

# Submission to the Northern Territory Government Public Accounts Committee

Review into the Costs of the Core Clinical Systems Replacement Program

## Introduction

This supplementary report is provided to the Northern Territory Government Public Accounts Committee as part of its review into the costs associated with the Core Clinical Systems Replacement Program (CCSRP). The purpose of this document is to offer further assessment of the CCSR program that can be used to support my attendance as a witness at the Hearing on 3<sup>rd</sup> March 2026.

## Background of the Core Clinical Systems Replacement Program

The CCSR was established to modernise clinical information systems across the NT health sector. The initial plan involved replacing legacy systems with a contemporary solution, now known as the Acacia system, to improve patient care, data management, and operational efficiency. The project was launched with a defined scope, timeline, and budget, reflecting the NT Government's commitment to digital health transformation.

## Assessment of Current Status

As of February 2026, the Acacia system has been partially implemented across several health facilities. While the system has delivered improvements in clinical documentation and workflow integration, the rollout has encountered significant challenges, including technical issues, change management hurdles, and broader stakeholder engagement concerns. These challenges have contributed to extended timelines and increased costs.

## Analysis of Project Challenges

My original submission has endeavoured to contribute to understanding the challenges that have been faced by the project from an enterprise architecture viewpoint, and this supplementary report is to explain in more detail what this actually means, and it will hopefully allow for a more effective and efficient question time during my allotted time at the hearing.

## Enterprise Architecture Viewpoint

To briefly explain what I mean by an enterprise architecture viewpoint, I draw on my TOGAF (The Open Group Architectural Framework) 9 certification I attained in the field of enterprise architecture while employed as a Business Analyst for a government health organisation in New Zealand some years ago.

To use the TOGAF definition, an architectural framework is a globally recognized, vendor-neutral methodology for designing, planning, implementing, and governing enterprise IT architecture. It provides a systematic, structured approach to align business goals with IT strategy, reducing errors and enabling digital transformation. Key components include an Architectural Design Methodology, Architecture Content Framework, and Enterprise Continuum.

It is knowledge and experience of the methodologies, etc. described in this framework that I believe were absolutely essential for the CCSRP program of work. My experience for many decades as a software engineer, solution architect and business analyst allowed me to appreciate their value. My concern is that I did not see any evidence of these skills or utilisation of them during my time on the project. I believe that this review committee has already investigated what qualifications the senior leadership team (SLT) for CCSRP held, so you will know better than me whether these skills and experience were available or not?

My proposition to the committee, is that if the Program Management Team had the appropriate qualifications and utilised the methodology provided by any well-established architectural frameworks, then the outcome of the project to date could have been much more successful.

This can be argued to be speculative on my part, and this is why I believe it may be necessary to have a completely independent audit performed by appropriately qualified IT professionals.

## Procurement and Program Replacement Expectations

Firstly, to support my proposition it is worth considering whether there is any justification for the entities involved (i.e. vendor and customer) believing initially that these sort of skills and experience should not have been necessary for this replacement program? In other words:

- Was there any justifiable expectation from both vendor and customer entities that the TrakCare product was already sufficiently capable of replacing the existing legacy systems simply with system setup and configuration of the TrakCare system for the Australian environment?
- Was there an unsubstantiated belief that possibly only minimal development for any potential NT nuances would need to be catered for?

Areas for further detailed investigation:

1. A review of the answers provided by InterSystems to the extensive Requirement Traceability Matrix used for the tender and procurement process. I believe this will demonstrate an over elevated belief in the ability for existing TrakCare functionality to meet requirements – this is based on my knowledge at the time from my training as a TrakCare Application Specialist and my extensive history working with NT Health. My attempts to raise this within InterSystems at the time was not received well, and I left the organisation shortly afterwards.
2. Was there a degree of naivety from NT Health and DCDD that the procurement of a Commercial-Off-The-Shelf (COTS) product like TrakCare would not significantly restrict their ability to expect the vendor to accommodate differences in their current clinical work practices? This was something they were completely used to under a customised development model with their previous vendor.
3. Was there a significant misalignment of enterprise architecture (EA) visions between the vendor and the customer for the program to manage?
  - a. EA definition: Enterprise architecture applies architecture principles and practices to guide organizations through the business, information, process, and technology changes necessary to execute their strategies.

## Program Reset Considerations

If this was the case, then there needed to be an immediate realisation and acceptance that those enterprise architecture skillsets I have already referred to had now become essential, even if they were not up to this point.

The five functional group (FG1-FG5) reset strategy seems to have recognised that there was an issue, but due to what I will simply summarise as the Kruger-Dunning Effect within the SLT of CCSRP, this strategy never fully appreciated the extent of the challenge, and therefore the SLT never responded appropriately.

N.B: Kruger-Dunning Effect definition: a cognitive bias where individuals with limited knowledge or competence in a domain greatly overestimate their own knowledge or competence.

When the potential gap in existing TrakCare product functional capabilities versus what expectations NT Health may have held became more obvious, some extremely important business objectives at the strategic level had to be established for the program to unambiguously govern all subsequent tactical level decision-making.

By this I mean that there needed to be a very clear understanding of the balance that was required between NT Health adopting existing standardised functionality within the COTS product and therefore accepting they may have to re-engineer some of their existing business practices to do so, versus InterSystems having to accommodate what NT Health considered unacceptable gaps within the existing TrakCare functionality.

This was an extremely critical point in the project where both InterSystems and DCDD failed to react to adequately, as it needed a significant reevaluation of the program's "replacement" objectives and strategic outcomes. It needed to be performed by experienced IT professionals with relative independence of the already vested program management personnel. Only this would enable a fully transparent and honest evaluation of the challenges ahead.

Again, I would suggest that a deeper investigation of the analysis and decision-making that occurred at that time by an independent audit would offer the best return-on-investment for lessons to be learned. Two key questions to be answered are:

1. Did the CCSRP SLT do their due diligence and report back with this important decision-making information?
2. If the decision-makers were informed at that time that a potential scenario of what has eventually come to bear in the program was a strong possibility, would they have still given it the go-ahead to continue as it did?

## Program Management Following Functional Group Reset

As I explained in my original submission, rather than CCSRP SLT adopting the necessary enterprise architecture skillsets and best practices, they simply engaged Subject-Matter-Experts who were typically end-users of the existing legacy systems to document their requirements for how they believed TrackCare should be modified to support their currently used work practices.

Having been in the software development field for a long period, I know only too well how end-users sincerely believe they can design the best solution in the world – this almost always proves overly optimistic, and once again the utilisation of experienced business and solution architecture experience is essential to deal with this.

The CCSRP SLT team eventually decided to setup a Product Specialist team to try and manage the avalanche of requirements that came through from this exercise. However, without the qualifications and experience needed within the leadership team itself, it once again never established the objectives, methodologies and governance practices that were necessary to be successful. There is well documented evidence of the large volume of outstanding requests for enhancements existing in Jira (issue Management tool).

N.B. I believe that the person first assigned to manage this team was never fully supported by the SLT and in fact was undermined to an extent that that person resigned. This person was replaced by an SLT member that had even less experience and fewer skillsets than necessary to perform the role well.

## Vendor Contribution

InterSystems have to take a degree of responsibility here too. InterSystems is a global software company with all the business and solution architecture skills that have already been highlighted. However, I personally did not see enough evidence of enterprise architecture best practices being utilised by them to address the challenges being experienced in the project. Maybe contractually they were not required to do so – once again an independent audit may be required to investigate further?

## Functional Group 4 Experience

I would now like to take the opportunity to focus specifically on what I myself and other members assigned to Functional Group 4, the replacement of PCIS and CCIS, experienced and how this needs to be taken into account in any future plans.

I believe it is widely accepted by all parties involved in CCSRP that the existing TrakCare product had never been deployed in a Primary Care setting before. What we experienced was that InterSystems initially believed it could easily be supported by existing TrakCare Outpatient functionality. This is not an unreasonable assumption for primary care in a typical urban environment. However, remote Primary Healthcare in the NT has significantly different requirements to an urban GP model of care.

This was definitely a case where there would need to be significant domain discovery by InterSystems and where enterprise architecture skills and experience would be paramount. However, the FG4 team experienced a complete reluctance by InterSystems to engage with us to establish the required resources and protocols needed to be successful (i.e. as enterprise architecture best practices would dictate).

I provide a single example of where a team of more qualified InterSystem personnel (i.e. more qualified than their Application Specialist staff resident in Darwin) met with us to begin to hear our concerns re the inability of the existing Outpatient functionality in TrakCare being able to satisfactorily replace PCIS. The FG4 team also demonstrated how we encountered current constraints within TrakCare when attempting to configure the product to meet remote health centre clinical best practices. The meeting seemed to go well, and we were assured by InterSystems that they would get back to us to continue engagement in this collective discovery of the requirements in this new domain for them. Unfortunately, even after significant prompting from us, no further engagement or progress was made.

This is another example of where the CCSRP SLT were out of their depth and were unable to manage any productive engagement with InterSystems. It does need to be noted that by this time the SLT were struggling with the considerable pressures of the FG1 challenges.

## Workplace Culture and Management

My other contribution to the review sadly has to do with the program management failings that led to what is being described by many as a toxic workplace culture. It is obvious that the inexperience and lack of appropriate qualifications for the management of the program led to individuals being placed under extreme stress. It resulted in those SLT members without the necessary skills reverting to bullying tactics to try and achieve what they believed was a sufficient outcome to be defended as success in their minds.

I have provided my personal experiences of this toxic culture in the investigation performed by Catherine Weber, and hopefully don't have to refer to it further here. I hope that this aspect can be investigated more fully via the testament of other more affected work colleagues within that investigation.

However, purely from a financial cost perspective this review may require the engagement of industrial psychologists to analyse how the toxic environment affected motivation and productivity and therefore contributed to even greater inefficiency of project budgets.

## Understanding the Budget-Cost Gap

To summarise, the gap between the initial project budget and actual costs from my perspective can be attributed to:

- Underestimation of the complexity involved in system replacement.
- Inability of DCDD to engage and utilise personnel with the enterprise architecture experience needed for the complexity involved.
- Poor engagement from the vendor in aiding DCDD in managing the complexities as they were encountered.

## Recommendations

My straightforward recommendation for this review is to organise an independent forensic audit of the program to date, and act upon their recommendations.

## Conclusion

The CCSRP and the Acacia system represent a significant investment in the NT health sector. While the program has delivered tangible benefits, the costs incurred to date highlight the importance of robust project planning and management. My assessment provides a foundation for understanding the budget-cost gap and hopefully enough evidence and justification for a thorough independent audit.

Submitted by:

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