



LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

15th Assembly

PUBLIC ACCOUNTS COMMITTEE

Public Briefing Transcript

Inquiry into the Acacia Digital Patient Record System

9.00 am to 1.00 pm, Tuesday 17 February 2026

Litchfield Room, Level 3 Parliament House, Darwin

Members: Mr Clinton Howe MLA, Chair, Member for Drysdale
Mr Manuel Brown MLA, Member for Arafura
Justine Davis MLA, Member for Johnston
Mr Matthew Kerle MLA, Member for Blain
Mr Andrew Mackay MLA, Member for Goyder
Mrs Laurie Zio MLA, Deputy Chair, Member for Fannie Bay

Witnesses: *Department of Health*

Chris Hosking PSM: Chief Executive Officer
Kim Charles: Deputy Chief Executive Officer
Prof Nadarajah Kangaharan: Acacia Clinical Sponsor and Co-Director of Medicine RDH
Angela Brannelly: Regional Executive Director – Top End Regional Health Service
Dr Andrew Bell: Chief Clinical Information Officer

Department of Corporate and Digital Development

Catherine Weber PSM: Chief Executive Officer
Greg Connors: Deputy Chief Executive Officer, Digital Services
Grace Johnson: Program Director, Core Clinical Systems Renewal Program

INQUIRY INTO THE ACACIA DIGITAL PATIENT RECORD SYSTEM
Department of Health

Mr CHAIR: On behalf of the committee, I welcome everyone to this public briefing into the Acacia digital patient record system.

I welcome to the table to give evidence to the committee from the Department of Health, Chris Hosking PSM, Chief Executive Officer; Kim Charles, Deputy Chief Executive Officer; Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine, RDH; Angela Brannelly, Regional Executive Director, Top End Regional Health Service; and Dr Andrew Bell, Chief Clinical Information Officer. Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of parliamentary privilege and the obligation not to mislead the committee apply. This is a public briefing and is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you say should not be made public, you may ask the committee to go into a closed session and take your evidence in private.

Could you each please state your name and the capacity in which you are appearing.

Mr HOSKING: Chris Hosking, Chief Executive, Department of Health.

Ms CHARLES: Kim Charles, Deputy CEO, Department of Health.

Dr BELL: Andrew Bell, Chief Clinical Information Officer, Department of Health.

Prof KANGAHARAN: Nadarajah Kangaharan, Clinical Sponsor for Acacia.

Ms BRANNELLY: Angela Brannelly, Regional Executive Director, Top End Region, Department of Health.

Mr CHAIR: Thank you all. Mr Hosking, would you like to make an opening statement?

Mr HOSKING: Yes, I would like to make some brief opening remarks, thank you.

Good morning, Mr Chair and colleagues and committee members, thank you for the opportunity to appear before the committee today and answer questions regarding the inquiry into the Acacia digital patient record system.

Before I start I would like to acknowledge that we meet today on the lands of the Larrakia people, traditional custodians and storytellers of these lands for many thousands of years. I pay my respects to the Larrakia, their elders, past, present and emerging, and I also acknowledge any First Nations people who join us here today.

As you mentioned in your opening remarks, Mr Chair, I am joined today by my colleagues. My deputy is Kim Charles. Professor Kangaharan—and for ease of use we usually call him Dr Kanga, so I think we will stick with that today. Dr Kanga is one of the Territory's most senior cardiologists and has been the clinical sponsor of the Acacia program since its inception. To my left is Ms Angela Brannelly. Angela is the regional ED for the Top End Health Service. Angela was leader in the Katherine region during the very first Acacia implementation back in July 2022, and she is also currently the senior executive in charge of Royal Darwin Hospital. Dr Andrew Bell is our Chief Clinical Information Officer. Dr Bell has practised medicine in the Territory for over 30 years and has been instrumental in digital innovation to support healthcare in the bush, and is an important part of our delegation today.

Acacia is a modern, contemporary digital system that will support the delivery of healthcare right across the Territory in all its clinical settings. Acacia is quite groundbreaking and once it is fully deployed will position the Territory in front of other Australian jurisdictions where multiple different systems are used across different hospitals and health services, making it really difficult to get a continuous longitudinal patient record. Acacia is not just terrific innovation; it is absolutely necessary. The obsolete clinical IT systems used across the Territory that are being replaced by Acacia are more than two decades old and are no longer supported by an enterprise software vendor.

The proposal on which the investment in Acacia was first approved was based on two key benefits. The first one was addressing this legacy technology risk. Operating an entire jurisdiction's public health services on obsolete software is not a sensible place to be. Most importantly, improving patient outcomes by putting patient information in the hand of clinicians in real time at the point of care, which makes a very real difference in terms of delivery of that care, and you will hear more about that today from the two doctors who join us.

This was a necessary step to mitigate risk and provide the Territory with a legal right to operate and modify these systems. We acquired the intellectual property rights to the old systems in order to keep those supported while we implemented Acacia. Much has been said about Acacia, and it has certainly received its fair share of media attention, some of it factual and some hyperbole, and we now turn the rigorous lens of the Public Accounts Committee to this critical strategic initiative.

Where is the project really up to? Acacia has been in day-to-day operational use in many Territory hospitals for a number of years now. The system was progressively rolled out in Katherine in July 2022, Gove in November 2022, Royal Darwin and Palmerston hospitals in November 2023, and in August last year Acacia was successfully introduced to over 1,500 system users across Alice Springs and Tennant Creek Hospitals. These were our smoothest implementations to date, with high levels of engagement and adoption from our NT Health people at all levels across those hospitals. Now that these Go Lives are complete Acacia is the core patient management system in all our Territory public hospitals, something that is a really special achievement.

It has not all been smooth sailing, and we certainly acknowledge that. These projects by their very nature are extremely complex and risky endeavours.

The project to deliver Acacia is the largest and most complicated and most significant investment in digital transformation ever undertaken in the Northern Territory, and implementing clinical IT systems is in and of itself extremely challenging. Case studies in Australia and, indeed, globally confirm this over and over again. We knew this when we started our work and we went in with our eyes open. The Acacia project has persevered through all the difficulties to achieve success.

There are two key areas that have not gone to plan. The original project budget of \$259m has needed to be supplemented by just over \$60m, bringing the total project budget to the \$320m mark. We have addressed this budget variation comprehensively in our written submission to the committee, and I expect it will form a line of questioning here today.

We have also experienced challenges in the emergency medicine department at Royal Darwin Hospital. These challenges led to the use of Acacia being temporarily suspended within the ED when they reverted to using the old CareSys system while further comprehensive enhancements to Acacia were undertaken. This work is now complete and the reimplementation of Acacia within the ED was executed smoothly and without incident in November 2025. This means that in our entire Northern Territory public health system—including all of our emergency departments—our clinicians are using Acacia every single day to do their work, providing high-quality healthcare for Territorians. That completes what has been challenging and complex work to accommodate the specificity and nuance of emergency medicine as it is practised in the Top End within a modern, contemporary clinical technology solution.

This parliamentary committee today is all about accountability. Accordingly, I would like to place some key remarks on the *Hansard* today.

I am a deeply committed Territorian. I grew up here. My wife and I have raised our children as Territorians, and I plan to die here. I have been a public servant in the Northern Territory since 1986. This year actually marks my 40th year of service to Territorians. When I started in the public service we did not have computers or IT systems; we used biros and pieces of paper.

Until I took on the role of Chief Executive with the Health department in September 2024 following the change of government, I was the Chief Executive of DCIS and later DCDD, accountable for the delivery of Acacia. As the Chief Executive of the Health department I am now accountable for the way that critical reforms such as Acacia are deployed within the Department of Health to support the delivery of patient care to Territorians—care that is contemporary and places the patient at the centre.

My personal accountability as a senior government official is something I take extremely seriously. In my 40-year career with government I have never worked harder, committed more time, focus or effort to any endeavour than I have to Acacia. This has received my very best effort for a period of almost 10 years.

While it has not been perfect—no project with this level of complexity is ever executed perfectly—it has been a resounding success. Acacia is making a tremendous and transformative difference in the care that is delivered to patients in our Territory hospitals every day.

On the *Hansard* today, I wish to state very clearly that I take full personal accountability for Acacia, for our omissions as well as our successes. I am here today with a team—and I stand shoulder to shoulder with our team of talented and committed professionals who have done this work. I am incredibly proud of what we have achieved together and I am very capably supported today by my colleagues.

We look forward to assisting the committee in their inquiry. We appreciate the opportunity to appear today before you, and we look forward to your questions. Thank you very much.

Mr CHAIR: Than you, Mr Hosking. Before I open to the committee for questions, I find it useful for us just to go through a timeline. If you could talk us through a timeline from when this project was first identified as a need and walk us through to today. Then I will open to my committee members for questions.

Mr HOSKING: I am stretching my memory banks; it goes back a long way. I think the very first proposal that the Health department brought forward identifying the obsolescence of their IT systems and seeking investment from the government at the time was around about 2014. I think the first iteration of the proposal was made to government then to invest in new systems, noting that the existing systems were reaching end of life. That did not make it through the

budget round in 2014. The business case was a little immature and I think they were told to go away and do some more work on it. Another attempt was had in 2015, which did not quite get there either.

In 2016 in the May budget, the then Giles government approved the very first business case for the program and the program commenced and we went to tender for new IT systems. There is a fairly protracted period of time after that when we went through the tender process, assessments, site visits and those sorts of things.

My recollection is a contract was awarded around about the second half of 2017 or thereabouts. Our vendor InterSystems was chosen, and we commenced planning and so forth around the program.

The decision in 2016 to approve the business case for the first time anchored the accountability for project delivery and the funding with the Department of Corporate and Information Services. That was not proposed in the submission. That was a decision that Cabinet made at the time to task that to DCIS, hence my involvement; I was with DCIS at the time.

Then work began on the project. There were a couple of obviously significant impacts to timeframe that occurred during the period of the pandemic. I do recall being very close to our first system Go Live in Katherine Hospital in late 2022, I think it was, and I do recall Angela ringing me to say we have had community-based transmission of COVID and Katherine went into lockdown. The Katherine implementation subsequently happened post pandemic in July 2023. We had attempted to persevere through the pandemic and get the system introduced, despite all the problems that introduced, but in the end it got the better of us. Certainly there was some protraction to the timeframes resulting from that.

Then we have been sequentially rolling the system out to subsequent hospitals. It went to Gove in November 2023; Royal Darwin and Palmerston, which are by far our largest cohort—there are about 5,000 system users across those two big hospitals—in November 2024; then the subsequent southern region and Barkly region deployments in 2025; and the reimplementing of the improved version of Acacia in the emergency department in last November, which is going very well.

We are at that point now where the system is fully deployed within our hospitals, within our acute care environment. There is still more to do and we have some moderate capacity to keep progressing some of the subsequent phases. There are some that are yet to be completed related to non-hospital care in areas such as remote primary care in the bush. We also have a digital medication system that is in scope to be replaced with the medications management functionality that is native to the Acacia system.

That pretty much brings us to today.

Mr CHAIR: Just to fill in some of that, the contract went out in 2017. It was awarded in 2017. If you could, just talk me through that contract, who it was awarded to, the timeframes on it and also the ministers who were overseeing and at what points did any ministers change as well.

Mr HOSKING: I might be a bit sketchy on dates when ministers changed; I will do my very best.

We did a two-stage tender process. We went to market, and I think we had 17 respondents to our initial public tender, of which four were highly competitive. Those four were shortlisted and taken into a more detailed and comprehensive tender assessment process, and the others held in reserve on the basis of that. That assessment process was extremely thorough. We had a number of different assessment panels assessing technology, commercials and clinical functionality. We had something like 50 clinicians involved in the assessment of tenders in subpanels, getting presentations from our vendors and so forth.

InterSystems were selected as the successful vendor. They were really the only one that could provide a solution that could work right across the span of public healthcare in the Territory in one code base. A number of the others had very good technology solutions, but needed to give us several different solutions that you would then need to bolt together to address hospital care and primary care and urban primary care.

The InterSystems one was within our affordability envelope, very importantly. Some were not; some were well beyond that.

We executed that contract with InterSystems around July 2017, if my memory serves me well. It is a fixed-price contract to deliver, so vendor costs are controlled through fixed pricing in the contract, which is a fair bit of work to negotiate, but serves you well when things get rocky or off-track later on in a project. Obviously no-one predicted that two years later we would be in a global pandemic.

In terms of the actual software it is a 10-year software support with two options for five years on top of that, so potentially a 20-year deal. Generally, you need a long contractual period like that to achieve your ROI from a major investment in a system like this. They are not the sort of thing you would change out on a regular basis. If you implement a system this thoroughly right across all aspects of healthcare, it is there for a long time. That is appropriate and sensible.

The implementation costs are fixed, so when we have had challenges in delivery that has not led to additional vendor costs because they are tied to fixed pricing. I am conscious that the vendor is in the audience today too, but anyway.

In terms of advice that was provided through to ministers, when the initial Cabinet decision to approve the program was delivered as part of the May 2016 budget, there was an obligation placed on DCIS at the time to report quarterly to Cabinet. That is still happening. That Cabinet reporting has been happening every quarter like clockwork. There has been a number of different ministers over that period of time, obviously—we had several changes of government in that time. Ministers have been kept very well briefed along the way. Certainly, in all the years I was accountable for delivery of the program it was a standing agenda item on my regular meetings with my minister. We reported openly, fulsomely and transparently to Cabinet on a quarterly basis. When we would run into delays in timing related to things like the pandemic or others, or where it has been a requirement to augment the funding because it was taking longer and therefore costing more—those are not decisions made by ministers, those are decisions made by public servants such as myself. Certainly, the responsible ministers were advised at every step along the way. We maintained a complete open book with that. That should be well evidenced in the documents that we provided to this committee.

Mr CHAIR: Which ministers have you briefed throughout your time in the position?

Mr HOSKING: I will start at the start. I think when the program was first kicked off in 2016, my minister at the time was Peter Styles.

Then we had a change of government in August 2016. Subsequent to that Lauren Moss held the DCIS portfolio for at least four years, so Lauren was my responsible minister for a period of time.

Subsequently, Paul Kirby, for somewhere between a year or two. I cannot remember the precise dates, but that would be matters of public record.

He was followed by Selena Uibo, who was also Minister for Health and DCIS—or DCDD we were by then—at the same time.

Obviously, since September 2024 when we had changes to machinery of government, I moved across to the Health department and have reported to Minister Edgington since then, although I need to make the point that at that point the single-point accountability on me as the Chief Executive of DCDD transitioned to Ms Catherine Weber who, I understand, will be giving evidence later this morning.

To the best of my recollection I would say Peter Styles, Lauren Moss, Paul Kirby, Selena Uibo and, most recently, Steve Edgington.

Mr CHAIR: Thank you, Mr Hosking.

J DAVIS: In terms of reporting to ministers, or briefing ministers, did that include raising patient risk concerns, clinicians' concerns, when you were briefing ministers or reporting to them?

Mr HOSKING: It was certainly part of the issues for consideration in any briefing, and I realise there has been a fair bit said about that publicly. It was not until the system was actually deployed and implemented in the use of clinicians that those sorts of questions arose, but they were discussed with various ministers. I think by the time the system was being used broadly by our clinical workforce, it was more towards the tail end of that time period. Certainly, it would have been discussed with Minister Uibo and more recently with Minister Edgington, who has had detailed briefings on this. I do not think it would have manifested in the briefings to earlier ministers because the project was not at that stage at that time.

J DAVIS: At what stage did clinicians raise concerns about patient risk et cetera in relation to Acacia?

Mr HOSKING: Generally when we first had some fairly strong representations around it, it was after the deployment into Royal Darwin Hospital in November 2024. Mostly those concerns were raised from the emergency department within Royal Darwin Hospital. I want to make the point on the *Hansard* that is not borne out by our clinical safety metrics, so some of those statements have been very broad and not substantiated by evidence. Nonetheless, when you hear them in the public domain they are cause for concern and they concern the public, so we take those things very seriously. Generally where there have been issues around patient safety, they have come through that emergency medicine subset.

If you would like a more detailed response to that, I would refer to Dr Kanga.

Prof KANGAHARAN: I have been the clinical sponsor from the very beginning, and, as I said, I have been a clinician here for 20 years. I trained in South Australia as well as New South Wales.

Our clinical systems were absolutely disconnected, and Acacia was our solution to the problem and to bring all the information together. Suddenly my role was to try to help with the process, and absolutely committed to make this work. Despite all the challenges, I think we are in a very good place.

With regard to clinical risk—Chris has mentioned the fact that people have been using Acacia from August 2020 during the pandemic. Because we could not do any implementation the technical team made a very good model of getting all the information transferred into what we call a view-only EPR, which is FG0, which has probably been the most saving

grace for us to survive through the pandemic. We could see the medication from remote, vaccination records and people could work from home—that kind of stuff. Really Acacia has been used since August by clinicians. Prior to that it was all working through design and how we are going to do it.

Implementation to Katherine Hospital and Gove Hospital—there have not been any direct patient safety issues. Obviously, any new system we implement there will be a change of workflow and people will have challenges, but there have not been direct patient consequences from Acacia or documented any clinical incidents. We monitor clinical incidents very carefully—that is our passion, so we do that to improve patient care, not to harm patients.

One of reasons things took longer is we always had the philosophy of patient safety first, so we want to get it right. In most projects when the budget is under pressure people try to push through and take shortcuts, and we always made sure there were no shortcuts. We discussed everything at every meeting, so all the governance meetings I have been part of, including the program governance group, every decision has been met with patient safety in mind.

J DAVIS: Can I just clarify no clinical risk concerns were raised until the end of 2024. Is that ...

Prof KANGAHARAN: Just to clarify when the emergency department went live in Royal Darwin, which was done with every member signing off ready to go, and obviously when it was implemented, with the hospital being overcrowded and it is a pretty complex workflow, it does cause stress in terms of inefficiency which probably made people working on the floor distressed, so there was some delays. There was some benefit and there was some risk. I do not think it was direct harm to patients, but there were some areas it took a longer time to assess the patients because you were getting used to the new system. The system needed to be redesigned. As for clinicians' concerns; they were worried about the patient safety as opposed to actual safety concern. So any delay in assessing a patient in the emergency department could potentially harm, but does not mean that harm was done.

J DAVIS: Understood; thank you.

Mr CHAIR: I will leave it with you, Member for Johnston. What we will do is just work from that end and will come down. Then we will go to all questions if you have follow-ups. The Member for Johnston has the floor.

J DAVIS: Following on from that you said earlier that because there was the rollout in Katherine, Gove and Palmerston, in terms of concerns raised there, were those concerns formally documented?

Prof KANGAHARAN: Every concern raised—I chair a clinical leadership group meeting, which is the frontline clinicians governance group which reports to the Program Implementation Committee, which involves executives as well as clinicians, and then to the program steering group. Issues were raised through the governance. Every issue is documented and tracked. Obviously not all the problems can be solved, but all the things are documented and addressed as best as possible at the time.

J DAVIS: Just coming back to where we started in terms of reporting to the minister, were those concerns reported to the minister?

Mr HOSKING: Generally that level of detail would not feature in a ministerial update. When I was briefing the minister I might make a general reference to some issues of clinical safety that had been raised and being addressed, but I would not get into the specificity of it. Generally they are quite complex and would often require a clinician to interpret. Generally that level of detail would not feature in a briefing to a minister. The fact that there were concerns being raised on the shop floor absolutely would have been discussed, but the specificity of a particular clinical workflow or something would not have formed part of that discussion.

J DAVIS: I am happy to move on and come back to me.

Mr BROWN: Morning, thank you for coming in everyone.

Where are we at with the Acacia project in regard to getting data? I come from Maningrida and we have got Mala'la Health there and based in Jabiru they have got Red Lily Health, with different systems. How does this work for us in the bush? Are we already on the system or do we need it?

Mr HOSKING: The non-government health sector were never part of the scope of Acacia because they are not part of government. There are legislative and policy impediments to us letting them on our system. Obviously, there would be some value in the longer term being able to have a single joined-up clinical information system across the Territory, particularly as we continue to transition remote primary care clinics to community control. I think currently there are about 67 under community control and I think we have about 46 left on our books, but that transition is a slow process and needs to be done carefully. Generally the non-government clinics use a different platform called Communicare. We do take some data feeds from them for the purposes of national reporting against funding KPIs and those sorts of things, but we do not take their clinical information into Acacia as part of our database.

What we are doing, and we are turning our attention to this now, is the Acacia system has the capability to provide what we call clinical portals so that if you were someone who came into Gove Hospital and had some form of clinical procedure but your follow-up care was being provided by Miwatj at Yirrkala, the clinician at Miwatj could have scaled-

down access to come into the system, see just the information that they are allowed to see—your discharge summary and your medication schedule and those sorts of things—so that all clinicians are working to the one core true set of information, that one clean record which is important. At the moment, we do that manually; we send them a discharge summary and other things. That is part of the work we are planning now the hospital rollout is complete. We are turning our attention to that.

Similarly, there is the ability for patients to eventually access their own records. If you were someone who was, say, a diabetic who needed to record your blood glucose reading several times a day, instead of doing it in a book you could do it on your smartphone, tapping into a patient portal screen. That is further enhancements that we have planned to the system.

When we awarded that contract to InterSystems in 2017 we structured it in such a way that if we got to a point in the future where there were no legislative or policy barriers to having one system across the government and non-government sectors in the Territory—we need to be a bit careful because when I say that, that by definition includes GP clinics and it starts to get pretty messy. Obviously there are no GPs out in the bush, and we rely heavily on the Aboriginal medical services. But if we had a policy environment that was conducive to that, we have structured our contract in a way that the AMSs could purchase their licences off our contract and not have to go to tender and get their own software. I think we are quite a way off that at the moment in terms of the authorising environment to support that, but you could see a future where it is all joined up. That would be better for the patients, particularly those people in the bush who are really crook and need a high level of clinical care.

Mrs ZIO: Thank you for attending today and helping us out with our questions; we really appreciate it.

We understand that Acacia is replacing five existing IT systems and they have been in operation in healthcare settings across the NT since the late 1980s. Can you clarify for us the risks and ongoing costs associated with maintaining these different systems?

Mr HOSKING: Acacia is our core system now, but prior to Acacia the core patient information system within NT Health was called CareSys. As a result of Acacia being fully deployed to hospitals, CareSys is now withdrawn from use. We have managed to address that one.

The cost of maintaining the residual systems—I could not give you a precise number off the top of my head. As they are no longer supported by an enterprise software vendor, we are not paying software support and maintenance and those sorts of charges. Back in 2018 the Health department, under a previous iteration, purchased the intellectual property rights to what is called the source code. We, essentially, own those. We are the owner/operator of the old systems now—which is an interesting place to be—but it was a good decision in 2018 because today, in 2026, we continue to rely on those systems for non-hospital care.

We use a vendor out of New Zealand called Jade Care to make—fix—changes and repairs to those systems. We are deliberately not investing in developing them further unnecessarily, because the idea is to replace them. It would not be sensible to be spending public money on something you will replace. However, sometimes we need to do things to make sure they keep operating properly, or to meet a rule change or a compliance-related change.

I do not have a figure I could give you today, Member for Fannie Bay. The budget for supporting those systems sits with the Department of Corporate and Digital Development as the IT support agency for government. I note they are appearing after us, but I do not want to drop Catherine in it because I am sure she does not have a precise number with her either, but it would not be difficult to provide as a question on notice if that was appropriate. We could get that for you; I just do not have it at my fingertips today.

Mr CHAIR: Would you like that on notice, Member for Fannie Bay?

Mrs ZIO: Yes, please.

Mr CHAIR: Could you please repeat the question for the record.

Mrs ZIO: I will just cut through to the second part of it. Can you please clarify for the committee the risks and ongoing costs associated with maintaining the five different systems that we have replaced?

Mr CHAIR: Mr Hosking, can you confirm you will take this on notice?

Mr HOSKING: The question is fine to accept. It is probably better to ask DCDD because they hold that information. If you would like to task me with it, I will happily accept that I will have to get the answer from DCDD.

Mr CHAIR: Member for Fannie Bay, are you happy to place that to DCDD?

Mrs ZIO: Yes, I am.

One of my questions was outlining the benefits to patients to have one integrated IT system, and we have gone through that and understand that. Can you provide an overview of the key benefits that the Acacia project seeks to deliver at each functional group stage?

Mr HOSKING: I could do that at a high level, and I might ask my medical colleagues. I can speak comfortably to issues around technology risk and those sorts of things, but the medical professionals here can speak about what is really important, which is about improving patient care.

Could you just repeat the question for me so I can answer it precisely?

Mrs ZIO: Sure. Can you provide an overview of the key benefits the Acacia project seeks to deliver at each functional group stage?

Mr HOSKING: Functional Group 0, which was the read-only version that Dr Kanga spoke about, put clinical information in the hands of all our clinicians. Functional Group 0, which was a read-only version of the system, took a feed from all our old systems into Acacia, so someone like me who grew up here and has a long patient history in our systems—a clinician anywhere, whether they are at RDH or out in the bush, could pull it up and look at it and see My Health Record over a longitudinal period, my medicines and surgeries I have had and any other contact I have had with the public health system. As Kanga said, it was incredibly beneficial during the pandemic because it put clinical information in the hands of our frontline people, whereas previously they would have had to go to a bunch of different systems and probably did not actually have access to those systems because they were not authorised users of them. If you are a doctor at Royal Darwin Hospital you do not necessarily have access to the systems used in the bush.

Functional Group 1 was the rollout of the hospital-based what we call the patient information system. That had additional clinical functionality in areas like emergency and maternal and child health, renal dialysis and others. Getting that system into our hospitals and into the hands of users and getting CareSys retired and off to the side means that we can now—there is a whole lot of other functionality native in Acacia which we currently do manually on paper-based forms and other manual workflows, so Functional Group 2 is about opening up that native functionality and putting it in the hands of our clinicians. One of the good things is we can do that gradually bit by bit. You do not need that big-bang wallop like we had with Functional Group 1 where you have train everyone and have Go Live on a certain day. You could release that functionality to different clinical cohorts or different parts of the Territory based on need, and that work is happening now. The short answer to Functional Group 2 is about providing digital functionality for things that we currently do in hospitals manually today and that will improve efficiency and data accuracy and a whole bunch of other things.

We have an old digital medicines system called MedChart which is in scope to be replaced. It is not integrated with Acacia; it sits off to the side, so you have to hop into there to have a look at MedChart. Acacia takes a feed from it, but the workflows are not integrated, so you can see the patient's medicines in Acacia, but you cannot work in the medicine space, so our pharmacists or others will use that. Functional Group 3 will see that replaced again with what is native functionality to Acacia. Acacia has a medicines management module. Functional Group 3 is about moving across from MedChart to that fully integrated medicines management module within Acacia, bringing another facet of functionality into the core single system.

I make it sound easy when I say it like that, but medicines is really complicated. It is one of the areas that needs incredible precision. You need to be very, very careful. Without sounding trite, errors in medication kill patients, so you need to be really careful. That is a separate body of work.

Functional Group 4 will see Acacia rolled out to remote primary care clinics and urban primary care clinics. Urban primary care clinics are pretty straightforward because they operate a bit like a GP clinic. It is fairly routine levels of care, whereas out in the bush the complexity of the care managed in those clinics is almost comparable to a hospital environment in some cases because we have very sick people with complex care needs. It is fairly unique to the Northern Territory; you do not see that level of complexity across 46 government clinics in other states in Australia. The software will need some more work in order to do that.

The last phase, Functional Group 5, is the functionality I referred to earlier, which is portals by which either providers like a non-government health service or a patient can access the system in a controlled and scaled-down way where they only see the bits they are allowed to see, and access the patient record. That forms part of the work that we are working on at the moment.

Mrs ZIO: Thank you; that was a really good overview.

I am wondering if you can please outline the delegation of responsibilities between—it is probably good that you have experience in both sides—DCDD and NT Health, including who the sole supplier and project sponsors were?

Mr HOSKING: Certainly. The program sponsor is the DCDD chief executive. That generally contemporary project management methodology, the sponsorship follows the money. Because the funding is vested to DCDD to deliver, it is published in their budget and reportable in their annual report.

In the time I was the DCIS and DCDD chief executive, there was a single-point accountability on me to deliver Acacia, be accountable for the money and performance, time, scope, budget—all those things. At the end of the long day, it is accountability on the chief executive.

In the Health department, on the other hand, the accountability on me is to ensure that solution is applied in a way that improves clinical care. That is a less precise thing than delivering on time, on budget and on scope.

In many ways, the accountability on the DCDD chief executive is more precisely defined than the one on me, but I think there is an important role that both me and the DCDD executive share. One that we are aligned on—I am sure you will ask Catherine about it later—is that between the two of us making sure that those two agencies are working constructively and harmoniously together is really important for these projects to be delivered well. I say today on the record today that I think that is operating very well at the moment. We are working extremely well together. The level of engagement and collaboration between our agencies is rock solid.

That was not always the case. Certainly in the early days of the program there were some tensions. I suspect those have probably manifested in some of the submissions that have been provided to this committee. For a whole range of reasons I think the decision to vest accountability for the project with DCIS, not NT Health, caught everybody by surprise, including me. I remember saying, 'Well, hang on a minute. Is that what that decision really means?' It was the right decision, and I stand by that one today. But it took a period of adjustment, and I think people worked through that.

Having worked on both sides of that now for many years and had that single-point accountability on me for both sides of that, I think we are in a really good place now, particularly now that the system is rolled out to all the hospitals, Functional Group 1 is complete, we are starting to get stuck into Functional Groups 2 and 5. I think the future for Acacia is incredibly bright. I think it is going to continue to make a really important difference for our clinicians. It has not been easy, and there have been some really difficult speed bumps to get over to get to here, but I think those are behind us now.

Mr CHAIR: We have quite a few questions, so I will just let everyone present know we will extend time this morning. We will take a five-minute break at 10 am to allow everyone to go to the bathroom and do whatever you need to do. To the DCDD staff who are watching, please anticipate a rough time—probably you might be coming on between quarter to and 11.

Noting that, Member for Fannie Bay, do you want to continue questioning?

Mrs ZIO: Sure. I might go into an area of project implementation now. Could you give us a really good overview of how healthcare workers and clinicians were prepared for the rollout of Acacia?

Mr HOSKING: Certainly I can, and then I might ask my clinical colleagues to supplement my answers if that is okay.

Preparation actually started when we went to tender. I mentioned earlier that when we undertook the tender assessment process we had more than 50 clinicians involved in that, and that was really deliberate. We involved emergency doctors, surgeons, nurses and physiotherapists. Everybody that was going to use this system, we tried to get representation from all those different clinical categories and across the Territory to make sure our regions were included. Logistically that is a lot of work, but getting our clinical workforce involved in the selection of the product is really important because you do not want your clinical users, the people who are going to use this system for the next 20 years, feeling that it was chosen by the IT people and inflicted on them. I know that sounds a little trite, but that is pretty much what happens. We went to a lot of trouble to do that.

We travelled and looked at reference sites where this system was used in other parts of Australia and other parts of the world. Dr Kanga travelled to Scotland where this software underpins the NHS public health system and there are some exemplar deployments of it there.

We pretty much adopted a first principle that said this program will be clinically driven and IT enabled so that clinicians will drive the program and the IT people will enable it. It will not be the IT people doing it to the clinicians, and we have maintained that view right through until today.

Subsequent to that, when we chose the InterSystems product I did a whole bunch of briefings for clinicians about why we chose that one. We had four that we looked at very closely, and depending on what you did in the public health system some looked more favourable than others. One in particular was probably the Rolls Royce of systems for acute public hospitals, so if you worked in the emergency department that would have been the one you would gravitate to. Unfortunately it was twice the price; we simply could not afford it, nor did they offer us a solution outside the hospital and primary care, so it was unsuitable. We did a lot of work to educate our workforce on why we chose the one we did.

When we set up the governance for the program, Dr Kanga mentioned chairing a clinical leadership group. We as part of our three-layered governance structure, we had a clinical leadership group where at one point we had around 40 clinicians, which is probably too many people to have an effective committee but it was very inclusive and representative and had every clinical discipline and north and south regions represented. They got to review all the material. That clinical leadership group had a pivotal role to play in the training and education that went into getting people ready to use the system.

We had change management and engagement professionals engaged in the project team who led the work to do what we call site preparation, to get the sites ready. That could be anything from—we knew in Alice Springs Hospital we had patchy wi-fi. We invested in wi-fi upgrades, we ran comprehensive training and we set pass marks for training and we monitored them closely. Any changeover is always a big change for people, but we did everything sensible and feasible to prepare our workforce to change over to the new system.

I might pause there and see if you would like to add any remarks, Dr Kanga.

Prof KANGAHARAN: I would like to just echo what Chris said. From the very beginning clinicians were involved in selection and site visits. In terms of ranking the product, the suitability is the most ranked as important for selection, not the budget. A lot of frontline people are involved in all aspects of the staff training, site preparations and super users. We had lots of what we call work implementation group meetings to make sure the executive level and the leadership team within the services where you go—for example, Katherine region, Angela might be able to articulate (inaudible) a good show in terms of everyone in the different working groups were signed off to go live, not acknowledging there may be problems but all ready to go with anticipated training, after having done the training.

Every step of the way that has been done very well, except for the Royal Darwin Hospital emergency department everything else was very smooth. For example, the renal dialysis area was so smooth, like within a day, and they are probably benefiting the most. All the renal across the Northern Territory is using Acacia for data collection, documenting information and stuff. They are probably feeling much more the benefits, which will be realised by the rest of the people in the future.

Mr HOSKING: Thank you, Dr Kanga.

Member for Fannie Bay, Dr Kanga made a good point about the local implementation working groups. Angela chaired those in Katherine and at Royal Darwin, so I might ask you to add some remarks, Ange.

Ms BRANNELLY: When we were rolling out Acacia into Katherine Hospital, we established an implementation working group which involved all clinical areas within Katherine Hospital. We would meet regularly to talk about what were the components of Acacia that were important to the clinicians in Katherine, and we would have very in-depth detailed discussions about their requirements. What we would consider is: can we go live with this? What are the things that would stop the program from going live? That was taken from a safety lens around safety for patients and for the staff.

Those meetings occurred regularly where we would go through in-depth detail about the program—what are we doing about diets? What are we doing about allergies? That very detailed discussion with the clinicians, and they were involved in those program decisions for Katherine. That type of implementation working group then carried forward into Gove, Alice Springs and Royal Darwin so that set the platform for how frontline clinicians were engaged in the nuances of Acacia and how it would work within their hospital setting.

When I moved up to Darwin we used the same format for the reimplementation of Acacia into the emergency department where the frontline clinicians were involved in: what were the issues you had; this is how we will fix it; does that suit you or not? There were robust discussion about whether it would work or not. Our frontline clinicians were passionate about what they would accept or not, and we listened to them. As I said, there were some robust discussions between us and our partners, who were DCDD, about what we could or could not accept.

Mr CHAIR: Before we go to a break—this is just for our record—we had former Minister Ngaree Ah Kit in from May 2022 until October 2023.

The time now is 10.03. We will break for five minutes and resume at 10.08 with the Member for Fannie Bay.

The committee suspended.

Mr CHAIR: We will reconvene. Member for Fannie Bay.

Mrs ZIO: I am just going to ask a question around my favourite thing, which is to reduce red tape, so I am going to go into an area that relates to that. We have rolled out some of the functionality and I want to know what impact that has had on NT Health staff, including their workload, stakeholder engagement, fatigue, staff turnover and mental health and wellbeing of staff. We know that is pretty big in the news cycles at the moment, so any information you can provide about the benefit that Acacia has provided to the staff on the ground would be really good.

Mr HOSKING: I can probably do that at a high level and then I might ask Angela to speak. Angela manages our largest hospital, so she is probably well placed to give you a frontline view on how our staff are going with that.

At a really basic level the business case for this reform was predicated on addressing that legacy technology risk. That is a hard sort of quantifiable thing and that is understood, but, most importantly, giving our clinical workforce one digital tool they can use on their browser that has all the functionality and the information they need to care for their patients so they are not hopping in and out of one and into another. I will use an example that was happening quite regularly

before we implemented Functional Group 0, which was the read-only version of the system, which we have had for around six years now ...

Mrs ZIO: Sorry; can I interrupt? I understand that they were using and going across different systems previously. I want to know is now, on the ground, are they experiencing increased productivity, better wellbeing because they do not have to jump between different systems? If you could go straight into what they are experiencing now, that would be great.

Mr HOSKING: I would say unequivocally yes. This has given people information at their fingertips. When someone from the bush comes in crook and they need to be treated at the hospital, the doctor does not have to try to ring the guy in the bush clinic to track down what this person was being treated for and what their records were; they have a digital record at their fingertips. Their appointments are managed in that. I fundamentally would say that is a vast improvement.

Generally when we implement a new system, we have the initial implementation which is difficult and change, then we hit a period of smooth sailing and greater adoption shortly after that. I think we are in that period of greater adoption now. I am in and out of our hospitals and clinics all the time. I pride myself on getting out and about. The feedback I get from staff is overwhelmingly positive. The most recent Go Lives in Central Australia and the Barkly were exemplary. I can walk through the hospital there and have people tell me how this has made their life better. For me, as the chief executive, that makes my heart swell; that is really special.

Angela, you are managing our biggest hospital and our biggest workforce, so I will hand to your to speak from the coalface.

Ms BRANNELLY: From a staff wellbeing point of view, it was a big change for staff. We cannot underplay the amount of change that we needed to do to bring Acacia back into Royal Darwin Hospital in the ED. While for the rest of the hospital Acacia is a tool that they use every day—it is business as usual; they just see it as part of their working life—in the emergency department we are still on the change journey. They are used to using the system. Every now and then there would be some concerns about getting used to the new system, but, overall, the staff are doing well with the system and are happy using the system.

As Chris said, having clinical information at your fingertips for a clinician is such an important part of your job. When you cannot find that information, it adds an element of stress to your routine day-to-day work when you are seeing patients. Now that they have access to that through Acacia, clinicians can do what they want to do every day, which is manage, treat and provide care for our patients quickly without delay. Acacia is the tool that enables our clinicians to do that.

Mrs ZIO: To summarise, you would say that overall staff are agreeing that this is improving workflows, their wellbeing is better and staff have the ability to do their job quicker and more effectively than they did under the previous systems?

Ms BRANNELLY: Yes; correct.

J DAVIS: You will have seen from the public submissions that we received—there were several that we could not publish—that view was very much not reflected. Part of our job is to ask about that. I heard both you and Mr Hosking say that it is difficult in emergency, but unequivocally it has made a difference to staff wellbeing. That has not been reflected in submissions that we received.

Also, a couple of submissions said that staff had been directed to only give positive comment about Acacia. I wanted to put that to you, because obviously that is of concern.

If you could comment on both of those things, thank you.

Mr HOSKING: Member for Johnston, I will take that one. I will make strong remarks now. I absolutely reject any assertion that staff have been told only to make positive comments; that is simply not accurate. I am very conscious I am on *Hansard* when I say that, but I reject that outright.

Yes, I have similarly reviewed the submissions that are public. In my view, I think Ms Brannelly is far better placed to make observations about the wellbeing of her staff than the authors of those submissions. I think she is in a position where she has got that information. She manages that workforce of 5,000 people. I think they are a view and they need to be respected, and I respect that this committee must listen to that and take them into consideration, but I do not accept them.

J DAVIS: Not the views of the AMA or the nurses federation—that is not quite the right title—or ...

Mr HOSKING: The ANMF.

J DAVIS: ... the ANMF—sorry—or the Royal Australian and New Zealand College of Psychiatrists? You would not take those views on board?

Mr HOSKING: I am happy to speak to those three specifically, if you are comfortable for me to do that, Member for Johnston.

Certainly I maintain a very open dialogue with the Australian Medical Association and the local Chair, Dr Zorbas, so I am not going to say anything now that Dr Zorbas and I have not spoken about previously.

I am aware of Dr Zorbas and the AMA voicing those views previously. I think he would have moderated or modified his view since then, since the reintroduction of the system within the emergency department at Royal Darwin, which has gone very smoothly and without incident. My view is that what is expressed in that submission was written at an earlier time and is, perhaps, somewhat dated now. I do not believe that to be a strongly held view at this point in time.

The ANMF and the College of Psychiatrists simply would not have the visibility into the program and have a level of knowledge of detail to be able to, I think, reasonably form the views that are expressed in those submissions. I have read them and I think they are making assertions based on very limited knowledge of what is a very complex program of work. That may well be their considered view, but I do not think it is a well-informed one.

J DAVIS: Thank you.

Mr MACKAY: Thank you for appearing today.

I want to talk about the money for a second; the purpose of the original inquiry was to do with the money. The total program spend in your submission was \$291m to March 2025. A \$243m project and now \$291m has been spent to March. In the submission it talks multiple times about another two years or two-and-a-half years.

With reference to the functional groups that have been achieved and rolled out, what was the cost per those functional groups from the Department of Health's view or whatever information you have available? How much remaining costs to implement the remaining four functional groups do you anticipate?

Mr HOSKING: Member for Goyder, it is going to be difficult for me to offer a precise spend against the different functional groups because some of that work has been conducted concurrently, so the bookkeeping is not organised that way, if I can put it that way.

Certainly the original funding envelope was—I think you mentioned \$243m. It was subsequently varied to \$259m, which is the public number that is generally spoken of. Through reprioritisation of funding, that was increased several years ago—that was at my initiation—to around \$320m, which is almost spent now. It has not all gone, but we are still progressing off that original envelope of funding.

I think we could perhaps model in fairly sensible numbers what the expenditure has been for Functional Groups 0 and 1; the components we have already worked on for Functional Group 2; and we are working on 5—3 and 4 have not progressed significantly—but it is not information I would have at my fingertips today.

We are at a point now where we are continuing to do work on Functional Group 2 at a fairly moderate level of cost because the residual budget is down to a fairly moderate amount. Doing those components of the system that are more about expanding the use of the existing functionality than implementing new things is making the best use of things that are already there.

In terms of providing you with a reasonable estimate per functional group we would probably need to take that on notice.

Mr CHAIR: To follow on with that, would you say at this point in time we will go over \$323m?

Mr HOSKING: That is a decision for government to make. At the moment we certainly will not be able to deliver Functional Groups 3 and 4 within that total envelope of \$323m. The program has a moderate amount and received \$6m for two financial years. There is a decision requiring DCDD to bring back a business case in the 2027 budget for funding to complete the residual phases, but that will ultimately be a decision for government that they will make in the budget process.

Mr CHAIR: I will just correct for the record, the current project budget—please correct me if I am wrong—sits at \$335m, with the allocation of \$12m in the 2025–26 budget. Is that correct?

Mr HOSKING: Yes, add the \$12m and you get the \$335m number.

Mr CHAIR: Member for Goyder, could you please restate the question for the record?

Mr MACKAY: Can you please provide a breakdown of the budget spent per functional group that has been achieved? I am assuming you cannot provide an estimate for future until submissions have been done, as you have just outlined, so I will accept what has been achieved; the budget allocation to achieve Functional Groups 0, 1; and what work has been done on 2.

Mr HOSKING: I think that we would accept the question, but similar to my earlier question on notice, I would suggest that the question be put to DCDD as they hold the budget and have that information. NT Health will certainly assist in the process to map out those costs.

Mr CHAIR: Thank you. Member for Goyder, are you happy to place ...

Mr MACKAY: I can do that to DCDD.

Mr CHAIR: I note that Health will also assist in providing them.

Mr MACKAY: In the submission, part of the \$60m that was reprioritised, \$24m was an internal reprioritisation of the NT Health budget. What exactly was cut or reallocated? What pools of money was \$24m reallocated from within the NT Health budget, which we all know is restricted? Where did they find \$24m in the NT Health budget to be reallocated to this project?

Mr HOSKING: Noting that the Health budget has been subject to considerable strain, although we have had a win recently, which we are very happy about, it is difficult for me to answer that question. I was not with the Health department at the time. I was in the DCIS chief executive role.

I certainly led that process to augment the budget. It was very evident through our governance arrangements and through our reporting to our committees that we were not going to live within the \$259m allocation and additional costs were going to be incurred to deliver what we needed to. There was talk at the time of putting a funding submission together. I thought it was really important for me, as the DCIS chief executive—and I impressed this upon the Health chief executive at the time—that we tried to manage that problem ourselves and not just go to government, cap in hand and ask for a top-up for a highly complex IT project. That augmentation was done at my initiative to try to manage this problem ourselves within existing funding without having to ask the government of the day to put their hand in their pocket.

Two-thirds of that augmentation I came up with within the DCIS budget. There was \$24m from Health. I spent several rounds of discussion with Dr Frank Daly, who was the Health chief executive at the time, because I felt it was really important that both agencies did their fair share of that heavy lifting to be able to address that budget concern.

As to where in the Health department it was drawn from and therefore what areas went without a bit of funding as a result, I could not say. I really only dealt with Frank on the macro number, and that was a difficult decision for Frank. The Health budget was experiencing difficulties at that time, as we have for a long time, and that is probably reflected in the apportionment of that budget that DCIS, although they were not the beneficiaries of the new system, bore two-thirds of the financial burden of addressing that gap. We tried really hard to do that in a way without being a burden to government and bringing a funding proposal forward that was yet another thing for government to deal with in the funding round.

Largely, if I can use a colloquialism, that was about being grown-ups and dealing with the problem ourselves. It was done with the full visibility of our respective ministers at the time. I kept my minister briefed on that, and that augmentation was reflected in our reporting to Cabinet that we were required to do periodically. It was an open and transparent process that two chief executives signed off on, and I understood how I was able to apportion the DCIS component of that. As to where it was drawn from within NT Health, it would be difficult for me to say with accuracy.

Mr CHAIR: Which minister endorsed that decision?

Mr HOSKING: My minister at the time was Ngaree Ah Kit. I am very conscious for the record—I apologise—I omitted Minister Ah Kit from my previous remarks; I forgot.

I need to be clear too—ministers generally do not endorse that. There would be a ministerial brief that is noted and signed off, but the public sector accountability framework—that decision-making is vested on chief executives as the accountable officers of agencies. Certainly the minister was kept well briefed, but those are not decisions for ministers. I just need to make that clear distinction.

Mr CHAIR: When you say it is not the decision of ministers—I understand the framework might place the CE as the authorising officer—if the minister does not endorse it, what happens?

Mr HOSKING: That would be a fairly courageous thing to do if your minister did not endorse it. Generally, those things are worked through with ministers and would only proceed if there was a level of understanding that this was an appropriate thing to do, which there was.

Mr CHAIR: We are trying to get the facts for the public, and the public will rest ultimate responsibility with ministers. Basically for this money to move, it required a minister to sign—or not.

Mr HOSKING: Not technically under the way the *Financial Management Act* operates; it is the remit of the chief executive. However, any seasoned and sensible chief executive would not make a change like that without including

their minister in those discussions, and that is exactly what I did. In terms of who is the accountable authoriser under the *Financial Management Act*, that is actually the chief executive. That is the way the legislation is written.

Mr Chair, I understand clearly the point you are making. To pass the pub test, you would expect that a minister was supportive and endorsing of that. Certainly, that course of action to augment the funding through reprioritising existing money was explained very carefully to ministers and, as I said, was subsequently briefed to Cabinet, so it was not a decision I took in isolation of my minister.

I make my remarks today very clearly to place on *Hansard* my full acceptance of my accountability as the chief executive, that it is my signature on the piece of paper.

Mr CHAIR: Speaking of the \$24m in Health—and it is widely known the pressures we have had on the Health budget—we obviously welcome the recent decision with the increase in spend. If you had \$24m additional today, is that something you could invest in maternity services at RDH?

Mr HOSKING: The obvious answer is yes. As very publicly reported, we have had our hooks into the Commonwealth for funding to do some modifications to the maternity service arrangements at Royal Darwin ...

Mr CHAIR: You will not go down the ...

Mr HOSKING: No—good question, and the answer is yes.

Mr CHAIR: This is to carry on from the Member for Goyder, who I will hand back to in a moment. On the publicising, I note that in your submission at 7.1—I will refer to lines 184 to 187. We saw that Estimates uncovered—for the record:

The internal remediation solution was ... foreshadowed publicly. On 21 June 2023, the Chief Executive Officer of DCDD gave evidence before the Estimates Committee. When asked if the Program was tracking to come in on budget, he said:

We have been repurposing internally to give ourselves some more capacity to address that [budget pressure due to delay]. You touched previously on the fact that there was a \$10 million residual in the CARE budget.

And it goes on.

I understand that has come out in Estimates and that is on the public record. Was it ever publicised by the government at the time? Did the minister ever publicise it?

Mr HOSKING: Not to my recollection, no. I certainly made those remarks in Estimates when questioned about it.

DCIS as a department, given it is a back-office administrative support department, was not in the habit of making media releases or public announcements. That remains the case today. I do not recall any public statement by a minister.

Mr CHAIR: So that minister was Minister Ah Kit. The following minister—correct me if I am wrong—was Minister Uibo. Was there anything public prior to that, up until the government changed?

Mr HOSKING: Not that I recall, Mr Chair.

Mr MACKAY: In that statement you made at the time to the Estimates Committee in 2023, you said:

At this stage, I can say with certainty that we will exceed that \$259m, but I am confident we can do it by managing within our overall allocation between ourselves and NT Health. I do not anticipate having to seek any additional funding from the government.

That was in June 2023. When did you become aware that you will now have to seek future funding from the government in addition to the \$60m reprioritisation?

Mr HOSKING: The key driver of cost in these sorts of projects is elapsed time. I mentioned earlier that the vendor is tied very strongly to a fixed-price contract. The main driver of cost is the resource cost. It is quite a large team of very high-end professionals. At its peak it was over 100 people. Many of them are specialist contractor resources—they are business analysts, testers and programmers—which we engage through local IT vendors at daily rates, so in very simple terms, delays equate to costs. The longer it runs the more it costs.

I would say that it became clear that we were not going to be able to live within that expanded envelope, which got us to just over \$320m, probably around the early part of last year. At the time when we took that action in 2023 to augment the budget, I was confident that would be sufficient. As things have taken longer, the protracted time we needed to withdraw the system from the emergency department go back and do a bunch of work to enhance the software and reimplement and a range of other things have all contributed to that elapsed timeframe. I would not be able to pinpoint a precise date, but probably in the last 18 months or so.

Mr MACKAY: In the submission some of these delays you were talking about happened prior. One of the delays is attributed to changing from a big bang to a phased implementation that led to a four-month delay; that was in 2019. The submission you have details the change in the structure of that, and it was made and approved by a whole bunch of different committees and groups. At what point would the minister have been made aware of the plan to change the implementation strategy? At what point would a cost analysis of ‘if we change the implementation strategy, will this affect the cost’—it resulted in a four-month delay to the project, so that should have been easy to factor in some kind of cost. When was the minister aware that the rollout structure changed? How much would that four-month delay have cost this project?

Mr HOSKING: As I mentioned in my earlier remarks, throughout the life of this project in my time as the accountable officer for delivering the project, which was both as the deputy CE and the CE of DCIS and later DCDD, Acacia was a standing agenda item with our minister meetings. We generally meet with the minister once a fortnight. If we were working through a significant change such as that at the time, it would have featured in the conversation. The decision obviously traversed those governance committees that you refer to that are set out in our proposal there.

We at no stage attempted to vary the budget then, so we obviously absorbed some time delays, but we were hopeful that we could absorb them within our existing funding. Hindsight is always very clear because we have the benefit of all the experience along the way, but going back to the very first business case which was modelled and built around that big-bang implementation that was approved in the 2016 budget, I would say now, and I would say this with real certainty and very clearly, that big-bang implementation approach was not remotely sensible. To try to go live with a system like this across 8,500 people—we are six hospitals, 46 remote clinics, 20 urban clinics—to do all that on one day would be, quite frankly, crazy. I mean even to roll out to six public hospitals we have had to do it sequentially and in a staggered way to be able to manage the impact on our people. It was a very necessary change and it has proven successful because that is exactly what we have implemented now.

At the time it would have been a considered a manageable variation within the overall budget and we would have hoped, and certainly I did at the time, that by moving away—because we were planning and preparing ourselves for that big bang, and it was clearly becoming very apparent that was not the sensible thing to do. By moving to a more manageable agile deployment strategy we would hope to actually get some more efficiency into the delivery model. Then whatever time we spent recutting the project we would make that up later.

Mr MACKAY: Another one of the delays was a nine-month delay due to the commissioning of Palmerston Regional Hospital. In 2018 the NT Health commissioned and opened Palmerston Regional Hospital; this resulted in a nine-month delay to the Acacia project rollout. Was that not a foreseeable delay? We are going back to 2016, Palmerston hospital is being constructed. A nine-month delay is three-quarters of a year, was it not foreseeable that there would be issues if you are rolling out a hospital and this project?

Mr HOSKING: Most definitely a yes, Member for Goyder. They were known things that were happening at the time. To be really frank, what I think had probably been underestimated in the earlier planning was the absolute criticality and the importance of having wide clinical involvement and engagement in that planning and preparation. That particular stage, around about that time, was when the functional requirements for the system were being documented, refined and tested, and having a clinical lens on that and having a broad range of different clinicians actively engaged in that—I suspect to some degree the resource impact of that was somewhat underestimated because, similarly, the commissioning of a new hospital draws away your clinicians. I think when push came to shove the commissioning of Palmerston hospital was prioritised and the program had to wait and be patient to get access to those key clinical stakeholders. While we may have thought that was a manageable impost earlier in the process, that proved not to be the case.

Mr MACKAY: With regard to the importance of the clinicians being involved in the process of rolling out Acacia, some of the submissions that have been received refer to extremely high turnover of clinician staff. Were there any senior figures, obviously you have changed CEO positions—but from the clinician point of view, has there been any significant changes over the last four or five years of the Acacia project that would have impacted delays, bringing someone else up to speed, that kind of thing?

Mr HOSKING: I will answer the question saying no, then I might ask Dr Bell and Dr Kanga to add to my remarks.

Interestingly, we have quite a churn in NT Health. I think our turnover rates, particularly of junior clinicians, sit in that 20% to 25 % band, often because our nursing workforce can be transient and move around quite a bit and our junior doctors are generally on a training pathway where they move around to address their training requirements. At the other end of that spectrum with our senior medical officers it is very stable. As I sit here I am thinking of all the senior doctors I have dealt with over the life of the project, and it is going to have its 10-year birthday in May, because that will be the anniversary of the first Cabinet decision, I have dealt, maybe with one or two exceptions, with the same cohort of very senior clinicians who are the ones who have the most input and influence to the program.

Certainly Dr Kanga I have been working closely with for 10 years, and Dr Bell. I might just defer to you, Kanga.

Prof KANGAHARAN: As a senior clinician, we chose the members of the leadership group quite at a high level who are influential and able to make changes. The turnover of that level of people is very low. All the nursing, medical and administrative members, the change of the membership has been pretty limited. When the Top End and Central

Australia were separate, we had to have a member from either side. We had a large cohort of people. Central Australia had a little bit more turnover than Top End, but generally a lot of senior clinical and frontline people were involved.

With the information that we had at the time, how do we implement, we did the best with the knowledge that we had. Then when we had more information on risk, especially Palmerston hospital—I recall we thought we would just go with the new system at Palmerston hospital. Then that was—we were worried about whether the current old legacy system would handle Palmerston hospital. That decision took a while, proper discussion, to make sure that was probably the right thing to do, because Acacia was not ready to be implemented safely at the time.

There were a lot of decisions applying the clinical safety lens. There was so much safety discussion that happened to make sure there was no safety compromise for a new hospital, new systems to make change.

Mr MACKAY: Relating back to the \$24m reprioritisation from the NT Health budget and then the other \$39.4m from the DCDD budget, was any approach made to the respective ministers at the time for a budget submission to not have to reprioritise NT Health funding? Was there, at any point, a discussion about asking for more money to top it up rather than taking away from other NT Health projects?

Mr HOSKING: I will not speak for Dr Daly, who was the head of the Health department at the time; I do not think that would be fair. Although I will clearly acknowledge that I drove this process; I was the one trying to achieve a budget outcome, so it was largely at my initiation.

It was discussed in passing at my regular meetings with my minister, but we never went to the stage of writing the little budget brief that goes in to try to get it as a business item for consideration by budget Cabinet. I spoke about it in general terms as a gap that would need to be addressed, but I felt—to this day I stand by the actions that were taken—it was incumbent on us as the two chief executives accountable for this program to try to solve the problem ourselves. I actually felt that going cap in hand to the government of the day, which had a considerable range of other funding pressures at the time—and asking for \$60m in tight times is always a difficult requirement. I thought it was incumbent on us to do the right thing and try to solve the problem ourselves. That is what we did.

The short answer to your question is it was discussed but never progressed.

Mr MACKAY: From a pub test point of view, from the public's point of view, there was a budget and \$60m was reprioritised. The question from the public is there was a \$10m saving on a DCDD project. That was easy to say there was \$10m left over. When you reprioritise funding, what occurs to members of the public is if you can reallocate \$24m out of the NT Health budget for this project, either something was cut or the NT Health budget was inflated by \$24m. I do not believe it is; I believe the NT Health budget has been under considerable stress and pressure. I welcome the funding announcement recently. From a public point of view, if you can repurpose \$24m, either the \$24m would have gone to waste anyway or you cut something.

Alternatively, what happened—this is the pub test, and you are welcome to comment on this—it appears that there was a culture in 2022 of, 'We cannot ask for more money in the health system. We are scared of asking the minister to go to Cabinet for more money in the health system'. This, to me, seems completely out of line with the public's expectation. Health is something that you imagine successive governments will try their best to accommodate.

Was that \$24m going to a project that was not worth time and money and would go to waste instead of, say, to maternity services? Or for the \$24m, did something get cut for it?

Mr HOSKING: I acknowledge your point, Member for Goyder. I understand the point you are making about the pub test.

The majority portion of that funding supplementation that occurred within DCIS at the time was fortuitous and did not take funding away from other initiatives. There were two key components. One was the residual where we had been able to deliver the CARE system with \$10m efficiency. That was appropriate to reprioritise that.

The residual of that was made up of—the department holds a central budget for managing a leased property portfolio, which is considerable annual expenditure, and it is linked to indexation around property rates. Obviously those buildings have indexation rates in their leases. After the pandemic those lease rates had been flat for several years. We had a fortuitous saving in that particular budget over the forward estimates—not in one year, but over the four-year forward estimates—all of which was used to meet the DCIS contribution of that. In respect of the DCIS component it was a true saving and it was one that was able to be put to this as our component of it.

I acknowledge the point you make about the \$24m in respect of Health, but, as I said, I do not want to speculate on where Dr Daly made those changes.

Mr MACKAY: If I were to ask that question on notice would the Department of Health be able to find out what reallocations were made in that time period?

Mr HOSKING: We could certainly attempt to do that, Member for Goyder. I do not know with what precision those records will have been kept, but we would certainly accept the question.

Mr CHAIR: Member for Goyder, could you please repeat the question for the record.

Mr MACKAY: Can the Department of Health please provide an understanding of where the \$24m in internal reprioritisations of the NT Health's budget in October 2023—what projects or areas was that money reallocated from?

Mr CHAIR: Mr Hosking, do you accept the question?

Mr HOSKING: Yes, I do.

Mr CHAIR: If there is a reprioritisation like what has occurred here, will it come up in budget documents? What I will get to is a bit of a frustration of mine with budget is it can be just the top level that you see. Would it come up in budget if there has just been reallocation?

Mr HOSKING: I will answer that to the best of my ability and then I might ask my deputy to chime in, who is a trained CFO with many years experience and will probably be able to answer it with better precision than me.

The answer I think is yes, but not in a way that would generally be visible to the average reader of the budget books. By that I mean that I mentioned a portion of the DCIS contribution to that came from our central budget for paying the rent on leased buildings. That is a standalone output in the DCDD budget books. If a portion of that was reprioritised from the out years to the current year to be able to meet that reprioritisation, it would generally mean that output would adjust downwards by a little bit in the out years. Having said that, there would also be indexation applied, so there are ons and offs and it would probably not be visible to the untrained eye. Whether it was referenced in the notes in Budget Paper No 3, I am not sure. If a variation is material in nature we will often add notes to those in our budget books. This may not have tripped that threshold in a property leasing budget of \$110m or \$120m.

I might just ask Ms Charles if she could add a little bit to that.

Ms CHARLES: Those sort of variations between agencies would be visible in budget books. There are always variation notes underneath the tables which explain that. I feel certain that variation into the department of DCDD at the time would have been noted in one of those footnotes because it would have been material. Then there are also notes that are attributed to movements between outputs. In terms of detail it may not be visible where it came from, but across the outputs there is likely movements in and out that did reduce the outputs within the NT Health budget.

Mr CHAIR: I now have a couple of questions which might feel like we are jumping around, but it is just as I have taken notes as we have gone through. Then I will finish with the core of what this committee wants to get to, which is how can we better strengthen going forward for not only Acacia and making sure we can get from this day a good run to delivery across the board, but any future investments government—be it ours or successive governments—makes. Just bear with me.

When we are looking at an investment like this—I understand it went to a tender. I also understand there is large input from government. Correct me if I am wrong, but that is both full-time workers that work for government and contractors. How does that relationship work? My private sector background is very much you get your contract and you deliver all of it yourself for the client. How does it work with the NT Government partnering with a private contractor on the delivery of this?

You spoke of options that are looked at. I was curious. Help me understand why there is not just a system in the free market that could be gone to and implemented. I note that there was a trip to Scotland I believe and the NHS, what were we looking for there? How do other jurisdictions do this?

Mr HOSKING: There are several questions there and I will do my best to rattle them all off. In terms of the contracting model I take your point that delivering an IT system is a bit different to building a bridge. If you want to build a bridge, you go to tender and you award a contract to a firm of engineers and they build the bridge to a spec. Although to be fair, civil engineering we have been doing for thousands of years and IT projects we have been doing for decades, so it is quite different.

To answer your question—is there a commercial system we can go and buy—that is exactly what we did. We bought TrakCare which is licensed software from InterSystems. Acacia is just the local name we give to that, but it is essentially the TrakCare software that is used in the NHS. It is used all over the UK and the US. It is used in about a thousand hospitals worldwide. It is one of the Tier 1 clinical software information systems.

The vendor brings their implementation services to the table as part of their contract. The contract is generally made up of a couple of key components. One is the purchase of the software, which is you buy your licence outright and then you pay annual software maintenance and support so that you get upgrades and things every year, and you pay that for as long as you continue to stay supported. Then there is an implementation component in the vendor costs, and these are the ones I referred to that are tied down to fixed-price deliverables which are about configuring the system to the way we want to use it and then delivering it into our IT environments.

These projects by their nature have a lot more facets to them than that. There is all of the work to get all of our forms and all the manual things that need to go into the system and be done in the digital medium; change management

engagement; prepping our hospitals; doing the training and all those things that go into getting our people ready to take the new system; and testing the software to make sure that it performs to the design spec and does the things it is supposed to do, then getting the vendor to fix the bugs and errors in it.

In terms of the apportionment of resources between the vendor and the client, the client generally has a larger burden to bear in terms of resourcing because those activities we need to do on our side of the fence—that you simply could not go and get an IT software vendor to come and do that is unfamiliar with your environment and cannot direct and engage your clinical workforce—generally, that is disproportionate, so a lot of those implementation costs are borne by us as the client. That is a fairly standard model used across Australia, in fact, the world; it is not that uncommon at all.

The composition of that team—I think at its peak the Acacia project team was probably about 130 people. Generally, it is about an 80–20 mix of public servants at 20% and contractors about 80%. The reason for that is bringing the contractors in as daily rate contractors you need different ones at different stages of the project, so you need to stagger your resourcing and onboard and offboard. That model gives you the flexibility to do that.

There is also an aspect there that those types of skill sets are in really high demand in the market, and the market rates for those are not really reflected in public sector rates pay. If I was to try to hire technical architects or high-end business analysts, the public sector salary rates are generally not competitive in those markets. The contracting model gives you the ability to attract and retain those resources for the period you need them, and then easily scale down at the point that they are not required.

The people who work in those types of roles pursue that as a career and follow the big projects around the nation. In fact, we did very well during COVID because the eastern seaboard shut down a lot of their big IT projects and most of the contractors found themselves out of a job; whereas, in the Territory you could come and do your two weeks in Howard Springs and then you could work. We picked up some really good people during the pandemic, ironically.

That is a fairly standard industry model used in IT. Sometimes the mix between public servants and contractors varies a little bit, but those apportionments are pretty standard. What is really important, though, is the senior roles—the positions of authority that make decisions, give instructions and determine things under our public sector accountability frameworks—are public servants because contractors cannot do that. You cannot exercise delegation under the *Financial Management Act* if you are not an employee of the government. Contractors simply cannot exercise delegation. Senior roles tend to be public servants, the directors and the leadership, and the high-end specialist technical expertise tend to be contractors. That is a fairly standard mix.

Mr CHAIR: In looking for opportunities for us, as a committee, to improve, in your opinion, looking back is there potential or scope for private contractors to take on more responsibility or risk? Do you think the way it is currently structured is the better way?

Mr HOSKING: I will give you my views, Mr Chair, but I must qualify this by saying they are Chris Hosking's personal views. I am not speaking for the government, the Health department or DCDD, but as someone who has worked in this industry for a very long time and seen successful projects and projects I can only describe as a train smash.

My personal view is that there will always be some variations in the model, depending on what you are implementing and what type of software product it is. I think the model, as I described it, is about right.

There is an alternate model often, or sometimes, used which is called a service integrator model, where the client, being the government, might engage InterSystems to deliver their software and then get someone like—I do not know—one of the big four consulting firms or one of those other really big private sector companies to SI the project, which is what we call a service integrator. The logic behind that model is that these people are specialists at this and are very good at what they do and they will come in and do it in a way that is better and superior to the government.

I am not a fan of that. Some of you who have been around the Northern Territory for a long time might remember the failed asset management system project back in 2014 that found itself in front of this very committee. In fact, I gave evidence to the committee about the asset management system. That was an SI project. Fujitsu were the SI—I do not mind saying that on the record because it is in the public domain—and it went horribly, horribly wrong. The government threw \$70m down the drain and started again.

Those projects are, I am afraid, all too common. The reason for that again is you can contract out the doing of technical activities and things that need specialist expertise, but you can never ever outsource your accountability or your governance. You need to own that and you need to step up and stand behind it.

I can remember when the asset management system started to go badly wrong, some of the explanations that were offered were, 'It is not us, it is Fujitsu; they are contracted to manage this.' Well, you are managing that contract; they are your contractor. That accountability, you never ever get to hand that off.

I personally feel that owning that accountability is your obligation, particularly as the chief executive, and while you might go and contract in some additional expertise should you need it, I think we are well served having a small amount of expertise to manage these type of arrangements at a level where they are public servants and they are accountable

under the code of conduct, PSEMA and the FMA and all those things. They can be instructed and directed by the chief executive or by their management, rather than getting into a contractual dispute when things do not work out.

I think that model may have some validity in other places, but here in the Territory we are small enough and joined up enough, and I think the various parts of government work together well enough, that we are far better served by doing that coordination and leadership piece ourselves. Outsourcing, if that was being put to me as a proposal, I would be strongly against it because I have seen it go horribly wrong right here in the NT.

Mr CHAIR: I have one more set question and then I will move into general comments that the department views we should take on board when looking at any recommendations to government. The one standalone question has just come from your submission, 7.1 line 176. We see that it is very common for ICT projects to go over budget. It is a question really for every department that we are doing this inquiry. If we see that there is an average of 30% to 40% over budget, and this was evidence published by Standards Australia that you have referenced, why do we not just include that in the budget?

Mr HOSKING: I will have to be careful how I answer this one, Member for Drysdale. Look, I have been quite forthright with all of this, this morning. My personal view—I am not speaking for my colleagues—is that 30% or 40% inflator would probably lead to a bunch of them not getting up in the first place. I am not sure about the accuracy of that number, but certainly IT projects have a bad reputation for running over and some of it is absolutely deserved.

I would add to that by saying that I think many organisations get into these projects without having really done the work on the front end to understand how much it really costs.

I will share an anecdote with you. I sit on the NT Government's ICT Governance Board which is a board we set up after the AMS project went horribly wrong to try to lift our game and do better. I was a member of that board at one of its very first meetings when the Health department brought their first Acacia—we need to replace our clinical information systems. I will not even call it a business case; it probably was not that mature. That flagged with us the technology risk of the old systems.

I will not identify the individuals because some of them still work here, but the estimate to replace the systems in that initial flush was \$36m. Given the conversation we have just had here today, you can see that is not remotely sensible. The view of the board at the time was, 'We think this might be a bit underdone. Go away and do some more analysis, please.' I stand by that.

I think if we did one thing to really do better in this regard—I take your point, Mr Chair; if everything had a 30% or 40% mark-up on it, we would do better because you would have more comfort in your funding arrangements, but I think what is really needed is the discipline to do the work and the analysis up-front.

Often the need to do the thing gets identified too late. The old system is going to fall over and the vendor is packing up shop or there is a degree of urgency or emergent circumstances driving it and the person who has been made responsible for it is probably getting pressed to come up with an answer or a solution. That leads to trying to do things quickly when, in fact, they need to be done thoroughly.

We talked about a good example today. I am sitting here today in 2026 and the thought of doing a big-bang implementation of our new clinical IT system would terrify me. If you asked me that today I would say, 'No way, that is not sensible. We should not do that.' Ten years ago no-one blinked.

I think what we really need to do is spend the time. We would be better off spending a few months more time thinking, on analysis and making sure our business case is well researched and we have looked at all the problems and hurdles, knowing full well that is probably going to add to the cost at the other end because you will need to address those things. But then we know those things and when we actually get into the doing phase, if you are fortunate enough for government to make the investment and get funding, you go in with your eyes open and you are far better prepared and are less likely to make mistakes, which, at the end of the day, is going to protect that funding and investment that has been entrusted to you by the government. Taking the time and making haste slowly and doing your thinking and analysis on the front end will pay off in spades when those things actually get going.

Some of our learning from Acacia is direct evidence of that, and I think it applies right across the board to projects large and small. I realise that is difficult if you have your executive, minister or someone saying, 'I need a solution to this problem; we have to go quickly.' Sometimes slowing it down a little bit will lead to a much better, quicker delivery of a solution and something that we are not having to fix our mistakes along the way. That, for me, would be the number one thing.

Mr MACKAY: In the early part of that statement you just made to answer the question, you said that the risk is if you actually quote what the blowout is expected to be you would have a hard time getting the government to agree to fund something. Are you insinuating there is a practice of CEOs across government underquoting projects so that the minister and government of the day end up looking like the idiots who overspent, rather than putting the true cost to Territorians in the initial business case where it can be assessed for its true value for Territorians?

Mr HOSKING: No. For the *Hansard*, I am not insinuating that. I would not dare do that. I think that when that happens it is well intentioned but clumsy. It is not deliberate.

Mr CHAIR: Yes. I am going to hand over to the Member for Arafura in a moment.

Thank you, Mr Hosking, because I think that perfectly answered considerations for us. I would like to give the opportunity, whilst we sit on that question about things for this committee, and allow every individual if you would like to add something to what we can do to create a better system going forward for the Northern Territory. I will open the floor. If we can start with you, Angela, and move across.

Ms BRANNELLY: I am supportive of Chris's responses. I think that with systems like this, it is about understanding the change impact. Ensuring how we support our staff to come on board with the change in using a new system is something we cannot underestimate, and is a really important part of the project in improving how we deliver IT solutions in Health. The main message I would like to get across is being really clear and strong and supportive of the staff who are using the system.

The other thing I have said to my staff is that IT systems do not care for patients, clinicians care for patients, and we must remember that we need to support our clinicians to do that through well-researched safe tools.

Ms CHARLES: I also support the comments of our CEO that the governance around this is far improved compared to previous years and we are learning lessons as we move through. The governance around that allows us to take those lessons and improve as we move forward.

I would also note that the centralised model through DCDD has brought drastic improvements because agencies with smaller resources are not trying to deal with these complex problems alone.

Also, Acacia was implemented at a time that other big major systems were implemented, so government were doing a lot to invest in IT systems. I do not know if there will be a time like that again where you would be replacing all of your systems at the same time, your key ones for Police, for the Child Protection agency, for the Health agency.

The comments about being more deliberate and planned with the ICT roadmap which we now have, which really does consider and plans in the future and staggers out that work, will also make an improvement to the delivery.

Dr BELL: I would like to make a couple of comments.

I would like to just make some remarks on the discussion initiated by the Member for Johnston around clinical risk. It is important to understand that we actually have significant levels of risk in our legacy systems. In my 35 years working in the Northern Territory there is a level of risk in the healthcare system, not just about IT. We have seen systems developed to make the health system safer. We now have levels of reporting and risk analysis and mitigation that we did not dream of 30 years ago, and information systems have been part of that.

We have a very rigorous system within the project, and now transferred into the Health department as we take on governance of Acacia, to analyse any risks that we are aware of before we go live. We know that every time you roll out new software you cannot avoid introducing risk, but you are also mitigating risks in the systems you are replacing, so the aim is always to look at how you mitigate and manage new risks but lower the overall risk of the system and monitor and improve the level of risk as you go forward. It has been quite a rigorous process.

We have a system within the Health department of reporting any clinical risks and any incidents that are identified. They are all logged. They come up through our clinical safety team. There is work between the clinical safety team and my office to analyse all those risks as we go forward with Acacia, look at how we further mitigate any risks that were known about and we find have not been adequately mitigated or any new risks that emerge as we take on a new system.

I really do want to emphasise that the biggest thing we can do to lower the risk of our systems at the moment is to retire the ones that are clunky and we were having difficulty supporting.

The other thing I wanted to note is we finished last year on a good note with having rolled out the very complex patient administration system across the whole of the Territory. That is the platform we can build on the exciting bits now, which is digitalising our hospitals which are now largely based on clinical documentation on paper. If clinical documentation is on paper it is only available in the silo it is written in. We cannot see progress notes from Katherine Hospital when somebody is transferred to Darwin hospital, for instance, and we have very limited capacity to share information beyond our own health service. Acacia has delivered huge benefits in sharing information between primary and secondary care within the Health department.

Acknowledging the Member for Arafura's comment, because I have had a lot to do with Red Lily Health Board and Mala'la and have worked for AMSANT, we get requests every week from other people, from external providers who see the benefit Acacia has provided within our own services, asking for access to Acacia.

Within the constraints of the Northern Territory *Information Act* as it is currently and remembering there is a social licence component of this of making sure that individual consumers of healthcare have control over who accesses their data, now we have a really good platform for going forward and developing—we call them portals—ways that provide when people move from one provider to the next, information moves with them and does not remain in a silo.

Part of that is that Acacia gives us a platform to work with further integration with the National Healthcare Interoperability Plan, which is My Health Record but far more its new standards and procedures for sharing data and sharing information between systems which are largely not interoperable.

We have already engaged with the Australian Digital Health Agency. Over the last few years we have had, I think, more than \$5m funding from ADHA for our participation in these projects. We are currently developing the first jurisdictional pilot of a provider directory which allows us to send messages to the right person when people are discharged from hospital and receive messages from people. Now the first step in a national system is work that we are doing in the Health department with the Australian Digital Health Agency to develop that national directory.

With Acacia at the stage it is at we now have a platform to build on. We are now really excited about proceeding with our clinical documentation in the hospitals but also FG5, which is increased ability to share information with both GPs and Aboriginal health services.

Prof KANGAHARAN: I would like to say I have been part of Acacia for 10 years and I want to take it as a good news story; it is an asset, a positive thing, for NT, even though we are having this discussion today. It is going to be the most transformative and when it is completed you are going to see the return on investment in saving lives plus efficiency.

I was just reflecting on—you could have potentially be on a coronial or some other unsafe incident related to a clinical information system, which in some of the other interstate and international experiences people get harmed, focusing on the cost-focused implementation as opposed to the safety-focused implementation that we did. Yes, it has taken longer, but I think every decision was done for the right reason. The vendor has been very good and the governance. I have been part of all the committees and I felt, as a clinician, that the discussion has been absolutely open and transparent. I think the system has come a really long way.

As Andrew said, we have got a really good foundation now to build what we call 'what we really want' in terms of getting AI and other really robust features that is going to make us look much better. I think we can potentially put the NT on the map across the world because we are the only system who has connected primary care and acute care. You do not have any other Australian health information system that has done that. We have done that very successfully and safely.

People can work remotely from any part of Australia. I think we have clinicians providing support to Maningrida from Sydney. We do that on telehealth, because we can do that because we have Acacia, to see the patient.

I am just saying that this is a really good investment. When we complete it, we will make a huge difference. In 20 years' time you will not talk about the cost; you will probably be much better off.

Mr CHAIR: Thank you, Dr Kangaharan, I appreciate that. Member for Arafura, I will hand over to you, and then we will call it.

Mr BROWN: Just a wrap-up from me. Given where we have come from, how inefficient, and just moving forward with the new Acacia system, how does that look in the future? Is there is any loophole as well that needs to be addressed in the near future? Also, will we be able to save money in the long run, given where we have come from?

Mr HOSKING: I will answer the last part of your question first. I have never seen a new IT system cost less than the old one. So will it save money? Probably not, but to be fair that was never a benefit identified in the business case.

We have gone from a 1930s pushrod engine to a modern Tesla. That is the quantum leap we have taken in terms of modern technology.

To your question about where to from here, I think the points that Dr Bell made and Dr Kanga rounded out with around the capability that this positions us to do things, particularly for those people who are some of the sickest Territorians living in the most isolated places who do not have—if I am unwell I can go to Royal Darwin Hospital; it is 10 minutes from home. I have my doctor on speed dial; I can send him a text message. But the people who really need the care are generally the people who are the least connected to care. This is a fundamental capability that is going to change that. When we get those components that we are working on now—so that organisations like Mala'la, Red Lily and others have real-time seamless digital access to records for the people who are living within the communities that they service, but get a significant proportion of their care from the broader public health system operated by NT Health—the more we join those things up, the better the care for those people will be.

The number one benefit in the proposal for this investment was around improving health outcomes for Territorians, which I think we are really poised now to do. We are already achieving that through what we have done, but the potential to extend that into the bush will make an enormous difference to those people who need it the most. You will see that accelerate at a rate of knots now—that is exciting.

It is a bit of a pivotal moment here, because we are looking at the project in the rear-vision mirror, as it were, at some of the things that potentially could have gone better or that have thrown up question marks or flags along the way, but the future trajectory is really bright. I am excited for what we are going to achieve.

I acknowledge the efforts of everybody who got us to here today over the last 10 years. Many of them are not here anymore. I think despite some of the challenges, it has been a resounding success. I am excited for the future.

Mr CHAIR: The Member for Blain has a couple of questions. Member for Blain, if we can keep them short; also, witnesses, if you can have direct answers for the Member for Blain.

Mr KERLE: I am not a regular member of the committee, but I have been invited on as I have some level of experience in this area.

Mr Hosking, I want to get on the record pre-COVID. We all understand that COVID had a massive impact on the functions of government. For the record, do you mind going over the control mechanisms that were established over the project that would normally be established for project health, risk of things going over time, and your recollection of how those were tracking before COVID—say, in March 2020?

Mr HOSKING: The project has a fairly sophisticated governance structure, but, in simple terms, it has a steering committee at the highest level that has the Chief Executives of Health and DCDD; senior representation from Treasury because it is a significant financial investment; and Dr Kanga as a key clinical representative. That is the peak governance body that meets monthly and has an accountability to report up to Cabinet and so forth to keep Cabinet regularly briefed.

Beneath that there is what we call our Program Implementation Committee which is a very senior committee, but it is executives and clinicians. That is actually the engine room that does the doing and drives the delivery. I chaired that for many years, and Kim, my deputy, chairs it now.

Then we have the Clinical Leadership Group that Dr Kanga has referred to which is our peak clinical engagement.

There are three layers of committees in terms of CEO level, senior executives and clinicians and then a clinically focused group. Everything would traverse those three steps as part of consideration. If we are making a decision to go live, that go-live decision would traverse the implementation working group in the hospital, then the Clinical Leadership Group and the implementation committee, and sometimes in a 24-hour period, but everything would traverse that in a very thorough way.

In addition to that, as the defined project lead or the accountable officer for delivering the project, I would meet with the program director on a weekly basis, and did so for many years. I continue to meet with them on a fortnightly basis now. Even though I am over in Health, I like to stay very close and connected to it.

I mentioned that we had it as a standing agenda item in our regular meetings with our minister and we reported quarterly to Cabinet. We also reported quarterly to the NT Government ICT Governance Board, so there are a few facets to that.

Again, given there was a single-point accountability vested in me there for many years, I tried my utmost to remain plugged in at every level, and I sat on all those committees. I attended them all and participated fulsomely in all of those, because for something this big and this complicated with this much inherent risk, you need to be across your material; you need to know what is going on. You cannot turn up to a steering committee once a month and hope to possibly understand what is going on. I think that part of the reason that I am able to speak here today thoroughly about the program is I have lived and breathed it for 10 years.

Mr Chair, your comments earlier on about lessons for the future and making sure we do these things well, I stand by what I said earlier about putting the effort into planning up-front. I have looked really hard at case studies of projects that have gone off the rails and ended in a real mess and there is a common thread through all of them where the senior executives do not buy in and take the time and the effort to really understand what is going on. There is a bit of a—and I am going to say it—cop-out that, 'It is an IT thing. I am not technical. I turn up to my steering committee once a month and read the papers.' That is not good enough. If you are going to be on the hook for delivering one of these things, you need to immerse yourself in it and you need to live and breathe it. That is exactly what I have done.

Mr KERLE: In the submission we had to go back and get a budget top-up around 2022, so prior to March 2020 were there indications that the project was deviating from its baseline significantly and, if so, where would you say the governance could have been improved?

Mr HOSKING: Good question, thank you, Member for Blain. I am going to say no. In 2020 I was still solidly optimistic that we would get done within the timeframe and within the funding envelope. It was early in the pandemic, things were a little blurry and uncertain.

Some strains probably emerged around about that time between DCIS and the Health department because, to be fair, the poor old Health department was focused on battling the pandemic. We were focused on, 'We have got this. We can keep going. Let us not give up; let us keep doing our level best to deliver here.' I can remember having some very

robust discussions with Health executives and clinicians at the time around, ‘Look, there is a global pandemic going on, do not get in our way’, and I am going, ‘Yes, I know, but we can do both. Let us keep going, keep the ball in play.’ Whether I would feel differently today given my change in responsibilities I am not sure.

I will say that in 2020 I was still optimistic and confident, and those concerns emerged a little later.

Mr KERLE: Going back to the governance, the issues when Acacia was rolled out to Royal Darwin Hospital ED are well ventilated in the media. You talked about how changes for Go Live go through a robust clinical process. Can you identify where those processes fell down that resulted in the issues that were ventilated in the media regarding Acacia’s Go Live in ED at RDH?

Mr HOSKING: Yes, certainly. I think Dr Kanga touched on this in his earlier remarks. To be fair, that process I spoke about where the Royal Darwin Hospital implementation group—which has very senior representation from emergency medicine—and those other committees all endorsed the Go Live decision. I remember being in the room. The process to go live means pulling an all-nighter. We start mid-afternoon and the system is live by about 7 the next morning. It is a long night, and I have sat through a few of those. I did fall asleep once or twice. I sat there with some of the senior emergency doctors on the Go Live night and we all gave ourselves a cheer and a pat on the back when we got there the next morning.

I think the fundamental thing that tripped us over with emergency was not that the software did not work. The software worked. As I said, this system is deployed in a thousand hospitals worldwide; it is being used in emergency departments everywhere. How we practise emergency in Darwin is pretty strained. You would have seen we were in code yellow about a week ago. I think we had 120 people in an ED designed for 60. We always sail pretty close to the wind there because our capacity is constrained. We are in an old hospital and we are incredibly busy. It is really busy there again today, unfortunately; Angela just updated me in the lift on the way up. We have had more people coming in the door than are going out, and that is what leads to problems.

What really became apparent in the days and weeks post-Go Live was that it was just taking too long to do a thing. We had that period of peak patient workload. It was a bit of a perfect storm where you are really busy, people have only just been trained in the system and they are still coming to grips with it. I think had we been in a more moderate cadence in terms of workload, things might have been different. But we were not; it was really busy. To be fair, we could not prevail on the emergency doctors to say, ‘Just hang in there; you will get used to it.’

All the work that has been done to modify and enhance the software since then when we withdrew it and brought it back—to give you an example of how much finesse went into that, there were 170 enhancements to workflows. Andrew and I sat there for a couple of hours every Friday afternoon for months and worked through them with the senior emergency doctors. I have viewed and navigated every single one on screen myself. It was a painstaking process of working through that, which leads to people being able to do a thing in two clicks instead of five or on one screen instead of three. It is some of those efficiencies that allow people to stay on top of their client—patient—workloads when things are really busy in real time, particularly those middle-level, fairly senior doctors who supervise the work of junior doctors. That is where the pain point was.

Mr CHAIR: I will call it here, because it was meant to be one hour and we approach our third hour. I really thank you for staying the extra time. It gives the committee and, essentially, the people of the Northern Territory a lot more, which we are all in service to. I thank you for the extra time; it is greatly appreciated. I know DCDD will be very keen to get in.

We will break here and resume at quarter to.

Mr HOSKING: Mr Chair, could I just enter on the record the thanks and appreciation of the Health department. My colleagues and I really looked forward to the opportunity to come along today and brief you. We are grateful for the chance. Thank you very much.

The committee suspended.

Department of Corporate and Digital Development

Mr CHAIR: I would like to first thank you for your patience this morning. We have gone well over; however, in the last session PAC got quite a lot of information and we wanted to get that. I will now kick into it.

We are opening with the Department of Corporate and Digital Development. On behalf of the committee, I welcome everyone to this public briefing into the Acacia digital patient record system.

I welcome to the table to give evidence to the committee from the Department of Corporate and Digital Development, Catherine Weber PSM, Chief Executive Officer; Greg Connors, Deputy Chief Executive Officer, Digital Services; and Grace Johnson, Program Director, Core Clinical Systems Renewal Program. Thank you for coming before the committee. We appreciate you taking the time to speak to the committee and look forward to hearing from you today.

This is a formal proceeding of the committee and the protection of the parliamentary privilege and the obligation not to mislead the committee apply. This is a public briefing and is being webcast through the Assembly's website. A transcript will be made for use of the committee and may be put on the committee's website. If at any time during the hearing you are concerned that what you will say should not be made public, you may ask the committee to go into closed session and take your evidence in private.

Could you please each state your name and the capacity in which you are appearing.

Ms WEBER: My name is Catherine Weber. I am the Chief Executive Officer of the Department of Corporate and Digital Development.

Mr CONNORS: My name is Greg Connors. I am the Deputy Chief Executive Officer, Digital Services, DCDD.

Ms JOHNSON: I am Grace Johnson. I am the Program Director for the Core Clinical Systems Renewal Program which is known as Acacia.

Mr CHAIR: Thank you. Ms Weber, would you like to make an opening statement?

Ms WEBER: I will make a few brief remarks, thank you, Mr Chair.

I would like to thank the committee for this really important opportunity to talk about the Acacia program, to outline how it came about and what the program is all about and what it is seeking to achieve. That opportunity has not arisen in the past, and it is a terrific opportunity to explain in full how the program came about and what it is for.

I have been the Chief Executive of DCDD since September 2024 and before that I was with the Department of Treasury and Finance, so I have had peripheral involvement with Acacia through the budget process in the past. I am also a past member of the ICT Governance Board, years ago, that the Acacia program used to report up to, as Chris Hosking outlined earlier.

The steering committee is focused on the risks of the existing systems, but, more importantly, the transformative difference that a single digital health platform will do for outcomes for Territorians. As a small jurisdiction if it can succeed anywhere it will be here in the Territory, given our size, scale and the extent of coverage of government-provided health services. I think that has been demonstrated really clearly here today by our Health colleagues earlier.

It is the largest ICT project ever undertaken in the Northern Territory, so for the former DCIS and now DCDD there has been much learning along the way that we have applied to this program but also other ICT projects, but there have also been some major interruptions along the way with this program. The program had to and has adapted to work with these changes in circumstances, and that is outlined in our joint submissions from Chris Hosking and myself.

We have worked hand in hand with the Department of Health all the way along. We provide the kind of mechanical system aspect of this project and Health provides the business knowledge. One cannot operate without the other; it is an essential partnership, and that is a feature of any ICT project.

I look forward to the committee's recommendations about how we can improve how we run these programs. I have some ideas if you ask me that question a bit later on.

That is what I would like to say to open, thank you.

Mr CHAIR: Thank you, Ms Weber. I will open to questions. Member for Johnston.

J DAVIS: Thanks for appearing today and for your patience this morning as well.

I think as the Chair said, a lot of the questions that I had have already been covered. I am interested in—there was some discussion about this in setting up this project and in the original tendering for it and things—what consideration was given to selecting the group that did it. What is happening in other jurisdictions? It was highlighted in some of the submissions that there were issues in other jurisdictions, and I wonder how that was taken into account when the tender was awarded.

Ms WEBER: I was not in the agency at that time, but the Department of Health was awarded through a budget process an initial amount of \$10m to develop the business case. Part of developing the business case would be looking at what happens in other jurisdictions, what products and functionality is out there in the market, whether it is in Australia or whether it is internationally. They would have drawn on the experience of other jurisdictions and other health systems, as well as the Department of Health itself and what it needed. That is as much as I can say.

Greg, do you have anything to contribute to that?

Mr CONNORS: I, likewise, to Catherine, was not involved in that process at the start, but I know that our normal procedure in terms of business cases is to scan jurisdictional information to make sure that we bring it to bear on our procurement process. I can tell you from experience doing other procurements of similar types of software and

implementations, we do a rigorous jurisdictional scan. Some of the comments in the submissions provided to us relate to experiences probably in flight, that they were learning as they were doing it, so it is very difficult for us to gain knowledge from that in the middle of our process. I would say my experience is we do jurisdictional scans. We have always taken a lot on board, notwithstanding the commentary around big bang versus the other ways of deploying.

J DAVIS: Understanding that you were both not there at the initial stage, are you able to comment on what key risks and challenges were identified initially when developing the project and what was put in place to mitigate those risks?

Ms WEBER: I imagine, because I was not involved, that the sorts of risks that the business case would have looked at is not only system risk and looking at what we call legacy systems—the multiple systems that this new proposal was seeking to replace from a technical perspective—but also the clinical risks that were involved with using multiple systems for every client. A big component of the consideration would have been clinical risk, patient risk and how that could and should be addressed, as well as learning lessons from other jurisdictions that had already looked at that.

J DAVIS: Moving into the rolling out of it here, what was the process for capturing, resolving and addressing issues throughout the rolling out of Acacia?

Ms WEBER: The program has quite an extensive risk management framework, and I might hand over to Grace to describe that in more detail. At the project steering committee level every meeting has a description of some of the highest risks, and we keep an eye on those. They might be system risks, implementation risks, financial risks or stakeholder engagement risks. All those sorts of things are documented and tracked along the way. The highest levels of risk are reported up through the governance committees and that framework.

I might hand over to Grace.

Ms JOHNSON: Just to add to that, obviously our colleagues in the Department of Health spoke about the Clinical Leadership Group, the Program Implementation Committee and the Program Steering Committee.

Underneath that CLG layer, we had 35 working groups that were made up by the business in their individual areas. For example, we had an emergency department working group, maternity, primary healthcare, medications—all of those different areas within NT Health, not just the hospital but also the primary, remote and mental health and AOD. They were the forums for NT Health staff to flag those risks and issues, either business related, implementation related or clinical safety related. Then they would be managed either in those groups or escalated up through the governance pathway.

Leading into implementation, as part of what we call a go/no-go decision, Chris mentioned we usually traverse all those governance groups in 24 hours. However, what we also do is before every implementation, a clinical safety case and a clinical safety assessment is conducted about what we are implementing. Though it is the same system that gets implemented across each of the hospitals, there are nuances on how it is used, depending on the hospital, so that clinical safety case is then updated as part of each of those implementations, with lessons from what occurred in the previous one—both what worked well and things that might have been degraded and rated lower. It was also things that we thought would only be a low clinical safety risk but actually turned out to be bigger, and any further mitigations that we put in place as well. All of those things were tracked and raised through our governance groups in various different forms, depending on when they were raised.

J DAVIS: Mr Hosking answered this partially, I think. In terms of documenting those risks, escalating them and notifying the minister, is there any record of those risks and concerns being logged, where they went to and how they were responded to?

Ms JOHNSON: In terms of raising them with the minister, I am not privy to those conversations. They were all raised, as part of that go/no-go pack, they are all documented and written in there. That go/no-go pack traverses through all of those governance forums up to the steering committee which has the chief executives across the Department of Health, DCDD and Treasury.

Then, as part of that, there is a decision by NT Health on what risk they will tolerate and what risk they will not tolerate. We obviously do that as part of a formalised process. NT Health, every second of every day, are assessing clinical safety risk, so they have a tolerance that they then decide on whether or not it is something that they are going to accept or not.

How that was then communicated up to ministers, I am not privy to that information during those conversations, but it was all documented through those formal clinical safety assessments.

J DAVIS: Is the documentation of that something we could get access to?

Ms JOHNSON: They are all part of the meeting records. I do not believe they are currently on the list of documentation that has been requested.

J DAVIS: Are we able to request it?

Ms JOHNSON: Yes.

Mr CHAIR: We will put that question on the record. Member for Johnston, if you would like to place the question on the record.

J DAVIS: Could we please get access to the meeting records? I am not specifically clear to ...

Mr CHAIR: Ms Johnson, could you please advise what records would give us the information that we are looking for?

Ms JOHNSON: If it is in terms of the clinical safety cases and assessments, they are called clinical safety cases and assessments, for each of the implementations.

Mr CHAIR: Can you confirm you are happy to provide them to the committee?

Ms JOHNSON: That would be a decision for the executive.

Ms WEBER: Chair, yes, we are happy to provide that information. We already have an extensive information request, so we will just include it in that. Unless you want to make it a specific question on notice, we can include it in that information list.

J DAVIS: We appreciate that.

Ms WEBER: Also noting that we maintain those risk registers, some of those would be extensive because it goes right down into a lot of detail. I am not sure how useful that would be, but when we provide our meeting papers you will see the sorts of risk reporting that comes with those documents.

J DAVIS: Specifically what I am interested in is not all the granular detail, but what risks were raised and how they were addressed.

Ms WEBER: You will see all of that in the documentation.

J DAVIS: Thank you.

I just want to ask about one of the issues that has been raised in terms of the patient record data breach. Can you provide a brief overview of what actually happened there, how that data breach happened?

Ms JOHNSON: Yes. That was something I actually managed in my previous role. I have had many different hats with CCSRP. I was the director of governance at that point in time.

The way that occurred, and I think we have touched on it in the submission, was as part of the design process for designing the new system and capturing what needs to be recorded in it, we request all of the paper documentation from NT Health, but also what documentation they store in their—what we call—legacy system, so the ones that we are replacing. This includes letters, reports, forms, registers—all that type of information. When that has come across some of it has come across blank or with test information in it redacted, but then some of it had come across with real patient data in it. That came across into program staff through multiple different avenues—USBs, physical paper documents, emails and uploading onto our SharePoint.

That was discovered—I am not going to try to remember the dates because it has been a long time. When it was discovered it was reported up to the DPS, so under where all of our digital project sits. It was reported up to the senior director at the time, and we stood up a little mini project.

Immediately all access was shut off to all our drives and SharePoint for all staff except for a core team who were doing the review. Then every piece of documentation and all paper and all USBs were removed. Then every document that was stored on those drives and on those SharePoint sites was reviewed as to whether or not they contained data and then were flagged. If they were flagged, then there was further detail. Sometimes you cannot tell whether something is test data or real data because people do not use the word 'test'; sometimes people use their own names, family members names and that type of thing to do testing, even though it is all fake data. It was quite a long process to work through that.

At the same time we were doing that, the vendor, InterSystems, were doing the same thing on their side as well. The data that was provided through to InterSystems, the majority of it was via emails and then there would have been a couple through USB. They then put all of that documentation into storage and provided that back to NT Health and wiped it from their database. Their database was stored in Australia, so it never left Australia, and it all went through formal channels.

J DAVIS: A big job.

What steps were taken to notify patients whose data had been inappropriately disclosed to a third party?

Ms JOHNSON: We met with the Information Commissioner, and it was determined that it was the discretion of the Department of Health chief executives on whether or not patients needed to be advised because it was not considered a formal data breach, because the people within the department, so within the CCSRP team, and within InterSystems would have access to that information, just not in the way that we received that information. We had access to that information through all of our test systems that have production data in them.

J DAVIS: Were any patients notified?

Ms JOHNSON: I do not believe so.

Mrs ZIO: How many patients were affected by that data breach?

Ms JOHNSON: There were 3,000 files, but we do not have listed in here the exact number of patients, so it would have to be a question that we take on notice.

Mr CHAIR: Member for Fannie Bay, could you restate the question for the record?

Mrs ZIO: Could you please provide information on how many patient files were breached during that process?

Mr CHAIR: Ms Weber, are you happy to take that question on notice?

Ms WEBER: Yes.

Mr BROWN: Thank you for coming in.

What ongoing support is InterSystems required to provide? What recourse is available to the NT Government if they fail to comply with their contractual obligations?

Ms WEBER: Acacia is in an unusual position where it is a system that is being used but is still being developed, as it were. The functionality that is being used is supported by InterSystems and by DCDD. InterSystems provides that support in the form of the software development, and because it is an international product it is constantly being updated and upgraded. I think as we are developing the system for other functionality and parts of the Department of Health, InterSystems is also constantly upgrading that system. We are in a situation where we are rolling out upgrades to the parts that have been rolled out and we are still developing new functionality. That occurs on a regular basis in accordance with the contract.

I can hand over to Greg to talk about the contract management aspect of that contract.

Mr CONNORS: There is a contract management governance structure in place where we meet monthly to work through milestone deliveries and things with the contractor. We have no evidence in our engagement with InterSystems thus far that would suggest that they would back away from their commitments. In fact, they have been very willing to get in and assist and help to work through issues we are discovering. One might think that is possibly above and beyond their actual requirements, but to date there has been no need for us to pull any contractual levers to get them or influence them to come to the table; they have been at the table the whole time. We do have contractual levers in our contracts that would allow us to bring them to bear and make them do the requirements set out in the contract. We have had no need thus far to exercise those levers.

Mrs ZIO: Thanks for attending today; we appreciate it.

My question is probably going to take a little bit of a different turn. I know there has obviously been cost blowouts, time blowouts and all that kind of stuff. My belief is that a lot of that can result from staffing and workplace culture and stuff like that. There has been a bit of media around this topic. I am just wondering if you can provide a bit of an overview about the status during the project and the rollout of the project in relation to workplace culture around leadership positions in the teams that were rolling out this work; the consequences for somebody who did raise any concerns around the rollout; staff turnover; skills and expertise for staff who were involved in the project—I know there is a lot of stuff in here.

Mr CHAIR: We might, just for ease of our witnesses, if you want to just hit each point.

Mrs ZIO: One at a time; okay. We can probably start on staff turnover for the project. Please, if we could have a quick chat about that?

Ms WEBER: The detail of that I would probably have to take on notice because it has been a program that has been live for at least eight years to date, and noting also that the staffing is a mixture of NTPS staff. That means DCDD/DCIS staff, Health staff who were assigned to the project being the subject matter experts, but then also, as Chris Hosking mentioned, a lot of ICT contractors who we source through the procurement system. They naturally turn over, depending on what type of work we need done at any particular time. Some, I think it is fair to say, have been with the program for a number of years; others come and go as different phases of the project are underway, and we need different expertise at different times.

In the NTPS staffing, as Chris said, he as the Deputy CE and then later the CE of the Department of Corporate and Digital Development was very much leading this project at the very senior executive level, but then we have had a senior project lead sitting over that and Grace working with those people. There have been maybe three or four in that senior project management role.

I might hand over to Grace for more detail. Grace has been with the program now for quite some time—several years—starting off in the governance function and then moving into the program director role. There has been a senior program director sitting over Grace because of the size of the project and the investment. That has somewhat reduced now that we have rolled out FG1 completely into all the hospitals, renal clinics and so on. Grace is leading that program now.

I will hand over, if you have any more detail.

Ms JOHNSON: Chris Hosking spoke about, roughly, our employee numbers. At the largest we were sitting at close to 170 staff, made up of NTG staff, contractors and NT Health staff.

I commenced in May 2017. I have only gone into the program director role in the last two weeks, because the previous program director has retired for his fifth time—he is in the audience today; get that on the record. We think this is the final time. In my time on the program, there have been three program directors, excluding me. There was also a senior director that we reported through to, where all of the digital programs and projects report to. That senior structure has been quite stable.

The makeup of the team underneath has changed multiple times. We have just done another change as well. We would have to take the question on notice.

I also would like to note, with what Catherine said, obviously we do change staff depending on the phase that we are in. Obviously, the build phase was a lot about gathering information. Then in the last three years a lot of the focus has been on implementing, which is a completely different cohort—not completely different, but you have got your change engagement training staff where you do not need those people when you are doing the build phase.

We also shared resources across the programs as well. We actually had quite a few resources working on SerPro and CARE—the Police and Territory Families projects—then some of those resources have come onto the program afterwards as well. Then also the host of other small projects that DCDD manage. Though they may have left the program, there are some who have then remained in other spaces within DCDD or moved on to the BAU team as well.

Mrs ZIO: Can you tell me whether the different people—DCDD, Health staff, contractors who were brought in—were co-located in the one location?

Ms JOHNSON: The majority in one location, noting that we are the NT, so we have staff across the NT. There have been some remote resources outside of the NT, based on their skill set.

Mrs ZIO: Moving on to the next part of the question in relation to hiring staff, experience levels. Can you give me a little bit of an overview of the prerequisites coming in? I note that you have talked about different phases and there are different experience levels. If we maybe talk about the implementation phase over the last few years—the leadership models in the team, experience and prerequisites that they need to come into that team?

Ms WEBER: At a very high level I can comment. Grace knows more detail. Jump in, Greg.

You need strong leadership, obviously, but you also need to understand the technical requirements. I am talking about a DCDD project lead, but you also need to have really good stakeholder engagement skills because you are working with a partner; it is a partnership. You need strong leadership on the business side, the Health side, as well because there is a lot of change in that agency in adopting a new system. It is that ability to understand the business and the ability to work with those stakeholders and the client to get where they need to get to but within what is possible in the system. You need good project management skills, you need to be really organised and all of that sort of thing. There are multiple component parts in any leader, particularly in an IT project.

Mr CONNORS: I will just add a little bit to that. In terms of filling these positions, we do not just pluck them and go, 'Here, your turn'; there is a recruitment process that we go through. We test the market. In some cases we are testing the market for contractors and there is an onboarding process for those individuals. We put requirements out; we actually go and seek what we need to fill those positions.

In the FTE, in the NT public service side of things, again there is a JD that goes to market, and we do an assessment—many, many applicants. We pick the best that we can out of that based on their capabilities.

At all times we are getting the best people for those positions that we can. Their responsibilities and skill sets are, as Grace and Catherine have said, predicated on what the work is we have got coming.

Mr CHAIR: This is obviously a highly technical field, so when hiring, especially managers and senior managers or senior leaders, throughout the Acacia program, how much weighting—there are two parts to the question—is put on technical capability; and how is that verified or checked through the recruitment process?

Ms WEBER: In a merit selection process, which is what would apply, as Greg has just described, you would go through an interview process. You ask technical questions and you make sure your panel composition has that technical nous and understands what they are asking and what the answers are. You would also go to referees and test them on their experience with that applicant about how they implemented things, what their technical skills and capabilities are.

From my perspective as an executive, I would also be looking for leadership capability and good strong management capability, as well as the technical. The technical is important, but it is not the only aspect that you are looking at and testing.

Mr CHAIR: Is there any set weighting? I understand you would want flexibility and variability as well when you are hiring, so is there a guide to the process?

Ms WEBER: The merit selection guide is the guide that we all use. Every panel will examine the job that they are trying to fill and come to a judgement as a panel about what that weighting should be for that particular job.

I guess it also depends on where you are at with the program, what type of skills and capabilities you really need. Early on you might need really technical skills or you might need really big organisational and logistical skills or they might be more important as you get into the implementation phase. It just depends, but it is up to the panel to determine which of those essential selection criteria have the greatest weight in any particular recruitment process.

Mr CHAIR: Just to follow up on the panels, how big is the panel and who sits in it? Are they involved and how do they fit into the organisation?

Ms WEBER: A panel is typically three people—it could be four—it depends on the role. The Chair is generally the senior executive whose responsibility sits over this project. The merit selection guide requires that at least one other person on that panel is independent of that work area and that business area and is at least at the same level as the Chair. Then the third person would either come with more detailed knowledge of the program or the project or, depending on the type of role you are recruiting to, might be a client—or that external person might be a client—who brings that perspective to that recruitment.

Mrs ZIO: I will move away from the panel process. I am lucky enough to have lots of experience in that space, so I understand the processes that you use.

Without giving any personal information or any idea of the context of any complaints, I am wondering about any complaints that were fed up through the system, through your HR teams, in relation to that rollout of Acacia. Do you have an idea of how many complaints came through from staff on the ground who were working on the project regarding personnel?

Also, I know that every agency does staff satisfaction surveys every year. Can you give me an idea of the results from your staff satisfaction surveys over the last three or four years, please? Just an idea—I do not need any detail; I would just love a bit of context in relation to that, please.

Ms WEBER: Yes, Member for Fannie Bay, you are right. We do participate in the People Matter Survey. I would have to check the exact numbers for those staff satisfaction surveys that were run last year and two years earlier. My recollection is it is in the order of 60% staff satisfaction, but I have to check. I will take that on notice, if that is all right?

I should also note that the staff satisfaction surveys are only undertaken by NTPS staff, so the contractors do not participate in that process. However, they have recourse to their employers who we call vendors—organisations that engage ICT professionals and then contract them out to us.

In terms of complaints there is a documented complaints policy and system in DCDD. I would have to get data on that for you. I am not conscious of complaints coming through that system. I do not have any data in that regard. I imagine that those sort of complaints are handled at the lower level. It is not the sort of thing that is reported up through the project steering committee. Having said that, though, with the public complaints that were aired in the third and fourth quarter of last year, I am undertaking an investigation into those specific complaints. I cannot talk about that at all.

We have implemented and augmented the project steering committee approach with all our ICT projects to include data about staffing, usage of contractors, risks in that regard and wellbeing and other systems that are in place to support staff who are a vital component part of any ICT project.

Mr MACKAY: Just to follow up on that, at the beginning, you said 60% satisfaction rate, so that means two out of five DCDD employees—not contractors but department staff—would not be rating it as satisfactory or satisfied?

Ms WEBER: Of that order—do not quote me on that number, but I will get that number for you. That is NT Health staff who are engaged in the program as well. There are a lot of factors that go into employee satisfaction.

Mr MACKAY: On that same line, does the department conduct exit interviews when staff turn over, leave or move on to new roles? Do they also conduct—is there a process to receive exit interviews from contractors who may have been involved as well when they move on? Is that information fed back to the department?

Ms WEBER: Exit interviews are available for anyone who is leaving our employment, whether they are separating from the service or whether they are transferring to another agency. We do encourage people to provide us with their views on exit. Sometimes people are hesitant to do that, it does not matter what business unit they are in, but sometimes they will respond to that. They will speak to a different manager or they might speak to an HR person or they are happy to provide their feedback. That facility is available to anyone.

Mr MACKAY: The question was: do you also receive any information about exit interviews from contractors—either the company has finished up or the individual has finished up—in addition to the DCDD staff exit interviews?

Ms WEBER: They are encouraged also to provide their feedback because that is valuable input for us about how we manage things and how we can improve. They would also speak with their employer. Those sorts of discussions would form part of our contract management discussions with those vendors.

Mr MACKAY: When a contract ends with a specific vendor—it is a different stage of the project, different expertise needed—is there a process to receive that exit feedback from a vendor level, from a company's perspective?

Ms WEBER: We operate a vendor panel—an ICT specialist panel I think it is called—which has many firms and individuals on that panel. We draw on different ones at different times. We do not necessarily end the contractual relationship altogether with a vendor; we might just cease or conclude that piece of work with that particular person that they have provided to us. Does that make sense?

Mr CHAIR: I believe there was a question and information was going to be provided, so we will actually put that on notice.

Mrs ZIO: My question was around the staff satisfaction surveys. Specific to the team operating around the Acacia project, if we could get some information from the department around the completion numbers and the results of those staff satisfaction surveys, please.

Ms WEBER: I am not sure if I can provide it down to that granular level. I am not sure; I will have to check, but certainly we will give you what we can. It might be rolled up into our digital projects services team which runs all the projects. I do not think we disaggregate down to that level of detail, but let me see what I can find.

Mrs ZIO: Thank you.

I just have one further question in follow-up from the Member for Goyder. He talked about exit interviews and you stated that staff are encouraged to participate in exit interviews. Can you tell me how you do that with staff, how you actually encourage them to participate?

Ms WEBER: Not having resigned myself before, I do not know how that works—I am being facetious.

I think when somebody logs their resignation or their transfer in the system with HR and the payroll system, that triggers a checklist to go to the manager of that person to make sure they have done all the things that they need to do before they leave. That includes offering that person an exit interview and offering them different mechanisms for providing that, either speaking directly with their manager or speaking to an HR person or providing it by email or online. That is part of that exit or cessation checklist process.

Mrs ZIO: Given the publicly available kind of claims that have been made over the last few years around this and staff that have come and gone from the department, is there anything at an executive level that you have implemented with your managers that align managing staff that are exiting to make sure that they are following those steps? Does a manager have to sign off that they have attempted to do that before that person leaves, or is it just you are trusting your managers to go through that process?

Ms WEBER: The cessation checklist requires the manager to sign that they have undertaken all those component parts of a person's ceasing, whether they are transferring or leaving altogether. That is reinforced through my two deputies and their senior managers, but that is part of the process.

Mr KERLE: I have a line of question around contracts. Before we get into that, you may need to take this one on notice. We are talking a lot about resources. The CEO of Health in the previous session said that the cost of contractors was quite a substantial portion, but there was also a portion of the cost that went to InterSystems. Is there any way to get an indication, without breaching commercial-in-confidence, of how much of the spend today is on contractors that the NT Government has managed versus the InterSystems spend? I understand that may not be down to the last cent because there could be contractual matters there, but some sort of indication?

Ms WEBER: We can take that on notice.

Mr KERLE: The CE of Health in the previous session said that were quite a lot of contractors on the Acacia project who were employed on a daily basis. You just said then that you have a panel contract for ICT providers. Can you give the committee an indication of where, in the oversight of the project, public servants would come into play? It seems that there were a lot of contractors doing the technical work at a low level. At what point would a public servant—who

is not sworn but has tenure with the NT Government—be in an oversight position? I think the CE of Health said it would be a senior director role. Can you advise us?

Ms JOHNSON: The majority of our technical roles are, as you said, contractor. Over the past two years, there has been a public servant in the program director position. Previous to that it was the senior director. That was a public servant. Within the team we then have the product manager role. They are basically overseeing the actual system. That position has been a public servant. The majority of the other public servant roles really sit in your change engagement training space. We have been able to try to build up the business analyst and project management space with more NTG staff, although that is a hard process.

Mr KERLE: Just to clarify, because we are looking at the history of how we got to this point, the senior director—would that be not an AO5, that would be SAO1 or that would be ...

Ms JOHNSON: ECO2 is the senior director usually.

Mr KERLE: It would be fair to say that for a fair chunk of the project's life span, the first point in the chain of command of the project where a public servant was involved in the leadership was at the ECO2 level?

Ms JOHNSON: No, our product manager position is considered in the leadership as well, and that is a SAO2 position.

Mr KERLE: Would project managers working underneath the program director be public servants?

Ms JOHNSON: Some of them, yes; some of them, no.

Mr KERLE: As part of the panel contract, chief executive, you just said that you can reallocate resources if you do not need them anymore. If you did not need a particular resource—given a public servant has guarantees around tenure—what kind of notice periods and processes are required if you do not need a contract resource through a panel contract?

Ms WEBER: It depends on the terms of the engagement. It is up to that panel contract firm and the contract that we have with them what sort of notice we may or may not be required to give for an individual worker. As Grace said, often we will redeploy that person to another project. If we do not need them on Acacia at the moment, we might use them on a different Health project or the education system that we are building and so on, but that would be up to the individual contract with that vendor firm.

It is fair to say that those contractors earn a daily rate and they engage with that firm on that basis, so their tenure is never 100% certain like a permanent public servant, but they are remunerated in exchange for that uncertainty.

Mr KERLE: Fair enough. There are a few points I would just like to get to, with the indulgence of the Chair.

Mr CHAIR: Yes, just flick your mic on, and we will push through it because I would like to wrap this up. We have gone way over.

Mr KERLE: I think the CE of Health said there was in the order of 100 staff on Acacia at one point during the project. Would you say probably the majority of those would have been contractors?

Ms WEBER: Yes.

Mr KERLE: Given that they are remunerated on a daily basis and they do not have security of tenure, would you say that their incentive—if the project took longer to deliver the same functionality, would they be better off?

Ms WEBER: Is your question: do they deliberately delay things to extend their employment?

Mr KERLE: What incentives are playing on the contractors, given that they are employed on a daily basis?

Ms WEBER: That is not how it works. It is up to the leads on the project, the managers, to make sure that we are getting best value from those contractors because they are very expensive.

Mr KERLE: You said before that resources can be redeployed. Can you give the committee an indication—you are welcome to take this one on notice—of the contractors not required anymore on Acacia how many were redeployed to other projects versus were not required at all?

Ms WEBER: That would take some time to gather, but we can pull that together. Over what period?

Mr CHAIR: Member for Blain, do you want that on notice?

Mr KERLE: Yes, we will take that one on notice. The key period is probably from 2017 through to 2024 or until FG1 was delivered.

Mr CHAIR: What was your question?

Mr KERLE: We could probably look at when FG1 was delivered, which was roughly ...

Ms JOHNSON: July 2022 was when it commenced.

Mr KERLE: When did the rollout of that start?

Ms JOHNSON: July 2022 was Katherine. I would have to look to see when the implementation activities commenced.

Mr KERLE: If we went three years prior to that—actually let us make it four. If we can go 2018, 2019, 2020 and 2021.

Ms JOHNSON: Yes. Just to note on that period, obviously it was the COVID period and so there were a lot of staff members that decided to return to where they came from so that they would not be separated and locked out of visiting their families. There would be a lot of that in those numbers over 2020, in particular.

Mr CHAIR: Ms Weber, are you happy to take that on notice?

Ms WEBER: Yes.

Mr KERLE: Given we are discussing security of tenure, would you say that if a resource had concerns, would they feel confident to raise those concerns, given their security of tenure that we have just discussed?

Ms WEBER: By 'resource' do you mean a person?

Mr KERLE: One of the contractors we have just been discussing.

Ms WEBER: Yes, the people that we hire from those firms.

Mr KERLE: Given that they constitute the majority of the workforce on the project and that public servants are not in the supply chain, I will say, until quite a senior level.

Ms WEBER: They should be confident to raise that with their employer. That is something for each employer with each contractor.

Mr MACKAY: Given that this is a Public Accounts Committee briefing that we are on, how much of the \$318.5m as of 31 December 2025 came from the DCDD budget and your predecessors versus NT Health—of the spend that has happened so far?

Ms WEBER: As Chris outlined earlier, the original budget amount was allocated to the former DCIS, now DCDD. When that additional budget of \$63.4m was applied to the program, \$24m of that came from the Department of Health. The rest was sourced from within DCDD.

Then there has been additional budget, in the last 2025–26 budget, of \$12m over two years added to it.

Mr MACKAY: Of that budget, has budget or resources that were allocated to Acacia ever been used for other projects?

Ms WEBER: Not to my knowledge, no.

Mr MACKAY: With the heavy ratio of contractors to public servants, have any employees in the DCDD team then gone on to become contractors for this project?

Ms WEBER: I am advised one or two, not huge numbers.

Mr MACKAY: I am happy to get that on notice if you want to double-check.

Ms WEBER: Sure, we can do that.

Mr CHAIR: Member for Goyder, please restate the question for the record.

Mr MACKAY: How many Department of Corporate and Digital Development, or its precursor, employees have gone on to become contractors who work on the Acacia project?

Mr CHAIR: Ms Weber, are you happy to take that on notice?

Ms WEBER: I am.

Mr MACKAY: Of the \$23.2m that was from the internal reprioritisation of DCDD's budget appropriation, as well as the \$6.2m from surplus cash balances that constituted part of the \$63.4m shortfall in addition with NT Health, what projects were they reprioritised from—the \$23m? When you robbed Peter to pay Paul, who was Peter?

Ms WEBER: I think as our submission outlines, there was a saving on the CARE project, the Territory Families project ...

Mr MACKAY: That is not included in either of those figures; that is additional. I have that one down pat.

Ms WEBER: I would have to go back and check that. As Chris Hosking outlined earlier, there were savings identified in the property management budget. As he also said, not only in that current year but also from forward estimates. I think that additional budget was applied to the whole project or the whole program, but it did not fall all in that year. Some of it was in future years, so there would have been transfers out of the property management budget in those future years, applied to future years of the program.

Mr MACKAY: With the project, when issues have arisen, and it has come back with new features or has been redeveloped to be more user friendly and address some of the issues that have been raised—when there have been additions to the scope of the project, is the budget re-forecasted at any point during that process, or is it an immediate, ‘We need to fix this now within the existing budget’? I am trying to get an understanding of—170, I think was the number that came back from Darwin—things that had to be added and tacked on. Obviously that takes time, money and energy. Was the budget recast at that point?

Ms WEBER: I will answer that at a high level. Then I might hand over to Grace who has more intimate knowledge of all those changes.

There is no doubt that the pause with the emergency departments has incurred more cost because of the time spent on them. As Chris said before, the InterSystems cost does not change because it is not a cost per piece of work; it is an overall delivery cost.

Certainly when those changes to scope are proposed, that goes through quite a rigorous governance process. It does not just happen because somebody would like to do something a bit different; it has to go through a rigorous review process because we have a finite budget and we need to make sure we stay on track and within scope. Any change of scope needs project steering committee approval.

I will hand over to Grace about those 170 variations.

Ms JOHNSON: The changes made in ED space are very different to the changes that have been made in other areas, because the ED space has had a direct impact on the budget because we did roll back. During that rollback period we were not able to implement the system anywhere else, so that one does have a direct budget cost.

In terms of other areas where they have wanted improvements, it does not have a direct cost on our budget because as someone mentioned today—I cannot remember who—the vendor does updates throughout the whole year. Our vendor in particular does six updates a year, whether that is introducing new features in the system or fixing any issues in it. Those are just naturally in those updates throughout the whole year, so there is no direct budget cost. For the ED there is because we did have that pause where we did not have resources able to be reprioritised onto other things, essentially. I think that had a rough—I think it was about a 10-month impact overall.

Mr MACKAY: This might be my last question, and I am probably going to get it on notice. With relation to the money that has been spent on contractors, what percentage of that has gone to local workforce versus interstate or international workforce?

Ms WEBER: I think we would have to take that on notice.

Mr CHAIR: Are you happy to take that on notice, Ms Weber?

Ms WEBER: Wherever possible. I will note, though, wherever possible if we engage an ICT contractor we do our level best to engage someone local, particularly through a local firm but also locally based. Those who are engaged from interstate, we require them to come to Darwin periodically so that they are part of the team when we need them to be here physically. We do our level best to promote local employment.

Mrs ZIO: Following on from the Member for Goyder, he asked you a question about the use of Acacia funds for other projects. In 2023 there was a reprioritisation of \$6m from Acacia to SerPro. We are not sure why that happened or how that happened. Can you talk to that?

Ms WEBER: I would have to go and find more information about that. I am happy to take that on notice.

Mr CHAIR: Member for Fannie Bay, can you restate the question for the record.

Mrs ZIO: In 2023 there was a reprioritisation of \$6m from Acacia to SerPro. Can we get some information about why that occurred and how that was approved?

Mr CHAIR: Ms Weber, do you accept the question?

Ms WEBER: Yes.

J DAVIS: This was partly covered with the previous witnesses, but given that only one stage, or whatever it is called, has been rolled out—there are still obviously four more—there has been a projected budget for what that is going to cost. Is that accurate in your view? What are we expecting that we are going to need to commit to actually fully implement Acacia?

Ms WEBER: I will note that two phases have been rolled out; what we call FG0, which was the electronic patient record, and then more recently FG1, which is the patient administration phase. They are the basic foundations for everything else.

Having said that, the total budget for the program at this stage is \$335m. We have not done any estimates on what would be required to complete the whole program. That would be the subject of a future potential budget submission if we are invited to put one forward.

J DAVIS: As in what will be required to roll out all five stages?

Ms WEBER: Yes, for the balance of the program.

J DAVIS: Are you anticipating that it will be on what is currently budgeted?

Ms WEBER: I am not sure I understand the question. Grace?

Ms JOHNSON: The \$335m that will be FG0 and FG1 which is complete. It is projected that FG2 will be completed and that FG5 will be commenced. The outstanding at the end of the \$335m should be the completion of FG5, which is the portals; the FG3, which is the medication system; and then FG4, which is the replacement for the primary, community and mental health and AOD—outside of the hospitals essentially.

J DAVIS: So that will be additional to what is currently ...

Ms JOHNSON: Yes.

J DAVIS: And no ballpark on that, I am imagining.

Mr CHAIR: I just have one question to ask in closed session, so I will ask everyone if they could please depart the gallery and we will go into closed session.

The committee suspended.

The committee moved to closed session.

The committee resumed open session.

Mr CHAIR: I will now open to the floor for final comments from the department. What we are looking for is how we, as a committee, can recommend a stronger system and process for our government and future governments. Please, if there is any advice, the floor is yours, Ms Weber.

Ms WEBER: Very happily I would like to contribute some thinking to that.

As Chris Hosking said, that early detailed planning up-front is really, really important. I think that is the purpose of the digital roadmap that DCDD now puts—contributes to the thinking towards what comes forward for budget Cabinet. That is a process by which we go out to agencies and ask them what they think they need in terms of ICT systems and business need going forward so that we can start planning that and foreshadowing that for the budget year but also the forward years. That helps Cabinet to understand what is looming, as well as new functionality that might be possible through technological change and so on, so that can be fed into an orderly budget and forward estimates process.

I think it is really important to take a strategic view and that process with budget Cabinet helps Cabinet take that broader strategic view because ICT projects, by their very nature, have a long lead-in and then there is often quite a lengthy implementation. It is not something that you can just decide now, 'Yes, we would like to have that new capability; let us do that next budget year.' You need plenty of time to plan and research and be confident in your estimates and your ability to deliver that program. Taking that longer-term strategic view is, in my view, really important.

The concept of that partnership between the business agency, in this case Health, and the delivery agency, in this case DCDD, is paramount. The strength of that relationship is really important. The need for that business agency to engage from the outset is really important and to commit time and resources to it. We can produce an IT system, but we do not

know what their business is; only they know what their business is, but they do not understand IT systems. It is a crucial partnership. I think the exemplar agency in that regard was Territory Families with the CARE system; they were in it from the outset and walked hand in hand with DCDD on the technical side of things. That model is really important.

The strength of the centralised system cannot be overstated. It is really important, that concentration of expertise. It is not possible to have the level of expertise in individual agencies that you need to run a big ICT project or even a medium-sized IT project.

IT systems are not shiny and bright, so they do not attract attention, but they are absolutely critical to functioning. That is always something governments have to grapple with when it comes to a budget process. There are lots of things they would like to do, but then there are critical underpinning systems and processes that also need that investment to function well.

That is all I would like to say.

Mr CHAIR: Thank you, Ms Weber. I will ask, if it can be very brief, Mr Connors.

Mr CONNORS: I will be very brief because I believe a number of things that Catherine said are spot on.

Our ability to succeed relies heavily on engagement from the client agency. I like to think it is something we are doing with them, not to them. In a lot of cases in a lot of ways with the Acacia program at times, because of the workload they were under because of the pandemic, it was something we were doing to them, and that is how it felt at times. It is no longer that way; it is something we are most definitely doing with them. The partnership is very good.

Probably the key for me is the learnings we have taken through CARE, SerPro and, now, Acacia is that Go Live and then the period after Go Live where it settles down is not the end of a period where we need to stabilise. By 'stabilise' I mean these programs take a long period of time to deliver. Requirements gathered sometimes are 10 years old or five years old. By the time we go live, an agency's requirements or their context have changed, and we need to then go back and revisit what the software needs to help them do. Those things need to be baked in, if we can, to our estimates of cost—a period after Go Live. We are going to implement for four years and then we have got an ongoing budget cost, that is our process for budget submissions work; we need to bake in a period of time after Go Live. There is not normal BAU before we get to what is ongoing, and then we need to be funded for the ongoing. I will say that again: we need to be funded for the ongoing. The normal process is we are not at that budget allocation point because maybe it is not known, but it is difficult for governments to fund outward at that point in time.

Mr CHAIR: Thank you. Ms Johnson?

Ms JOHNSON: Mine would be the size of these programs. They are not just implementing IT systems. The IT side of it is the easy side; it is the change management side that needs to occur within the business when there are such core systems, such as SerPro, CARE and Acacia. I think that often gets overlooked as to how big of an impact that will have, especially on the agency staff. People do not like change, by nature, and especially when you are doing something across such a large organisation as NT Health and the fact that they are split into multiple different regions; everyone likes to do things their way, but then everyone has to change and compromise and come to a central way to do things.

I think that is something that, when you are looking at programs in particular, needs to have a bigger emphasis because it is the hardest part. You cannot control how people react to things; you can control systems and IT a lot better than you control how people are going to react to such big changes, especially going from systems that are 30 years old to a system that gets six releases every year. It is a significant change to a system that was customised for exactly how they wanted to do it to something that we are trying to go to, which is how it is used elsewhere and using that as it is designed so that we do not get into the same position we are in now in 20 years' time with a system that is so customised we cannot change it. I think that is something that gets overlooked a little bit.

Mr CHAIR: Thank you, and thank you for your patience and a very long day. We appreciate it. I now close the hearings.

The committee concluded.
