PAC Submission on Acacia

Introduction

Please accept this submission in relation to the investigation into the costs associated with the implementation and management of the Acacia digital patient record system, also known as the Core Clinical Systems Renewal Program (CCSRP).

This submission offers the perspective of an IT professional who was directly involved in CCSRP. The call for an investigation into the costs associated with CCSRP is certainly called for, as the costs for the program have far exceeded those originally budgeted for. The recent suicide of Sean Joyce and allegations of a toxic work environment have added to the need for an investigation into the management within the program.

Firstly, let me divulge my involvement with CCSRP, and my association with Northern Territory Health:

- The development of the Community Care Information System (CCIS) and Primary Care Information System (PCIS) from 1999 – 2013, and ultimately as the Product Owner for these solution offerings:
    - Firstly, as an an employee of Jade Software Corporation and then Ascribe UK Plc
    - These systems were effectively customised developments for the NT Health environment
- In 2017 accepted Application Specialist role with InterSystems (ISC) based in Darwin at initiation of CCSRP:
    - Left ISC when it became obvious to me that the existing TrakCare product design was primarily based on use within private hospitals and there was only limited functionality that would be able to replace the legacy CCIS and PCIS capabilities:
        - When ISC informed me that it would not be acceptable to them for me to openly discuss this with NT Health, I resigned immediately
- In 2021 I accepted a Business Analyst role with DCDD on CCSRP:
    - Contract terminated in May 2025.

As someone who worked within the program, I believe that a thorough independent audit needs to be performed to expose the underlying reasons for the program's cost blow out and therefore what lessons need to be learnt to avoid it being repeated. I also believe that the NT taxpayer has every right to know how poorly managed this program was.

Program Management Issues

In this submission I focus on the program management issues I believe significantly contributed to the difference between the initial project Budget and the cost of procuring, implementing and managing the Acacia system to date.

Firstly, when I started with ISC in 2017, I learnt of a couple of things that I believe had a detrimental effect on the overall success of the program right from the outset:

- I was informed that DCDD was given responsibility for the program on behalf of NT Health because there was a belief that NT Health could not deliver a successful outcome on their own – this showed a level of arrogance that I experienced within the project, and in hindsight certainly hindered the program
- Too much credence was given by those involved in the selection process to ISC's tender responses, indicating that the already available TrakCare product functionality could easily satisfy the majority of the CCSRP Requirements Traceability Matrix items used for the tender evaluation process.

Over my four-year involvement as a Business Analyst with DCDD on CCSRP, I have made the following observations that I believe warrant further investigation:

1. There was a lack of awareness within the CCSRP senior leadership team on the challenges of purchasing and implementing a Commercial-Off-The-Shelf (COTS) product like TrakCare as a replacement for existing custom-developed legacy solutions based on unique operating practices within the NT Health environment, and for which ISC had only limited domain knowledge:
    a. The exercise of replacing the exiting legacy systems with TrakCare could not have been begun from two more diverse starting points – the underlying business architectures of TrakCare and the legacy systems were significantly different. To justify this, I offer a couple of examples:
        i. The Outpatient functionality within TrakCare was designed around clinicians managing their own engagement for patients who would simply present to an urban clinic setting, whereas the nature of patient engagement in the NT was based around clinical administrators managing patient contact with non-clinician specific resources typically in a Specialist Outreach model of care, and where remote Health Centre staff needed to be a proxy for managing patient presentation
        ii. The Emergency Department functionality gap appears to have been another example?
    b. At some point after project inception, there needed to be a realisation that the gap between the TrakCare global product offering and any

alignment with current fundamental business practices at NT Health were much greater than originally anticipated:
    i. To a degree, I understand that this did occur and this resulted in a program reset that introduced the five Functional Group (FG) phase approach
2. However, this FG approach adopted by CCSRP has to be questioned. The overarching approach was for ISC to simply demonstrate the existing TrakCare functionality and then for DCDD engaged Subject Matter Experts (SMEs), drawn from the business, to document their requirements for how they would like the TrakCare solution to be enhanced/modified at a detailed User Interface level, and to better reflect the way existing legacy systems supported current work practices:
    a. This was at best an exercise in how to "fit a square peg in a round hole"
    b. It completely avoided the exercise of evaluating the different business architectures (principles) involved and rationalising business transformation objectives
    c. This chewed up a significant amount of time and resource, and it can now be argued that the return on investment was very unsatisfactory
    d. It is fair to say that this approach resulted in significant frustration from all parties involved (i.e. ISC, DCDD CCSRP participants, and ultimately Acacia end users where a common statement of it just not being "fit for purpose" was often provided)
3. CCSRP lacked the business architecture expertise needed for a challenging software replacement exercise of this nature. The senior program managers within CCSRP did not have the experience to recognise that the adopted implementation strategy would lead to the outcome that has resulted to date. They were rigid in enforcing their approach as summarised above and were not prepared to be challenged by individuals within the program who raised concerns:
    a. Program management needed to appreciate that their approach was effectively taking a COTS product down a path of significant customised development, rather than transforming their business practices to adopt the COTS product with minimal enhancements incorporated into a global product's roadmap
4. ISC also need to take a great deal of responsibility for the outcomes that have resulted. They showed a significant lack of leadership and guidance in dealing with the challenges experienced within the program:
    a. The tension between an expected straightforward COTS implementation vs the accommodation of significant customised enhancements was never professionally managed, and therefore did not allow for

architectural design and associated cost implications to considered and planned for:

i. Business and solution architectural principles needed to be adopted that could govern informed decision-making to address these tensions, particularly in regard to resourcing and cost implications

b. Many attempts were made within CCSRP to engage with ISC on making progress on the Functional Group 4 phase of the program (the replacement of CCIS and PCIS) – however none of these were successful

i. The poor leadership within DCDD and the continued absorption of time and resource in the FG1 phase allowed ISC to continually defer any obligations to engage in addressing the significant gap in capabilities of the existing TrakCare product and Remote Primary Care requirements – this suited ISC down to the ground and allowed the program budget to be used up without exposing TrakCare to costly enhancements

5. It is not surprising that a program like CCSRP did not achieve the success hoped for and therefore it would unfortunately become subject to destabilising work environment pressures:

a. Combine this with the promotion of managers without the experience necessary to manage these circumstances, then a toxic workplace culture will inevitably develop:

i. Bullies were allowed to flourish and ignore the communications of others trying to improve the situation. Employees were placed in unfair situations and threatened with dismissal by managers if they pushed back

ii. There is hopefully documented evidence of this in the internal investigation launched by Catherine Weber following the suicide of Sean Joyce, and the findings of which have been made available to the committee.

<u>Conclusion</u>

I hope that this submission is one of many that can provide invaluable insights into why CCSRP has cost what is has to date, and to ensure that significant improvements can be considered for any potential project completion.

Due to the lack of professional IT solution architecture and business transformation expertise utilised in the program, an independent audit will almost certainly be required to overcome biased conjecture from different parties involved. I wish the committee all the best in their review.