic action and description in this Plan is identical to the wording used in those documents.

Document	What it contains
DEI Action Plan	This document. The strategic DEI actions, what each one means, who they are for, and when accountability will be established.
DEI Implementation Plan	What each action breaks down into: how we know each is done, whether it can be resourced, and the existing work it can build on.
DEI Measures and Metrics	Equity outcome measures for each strategic action, with a plain-language definition, a data collection plan and a target.
DEI Governance Structure	Who owns each action, who they report to, and how progress reaches the Consumer Advisory Committee and Executive Quality and Safety.

Our priority populations

Peter Mac has identified three priority population groups for the initial focus of this Action Plan:

- People experiencing socioeconomic disadvantage or financial toxicity
- People experiencing emotional or psychological distress
- People from regional and rural communities.

These groups were identified through an evidence-informed prioritisation of the 12 priority populations in the Victorian Cancer Plan. The process considered the severity of inequities, unmet needs, gaps in existing services and system responses, Peter Mac's current capacity to respond, and opportunities to make a meaningful difference. It found that these three groups had the highest current level of unmet need, with significant inequities and system gaps occurring alongside limited or fragmented responses. They are therefore the starting point for action to address barriers to navigating cancer care, accessing inclusive and clear communication, and obtaining the wellbeing supports and services people need.

Peter Mac recognises that people may belong to more than one priority population and may experience overlapping and compounding barriers. For example, living in a regional or rural community may create additional financial pressures and contribute to emotional or psychological distress. This Action Plan therefore takes an intersectional approach: actions will respond to the ways people's identities, circumstances and experiences interact and will be tailored to achieve equitable outcomes, rather than delivered identically to everyone.

The initial focus on these three groups does not exclude other priority populations. It represents the first phase of Peter Mac's ongoing work to strengthen diversity, equity and inclusion across cancer care.

Carers

Carers are named explicitly throughout this Plan wherever an action applies to them, rather than being included implicitly within references to patients and families. Consumer feedback was clear that carers can carry a substantial share of the burden this Plan addresses, particularly the financial burden, and that planning for them only works when they are named.

What we heard

The co-design phase delivered a comprehensive understanding of the experiences of priority population groups and carers across the cancer pathway. Through journey mapping and lived experience consultation, the project identified key inequities relating to care navigation, communication and access to support services. These findings informed the development of a co-designed DEI Action Plan, including strategic actions aligned to the Patient and Carer Experience Strategy objectives and the VCCC Alliance Cancer Equity Framework, providing a foundation for implementation and evaluation.

People experiencing socioeconomic disadvantage or financial toxicity

For patients experiencing socioeconomic disadvantage or financial toxicity, financial hardship, health literacy challenges and structural barriers significantly influenced access to care, support services and information. Participants described difficulties navigating complex systems, managing competing financial and family responsibilities, and accessing timely support, with financial toxicity and eligibility barriers further compounding disadvantage. Positive experiences were associated with trusted relationships, flexible models of care, community supports, proactive assistance, and clear information. Findings highlight the need for equity-focused approaches that strengthen navigation, improve access to support, and address financial and practical barriers early in the cancer experience.

People experiencing emotional or psychological distress

For patients experiencing emotional or psychological distress, uncertainty, anxiety and emotional burden were prominent throughout the cancer experience. Participants reported challenges in accessing timely information, psychological support and coordinated care, often feeling unprepared for the cognitive and emotional impacts of cancer and treatment. Positive experiences were associated with trusted and empathetic clinicians, peer support, timely information, and access to specialised mental health services. Findings highlight the need for psychologically informed care, routine psychosocial screening, proactive communication, and stronger survivorship support.

People from regional and rural communities

For patients from regional and rural communities, distance from services created significant challenges across the cancer experience. Travel, accommodation, financial costs, workforce shortages and difficulties accessing local support services increased the burden of care. Participants valued coordinated care, clear communication, local support options, and services delivered closer to home. Findings highlight the need for rural-responsive models of care that improve access, reduce travel burden, and strengthen care coordination and local support pathways.

Carers

For carers, the cancer experience was characterised by substantial emotional, practical and coordination burdens. Many carers described feeling overlooked within healthcare interactions despite their central role in supporting patients, while fragmented care and gaps in support increased stress and uncertainty.

Positive experiences were associated with coordinated care, responsive communication, trusted clinician relationships, and access to psychological support. Findings highlight the importance of recognising carers as partners in care and providing tailored emotional, practical and informational support throughout the cancer pathway.

Our approach to advancing cancer equity

This Action Plan is guided by the VCCC Alliance Cancer Equity Framework. The intent of cancer equity is that everyone has a fair and just opportunity to access high-quality cancer care and achieve the best possible outcomes. Equity does not mean providing the same support to everyone. It means understanding people's different needs and removing unfair and avoidable barriers, including those created by systems, policies, discrimination, and the social determinants of health.

The VCCC Alliance Cancer Equity Framework describes three connected areas of action:

Equity action	What this means for Peter Mac
Assessing Inequities	Use equity data, lived experience, journey mapping, Health Equity Impact Assessments and reviews of policies, services and care pathways to identify inequities, gaps in information and their root causes.
Addressing Inequities	Partner with priority population groups to co-design, test and adapt actions. Address barriers at the individual, service, organisational, community and structural levels, and monitor whether changes are making a difference.
Striving for Equity	Make equity a long-term organisational commitment supported by leadership, appropriate resources, workforce capability, partnerships, accountability, and continuous improvement.

Across all three areas, Peter Mac will:

- Apply an intersectional approach that recognises how people's identities, circumstances and experiences can overlap and compound inequities
- Practice data equity by collecting and using data responsibly, transparently and in partnership with communities
- Embed patient- and carer-centred co-design, ensuring people with lived experience help shape, implement and evaluate improvements
- Support culturally safe, trauma-informed care through ongoing learning, self-reflection, safety, trust and supported choice
- Use inclusive, non-stigmatising and strengths-based language that values the knowledge, capabilities and resilience of individuals and communities
- Continually review, learn from and improve actions to ensure they are reducing inequities.

These principles guide how the commitments in this Action Plan will be implemented across navigation, communication and access to wellbeing and support services.

Priority Area 1: Navigating Your Cancer Pathway

Objective 1.2: Strengthen Navigation for Priority Population Groups

Responsibility is shown as 'to be confirmed' pending endorsement of the DEI Governance Structure, which sets out proposed owners for each action.

Strategic Action	What this action means	Priority population	Timeline	How this will be measured
N1: Provide an Equity-Focused Cancer Navigation Model People in the three priority groups know who to contact, get a coordinated answer, and are not held up by confusing or missing contact points.	Design a navigation model with patients and carers, so people in the three priority groups always know who to contact, get a coordinated answer, and are passed safely to the right person when their needs change. Covers the whole cancer experience, from referral through to after treatment ends.	Peter Mac's priority population groups	TBA	N1-E1 — Knowing who to contact throughout their cancer care N1-E2 — Complaints about not knowing who to contact
N2: Provide Inclusive, Tailored Navigation Support Patients and carers in the three priority groups get orientation and navigation help at the right time, in a way that suits how they read, what they can access, and what is going on in their lives.	Offer patients and carers in the three priority groups clear orientation and navigation help at the points where care changes — referral, first visit, treatment decisions, end of treatment and transfer to ongoing care. Offer it proactively rather than waiting to be asked, and tailor how it is given to what each person needs.	Peter Mac's priority population groups	Short Term	N2-E1 — Understanding what happens next N2-E2 — Feeling prepared before the first visit
N3: Reduce Barriers to Equitable Care Pathways Digital access, travel, income, caring responsibilities and other circumstances do not cause people in the three priority groups avoidable delays, or shut them out of care.	Find and remove the practical things that stop people in the three priority groups getting to their appointments — travel, cost, work, caring responsibilities and digital access. Coordinate appointments where it is possible to do so, and make sure people can choose a digital or a non-digital way of dealing with Peter Mac.	Peter Mac's priority population groups	Short Term	N3-E1 — Practical barriers causing missed or delayed care N3-E2 — Missed appointments, read as a fairness signal
N4: Expand Equitable Regional Access and Care Closer to Home Regional and rural patients and carers, and people in financial hardship, travel less, spend less and have their treatment disrupted less, while still getting safe and coordinated care.	Reduce how far regional and rural patients and their carers have to travel, and how much it costs them, by delivering more care locally or by telehealth where partner sites exist. Help with travel, accommodation and costs, and have a plan for when weather or transport disrupts treatment.	People from regional and rural communities; people experiencing socioeconomic disadvantage or financial toxicity	Short Term	N4-E1 — Travel and cost getting in the way of treatment N4-E2 — Care delivered without travelling to Melbourne
N5: Strengthen Equitable Care Transitions and Shared Care Patients and carers in the three priority groups know who is responsible for their care when it changes hands, and information gets to the next team on time.	Make sure patients and carers in the three priority groups do not fall through the gaps when their care changes hands — at the end of treatment, when disease returns, or when care moves to their GP or a local service. Say clearly who is responsible, and hand over on time.	Peter Mac's priority population groups	Short Term	N5-E1 — Knowing who is responsible after care changes N5-E2 — Feeling connected to support after treatment ends

Responsibility for every action in this objective: to be confirmed.

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Priority Area 2: Patient Communication and Personalising Information

Objective 2.4: Provide More Support for Patients Who Need Help Communicating, With a Focus on Priority Population Groups

Responsibility is shown as 'to be confirmed' pending endorsement of the DEI Governance Structure, which sets out proposed owners for each action.

Strategic Action	What this action means	Priority population	Timeline	How this will be measured
C1: Deliver Accessible, Personalised and Inclusive Information Patients and carers in the three priority groups get information they can read, understand and use to make decisions about their care.	Give patients and carers in the three priority groups information they can actually read and use — in the language and format they have told us they prefer, where that format exists. Adjust for how easily someone reads health information, for disability, for digital access, and for people who are distressed.	Peter Mac's priority population groups	Medium Term	C1-E1 — Understanding the information given C1-E2 — Getting an interpreter when one is needed
C2: Build an Equity-Responsive Communication Workforce Staff communicate with patients and carers in the three priority groups in a way that is respectful, clear, and takes account of what those people are dealing with.	Build staff skill in communicating well with patients and carers in the three priority groups. Covers understanding people's culture and circumstances, recognising that past trauma affects how people receive information, checking that people have understood, supporting people to make their own decisions, and making it safe to speak up.	Peter Mac's priority population groups	Medium Term	C2-E1 — Being treated with respect and listened to C2-E2 — Complaints about how staff communicated
C3: Include Carers and Families in Equitable Communication Carers and chosen support people are included in a way that helps, without taking away the patient's choice, privacy or consent.	Let carers, families and chosen support people take part in conversations about care, and give them information and support of their own — while always respecting what the patient wants shared, with whom, and their privacy and consent.	Peter Mac's priority population groups	Short Term	C3-E1 — Carers feeling included and prepared C3-E2 — The right people being involved
C4: Provide Inclusive Communication for People Experiencing Emotional or Psychological Distress People experiencing emotional or psychological distress are listened to and supported, without being judged and without physical symptoms being wrongly put down to their mental health.	Make sure people experiencing emotional or psychological distress are spoken to with respect, without stigma, and with their consent, throughout their cancer experience.	People experiencing emotional or psychological distress	Short/Medium Term	C4-E1 — Feeling heard and not judged C4-E2 — Feedback describing stigma or being dismissed
C5: Use Equity Data and Co-design to Improve Communication Communication improvements are shaped by the people affected, and can be shown to reduce the gap between priority groups and everyone else.	Use feedback and data from patients and carers in the three priority groups to find where communication is not working as well for them as for everyone else. Fix those things with them, and check afterwards whether the fix actually worked.	Peter Mac's priority population groups	Short Term	C5-E1 — Whether feedback comes from everyone C5-E2 — Number of measures still showing a large gap

Responsibility for every action in this objective: to be confirmed.

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Priority Area 3: Supports and Services for Your Care, including inside and outside of Peter Mac

Objective 3.2: Connect Priority Population Groups with The Wellbeing and Support Services They Need

Responsibility is shown as 'to be confirmed' pending endorsement of the DEI Governance Structure, which sets out proposed owners for each action.

Strategic Action	What this action means	Priority population	Timeline	How this will be measured
S1: Embed Equitable, Proactive Supportive Care Screening Patients and carers in the three priority groups have their needs picked up early and get help quickly, instead of having to find services themselves.	Ask every patient, and their carer, at set points in their care whether they need practical, emotional, financial or cultural support — rather than waiting for them to raise it. Then connect them to help quickly, check the connection worked, and follow up.	Peter Mac's priority population groups	TBA	S1-E1 — Being asked about needs beyond the cancer S1-E2 — Getting help after saying you needed it
S2: Identify and Respond Early to Financial Toxicity Money problems are found early, and patients and carers get practical information and help before cost disrupts their cancer treatment.	Ask patients and carers about money worries early and sensitively, and connect people in financial hardship and people in regional and rural areas to clear cost information, financial help and practical support — before cost starts to affect their treatment.	People experiencing socioeconomic disadvantage or financial toxicity; people from regional and rural communities	Medium Term	S2-E1 — Care missed or delayed because of cost S2-E2 — Knowing what treatment will cost before deciding
S3: Reduce Inequitable Financial Barriers to Cancer Care Costs are less likely to delay, interrupt or stop cancer treatment for patients and carers in financial hardship or in regional and rural areas.	Reduce the costs that fall hardest on patients and carers in financial hardship and in regional and rural areas, by working with partners and by changing what Peter Mac can change.	People experiencing socioeconomic disadvantage or financial toxicity; people from regional and rural communities	TBA	S3-E1 — Getting practical help with costs S3-E2 — People needing help but not qualifying for it
S4: Expand Inclusive Mental Health, Peer and Carer Support People experiencing emotional or psychological distress, and their carers, can get mental health, peer and carer support quickly and safely.	Improve how quickly and fairly patients and carers can get cancer-specific mental health support, peer support and carer support — between appointments, during treatment and after it finishes.	People experiencing emotional or psychological distress	TBA	S4-E1 — Getting emotional support when needed S4-E2 — Waiting time for psychological support
S5: Strengthen Equitable Connections to Community Supports Patients and carers in the three priority groups can connect with trusted community supports wherever they live, whatever their finances, culture or digital access.	Connect patients and carers in the three priority groups to trusted local, regional and community-led supports, and remove the barriers on Peter Mac's side that stop people getting to them — such as not knowing they exist, transport, cost and digital access.	Peter Mac's priority population groups	TBA	S5-E1 — Being connected to the support you needed S5-E2 — Knowing what support exists

Responsibility for every action in this objective: to be confirmed.

Timeframes (Appendix A of the Action Plan)

These definitions describe when responsibility and accountability for an action will be established. They do not describe when the work will be completed. Delivery timing is set out in the DEI Implementation Plan.

Timeline	Definition
Short term	Responsibility and accountability for the action will be established within 12 months of the completion of the DEI Action Plan.
Medium term	Responsibility and accountability for the action will be established within 24 months of the completion of the DEI Action Plan.
Long term	Responsibility and accountability for the action will be established within 36 months of the completion of the DEI Action Plan.
Ongoing	The action is already established or underway, with responsibility and accountability already assigned.
TBA	The timeframe for establishing responsibility and accountability has not yet been agreed.

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Appendix H: DEI Implementation Plan Summary

The Implementation Plan breaks the 15 strategic actions into 60 outputs and 164 activities. Table H1 summarises its structure and Table H2 lists the outputs. The full plan, which also sets out activities, completion tests, lead and partner teams, timing, risks and links to existing work, has been handed over to Peter Mac.

Table H1. *Structure of the Implementation Plan*

Feature	Detail
Structure	Each strategic action has four outputs. An output is a specific thing that will exist when the work is done. Each output has two to three single-step activities, each with a yes-or-no test of completion (164 activities in total).
Resourcing status	Resourced: 15 outputs. Partly resourced: 23. Needs new funding: 18. Needs a business case: 4.
Links to existing work	A register of 110 current, planned and proposed initiatives was compiled from the environmental scan, the PCXS implementation plan and the Disability Accessibility Plan. Fifty-three outputs build on at least one entry. Seven have nothing to build on: N1.4, N4.4, N5.2, C4.1, C4.2, S2.2 and S3.3.
Link to the Think Tanks (added for this report)	Direct participant suggestion: 25 outputs. Developed by the project team in response to a documented barrier or theme: 25. Implementation step with no direct Think Tank source, such as baseline mapping: 10.

Table H2. *The 60 outputs*

Output	Description	Resourcing	Think Tank link
N1.1	A map of how patients and carers currently make contact and get problems escalated, at every stage from referral to after-hours care.	Resourced	Step
N1.2	A written service model, designed with patients and carers, that names each navigation role — patient navigator, clinical nurse consultant, Patient and Carer Support, referral administration and the treating team — and says exactly which of them handles clinical questions, practical questions and general questions.	Partly resourced	Developed
N1.3	One published way to get general help with navigating care: one phone number, one email address and one Health Hub entry point.	Needs a business case	Suggested
N1.4	A published set of response standards, saying the longest a patient or carer should wait for an acknowledgement of their referral, an update on where things are, a call back, and escalation of an urgent or non-urgent problem.	Needs new funding	Suggested
N2.1	A list of every welcome, orientation and pathway document Peter Mac currently gives patients and carers, checked against accessibility standards and against what consumers said they need.	Resourced	Step

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Output	Description	Resourcing	Think Tank link
N2.2	An agreed orientation pathway and checklist, tested with consumers, setting out what a patient and their carer are told at six points: referral, first visit, treatment decision, treatment change, end of treatment, and transfer to ongoing care.	Partly resourced	Suggested
N2.3	A set of orientation materials that have passed accessibility testing and been tested with patients and carers from the priority groups: a plain-language written guide, a campus map and signage, a short video or virtual tour, and a printed version.	Needs new funding	Suggested
N2.4	An orientation pack for regional and rural patients and their carers, offered before their first visit, covering how to find their way around, travel, parking, accommodation, what care is available locally, telehealth and community supports.	Partly resourced	Suggested
N3.1	An agreed short set of fields in the electronic medical record, filled in with the person's consent, recording what they need: an interpreter, an accessibility adjustment, a preferred way of being contacted, whether they can use digital tools, their work and caring commitments, how far they travel, and any privacy needs.	Partly resourced	Developed
N3.2	One standard set of appointment messages, tested with consumers and used across services.	Resourced	Developed
N3.3	A way for patients and carers to choose and change appointments, available both through Health Hub and by phone to a real person.	Partly resourced	Suggested
N3.4	A completed equity check before every major change to appointments, digital systems or telehealth, with the problems it finds written down and fixed.	Resourced	Developed
N4.1	A check completed with each regional and rural patient, with their consent, before their appointments are booked.	Partly resourced	Developed
N4.2	An agreed and published list of which scans, tests, treatments, allied health appointments and follow-up can be delivered near home or by telehealth through a regional site, and which cannot.	Needs a business case	Suggested
N4.3	An offer of help with transport, accommodation, parking, fuel and travel assistance schemes, made to regional and rural patients and their carers rather than waiting to be asked.	Partly resourced	Suggested
N4.4	A regional service directory with named contacts at Peter Mac, WCMICS, regional health services, Primary Health Networks, GPs and community organisations, checked at least every six months.	Needs new funding	Suggested
N5.1	An analysis of where handovers currently go wrong, covering five situations: end of treatment, watch and wait, cancer that has returned or spread, survivorship, and transfer to a local service.	Resourced	Step
N5.2	An agreed standard for shared care and handover that names which team is responsible at each transition, states the longest time the GP or local service should wait for the handover information, and says who is accountable for follow-up, late effects of treatment and any new concerns.	Needs new funding	Developed

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Output	Description	Resourcing	Think Tank link
N5.3	A written plan given to the patient and their carer before treatment ends or care changes, covering recovery, late effects of treatment, warning signs to watch for, medicines, rehabilitation, next appointments, local supports and one named person to contact.	Partly resourced	Suggested
N5.4	Written referral arrangements with at least one named provider in each type of post-treatment support: rehabilitation, exercise, return to work, mental health, peer support, carer support and community services.	Partly resourced	Developed
C1.1	An approved organisation-wide standard for accessible information, with templates and a sign-off step.	Needs new funding	Developed
C1.2	A record, kept with consent, of how each patient and carer prefers to receive information — language, format and channel — and any support they need.	Partly resourced	Developed
C1.3	A defined list of the highest-risk patient and carer documents — referral, diagnosis, treatment, side effects, medicines, urgent help, support services and aftercare — rewritten in plain language, tested with patients and carers from the priority groups, and available in accessible and translated formats.	Partly resourced	Suggested
C1.4	A written or recorded summary given to the patient and their carer after each important clinical conversation, explaining where things stand, the options, side effects, what happens next and who to contact.	Partly resourced	Suggested
C2.1	A picture of how well staff currently communicate, by role and by setting, built from complaints, patient experience data, watching practice, staff feedback and what people in the priority groups say.	Resourced	Step
C2.2	An agreed framework setting out what each staff role needs to be able to do: use plain language, check understanding by asking people to say it back, listen actively, support people to make their own decisions, understand people's culture and circumstances, recognise the effect of past trauma, avoid assuming a physical symptom is caused by someone's mental health, include carers, and handle difficult conversations.	Resourced	Developed
C2.3	The core equity communication skills built into the orientation and mandatory training staff already do, with some sessions designed and delivered by patients, carers and community members from the priority groups, who are paid for their time and protected from being over-relied on.	Needs new funding	Developed
C2.4	A yearly report showing whether the training actually changed how staff communicate and what patients and carers say about it, broken down by priority group, role and service.	Resourced	Step
C3.1	An approved standard for communicating with carers and families, with a consent step built into the electronic medical record.	Partly resourced	Developed

Output	Description	Resourcing	Think Tank link
C3.2	A record for every patient of who they want involved in their care, what information may be shared with that person, and whether that carer has their own communication, accessibility, language or support needs.	Partly resourced	Developed
C3.3	A staged set of information for carers, covering what the caring role involves, the emotional and practical effects, medicines and side effects, who to call urgently, looking after themselves, and what carer support exists.	Partly resourced	Suggested
C3.4	A check-in with the carer about how they are coping and what practical help they need, offered at diagnosis, when treatment changes and at transition — with a warm handover to psychological, peer, financial or community support where it is needed.	Needs new funding	Developed
C4.1	An approved protocol, agreed with consumers, for recording mental health history, communication preferences, current supports, triggers and safety information — only with the person's consent, and written so that a recorded diagnosis cannot be used to limit or dismiss their care.	Needs new funding	Developed
C4.2	Prompts built into the electronic medical record requiring any new physical symptom to be assessed on its own merits, so it is not wrongly put down to a person's mental health.	Needs new funding	Developed
C4.3	Training delivered to the staff roles that need it, covering stigma about mental health, not assuming physical symptoms are caused by mental health, the effect of past trauma on how people receive information, supporting people to make their own decisions, and escalating safely.	Needs new funding	Developed
C4.4	Clear, non-judgemental information about distress, anxiety, depression, difficulty thinking clearly during treatment, side effects, urgent help and after-hours crisis support — offered at several points rather than once, and built on existing a cancer charity and Victorian Integrated Cancer Services material.	Partly resourced	Suggested
C5.1	An agreed short list of the information Peter Mac needs to collect to see inequity — where someone lives, how they prefer to communicate, whether they need an interpreter or an accessibility adjustment, whether they can use digital tools, whether they have a carer, and relevant social needs.	Partly resourced	Developed
C5.2	Feedback offered in five ways — online, on paper, by phone, with an interpreter, and with someone helping — so that taking part does not depend on reading ability, technology or confidence.	Partly resourced	Suggested
C5.3	A dashboard comparing communication access, experience, complaints, waiting times, referrals and outcomes between priority groups and everyone else, with small numbers hidden to protect identity.	Resourced	Developed
C5.4	A supported advisory group of patients, carers and people from the priority groups with written terms of reference, and a yearly public summary saying what was done, whether it reached everyone equally, what consumers said, and what will change next.	Resourced	Step

Output	Description	Resourcing	Think Tank link
S1.1	A picture of how supportive care and distress screening happens now — how often it is completed, where referrals go, and what happens next — broken down by stage of care, site and priority group.	Resourced	Step
S1.2	A short screening tool, designed with patients and carers, covering emotional, financial, practical, social, cultural, spiritual, carer and communication needs.	Partly resourced	Suggested
S1.3	Screening offered to everyone at five points — referral or first visit, when treatment is decided or changed, when a concern comes up, at the end of treatment, and at transition — with a stated score at which a referral is triggered, and the option for a patient or carer to ask for a review at any time.	Needs new funding	Suggested
S1.4	An agreed way of handing someone over to a support service properly: explain it, get consent, make the connection rather than handing over a phone number, respond within a set time, follow up if contact fails, and confirm back that the person was actually seen.	Needs new funding	Suggested
S2.1	A picture of how money problems are currently picked up and dealt with: when and how they come to light, who responds, what services exist inside and outside Peter Mac, where referrals fail, and which groups are not being reached at all.	Resourced	Step
S2.2	A short, agreed set of questions about money worries, adapted for cancer from an established tool such as the COSA Financial Toxicity Roadmap, with a stated point at which it triggers help.	Needs new funding	Developed
S2.3	Staff trained to talk about money worries without making people feel judged, spot who is at risk, give first-line information and hand people over properly — including patient navigators, who already hear about money problems but currently have nowhere to send them.	Needs new funding	Suggested
S2.4	A staged, easy-to-read guide for patients and carers covering likely costs, protecting income, superannuation, Centrelink, Medicare and the PBS, work and leave, and legal, charitable and urgent help.	Needs new funding	Suggested
S3.1	A list of the main costs patients and carers actually face across their cancer experience — both direct costs like scans and medicines, and indirect ones like travel, parking, lost income and childcare — with an agreed shortlist of changes Peter Mac could make to prevent or reduce them.	Resourced	Developed
S3.2	Written referral arrangements with at least one named provider in each category — financial counsellors, a cancer charity, legal services, community organisations and charitable funds — setting out how referrals are made and how quickly they will be answered.	Partly resourced	Suggested
S3.3	Clear written information about what a patient is likely to have to pay, and any lower-cost options, given before they decide or commit to treatment.	Needs new funding	Suggested

Output	Description	Resourcing	Think Tank link
S3.4	A single response for people who fall outside normal support: published rules for practical help with parking, travel, fuel, accommodation, childcare, food, help at home and small emergency grants; a written pathway for patients who are not eligible for Medicare or are affected by visa or work-rights restrictions; and a referral route to return-to-work, workplace adjustment and income support for both patients and carers.	Partly resourced	Developed
S4.1	An analysis of cancer-specific psychological and psychiatric support: how much is needed, how long people wait, whether they see the same person, what is available after hours, and how referrals are made — broken down by stage of care and priority group.	Resourced	Step
S4.2	An approved stepped model of mental health support with published access rules: what level of need gets what kind of help, how someone refers themselves or is referred, how they are handed over, how urgent cases are escalated, whether they see the same person, and what happens when a clinician is away.	Needs new funding	Developed
S4.3	A published route for patients and carers to get reassurance, crisis support or urgent clinical advice between appointments and after hours, repeated at several points so people know it exists when they need it.	Needs new funding	Suggested
S4.4	An opt-in peer support offer with written rules about facilitation, privacy, boundaries and escalation — available in person, by phone and online, with sensible matching, and including culturally and spiritually appropriate options and quieter, low-stimulation options.	Partly resourced	Suggested
S5.1	An agreed list of what counts as a wellbeing or support service, and a map of what exists — inside Peter Mac, on each campus, regionally, in primary care, in the community, and through peer, financial and practical services — recording for each one who can use it, how it is delivered, where it is and how to refer.	Resourced	Step
S5.2	A searchable, accessible directory of support services for patients, carers and staff, with a named owner, checked at least every six months, and a simple way for anyone to report an entry that is wrong or missing.	Needs a business case	Suggested
S5.3	A plan for telling patients and carers what support exists, through orientation, clinical teams, navigators, Health Hub, printed material and community channels — so people are told rather than having to find it themselves.	Partly resourced	Developed
S5.4	A review of what wellbeing and support services patients and carers can actually reach at Parkville, Bendigo and other sites, with a costed proposal for each real difference found.	Needs a business case	Developed

Suggested = direct participant suggestion. Developed = developed by the project team from a documented barrier or theme. Step = implementation step. Names of external organisations have been replaced with general descriptions.

VICS WESTERN & CENTRAL MELBOURNE INTEGRATED CANCER SERVICE

Appendix I: DEI Measure Index and Identification Limits

The measure set gives each strategic action two equity outcome measures. Each measure compares a priority group with all patients. Targets are set from a measured baseline. Table I1 lists the measures, Table I2 shows which groups can currently be identified in Peter Mac data, and Table I3 lists the limits recorded in the measure set.

Table I1. *The 30 equity outcome measures*

ID	Measure and what is measured	Target	Data sources
N1-E1	**Knowing who to contact.** The percentage of patients and carers who say they know who to contact at Peter Mac when they have a question about their care. Reported for all patients, and separately for each priority group we can identify. The equity part is the difference between each group and the overall figure.	Set a baseline over the first two quarters. Then close the gap between regional and rural patients and all patients by half within 24 months, with no group sitting more than 10 percentage points below the overall figure.	Real-time feedback; demographic data
N1-E2	**Complaints about not knowing who to contact.** The number of complaints about not knowing who to contact, not getting a response, or being passed between teams. Counted for each priority group per 1,000 episodes of care, and compared with the overall rate.	Set a baseline from 12 months of back-coded complaints. Then reduce the navigation complaint rate for regional and rural patients by 30% within 24 months, with no increase in the overall rate.	Compliments and complaints; demographic data
N2-E1	**Understanding what happens next.** The percentage of patients and carers who say they understood what would happen next in their care, asked after their first appointment. Compared between priority groups and all patients.	Set a baseline over the first two quarters. Then close the gap between regional and rural patients and all patients by half within 24 months.	Real-time feedback; demographic data
N2-E2	**Feeling prepared before the first visit.** The percentage of regional and rural patients and carers who say they had the information they needed before their first visit, covering travel, parking, accommodation and what to expect.	Set a baseline now, before the regional orientation pack is introduced. Then increase by 20 percentage points within 24 months of the pack going out.	Real-time feedback; demographic data
N3-E1	**Practical barriers causing missed or delayed care.** The percentage of patients and carers who say that travel, cost, work, caring responsibilities or lack of internet access caused them to miss or delay an appointment. A lower number is better. Compared between priority groups and all patients.	Set a baseline over the first two quarters. Then reduce for regional and rural patients by half within 24 months, with no increase for any other group.	Real-time feedback; demographic data
N3-E2	**Missed appointments, read as a fairness signal.** The percentage of booked appointments not attended, comparing regional and rural patients with all patients. Read as a measure of whether the system works for people, not whether patients turn up.	Set a baseline from 12 months of existing data. Then close the gap between regional and rural patients and all patients by half within 24 months.	Service records; demographic data

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ID	Measure and what is measured	Target	Data sources
N4-E1	**Travel and cost getting in the way of treatment.** The percentage of regional and rural patients and carers who say travel, cost or disruption interfered with their cancer treatment.	Set a baseline over the first two quarters. Then reduce by one third within 24 months.	Real-time feedback; demographic data
N4-E2	**Care delivered without travelling to Melbourne.** The percentage of appointments for regional and rural patients delivered locally or by telehealth, rather than requiring travel to Melbourne.	Set a baseline from 12 months of existing data. Then increase the proportion delivered locally or by telehealth by 15 percentage points within 24 months, limited to the services agreed in output N4.2.	Service records; demographic data
N5-E1	**Knowing who is responsible after care changes.** The percentage of patients and carers who say they knew who was responsible for their care after treatment ended or care moved to another team. Compared between priority groups and all patients.	Set a baseline over the first two quarters. Then close the gap between regional and rural patients and all patients by half within 24 months.	Real-time feedback; demographic data
N5-E2	**Feeling connected to support after treatment ends.** The percentage of patients and carers who say they were connected to the support they needed after treatment finished.	Set a baseline over the first two quarters. Then increase by 15 percentage points overall and close the regional and rural gap by half, both within 24 months.	Real-time feedback; VHES; demographic data
C1-E1	**Understanding the information given.** The percentage of patients and carers who say they understood the information they were given about their care. Compared between people who need an interpreter, people in the priority groups, and all patients.	Set a baseline over the first two quarters. Then close the gap between people who need an interpreter and all patients by half within 24 months.	VHES; real-time feedback; demographic data
C1-E2	**Getting an interpreter when one is needed.** The percentage of appointments where an interpreter was needed and a qualified interpreter was actually present.	Set a baseline from 12 months of existing records. Then close the gap to full fulfilment by half within 24 months, and halve the number of appointments where care was delayed for language reasons.	Service records; demographic data
C2-E1	**Being treated with respect and listened to.** The percentage of patients and carers who say they were treated with respect and listened to. Compared between priority groups and all patients. This is the outcome measure for the training — completion rates only show who attended, not whether anything changed.	Set a baseline over the first two quarters. Then close the gap between regional and rural patients and all patients by half within 24 months, while keeping the overall figure at or above baseline.	VHES; real-time feedback; demographic data
C2-E2	**Complaints about how staff communicated.** The number of complaints about communication — not being listened to, feeling dismissed, or things not being explained — for each priority group per 1,000 episodes of care, compared with the overall rate.	Set a baseline from 12 months of back-coded complaints. Then reduce the communication complaint rate for priority groups by 30% within 24 months.	Compliments and complaints; demographic data

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ID	Measure and what is measured	Target	Data sources
C3-E1	**Carers feeling included and prepared.** The percentage of carers who say they were included in conversations as much as the patient wanted, and felt prepared for the caring role.	Set a baseline over the first 12 months, because carer response numbers are low. Then increase by 15 percentage points within 24 months of the baseline.	Real-time feedback
C3-E2	**The right people being involved.** The percentage of patients who say the people they wanted involved in their care were actually included.	Set a baseline over the first two quarters. Then close the gap between priority groups and all patients by half within 24 months.	Real-time feedback; demographic data
C4-E1	**Feeling heard and not judged.** The percentage of patients and carers who say they felt listened to and not judged when they raised how they were feeling emotionally.	Set a baseline over the first two quarters as a whole-hospital figure. Then increase by 10 percentage points within 24 months, and start reporting the gap by distress as soon as identification exists.	Real-time feedback
C4-E2	**Feedback describing stigma or being dismissed.** The number of complaints and feedback comments describing stigma, being dismissed, or a physical symptom being put down to someone's mental health.	Set a baseline from 12 months of back-coded feedback. Then review and act on every case of this type within one reporting cycle, with the count falling year on year.	Compliments and complaints
C5-E1	**Whether feedback comes from everyone.** How closely the people who give feedback match the people Peter Mac actually treats. Compares each priority group's share of feedback responses against that group's share of all patients.	Set a baseline over the first two quarters. Then close the gap between each priority group's share of responses and its share of patients by half within 24 months.	Real-time feedback; VHES; demographic data
C5-E2	**Number of measures still showing a large gap.** The number of measures in this workbook where a priority group sits 10 or more percentage points below all patients, and whether that number is falling.	Set a baseline at the first full reporting cycle. Then halve the number of measures showing a 10-point gap within 24 months.	Calculated from the measure set
S1-E1	**Being asked about needs beyond the cancer.** The percentage of patients and carers who say someone at Peter Mac asked them about practical, emotional or financial worries, not just their treatment.	Set a baseline over the first two quarters, before screening starts. Then increase by 25 percentage points within 24 months of screening starting, with no group more than 10 percentage points below the overall figure.	Real-time feedback; demographic data
S1-E2	**Getting help after saying you needed it.** The percentage of patients and carers who said they had a support need and then say they got help that was actually useful.	Set a baseline over the first two quarters. Then close the gap between priority groups and all patients by half within 24 months.	Real-time feedback; service records

ID	Measure and what is measured	Target	Data sources
S2-E1	**Care missed or delayed because of cost.** The percentage of patients and carers who say the cost of their care caused them to delay, skip or stop an appointment, test, medicine or treatment. This is the harm the whole action exists to prevent.	Set a baseline over the first two quarters, before screening starts. Then reduce by half within 24 months of screening starting.	Real-time feedback; demographic data
S2-E2	**Knowing what treatment will cost before deciding.** The percentage of patients and carers who say they were told what they would have to pay before they made a decision about treatment.	Set a baseline over the first two quarters. Then increase by 30 percentage points within 24 months, with no group more than 10 percentage points below the overall figure.	Real-time feedback; demographic data
S3-E1	**Getting practical help with costs.** The percentage of patients and carers who said they struggled with costs and then say they got practical help — with travel, parking, accommodation, food or other costs.	Set a baseline over the first two quarters. Then increase by 25 percentage points within 24 months.	Real-time feedback; service records; demographic data
S3-E2	**People needing help but not qualifying for it.** The number of patients and carers assessed as needing financial help who fell outside the eligibility rules for every scheme available. Counted rather than turned into a rate, because each one is a person who can be helped this week.	Set a baseline over the first two quarters after the field is added. Then review every case within one cycle and find an alternative for at least half of them, within 24 months.	Service records
S4-E1	**Getting emotional support when needed.** The percentage of patients and carers who say they could get emotional or psychological support when they needed it. Compared between priority groups and all patients.	Set a baseline over the first two quarters. Then close the gap between regional and rural patients and all patients by half, and increase the overall figure by 10 percentage points, both within 24 months.	Real-time feedback; VHES; demographic data
S4-E2	**Waiting time for psychological support.** The number of days between referral and first contact with the psychology service, comparing regional and rural patients with all patients. Reported as the middle value and the slowest 10 per cent.	Set a baseline from 12 months of existing records. Then close the gap in waiting time between regional and rural patients and all patients by half within 24 months.	Service records; demographic data
S5-E1	**Being connected to the support you needed.** The percentage of patients and carers who say they were connected with the wellbeing or support services they needed. Compared between sites, and between priority groups and all patients.	Set a baseline over the first two quarters. Then close the gap between Bendigo and other sites and the Melbourne campus by half within 24 months.	Real-time feedback; demographic data
S5-E2	**Knowing what support exists.** The percentage of patients and carers who say they were told about the wellbeing and support services available to them, rather than having to find out for themselves.	Set a baseline over the first two quarters. Then increase by 25 percentage points within 24 months, with no site more than 10 percentage points below the overall figure.	Real-time feedback; demographic data

VHES = Victorian Healthcare Experience Survey. Demographic data are held in Peter Mac's reporting system.

Table I2. *Which priority groups can be identified in Peter Mac data*

Priority group	Identifiable now?	Proposed identifier	Interim reporting	Outputs that close the gap
People experiencing socioeconomic disadvantage or financial toxicity	No	A validated, person-level financial toxicity screen with a defined escalation threshold, consistent with the COSA roadmap[17]	Area-level socioeconomic profile of all patients, concession card status where recorded, financially coded social work referrals and Medicare-ineligible patients, each labelled as an indicator and not as prevalence	S2.2, S1.3, C5.1
People experiencing emotional or psychological distress	Not systematically	Distress screening at defined points in the pathway, with a documented referral threshold and a consent-based recording protocol	Screening completion in an existing survivorship pilot and psychology referral volumes, labelled as service signals. Whole-of-hospital experience questions on feeling heard and supported	S1.2, S1.3, C4.1
People from regional and rural communities	Yes	Modified Monash Model category derived from residential locality, with categories 3 to 7 treated as regional and rural[16]	Not needed. The derivation is a reporting task that can begin immediately. People who relocate for treatment or have no fixed address are reported as not classifiable	N4.1, C5.1

Table I3. *Limits recorded in the measure set*

Limitation	What it means and the response
Two of the three priority groups cannot be identified yet	Measures can be split by regional and rural status now. They cannot be split by financial hardship or distress until outputs S2.2 and S1.3 are delivered. Each measure states which groups it can currently be split by.
Surveys reach some people more easily than others	Digital-only surveys under-reach people without internet access, people who find reading hard and people who do not speak English. Phone, paper and interpreter-supported completion are to be offered, and measure C5-E1 checks whether respondents reflect the patient population.
Small numbers	Figures based on fewer than 10 people are not reported. Figures based on 10 to 29 are flagged as unreliable and are not used alone to start or stop an action. Quarters can be combined.
Area-level data are not person-level data	Area-level disadvantage describes a neighbourhood, not a person. It is used to describe groups and never to label an individual.
Complaints can move in either direction	Complaint numbers can rise because people feel safer to complain. A complaint measure is always read beside the matching experience measure.
A gap can close for the wrong reason	A gap narrows if a group improves or if everyone else gets worse. Every gap measure is reported with the overall figure beside it.
Baselines come before targets	No target is a number chosen in advance. Each is an improvement from a baseline that is measured first.

Appendix J: DEI Governance Structure and Reporting Cycle

The DEI Action Plan is governed through the Patient and Carer Experience Strategy. DEI reporting follows the Strategy's reporting line and there is no separate DEI reporting route. Roles are shown by position. Action owners and delivery leads are proposed in the DEI Governance Structure and are to be confirmed by Peter Mac.

Reporting line. Strategic action owners report to the DEI Implementation Group, which reports to PCXS governance. PCXS governance reports to the Community Advisory Committee and the Executive Quality and Safety Committee, which report to the Peter Mac Board of Directors. Table J1 sets out roles and Table J2 the reporting cycle.

Table J1. *Roles and accountabilities*

Role	Held by	Accountable for	Reports to
Accountable executive	Chief Medical Officer	Equity outcomes across the whole plan, including progress and any unresolved resourcing gap	Executive Quality and Safety Committee
Project sponsor	Director, Patient Experience and Wellbeing	Securing resources, removing barriers and approving any change to the scope of the plan	Accountable executive
Program lead	Manager, Patient Experience	Owning the plan, chairing the DEI Implementation Group, preparing the equity section of the PCXS report, and oversight of the Implementation Plan and measures	Project sponsor
Consumer representatives	Members of the Consumer Register and the Community Advisory Committee, including people from all three priority groups	Testing whether changes work for the people the plan is about, and holding the group to what was co-designed	Program lead and the Community Advisory Committee
Data and reporting	Business intelligence and analytics team	Producing the measures split by priority group, and the equity gap report	Program lead

Table J2. *Monitoring and reporting cycle*

What is reported	Prepared by	Reported to	How often
Project updates for strategic actions	Action owners	DEI Implementation Group	Every two months
DEI measures (year one establishes baselines)	Program lead with the business intelligence and analytics team	DEI Implementation Group	Quarterly
Equity gap report: every measure where a priority group sits 10 or more percentage points below all patients, with a named owner and a date	Program lead	PCXS governance	Every six months
DEI section of the PCXS report	Program lead	Community Advisory Committee	Four times a year
DEI section of the PCXS report	Program lead	Executive Quality and Safety Committee	Twice a year
Annual patient experience and wellbeing report	Project sponsor	Peter Mac Board of Directors	Annually
Resourcing position: outputs that cannot proceed without new investment	Project sponsor	PCXS governance, then the Executive	Annually, or by exception

Sign Off

Executive Sponsor approved by:

Name:	Kath Quade
Position:	Program Director, Western & Central Melbourne Integrated Cancer Service
Date approved:	07/10/2026

WCMICS approved by:

Name:	Kath Quade
Position:	Program Director, Western & Central Melbourne Integrated Cancer Service
Date approved:	07/10/2026