

Submission to the Public Accounts Committee Inquiry into the Acacia Digital Patient Record System

Supplemental Information



Australian Medical Association Northern Territory

21st July 2026

Confidentiality

The AMA has received a request from the Public Accounts Committee for further information on a number of Acacia workflows that were raised as examples of clinical harm in our original submission. We have sought further information from members to fulfill that request.

It is important to note that doctors all raised significant concerns around confidentiality. A repeated refrain from doctors was concern for their employment if they were to speak up about issues they encountered with Acacia. The AMA NT has not seen a chilling effect like this with other projects in the NT and it must be noted that this is a significant barrier to the government receiving true information about the current state of Acacia. Doctors approached do not have faith in NT Health, DCDD, or whistleblower structures to protect them from retaliation.

This should be a primary concern for the PAC. Such chilling effects can only harm patients in the NT.

There are a number of senior clinicians who could certainly provide further and more detailed information. However, it is likely that they would only do so if the PAC were able to hear from them directly and in camera, without the knowledge of NT Health or DCDD.

The AMA does not specifically request that this submission be kept confidential, although care has been taken to prevent identification of those who brought the information to us.

Risk Management

The CCSRP/Acacia project lives inside DCDD, with NT Health as the primary customer. There are significant issues with risk management across both agencies with regards to Acacia, as there has never been a unified risk management approach.

NT Health use a risk management system known as RiskMan, whilst DCDD manage issues with a system known as Jira. The two systems are not interoperable, and during the lifespan of Acacia, clinicians have told the AMA that there was no single reporting mechanism or single “system owner” for risk management.

As a consequence, a significant number of open RiskMan reports and Jira tickets remain. The AMA NT has been told that CCSRP have upwards of 1,500 unresolved Jira tickets and ABS Acacia Support have upwards of 1,200 unresolved Jira tickets. Things are more opaque in RiskMan with no total numbers available. It is understood that NT Health has an Acacia dashboard that attempts to capture all RiskMan tickets that reference Acacia. This is a private dashboard that frontline staff don't have access to, but would be easily discoverable by a government authority who were seeking this information. This dashboard is understood to have “thousands” of open risks, but the AMA NT is not able to verify this number.

Surgical Services

This is an area that has suffered what appears to be the greatest impact.

The existing workflow to book or re-book a patient for an operation took around five minutes. Elective patients that cancel or “do not attend” take approximately 18 to 25 minutes to rebook for theatre. In worst case examples, this process can take 30 to 40 minutes. The interface has been described as clunky and non-intuitive, with only marginal time gains since the system was introduced and familiarity with the system was gained.

Next-of-kin import mismatches seem to be the hardest to rectify. For reasons that remain unknown, Acacia has imported the incorrect next-of-kin for patients in an unpredictable manner. This is a manually corrected process and the issue is usually identified when the reported next-of-kin is uncontactable. The impact of this issue is unknown but has obvious elevated risk. For example, the NT has the highest rates of domestic and family violence (DFV) in the country. It is not uncommon for a next-of-kin to be a perpetrator of DFV and the disclosure of medical information to this person would not be acceptable or safe for the patient. This issue has been reported via RiskMan/Jira with no resolution.

Deceased patients being booked for operations is an issue that was raised with us. It is unclear how this is occurring. A manual audit process has been instituted to correct the issue (a common solution to issues raised by health practitioners that remain unresolved via the risk management systems). The manual audit requires checking the patient’s record across legacy systems to ensure they are not deceased and typically takes approximately two minutes per patient. Auditing is done on a weekly basis which totals >100 patients. This is a slow process because if a patient is accidentally “deceased” and then “un-deceased”, not all of the existing record is restored and workload is significantly increased.

It was also identified that removing Aboriginal & Torres Strait Islander status from a record removes it from all episodes in the system retrospectively. This is an intended function of the system according to CCSRP, but there is no safeguard to prevent this from being done accidentally. It is hard to see why such a modification can be made to someone’s entire medical record and without error checking. This is not acceptable from a clinical standpoint given the importance of culturally safe person-centred care in the NT. This is an example of a feature of the system that has been designed without appropriate consultation with patients or healthcare providers. To software engineers, this may appear as a demographic error. To clinicians, this is critical information that affects evidence based care for the diagnosis of rheumatic heart disease, coronary artery disease and gestational diabetes screening.

Emergency Departments

Issues with the Emergency module were well publicised during the initial rollout and subsequent rollback. They were many and numerous, with the main issue being around “visibility”. It was difficult to see where patients were in the department and to maintain a mental model of where the workload or severity was. The interface failed to clearly display the patient location and acuity across the department, creating a lack of awareness for senior clinicians and posing a serious patient safety risk. This has been rectified somewhat but it required a concerted effort from the Acacia team over several months, but remains an inferior replacement of the previous low functioning system. The cost of this exercise was likely incredibly high and completely unnecessary, had early consultation and codesign and/or user acceptance testing been done with emergency medicine doctors prior to the rollout.

Feedback from Katherine District Hospital highlighted a number of these workflow concerns that were ignored or not dealt with appropriately prior to the rollout in Royal Darwin & Palmerston Hospitals. It should have been well known that these issues would occur in RDPH given the feedback provided from KDH.

The most useful metric to look at is ED wait times. The Australian Triage Scale (ATS) is a standardised model for ED triage across the country. ATS category wait times are easily recorded and reported to the Commonwealth. There is a correlation between wait times and the rollout/use of Acacia, which can be found in NT Health reporting and national safety & quality databases such as the Health Roundtable.

The following page is a screenshot of the Australian Emergency Department Report from the Health Roundtable. This is a national report that almost all emergency departments in Australia report to. It is an essential resource for monitoring safety within departments, and detecting trends that may demonstrate either superlative processes or patient harm. Crucially, they enable a health service to compare its performance to peers, to help recognise where performance can be improved. The screenshot demonstrates the ability of RDH to meet Category 1 (immediately) and Category 2 (within 10 minutes) wait times.

The purple line demonstrates RDH's performance over time. The initial rollout of Acacia is clearly demonstrated by the rapid deterioration of performance, with Cat 1 performance falling from 100% to 20% and Category 2 performance falling from ~40% to ~10%. When Acacia was rolled back and CareSys was switched back on, the performance immediately returned to baseline levels. You can then see the repeat deterioration in performance when Acacia was re-enabled later in the time period.

ATS times are a critical metric for safety. The fact that this data is coming to the PAC via the AMA NT and not NT Health or DCDD is a concern for the systems that are in place to protect our patients. We encourage the PAC to interview those who have access to datasets such as the Health Roundtable and are able to provide a clinical opinion to the PAC on its results. The AMA NT would be happy to assist with this process, although it must be noted that senior clinicians with this skillset will be unlikely to assist without the confidentiality protections discussed above.

Triage Performance - Category 1

Triage 1 performance at your hospital was 66% compared to the All Health Roundtable at 78% in the April-25 to March-26 period.

66%

My Hospital

78%

All Health Roundtable



Triage Performance - Category 2

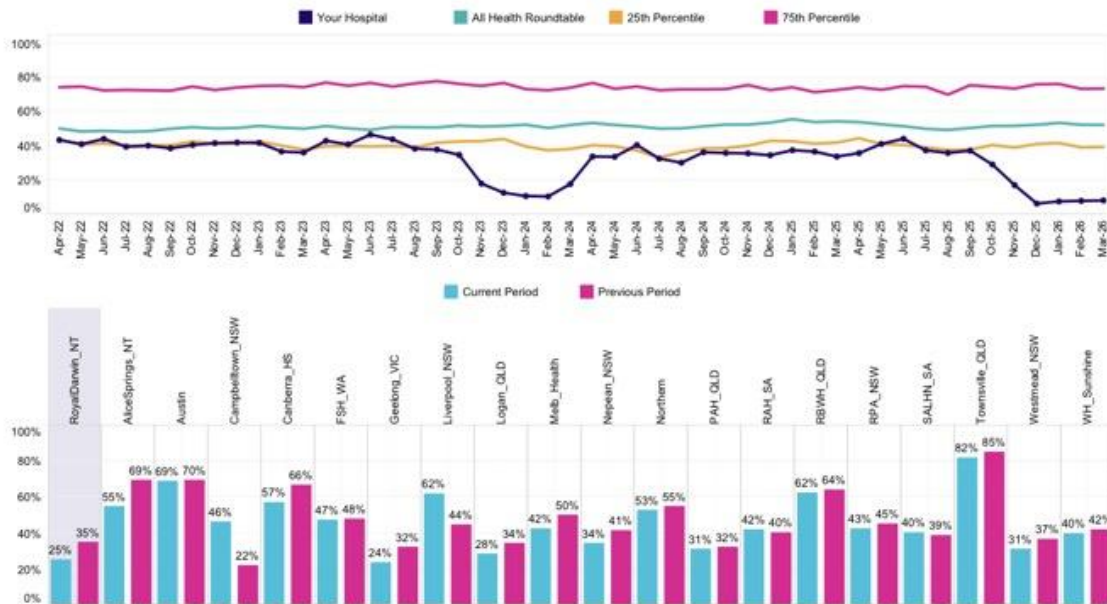
Triage 2 performance at your hospital was 25% compared to the All Health Roundtable at 52% in the April-25 to March-26 period.

25%

My Hospital

52%

All Health Roundtable



The Core Issue: Change Management

There has been a dual project structure since the commencement of the CCSRP that has doomed the project from the start. The project sits within DCDD with NT Health as the customer agency. The organisational structure gave no effective power to frontline staff and did not appropriately escalate concerns from frontline staff. Common feedback from those who attempted to report these issues was that they were “gaslit” into thinking they were the issue rather than the software.

I remind the committee of the comments that were shared with us where two senior DCDD engineers described DCDD as “the tail that wags the dog”, with NT Health being the dog.

As the rollout of Acacia continued, it appeared that there was no healthcare change management methodology in use. Change management in healthcare is notorious for being incredibly difficult and without the appropriate change management model, healthcare projects almost always universally fail. Projects of this nature require experts in healthcare change management. Sadly, we have those experts in NT Health (many of them are frontline staff) and they were not involved in the project in a meaningful way.

Had DCDD stepped back at the start and consulted experts in NT Health on healthcare change management appropriately, we may not be having this inquiry today.

How to Salvage Acacia

The AMA NT stated that the worst position we could find ourselves in is the situation we find ourselves in today: a partial rollout with no clear path forward. Acacia has come at an inexcusable cost to date and the amount of healthcare that we have had to forego resourcing because of the gargantuan cost of Acacia is unacceptable.

In health IT, a PAS (Patient Administration System) manages hospital logistics and patient details, like names and appointments. A CIS (Clinical Information System) manages actual patient care and medical data, like test results and doctor notes. The simplest path forward, at a high level, would be to retool Acacia to serve only as a simple patient administration system (PAS). This would allow areas of NT Health to seek appropriate clinical systems at the level of departments, divisions or health services.

There is a much larger conversation to be had here on healthcare change management, the interagency relationship between DCDD/NT Health and the potential role for the CCIO office. The AMA NT would welcome such conversations.