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RESEARCH ARTICLE

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Priority setting: Development of the South Australian Aboriginal Chronic Disease Consortium RoadMap for Action

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Abstract

Issues Addressed: Aboriginal and Torres Strait Islander (Aboriginal) people in South Australia are overburdened by cardiovascular disease, diabetes and cancer. The South Australian Aboriginal Chronic Disease Consortium (Consortium) was established in June 2017 as a collaborative partnership to lead the implementation of three state-wide chronic disease plans using a strategic approach to identifying key priority areas for action.

Methods: In 2017–2018, the Consortium Coordinating Centre facilitated a priority setting process, which involved extensive consultation, including a prioritisation survey and stakeholder workshops. The Consortium's Aboriginal Community Reference Group was instrumental in leading the identification of priorities for action.

Results: The Consortium RoadMap for Action identified seven across-plan priorities and six condition-specific priorities. It acknowledged that: strengthening social and emotional well-being is central to improving health outcomes; prevention and early detection, acute management and ongoing management are all components of the continuum of care; and improving access to services, strengthening the workforce, and monitoring and evaluation are required across the continuum of care.

Conclusion: Widespread implementation failure in the past across the health system and health services implementation and research translation highlights the value of the Consortium approach and its commitment to implementing the state-wide chronic disease plans in a collaborative manner. The Consortium relies on and fosters cross-sectoral alignment, with all key players including all public, private and Aboriginal Community Controlled health services, to progress its priorities and aspirations to improve health outcomes for Aboriginal people using evidence-based strategies.

So What? Rigorous and transparent priority setting processes that bring together research, clinical practice, health services operations, policy and community perspectives can foster intersectoral collaboration and partnership and support the implementation of shared priorities.

KEYWORDS
Aboriginal and Torres Strait islander, cancer, cardiovascular disease, chronic disease, diabetes, health services, Indigenous, intersectoral collaboration, policy

1 | BACKGROUND

Historical and ongoing structural inequalities in Australian society are causally linked to health inequities,[1] making colonisation the underlying factor influencing the social injustices that result in health disparities for Aboriginal and Torres Strait Islander (hereafter, respectfully, Aboriginal[1]) people in Australia.[2] Disparities in health status are particularly evident in the case of chronic conditions. Cancer and cardiovascular disease represent the leading causes of death for Aboriginal people, while diabetes prevalence presents at 2.8 times the rate for non-Indigenous Australians.[3] The health and well-being of Aboriginal people requires long-term commitment, partnership and collaboration among the health sector and broader system.[4] Critically, it requires leadership from the Aboriginal community to ensure that policy and practice meet the needs of Aboriginal communities, are culturally responsive and address the underlying socioecological drivers of health disparities.[5]

In South Australia, the absence of state policy for prevalent chronic diseases in the Aboriginal population led to the commissioning of the development of three state-wide chronic disease plans: the South Australian Aboriginal Heart and Stroke Plan 2017–2021 (Heart and Stroke Plan),[6] the South Australian Aboriginal Diabetes Strategy 2017–2021 (Diabetes Strategy),[7] and the South Australian Aboriginal Cancer Control Plan 2016–2021 (Cancer Control Plan)[8] by the South Australian Government. Each plan lists a wide range of individual priority action items, recommendations and strategies. One challenge for implementing these plans was identifying how the individual elements of each plan could be actioned in a coordinated way to enable a strategic implementation approach, prevent inefficiency and repetition, and contribute to a way forward that considered a whole-of-system and more holistic approaches to health policy. This focus on coordinated action was especially important given the tendency for commissioned health reports to remain as documented evidence, rather than being appropriately resourced and implemented in practice.

In order to support the implementation of the evidence into policy and practice and thereby improve health outcomes for Aboriginal people in South Australia, a South Australian Aboriginal Chronic Disease Consortium (Consortium) was established in June 2017 to implement the three state-wide plans.[9] The Consortium is a partnership of government, non-government, research and community organisations and Aboriginal communities that strives to shape Aboriginal health policy and service systems to have a meaningful impact on chronic disease inequality experienced by Aboriginal people in South Australia. Through a collaborative, appropriate and well-coordinated approach, the Consortium aims to successfully implement the priorities from the three plans.

Importantly, the Consortium includes Aboriginal community and health leaders, policy-makers, clinical expertise, university partners and private foundations within this shared vision. Its governance structure ensures clinical relevance, cultural appropriateness and responsiveness, and involvement of system-level decision-makers. It is composed of an Aboriginal Community Reference Group, an Executive Committee, and three Condition-specific Leadership Groups. Aboriginal community input is integral to the governance structure, with Aboriginal leadership and representation at every level of governance. For example, each level of the governance structure has at least one Aboriginal co-lead. The Consortium Coordinating Centre, funded by the South Australian Government, provides operational and executive support, facilitating the cooperation of all interested parties and fostering and sustaining effective partnerships and collaborations across the system.

This paper describes the process taken to identify across-plan priorities that address common key elements, as well as priority action areas unique to the three plans. It details the process of gaining consensus on the priorities and the development of the first 5-year implementation plan—the Consortium's RoadMap for Action 2017–2021 (RoadMap)[10]—and discusses the implications of this approach for supporting policy implementation and cross-sector alignment.

2 | METHODS

During 2017 and early 2018, the Consortium engaged in extensive consultation to identify key priorities from within the suite of strategies, recommendations and actions (hereafter referred to as 'strategies'[2]) documented in each of the three South Australia-wide chronic disease plans: the Heart and Stroke Plan,[6] the Diabetes Strategy[7] and the Cancer Control Plan.[8] The aim of this consultation process was to reach a consensus regarding the priority actions for the Consortium for the next 5 years. The consultation process identified priorities within each of the three plans and the overarching across-plan priorities.

The Consortium Coordinating Centre led the priority identification, which was developed through an extensive consultation process, including a prioritisation survey and three stakeholder workshops. The

Consortium's newly established Aboriginal Community Reference Group was instrumental in leading both the refining of content and identification of priorities. The Aboriginal Community Reference Group members included many who were part of the development of the plans themselves, so their leadership drew on their extensive experience with the evidence. The Condition-specific Leadership Groups included Aboriginal community representatives (who also sat on the Aboriginal Community Reference Group), clinicians and system managers, provided leadership through lived experience and clinical knowledge of the specific conditions.

The prioritisation process was undertaken in six stages: (1) prioritisation of strategies within each plan individually; (2) a roundtable workshop to rank the strategies and identify across-plan priorities; (3) a roundtable workshop to validate the identified priorities and refine the across-plan priorities; (4) a world café workshop to explore elements of implementation; (5) critique of the emerging RoadMap by the Aboriginal Community Reference Group and Condition-specific Leadership Group members; and (6) critique and sign-off of the RoadMap for Action by the Consortium Executive Group. These stages are illustrated in Figure 1.

2.1 | Prioritise strategies in each plan individually

The aim of the first level of prioritisation was to identify which strategies within each of the three plans took priority over others. This was undertaken to focus further discussion on a consolidated number of strategies and provide targeted direction to progress implementation. The Heart and Stroke Plan had 22 strategies,[6] the Diabetes Strategy had 23[7] and the Cancer Control Plan had 10.[8] Although all strategies remained relevant to the condition-specific plans, creating a workable RoadMap for Action required the streamlining of key strategies that could be implemented in a timely manner. This prioritisation stage guided subsequent stages of priority identification.

The prioritisation process applied a collaborative approach to ensure integration of broad stakeholder values, including Aboriginal community members. A web-based prioritisation survey utilising seven criteria and a five-point rating scale was developed to score individual strategies and recommendations (Table 1). The criteria were adapted from the Essential Service Standards in Equitable National Cardiovascular Care for Aboriginal and Torres Strait Islander people Measurement Indicators and Standards criterion[11] that had been developed following a review of Australian and UK literature. The criteria encompassed expected impact, importance, feasibility (time frame, funding, system change), organisational alignment and effectiveness of current activities.

Members of the Condition-specific Leadership Groups and the Aboriginal Community Reference Group were asked to participate in the prioritisation survey. The Condition-specific Leadership Group members (content experts) were asked to rate each strategy in the relevant plan using all seven criteria. Consideration of all these factors was vital for successful implementation of a comprehensive RoadMap. To enable the prioritisation of Aboriginal voices and worldviews, an independent process enabled Aboriginal community members to provide their input into the ranking activity. Aboriginal Community Reference Group members were asked to review strategies across all three plans, but only against the criteria of impact and importance.

The survey responses were analysed according to each plan to identify preliminary priorities using the criteria of impact and importance. The study team calculated an average score for expected impact and importance, then created an average feasibility score (time, systems change, funding). The average impact and importance scores were used to determine preliminary prioritisation, while the feasibility scores were synthetised and documented to provide context to program planning and development.

2.2 | Workshop 1: Rank priorities, identify across-plan priorities

A full day session with state-wide attendees representing Aboriginal communities and key parties from government and non-government organisations was split into three roundtable workshops. Workshop participants included representation from the Aboriginal community, Aboriginal senior leadership, chronic disease and condition-specific experts (diabetes, cardiovascular and cancer), health service providers, health system leaders and policy-makers across the continuum of care.

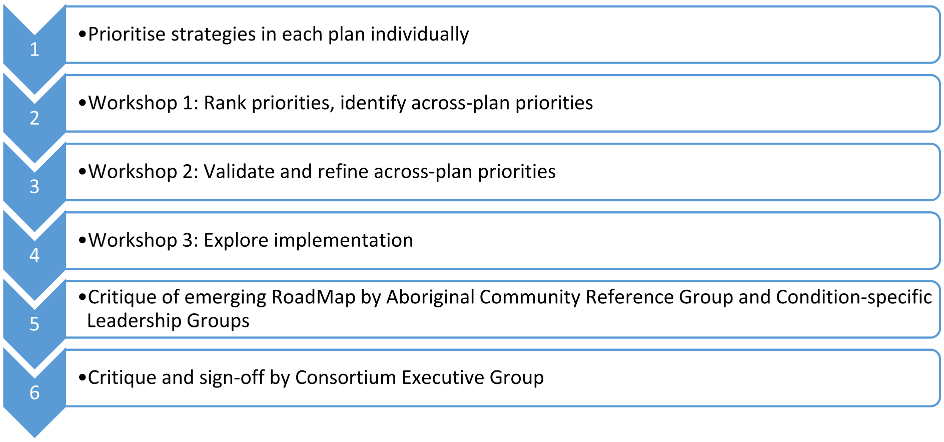


FIGURE 1 Prioritisation process.

TABLE 1 Prioritisation survey: criteria and rating.

	Rating scale: 1 = lowest, 5 = highest					Don't know	N/A
	1	2	3	4	5		
Expected impact							
If this strategy was delivered to all Aboriginal people needing it across South Australia, what impact would it have on closing the gap in health outcomes for Aboriginal people in South Australia?	Low impact		Some impact		High impact		
Importance							
How important is it that *this* strategy be delivered for Aboriginal people in South Australia compared to the others?	Low importance		Somewhat important		Very important		
Feasibility—time frame							
When could it be implemented across South Australia?	5 years or more		2–3 years		Immediately		
Feasibility—funding							
To what extent is new funding needed for effective implementation across South Australia?	Significant new $		Some new $		No new $		
Feasibility—system change							
To what extent does the system need to be changed to support effective implementation?	Complete change needed		Some change needed		No change needed		
Organisational alignment							
To what extent is the strategy aligned with your organisation's current strategy?	No alignment		Some alignment		Strong alignment		
Current activity							
How effective is your organisation at meeting this strategy currently?	Not effective		Somewhat effective		Very effective		

Abbreviation: N/A, not applicable.

The aim of the first roundtable workshop was to review the shortlisted strategies (i.e., ‘priorities’) that emerged from the first prioritisation stage within a broader network of relevant stakeholders. Each condition-specific plan had two roundtables of approximately 10 key stakeholders each completing the activity. The workshop was facilitated by experienced Aboriginal health researchers following a predefined method based on an adapted World Café methodology.[12]

Participants were asked to rank the priorities in order using the criteria of ‘most important’ and ‘most expected impact’ (definitions per Table 1). In addition, they were to identify priorities relevant to all three plans; this is because it was recognised that many actions across the three plans could be streamlined. This gave rise to the notion of ‘across-plan priorities.’ After the activity had finished, a representative from each table shared the findings with the room. The rankings were compared between the two condition-specific tables and agreement was reached on the combined ordering of importance and impact for each condition. Consortium Coordinating Centre members summarised the suggested across-plan priorities and developed a preliminary set of corresponding action areas.

2.3 | Workshop 2: Validate and refine across-plan priorities

The aim of the second roundtable workshop was to validate and refine the identified across-plan priorities, guided by the prioritisation survey results and stakeholder feedback provided in Workshop 1. Participants were grouped by sector: Aboriginal community, clinical, non-government organisation, policy. Participants worked in pairs to consider the emerging across-plan priorities by completing a worksheet (Table 2) that asked them to agree or disagree that the proposed priorities were important for all three plans and provide comments. Worksheets and butcher's paper were collected for each pair. Notes were taken while table representatives spoke and these notes were added to the priority findings. Findings from all groups were compared and preliminary top priorities were recorded.

Upon completion, participants worked within their sector group to identify which across-plan priorities were a ‘must do’ and which they felt were a ‘big problem’. Table facilitators then reported back to all participants.

2.4 | Workshop 3: Explore implementation

For the third roundtable workshop, participants engaged in discussion using a World Café approach (Brown and Isaacs, 2005) aligned with the preliminary across-plan priority areas: prevention, ongoing management, improving the workforce, social and emotional well-being, and monitoring, evaluation and data (Table 2). Participants shared ideas and contributed their knowledge on three of the five priority areas. Each table facilitator described the priority area and its

TABLE 2 Worksheet used in Workshop 2.

Workshop 2—Defining ‘across plan priorities’		
Do you agree that these are important across plan priorities?		
Prevention		Comments
• Primary prevention and health promotion	Yes/no	
• Individual risk assessment, screening and management	Yes/no	
Ongoing management		Comments
• Discharge system including systematic referrals to primary care	Yes/no	
• Rehabilitation and secondary prevention including survivorship	Yes/no	
• Ensure continuity of care	Yes/no	
• Access to medication	Yes/no	
Improving the workforce		Comments
• Coordinating multidisciplinary care	Yes/no	
• Access to specialist outreach services	Yes/no	
• Improving culturally appropriate care	Yes/no	
• Increasing Aboriginal workforce	Yes/no	
• Increased and ongoing ‘specialty’ training to Aboriginal Health workforce	Yes/no	
Social and emotional well-being		Comments
• Integrating social and emotional well-being into care	Yes/no	
• Availability of transport and accommodation	Yes/no	
• Culturally appropriate and effective health promotion materials	Yes/no	
• Addressing racism	Yes/no	
Monitoring, evaluation and data		Comments
• Periodic monitoring of the implementation of the plans across the 5 years	Yes/no	
• Utilisation of the ‘best evidence’ to drive best practice and enhance service delivery outcomes	Yes/no	

proposed aim along with potential actions. Table discussions were guided by the following questions: (1) What is already happening now across South Australia that should be considered when planning the implementation of this across-plan priority? (2) Who would be helpful in making this happen? Key points were summarised in posted notes and each sheet of butcher's paper was transcribed and results later collated by facilitators.

Following the workshops, members of the Consortium Coordinating Centre began drafting the implementation plan by mapping strategic actions to priority areas and defining these as core elements within a RoadMap for Action. The outcomes were synthesised into the first draft plan and overview of the RoadMap, including a detailed description for each priority area and corresponding actions.

2.5 | Critique of emerging RoadMap by Community Reference Group and Condition-specific Leadership Groups

To progress a critique of the emerging RoadMap, members of the Heart and Stroke Leadership Group, Diabetes Leadership Group, Cancer Leadership Group, and Aboriginal Community Reference Group were asked to scrutinise, reorient, validate and review the draft RoadMap. Key themes were validated by the Condition-specific Leadership Groups and the Aboriginal Community Reference Group. These included the following across-plan priorities: prevention and early detection; acute management; ongoing management; improving workforce; improving access to services; monitoring and evaluation; strengthening social and emotional well-being; and condition-specific priorities for cancer, diabetes, and heart and stroke. Condition-specific Leadership Group members were also asked to consider what was important in their condition-specific plan which was not covered as an across-plan priority but that should be highlighted for action. The latter was key in enabling individual plans to progress unique condition-specific priorities. Under each priority area, priority actions were identified for attention over 5 years. It was noted that achieving progress in some actions would have flow-on effects into other actions. The Leadership and Community Reference Groups then met to review the acceptability of the RoadMap and provided feedback during the meeting.

2.6 | Critique and sign-off by Consortium Executive Group

Consortium Coordinating Centre staff reworked the RoadMap in response to the feedback and recommended changes from the Condition Specific Leadership groups and Aboriginal Community Reference Group. The emerging RoadMap was then reviewed and critiqued by the Consortium Executive Group. This was important for success as each partner organisation supporting the Consortium Executive Group needed to be engaged in decision-making processes and endorsement of the RoadMap from both an advisory and resourcing perspective. Once the RoadMap was finalised, it was submitted for approval by all groups and sign-off by the Consortium Executive Group. The RoadMap and high-level implementation plan was presented to SA Health, the South Australian Academic Health Science and Translation Centre (currently, Health Translation South Australia) of which the Consortium is a flagship project, and the South Australian Aboriginal Health Partnership, a partnership between the Commonwealth Department of Health, the South Australian Department of Health and the Aboriginal Health Council of South Australia. Unanimous endorsement of the RoadMap confirmed its completion.

3 | RESULTS

3.1 | Participants

Approximately 60 people participated across the survey ($n = 42$) and workshop ($n = 54$) activities, representing key organisations, stakeholders and partners of the Consortium. These included Aboriginal community members and Aboriginal people working in the health sector.

3.2 | Survey results

The prioritisation survey identified the strategies that rated the highest for each plan. From the Cancer Control Plan, 'Increase Aboriginal people's participation rates in cancer screening programs' was identified as most impactful and important by both the Leadership Group members and the Community Reference Group. As there were only 10 Cancer Control Plan strategies, all 10 proceeded to the workshop ranking exercise in the following stage. Regarding the Heart and Stroke Plan, 14 of the 22 strategies scored above 4 (maximum score of 5) in either the impact or importance and were presented for ranking at the workshop. For example, 'Establish sustainable heart and stroke awareness and prevention campaign(s) across South Australia' rated highest on importance and impact. Similarly, 13 of the 23 strategies from the Diabetes Strategy scored above four in either impact or importance and were put forward as 'priorities' in the following stage. These included, 'Implement a state-wide approach to diabetes prevention that has application across the lifespan, is consistent and culturally appropriate' as the highest rated.

3.3 | Workshop results

The results of the first workshop, which ranked the shortlisted strategies according to importance and impact, identified a total of 14 across-plan priorities (Table 3). Prevention activities, both awareness raising and screening or health checks, ranked the highest in all plans. In addition, providing care that is accessible and culturally appropriate was a strong theme. The second workshop then assessed and validated these across-plan priorities, provided the evidence to

TABLE 3 Ranking of priorities by condition.

Condition	Rank	Priority
Cancer	1	Increase Aboriginal people's participation rates in cancer screening programs.
	2	Increase Aboriginal people's awareness and understanding of cancer prevention and treatment strategies through culturally appropriate and effective programs.
	3	Increase the understanding of, provision of, and access to culturally appropriate supportive care for Aboriginal people with cancer and their families across the cancer continuum.
	4	Continual improvement of access to safe, timely, optimal, equitable and culturally appropriate treatment services for Aboriginal people in South Australia.
Diabetes	1	Implement a state-wide approach to diabetes prevention that has application across the lifespan, is consistent and culturally appropriate.
	2	Increase the number of Aboriginal and Torres Strait Islander people receiving annual health checks.
	3	Develop and implement a Type 2 Diabetes Model of Care for Aboriginal people.
	4	Encourage Aboriginal people to use primary health care services.
	5	Embed diabetes in pregnancy in a state-wide Model of Care.
Heart and Stroke	1	Establish sustainable heart, stroke and diabetes awareness and prevention campaign across South Australia.
	2	Increase awareness of the warning signs and symptoms of heart attack and stroke among Aboriginal community and service providers.
	3	Build capacity in primary health care to provide coordinated management, secondary prevention and ongoing care for clients with established disease.
	4	Increase the use of cardiovascular risk assessment and management in all primary care settings.
	5	Develop a model of care and protocols to provide patient-centred and safe discharge from hospitals.

refine the 5-year RoadMap, and enabled the determining of implementation priorities for the first year. The third workshop built on the existing momentum of the plans to develop a shared, cross-condition strategy and actions for each across-plan priority area, in order identify funding and champions to lead the work and promote shared purpose across stakeholders.

3.4 | Emerging RoadMap

The emerging depictions of the RoadMap evolved from Figures 2A,B to 3. A key recommendation by the Aboriginal Community Reference Group, featured in the final version of the RoadMap (Figure 3), was that ‘strengthening social and emotional well-being’ be shown on the top and as the background of the figure to demonstrate its core importance in implementing all strategies.

3.5 | RoadMap for Action

The final South Australian Aboriginal Chronic Disease Consortium RoadMap for Action 2017–2021,[10] as approved and endorsed by Consortium's governance structure, consists of 7 across-plan priority areas and 6 condition-specific priority areas covering 27 actions. It includes a description of each priority action area with a definition and a rationale, a list of specific actions for this priority action area, and a comment on the proposed feasibility of those actions. The RoadMap also documents the role of the Consortium Coordinating Centre and potential partners. Actions are mapped to strategies in each condition-specific plan.

Prevention, risk identification and screening were identified and validated as a high priority across all three plans. Therefore, it was recommended that ‘prevention and early detection’ be the key priority for the first 12 months of Consortium activities. This included recommending a state-wide approach to increase access to risk factor identification and screening for chronic diseases for Aboriginal people across South Australia. All groups involved in the Consortium's governance structure agreed that the actions in the RoadMap would continue to be progressed and workplans developed as resources became available. Activities and initiatives would also be monitored over time.

The development of the Consortium's RoadMap for Action acknowledges that: (1) strengthening social and emotional well-being is central to improving health outcomes; (2) prevention and early detection, acute management and ongoing management are all components of the continuum of care; and (3) improving access to services, strengthening the workforce, and monitoring and evaluation are required across the continuum of care. It is important to note that while priority action areas have been individually defined in the RoadMap, there is potential for significant overlap: achievements in one area are likely to impact on delivering successful outcomes in another.

4 | DISCUSSION

In the context of widespread implementation failure in both Aboriginal policy and research settings,[13] the founding of the South Australian

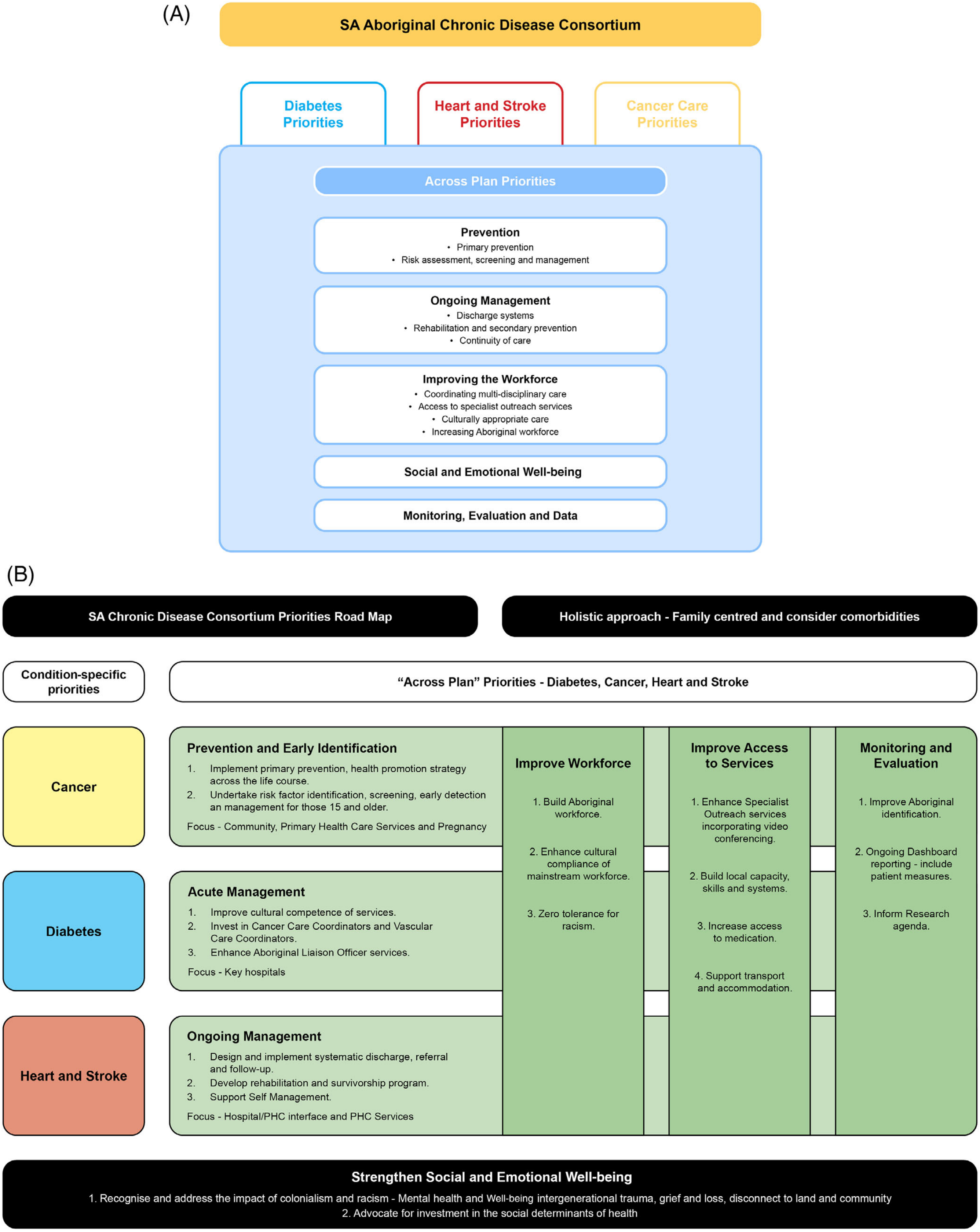
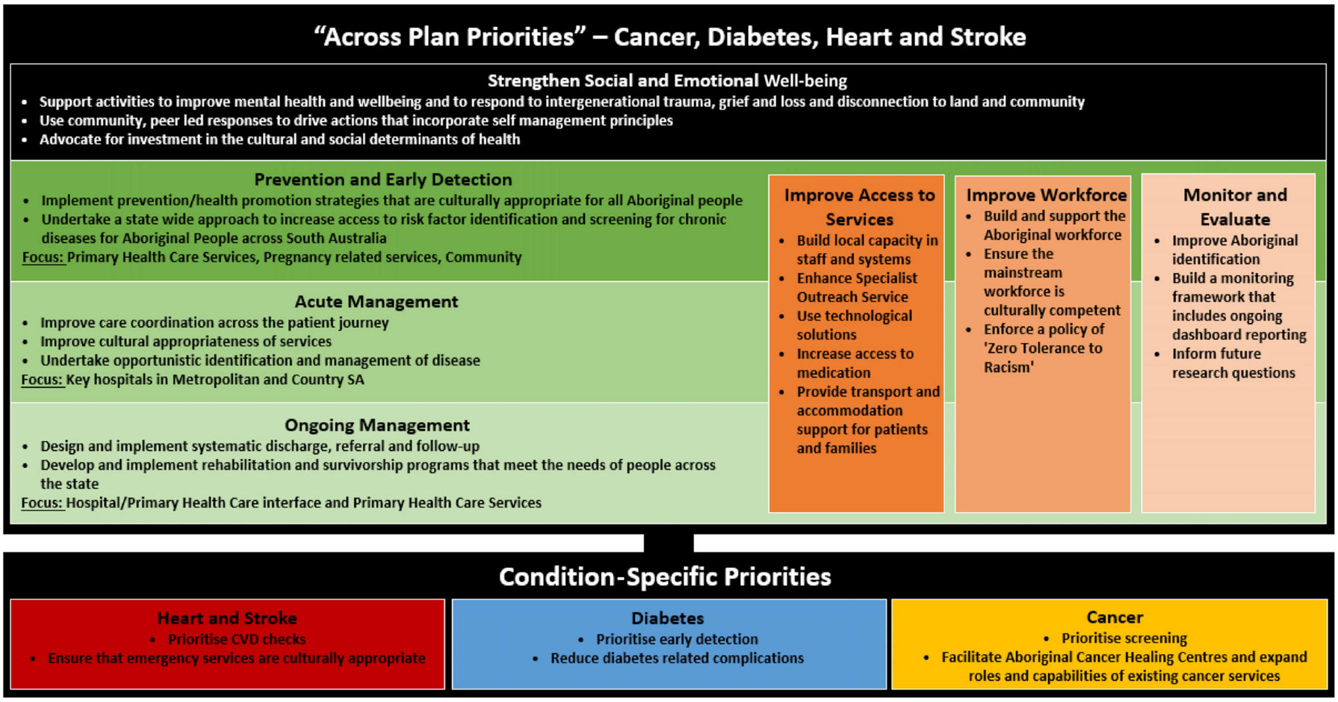


FIGURE 2 Preliminary depictions of the RoadMap. (A) First iteration of the RoadMap. (B) Second iteration of the RoadMap.



"Across Plan Priorities" – Cancer, Diabetes, Heart and Stroke

Strengthen Social and Emotional Well-being

- Support activities to improve mental health and wellbeing and to respond to intergenerational trauma, grief and loss and disconnection to land and community
- Use community, peer led responses to drive actions that incorporate self management principles
- Advocate for investment in the cultural and social determinants of health

Prevention and Early Detection

- Implement prevention/health promotion strategies that are culturally appropriate for all Aboriginal people
- Undertake a state wide approach to increase access to risk factor identification and screening for chronic diseases for Aboriginal People across South Australia

Focus: Primary Health Care Services, Pregnancy related services, Community

Acute Management

- Improve care coordination across the patient journey
- Improve cultural appropriateness of services
- Undertake opportunistic identification and management of disease

Focus: Key hospitals in Metropolitan and Country SA

Ongoing Management

- Design and implement systematic discharge, referral and follow-up
- Develop and implement rehabilitation and survivorship programs that meet the needs of people across the state

Focus: Hospital/Primary Health Care interface and Primary Health Care Services

Improve Access to Services

- Build local capacity in staff and systems
- Enhance Specialist Outreach Service
- Use technological solutions
- Increase access to medication
- Provide transport and accommodation support for patients and families

Improve Workforce

- Build and support the Aboriginal workforce
- Ensure the mainstream workforce is culturally competent
- Enforce a policy of 'Zero Tolerance to Racism'

Monitor and Evaluate

- Improve Aboriginal identification
- Build a monitoring framework that includes ongoing dashboard reporting
- Inform future research questions

Condition-Specific Priorities

Heart and Stroke

- Prioritise CVD checks
- Ensure that emergency services are culturally appropriate

Diabetes

- Prioritise early detection
- Reduce diabetes related complications

Cancer

- Prioritise screening
- Facilitate Aboriginal Cancer Healing Centres and expand roles and capabilities of existing cancer services

FIGURE 3 The South Australian Aboriginal Chronic Disease Consortium RoadMap for Action 2017–2021.

Aboriginal Chronic Disease Consortium and its commitment to implementing the state-wide chronic disease plans in a collaborative and strategic manner represents a concerted attempt to effectively translate research evidence into health care practice. The process of developing the implementation framework, the RoadMap for Action, utilising the extensive stakeholder knowledge, demonstrates this. Implementation failure refers to limitations in practically delivering health care innovations despite an abundance of evidence characterising what is required.[14] Implementation barriers may arise at multiple levels,[15] yet good governance can increase the effectiveness of health care interventions.[16]

Strong governance, including extensive Aboriginal leadership within its layered governance structure and strategies grounded in Aboriginal community engagement, allowed the development of the Consortium's RoadMap for Action to represent the voices and views of those with lived experience, a vital step in improving health equity.[17] Comprehensive frameworks for implementation consider multiple domains, such as the initiative itself, the inner and outer settings in which an initiative is to be applied, the individuals involved, and specific implementation processes.[15] By drawing on systems and clinical experience of feasibility and alignment to current activities, the Consortium was able to identify feasible priorities aligned with progressive action. Cultural suitability, a construct not always considered in mainstream frameworks, is important to Aboriginal program implementation, particularly where cultural specificity underlies program design.[18]

The Consortium both relies on and fosters cross-sector alignment to progress its priorities and aspirations, shared by its members, to improve health outcomes for Aboriginal people using evidence-based strategies. Sector alignment, in partnership with relevant communities, positions both communities and the agencies that serve them to better address health inequalities in innovative and meaningful ways.[19] Cross-sector alignment may be moderated by factors such as the degree to which communities are engaged, the availability of evidence to implement change, individual and organisational trust, and the ability of partners to hold one another accountable for community members' needs and goals.[20] Community voice is a vital element of cross-sector alignment, which lends itself to sustainable collaborations.[21] The Consortium provides multiple avenues for community voice to guide the prioritisation and implementation of activities to reduce the burden of chronic disease. Sustainable funding remains an enduring challenge for the Consortium.

Furthermore, implementation of the RoadMap was significantly disrupted by COVID-19. From early 2019, partner services began preparing for COVID-19. This affected both primary and tertiary sectors and continued at least until end of 2020. This meant that there were limited human resources within partner services to action implementation outside of projects focused on COVID-19. There was, however, increased focus on telehealth (and virtual care) and enhancing remote access, which aligns with RoadMap priorities. Since 2021, the plans have been reviewed and strategies assessed for ongoing appropriateness. It has been determined that the RoadMap priorities remain. Further information about the achievements of the Consortium in its first 5 years can be found in Morey et al. (2023).[9]

5 | CONCLUSION

The South Australian Aboriginal Chronic Disease Consortium was established in 2017 to drive, coordinate and sustain the implementation of the South Australian Aboriginal Heart and Stroke Plan 2017–2021, the South Australian Diabetes Strategy 2017–2021, and the South Australian Aboriginal Cancer Control Plan 2016–2021. The Consortium is a partnership between state, federal and non-government agencies, including the Aboriginal Community Controlled Health sector, the universities and research sector. Aboriginal community members are vital decision-makers, actively engaged in the governance, priority setting and program implementation. A rigorous and transparent process of priority setting that brought together research, clinical practice, service providers, policy and community has fostered intersectoral collaborations and partnerships for implementation that responds to shared priorities. The inclusive process of RoadMap development brought all stakeholders together around a shared vision and purpose, which has been important in the implementation that has fostered and grown collaborations and partnerships.

ACKNOWLEDGEMENTS

The authors write on behalf of the South Australian Aboriginal Chronic Disease Consortium Leadership Groups including the Aboriginal Community Reference Group. The Consortium is located on the traditional lands of the Kaurna people—the authors acknowledge the Kaurna people's ongoing physical and spiritual connection to their Country.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analyzed in this study.

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ENDNOTES

[1] In South Australia, where this work was undertaken, Aboriginal is a term widely accepted across Aboriginal and Torres Strait Islander communities, and the use of ‘Aboriginal’ by the Consortium has been supported by the Aboriginal Community Reference Group.

[2] Language between the three Plans varied. The Heart and Stroke Plan used the language of strategies, the Diabetes Strategy used the language of recommendations, actions and enablers, and the Cancer control plan used the language of actions.

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