LEGISLATIVE ASSEMBLY OF THE NORTHERN TERRITORY

15th Assembly

PUBLIC ACCOUNTS COMMITTEE

Public Hearing Transcript

Inquiry into the Acacia Digital Patient Record System

1.00 pm to 3.45 pm, Tuesday 3 March 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 Brian O'Gallagher MLA, Member for Karama
Mr Matthew Kerle MLA, Member for Blain

Witnesses: ***Australian Medical Association NT***
Dr John Zorbas: President

Adelphos AI
André Snoxall: Chief Information Officer

Private Citizen
Rod McDonald: Business Analyst

Private Citizens
Kara Joyce: ex CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, Department of Corporate and Digital Development
Bernard Yehuda: ex Lead Business Analyst CCSRP Program, Department of Corporate and Digital Development

INQUIRY INTO THE ACACIA DIGITAL PATIENT RECORD SYSTEM
Australian Medical Association NT

Mr CHAIR: Thank you all for coming to the Public Accounts Committee in our Acacia inquiry. This afternoon session will all be public hearings and we are streaming live.

This morning we did host private briefings. A reminder to all that interfering with witnesses is contempt of parliament, and those witnesses from this morning enjoy the protection of this committee.

Coming to our first one today is Dr John Zorbas. I will read through a statement and then I will hand over to you for an opening statement, if you wish, and then we will move into questions. Just before that, I acknowledge publicly your advocacy in the recent federal financial deal with Health, so on behalf of all Territorians, thanks for your advocacy on that.

On behalf of the committee, I welcome everyone to this public hearing into the Acacia digital patient record system.

I welcome to the table to give evidence to the committee from the Australian Medical Association NT, Dr John Zorbas, President. Thank you for coming before the committee. We appreciate you taking 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 hearing 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 a closed session and take your evidence in private.

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

Dr ZORBAS: Thank you. My name is Dr John Zorbas and I am here as the President of the Australian Medical Association Northern Territory branch. I should note I am also an employee of NT Health and I am not here in that capacity today. I make these comments today as a representative of the AMA, and therefore representative of all doctors in the Northern Territory.

I take your thanks and extend them to those who helped us with that battle for finances, including our chief executive and our Health minister.

I will keep my opening statement brief, as I appreciate that there is not a lot of time today. I want to elaborate on two things: clinical risk and workflows with clinical systems.

On 17 February this committee heard from witnesses and a statement that was made on the record was that there have not been direct patient safety issues. This is in reference to association with Acacia. Our members, our doctors, would reject that statement wholeheartedly.

The system used to track bugs and tickets in DCDD is known as Jira, and the system used to track risk issues in NT Health is known as RiskMan. There are tickets in the hundreds—that is not hyperbole—on Jira and RiskMan attributed to issues around Acacia and how they affect patient care.

Some examples of these issues include next-of-kin mismatches with incorrect imports from legacy systems; triage times in emergency departments blowing out well above national benchmarks and performance prior to the implementation of Acacia; ATSI status for patients being wiped out retrospectively over a whole-of-life record when an error is made; deceased patients being booked for operations or outpatient appointments; return to operating theatres now becoming a four-page process taking in the order of 30 to 40 minutes when the existing process took two minutes. The example we used in our submission is the head injured patient in the emergency department who had to wait for 60 minutes while a record was locked, leaving us unable to access that clinical record.

At the time at its peak the system was rolled back because of issues with the system. I thank the staff involved in that rollback for recognising the seriousness of the issue and taking on what was politically an unsatisfactory decision to make, but was the right decision in the interests of patient care. At that time we had battle-worn emergency physicians, and I do not use that term lightly; I mean emergency physicians who literally work in warzones on a regular basis reduced to tears because of the way the system was functioning and the lack of capacity they had to deliver clinical care.

We have moved on since that time, and I just want to reflect on why a statement such as 'there have been no direct patient safety issues' would have been made and taken in good faith.

In Health, not just in the NT, we judge risk using a clinical incident severity risk score, looking at the likelihood and impact of any issue, very similar to what is found in other industries, attributing a score of one to five. It looks at the level of harm, the duration of harm and the level of care required, including any escalation of care that might be needed.

In the Territory we tend to consider ISR 1 and ISR 2 issues as high-risk issues. We do not necessarily consider ISR 3, 4 or 5 to be high risk. As an example, an ISR 1 issue would be an unexpected death resulting in a coronial referral. Perversely, and out of step with every other jurisdiction in the country, we round down near misses to an ISR 5. That leaves us with a system that is reactive, not proactive. In this framework I think it is possible that this statement that has been made can be held to be true, but does not reflect reality. ISR 3, 4 and 5 issues are no less risky than ISR 1 or 2 over time.

To discuss workflows, there has been a quote provided to us—I have not been able to establish the veracity of it—from a software engineer to a subject matter expert in the early stage of Acacia, 'The problem is not the system; it's your patients. They don't follow the linear workflows in the software.' It is a perverse sentence, but I do think it captures the tension that we have between what is expected from a clinical point of view and what has been delivered from a technical point of view. It is true that TrakCare—which is the software that underpins Acacia—comes from a background of linear workflows and has struggled with parallel workflows, as we have seen in the emergency department in Royal Darwin Hospital.

As an example of perverse workflows and solutions, in early stages in Katherine there was a limitation in the software, we understand—I have not been able to establish this—of 100 episodes of care per patient. Dialysis patients will receive, on minimum, three episodes of care a week, so you can see that limit can be hit quite quickly. At that point the initial advice was to create another HRN number, or unique identifier, for patients. That would increase risk significantly. It is not something we would do clinically unless a patient was unconscious and we were unable to establish their identity. That was the incorrect solution from a clinical point of view, but seemed reasonable from a technical point of view.

Hospitals and healthcare systems are not held up by bricks and shiny technology; they are held up by spreadsheets and good people. For every process we have in clinical healthcare, we have a series of workarounds, and that is true for even the best functioning health systems in Australia. There is now a shadow workforce in NT Health that has not been captured on any budget of people who are deployed to recognise faults with these clinical workflows to measure their impact, to remediate this impact and to monitor. Some estimates in surgery have around 22 FTE now being deployed to use workarounds to deliver business as usual.

On our submission we have made a number of recommendations, and I will not reiterate them; they are there for the public record. What I will say is the worst outcome is that we stay where we are. We have only partially delivered Acacia, and that has left us with a system that has not allowed us to mitigate the risk of our legacy systems—we have not been able to switch off all our legacy systems—and yet we do not have a system today that we consider fit for purpose. This is the worst place we could leave the Territory. I do not know where we will be five or 10 years from now, but it will be a disaster if we stay where we are now.

I will leave my comments for questioning.

Mr CHAIR: Thank you, Dr Zorbas, for that opening statement. It reinforces other things the committee has heard.

I will open to the floor.

J DAVIS: Thank you, Dr Zorbas, for coming today and for your submission and for clearly outlining issues there.

I just want to come to clinical risk. You said that there are some things that have changed over time. What would you say is the level of clinical risk at the moment?

Dr ZORBAS: Significant but difficult to capture in terms of harm. We have daily issues with the use of Acacia on the front line. It is impossible to know how that translates to patient harm over the long term; however, unmitigated risk always leads to harm.

J DAVIS: I know you also said that some things have changed. In our hearings with the department the CEO, when we asked about evidence that was given by the AMA and other organisations, said that in general people were very positive about Acacia. In relation to AMA, I quote:

> *My view is that what is expressed in that submission was written at an earlier time and … I do not believe that to be a strongly held view at this point in time.*

Can you comment on that?

Dr ZORBAS: The submission that we made at that time was reflective of how the system was at that time; that is true. However, the core recommendations that we have made in our submission still stand, and were we to resubmit today those recommendations would remain unchanged.

At that point in time there was an opportunity to potentially abandon the pursuit of Acacia and look at other systems. That has become much more difficult now. I cannot provide costings on what that would look like, but certainly if we were making the submission today it would reflect that reality. Yes, the submission would differ in that respect, but as to the core recommendations they would be the same.

J DAVIS: Our understanding in terms of the rollout is that FG0 and 1 have been rolled out. There is currently no plan or no budget for rolling out of the rest of the system; is that correct?

Dr ZORBAS: That is our understanding. We have received comment from members that stage FG2A has been rolled out, although we are not in the position to confirm that. My understanding is that there is a move to focus on FG5, which would step up the external providers' ability to access Acacia. Regardless, there is not enough funding that is being costed to deliver Acacia in full.

J DAVIS: From a clinical perspective, what does it mean if the rest of Acacia is not rolled out?

Dr ZORBAS: The point of Acacia was one cohesive system across multiple areas of the Territory in multiple settings. If Acacia is not rolled out those legacy systems cannot be switched off. The risk that led to the development of Acacia in the first place all the way back in 2016 still remains, remains unmitigated and has worsened over time as those software providers are no longer actively managing those legacy systems. Were we to do nothing, that places us in potentially the highest risk outcome. There has to be a way forward in terms of how those legacy systems are shut down. Whether that means we continue with Acacia as it is, or some other form of Acacia, or a system with Acacia underlying systems on top of that; I am not sure, but to do nothing would be disastrous for the Territory.

J DAVIS: Just one more question. This is in relation to your members. We have heard evidence in submissions that people were told not to say anything negative about Acacia. They felt that was very high risk. We had people come to us privately saying they did not want to give evidence because they were concerned about that. Can you comment on the workplace culture around Acacia and how that may have impacted on how the system has been rolled out?

Dr ZORBAS: Within NT Health?

J DAVIS: Yes, and DCDD.

Dr ZORBAS: I would not be able to speak to DCDD; I do not sit inside or on committees there. My only experience with DCDD has been in user acceptance testing or Acacia training.

Within NT Health, the cultural damage from the initial rollout of Acacia was significant. It remains. There is a fatalism around the use of Acacia at the moment.

Change is difficult in Health. Doctors, nurses and clinicians are often criticised for being laggards, and I think that is a fair criticism, but it is important to separate when inertia is there for reasons of patient safety and when inertia is there because change is hard. We do not support inertia for inertia's sake, but we certainly support inertia when it matters to issues of patient safety.

One of the issues we had with culture in the rollout initially was that in early stages of testing or training, when issues were identified by frontline clinicians that were definitely going to transpire to be safety issues, essentially what was fed back to them at that point and what they told us is, 'This is what we have and we have to work with it'. There is a limit to that if there are fundamental design flaws with the product.

J DAVIS: In terms of Health can you comment at all on the relationship between Health and DCDD and how that is playing out, particularly at the staffing and clinical level, what that means for people?

Dr ZORBAS: Yes. It has been a long-held view of the AMA that the interface between IT and Health in the Territory does not function well. There are nine systems, or nine pillars, by which you might judge a clinical microsystem and how they might be able to improve what they are able to deliver. Information and communication technology is one of those pillars; it is an incredibly important pillar. When you have two different agencies to talk to in order to request system change, there is an inertia that makes it impossible to change things in an agile manner. This was best reflected during COVID and this was not unique to Darwin.

During COVID we saw decisions that had to be made within 24 or 48 hours because the clinicians recognised that if we did not make those decisions there would be harm. Almost every safety structure, health structure and IT structure in the public sector delivery of healthcare cannot move that quickly, so decisions were made regardless. Changes were made without seeking the necessary approvals; they were made because they were necessary.

The system we have and the relationship we have between NT Health and DCDD is not one that encourages proactive and innovative change. That is not to say that is anybody's fault; it is just a system where there are two different masters, and it is often impossible to reconcile the two.

J DAVIS: When you say 'two different masters', who ultimately is the master here?

Dr ZORBAS: I think to most frontline clinicians that is not clear. NT Health is the customer and DCDD is the delivering agency. It is unclear when a customer requests a change how that request is managed, what level that gets to and what level that should get to. We have two separate governance structures that do not necessarily intertwine or overlap, and it is hard to know whether a matter is being addressed at the appropriate level or not, at least from the outside.

Mr O'GALLAGHER: I cannot get the right quote, but you mentioned where they raised—I think the words were, 'The problem is the patient, not the linear system'. That seems to be something out of a script from *Yes Minister*.

Dr ZORBAS: *Utopia*, maybe.

Mr O'GALLAGHER: Yes. You remember Sir Humphrey telling the minister, 'We have a fantastic hospital'. Then the minister said, 'But you have no patients'. So you can run a very good system, but I think the purpose of the health system is to actually look after patients first and foremost. I can understand that it is a bit funny why we are turning it around that way.

I am concerned, though, that you do mention that we have got almost the worst of both. We have a partial Acacia system, but you still have to keep the legacy systems going as well, so that is a duplication or a doubling up in some ways. It is certainly an overload of workload. Can you explain a little bit more how that happens?

Dr ZORBAS: Absolutely. With the rollout of Acacia there was always going to be a period of time—and this is not unique to Acacia—that there would be duplicate use of legacy systems at a point, but we cannot stand in the quicksand. We have now entered this period of uncertainty where the rest has not been funded, so it is unclear how long we are going to stand here in this quicksand and continue to have to duplicate work.

In some areas of the hospital that means you have to move into Acacia from a legacy system, or from Acacia into the legacy system. Sometimes it means parallel workflows where you need to log the activity in both Acacia and the existing legacy systems. The problem with that—I mean, there is a significant clinical risk there.

Firstly, the significant increase in workload. I do not have to tell this committee that we are stretched as it is for workforce in healthcare.

Secondly, it introduces the risk for data error. We have had instances where we have been unable to record who was present for an operation on an operation record in one system and not the other. That then has knock-on effects. For example, if we are unable to verify to the Royal Australasian College of Surgeons who was in the room for an operation, we are unable to manage logbooks for trainees, which means we would lose accreditation to have trainee surgeons here, which would shut down surgery, effectively. I am not saying there is necessarily a high risk of that happening, but it is a possibility from these types of errors.

We have to joke in healthcare about things like statements that you would find in *Yes Minister*, but they do turn a clinician's heart cold. You point out that the point of Acacia was to help us facilitate better patient care, and we are left in this bittersweet situation where we have a system that is not complete and does not allow us to get to that goal that we set in 2016, and yet maybe we could have. I do not know what the pathway could have been, but I know other jurisdictions have been able to deliver EMRs and DMRs—never on budget or under time; that is not unique to Darwin and it is not unique to Acacia—but we are now 10 years down the track and we have only got FG1.

Mr CHAIR: I will just jump in on a follow-on question on that. I think you might be one of the best placed to provide some insight.

As we look at this problem, there is obviously what other jurisdictions have done in the public system, but also what has private industry done. If I look at a company like Healthscope and if they are managing a variety of hospitals and want to upgrade their IT to support patients, how is what we have done so different? Are there examples you can look to within the country, be it private or public, that have done this well?

Dr ZORBAS: The variability in IT projects in healthcare is absolutely huge. We have the electronic medical record project in the ACT I believe—and I would have to check this—now above $1bn, so it could be worse. Then we have environments in Western Australia where the Virtual Care Connect system—this was a home-built EMR system that was designed for their virtual emergency department (WAVED)—was built in a low-code environment. While I do not have exact numbers and figures, I believe it took about six months and less than $10m. So there is a wide spectrum.

Is it done more efficiently in the private sector? Not necessarily. They are the same pieces of software and the same vendors. You can divide them roughly into patient administration systems and clinical information systems. You can have different clinical information systems that talk to different patient administration systems.

What is different about what we have done is we are the only jurisdiction in Australia to attempt to do everything with one piece of software. For one product that serves the needs of pre-hospital care, general practice, remote clinics, secondary and tertiary hospitals is unusual. I do not believe it has been attempted in Australia before. That does place us in a higher risk position from the very start of the tender.

Mr CHAIR: Do you think it is a worthy objective, trying to achieve it, but maybe it has been misjudged on how difficult that is?

Dr ZORBAS: I do not think anybody—NT Health or DCDD—came to work to do a bad job. I have not seen any malice or malfeasance, but it was a mammoth task. It is a mammoth task. I think people did the best with what they could. What we need to do now is work out where we go from here.

That is going to require re-baselining, as we mentioned in our submission, and I think it is going to require a greater focus on clinical governance, an interplay between the clinical and the technical. It is rare to find a situation where we cannot find a solution, but, clearly, in this case we have ongoing clinical governance issues with the clinical governance model that we have, and maybe it is time to think of a new structure for the next phases of Acacia.

Mr O'GALLAGHER: Can I just ask you very simply, do the clinicians trust this system anymore?

Dr ZORBAS: It is a hard one to answer because we use it in different settings. Certainly, there are aspects of it that are faster and better than the legacy systems that we had. The fact that we can have data mismatches is concerning, so the fact that we have got clinicians reporting that next of kin are recorded incorrectly or we cannot record the right surgeon against an operation report, that erodes trust and we cannot place our faith in that.

What I will say, though, is that the workarounds in healthcare are excessive and impressive in terms of their volume. That is, again, not a Darwin thing. It is not uncommon to work in healthcare, public or private, and have to have workarounds for the system that we use. Whether they do not trust the system or not, I think it is academic in the sense that we have always got a workaround. We do not let the patient come to harm if we can avoid it. If that means not using the approved process, it means not using the approved process. In that sense it just means they have to spend more time on workarounds, and there is a finite limit to how much time they have in the day, which erodes the amount of time they have to spend on the extra bits of care or the other bits of care that we think are very important but do not necessarily show up in a budget or a spreadsheet.

Mr O'GALLAGHER: If I just go back to your submission, where you talk about the impact on health system operations, one area you do bring up is staff morale and change fatigue. You go on:

> *The chaotic ED implementation, subsequent rollback, and the need to switch back to legacy workflows likely had a detrimental impact on staff morale, potentially increasing cynicism and change fatigue among clinicians who had invested time in learning the new system.*

Is that staff morale still low? Is it improving or is anything being taken to address it?

Dr ZORBAS: Morale is still an issue. We had clinicians who left not solely because of Acacia but because Acacia was the straw that broke the camel's back for that period of time. That was a particularly chaotic and hectic time, a very dangerous time. Quite simply, there were a handful of people who felt they could not

deliver safe care and so they did not want to stay, and that is a shame because they were people that we probably could have kept.

Change management is difficult no matter what, and we only get so many bites of the cherry. My concern is that we have used a lot of bites to get here, and it is going to take a concerted effort and focus on change management and morale and the preservation and uplift of morale, if we are going to progress from here.

Mr O'GALLAGHER: My final question, and I do not know whether you have a view on this, but we have heard from other submissions and people that their view was that DCDD had the whip hand in all this and the Department of Health was the lower partner. Resultingly, the Department of Health is actually the customer, in some ways, looking after patients. Would it have been better if the Department of Health had the lead or the final sign-off as opposed to DCDD?

Dr ZORBAS: Yes.

Mr O'GALLAGHER: To bring the right emphasis to it.

Dr ZORBAS: Yes. Clinical systems require final clinical sign-off, we believe. We would say that; we are the doctors. But time and again, it has been proven in the evidence that if you do not focus on the patient and you do not focus on the clinical risk, your system will not serve the purpose it is designed to serve.

J DAVIS: You have said very clearly it cannot go on as it is. You have made some recommendations in your submission. In your view, if those recommendations were followed, do you think we could have a fit-for-purpose system in the Northern Territory?

Dr ZORBAS: Potentially. A key risk, I think, is up until now there has been a very dogmatic view that we have to fit everything into Acacia. Given the cost and the time it has taken to progress, if that were relaxed to the point where areas that are high risk and are not quite working can be carved out and we use different systems—that means investing in looking for developing new systems—if we have that for the areas that are high risk, as judged by clinicians hand in hand with software engineers and we implement these recommendations, there is potentially a path forward. I do not know how much that will cost.

J DAVIS: If that does not happen, if things keep going as they are, what does that mean for the Territory, basically?

Dr ZORBAS: We cannot stay here. If our position is that there is risk that remains in the current system and risk leads to harm, we will lead to patient harm. What that looks like, I do not know. Risk in healthcare has the unfortunate side effect of looking like an ISR 5 until it is on the front page of the *NT News*—and that is just healthcare. We do not want to see that happen; no clinician does.

Mr BROWN: Dr Zorbas, thank you for coming.

I have some of the worst cases of chronic illnesses in my communities, in Maningrida, Wurrumiyanga and Gunbalanya. It horrifies me that we have a system that misplaces information. Where are we at in capacity? I want some of my people to come to Darwin and walk into RDH and have their information there, but some of them do not have identification and all that medication; they do not really carry it. I am just a little bit concerned in that aspect and where you think we should go forward with that.

Dr ZORBAS: You are right in that you have some of the sickest patients in the country, in those areas that we continually fly to RDH via CareFlight to treat in RDH, and that often there is no identification or there is not a proper handover of the notes—whatever the case may be.

Humans have always been the glue in these systems, though. It is rare for us to rely on the IT system as the sole piece of infrastructure that gives us the information we need. Family members, the patients, the people around them in the department, the escorts and the clinic staff that we call to speak to, they are the ones who have the most current information. Just because it is not in an electronic medical record does not mean it is not available to us; it just takes more work. We have always trusted the patient more than we have trusted the computer, and I do not see that changing any time soon.

Mr CHAIR: At the moment, are healthcare workers in the NT able to access, use and have input into electronic patient records, including workers in hospitals, primary healthcare and community healthcare settings?

Dr ZORBAS: Levels of access are different in different areas. In the emergency departments it is used as a full system with read and write access. Most clinicians elsewhere in the system either have read-only access or no access at all.

Outside of NT Health, you would have to go to DCDD for the current state, but, ultimately, if you are outside of NT Health you do not have access to the system. As it stands right now, a community-controlled health organisation in regional and rural NT cannot access the information inside Acacia. I may be wrong on that; that would have to be checked with DCDD.

Mr KERLE: You may or may not be able to answer this, but just looking forward, what has been delivered to date—FG0 and FG1—we have been told is a PAS (patient administration system) and there are remaining modules around clinical data, pathology, medication and the full electronic medical record. Do you have any advice from your members about some kind of indication about the relative scale of what is remaining compared to what has already been delivered? Say, if what has already been delivered is a one, is there two times remaining, three times?

Dr ZORBAS: Yes, again, difficult. it depends on the setting. Let us say a third, with another two-thirds to go. That is back of the napkin. In some areas, let us take an intensive care unit, integration with the EMR there is going to require remote monitoring and telemetry and stuff that may or may not be present or enabled at the moment with TrakCare. In other areas like ward environments, we already use it for clinical notes in the emergency department, so it is feasible that it could be used in that setting, probably with greater ease than the rapidity and parallel workflows in the ED.

Mr KERLE: Just to summarise for the record, you said one-third done, two-thirds remaining, so that would be if one is what is done already, then roughly double is still to come. Would you say from your members that they have confidence that remaining body of work can be delivered if things continue in the way they have been?

Dr ZORBAS: No, because the money is not there but also I think clinical governance is still an ongoing issue for frontline staff. They feel that there is not enough weight placed on key clinical issues. It does not mean that everything has to be a go/no-go decision, but it does mean that there has to be more of a clinical lens when we look into issues that we find in the system to work out if they are actually issues or not, because that is an important part of this, so clinical governance would have to change.

One of our recommendations proposes a benefits realisation framework. I think a BRF would be a hugely important part of this, because if the goal of Acacia is to improve patient care a BRF would make it very clear which parts will achieve that and how.

Mr CHAIR: Thank you, Dr Zorbas. I really appreciate your time today in answering our questions. On behalf of the committee, thank you and all the best.

Dr ZORBAS: Thank you very much.

The committee suspended.

Adelphos AI

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

I welcome to the table to give evidence to the committee from Adelphos AI, Andre Snoxall, Chief 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 hearing 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 a closed session and take your evidence in private.

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

Mr SNOXALL: My name is Andre Snoxall, and I am appearing as a former contractor to DCDD and NT Health in support of implementing the Acacia electronic patient record system.

Mr CHAIR: Thank you. I open the floor to you, if you would like to make an opening statement or discuss any matters that you would like, and then we will move into a period of questions by committee members.

Mr SNOXALL: Thank you for the opportunity to appear today.

My evidence is based on direct involvement in the Acacia program and on more than two decades delivering electronic patient record systems in other jurisdictions across the UK, New Zealand, Australia and the Middle East.

I want to focus on three specific matters: the delivery; the cost; and the governance discipline of the program. First of all, the delivery. This was a $335m investment that has not yet produced a fully operational end-to-end electronic patient record across the Northern Territory hospital network that allows clinicians to admit, document, prescribe, order investigations, receive results and discharge patients within a single self-sufficient system without reliance on legacy platforms or parallel processes. If that assertion is disputed, the committee should request documentary evidence of which legacy systems have been formally decommissioned, which clinical workflows operate without fallback or duplication and when a formal transition to operations acceptance gateway was actually passed.

The second thing I want to talk about is the cost. The Northern Territory operates two medium-sized hospitals—and that is quite generous; they are not big by any world standard—and three very small regional hospitals. In comparable health systems internationally, base-level patient administration systems—which is what, arguably, has been implemented so far—and core EPR capability for a footprint of this scale has typically been delivered for materially less than the expenditure that is now committed. The issue is not geography; it is governance discipline, scope control and benefits management.

The third thing I want to talk about is governance. The questions in your terms of reference—budget revisions, unresolved issues, rollout suspensions and outstanding scope—cannot be properly answered without reference to the original approved program implementation plan, which was essentially the program initiation document; the stage plans; the tolerances; the change control records; and the benefits realisation strategy. If those artefacts were not actively used to control delivery then cost growth, scope drift and prolonged stabilisation are predictable outcomes. Large digital health programs do not fail because the software is difficult; they falter when governance documents exist but are not enforced, when benefits are described but not owned and when transition to operations is treated as an administrative step rather than a controlled acceptance event.

My evidence is offered to the committee in determining whether this was fundamentally a technology problem or a governance problem.

I also want to say, following on from the last speaker, that the committee may wish to consider whether responsibility for defining health service innovation should sit primarily with NT Health as the service owner and accountable owner for benefits realisation, rather than with DCDD, who should be providing technical delivery and assurance rather than any strategic direction.

Mr CHAIR: Thank you for that opening statement.

I have a couple of questions before I will pass on. My first one is in relation to your submission. You state senior leadership did not engage with public review of the South Australian electronic record reform and discouraged engagement with other jurisdictions in Australia that use TrakCare. Why did this occur and what have the impacts been?

Mr SNOXALL: South Australia had similar ambitions to the Northern Territory in terms of putting in an electronic patient record system across the entire state to support both primary care and their hospitals. The program—I am speaking from memory now—started with something like a $200m budget. When it had exceeded $500m—and this was before Acacia was very far down the track—the state government in South Australia got an independent reviewer in to have a look. What they found was a lot of the things that I believe you will find with the Acacia implementation—that is, a lack of ownership, driving and leadership from the Health department; too much focus on technology; not enough engagement of clinicians; and, in my opinion, poor governance practices.

What the South Australian Government did as a result of that was shut down the program. They moved the effort into the business-as-usual capability, the people actually working to support the business in delivering these systems, and arguably it has been more of a success since. They have actually got to the point where it has been rolled out across, I believe, all South Australian hospitals and is used and embedded in their business processes, and it seems to be working okay.

The point is that a lot of these issues were raised some time ago, but there really does not ever seem to have been an independent external review of what was happening in DCDD and how we got to this stage.

Mr CHAIR: Do believe that was avoided on purpose? Was decision-making being made to avoid external scrutiny? I am curious why there was a discouragement of engaging interstate.

Mr SNOXALL: My personal knowledge is that I was told directly many times that the success of the program was a direct reflection on DCDD; therefore, DCDD would maintain tight control and there should not be any suggestion—my experience is that you do not question in DCDD. You do not question; you do not argue; you do not raise issues, because they do not want to hear.

Mr CHAIR: Do you think there is a clear link between the culture at DCDD and where we are at with this project both in cost and deliverables so far?

Mr SNOXALL: I believe so. I think a lot of that is down to the quality of management. I think there is a misunderstanding of what DCDD should be offering to the rest of NT Health and the agencies. In my view, having been a CIO for a long, long time, DCDD really should be providing IT service management capability to the agencies. They should not be providing leadership to the agencies in how they use technology or what they use it for. Their job should be providing technology at the lowest possible cost and the highest possible quality, so their focus should be on that. Unfortunately, there are those—or there were those—within DCDD who had the view that in some way DCDD were the experts on how IT should be used in business, and nothing could be further than the truth.

J DAVIS: Thank you, Andre, for coming today and for your submission. Just following on from what you have raised around those questions of governance, what happened when you raised those questions, if you did with appropriate people at the time?

Mr SNOXALL: Typically it was cancellation. Basically, you would stop getting invited to meetings. I would hear through the grapevine that people had been told to stop speaking to me.

In the one instance where I started to get some real traction with Health, where I was working with their Chief Financial Officer and the implementation committee, and we had started down a path of looking at how we might realise benefits from the implementation and manage the disbenefits of the implementation so that Health got the most out of it, that was shut down in favour of—actually, I believe it was shut down out of DCDD, who basically said, 'We've done a deal with Menzies institute of health where we will measure benefits when they occur after the program, and we are not going to focus on managing benefit realisation during the Go Live process'. That is an example, and that is the worst example. I was basically shut down and told, 'We won't be talking about benefits anymore. Don't do it.' It was fairly typical of what happened; you would get excluded and they would stop inviting you to meetings and then they would tell people not to talk to you.

J DAVIS: Broadly, what was the impact of that approach around workplace culture for staff, clinically and the implementation of Acacia?

Mr SNOXALL: I do not have experience from the clinical side. While I have many, many friends who are senior clinicians in the Department of Health, that is not what I can testify to.

What I can say is that it is very demoralising for the people within DCDD. Even within DCDD there were camps; you had the program and then you had the others. People in the program were quite derogatory of the people in the business-as-usual setting. The people in the business-as-usual setting were trying very hard to improve their services and do their best. It was very demoralising.

Basically, there just was no debate. You could not debate, discuss or work out how something might be done better because that seemed to be beyond the intellectual capability of the people in the program. They were just focused on, 'We've just got to get this across the line. We've got to do this. We've got to meet this schedule.' A schedule without a realistic plan is not really a very useful thing.

J DAVIS: You have talked about there not being a program management office or a project management plan in place. You said it was never adopted. Was it ever formally presented?

Mr SNOXALL: Yes, I developed the program implementation plan for them.

Just to understand the context, a program is the overarching strategic piece of work that is being done. Within the program there needs to be projects. Projects are very tightly defined; they define how much money they have got, what they are going to deliver and when they will deliver it. They are the actual pieces of machinery, if you like, within a program that do the work. The program sets strategic direction. It says, 'This is the high-level view of what we are trying to achieve. This is the general approach we are going to take.' It is a more strategic document.

Yes, there was a program implementation plan. It was signed off all the way to the top of DCDD. I never saw any evidence that it got signed off by anybody in Health. The challenge with that is a program implementation—a program is setting out to provide the framework within which Health is going to be able to deliver the benefits that have been projected in the business case. If Health have not signed off and committed to the program and how it is going to be run, it really is a fairly pointless document.

At the time it was outside my scope to be able to take it any further. I was directed not to speak to Health, as were many other people on the program.

As I said, I know it was signed off right up to the top level of DCDD, because I saw the signatures, but I do not know whether it was ever shared or promulgated within the Health department, apart from by me speaking to their IT department at the time.

Mr O'GALLAGHER: I want to go back to your South Australian experience you were telling us about. Correct me if I am wrong, but I think you said maybe initially $200m but it blew out to $500m.

Mr SNOXALL: Yes.

Mr O'GALLAGHER: But then they did an independent review.

Mr SNOXALL: Yes.

Mr O'GALLAGHER: Following that, they went back to the business units to look at what they could do with it, and they have got it working and functioning. What was that additional cost after you spent $500m to get to that stage to make it work?

Mr SNOXALL: That is a really good question. I do not know. I suspect they still ended up spending a lot of money. They did stay with the same system, but because they shut the program down, in this case call it CCSRP—they shut it down and they buried it in BAU—it became less visible in a public setting. I do not know if that is a good recipe or not. The fact is they got to the end result without the trauma of having the public exposure that they had previously. That may not have been the only change they made.

One of the things about government departments—and I have worked for many government departments—is that they do tend to be pretty good at business as usual. They are pretty atrocious at projects. They do not do projects well and they do not do programs well, but BAU, they tend to manage that a lot better; they have better governance structures in place and, I suspect, that could be part of this story.

Mr O'GALLAGHER: I am just thinking, is it an option for us to consider to go forward?

Mr SNOXALL: I think it would be a really good option, and it is something that I have discussed at length with a number of people within DCDD. I know there is support for that option. The BAU unit in DCDD when I left it, which I have to say is nearly 18 months ago, had a much better rapport and business relationship with Health than did the program.

J DAVIS: I think what you just said is that you think it would be a very good option to continue to roll out Acacia; is that right?

Mr O'GALLAGHER: No, an independent …

J DAVIS: An independent review, sorry.

Mr SNOXALL: What I would say is this: it is not the technology that is the problem; it is the way that the program has been managed. It is clarity of understanding about what is going to be delivered, when it is going to be delivered and having some formal plans in place to achieve that. It would not matter whether you stopped and went with another system or you keep going with the same system, without having a good program and project management capability in place either in DCDD or in Health, it is going to have the same problems.

Mr KERLE: I have asked this question of previous witnesses, so I will ask you as well, so that we have a good idea for the record of what is remaining. What has been delivered so far, we are told, is FG0 and FG1, which is the PAS (patient admin system). Compared to that amount of work, how much effort would you estimate is remaining for FG2, 3, 4 and 5? In terms of relative gut feel, is it less, the same amount of effort again, is it double or is it three times? Given that there is clinical …

Mr SNOXALL: I understand what you are saying. Let me start with FG0. FG0 was supposed to be a read-only electronic patient record containing data from all of the existing legacy systems. Basically, a doctor should

be able to log on to FG0 and see a full history for their patient. To the best of my understanding, that has not been delivered. It is, in fact, only a partial view of the patient record and is very lightly used.

One of the challenges that I had dealing with Health and DCDD was to say, 'Look, when you roll this out, why don't you measure the take-up and ensure that you are engaging with doctors if they are not using it to work out why not and fix those gaps'. To the best of my knowledge, never done. I do not believe if you were to ask for evidence now that you would find that FG0 is, in fact, of much use to doctors at all, but that is something for you to determine.

FG1 is patient administration, and absolutely it is probably the most difficult and sophisticated thing that you ever have to do in a hospital. You are trying to manage patient flow, you have got outpatient clinics and inpatients, you have got that difficult transition between the emergency department and the hospital. It is very difficult. The fact they have accomplished probably 90% of that in reality is not bad. It is the toughest bit to do; it is definitely the biggest hump to get over. My understanding is anecdotally the outpatients component is, in fact, very good.

The next bits that they need to do to get to a basic medical record is what we call order communications. That is when the doctor or nurse or allied health professional can log onto the system and order, requisition, an investigation from the lab—five different labs in the Northern Territory—the radiology department or prescribe drugs and the results of that effort get sent back electronically and they are able to review the results on screen.

That is a much easier thing to do technically. It still needs quite a lot of technical sophistication because you have to integrate with five different labs, for example, and they are all slightly different to each other. But it is a little bit more difficult in terms of the logistics of the change management because, first of all, you have to set those orders up so that they make sense to the doctor doing the ordering. The way a surgeon orders or an ICU specialist orders or the emergency department orders are all different, so they all do not necessarily want to look at the same menu. You have got to work closely with them to design and build that stuff.

Secondly, you have to visit every doctor and everybody who can order and make sure they know how to use the system, and make sure it is intuitive and easy to use and that they cease using paper, because if they continue using paper you will double the cost of everything you are doing and have the same propensity for errors.

Then there are some process difficulties. When the lab result comes back, if that doctor is no longer treating that patient, who is looking at that lab result? Is someone looking at it? Has someone signed it off? There is a whole lot of change management and governance-type things that have to be done within that.

Is it easier? You get the doctors on side more because it is nicer for them to be able to operate in that environment, but is it easier for IT people to do that? No, it is much more difficult because they really do have to engage and work with clinicians to get the right outcome.

There is still a big chunk of work to be done around some clinically technical processes, so I think it is about 50% from having a complete hospital system. That is not primary care; all of this stuff has to be done differently for primary care. The way a primary care clinicians orders, results and booking and scheduling of appointments is all totally different. You are not even 50% of the way through the program. It is probably about 30% of the way through the program.

Mr KERLE: Would you say it is accurate to say that of the amount of work done to date, there is at least the same amount again, perhaps double the amount of work remaining, and the work remaining requires a high degree of collaboration with clinical staff? Would that be fair to say?

Mr SNOXALL: Agree 100%.

J DAVIS: I think you also said in your submission that FG0 and FG1 are not fully operating; is that correct?

Mr SNOXALL: FG0 is definitely not fully operating, to the best of my knowledge from what people have told me. FG1—and you have statements to the effect that it is being used across all of the hospitals successfully—what I understand of that, though, is that the system it was supposed to replace is still in place, still costing the Northern Territory money and there is no clear plan for decommissioning it.

Mr BROWN: Just reading a line in your conclusion in your submission:

> *Acacia's difficulties are not isolated anomalies; they are manifestations of broader patterns in NT digital governance.*

Could you expand on what you mean by that?

Mr SNOXALL: Yes. I sort of alluded to this, but the challenge here is that DCDD, as I said earlier, should be really an organisation that is focusing on providing the technology that the Northern Territory needs at the lowest possible cost and to the best possible quality and security and safety. To that end, the entire focus of that organisation should be on becoming more efficient and more effective about doing that. There is a whole science behind providing information technology to business agencies. However, the lines have been blurred.

DCDD is being expected, so I am told, to provide advice on how agencies should use technology, what they should use it for and how they should get the most out of it. That is not the function of an IT department. It is the function of, say, a chief information officer or a chief digital officer, who normally sits within the client agency, not within DCDD. What has happened in DCDD is they moved all that capability out of the agencies into the centre, where it was all a bit foreign to them.

The model is still wrong. It needs work. It needs to focus on the science of IT service management, making sure people get the best possible technology for the money, and stop focusing on business outcomes and let the agencies get on with doing that.

My understanding and my observation is that in the Northern Territory the police have really started to take a bit more control over their own destiny in that regard. That is working reasonably well, but I still think Health is not in a good place.

Mr CHAIR: Thank you, Mr Snoxall, for coming in. All of us on the committee thank you for your time this afternoon in providing that information to assist us with our inquiry. All the best.

Mr SNOXALL: Thank you, and thanks for hearing me.

The committee suspended.

Private Citizen

Mr CHAIR: We will recommence. Thank you, Mr McDonald, for coming in today. I will read through the brief and then it will be open to you for an opening statement and then we will move into questions.

On behalf of the committee, I welcome everyone to this public hearing into the Acacia digital patient record system.

I welcome to the table to give evidence to the committee, Rod McDonald, Business Analyst. Thank you for coming before the committee. We appreciate you taking 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 hearing 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 a closed session and take your evidence in private.

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

Mr McDONALD: Thank you for the opportunity. My name is Rod McDonald. I am here in the capacity of having a long history with Northern Territory Health, primarily as the product owner for the development of the Primary Care Information System and the Community Care Information System. I was also employed by InterSystems for a period of about 13 months back at the beginning of the CCSRP program as an application specialist when they set up their presence in Darwin. I was employed as a business analyst, as a contractor, on the CCSRP program for the last four years. I finished up in May last year.

Mr CHAIR: Thank you. I will now open for an opening statement. Just on that employment as business analyst, do you know the start date as well? You finished in May last year. Just so we get a good picture then.

Mr McDONALD: It was about May or June, between the two COVID periods. I think we are talking about 2021 or 2022, somewhere around there.

Mr CHAIR: Fantastic, thank you. You may continue with an opening statement if you wish.

Mr McDONALD: I am pleased to be here to present to this hearing some genuine reasons why I think we have reached the outcome of the CCSRP program that we have got to date. I have made myself available to answer questions to those reasons that I submitted in my original submission and a follow-up supplementary report that I hope you all have.

I do not believe that I have all the answers necessarily, and I think that an external audit, much like a number of other people have probably already suggested, should be held to really get to the bottom of how serious this budget overrun is and what has been perceived as a lack of success.

I would like to think that I am here on behalf of the NT taxpayer, which I was one, and give them a clear and concise explanation as to how their taxes have been spent and whether that has been in the most prudent manner.

I am here on behalf of NT Health because I have that long history, and I believe they have a right to know why CCSRP has not been the success story that they originally hoped within the budget that was allocated.

Finally, I am here on behalf of the persons within the program who allege that we maybe work within a bit of a toxic environment and how that probably also did not help the success of the program and therefore could also have contributed to poor delivery outcomes and, once again, excessive cost.

Mr CHAIR: I will open with a couple of questions before I pass over to my peers.

What was the relationship between DCDD and NT Health like throughout the project and, in particular, how were clinicians involved in decision-making and governance?

Mr McDONALD: I did not see much evidence of how NT Government was involved in the project other than the hiring of subject matter experts to come up with requirements. This is once we had the program reset to FG0 to FG5. There seemed to be a realisation in terms of the gap. There was quite a misalignment, I believe, in the expectations of what the project would deliver between the vendor and the customer.

We talk about the customer, and it is always confusing as to whether you are talking about DCDD or NT Health. Ultimately, as everybody said, NT Health was the customer, but DCDD was obviously managing it on behalf of NT Health.

There was a misalignment of expectations, I believe, that needs to be investigated fully, and that is the reason why we have ended up with the outcome we have. That was not managed well by the program management team. It was a significant challenge once they realised that.

Mr CHAIR: Was that gap raised early by people and, if so, how did leadership respond to that?

Mr McDONALD: I was not part of the CCSRP program when they did the reset and came up with the FG0 to FG5 strategy. I had a period where I was not involved from having worked with InterSystems in the beginning and then coming along. I am not sure how that unfolded.

I can comment on that strategy and how it unfolded and the way it was managed ended up with the result that we have. My suggestion in my submissions is the really needed skill sets and experience, enterprise architecture is what I call it, a specialist skill set, that the program management team within DCDD did not have and therefore could not really understand the magnitude of this challenge, establish the right mechanisms to deal with it—Andre spoke about it before—and therefore be able to plan for the resources that were needed. Therefore, the cost blew out as a result.

Mr CHAIR: We have heard about some culture stuff, and you raised it as well in your opening statement. If you could elaborate on that but also that technical knowledge gap, do you think that played into the culture?

Mr McDONALD: It has to. If you do not have the skill set to manage that challenge and manage it successfully, you are going to find that you are working in a team that is under pressure trying to find ways to deliver something that will be considered successful. That definitely plays into that culture, and Andre also mentioned it. Critical thinking is what I call it, where you are questioning the strategy, the lack of governance to understand what is going on and manage it.

That leads to a toxic environment. You are not collaborating together well. I can give examples where I submitted documents or emails to my superior who I was reporting to, saying, ‘This is my understanding of the challenge and issues we are facing here. Who do I raise this with? How do I go about working through this?’ The response I got back was, ‘I cannot support you with this. If I take this any further, I could lose my job.’ I was very shocked at that, but that is where I left it.

Mr CHAIR: So what happened to that problem?

Mr McDONALD: Buried. It was very obvious that this critical thinking and trying to understand the gap with what we were delivering and what the business expected, and how it was going to be managed—'No, we don't want to introduce more work or more understanding around that, because that will not help us deliver this in the timeframe that we have got'. That is how I saw that.

Mr KERLE: Hi, Rod, thank you for coming and testifying today.

Just for the information of the committee, are you currently working for or contracted to NT Government at the moment?

Mr McDONALD: No.

Mr KERLE: Okay.

Going to your evidence just then, can you share with the committee any other instances? What was the commonness or frequency where people felt that they could not speak up because their jobs or their future career may be at risk?

Mr McDONALD: I do not think I can speak on other people's behalf. I am assuming submissions have been made and you have discussed that with them individually.

I had one or two scenarios like that. I have documented that well with the internal investigation that is going on around the toxic environment and whatever else unfolded from that, so I hope you will get the information from that and can utilise that in your decision-making.

Mr KERLE: Understand that this is a public hearing and there are representatives of the departments in the audience.

J DAVIS: Thanks, Rod, for coming today and for your submission.

At what point do you think the challenges that you have outlined in terms of the implementation should have been recognised?

Mr McDONALD: Very early on. If you have the program management structure to implement a program like this, a hugely complex program in my mind, then that should have been realised very early on. There was a tension, and balance needed to be achieved, between procuring a commercial off-the-shelf product, which is basically a global standard around the world, and implementing that and saying, 'This is what you purchased; you should be trying to adopt it as it is as much as possible because that way it is more cost-effective for you ongoing and you get the benefit of enhancements that are implemented in the product around the world'. But when you are putting that into an environment that is so completely different from the functionality that is provided in that, you have a real challenge.

J DAVIS: I think you said 'trying to fit a square peg into a round hole' in your submission.

Mr McDONALD: That is what it felt like to me; the gap was that huge. One perspective was you purchased the commercial off-the-shelf product. That is what we will implement—this is InterSystems—we will give you the skill sets to configure it and implement it.

It was not like we were a development shop where you can come along and say, 'That is what we bought off the shelf, but, man, we want to make some changes to it because this is how we run our clinical practices in the Northern Territory'. I think everybody will accept the Northern Territory has some unique challenges with their health practices with the environment that they operate in. I am very aware of those, having had to develop PCIS for that environment. When they came to us as a software development house back then, they had searched the market and could not find anything, so they needed custom development to achieve what they wanted.

The program had those tensions all the way along. I do not believe that was managed well. There was a realisation, obviously, when they came up with the reset—FG0 to 5—but once again, I do not think the program management team had that enterprise architecture skill set to really appreciate the challenge that was here, putting the square peg in the round hole. Somebody has to make some decisions as to which way you are going to go, or we are going to spend a lot of work collaborating and getting information from both sides and deciding where we are going to meet in the middle.

J DAVIS: You talked a bit about this, when those concerns were raised …

Mr McDONALD: I was not part of the program, I believe, when they probably were first raised and they came up with that.

J DAVIS: But later on you were.

Mr McDONALD: Yes. I stayed on the path of, 'This is what we're doing in this FG0 to FG5'. My skill set was for FG4, to replace the Primary Care and Community Care Information Systems, so I was to be utilised in the interim until that got fully underway, helping with the hospital implementation, which is not my skill set or expertise. We could never get to FG4 to even begin that part of the program. How much work is left to do that, I would not want to guess, but I would say significant.

Once again, that is where you bring in these skill sets to sit down and work out where the goalposts are, how we are going to do it and cost it up-front. It was never done, because I think the fit was considered so close that we were meant do some configuration, and most things will just fall out from that.

J DAVIS: I just wanted to understand when issues were raised—and you talked about that toxic workplace and used the word 'bullies'—there was pushback. That is what you experienced when you tried to raise issues. I know you said you did not want to speak on other people's behalf.

I have another question, but I will come back to it because it is separate.

Mr O'GALLAGHER: There have been a couple of themes that have gone through various submissions to us, and I am just trying to see if it links into some of your testimony here. One was that a lot of people seemed to indicate that they thought DCDD had the whip hand over NT Health—right …

Mr McDONALD: Yes.

Mr O'GALLAGHER: … in some ways in terms of making the decisions. Also, that DCDD seems more focused on looking after the vendor rather than the client in terms of NT Health-type stuff. Whether you agree with that—but I am just looking at your own testimony.

Did InterSystems have the whip hand over DCDD? I go back to:

> *The poor leadership within DCDD and the continued absorption of time and resource in the FG1 phase allowed ISC …*

InterSystems:

> *… to continually defer any obligations to engage in addressing the significant gap in capabilities of the existing TrakCare product and Remote Primary Care requirements—this suited ISC down to the ground and allowed the program budget to be used up without exposing TrakCare to costly enhancements*

Mr McDONALD: Correct.

Mr O'GALLAGHER: So do you think InterSystems had the sort of wood over them?

Mr McDONALD: Yes, but I am not privy to what the contract was.

Mr O'GALLAGHER: But just in terms of who was driving it and saying, 'Hey, do it this way'.

Mr McDONALD: The impression I got from InterSystems …

Mr O'GALLAGHER: I know you have worked with both.

Mr McDONALD: … was you bought a commercial off-the-shelf system. You need to modify your business practices to utilise the functional capability within this product. You have not bought something that we are going to turn around and customise for the specific Northern Territory needs.

Mr O'GALLAGHER: The other part in your testimony which touches on what Justine was talking about, in this case the workplace culture:

> *It is not surprising that a program like …*

The Core Clinical Services Renewal Program:

… did not achieve the success hoped for and therefore it would unfortunately become subject to destabilising work environment pressures:

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

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

That is one thing, and I will leave it at that. Did you see any of those sorts of behaviours happening?

Mr McDONALD: Yes. As I said just before, the person who I reported to and said, 'Take this further', she said, 'No, I could not take that. It would put me at jeopardy of losing my contract.' I have mentioned names with the Catherine Weber investigation, so I presume that can be corroborated or not.

Mr O'GALLAGHER: You did go on:

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

Mr McDONALD: The pressures that you as employee are under to deliver on these timeframes with a failing project, it can be very stressful.

Mr O'GALLAGHER: I accept that. Thank you very much.

Mr BROWN: Good afternoon, Rod. Just listening to you then, was there no mechanism in place in regard to reassessing or pivoting when things were going downhill with some of these projects or programs?

Mr McDONALD: That is a very good question.

Mr BROWN: Were there no mechanisms in place? I am gobsmacked trying to see how things rolled out and then they would bury suggestions—I do not know if suggestions or recommendations.

Mr McDONALD: I did not see any evidence of it. Having gone to my senior report with suggestions and being told that they would not take them any further for fear of losing their job, I guess I did go back through my agency as a contractor; I informed them. I am assuming my agency discussed it with HR. I am sure there is documentation in there again that these things were brought up, but no benefit seemed to come from them that I was aware of.

J DAVIS: Rod, I think you said you were initially contracted to develop FG4; is that right?

Mr McDONALD: That was my forte, why I thought I would be brought on board when it came to replacing the product that I was the product owner of and developed. I thought I could be a great facilitator in terms of how to configure the product to make sure that we accommodated all the practices that PCIS handle. There was an FG4 team formulated. We had meetings. We tried to engage with InterSystems to make progress on it, but we could not get anywhere. I think in my supplementary report I gave an example of a meeting that we thought would be fruitful; nothing came from it.

J DAVIS: Our understanding is that FG0 and FG1 have been rolled out and there currently is not a plan or a budget for the remaining functional groups.

Mr McDONALD: That is what I believe. There is no money left for FG4.

J DAVIS: I do not know whether this is within your area of expertise or not, but without all five functional groups, what does that mean about the functioning of Acacia?

Mr McDONALD: It has to continue to collaborate with those other external systems. I presume there is clinical risk of failures in terms of that collaboration between those systems and the ageing infrastructure for those legacy systems. There must be some concern there. I would be worried.

J DAVIS: I know you have said that there needs to be an independent audit. Do you have any views on what could happen from here? Do you think this system is recoverable, we need to be continuing with it or we need to be looking at something else?

Mr McDONALD: Only personally, I would be looking for a best of breed another system for the primary care setting. If you are going to continue with Acacia, making sure there was a good integration strategy. Once again, you are going to need enterprise architecture skills to do that, which is totally different to buying something off the shelf and just implementing it, so we just train you how to use it. That requires additional funding. Where is that coming from?

J DAVIS: I think it also requires, from looking at your submission, a different mindset, it sounds like, to be …

Mr McDONALD: It does.

J DAVIS: Is that what …

Mr McDONALD: Yes, definitely. It requires a completely different mindset.

J DAVIS: Which would be prioritising what? I mean, you have just kind of said it.

Mr McDONALD: Dealing with managing a movement away from existing practices to something else that is purchased, with good clinical reasoning behind that and how you would go through that change management versus 'No, we are unique here'. There is no software developed out there that fully aligns and supports the current practices. PCIS is now dated, but it was the best at the time when they stopped investing in it, I believe. Now what is the best alternative? There must be—I am hoping, and I do not want to give advice here, but there are other systems out there that would be worthwhile looking at.

I do not see how they could do it within TrakCare with the current functionality, using outpatient management functionality to run the remote health clinics. We have been saying, 'No, that is just too big a gap'. There would be significant development required.

J DAVIS: In addition to the complexities of the development, building on what Brian was saying and you said in your submission—it is sort of like, 'Who is making the decisions at the end of the day?'

Mr McDONALD: Yes.

J DAVIS: You talked in your submission about a belief that DCDD was given responsibility because there was a belief that NT Health could not do it. Your words were 'a level of arrogance' that you experienced, which hindered the program. Who is making the decisions, on what basis, and what is your view in terms of moving forward in relation to that? It is around governance, I guess, and decision-making.

Mr McDONALD: NT Health needs to be brought back into it as more of a master, if you like, because it is their software system to support their customers. The concept of a government department doing that generically for all the different lines of business is an economy of scale, but you cannot have that arrogance of, 'We know better than you. Your track history of what you have done with PCIS, CCIS, whatever, shows that you are not necessarily up to this.' That is what comes from that statement. That is not a good statement to be making, I am sorry.

Mr CHAIR: Thank you, Mr McDonald, for coming today. The committee genuinely appreciates your time and your input into building our inquiry and what we do with it, so thank you again.

The committee suspended.

Private Citizen

Mr CHAIR: I will read through the standard opening and then I will put it to the floor for a statement or anything you wish to discuss, and then we will move into questions.

On behalf of the committee, I welcome everyone to this public hearing into the Acacia digital patient record system.

I welcome to the table to give evidence to the committee Kara Joyce, ex-CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, Department of Corporate and Digital Development; and Bernard Yehuda, ex-CCSRP Lead Business Analyst, Department of Corporate and Digital Development. 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 hearing 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 a closed session and take your evidence in private.

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

Ms JOYCE: Kara Joyce, ex-contractor for CCSRP.

Mr YEHUDA: My name is Bernard Yehuda. I worked as a business analyst in CCSRP for nine years and about three of those years coincided with Kara. I am here as a private citizen in support of Kara. I am happy to answer any questions.

Mr CHAIR: Thank you. What I will ask is if you could both turn your microphones on, so there should be a red light, and just leave them on the whole time. If you could just restate your names for the record.

Ms JOYCE: Kara Joyce, ex-CCSRP contractor.

Mr YEHUDA: Bernard Yehuda, business analyst in CCSRP from December 2016 to December 2025.

Mr CHAIR: I now invite Ms Joyce, if you would like, to make an opening statement.

Ms JOYCE: Good afternoon, Chair and members. Thank you for the opportunity to appear today.

I believe there has been a systemic failure in the management of CCSRP that has resulted in the death of my brother Shaun Joyce. Whilst Shaun was just one person, he is symbolic of broader issues which have led to the ultimate failure to deliver.

I am still dealing with the loss of my brother and the manner in which CCSRP mishandled this tragic incident, so please forgive me if I get a little bit emotional today. In spite of this I believe I have enough evidence to back up any claims, and I am happy to provide follow-up documentation if required.

Over the past few weeks I have heard the word 'accountability' used multiple times in this forum; however, as someone who worked within this environment for four years and experienced its culture, as far as I can see it is just a word, and this is without considering my brother's death. Accountability requires curiosity to sit with difficult conversations, an honest admission of systemic failings and a meaningful effort to do better.

I agree that the Acacia program is a complex implementation that is important for all Territorians, clinicians and patients alike. Its complexity, however, is not a justification for why we are here today. If we were to do a root cause analysis I believe it would show that the failures are partially due to a culture that rewards obedience and punishes constructive dissent which in itself creates the presence of huge psychosocial hazards for all those involved. Under those circumstances no team can be high functioning let alone innovative.

Whilst the human cost of this may be more obvious, I would like to call out the financial impact. High staff turnover, loss of knowledge, recruitment costs, burnout and timeline slippage directly impact the budget, and now that psychosocial hazard management is a legal obligation under work health and safety legislation, leaders can no longer afford to treat culture and safety as intangible. They are governance levers, risk mitigators and performance enablers. The current program has opened up the government to potential liability.

The current CCSRP leadership does not have the capabilities to implement Acacia with maximum adoption whilst putting people first. This is not an opinion; it is a statement of fact, and if you need any more evidence look no further than the fact that we are here today.

I welcome the opportunity to provide any information to the committee that can help them understand what went so wrong. I encourage you to hold people to account as, from a personal viewpoint, my brother's death should not be in vain. There is an opportunity to make things right, and I want to make sure this does not happen to someone else and their family.

Mr CHAIR: Thank you, Ms Joyce, and thank you for giving evidence today, particularly on such a personal and what I can imagine has been very devasting impact for yourself.

Bernard, would you like to make any statements?

Mr YEHUDA: A very small one. I worked in CCSRP for nine years from the very beginning, and I resonate with what Kara has found. It was very tragic what happened with Shaun Joyce. Through my understanding, he was not the first victim, but I am hoping he will be the last.

Mr CHAIR: Ms Joyce, you spoke of a culture that rewards obedience. It has been a theme we have heard throughout our inquiry. Could you elaborate on that? If you could provide examples of what happened to individuals who criticised or raised issues—any elaboration on that.

Ms JOYCE: Sure. The program do not understand that every program needs an agitator, someone to challenge conventional thought. We are working in IT. Often the people we work with are on the spectrum and maybe do not engage in ways that they are used to, but they did not understand how to take someone's viewpoint, validate the points that can be useful and potentially have a collaborative discussion.

I would see that, particularly with my brother. He often confided in me. He was quite technically gifted. He was also clinical. He would raise issues and they would be disregarded, just pushed to the side multiple times. He often would come up with robust schedules with proper resourcing and they were just disregarded. He is probably my best example. However, I have seen people walked, middle of the day, without a direct conversation had—sometimes because of their personality type, sometimes because they were not performing, but no-one wanted to have that direct conversation with them.

Mr CHAIR: Were there any systems in place by management to deal with these kind of things? If not, you can just say there was not, or they were not followed.

Ms JOYCE: In order for a system to be in place they have to recognise the problem to begin with. I would not even begin to bring this to my manager because it would have been disregarded and forgotten about. So, not that I could see, not that were obviously visible to me.

J DAVIS: Thank you, Kara, for coming. I am very sorry about the loss of your brother. Thank you for continuing to work for justice for him. I am sure this is difficult, and we are very grateful for your evidence.

You have talked about safety—patient safety, clinical safety and workplace safety. I just wanted to ask quickly about clinical and patient safety. In your submission you said that at the date of writing your submission there was no 'suitably qualified and experienced clinical safety officer in place' and talked about the issues that raises and then align that with what is happening with Jira and the more than a thousand unresolved tickets. Could you talk a little bit about that?

Ms JOYCE: Sure. Possessing an AHPRA registration does not make you qualified to assess clinical safety. There are courses out there that give you the education and the insight on how to do that role.

I would be also asking the question as to why the departing clinical safety team left. To my knowledge, I believe they got pretty sick and tired of non-clinical people rewriting their work to align with whatever narrative they wanted.

At the moment there are a lot of gifted clinicians on the program. They are really hard workers—I do not want to take away from that—but, this is a very nuanced skillset. I certainly could not do it—and I would, hand on my heart, say that absolutely—without proper training.

The problem with that is that we are moving into FG2, which is clinicals, so we need to have the proper qualified people who are independent from the NT clinical health team, but work collaboratively, because they will spot different things. They will look at it from a different point of view. NT Health might look at it from a whole workflow point of view, but from a system point of view it would be really good to have someone in that role. I think that opens up a lot of risk here, because the default will be to people in leadership roles who are not qualified to comment on clinical safety.

J DAVIS: In terms of people with leadership roles, we have two departments here who are working—we have heard a lot of evidence about how they have or have not worked together. I would be interested in your views on that and on who has actually been driving and making decisions, from your perspective.

Ms JOYCE: I think it is inconsistent. I have seen some work areas collaborate amazingly with Health. It comes down to usually their tireless efforts to do so and their soft skills to engage people to kind of sell the idea of what is in it for them. They have really invested in that.

On the whole, this is not the case. It means that clinicians will not take time out of their busy day—which is absolutely fair enough—to come to a meeting where they do not feel that there is benefit for them. The default position then is to assume that no feedback is positive feedback, so often things go through processes without rigorous review from the right people.

I do feel for Health, because being able to give CCSRP enough time is a challenge for them. The program does need that drive from Health, and that needs to be top-down as well; that this is important to them. I fear that we have reached a point where there is zero trust in the program to deliver, so if I was working as a clinician I would not want to engage.

J DAVIS: What does that mean for the future, if that is where it is at now?

Ms JOYCE: I would imagine that some sort of big re-baselining needs to occur. Trust is really hard to get back, particularly, as John mentioned, in an environment where change is difficult.

The NT has a really interesting clinical population where it is often a little bit more junior than other jurisdictions and a bit more transient. In the time that the program has been in its inception, some of those senior roles have stayed current, but the end users change constantly.

Whatever happens next needs to happen in an efficient manner to make sure we are engaging the right people over the right time. I do not think that CCSRP can deliver that; it needs to be re-baselined. Perhaps Health would be a better driver. If we look at other jurisdictions, a lot of successful programs are clinically led.

J DAVIS: When you say 're-baselined' does that mean reconfigured or started again?

Ms JOYCE: Yes. I honestly think the current leadership team does not have the skills to deliver or the curiosity or insight to actually critically look into how they are doing things and how they can do things better. They need to bring someone in who has done this before in health because Health is a different beast. I have seen it time and time again working in the program; they want Health to align to these generic workflows, but when you are delivering care to a patient, it is this Swiss-cheese model of care—at any given point you could do 20 different things, and the system needs to be able to accommodate that. I do not feel that the leadership team can even begin to fathom that concept.

J DAVIS: When you say the leadership team, you are talking about the …

Ms JOYCE: CCSRP leadership team.

Mr O'GALLAGHER: Thank you very much. Like everyone, I give my condolences on the loss of your brother.

Ms JOYCE: Thank you.

Mr O'GALLAGHER: One of the common themes we have had from a number of submissions, both private and public, is they make reference to a toxic workplace culture. I notice you picked this up in your submission where you talk about leadership and accountability concerns. I might just quote some of those out there, and then you might add to it or you might expand on something. I think it is important that we get it on the record.

Without reading it all, but paraphrasing some, you talk about 'program leadership lacking required technical and project capability'. You go on to say:

> *Program Directors … presided over a deteriorating workplace culture.*

You give examples:

> *Multiple staff escalated concerns about a Program Director's behaviour in 2023, including claims of a toxic culture, yet commitments from senior executives to remove her were not acted on.*

Who was 'her'?

Ms JOYCE: The program director in 2023.

Mr O'GALLAGHER: Is there a name?

Ms JOYCE: [redacted]

Mr O'GALLAGHER: Okay; I just wanted to know who is who. Then you go on:

> *Despite acknowledged performance and behavioural issues, they …*

I am assuming you are talking about program directors:

> *… were retained as a contractor resource even after their demotion, reflecting a failure of accountability.*

You saw that happen quite often?

Ms JOYCE: Absolutely. I can expand on that if you like, with names.

I believe that the implementation to Royal Darwin Hospital was a textbook case of what not to do. The project director at the time went MIA after the implementation, and my brother was left working extremely long hours.

Mr O'GALLAGHER: Who was that program director?

Ms JOYCE: That was [redacted]

He was very burnt out, very stressed, had the on-call phone often. He and some other people, who I cannot name unless we go closed session, escalated this up to the CE at the time, Chris Hosking, and they were given assurances that this person would be removed. Shaun was going to a conference at the end of the year, so he was told that it would be sorted when he came back. When he came back it was not sorted, and that person was removed, [redacted], into the PMO role, continuing to influence and behave exactly as before.

Mr CHAIR: We are very happy to take names, but we might move into a private session at the end for the committee to take names. We will stay public at the moment, continue the line of questioning and then we can move in at the very end and get that information.

Mr O'GALLAGHER: Just on the more general thing, you said:

> *Multiple staff progressed rapidly into senior delivery and product management roles despite lacking background in IT, health, or project delivery.*
>
> *They are now responsible for delivery of critical systems (functional groups 2–5) without the foundational expertise required, creating significant delivery and safety risk.*

Is this that they have been over-promoted? Is that a general theme you are worried about or concerned about?

Ms JOYCE: Yes, absolutely. I think it requires a nuanced skill to be able to identify your boundaries and things you need to work on, and I do not think people have that skill.

Mr O'GALLAGHER: In your conclusion, you say:

> *Acacia is no longer simply a troubled IT project, it is the outcome of a leadership culture that tolerated risk suppression, poor governance, and the mistreatment of staff.*

Ms JOYCE: Yes.

Mr O'GALLAGHER: Is there anything further you want to add to that?

Ms JOYCE: I think over 65 people have come forward to participate in Catherine Weber's investigation and that should speak volumes. I understand that people might think me coming forward is a personal vendetta. It is not; it is about accountability and it is being able to speak up for all those people that have spoken up before—been dismissed, been intimidated to retract complaints—and make sure this does not happen again. If you read their stories you will understand why I am so outraged, and I actually think outrage is the perfect emotion that I should be feeling at the moment.

Mr BROWN: Thanks for coming. I have read your submission and you outlined there—a bit like what Brian said—the lack of professionalism and expertise from those working in the field. I am just trying to get an overarching view. With the Acacia system not progressing, are there people getting recruited or are there people being blocked from advancing Acacia to where it needs to be in the future? Did you see any of that?

Ms JOYCE: Yes, absolutely. It happened to my brother Shaun all the time. The thing is that when people raised issues instead of being listened to they were seen as blockers—blockers to a go-live date. A go-live date is just a little blip on this bigger journey that we are on. They were disregarded. It would happen all the time. Often it meant that the program bled expertise because anyone with half a brain would leave and say, 'I am not putting up with this', and they could get a job elsewhere. Unfortunately for a lot of people, Darwin is their home.

Another issue, and I know this happened to my brother and it happened to me, is we were often it felt like blocked from leaving the program until we delivered. I personally went to my vendor and raised some issues

that I was having, that I found the environment not tolerable and could they please find me somewhere else. My brother applied for multiple jobs. I believe that the program director at the time made the comment that he was not to leave until he delivered, until they went live—and at the cost of his life, evidently.

Mr KERLE: When we are *in camera* later, do you mind going into that? Not now.

Ms JOYCE: I sure can.

Mr KERLE: I would just like to thank you for your bravery and courage coming forward. I express my deepest condolences for the loss of your brother.

I think you have covered fairly well the aspects of the culture, environment, the limitations that people felt to express risks that they saw. Would you say it is fair to say that if someone saw a risk that would impact the project moving forward or a Go Live, were they—I know you have already said this—free to express that? What would be the consequences if they did express that?

Ms JOYCE: I think we all learned not to. At the end of the day, we are there to put food on the table for our families, so people learned what battles to pick, and how to maybe get their message across required a lot more effort to do that, other than a direct conversation. I just never saw it happen. Often, within small pockets, we would have really good robust conversations, but certainly it would happen less at a senior level.

In fact, you asked a question before about decision-making. Decision-making happened in a closed silo with the senior leadership team in CCSRP and then their directives were filtered down to the team to do. It was not a conversation; they did not leverage expertise.

Mr KERLE: Did you ever observe, in your time on the project as a project manager, when timelines and schedules were being produced or updated were the people actually doing the work consulted on tasks, timelines, duration, effort? Was there feedback represented in the timeline, or did it come from somewhere else?

Ms JOYCE: The action of consultation happened. I think it is probably worth mentioning my title says 'project manager', but at best I was able to operate in a project support officer role. We would be consulted. Sometimes the answer was, 'I cannot give you that information; there are too many variables.' I would be told, 'Put in whatever and I will do some jiggery pokery in the backend'. This would happen with schedules. This would happen with reports.

What I did notice is that I have never been a part of a program that has re-baselined so many times. Every time we would re-baseline, they would not keep the original Go Live date, so we would report green. In fact, there is a joke in DCDD, 'Is it actually green or is it SerPro green?', because everyone knew the SerPro project was behind, so I would say that CCSRP has been SerPro green for a very long time.

Mr KERLE: To expand on that, we have heard that you can use a traffic light analogy, green means everything is fine, sticking to the schedule; amber there are some issues that we are working through; red there are blockers, the project is in trouble. To your knowledge, in the time you were on the project, what status was the project actually in versus what status would it have been reported as—if you know?

Ms JOYCE: Some of the functional groups I probably did not keep across, but I can definitely say Functional Group 4 and 3 should be red. Evidently, Functional Group 2 should be red. Look where we are. Functional Group 1 should have been red for a while and it was not. Maybe being clear about where we really were would have actually helped to have some difficult conversations once again, and we could have come up with some creative solutions to move forward.

I want to comment, though, that when I came onto the program I was part of the medication management team. To my knowledge, the medication management solution was not costed as part of the original costing; it was separate. There were five of us and that went on for four years. I would encourage you to look into what the original budget was and what it is now, what money is left over, because my brother did a close-out report. I believe they chewed through a whole heap of money, and all the work we did will have to be revalidated because it is out of date. The workflows are out of date. Everything is out of date.

Health are now put in a situation where their medication management systems at the moment are about to fall over. I spent three months after I left CCSRP in BAU helping that. They worked tirelessly to keep these systems running. It is not sustainable, so it was just a waste of time.

Mr CHAIR: We will move into closed session. I would like to say too the committee is really glad you have come in today. You made the comment some people might think it is a personal vendetta. I will say this as the Chair of the committee: it is extremely useful to have you here. It can be very hard to find meaning in

tragedy, but I hope you coming here today gives us a genuine insight into the real problems. I hope you see some of the meaning in that as well.

Ms JOYCE: Thank you.

Mr CHAIR: We will now clear the gallery and move into a closed session.

The committee suspended.

The committee moved to closed session.

The committee concluded.
