Legislative Assembly of the Northern Territory

Public Accounts Committee

Inquiry into the Acacia Digital Patient Record System

August 2026

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Legislative Assembly of the Northern Territory

Parliament House
State Square
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Contents

Chair's Preface

This report sets out the findings and recommendations of the Committee's inquiry into the Acacia Digital Patient Record System, referred by the Treasurer, the Hon Bill Yan MLA, on 13 February 2025.

The Acacia Digital Patient Record System (Acacia) refers to the new clinical ICT software in the public healthcare system of the Northern Territory. Delivered by the Core Clinical Systems Renewal Program (CCSRP) housed within the Department of Corporate and Digital Development (DCDD), the Department of Health is the client agency, and will be the end-user of Acacia. Acacia is built on the foundation of 'TrakCare', a commercial-off-the-shelf clinical ICT software purchased from InterSystems.

Partially funded in 2016, with a budget allocation of $185.9 million, the program was planned to be completed by the end of the 2020-21 financial year. In May 2017, the CCSRP was fully funded, bringing the total budget to $259 million. In 2019, Acacia was planned to be deployed in 6 different stages, called Functional Groups (FG). However, to date, only 2 of the 6 stages have been delivered: FG0 and FG1. Existing funding is not sufficient to deliver any further stages in full. Despite this, the program budget has increased to $335 million, with $319.6 million spent to March 2026.

As Chair, I am of the view that Acacia also reveals a broader breakdown in the fundamental role of ministerial oversight. The Committee heard evidence that Acacia was a standing agenda item in regular ministerial meetings, held approximately fortnightly, and that responsible Ministers were briefed as delays continued and additional funding was required. The Committee also heard that clinical concerns were discussed with multiple Ministers. I do not suggest that every cost overrun or delay is evidence of failure. Complex government projects will encounter unforeseen costs and legitimate difficulties. The problem is when overruns cease to trigger scrutiny and instead become normalised. Oversight exists to distinguish an unavoidable variation from evidence that something deeper is going wrong. But identifying that point is meaningless if no-one with authority acts upon it. Briefing is not governing.

The principle of responsible government requires more than Ministers being informed of what the administration is doing. It requires elected Ministers to exercise judgement, ask difficult questions and ultimately accept responsibility for the operation of government. Ministers do not need to personally manage an ICT project, but they are responsible for determining whether hundreds of millions of dollars of public money are delivering what Government approved and whether continued delay, cost escalation and diminished scope require intervention. In my view, Acacia demonstrates what can occur when responsibility becomes dispersed across departments, steering committees, boards, contractors and specialist officials until everyone possesses part of the authority, but no-one appears to own the outcome. Administration must be delegated in modern government; responsibility cannot be.

I also acknowledge that this problem is not unique to Acacia or to one government. Modern government necessarily relies on independent expertise, boards and steering committees, and this Committee itself recommends stronger independent and expert representation in

the governance of complex ICT projects. These structures can improve decision-making, challenge assumptions and provide an important safeguard against political or administrative failure. Independent bodies should inform and test executive decisions; they should not become a substitute for executive responsibility. The public can remove a Minister; it cannot vote out a steering committee. Ultimate responsibility for the exercise of executive government must therefore remain clear, visible and capable of being exercised by those who are democratically accountable.

I hope this inquiry contributes to a broader discussion about what Territorians expect from their Ministers and their Parliament. It may surprise many people how removed elected representatives can become from the day-to-day machinery of government for which they remain publicly accountable. Independent safeguards are essential, but so too is a clear line of democratic responsibility. If we expect Ministers to answer for the decisions of government, they must also possess—and exercise—the authority necessary to do so. Westminster permits the delegation of administration. It does not permit the delegation of responsibility.

Following detailed consideration of the evidence provided to the Committee — including submissions from stakeholders, testimony in public hearings, key internal documents from the CCSRP, and answers to written questions from the Committee to DCDD and NT Health — the Committee has developed a number of recommendations which seek to address the key issues highlighted in this Inquiry. Firstly, given the outstanding questions the Committee has regarding the program budget and costs to date, the Committee recommends that the Government commission a financial audit of Acacia.

Subsequent recommendations seek to address the broad range of issues identified within the CCSRP, which the Committee understands as having significantly impacted the delivery of Acacia to schedule and on budget. Issues identified by stakeholders include:

- the responsiveness of the CCSRP to issues identified by clinicians that impacted workflows and presented patient safety risks, both prior to deployment and following implementation
- the difference between TrakCare and the requirements of NT Health, insufficiently planned and undertaken re-engineering of NT Health business practices, and a resulting need to extensively customise TrakCare
- governance matters, including change management, benefit management and realisation, utilisation of program management methodologies, oversight and reporting of the program, and workplace culture.

A suite of governance reforms are the focus of the first tranche of recommendations. Importantly, the Committee recommends that a review of the *NTG ICT Governance Framework,* which has not been updated since 2015, be undertaken. This review should assess lessons learned from Acacia and other ICT programs and projects delivered by DCDD on behalf of client agencies, such as SerPro, as well as best practice across jurisdictions.

Further governance reforms recommended by the Committee include the:

- requirement for independent and expert membership on steering committees of complex ICT programs and projects
- elevation of benefits management and realisation throughout the lifecycle of programs and projects
- enhancement of reporting and oversight mechanisms to enable governance bodies to accurately assess the status and health of complex ICT programs and projects
- development of a cross-government reporting framework for all agencies for consistency and clarity of reporting and oversight.

Additionally, in response to concerns regarding the lack of resolution of clinical issues, the Committee recommends that Service Level Agreements or an appropriate alternative mechanism be implemented between DCDD and client agencies to ensure that there are agreed outcomes and standards of functionality when DCDD delivers ICT projects and programs, and avenues for recourse if those standards are not met.

The Committee was particularly concerned to hear from stakeholders of serious issues regarding what was referred to as a 'toxic' workplace culture in the CCSRP, and the impact this had on program delivery and costs. To address some of the root causes of these workplace culture issues, the Committee recommends that DCDD review its induction process for contractors and develop an annual survey of personnel contracted within DCDD aligned to the People Matter Survey, with results to be published in their annual report. These mechanisms seek to both ensure that DCDD contractors understand their workplace health and safety rights and obligations, and are aware of complaints processes and procedures; and enable public scrutiny of DCDD's commitment to improving their workplace culture on an ongoing basis.

The Committee also considered the future of Acacia. While the Committee considers that ongoing reliance on the existing legacy systems is untenable, it is not confident that Acacia and the CCSRP are necessarily the most appropriate pathway forward for the Northern Territory. Accordingly, the Committee recommends that strict cost controls are implemented whereby any additional funding is subject to an independently prepared business case that includes rigorous clinical engagement and elevates clinical decision-making in governance, and evaluates the costs, objectives, benefits and implementation timeframe of any proposed future works.

In addition, the Committee recommends that DCDD and NT Health identify any staffing costs to NT Health that have arisen due to the implementation of Acacia that are required to maintain pre-existing levels of functionality and patient safety, such as manual system auditing. Alongside this, the Committee recommends the underlying issues be remediated to eliminate those ongoing costs.

The Committee considers that the existing budget should be utilised on the assumption that no further funding is to be granted to the Acacia program. As such, the Committee recommends that work be conducted to make Acacia fit-for-purpose as a patient administration system for the long-term and integrated with the existing legacy systems. The Committee considers that further development of FG2-5 should only be conducted upon completion of these activities and the remediation of ongoing additional costs to NT

Health. Even then, the Committee considers the program should only pursue those FGs that can be delivered and provide clinical benefits within the existing program budget.

Despite the Inquiry's focus on the failings of CCSRP, it is important to highlight that the structural governance and program leadership issues do not reflect on the majority of personnel within the CCSRP. Indeed, I note that the Committee heard extensive evidence of the dedication and efforts of CCSRP employees and contractors alike, who sought to do their best in a particularly demanding, time-pressured and challenging work environment. On behalf of the Committee, I commend the resilience of those in the program and thank them for their dedication and efforts to deliver for Territorians.

For many witnesses, the evidence given recounted times of hardship in their lives, and in some tragic cases, loss. I appreciate what was given in those moments, and extend the Committee's sincere thanks to all submitters and witnesses — whether their evidence was provided in public or in private — for sharing their experiences and supporting the Committee's inquiry into Acacia.

Similarly, reflecting on the impact the roll out of Acacia has had on NT Health staff, I also thank the clinical, administrative, and technical staff on the frontline of the NT public healthcare system for their commitment to excellence in patient care and safety. Finally, I would like to thank my fellow Committee members for their bipartisan focus on accountability in matters of significant public importance.

Mr Clinton Howe MLA
Chair

Committee Members

Chair:	Mr Clinton Howe MLA Member for Drysdale
Deputy Chair:	Mrs Laurie Zio MLA Member for Fannie Bay
Members:	Justine Davis MLA Member for Johnston
	Mr Brian O'Gallagher MLA Member for Karama
	Mr Ed Smelt MLA Member for Nightcliff

On 8 May 2026, Member for Arafura, Mr Manuel Brown MLA was discharged from the Committee, and the Member for Nightcliff, Mr Ed Smelt MLA was appointed to the Committee.

Committee Secretariat

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Acknowledgments

The Committee acknowledges and thanks all those that provided written submissions or oral evidence at public and private hearings. Through evidence provided, the Committee heard accounts of hardship experienced by those working within the Core Clinical Systems Renewal Program. The Committee also heard that the program had deleterious impacts on clinicians. The Committee commends the resilience demonstrated by these accounts and the evident dedication to clinical safety and patient care.

Acronyms and Abbreviations

ABS—HSS	Agency Business Systems—Human and Shared Services
Acacia	Acacia Digital Patient Record System
AMA NT	Australian Medical Association Northern Territory
ANMF NT	Australian Nursing & Midwifery Federation Northern Territory
ASH	Alice Springs Hospital
BAU	Business as Usual
CAH	Central Administrative Hub
CCIS	Community Care Information System
CCSRP	Core Clinical Systems Renewal Program
CLG	Clinical Leadership Group
Committee	Public Accounts Committee
CWS	Clinical Workstation
DCIS	Department of Corporate and Information Services
DCDD	Department of Corporate and Digital Development
DFV	Domestic and Family Violence
ED	Emergency Department
eMMa	Electronic Medication Management Application
EPR	Electronic Patient Record
FG	Functional Group
FTE	Full-time equivalent
GDH	Gove District Hospital
ICT	Information and Communications Technology
InterSystems	InterSystems Australia Pty Ltd
IPS	Implementation Planning Study
ISR	Incident Severity Risk
KDH	Katherine District Hospital
MEUI	Mobile Enabled User Interface
NT	Northern Territory
NTG	Northern Territory Government
PAS	Patient Administration System
PCIS	Primary Care Information System
PIC	Program Implementation Committee
PMO	Program Management Office
PSC	Program Steering Committee
RAN	Remote Agency Nurse
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RDPH	Royal Darwin and Palmerston Hospital

SerPro	Serve and Protect project
SFNT	Solicitor for the Northern Territory
SME	Subject Matter Expert
SUVT	Site User Validation testing
TCH	Tennant Creek Hospital
TCUI	Traditional Clinical User Interface
UAT	User Acceptance Testing

Executive Summary

The Acacia Digital Patient Record System (Acacia) is the name of the new clinical ICT software in the public healthcare system in the Northern Territory. Delivered by the Core Clinical Systems Renewal Program (CCSRP) housed within Department of Corporate and Digital Development (DCDD), the Department of Health are the client agency, and will be the end-users of Acacia. Acacia is built on the foundation of 'TrakCare', a commercial-off-the-shelf clinical ICT software purchased from InterSystems.

Chapter 2 – Background to the Acacia Digital Patient Record System

Chapter 2 provides background context to the Committee's Inquiry. It outlines key recommendations of the Public Accounts Committee's 2014 report *Management of ICT Projects by Government Agencies* and subsequent reform to ICT governance and delivery in the Northern Territory Public Sector. It also provides context regarding the CCSRP, including the existing clinical ICT systems used in the Northern Territory and the proposal and rationale to replace these systems with the Acacia platform.

Chapter 3 – Program Timeline

Chapter 3 outlines the timeline of the CCSRP, including when key decisions were made regarding the program and the scheduled dates of delivery for different elements of the program. Most notably, this Chapter outlines the repeated revisions to the program schedule and extended delays to the implementation of Acacia.

Chapter 4 – Program Budget and Cost to Date

Chapter 4 responds to the first element of the Inquiry Terms of Reference, examining the difference between the initial program budget and the cost of procuring, implementing and managing the Acacia system to date. With an initial program budget of $242 million—shortly revised to $259 million—this Chapter finds that the program has spent $319.6 million procuring, implementing and managing Acacia, to March 2026. Additionally, at least $34.4 million has been spent securing the perpetual rights to the legacy systems and maintaining them since commencement of the program, outside of the program budget.

Chapter 5 – Cost Revisions and Rationale

Chapter 5 responds to the second element of the Inquiry Terms of Reference, examining each cost revision to the program and the rationale for each revision. This Chapter identifies 4 cost revisions: $17 million in 2016; $63.4 million in 2022; minus $6 million in 2023; and $12 million in 2025. Across the life of the program, a major cost driver has been the time spent implementing the program. Associated staffing costs with additional years of implementation have been significant: to April 2026 staffing costs were $234.6 million. Key reasons necessitating extensions to the program delivery timeline were identified as the commissioning of Palmerston Hospital, InterSystems' delivery of functionality to the

program schedule, the revision of the implementation plan, the COVID-19 pandemic, and extensive customisation of TrakCare

Chapter 6 – Issues Raised During Implementation

Chapter 6 responds to the third element of the Inquiry Terms of Reference, examining issues raised during the implementation of Acacia, as well as ministerial notification of issues, length of time for issues to be resolved, and the cost of resolution. Three major implementation issues were raised with the Committee, including a transfer of patient data across 2018-19 to InterSystems, and the implementation of Functional Group 1 to the Theatre Scheduling and Emergency Departments of the Royal Darwin and Palmerston Hospitals. A range of discrete technical issues are also discussed, as well as matters raised by stakeholders regarding the responsiveness of the program to clinical concerns preceding deployment and issues logged and ticketed following implementation of Acacia.

Chapter 7 – Impact and Cost of the Rollback

Chapter 7 responds to the fourth element of the Inquiry Terms of Reference, examining the impact to the health system and the cost of any rollbacks of Acacia to the previous systems. This Chapter finds that the rollback of Acacia to CareSys occurred only in the Emergency Department of the Royal Darwin and Palmerston Hospitals—in all other cases any issues were remediated *in situ.* This Chapter highlights that the costs associated with the rollback primarily related to: 1) the management of dual patient administration systems within the same hospital; and 2) the inhibitory impact the Emergency Department remediation project had on the development and implementation of later stages of Acacia.

Chapter 8 – Current Status and Outstanding Steps

Chapter 8 responds to the final element of the Inquiry Terms of Reference, examining the current status of implementation against the original phased implementation plan, as well as the outstanding steps and costs to complete the program. This Chapter finds that, of the 6 Functional Groups (FG0-5) planned to be implemented by the Core Clinical Systems Renewal Program, only Functional Group 0 and Functional Group 1 have been delivered. The Chapter identifies evidence demonstrating that extensive work remains to complete the program. Indeed, while work has commenced and progressed on Functional Group 2-5, this Chapter finds that only some elements of Functional Group 2 will be delivered within the current program budget of $335 million. Work on Functional Groups 3 and 4 have been deferred indefinitely pending further funding. Work has commenced on Functional Group 5 but no functionality will be delivered within the existing budget.

Chapter 9 – Further Findings and Recommendations

Chapter 9 examines several issues associated with multiple different elements of the Terms of Reference. These primarily relate to the effectiveness of the program governance, the recurring delays to the program schedule, and therefore the overall cost of the program. Matters discussed encompass a range of issues raised by stakeholders regarding the governance of the program, including change management, benefit

management and realisation, utilisation of program management methodologies, oversight and reporting of the program, and workplace culture. Consequently, this Chapter makes a range of recommendations seeking to address and resolve identified governance issues for future complex ICT programs and projects in the Northern Territory. Additionally, this Chapter considers the appropriate future of Acacia and makes recommendations that seek to balance the unresolved need to replace the legacy systems in operation in the NT public healthcare sector with the evident failures of the Acacia program to date.

Terms of Reference

On 13 February 2025, the committee received the following inquiry referral from the Treasurer, the Hon Bill Yan MLA.

TREASURER

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Public Accounts Committee - Acacia - Costs associated with implementation and management

I refer to the Public Accounts Committee for further investigation the costs associated with the implementation and management of the Acacia digital patient record system.

I request that the Public Accounts Committee investigate and assess the following:

- The difference between the initial project Budget and the cost of procuring, implementing and managing the Acacia system to date
- A timeline of each of these cost revisions with an explanation for each revision
- Any issues that were raised during implementation of the system, when the responsible Minister was notified of these issues, how long it took for these issues to be resolved, if they were resolved at all, and their cost
- The impact to the health system, and the cost, of any rollbacks/suspensions of using the software in hospitals that occurred during implementation
- The current status of implementation against the original staged project plan and the outstanding steps, and their cost, required for project completion

Yours sincerely

BILL YAN

NORTHERN TERRITORY GOVERNMENT

Recommendations

Program Budget

Recommendation 1

The Committee recommends that the Government commission a financial audit of the Acacia Digital Patient Record System ICT program.

The Future of Acacia

Recommendation 2

The Committee recommends that strict cost controls are implemented whereby any additional funding is subject to an independently prepared business case that:

(a) is developed following rigorous clinical engagement,

(b) provides an enhanced governance structure which facilitates clinical decision-making, and

(c) identifies the cost, objectives, benefits and implementation time frame of any proposed future work to be undertaken in relation to the Acacia Digital Patient Record System.

Recommendation 3

The Committee recommends that, as a matter of priority, DCDD and NT Health:

(a) identify all additional ongoing FTE costs in NT Health resulting from the deployment of the Acacia Digital Patient Record System that are currently required to maintain previously existing levels of functionality and safety, such as manual system auditing, and

(b) undertake the necessary remediation of the Acacia Digital Patient Record System to eliminate the need for the identified additional ongoing FTE costs.

Recommendation 4

The Committee recommends that, within the existing program budget, DCDD undertake work to:

(a) ensure the existing deployed functionality of Acacia is fit-for-purpose,

(b) deliver enhancements outlined in Recommendation 3, and

(c) prioritise additional features that can be completed within the scope of the existing budget.

Governance

Recommendation 5

The Committee recommends that the Government review and revise the *NTG ICT Governance Framework* and associated agency guidelines to enhance governance practices and incorporate lessons learned from the implementation of the Acacia Digital Patient Record System.

Recommendation 6

The Committee recommends that the *ICT Governance Models: Guidelines for Agencies* be amended to provide that membership of Steering Committees of complex ICT programs and projects include ICT experts independent of DCDD and the client agency.

Recommendation 7

The Committee recommends that the Government implement Service Level Agreements or an appropriate alternative, to include agreed outcomes and standards of functionality, between DCDD and client agencies for the operation of complex DCDD delivered ICT projects and programs.

Recommendation 8

The Committee recommends that the role and functions of the ICT Governance Board, as set out in the NTG *ICT Governance Framework*, be amended to explicitly include monitoring of ongoing benefits management and realisation over the lifecycle of ICT projects and programs as set out in Treasurer's Direction ICT1.3.5, ICT1.3.6, and ICT3.1.2.

Reporting and Oversight

Recommendation 9

The Committee recommends that, taking into consideration the Committee's findings, the Government review the effectiveness of existing reporting mechanisms relating to the progress of ICT programs and projects with a view to enhancing the ICT Governance Board's oversight of complex ICT programs and projects.

Recommendation 10

The Committee recommends that the Government develop a cross-government reporting framework for all programs and projects.

Workplace Culture

Recommendation 11

The Committee recommends that DCDD review its induction process for all contractors to ensure that it includes information on contractors' health and safety rights and obligations and complaints processes and procedures.

Recommendation 12

The Committee recommends that DCDD develop an annual survey mechanism similar to the People Matter Survey for personnel contracted by DCDD for a minimum of 6 months and publish the results in their annual report.

1 Introduction

Inquiry Referral

1.1 Pursuant to clause 1(d)(ii) of its Terms of Reference[1], on 13 February 2025 the Public Accounts Committee received an inquiry referral from the Treasurer, the Hon Bill Yan MLA, requesting that the Committee investigate the costs associated with the implementation and management of the Acacia Digital Patient Record System. The Inquiry referral did not include a date by which the Committee was required to report on its findings.[2]

Conduct of the Inquiry

1.2 On 2 April 2025 the Committee called for submissions by 30 April 2025. The call for submissions was advertised via the Legislative Assembly website, Facebook and email subscription service. In addition, the Committee directly contacted a number of individuals and organisations to seek submissions.

1.3 The Committee received 6 submissions to its inquiry (see Appendix 1). However, following receipt of a further 2 inquiry referrals with reporting dates of 31 October 2025, at its meeting of 21 May 2025 the Committee resolved to defer public hearings on the Acacia inquiry until November 2025.

1.4 Noting its disappointment with the low number of submissions received and the fact that the system had since been rolled out in the Alice Springs and Tennant Creek Hospitals and was set to be reintroduced to the Royal Darwin and Palmerston Hospital Emergency Departments on 13 November 2025, on 5 November 2025 the Committee issued the following public statement:

> The Public Accounts Committee advises that initial submissions regarding the Acacia Project have been received. However, the Committee has noted with concern the limited number of submissions received to date. Given the significance of this matter, the Committee believes there may be additional individuals who have information that could assist its work.
>
> In response, the Committee has agreed to issue a further public call for submissions. The Committee encourages individuals — including former employees and others with relevant knowledge — to provide either public or confidential submissions, with appropriate protections available under parliamentary procedure.
>
> The Committee advises that submissions are due by 31 January 2026.[3]

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[1] See Public Accounts Committee – Terms of Reference, https://parliament.nt.gov.au/__data/assets/pdf_file/0005/1453595/PAC-Terms-of-Reference-16-October-2024.pdf

[2] See Acacia Digital Patient Record System, Inquiry Referral, https://parliament.nt.gov.au/committees/list/public-accounts-committee/Acacia-Digital-Patient-Record-System#TOR

[3] Public Accounts Committee, *Public Statement – 5 November 2025,* https://parliament.nt.gov.au/committees/list/public-accounts-committee/Acacia-Digital-Patient-Record-System

1.5 The Committee also invited those who had previously made submissions to provide a supplementary or updated submission for the Committee's consideration. As detailed in Appendix 1, a further 10 submissions were subsequently received.

1.6 On 4 February 2026, the Committee provided the Department of Health (NT Health) and the Department of Corporate and Digital Development (DCDD) a list of key documents associated with the program and requested that they be provided to the Committee. The Committee received these documents from NT Health and DCDD (the Departments) on 20 February 2026.

1.7 Following consideration of the submissions, the Committee held a public briefing with representatives from NT Health and DCDD on 17 February 2026. Public hearings with 5 witnesses were held in Darwin on 3 March 2026.

1.8 On 12 March 2026, the Committee requested the Departments provide additional information in writing to the Committee by 13 April 2026. Further information was also requested of the Departments on 25 June 2026, due by 15 July 2026. The Committee also requested additional information from the Australian Medical Association Northern Territory (AMA NT), which was received on 21 July 2026. The Committee thanks the Departments and the AMA NT for their assistance.

1.9 In conducting this inquiry, the Committee has experienced challenges in collecting evidence for use in this report. Many submitters and witnesses were not willing to appear on the public record due to fears they held regarding the likelihood they would sustain retaliation in their professional lives for speaking out about their experiences with Acacia. Because of these concerns, 6 submitters asked the Committee to either withhold their name from their submissions or not to publish their submissions at all. Additionally, the Committee heard from 11 witnesses in private hearings who were not comfortable speaking publicly. The Committee notes that evidence provided in confidential submissions and the experiences of those heard in private hearings largely reflects the evidence given to the Committee in public.

Report Structure

1.10 Chapter 2 provides background on the Acacia Digital Patient Record System.

1.11 Chapter 3 provides a timeline of key decisions and events in the development and deployment of the Acacia Digital Patient Record System.

1.12 Chapter 4 considers evidence provided to the Committee related to the first element of the Terms of Reference, examining the program budget and cost to date.

1.13 Chapter 5 considers evidence provided to the Committee related to the second element of the Terms of Reference, examining cost revisions and the rationale for those revisions.

1.14 Chapter 6 considers evidence provided to the Committee related to the third element of the Terms of Reference, examining the issues raised during the implementation of Acacia.

1.15 Chapter 7 considers evidence provided to the Committee related to the fourth element of the Terms of Reference, examining the impact and cost of the system rollback.

1.16 Chapter 8 considers evidence provided to the Committee related to the fifth and final element of the Terms of Reference, examining the status of the program and any outstanding steps.

1.17 Chapter 9 outlines further findings made by the Committee and recommendations.

2 Background to the Acacia Digital Patient Record System

2.1 This Chapter provides an overview of the Acacia Digital Patient Record System (Acacia), including contextual information regarding Information Communication Technology (ICT) projects and programs in the Northern Territory (NT), the core features of Acacia, and the rationale for Acacia.

Management of ICT Projects by Government Agencies

2.2 In 2014, the Public Accounts Committee reported on their *Inquiry into the Management of ICT Projects by Government Agencies*.[4] Precipitated by the $70 million failure of the Asset Management System project, the Committee undertook an extensive literature review of factors that enable success or facilitate failure in ICT projects, a comparative analysis of three NTG ICT-enabled projects, and made 15 recommendations for improvement in the future. These recommendations included:

- implementation of the All-of-Government ICT Governance Framework
- mandatory use of staged gateway reviews for major projects
- development of an ICT Capability Framework
- development of a Project Management Methodology Framework.[5]

2.3 Following the report, the Department of Corporate and Information Services (DCIS)[6] undertook a reform program to address the recommendations of the Committee. The ICT Governance Board held oversight of this reform program.[7] By the end of 2014-15, '16 recommended actions were completed and the remaining six [were] scheduled for implementation in 2015-16.'[8] These included a range of governance reforms. Enhanced oversight of the management of ICT projects across different agencies was implemented by the ICT Governance Board.[9]

2.4 In response to the recommendations of the Committee—although extending beyond them—in the following year wider reform saw DCIS take on a centralised role in directly managing ICT projects and programs on behalf of agencies.[10] The Core

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[4] Public Accounts Committee, *Management of ICT Projects by Government Agencies,* May 2014, https://parliament.nt.gov.au/committees/list/public-accounts-committee/PAC-reports/12th-assembly/PAC_Report_ICT_Inquiry_Management_in_the_Northern_Territory_Government.pdf.

[5] Public Accounts Committee, *Management of ICT Projects by Government Agencies,* May 2014, https://parliament.nt.gov.au/committees/list/public-accounts-committee/PAC-reports/12th-assembly/PAC_Report_ICT_Inquiry_Management_in_the_Northern_Territory_Government.pdf, pp. 18-20.

[6] DCIS later underwent machinery of government changes and was renamed the Department of Corporate and Digital Development.

[7] Department of Corporate and Information Services, *Annual Report 2014-15,* 2015, p. 54.

[8] Department of Corporate and Information Services, *Annual Report 2014-15,* 2015, p. 17.

[9] Department of Corporate and Information Services, *Annual Report 2014-15,* 2015, p. 54.

[10] Department of Corporate and Information Services, *Annual Report 2015-16,* 2016, p. 4; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 13.

Clinical Systems Renewal Program (CCSRP) was the first project or program to be run by DCIS on behalf of another agency.[11]

What is Acacia?

2.5 Currently, 5 systems form the core of the NT healthcare sector clinical ICT system: CareSys; Clinical Workstation (CWS); Primary Care Information System (PCIS); Community Care Information System (CCIS); and Electronic Medication Management Application (eMMa). Each system has a different function within the healthcare system:

- CareSys is the patient administration system that records clinical information of individual patients in hospitals, renal clinics, and correctional health services.
- CWS records live information on patient admissions, discharges and transfers.
- PCIS records individual patients' clinical information in primary care facilities, and facilitates medication prescription, pathology and radiology reports.
- CCIS records individual patient clinical information in community-based services.
- eMMa is the medication prescription service in hospitals.[12]

2.6 Acacia is the new electronic patient record management and administration system being delivered by the CCSRP, a program within DCDD. NT Health are the end services users of Acacia.[13] Rather than individually upgrading or replacing the existing core ICT systems, Acacia was planned to replace the functionality of all 5 of these systems. Accordingly, once fully deployed, Acacia would provide one integrated system for use as the primary clinical ICT system in a range of healthcare settings across the Northern Territory, including all 6 hospitals and 72 primary care facilities.[14]

2.7 The CCSRP has contracted InterSystems, a private healthcare information management systems company, to deliver the Acacia platform. InterSystem's modular clinical software 'TrakCare' is the foundation of Acacia.[15] This is a commercial-off-the-shelf product. However, this product is being customised by InterSystems and configured by CCSRP to better suit patient workflows in the NT.

2.8 Acacia is being deployed in 6 separate stages, called 'Functional Groups' (FGs). Most FGs replace an ICT system, and each FG deploys an additional level of functionality to Acacia. Table 1, provided by the Departments, outline the specifics of each FG.

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[11] Department of Corporate and Information Services, *Annual Report 2015-16,* 2016, p. 4.
[12] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 4-5.
[13] DCDD being the successor agency of DCIS, following Machinery of Government changes in 2019.
[14] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 1.
[15] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 4.

Table 1: Description of Functional Groups which Comprise the Acacia Program[16]

FG	Title	Description	Legacy system replaced
FG0	Acacia: Electronic Patient Record **(EPR)**	Electronic, read-only patient record containing over 20 years of longitudinal patient data from legacy systems.	New functionality
FG1	Acacia 1.0: Patient Administration+	Patient administration system for the management of patients throughout their hospital journey, including through wards, renal clinics and correctional health centres.	CareSys
FG2	Acacia 2.0 & 3.0: Hospital Care	Introduces native TrakCare functionality to support the ordering and receipt of pathology and radiology scans and tests, and other clinical documentation.	CWS
FG3	Acacia 2.0 & 3.0: eMedication	Introduces native TrakCare functionality to support digital patient medication management.	eMMa
FG4	Acacia 4.0: Remote and Urban Primary Care	Introduces Acacia to remote clinics and other primary healthcare centres.	PCIS & CCIS
FG5	Client and Healthcare Provider Portal	Provides private, interstate, and non-government clinical access, and patient access, to patient records through a secure public portal.	New functionality

2.9 NT Health's *Annual Report 2024-25* also outlines that Acacia will replace the Jade Care Clinical Booking System.[17]

The Rationale for Acacia

2.10 The Departments advised the Committee of several reasons justifying the replacement of these systems. Fundamentally, they told the Committee that CareSys, CWS, PCIS, and CCIS require replacement because they have each

[16] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 21.
[17] Department of Health, *Annual Report 2024-25*, p. 83.

'exceeded their operational lifespan'.[18] They are legacy systems which are no longer supported by their product vendors. Accordingly, DCDD is required to maintain specific technical support for these systems, either in-house or through external contractors.[19] For example, CareSys—the oldest of the platforms—has been in use in the NT since 1989. The Departments told the Committee that the NT is the last jurisdiction in the world to use CareSys. Similarly, CWS was deployed in the 1990s and the NT is the only jurisdiction where it is still in use. eMMa is the most recent addition to the NT's network of clinical ICT systems, deployed in 2008. It is the only one of the 5 systems that still receives support from its product vendor.[20]

2.11 The Departments advised the Committee that NT Health had experienced ICT issues because of the legacy nature of these systems, including system performance instability and unscheduled ICT outages. The Departments further advised that they are experiencing challenges in maintaining and upgrading these systems due to 'a lack of specialist expertise' associated with their singular use in the NT, as well as fundamental functionality limitations.[21] Continued reliance on these legacy systems means there is a substantial risk of product failure, which could have a substantial impact on clinical care and patient safety.[22]

2.12 Additionally, in-house maintenance of these systems has financial implications for the NT. Where multiple jurisdictions use a system, design and implementation costs of upgrades are shared between them. Having in-house responsibility for these systems means that any further upgrade work on these systems is the financial responsibility of the NT alone.[23]

2.13 The current network of ICT systems also lacks features that are expected within a modern healthcare system. For example, CareSys cannot operate on mobile devices.[24] Clinicians do not have individual logins to access patient data, instead sharing generic logins, which risks patient privacy.[25] There is a heavy reliance on paper-based records across CWS, PCIS, and CCIS.[26] The Departments also advised the Committee that very little information is capable of being shared between the existing systems. Because of this, the current systems are not capable of accurate data analytics and reporting. The Departments submitted to the Committee that:

> NT Health has been unable to accurately store, report and analyse important health metrics, such as patient outcomes, data on disease prevalence, and use of resources. Accurate datasets of this nature are important in a contemporary health service as they support transparency, accountability and improvement across the health service. Accurate data sets are also crucial to ensuring the

[18] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 5.
[19] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 5-6; Department of Health, Committee Transcript, 17 February 2026, p. 17.
[20] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 5.
[21] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 5-7.
[22] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 5-6.
[23] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 6.
[24] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 8.
[25] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 8.
[26] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 8.

> Northern Territory receives a fair allocation of Commonwealth health funding, as it is tied to service delivery.[27]

2.14 Continued reliance on the existing systems has negative operational impacts on the day-to-day work of clinicians and the experiences of patients in the healthcare system. Clinicians must access multiple systems to develop a complete picture of a patient's healthcare journey.[28] Further, clinicians must often enter duplicate information into different systems and request data from across different healthcare settings. At times information is lost between systems or tests duplicated. In cases of acute care, associated time delays in receiving accurate clinical information pose a risk to patient safety. More broadly, duplication of work to input and extract information from the system is a poor use of clinical time and inefficient use of resources.[29]

2.15 The Departments advised that a single integrated system would provide extensive benefits to the Northern Territory.[30] In particular, as the Northen Territory has a highly transient population, an integrated system enables significant improvements to patients' care journey between different healthcare settings.[31]

[27] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 8.
[28] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 7.
[29] Department of Corporate and Information Services, *Annual Report 2016-17,* p. 40.
[30] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 27-37.
[31] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 9-10.

3 Program Timeline

3.1 This chapter provides a timeline of key dates and decisions throughout the development and implementation of the program. As evidenced below, there have been extensive delays to the implementation of Acacia. Whilst initially planned to be complete in September 2021, the program is still in development at the time of this report. Whilst some significant milestones have been reached, legacy systems remain in use.

Business Case and Procurement

3.2 Acacia began to be developed in 2014, going through several iterations of business cases that were not approved and did not receive funding.[32] In 2015, the Northern Territory Government (NTG) allocated $10 million to NT Health to develop a business case to replace CareSys, CWS, CCIS and PCIS. This business case was either prepared *by* DCIS or *in conjunction* with DCIS.[33] The business case was completed by 17 January 2016 and submitted in March 2016.[34] It estimated that the total cost of the program would be $242 million.[35] A budget allocation of $185.9 million was provided for the program in Budget 2016-17.[36] The program was initially scheduled to run over the following 5 years, to the 2020-2021 financial year.[37]

3.3 Preparing for the procurement process, the CSSRP established a Procurement Governance Committee, which determined the requirements of the new system through engagement with clinical staff:

> Over 100 workshops were held with more than 500 end users – largely clinicians – to determine the requirements of the new system. That included identifying the precise features, processes and outcomes which the new system would need to deliver, and informed the requirements set out in the Request for Tender.[38]

3.4 In June 2016, DCIS and NT Health provided industry a briefing on key facets of the program, including 'the Northern Territory's unique health environment, the procurement process which would follow and the mandatory local content weighting.'[39] Then, in July 2016, the DCIS and NT Health released a Request for Tender for the delivery of the new system, which closed 12 August 2016. 14 tenders were received, of which 4 were shortlisted by the Procurement Governance

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[32] Department of Health, Committee Transcript, 17 February 2026, pp. 3-4.
[33] Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 1; Minister for Health, *Answer to Question Number 663: Core Clinical Systems Renewal Program (CCSRP),* August 2019, p. 1.
[34] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 1; Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 3.
[35] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.
[36] Northern Territory Government, *Budget 2016-17: Agency Budget Statements 2016-17 (Budget Paper No. 3)*, p. 88.
[37] Department of Health, *Annual Report 2015-16,* p. 28.
[38] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 17.
[39] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 17.

Committee.[40] Shortlisted tenderers participated in a second round of engagement between 30 September 2016 and 14 November 2016, where they were asked to demonstrate how their products would meet the needs of the NT:

> Shortlisted tenderers were provided with a comprehensive set of over 2,700 requirements, and provided detailed written submissions explaining how their solution met those requirements. Tenderers were required to provide presentations and system demonstrations, and were required to show how their solution would navigate a number of clinical scenarios. Those scenarios were developed with input from clinicians on the CLG.[41]

3.5 The Commercial Division of the Solicitor for the Northern Territory (SFNT) supported the tendering process:

> In 2016-17, the Commercial Division of SFNT worked with external legal advisers to assist in developing the tender process, draft the contract and conduct negotiations, for a highly complex two-phase tender to deliver the new core clinical system for the Department of Health.[42]
>
> The tender assessment process was separated across multiple panels, involving 64 participants, with SFNT participating on the legal and commercial risk sub-panel.

3.6 Summarising the procurement process in their 2016-17 Annual Report, DCIS reported that:

> The procurement process was underpinned by substantial engagement with clinicians across the NT to ensure that the new system meets clinical requirements. To inform the tender process more than 3000 system requirements were developed and documented by clinicians from all disciplines. This was achieved through over 100 workshops held in Darwin, Katherine, Nhulunbuy, Alice Springs and Tennant Creek, where more than 600 clinicians provided input to the process.
>
> Assessments of tenders was undertaken by 64 participants from clinical, information technology and heath information systems backgrounds. No stone was left unturned to ensure that the right stakeholders from all parts of the health sector were involved in the process.
>
> The tender assessment process included system demonstrations and a proof of concept based on four complex clinical scenarios that capture unique patient journeys typical to the NT.[43]

3.7 Following this second round of engagement, InterSystems was selected as the preferred product vendor, then awarded the contract in April 2017.[44] The demonstrated and purchased version of TrakCare was the Traditional Clinical User Interface (TCUI).[45] Explaining this decision, the Departments advised the Committee that:

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[40] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 17-18.
[41] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 18.
[42] Department of the Attorney-General, *Annual Report 2016-17*, p. 56.
[43] Department of Corporate and Information Services, *Annual Report 2016-17,* 2017, p. 40.
[44] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 18-19.
[45] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 5-6.

(a) InterSystems' proposed solution was the only true enterprise-wide solution, whereas other tenderers were strong in some settings (e.g. acute hospitals) but poor in others (e.g. remote and urban primary care clinics).

(b) While other tenderers performed well against some specific clinical requirements, they performed poorly against others and did not demonstrate the capability to adapt their systems to better meet those needs, while InterSystems' proposed solution demonstrated comprehensive configurability.

(c) InterSystems was the only tenderer which provided a complete solution using one system, whereas other tenderers relied upon a combination of their own and third party products. For example, one tenderer did not propose to replace the legacy CareSys at all, meaning a new system would need to be separately procured, developed and integrated by NT Health.[46]

3.8 Chris Hosking PSM, former CEO of DCDD and CEO of NT Health at the time of the public briefing, further explained that:

> InterSystems… were really the only one that could provide a solution that could work right across the span of public healthcare in the Territory in one code base. A number of the others had very good technology solutions, but needed to give us several different solutions that you would then need to bolt together to address hospital care and primary care and urban primary care.
>
> The InterSystems one was within our affordability envelope, very importantly. Some were not; some were well beyond that.[47]

3.9 Following the completion of the procurement process, the program was fully funded for $259 million in Budget 2017-18, in May 2017.[48]

Planning and Development of the Program Schedule[49]

3.10 In 2017-18, an Implementation Planning Study (IPS) was undertaken in conjunction with InterSystems.[50] This was the first key phase of the CCSRP:

> The Implementation Planning Study (IPS) was the initial phase within the Core Clinical System (CCS) implementation which focused on bringing clinical, administrative, technical, and vendor stakeholders together to plan the design and implementation of the new core clinical system.
>
> The IPS phase consisted of three focus areas, which were progressed concurrently:
>
> 1. Functional – clinical and administrative processes and functions of the new system;
>
> 2. Non-functional – technical aspects of the systems such as data migration, integration and technical architecture and infrastructure;
>
> 3. Program Management - planning for program implementation over the next five years.

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[46] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 19.
[47] Department of Health, Committee Transcript, 17 February 2026, p. 4.
[48] Northern Territory Government, *Budget 2017-18: Speech and Appropriation Bill 2017-18 (Budget Paper No. 1)*, p. 10.
[49] **Note:** the Committee requested from the Departments the initial program schedule and each revision to the schedule. Internal documents provided to the Committee largely reflect proposals for variations to schedule, which on the basis of the Committee's request for each revised schedule, the Committee takes as having been agreed to. This applies to the majority of internal documents outlining schedule revisions.
[50] Department of Corporate and Information Services, *Annual Report 2017-18,* p. 38.

> Outputs from the IPS included (but not limited to) solution design documents; requirements traceability matrix; "parking lot items" for follow up during the Solution Build stage; high level solution design, proposed approach for design, architecture and implementation; along with project planning documentation and further contract specification. [51]

3.11 A key output of the IPS was the *CCSRP Program Master Schedule*, which was confirmed in April 2018.[52] Deployment of Acacia was planned in two stages. Firstly, the majority of Acacia would be sequentially deployed in all clinical locations in a region, called 'regional big bangs'.[53] This was to be followed by a secondary deployment of a community portal feature across the whole NT. The program was scheduled to have the first phase prototype complete by February 2019 for a technical go-live in August 2019.[54] System testing and User Acceptance Testing (UAT) were to occur in the subsequent months, before deployment of Acacia at:

- Katherine region in October 2019
- Darwin region in May 2020
- Alice Springs region in September 2020
- Tennant Creek region in January 2021
- Nhulunbuy region in April 2021.[55]

3.12 Following deployment in Nhulunbuy, the personal community portal was scheduled to be deployed NT-wide in June 2021. Project closure was scheduled for September 2021.[56]

3.13 In the same 2017-18 financial year DCIS completed their documentation of all clinical processes throughout the Northern Territory.[57] Further, an additional business case was undertaken to replace eMMa, completed in June 2018.[58] This was then integrated into the CCSRP.[59] Additionally, the redeveloped Enterprise Data Warehouse was scheduled to go-live in alignment with Acacia.[60] Several additional foundational projects were also folded into the CCSRP, including the:

- Information Security and Access Framework[61]
- Enterprise Master Person Index (EMPI)[62]

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[51] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 10.
[52] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 10; Deloitte, *Northern Territory Government – Assessment 2: Program Health Check*, May 2018, p. 15.
[53] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy,* December 2019, p. 8.
[54] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[55] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[56] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[57] Department of Corporate and Information Services, *Annual Report 2017-18,* p. 38.
[58] Minister for Corporate and Information Services, *Answer to Question Number 209*: *Agency Administration*, May 2018, https://parliament.nt.gov.au/business/written-questions/wq/13th-assembly/answers/Aqst-209-Higgins-Agency-Administration.pdf, p. 13; Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 13.
[59] Department of Corporate and Information Services, *Annual Report 2017-18,* p. 39.
[60] Department of Health, *Annual Report 2017-18,* p. 38.
[61] Department of Health, *Annual Report 2017-18,* p. 49.
[62] Department of Health, *Annual Report 2017-18,* p. 49.

- Transforming Information Systems and Services.[63]

3.14 Throughout 2018 the CCSRP undertook solution design, configuration, and build activities. This required extensive clinical engagement:

> In order to configure the TrakCare application so that it is fit-for-purpose for NT Health, Design and Configuration workshops involving more than 350 clinical, administrative and technical stakeholders from TEHS, CAHS and DoH are being conducted as part of the Solution Build stage.[64]

3.15 However, by late 2018 the CCSRP had determined that the program was off-track from scheduled delivery timeframes. Revisions to the schedule were agreed by governing committees, including:

- a 6-month delay to the completion of the prototype build, to August 2019
- a 10-month delay to the technical go-live, to June 2020
- a 9-month delay to deployment in the Katherine region, to July 2020
- a 9-month delay to deployment in the Darwin region, to February 2021
- a 9-month delay to deployment in the Alice Springs region, to June 2021
- an 8-month delay to deployment in the Tennant Creek region, to September 2021
- a 5-month delay to deployment in the Nhulunbuy region, to September 2021
- a 3-month delay to deployment of the personal community portal NT-wide, to September 2021
- a 3-month delay to project closure, to December 2021.[65]

3.16 Further engagement activities occurred throughout the 2018-19 financial year. DCIS reported on these activities in their annual report:

> Performance Achievements in 2018-19…
>
> Engaged more than 1500 NT Health clinicians and health professionals through the facilitation of over 600 system design workshops, to collaboratively document the detailed solution design requirements.
>
> Captured 4800 detailed design requirements to configure the new core clinical system…
>
> Prepared approximately 9000 manual and 4000 automated test cases across the core system and foundation projects.
>
> Executed over 3500 test cases for the legacy data migration and integration projects.[66]

[63] Department of Health, *Annual Report 2017-18,* p. 38-39.
[64] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 10.
[65] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[66] Department of Corporate and Information Services, *Annual Report 2018-19,* p. 39.

Revision of the Implementation Plan

3.17 In September 2019 it was agreed that an additional phase be incorporated into the program to deploy an electronic read-only version of patient records prior to the full deployment of Acacia.[67] Access to this Electronic Patient Record (EPR) was to be available across the whole NT upon deployment.[68]

3.18 In October 2019, the Minister for Corporate and Information Services confirmed that the 'new CCSRP system is expected to be rolled out across the Territory by late 2021.'[69] However, by December 2019 internal documents provided to the Committee outlined that the approved schedule had been further revised to push back deployment dates by 2 months from the schedule outlined in paragraph 3.15. Additionally, this document outlined that the current schedule for delivery based on actual progress was further off-track from this revised approved schedule, outlined in Table 2:

Table 2: Program Roadmap, December 2019[70]

Deployment	Approved schedule	Current schedule	Months behind schedule
Read-only electronic patient record deployment	-	June 2020	-
Technical go-live	August 2020	May 2021	+9
Katherine deployment	September 2020	June 2021	+9
Darwin deployment	April 2021	January 2022	+9
Alice Springs deployment	August 2021	May 2022	+9
Tennant Creek deployment	November 2021	August 2022	+9
Nhulunbuy deployment	November 2021	August 2022	+9

[67] Department of Corporate and Information Services, *CCSRP Program Steering Committee: Business Paper - Meeting 2020-12 – Acacia Deployment and Adoption Strategy and Plan*, December 2019, p. 1.
[68] Core Clinical Systems Renewal Program (CCSRP), *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 8.
[69] Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 4.
[70] Core Clinical Systems Renewal Program (CCSRP), *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

Deployment	Approved schedule	Current schedule	Months behind schedule
Personal community portal deployment	November 2021	August 2022	+9

3.19 The *Deployment and Adoption Strategy and Plan* was adopted in December 2019, which significantly revised the Acacia implementation plan. Instead of delivering Acacia through a series of 'regional big bangs', in November and December 2019 the Clinical Leadership Group (CLG), Program Implementation Committee (PIC) and Program Steering Committee (PSC) each agreed to shift to a 'phased implementation' approach. Under this plan, successive iterations of Acacia functionality were to be deployed in each region, replacing one system at a time. At this point, the program was separated into six FGs:[71]

- FG0, the EPR, was scheduled to be deployed between June and November 2020.[72]
- FG1, the new patient administration system which would enable the retirement of CareSys and CWS, was scheduled to be deployed at the following locations in the following months:
  - Katherine District Hospital (KDH) in November 2020
  - Tennant Creek Hospital (TCH) in December 2020
  - Gove District Hospital (GDH) in December 2020
  - Alice Springs Hospital (ASH) in February 2021
  - Royal Darwin and Palmerston Hospitals (RDPH) in March 2021.[73]
- FG2 and FG3 were to be deployed concurrently. FG2 was to replace eMMa and FG3 was to reform clinical documentation processes. These were to be deployed in the following locations in the following months:
  - RDPH in September 2021
  - KDH in October 2021
  - ASH in March 2022
  - TCH in April 2022
  - GDH in April 2022.[74]

[71] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 20-21.
[72] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.
[73] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.
[74] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.

- FG4, the new primary care system which would replace PCIS and CCIS, was scheduled to be deployed across the NT between September 2021 and June 2022.[75]
- Finally, FG5, the personal community portal was scheduled to be deployed in May 2022, NT-wide.[76]

3.20 In 2019-2020 it was agreed to adopt the Mobile Enabled User Interface (MEUI) version of TrakCare, instead of the TCUI version.[77] The Departments advised that 'the user interface and experience was far superior' in the MEUI version.[78]

Deployment of FG0

3.21 In August 2020, FG0 was deployed amongst 30 clinicians in a 'soft launch'.[79] After UAT this was expanded to 200 users. Then, in September deployment was further extended and 'progressively implemented across the Territory.'[80] Deployment was 'completed in 2020-2021.'[81]

Deployment of FG1

3.22 As noted, under the phased implementation approach, FG1 was first scheduled to be deployed at KDH in November 2020.[82] However, following the COVID-19 pandemic, the deployment schedule was revised. Deployment was pushed back to the following schedule:

- FG1:
  - to July 2021 in KDH
  - to September 2021 in TCH
  - to September 2021 in GDH
  - to November 2021 in ASH
  - to February 2022 in RDPH.
- FG2 and FG3:
  - to July 2022 in RDPH
  - to September 2022 in KDH
  - to November 2022 in ASH

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[75] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.
[76] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan,* December 2019, p. 20.
[77] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 5-6.
[78] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 5-6.
[79] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 22.
[80] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 22.
[81] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[82] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.

    - to November 2022-January 2023 in TCH
    - to November 2022-January 2023 in GDH.
- FG4 to January 2023, across the NT
- FG5 to December 2022, across the NT.[83]

3.23 Additionally, this schedule appeared to rescope FG1 to replace CareSys only, rather than both CareSys and CWS. The replacement of CWS was instead noted as a feature of FG3, alongside clinical documentation.[84]

Deployment at Katherine District Hospital

3.24 Further delays to FG1 implementation in KDH occurred following localised outbreaks of COVID-19 and vendor network outages. FG1 deployment in KDH was rescheduled to October 2021,[85] then November 2021,[86] and finally July 2022.[87] This had consequential effects on subsequent FG1 deployments. The sequence of deployment was altered to bring FG1 deployment at RDPH ahead of GDH, and all deployments were pushed back, to November 2022 (RDPH), February 2023 (GDH) and May 2023 (ASH and TCH).[88]

3.25 User Acceptance Testing for FG1 was undertaken across the NT throughout October and November 2021:

> between 4 October 2021 and 22 October 2021, User Acceptance Testing for Acacia 1.0 took place across Katherine, Gove, Tennant Creek, Alice Springs, Royal Darwin and Palmerston Hospitals. 268 clinicians participated. 88% of those sessions passed testing, with the failures attributable to both new and existing defects, and resulted in requests to change the system workflow - that is, the layout and processes which users engage with to navigate the system.[89]

3.26 Additionally, a range of preparatory activities were undertaken in advance of the deployment of FG1 at KDH:

> A number of ICT infrastructure upgrades were required to be made to the Katherine Hospital campus to support the deployment of Acacia 1.0, including to the campus' Wi-Fi coverage, speed and throughput… Those upgrades were audited by Program staff in early 2021 and completed in June-July 2021.
>
> …a specific Katherine Implementation Working Group **(KIWG)** was established in March 2021 to provide expert local oversight regarding the readiness of the hospital and clinicians for the deployment. Two rooms on the Katherine Hospital

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[83] *Core Clinical Systems Renewal Program*, *Program Schedule Revision - Adjustment due to impact of COVID-19,* November 2020, pp. 9-10.
[84] Department of Corporate and Digital Development, *Program Schedule Revision - Adjustment due to impact of COVID-19, Core Clinical Systems Renewal Program (CCSRP),* November 2020, p. 12.
[85] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 21-09 – Revised CCSRP Schedule – InterSystems Network Outage*, September 2021, p. 2.
[86] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 21-09 – Revised CCSRP Schedule – InterSystems Network Outage*, September 2021, p. 2.
[87] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[88] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-04 – Core Clinical Systems Renewal Program, Revised CCSRP Functional Group 1 Schedule,* April 2022, pp. 2-3.
[89] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23; Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-28: Functional Group 1 (FG1) ED Remediation Project – Revised Schedule* [Sic], August 2024, p. 1.

> campus, and a conference room at a nearby facility, were made available for staff training. Nominated "super users", which are end users who are selected to be comprehensively trained in the workings of the system so that they can assist other users and answer questions, were inducted…
>
> In addition, a *Play and Learn* icon was installed in the Katherine Hospital software library, so that users could download and "play" with the system in a "sandbox" environment to get used to it prior to its implementation.[90]

3.27 Shortly before scheduled deployment, the Departments advised the Committee that further UAT took place in June and July 2022 in KDH:

> Twelve further User Acceptance Testing sessions were held between 23 June 2022 and 8 July 2022 covering palliative care; operating theatres; allied health; patient flow and bed management; outpatients; patient flow from ED to inpatient; walk-ins; and clinical coding.[91]

3.28 Additional training was also provided:

> In the weeks leading up to the Go Live in July 2022, further training was delivered by Program staff, DCDD, and nominated super users, with support provided by InterSystems. By Go Live, 92% of Acacia users had completed training.[92]

3.29 On 30 July 2022, FG1 was deployed in KDH.[93]

Deployment at Gove District Hospital

3.30 Following the deployment rescheduling in April 2022 (see paragraph 3.24), the order of FG1 deployment was again revised. By November 2022 the deployment of FG1 at GDH was returned to occur ahead of deployment at RDPH. Deployment in GDH was scheduled for later that month in November 2022, RDPH for June 2023, and ASH and TCH for October 2023.[94]

3.31 FG1 was rolled out in four renal units in the Top End in October and November 2022. FG1 was then deployed at GDH in November 2022.[95] Training and implementation support similar to that in KDH was provided.[96]

Deployment at Royal Darwin and Palmerston Hospitals

3.32 Between September 2021 and March 2023, FG2, FG3, FG4 and FG5 did not have deployment dates.[97] A document provided to the CCSRP governing committees in March 2023 outlined further revisions to the program schedule. Although the deployment date for FG1 at RDPH remained on-track for July 2023, deployment of

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[90] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[91] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[92] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[93] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[94] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 22-11: Revised Functional Group 1 Schedule*, November 2022, pp. 1-2.
[95] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 24.
[96] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 24.
[97] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 21-09 – Revised CCSRP Schedule – InterSystems Network Outage*, September 2021, p. 2; Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, p. 1.

FG1 in ASH and TCH was pushed back to November 2023.[98] This document also outlined revised timeframes for FG2 and FG3. Previously planned to be deployed concurrently, they were now planned to be deployed iteratively at each site:

- FG2 deployment:
  - in Gove region in March 2024
  - in Big Rivers region in May 2024
  - in the Top End region in September 2024
  - in Central Australia/Barkly region in November 2024.
- FG3 deployment:
  - in Gove region in April 2024
  - in Big Rivers region in July 2024
  - in the Top End region in October 2024
  - in Central Australia/Barkly region in February 2025.[99]

3.33 Further, this document detailed amendments to the content of FGs. FG2 now implemented clinical documentation and process support, whereas FG3 implemented medication management. It also further outlined the reduction in the scope of FG1 to exclude the replacement of CWS—which had previously been a feature of FG1 in the 2019 *Acacia Deployment and Adoption Strategy*—and the subsequent expansion in the scope of FG2 to absorb this element of the program.[100]

3.34 Deployment of FG1 to RDPH did not occur in July 2023. By July 2023, internal documents provided to the Committee indicate that rescheduling had occurred for FG1 to go-live in the outpatient units in September 2023 and the inpatient units in October 2023.[101] By August 2023, internal documents provided to the Committee indicate that further rescheduling had occurred for FG1 to go-live in the outpatient units in October 2023 and the inpatient units in November 2023.[102]

3.35 Significant preparatory work was undertaken in advance of deployment at RDPH, including improvements to Acacia following the KDH deployment.[103] The Departments outlined some of the preparation:

> a large body of work had been completed by the Program team, alongside clinical leaders and InterSystems staff to prepare for Go Live. In particular:

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[98] Department of Corporate and Digital Development, CCSRP Roadmap: Re-baselined Schedule, March 2023, p. 1.
[99] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, pp. 1-2.
[100] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, pp. 4-5; Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, pp. 18-20.
[101] Core Clinical Systems Renewal Program, *Acacia Digital Health Transformation: Proposal to Menzies School of Health,* July 2023, p. 6.
[102] Department of Corporate and Digital Development, *Untitled,* August 2023, p. 1.
[103] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 24-25.

(a) Face-to-face and online training sessions were made available to all users for the new Acacia system. At the time of Go Live, training uptake was above target at 81%.

(b) User Acceptance Testing scenarios were facilitated with ED clinicians to simulate the ED to Inpatient patient journey, and with theatre scheduling staff to simulate the day-to-day activities of theatre scheduling.

(c) Eight weeks of face-to-face training was specifically made available to ED staff.

(d) 39 super users were trained[104]

3.36 Ultimately, FG1 was deployed in the outpatient units of RDPH on 4 November 2023, and shortly afterwards in the inpatient units on 11 November 2023.[105]

Rollback at the Royal Darwin and Palmerston Hospital Emergency Departments

3.37 However, on 20 March 2024 the use of Acacia was suspended in the RDPH Emergency Departments (EDs), which reverted to CareSys. This followed significant clinical concerns regarding the negative impact Acacia was having on clinical work and the consequential risks to patient safety.[106]

Remediation at the Royal Darwin and Palmerston Hospital Emergency Departments

3.38 The requirements for remediation at RDPH EDs were approved in April 2024 and scheduled to be deployed in February 2025.[107] By August 2024 deployment of the remediated Acacia solution was pushed back to April 2025.[108] Deployment did not occur on this date, and in May 2025 the FG1 remediation deployment date was under review with no date confirmed.[109]

3.39 By September 2025 the deployment date of the remediation project in RDPH was November 2025.[110] In preparation for this, simulation testing and training were undertaken, a clinical safety case and pre-implementation assurance review conducted, and a post-go-live support centre stood up.[111]

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[104] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.
[105] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.
[106] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 40-41.
[107] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-21: Functional Group 1 (FG1) ED Remediation Project– Shedule* [sic], August 2024, p. 2.
[108] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-28: Functional Group 1 (FG1) ED Remediation Project– Revised Shedule* [sic], August 2024, p. 1.
[109] Core Clinical Systems Renewal Program, *CCSRP Governance Committees - Briefing Paper: Central Australia and Barkly Implementation Schedule*, May 2025, p. 1.
[110] Department of Corporate and Digital Development, *CCSRP Steering Committee Decision Paper – Meeting 25-09 Out of Session Revised Program Roadmap*, September 2025, p. 3.
[111] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 4.

3.40 The FG1 remediation project was successfully deployed in the RDPH on 13 November 2025.[112] The Departments advised this occurred with 'No significant issues… reported.'[113] NT Health elaborated on this matter further:

> [Enhancements are] now complete and the reimplementation of Acacia within the ED was executed smoothly and without incident in November 2025. This means that in our entire Northern Territory public health system—including all of our emergency departments—our clinicians are using Acacia every single day to do their work, providing high-quality healthcare for Territorians. That completes what has been challenging and complex work to accommodate the specificity and nuance of emergency medicine as it is practised in the Top End within a modern, contemporary clinical technology solution.[114]

Deployment at Alice Springs and Tennant Creek

3.41 In December 2024, FG1 was scheduled to be deployed to ASH and TCH in June 2025.[115] However, in May 2025 it was agreed to postpone deployment of FG1 to ASH and TCH to August 2025.[116] The Departments advised the Committee that extensive preparation for deployment occurred:

> (a) Training commenced on 7 July 2025 at the Alice Springs Hospital, and on 4 August 2025 at the Tennant Creek Hospital. Over 1,200 training attendances were recorded across multiple sessions in Alice Springs, and over 150 in Tennant Creek. In addition, 45 Super Users, which are end users who are selected to be comprehensively trained in the workings of the system so that they can assist other users and answer questions, were inducted across nursing, administration, and medical streams. By Go Live, training uptake exceeded the Program target of 70%, with 72% of users completing Instructor-Led Training (IL T) in Central Australia, and 78% in Barkly.
>
> (b) Simulation and testing was undertaken in three key areas, on the basis of the lessons learned from earlier deployments as to where issues were most likely to arise, being the Emergency Department, Outpatients Department, and Operating Theatre (covering theatre scheduling and theatre clinicals). These sessions were completed after training in the Acacia environment had been undertaken, and were designed to allow for the identification of any practical errors, bugs or issues prior to the Go Live. Those simulation sessions were successful, with a number of changes identified and made to both the Acacia system, and to existing clinical business processes, following those sessions and prior to Go Live.
>
> (c) A comprehensive Clinical Safety Case was prepared which identified, assessed, and mitigated any clinical risks. The Clinical Risk Reviewers who developed the Clinical Safety Case included clinicians, and concluded that the risks could be appropriately managed with Go Live.
>
> (d) A 24-hour, 7-day support roster of approximately 30 Program technical staff was put in place following Go Live, to immediately respond to and assist staff with any issues. At-elbow support, in which staff were located on site, was provided at the Alice Springs Hospital from 7 am until 7 pm from Go Live until 24 October 2025, a period of eight weeks. In Tennant Creek, at-elbow support

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[112] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[113] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 2.
[114] Department of Health, Committee Transcript, 17 February 2026, p. 3.
[115] Core Clinical Systems Renewal Program, *CCSRP Governance Committees - Briefing Paper: Central Australia and Barkly Implementation Schedule*, May 2025, p. 1.
[116] Core Clinical Systems Renewal Program, *CCSRP Governance Committees - Briefing Paper: Central Australia and Barkly Implementation Schedule*, May 2025, p. 2.

> was provided until 26 September 2025. In addition, on-call support was available overnight and on weekends.[117]

3.42 FG1 was successfully deployed in ASH and TCH on 23 August 2025.[118] The Departments noted that the deployment occurred 'without significant incident'.[119]

Deployment of Additional Functional Groups

3.43 By February 2025, FG2 and FG3 no longer had scheduled deployment dates.[120] Nor did FG4 and FG5 in April 2025.[121] By September 2025, some elements of FG2 were scheduled to start being deployed in March-June of 2026.[122] Indeed, the Departments advised the Committee that some FG2 works had already been deployed in 2025:

> A core team of the Program's most highly skilled project professionals continue to work towards the deployment of Functional Group 2 - Clinical Documentation. Elements of Functional Group 2 will be delivered based on NT Health's clinical priority areas. This will support further transition to digital workflows, removing paper-based processes in key areas, and will allow the retirement of the Clinical Workstation (CWS) legacy system.
>
> Certain of the features of Functional Group 2 have been deployed into the Central Australian Renal Units (in February/March 2025) and the Top End Renal Units (in June/July 2025).[123]

3.44 As of April 2026, FG2 and FG5 activities are scheduled to be conducted through 2025-26 and 2026-27.[124] FG3 and FG4 remain suspended pending additional funding.[125]

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[117] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 2.
[118] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[119] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 2.
[120] Core Clinical Systems Renewal Program, *Program Steering Committee: CCSRP Acacia Timeline – Key Dates*, February 2025, p. 3.
[121] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 46.
[122] Department of Corporate and Digital Development, *CCSRP Steering Committee Decision Paper – Meeting 25-09 Out of Session Revised Program Roadmap*, September 2025, p. 3.
[123] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 5.
[124] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[125] Department of Corporate and Digital Development, *CCSRP Steering Committee Decision Paper – Meeting 25-09 Out of Session Revised Program Roadmap*, September 2025, p. 2.

4 Program Budget and Cost to Date

4.1 The Treasurer instructed the Committee to identify the difference between the initial project Budget and the cost of procuring, implementing and managing the Acacia system to date. This Chapter examines evidence provided to the Committee which responds to this element of the Inquiry Terms of Reference. As outlined in the following section, the Committee has identified a significant difference between the initial program budget and the cost of procuring, implementing, and managing the Acacia system to date.

Initial Program Budget

4.2 In Budget 2015-16, NT Health was allocated $10 million to conduct a business case to replace the core clinical systems within the public healthcare sector:

> $10 million to undertake detailed planning, analysis and market testing for the new core clinical system renewal program to create a comprehensive, contemporary package of clinical business systems, which is essential to the successful operation of all public health services in the Territory[126]

4.3 The 2016 business case estimated that the total cost of delivering a replacement to the existing legacy systems was $242 million.[127] The business case sought an investment of $173 million of new funding. Additionally, $50.9 million was proposed to be reprioritised from the NT Health's existing ICT budget, and a further $18 million was proposed to be funded jointly by NT Health and Top End and Central Australia Health Services.[128] $4.0 million per year of additional funding following completion of the program was sought on an ongoing basis.[129] The business case was submitted for consideration in March 2016.[130] The program was 'partially funded' in May 2016, with $185.9 million in appropriations in Budget 2016-17.[131] This left $56.1 million of funding outstanding.[132]

4.4 Later that year, following initial tendering, the total cost of the program was revised from $242 million to $259 million.[133] After a change in government, a second submission for funding went to Cabinet in 2017.[134] In Budget 2017-18 the program was 'fully funded', adding an 'additional $73 million' to the program budget.[135] This

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[126] Northern Territory Government, *Budget 2015-16: Budget Overview*, p. 16.
[127] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.
[128] Department of Health, *Business Case: Core Clinical Systems Renewal Program,* 17 January 2016, pp. 8-9.
[129] Department of Health, *Business Case: Core Clinical Systems Renewal Program,* 17 January 2016, p. 25.
[130] Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 3.
[131] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.
[132] Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 3.
[133] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.
[134] Minister for Corporate and Information Services, *Answer to Question Number 717: Core Clinical Systems Renewal Program (CCSRP),* October 2019, p. 3.
[135] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16; Northern Territory Government, *Budget 2017-18: Speech and Appropriation Bill 2017-18 (Budget Paper No. 1)*, p. 10.

allocation covered both the outstanding funding required and the additional estimates of cost, bringing the total funding of the program to $259 million.

Cost of Procuring, Implementing and Managing Acacia to Date

4.5 To date the costs of the program have far exceeded both the initial program budget of $242 million and the revised program budget of $259 million. As of 31 December 2025, $318.5 million had been spent procuring, implementing and managing the Acacia system.[136] In information provided to the Committee on 12 March 2026, this figure had increased to $319.6 million.[137]

4.6 NT Health provided the Committee a breakdown of costs attributable to different elements of the program. By far the greatest share of costs were associated with FG1, at $163.4 million over the life of the program. Following this, foundational system work, program support functions, and FG0 composed another $101.3 million between them, costing $31.3 million, $36.5 million and $33.5 million respectively. A full breakdown of costs as provided by NT Health is reproduced in Table 3.

Table 3: Breakdown of Budget per Functional Group[138]

Acacia[139]	**$000**
Core clinical System – foundational system work	31,309
End user device preparation and enablement	1,765
Enterprise Master Person Index – unique patient directory	5,613
Health Interoperability Platform – integration with other systems	24,897
Summary of Care View	91
Procurement / Contract Management/Legal	3,940
Program Support Functions	36,492
Functional Group 0 – Legacy Data Conversion (**complete**)	33,448
Functional Group 1 – Patient Admin + Core Clinicals (**complete**)	163,394
Functional Group 2 – Orders, Results and Clinical Docs (in progress)	5,526
Functional Group 3 – Electronic Medications Management (on hold)	11,111

[136] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 4.
[137] Department of Health, *Answers to Questions Taken on Notice*, 12 March 2026, p. 2.
[138] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2.
[139] Department of Health, *Answers to Questions Taken on Notice*, 12 March 2026, p. 2.

Acacia[139]	**$000**
Functional Group 4 – Community and Primary Care (on hold)	1,985
Program Total	319,571

Legacy Systems

4.7 The Committee has identified additional costs associated with Acacia that are not included in the above figures. These are costs associated with the legacy systems that Acacia was designed to replace. Firstly, the Departments advised that the perpetual right to CareSys was purchased for $6 million in 2018.[140] The Departments later clarified that this purchase included a suite of Jade Platform Software, including CareSys, CWS, CCIS and PCIS.[141] The purchase of the perpetual right was made by NT Health, rather than from within the CCSRP budget.[142] This means this cost was not captured within the above $319.6 million spend to date for the CCSRP.

4.8 Because the NTG owns the right to use this suite of software in perpetuity there are no ongoing costs associated with using or licensing the legacy systems. This was explained by Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health:

> As they are no longer supported by an enterprise software vendor, we are not paying software support and maintenance and those sorts of charges. Back in 2018 the Health department, under a previous iteration, purchased the intellectual property rights to what is called the source code. We, essentially, own those. We are the owner/operator of the old systems now—which is an interesting place to be—but it was a good decision in 2018 because today, in 2026, we continue to rely on those systems for non-hospital care.[143]

4.9 However, when these systems need maintenance, external support is necessary:

> We use a vendor out of New Zealand called Jade Care to make—fix—changes and repairs to those systems. We are deliberately not investing in developing them further unnecessarily, because the idea is to replace them. It would not be sensible to be spending public money on something you will replace. However, sometimes we need to do things to make sure they keep operating properly, or to meet a rule change or a compliance-related change.[144]

4.10 Since 2019, DCDD have been responsible for meeting the ongoing costs of maintaining these systems. This cost also sits outside the Acacia program budget.[145]

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[140] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 6.
[141] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[142] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[143] Department of Health, Committee Transcript, 17 February 2026, p. 7.
[144] Department of Health, Committee Transcript, 17 February 2026, p. 7.
[145] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.

Instead, the Departments advised that they sit with the Agency Business Systems—Human and Shared Services (ABS—HSS) budget:

> Following Machinery of Government changes in 2019 when agency business systems were centralised in DCDD, ongoing support costs are now met by the DCDD ABS–HSS budget.[146]

4.11 Between 2019-20 and December 2025, supporting and maintaining the legacy systems that Acacia was designed to replace has cost an additional $28.4 million. NT Health advised the Committee that contributions to this cost were $4.8 million on personnel, $17.9 million on support and maintenance, and $5.6 million on hosting.[147]

4.12 Although these costs would have been incurred if the CCSRP had not been funded, the Committee notes the initial timeline for delivery of Acacia and subsequent retiring of the legacy systems would have seen the program complete by the end of the 2020-21 financial year.[148] Accordingly, the majority of these costs would not have been incurred if the program had been delivered on time. As such, the costs of legacy systems are largely due to delays to the program, despite being funded from outside the Acacia program budget. In total, costs associated with the legacy systems include at least $34.4 million. Additional costs are likely to have been incurred by NT Health in maintaining the legacy systems prior to the 2019 Machinery of Government changes.

Stakeholders In-Kind

4.13 The Committee asked the Departments whether NT Health had been charged by DCDD for any services or otherwise been required to absorb any other costs as a result of Acacia. The Departments advised that NT Health had absorbed $18 million of costs through contributing 'stakeholders in-kind towards workshop participation and training.'[149] The Committee asked the Departments to specify whether these costs were included in the total spend to date. However, the Departments did not clarify this matter.[150] Accordingly, it is unclear whether this contribution is included in the program budget and spend to date.

4.14 In summary, the initial 2016 program budget was $242 million, increased to $259 million in the same year. As of 12 March 2026, the total spend of the program has been $319.6 million. In addition, the Departments have spent a minimum of an additional $34.4 million securing the perpetual rights to the legacy systems and maintaining them. This sits outside the CCSRP budget. The majority of the maintenance costs would not have been incurred had the program been completed

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[146] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[147] Department of Health, *Answers to Questions Taken on Notice*, 12 March 2026, p. 2.
[148] Department of Health, *Annual Report 2015-16,* p. 28.
[149] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[150] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.

by its original delivery date. It is unclear whether the $18 million worth of stakeholder in-kind costs absorbed by NT Health are included in the total spend to date.

5 Cost Revisions and Rationale

5.1 The Treasurer instructed the Committee to identify a timeline of each cost revision and an explanation for each revision. This Chapter examines evidence provided to the Committee which responds to this element of the Inquiry Terms of Reference. As outlined in the following sections, the $10 million business case identified that the total cost of the program would be $242 million.[151] The Departments have advised that the total program budget is now $335 million.[152] Four separate cost revisions to the program have occurred, each discussed below:

- $17 million in 2016
- $63.4 million in 2022
- -$6 million in 2023
- $12 million in 2025.

5.2 As discussed, the program was partially funded in May 2016 (paragraph 3.2). When it was fully funded in 2017 an additional $73 million was allocated to the program (paragraph 3.9). The Committee does not discuss this matter further in this Chapter, as it notes that this was a revision to the funding of the program rather than an estimate of the cost of the program.

2016: $17 Million Identified Throughout the Tender Process

5.3 As discussed in Chapter 3, following the initial allocation of funding in 2016, the program began the tender process to select a software vendor. Of the 14 tender submissions, the CCSRP short-listed 4 vendors who progressed to a second tender stage. This second stage required vendors to demonstrate how their products would meet the requirements of the Northern Territory.[153]

5.4 The total budget was revised upwards by $17 million after the completion of this tender process. The Departments explained that information gained throughout this process had indicated that the initial budget was insufficient:

> During the initial tendering process in mid-2016 for the core product which would underpin Acacia, information provided by tenderers made apparent that the initial budget planned in the business case would be insufficient to cover the full cost of the Program. Based on detailed information provided by the tenderers, DCIS forecasted that an increase in the Program budget of $17 million would be necessary to fully fund the Program.[154]

5.5 The Committee asked the Departments for further detail regarding where these additional costs had arisen, compared to the initial business case. The Departments did not specify which elements of the program had been under-costed, but advised

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[151] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.
[152] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 2.
[153] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 17-18.
[154] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16.

that the revised costing drew on pricing from InterSystems. This brought the total cost to $259 million:

> The original figure of $242 million in the business case was an estimate, developed based on market research. A revised estimate of $259 million was developed following the tender process, which provided market pricing from vendors. The revised estimated costs factored in actual pricing from [InterSystems] as the successful vendor.[155]

2022: $63.4 Million Reprioritisation

5.6 Throughout 2020, despite the COVID-19 pandemic and prior delays, the Departments were confident that they would be able to deliver the program on budget. As Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee:

> In 2020 I was still solidly optimistic that we would get done within the timeframe and within the funding envelope. It was early in the pandemic, things were a little blurry and uncertain.
>
> Some strains probably emerged around about that time between DCIS and the Health department because, to be fair, the poor old Health department was focused on battling the pandemic. [DCIS] were focused on, 'We have got this. We can keep going. Let us not give up; let us keep doing our level best to deliver here.' I can remember having some very robust discussions with Health executives and clinicians at the time around, 'Look, there is a global pandemic going on, do not get in our way', and I am going, 'Yes, I know, but we can do both. Let us keep going, keep the ball in play.' Whether I would feel differently today given my change in responsibilities I am not sure.
>
> I will say that in 2020 I was still optimistic and confident…[156]

5.7 However, by 2022, the Departments advised the Committee that the CCSRP had determined they would need additional funding:

> However, by early 2022 it became apparent that the remaining budget, while sufficient to sustain the Program for another couple of years, would not be sufficient to complete the Program. That was reported as part of the Program's ongoing quarterly financial reporting to Government… Subsequent detailed financial modelling anticipated a shortfall of $63.4 million to the Program.[157]

5.8 In August 2022, the PSC agreed to find additional funding for the program from within existing budgets, rather than seeking new funding allocations from Cabinet:

> As part of the Program leadership's efforts to manage the growth in the Program budget and to minimise the effect of any budget increases, in August 2022 the PSC endorsed the Chief Executive Officers of DCDD and NT Health exploring options to meet the increased costs from within their existing budget appropriations, without needing to seek additional appropriation from Government as part of the annual budget process. [158]

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[155] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[156] Department of Health, Committee Transcript, 17 February 2026, pp. 22-23.
[157] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 39.
[158] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 39.

5.9 In October 2022 the program budget was increased by $63.4 million, bringing the total cost to $323 million.[159] The Departments did not seek additional appropriations through the budget process. Instead, this funding was allocated from pre-existing budget:

> By October 2022, the Chief Executive Officers of DCDD, NT Health and officials from the Department of Treasury and Finance had identified and agreed a remediation solution to be achieved from within DCDD's and NT Health's existing budgets. The $63.4 million shortfall was met by:
>
> (a) $23.2 million from internal reprioritisation of DCDD's budget appropriation;
>
> (b) $10 million resulting from the CARE project being delivered under budget;
>
> (c) $6.2 million from surplus cash balances held by DCDD; and
>
> (d) $24 million from internal reprioritisation of NT Health's budget appropriation.[160]

5.10 Chris Hosking PSM elaborated on DCDD's contribution outside of funds released from the CARE project underspend:

> The residual of that was made up of—the department holds a central budget for managing a leased property portfolio, which is considerable annual expenditure, and it is linked to indexation around property rates. Obviously those buildings have indexation rates in their leases. After the pandemic those lease rates had been flat for several years. We had a fortuitous saving in that particular budget over the forward estimates—not in one year, but over the four-year forward estimates—all of which was used to meet the DCIS contribution of that. In respect of the DCIS component it was a true saving and it was one that was able to be put to this as our component of it.[161]

5.11 The Committee asked NT Health where its contribution of reprioritised funding for Acacia had been reprioritised from. They advised that the savings came from bottom-line efficiencies:

> The $24 million reprioritisation for ACACIA was split over 2 financial years, $10 million in 2024-25 and $14 million in 2025-26. This was applied as a bottom-line efficiency across the Hospital and Support Services output.
>
> Managing the reduction at the output level preserved baseline program and service allocations and avoided material changes to individual program budgets.[162]

5.12 The Committee asked for further information regarding the reprioritisation from NT Health's existing budget, specifically highlighting the need for additional detail compared to information provided to the Committee previously. The Departments largely reiterated the same information:

> $10 million was from 2024-25 and $14 million from 2025-2026. It was taken from bottom-line efficiency across Hospital and Support Services output, not taken from one area. There was no direct clinical impact from the reprioritisation.[163]

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[159] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 39-40.
[160] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 39.
[161] Department of Health, Committee Transcript, 17 February 2026, p. 16.
[162] Department of Health, *Answers to Questions Taken on Notice*, 12 March 2026, p. 2.
[163] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.

5.13 The Committee asked the Departments what elements of the program the internal reprioritisation was allocated toward. The Departments advised that the reprioritisation was not specifically tracked and was broadly spent across many key facets of the program:

> The $63.4 million was allocated to the overall Program budget so was spent on FG1, RDPH ED Remediation, FG2 and aspects of FG3 and FG4. It was not tracked separately to the rest of the Program funds.[164]

5.14 The Committee observes that the Auditor-General for the Northern Territory has previously been advised by the relevant Department that reprioritised funding from DCDD and NT Health associated with Acacia in 2022 was to a value of $61 million.[165] It is unclear why the Committee and the Auditor-General have been advised of different figures.

5.15 The Departments told the Committee that these internal reprioritisations were needed to cover a funding shortfall driven by 3 key issues and associated delays.[166] These 3 matters are examined in the sections below.

Commissioning of Palmerston Hospital

5.16 As explained by the Departments, the first delay was caused by the commissioning and opening of Palmerston Hospital. Because clinical resources that the CCSRP had relied on were shifted to the Palmerston Hospital, the program was delayed by 9 months.[167] The Committee asked the Departments when they advised the responsible Minister of delays to the program associated with the commissioning of Palmerston Hospital. The Departments told the Committee that this issue was reported to government in 2018.[168]

5.17 The Committee notes that the construction of the Palmerston Hospital began in 2015. Asked about the foreseeability of resourcing conflicts when commissioning a new hospital, former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, advised that:

> They were known things that were happening at the time. To be really frank, what I think had probably been underestimated in the earlier planning was the absolute criticality and the importance of having wide clinical involvement and engagement in that planning and preparation. That particular stage, around about that time, was when the functional requirements for the system were being documented, refined and tested, and having a clinical lens on that and having a broad range of different clinicians actively engaged in that—I suspect to some degree the resource impact of that was somewhat underestimated because, similarly, the commissioning of a new hospital draws away your clinicians. I think when push came to shove the commissioning of Palmerston hospital was prioritised and the program had to wait and be patient to get access

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[164] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026*, 13 April 2026, p. 3.

[165] Auditor-General of the Northern Territory, *Report to the Legislative Assembly No 3: 2024-25: Public Information Referrals: Public Information Act 2010,* 2025, p. 12.

[166] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 43.

[167] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 39.

[168] Department of Corporate and Digital Development and Department of Health*, Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.

> to those key clinical stakeholders. While we may have thought that was a manageable impost earlier in the process, that proved not to be the case.[169]

5.18 Indeed, the business case for the CCSRP proposed to implement Acacia into the Palmerston Hospital directly, to be deployed by March 2018.[170] This would have meant that the Palmerston Hospital never used the legacy systems. This was outlined in the business case for the CCSRP:

> The Acute Care Information Systems support team has assessed the CareSys and CWS systems for deployment into the new Palmerston Hospital. The advice received as a result of this assessment is that deploying CareSys and CWS into Palmerston will further exacerbate the existing system risks associated with system instability, continuing database growth (without archive options) and poor system performance, dramatically increasing the likelihood of catastrophic system failure impacting all NT hospitals. As a result, all options considered within this business case include the implementation of a new solution into Palmerston.[171]

5.19 Accordingly, these delays are partially explained by the fact that the business case on which the investment decisions were made saw the deployment of Acacia to Palmerston Hospital as an element of the commissioning of Palmerston Hospital, rather than a competing priority. The Committee acknowledges that timeframes in business cases often need refinement following approval and procurement.

5.20 Indeed, the decision not to deploy Acacia directly into the Palmerston Hospital was a result of the determination that the Acacia software was not ready for deployment. As Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine at Royal Darwin Hospital, explained to the Committee:

> I recall we thought we would just go with the new system at Palmerston hospital. Then that was—we were worried about whether the current old legacy system would handle Palmerston hospital. That decision took a while, proper discussion, to make sure that was probably the right thing to do, because Acacia was not ready to be implemented safely at the time.
>
> There were a lot of decisions applying the clinical safety lens. There was so much safety discussion that happened to make sure there was no safety compromise for a new hospital, new systems to make change.[172]

5.21 The Committee asked the Departments to quantify the cost of the 9-month delay to the program schedule. The Departments advised that they were unable to do so, because of additional factors also impacting the program at the same time:

> It is not possible to isolate the cost impact of NT Health staff being prioritised onto the Palmerston Regional Hospital project as there were two other delay factors at the same time (engaging contractors for CCSRP and system changes required for Primary and Remote Health Care).[173]

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[169] Department of Health, Committee Transcript, 17 February 2026, p. 15.
[170] Department of Health, *Business Case: Core Clinical Systems Renewal Program*, 17 January 2016, p. 93.
[171] Department of Health, *Business Case: Core Clinical Systems Renewal Program*, 17 January 2016, p. 7.
[172] Department of Health, Committee Transcript, 17 February 2026, p. 16.
[173] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.

5.22 The Committee observes that these additional delay factors were not raised in the Departments' initial submission as a driver of the delays to the program.[174] Additionally, the Committee notes that the Departments were able to quantify the timeframe impact of the commissioning of the Palmerston Hospital to the program schedule, despite other delay factors occurring at the same time. Internal documents provide some alternative insight. The November 2018 *CCSRP Integrated Master Program Schedule* estimated that the financial impact of the delays to the program at that time was $18.9 million.[175] The *CCSRP Integrated Master Program Schedule* notes that this represented the majority of available contingency.[176] Advice provided by the Departments specifies that total contingency in the $259 million budget was 12%, or $30.96 million.[177]

Implementation Plan

5.23 Secondly, as discussed in Chapter 3, in December 2019 the decision was made to shift the implementation plan from a 'regional big bang' approach to a 'phased implementation' approach that sought to deliver Acacia by FGs. The Departments advised the Committee that revisions associated with this change delayed the program by 4 months.[178]

5.24 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, advised that this delay was initially absorbed within the existing budget. In fact, he explained that the delay was even seen to be balanced by potentially creating time savings later in the program:

> We at no stage attempted to vary the budget then, so we obviously absorbed some time delays, but we were hopeful that we could absorb them within our existing funding… At the time it would have been a considered a manageable variation within the overall budget and we would have hoped, and certainly I did at the time, that by moving away—because we were planning and preparing ourselves for that big bang, and it was clearly becoming very apparent that was not the sensible thing to do. By moving to a more manageable agile deployment strategy we would hope to actually get some more efficiency into the delivery model. Then whatever time we spent recutting the project we would make that up later.[179]

5.25 The Committee notes that the first iteration of the phased implementation schedule (see paragraph 3.19) outlined completion of the program by June 2022, while the big bang schedule outlined completion of the program by November 2021.[180] Time savings in the phased implementation approach were projected only when compared against the actual progress of the big bang approach, which—because

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[174] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 38.
[175] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 14.
[176] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 15.
[177] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.
[178] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 39.
[179] Department of Health, Committee Transcript, 17 February 2026, p. 15.
[180] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

of existing delays in the program—had seen the completion date pushed back to August 2022 (see paragraph 3.18).[181]

5.26 The shift from the big bang approach to phased implementation of FGs was predicated on several factors, including the greater risk of deploying the full clinical suite of upgrades at once in a region, ease of build and configuration, resource management, and minimisation of disruption.[182] Each of these were explained in the *Acacia Deployment and Adoption Strategy*. Firstly, the clinical risk became more apparent as design was progressed:

> During the Design phase of the program it became evident that the risks associated with attempting to deploy the program using a regional 'big bang' model was unlikely to be manageable and an alternative, safer approach was sought to inform the development of a revised model. Options involving the operational management of Acacia by the program team while deployment and adoption was occurring and, also attempting to link the community, urban and remote care deployments to the hospital deployments were also considered. These were agreed with key Subject Matter Experts (SMEs) to present a level of risk that was considered unacceptable to NT Health, therefore other options were needed.[183]

5.27 Further, the complexity of the build required restructuring of the program:

> The Design phase was structured around 20 functional work streams, which focused on clinical functionality, patient administration services, billing and system configuration. As the Design workshops progressed, additional workstreams were added, with some of the existing 20 functional workstreams split out so that specific areas of focus could be addressed (e.g. Child and Women's Health became two workstreams being 'Maternity & Midwifery' and 'Paediatrics').
>
> As CCSRP moved from the 'Design' phase into the 'Build and Configuration' phase, it became evident that the build and configuration (i.e. delivery) of functionality and the subsequent deployment and adoption of the functionality would need to be restructured to align with the functionality that was being replaced in legacy systems.[184]

5.28 Thirdly, phased implementation enabled better resource management:

> Modelling and analysis highlighted the benefits of a 'phased' deployment outweigh the benefits of regional 'big bang', not least because it offers less impact and a reduced risk profile to NT Health staff by enabling change to be delivered gradually. The phased approach, in line with replacing current functionality in legacy systems, significantly reduces clinical risk and allows for greater control and management of each deployment, specifically allowing for resourcing constraints and the impacts to operational staff to be managed.[185]

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[181] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

[182] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, pp. 8-9; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 20.

[183] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy,* December 2019, p. 16.

[184] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 17.

[185] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 9.

5.29 Finally, this model sought to minimise disruption and allow clinicians to learn how to use Acacia piece-by-piece:

> Each phase has a specific objective, and allows the departments to retire those obsolete legacy systems being replaced in a staggered approach. That approach minimises disruption and allows users to familiarise themselves with each new tranche of functionality, one at a time.[186]

5.30 Reflecting on the initial 'big bang' approach, both André Snoxall, former contractor to DCDD and NT Health, and former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, told the Committee that it was unrealistic.[187] For example, Chris Hosking said that:

> Hindsight is always very clear because we have the benefit of all the experience along the way, but going back to the very first business case which was modelled and built around that big bang implementation that was approved in the 2016 budget, I would say now, and I would say this with real certainty and very clearly, that big bang implementation approach was not remotely sensible. To try to go live with a system like this across 8,500 people—we are six hospitals, 46 remote clinics, 20 urban clinics—to do all that on one day would be, quite frankly, crazy. I mean even to roll out to six public hospitals we have had to do it sequentially and in a staggered way to be able to manage the impact on our people. It was a very necessary change and it has proven successful because that is exactly what we have implemented now.[188]

5.31 The Committee notes that, despite what Chris Hosking PSM advised, the initial deployment model did not seek to deploy Acacia at all healthcare locations on one day. Instead, it was planned to deploy Acacia through a series of regional big bang deployments (see paragraph 3.11).

COVID-19

5.32 Despite the pandemic, work on FG0 was at a stage where it was able to be deployed to the original phased implementation program schedule:

> the work required for Functional Group 0, the release of the Read-Only version of Acacia, was sufficiently progressed to enable this to continue[189]

5.33 Indeed, FG0 proved to be an invaluable tool for clinicians throughout the pandemic. Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine at Royal Darwin Hospital, told the Committee that FG0 was 'the most saving grace for us to survive through the pandemic.'[190] Further, the Departments told the Committee that:

> The EPR was a critical tool in NT Health's response to the COVID-19 pandemic, as it allowed clinicians to access patient data from remote locations, as well as supporting telehealth consultations and remote case conferences between acute and primary care providers, at a time when travel to remote locations was not possible. The EPR was also the primary tool used by NT Health for

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[186] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 20.
[187] André Snoxall, Submission No. 7, p. 6; Department of Health, Committee Transcript, 17 February 2026, p. 15.
[188] Department of Health, Committee Transcript, 17 February 2026, p. 15.
[189] Department of Corporate and Digital Development, *Program Steering Committee – PSC report – Meeting 2020-09: COVID-19 Impact to CCSRP Schedule*, September 2020, p. 1.
[190] Department of Health, Committee Transcript, 17 February 2026, pp. 5-6.

> assessing the vaccination status of patients and staff throughout the pandemic.[191]

5.34 However, the COVID-19 pandemic required deployment plans of later FGs to be paused on several occasions (see paragraphs 3.22 and 3.24). This was because the pandemic required clinical resources actings as SMEs to the CCSRP to be prioritised at the frontline of the healthcare system, rather than progressing development of Acacia. As an internal briefing note outlined:

> At the outset of the COVID-19 global pandemic in early 2020 all CCSRP clinical engagement activities were suspended as a necessary step to enable NT Health to prioritise its response effort to this public health emergency.
>
> This involved the cancellation and deferral of workshops and working groups and the suspension of regular Clinical Leadership Group (CLG) meetings as the key clinical governance lens over the program. Key clinical subject matter experts (SMEs) working within the program were also advised to be ready for recall to frontline duties if required.[192]

5.35 This meant that development of Acacia had to be suspended for significant periods of time. Whilst FG0 had been sufficiently progressed through the design, build and testing phases to continue with deployment, this was not the case for FG1. This resulted in recurring delays to the program schedule:

> During the course of the Health pandemic from early 2020 there have been a number of changes to the Program schedule to account for periods where the Program could not engage with NT Health stakeholders as well as the impact of a global InterSystems network outage in mid-2021.
>
> In late 2021 the Program Steering Committee agreed to revise the Katherine FG1 implementation schedule however would decide the remaining FG1 implementations and FG2, 3 and 4 after the Katherine implementation. The FG1 Katherine implementation in November 2021 did not proceed resulting in the whole CCSRP schedule no longer being achievable.[193]

5.36 Further, discrete outbreaks of COVID-19 within the community delayed deployment plans at KDH. For example, clinical resources supporting the CCSRP again withdrew to return to the frontline at the start of 2022:

> the Territory's borders opened in December 2021 and a widespread outbreak of COVID-19 followed.
>
> As a consequence, NT Health advised CCSRP that they could not support CCSRP activities for the first quarter of 2022. Subject Matter Experts (SMEs) seconded to CCSRP to support delivery of Acacia were recalled to frontline duties, meetings of the Clinical Leadership Group (CLG) were suspended and all clinical engagement placed 'on hold'.
>
> The implementation schedule for all elements of CCSRP was impacted by this and program reporting quickly trended to 'red' in all reporting channels.[194]

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[191] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 28.

[192] Department of Corporate and Digital Development, *Program Steering Committee – PSC report – Meeting 2020-09: COVID-19 Impact to CCSRP Schedule*, September 2020, p. 1.

[193] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 1.

[194] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 1.

5.37 By April 2022, clinicians began to return to the CCSRP:

> As the COVID threat has trended down this situation has gradually resolved itself. By April SMEs had returned to their roles within the CCSRP team, CLG meetings had recommenced and clinical engagement activities began to ramp up again.
>
> In April 2022, the Program Steering Committee (PSC) endorsed the revised FG1 schedule noting that the schedule and implementation approach for subsequent FGs was under review with key NT Health stakeholders. The implementation of FG1 will commence in July 2022 in Katherine.[195]

5.38 Throughout 2020 and 2021, delays associated with the pandemic were absorbed by contingency:

> During schedule reviews in 2020 and 2021 it was noted by governance committees that there would not be an impact on the Program funding as contingency was sufficient to deal with this. This situation resulted mainly from the difficulty experienced in sourcing expert technical resources which meant that the program never achieved full resource capacity and total spend was lower than predicted.[196]

5.39 However, by December 2021 funding issues had emerged:

> The series of deferrals and impacts to the delivery timeframe now mean there will be insufficient funding towards the end of the Program to complete all required work. Put simply, the Program will require additional funding to deliver the full Acacia solution to completion.
>
> The exact amount of this shortfall is not able to be determined with precision until the full Program schedule has been fully revised, there are currently three options being considered each with different input costs due to time taken to deliver. The key expenditure for the Program is resourcing costs which is directly tied to by the Program's implementation schedule. All vendor costs are fixed and codified in the commercial contract between NT Government and InterSystems.
>
> This funding issue has been discussed explicitly at all CCSRP governance committee meetings since December 2021 and preliminary discussions have occurred with the ICT Governance Board and the Department of Treasury and Finance.[197]

5.40 In total, the Departments advised that 20 months of delay for FG1 were attributable to COVID-19.[198]

5.41 In summary, as outlined by the Departments, delays associated with the commissioning of the Palmerston Hospital, redevelopment of the implementation plan, and the COVID-19 pandemic necessitated additional funding for the program above the fully funded $259 million budget allocated in May 2017. $63.4 was reprioritised from within the Departments to enable work to continue on the program.

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[195] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 1.

[196] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 1.

[197] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 2.

[198] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 8.

2023: $6 Million Away from the CCSRP

5.42 The Auditor-General's *Report to the Legislative Assembly No 6: 2025-26: Police Information System Replacement Project* highlighted that $6 million was reprioritised from Acacia to the Serve and Protect project (SerPro) in July 2023.[199] This reprioritisation was endorsed by the Minister for Corporate and Digital Development in the '2023–24 Mid-Year Report administrative variations process'.[200] The Committee observes that the Departments did not tell the Committee of this reprioritisation in their initial submission to the Committee.[201]

5.43 The Committee asked why there was authorisation to shift $6 million from the Acacia program to SerPro, noting that additional funding was sought for Acacia in a later budget cycle (see paragraphs 5.47—5.51). The Departments advised the Committee that SerPro was a higher priority than Acacia:

> At that time, it was decided that funding requirements for the SerPro program were a higher priority. As a result, funds were redirected from CCSRP.[202]

5.44 Additional information requested of the Departments specified that the reprioritised funding from Acacia to SerPro was not the same funding which had been reprioritised to Acacia from NT Health. Additionally, the Departments told the Committee that the funding had not been later returned to the program, meaning the reprioritisation was in effect a reduction in funding for Acacia.[203]

5.45 The Committee notes that, as outlined by the Auditor-General, transfers of funding between government departments require a written direction of the Treasurer,[204] whilst internal reprioritisations may be approved by the CEO of a department, with endorsement of the Minister:

> reallocation of funds to changing priorities within a department is at the discretion of its chief executive officer, subject to an endorsement by the responsible minister. Transfers of excess appropriation between government departments, on the other hand, require a written direction of the Treasurer, which must be tabled in the Legislative Assembly in accordance with section 20 of the Financial Management Act 1995.[205]

5.46 Accordingly, because DCDD holds the funding for IT projects and programs for its client agencies, it is able to transfer funding from projects or programs that benefit one agency to another agency with less public oversight than would be required if

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[199] Auditor-General of the Northern Territory, *Report to the Legislative Assembly No 6: 2025-26: Police Information System Replacement Project,* 2025, p. 19.
[200] Department of Corporate and Digital Development, *Answers to Questions Taken on Notice,* 19 March 2026, p. 8.
[201] Including in their 'timeline of each cost revision', see: Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 43.
[202] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.
[203] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.
[204] Financial Management Act 1995 (NT), section 20.
[205] Auditor-General of the Northern Territory, *Report to the Legislative Assembly No 3: 2024-25: Public Information Referrals: Public Information Act 2010,* 2025, p. 12.

those projects were being undertaken by the client agencies themselves and sought to move funding from one agency to another agency.

2025: $12 Million Allocation in Budget 2025-26

5.47 In the 2025-26 Budget the CCSRP was allocated an additional $12 million in 'new appropriation funding', split evenly between the 2025-26 and 2026-27 financial years.[206] Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that the need for additional funding became evident towards the end of 2024 and the start of 2025:

> I would say that it became clear that we were not going to be able to live within that expanded envelope, which got us to just over $320m, probably around the early part of last year. At the time when we took that action in 2023 [sic] to augment the budget, I was confident that would be sufficient. As things have taken longer, the protracted time we needed to withdraw the system from the emergency department go back and do a bunch of work to enhance the software and reimplement and a range of other things have all contributed to that elapsed timeframe. I would not be able to pinpoint a precise date, but probably in the last 18 months or so.[207]

5.48 The Committee heard from Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer in DCDD, that the Departments had not determined what the allocated funding would be spent on:

> The roadmap that was presented to ministers to secure funding for 2026/27 was not based on a detail schedule with proper resource allocation to support its viability. Like so many other delivery dates it was 'best guess'. This means the program do not actually have a plan for how they will spend the funding envelop for 2026/27.[208]

5.49 However, in their second submission, the Departments advised the Committee that this funding enabled the complete deployment of FG1 and additional works:

> That funding enabled the completion of the deployment of Functional Group 1 by the end of 2025, with Acacia 1.0 now operational at all six tertiary hospitals across the Northern Territory, along with all renal dialysis facilities. The current Budget appropriation also allows the Program to continue at a reduced scope and resourcing level, focused on delivering the most critical priorities first.[209]

5.50 The Committee asked the Departments for further detail on what the additional funding provided in Budget 2025-26 had been allocated towards. In contrast to the previous advice outlined, in this response the Departments did not mention the deployment of FG1. Instead, they advised that this funding had been allocated towards:

> Delivery of FG2 to replace clinical documentation in CWS and paper clinical documentation in the hospitals with electronic documentation.[210]

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[206] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 4.
[207] Department of Health, Committee Transcript, 17 February 2026, p. 14.
[208] Kara Joyce, Submission No. 11, p. 2.
[209] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 4.
[210] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.

5.51 The Committee asked the Departments whether any additional funds had been sought or internally reallocated since Budget 2025-26. The Departments told the Committee that there had been no further funds allocated or reprioritised.[211]

Costs of Additional Projects

5.52 Several additional projects sit within the CCSRP that were either foundational activities in the program business case or were folded into the program at a later date. These include FG0, the electronic medication management project (FG3), the Information Security and Access Framework, EMPI, and Transforming Information Systems.

5.53 FG0 was not initially a part of the program. Accordingly, FG0 was not included in the agreement between the NTG and InterSystems at the time of contract signing. Licensing costs for the expanded functionality were $1.2 million.[212]

5.54 Nor did the 2016 Acacia business case include in its scope the replacement of the electronic medication management system, which has become FG3. Instead, electronic medication management was highlighted as an optional element of the program.[213] In 2017-18 a business case for a solution to the electronic medication management system was undertaken, costing $60,000.[214] The business case was approved in June 2018.[215] $18 million was allocated to this project.[216] The delivery of the electronic medication management system was 'run as an adjunct project by CCSRP… coordinated within the single program of work'.[217]

5.55 At first, the Departments advised that the funding for this project was not a part of the $259 million budget for Acacia but was a part of the current $335 million total budget. This suggested that the funding was later absorbed into the total program budget, effectively making it a variation to the total program budget and cost of the program:

> $18 million in funding for Electronic Medications Management was not included in the original budget but is now included in the $335 million figure.[218]

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[211] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.
[212] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[213] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 16; Department of Health, *Business Case: Core Clinical Systems Renewal Program*, 17 January 2016, p. 29, 41, 144.
[214] Minister for Corporate and Information Services, *Answer to Question Number 209*: *Agency Administration*, May 2018, https://parliament.nt.gov.au/business/written-questions/wq/13th-assembly/answers/Aqst-209-Higgins-Agency-Administration.pdf, p. 13.
[215] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 13.
[216] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.
[217] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 13.
[218] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.

5.56 Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, also told the Committee that the budget for electronic medications management was originally separate to other funding for Acacia:

> 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.[219]

5.57 However, following additional questioning from the Committee, the Departments told the Committee that their previous advice was incorrect and the $18 million associated with the electronic medication management project had always been a part of the $259 million budget funded in May 2017:

> Confirmed the $18 million is included in the overall budget of $259 million for 2017-18…
>
> Acknowledging the response to written question 8 (April 2026, p. 2) had incorrectly inferred it was not part of the $259 million budget.
>
> *"$18 million in funding for Electronic Medications Management was not included in the original budget but is now included in the $335 million figure"*[220]

5.58 The Committee observes that the $259 million funding was allocated in 2 tranches in May 2016 and May 2017. However, the business case for the electronic medication management project was not approved until June 2018.[221] Accordingly, the Committee queries why funding for the electronic medication management project was allocated *prior* to the business case being approved in 2018.

5.59 Several other projects have been folded into the CCSRP, including the Information Security and Access Framework, EMPI, and Transforming Information Systems and Services:

> To support the delivery of Acacia, services provided by the Department's Information Communications Technology function will be enhanced. The Transforming Information Systems and Services project has become a core project under the Core Clinical Systems Renewal Program…
>
> The Information Security and Access Framework and the Enterprise Master Person Index (EMPI) project were integrated into the Core Clinical Systems Renewal Program (CCSRP).[222]

5.60 The Committee notes that the EMPI and Transforming Information Systems and Services project were a part of the foundational activities in the scope of the business case.[223] Costs associated with the EMPI within the Acacia program budget are $5.6 million to 12 March 2026.[224]

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[219] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[220] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 2.
[221] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 13.
[222] Department of Health, *Annual Report 2017-18,* pp. 38-39, 49.
[223] Department of Health, *Business Case: Core Clinical Systems Renewal Program*, 17 January 2016, p. 29.
[224] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2.

5.61 The Committee asked the Departments whether any funding associated with additional projects had been folded into the CCSRP. The Departments advised that no other projects with existing funding have been folded into the program.[225]

Broader Cost Drivers

5.62 Alongside the rationale for discrete program cost revisions, the Committee has identified several broader cost drivers. These include staffing costs associated with elapsed time, InterSystem's delivery to schedule deadlines, and the extent of configuration required to TrakCare. These matters are discussed below.

Elapsed Time and Staffing Costs

5.63 The greatest driver of increased costs over the life of the program have been the delays to schedule and the associated staff costs over the additional years of program implementation. As described by the Departments:

> The single biggest contributor to the Program budget variation is staffing and resource costs due to extensions to timelines. The Program employs a large number of specialist ICT contractors, which attract daily rates for work performed. The number of contractors rises and falls with each phase of the Program.[226]

5.64 This was elaborated on by former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM:

> The key driver of cost in these sorts of projects is elapsed time… The main driver of cost is the resource cost. It is quite a large team of very high-end professionals. At its peak it was over 100 people. Many of them are specialist contractor resources—they are business analysts, testers and programmers—which we engage through local IT vendors at daily rates, so in very simple terms, delays equate to costs. The longer it runs the more it costs.[227]

5.65 Each delay to the program has pushed out the timeframe where the CCSRP must retain staff to deliver the program. FG1 was initially envisioned to be deployed between November 2020 and March 2021, a period of 5 months.[228] Setting aside the impacts of COVID-19 in delaying the first deployment of FG1 to KDH, deployment of FG1 ultimately occurred between July 2022 and November 2025, a period of 3 years and 4 months. The whole program was initially envisioned to be complete by September 2021 but is still ongoing almost five years after this date. This has had a large impact on the program budget: as of April 2026, total staff costs have been $234.6 million.[229]

5.66 The maximum number of staff working on Acacia at any one time is unclear. At various points throughout this Inquiry, the Committee has been advised that total

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[225] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.
[226] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 38.
[227] Department of Health, Committee Transcript, 17 February 2026, p. 14.
[228] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Plan*, December 2019, p. 20.
[229] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.

staffing of the program 'At its peak was over 100',[230] was 'about 130',[231] and was 'close to 170' staff.[232]

5.67 Contractor costs have been a significant portion of these costs. Catherine Weber, CEO of DCDD, told the Committee that a majority of staff were contractors, whilst former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, told the Committee that roughly 80% of staff were contractors throughout the program.[233] As of 31 January 2026, the total cost of contractors within the Acacia program was $158.8 million.[234] This is also reflected in the breakdown of costs of different staff who have supported the program. The Departments told the Committee in April 2026 that of the $234.6 million staffing costs, $41.7 million were for permanent staff within DCDD working on the Acacia program, $168.0 million were for contractors working on the program, and the remaining $24.9 million were for NT Health staff primarily working on the program.[235] All of these costs were paid from the CCSRP budget.[236]

5.68 Extensive use of contractors was explained by former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM:

> The composition of that team—I think at its peak the Acacia project team was probably about 130 people. Generally, it is about an 80–20 mix of public servants at 20% and contractors about 80%. The reason for that is bringing the contractors in as daily rate contractors you need different ones at different stages of the project, so you need to stagger your resourcing and onboard and offboard. That model gives you the flexibility to do that.
>
> There is also an aspect there that those types of skill sets are in really high demand in the market, and the market rates for those are not really reflected in public sector rates pay. If I was to try to hire technical architects or high-end business analysts, the public sector salary rates are generally not competitive in those markets. The contracting model gives you the ability to attract and retain those resources for the period you need them, and then easily scale down at the point that they are not required.[237]

5.69 However, despite flexibility being a core reason for using contractors, in some cases, the Committee heard that contractors worked on the program for a number of years:

> a lot of ICT contractors who we source through the procurement system. They naturally turn over, depending on what type of work we need done at any particular time. Some, I think it is fair to say, have been with the program for a

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[230] Department of Health, Committee Transcript, 17 February 2026, p. 14.
[231] Department of Health, Committee Transcript, 17 February 2026, p. 18.
[232] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 28.
[233] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 31; Department of Health, Committee Transcript, 17 February 2026, p. 18.
[234] Department of Corporate and Digital Development, *Answers to Questions Taken on Notice,* 19 March 2026, p. 4.
[235] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[236] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[237] Department of Health, Committee Transcript, 17 February 2026, p. 18.

> number of years; others come and go as different phases of the project are underway, and we need different expertise at different times.

5.70 Indeed, some submitters told the Committee that staff or contractors were employed for years without substantive work programs. For example, Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, told the Committee that at:

> around the beginning of 2024, [FG2 and FG3] teams were prevented from progressing or deploying this work, with no clear direction, revised scope, or alternative workplan provided. As a result, for an extended period (approaching two years) teams remained largely under-utilised, with limited meaningful work to undertake. This represents a significant waste of public funds, workforce capability, and NT Health resources, and further demonstrates the absence of effective forward planning, sequencing of work, and alignment between program strategy and operational delivery.[238]

5.71 Kara Joyce later clarified that the FG3 team consisted of 5 people.[239] It appears that extensive periods without full work programs occurred because resources necessary to develop later FGs were prioritised to support FG1 implementation, leaving later FG teams without the ability to progress their own work. The Departments advised that parallel work progression was constrained by FG1 deployment:

> Parallel activity occurred during FG1 with FG2, FG3 and FG4 however, during implementation, resources for other FGs were directed to FG1. The support teams are not organised by FG due to the nature of the work conducted by these teams (setup and configuration, testing, reporting, integration). Therefore, the support teams were prioritised to FG1 activities…
>
> The delays caused by FG1 and their effects on the other FGs cannot be separated.[240]

5.72 It appears likely these impacts were significant. As discussed above, the actual implementation period of FG1 was 3 years and 4 months. This was far longer than the 5 months outlined in the December 2019 phased implementation schedule, inhibiting progress on later FGs longer than anticipated.

InterSystems and Deadlines for Delivery

5.73 The Committee enquired into the contractual arrangements agreed between the CCSRP and the software vendor, InterSystems. Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, advised the Committee that the costs associated with procuring the software from InterSystems and InterSystem's fees for implementing Acacia are fixed:

> We executed that contract with InterSystems around July 2017, if my memory serves me well. It is a fixed-price contract to deliver, so vendor costs are controlled through fixed pricing in the contract, which is a fair bit of work to negotiate, but serves you well when things get rocky or off-track later on in a project… The implementation costs are fixed, so when we have had challenges

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[238] Kara Joyce, Submission No. 11, p. 3.
[239] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[240] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.

> in delivery that has not led to additional vendor costs because they are tied to fixed pricing.[241]

5.74 In particular, contractual arrangements provided that InterSystems would be paid on a milestone-based system:

> the agreement with InterSystems is predicated on a milestone-based payment arrangement, in which InterSystems is paid per delivery of each development milestone, not per time period. On that basis, the software costs are essentially fixed and are not a primary contributor to the Program budget variation.[242]

5.75 At the time the contracts with InterSystems were signed, the total agreed payable costs to InterSystems upon program completion for licencing, milestone payments, and annual product support were $14.4 million, $28.6 million, and $4.3 million per year, respectively, excluding GST.[243] Annual product support costings were subject to CPI adjustments.[244] The Committee understands that annual product support costs were expected to be incurred for at least 10 years, with 2 options to renew for an additional 5 years each:

> In terms of the actual software it is a 10-year software support with two options for five years on top of that, so potentially a 20-year deal. Generally, you need a long contractual period like that to achieve your ROI from a major investment in a system like this. They are not the sort of thing you would change out on a regular basis. If you implement a system this thoroughly right across all aspects of healthcare, it is there for a long time. That is appropriate and sensible.[245]

5.76 However, of these anticipated costs, payments to InterSystems to date have been underbudget. To 31 January 2026, total InterSystems costs were $31.5 million.[246] A more up-to-date breakdown of figures was provided to the Committee in April 2026. Licencing, milestone payments, and annual product support costs were $7.9 million, $20.0 million, and $3.3 million (total across 7 years), respectively, excluding GST. Of the annual product support, $0.49 million has been funded from the CCSRP budget whilst the remaining $2.88 million was funded from the ABS—HSS budget, separate to the CCSRP but within DCDD.[247] A further $4.0 million has been paid to InterSystems outside of these key contractual costs, including $1.2 million additional functionality licensing (FG0) and $2.7 million of additional costs associated with 'enhancements'.[248] The Departments did not specify which specific features of Acacia were associated with these enhancements.[249]

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[241] Department of Health, Committee Transcript, 17 February 2026, p. 4.
[242] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 38.
[243] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[244] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[245] Department of Health, Committee Transcript, 17 February 2026, p. 4.
[246] Department of Corporate and Digital Development, *Answers to Questions Taken on Notice,* 19 March 2026, p. 4.
[247] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[248] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[249] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.

5.77 Despite contractual arrangements preventing additional fees to InterSystems being incurred due to delays, the Committee notes that some additional costs are attributable to InterSystems. For example, internal documentation makes clear that the commissioning of Palmerston Hospital during 2018 was not the only driver of the 9-month delay specified by the Departments. Indeed, it was only one of 7 different issues outlined in the *CCSRP Integrated Master Program Schedule* which made the case for rescheduling the program. Several factors that caused the 6-month delay to the planned February 2019 delivery date of Acacia were attributed to InterSystems:

- Significant additional development of the TrakCare application needing to be undertaken to meet NT Health's requirements in the area of Primary Health Care which is considerably more complex in the Northern Territory context than in other jurisdictions.
- Instability in InterSystems resourcing – loss of Project Director, and Contractors Authorised Representative.
- Delays in completion of key InterSystems contracted deliverables.
- Multiple projects competing for resources and focus e.g. commissioning of Palmerston Regional Hospital.
- Difficulty resourcing key specialist roles – impacting both NT Government and InterSystems.
- Availability of clinical and administrative subject matter experts to participate in Design and Configuration workshops.
- Delays in demonstrating progress of configuration to workshop participants (through regular iterative releases) has impacted the effectiveness of decision making during the Design and Configuration workshops.[250]

5.78 In particular, the Committee notes that this document demonstrates that InterSystems was unable to deliver Acacia to the agreed deadline due to a misestimation of the complexity involved in configuring TrakCare for the needs of the Northern Territory. As the *CCSRP Integrated Master Program Schedule* explains:

> As the Solution Build phase progressed, InterSystems recognised that the work effort to configure TrakCare had been underestimated, and that the product development work required to meet NT Health requirements (specifically Primary Health Care) would require additional time and resources. This confirmed a number of joint CCSRP / InterSystems program risks that were being managed, with InterSystems highlighting that the scheduled delivery date of February 2019 for the configured system could not be achieved.[251]

5.79 Additionally, internal documents demonstrate that some limited delays to the program occurred due to outages within InterSystems' network. The outage occurred between 31 July 2021 and 18 August 2021, with a 5-to-6-week impact on the program schedule. This was because planned activities had to be postponed:

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[250] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 7.
[251] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule,* November 2018, p. 9.

> Following the detection of suspicious activity on its network, [InterSystems] removed all network connectivity and took down their internal network (rendering it unavailable to their software development teams) to mitigate risk of a cyber-attack. As a result [InterSystems] were unable to progress development or defect fixes, make local set up changes or promote changes through its' environments. Cycle 2 User Testing - End to End Simulations (round 2) had been scheduled to run from 4 August to 10 August 2021 however were unable to proceed due to the outage.[252]

5.80 The Committee asked the Departments about the impact of delays that were associated with InterSystems' failure to deliver to the program schedule delivery dates throughout the life of the program. The Departments advised that they could not determine the impact of InterSystem's failure to meet deadlines due to other associated factors:

> Determining the impact of [InterSystems] missing delivery dates is challenging due to numerous contributing factors. For example, NTG's delays affect [InterSystems'] schedules, COVID-19 had a significant impact and RDPH ED remediation was not included in [InterSystems'] contracted timelines.[253]

Configuration of TrakCare

5.81 The Committee heard that an additional driver of costs—also associated with InterSystems—is the extent of customisation and configuration that has been necessary to align TrakCare with NT Health requirements. It appears to the Committee that this has had a significant impact on delivery timeframes. These matters reflect the importance of government agencies acting as 'intelligent clients', as outlined in the Committee's 2014 *Management of ICT Projects by Government Agencies*.[254]

5.82 Rod McDonald, a former employee of InterSystems and later contractor in the CCSRP, explained to the Committee that the extent of configuration of TrakCare was far greater and more complicated than the CCSRP expected. Indeed, he told the Committee that the differences between TrakCare and desired end-state-Acacia were significant:

> There was a lack of awareness within the CCSRP senior leadership team on the challenges of purchasing and implementing a Commercial-Off-The-Shelf (COTS) product like TrakCare as a replacement for existing custom-developed legacy solutions based on unique operating practices within the NT Health environment, and for which [InterSystems] had only limited domain knowledge:
>
> The exercise of replacing the existing legacy systems with TrakCare could not have been begun from two more diverse starting points – the underlying

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[252] Department of Corporate and Digital Development – Core Clinical System Renewal Program, *CCSRP Program Steering Committee: Briefing – Meeting 21-09 - Revised CCSRP Schedule – InterSystems Network Outage*, September 2021, p. 1.

[253] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 6.

[254] Public Accounts Committee, *Management of ICT Projects by Government Agencies,* May 2014, https://parliament.nt.gov.au/committees/list/public-accounts-committee/PAC-reports/12th-assembly/PAC_Report_ICT_Inquiry_Management_in_the_Northern_Territory_Government.pdf, p. 24.

> business architectures of TrakCare and the legacy systems were significantly different.[255]

5.83 Because of this, attempts to reconcile TrakCare and NT Health requirements resulted in major works that have used extensive program resources:

> [Configuration] was at best an exercise in how to "fit a square peg in a round hole." It completely avoided the exercise of evaluating the different business architectures (principles) involved and rationalising business transformation objectives…This chewed up a significant amount of time and resource, and it can now be argued that the return on investment was very unsatisfactory…It is fair to say that this approach resulted in significant frustration from all parties involved (i.e. [InterSystems], DCDD CCSRP participants, and ultimately Acacia end users where a common statement of it just not being "fit for purpose" was often provided).[256]

5.84 Dr John Zorbas, President of the AMA NT, similarly advised that there was a misalignment between TrakCare patient workflows and clinical care in the NT:

> 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.[257]

5.85 Internal documentation provided to the Committee highlights this issue in the context of FG4. This matter contributed to a revision in the program schedule (as discussed in paragraphs 5.77 and 5.78):

> InterSystems recognised that the work effort to configure TrakCare had been underestimated, and that the product development work required to meet NT Health requirements (specifically Primary Health Care) would require additional time and resources... InterSystems highlight[ed] that the scheduled delivery date of February 2019 for the configured system could not be achieved. [258]

5.86 Rod McDonald advised the Committee that the misalignment between TrakCare and NT Health requirements were partially due to the CCSRP accepting InterSystems' assurances that most features that Acacia required would be met by the commercial-off-the-shelf version of TrakCare 'out-of-the-box':

> Too much credence was given by those involved in the selection process to [InterSystems'] tender responses, indicating that the already available TrakCare product functionality could easily satisfy the majority of the CCSRP Requirements Traceability Matrix items used for the tender evaluation process…
>
> There was a lack of awareness within the CCSRP senior leadership team on the challenges of purchasing and implementing a Commercial-Off-The-Shelf (COTS) product like TrakCare as a replacement for existing custom-developed legacy solutions based on unique operating practices within the NT Health environment.[259]

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[255] Rod McDonald, Submission No. 9, p. 2.
[256] Rod McDonald, Submission No. 9, p. 2.
[257] Australian Medical Association Northern Territory, *Committee Transcript,* 3 March 2026, p. 3.
[258] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 9.
[259] Rod McDonald, Submission No. 9, p. 2.

5.87 Rod McDonald told the Committee that the belief that TrakCare and NT Health requirements were closely aligned meant the intensive planning and resourcing required to properly determine the solution build had not occurred:

> 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…
>
> 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.[260]

5.88 Additionally, Rod McDonald told the Committee that complex ICT reform like Acacia requires a balance to be found between ensuring that software is fit for purpose for end-users and amending business practices to take advantage of the vendor solution as provided. In the context of the NT:

> there needed to be a very clear understanding of the balance that was required between NT Health adopting existing standardised functionality within the COTS product and therefore accepting they may have to re-engineer some of their existing business practices to do so, versus InterSystems having to accommodate what NT Health considered unacceptable gaps within the existing TrakCare functionality.[261]

5.89 However, exacerbating the configuration challenges faced by the CCSRP, he told the Committee that in this case the Departments had not sufficiently sought to re-engineer NT Health business practices to better utilise the out-of-the-box functionality delivered by InterSystems:

> The overarching approach was for [InterSystems] to simply demonstrate the existing TrakCare functionality and then for DCDD engaged Subject Matter Experts (SMEs), drawn from the business, to document their requirements for how they would like the TrakCare solution to be enhanced/modified at a detailed User Interface level, and to better reflect the way existing legacy systems supported current work practices… It completely avoided the exercise of evaluating the different business architectures (principles) involved and rationalising business transformation objectives[262]

5.90 Dr John Zorbas, President of the AMA NT, explained the desire for consistency in clinical systems from a clinical perspective, highlighting prioritisation of patient safety:

> 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.[263]

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[260] Rod McDonald, Committee Transcript, 3 March 2026, pp. 15-16.
[261] Rod McDonald (Supplementary), Submission No. 16, p. 3.
[262] Rod McDonald, Submission No. 9, p. 3.
[263] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 4.

5.91 As a result of these intertwined issues, Rod McDonald told the Committee that the program had to extensively reconfigure the commercial-off-the-shelf product:

> their approach was effectively taking a COTS product down a path of significant customised development, rather than transforming their business practices to adopt the COTS product with minimal enhancements incorporated into a global product's roadmap[264]

5.92 In the case of FG4, Rod McDonald told the Committee that the work to try to address the gap in architecture was continually delayed by InterSystems because of the significant work required to align TrakCare with the requirements of FG4. Further, he told the Committee that the program management did not seek to resolve InterSystems' deferral as they prioritised the issues they were dealing with regarding FG1:

> Many attempts were made within CCSRP to engage with [InterSystems] on making progress on the Functional Group 4 phase of the program (the replacement of CCIS and PCIS) – however none of these were successful…The poor leadership within DCDD and the continued absorption of time and resource in the FG1 phase allowed [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 [InterSystems] down to the ground and allowed the program budget to be used up without exposing TrakCare to costly enhancements.[265]

5.93 The Committee asked the Departments about the misalignment of expectations regarding TrakCare's ability to meet NT Health needs out-of-the-box and associated delays to configure TrakCare to meet NT Health needs. The Departments advised that the impact of this could not be assessed:

> It is not possible to assess the impact to the Program schedule of the customisation required by NT Health as it occurred throughout the life of the Program including prior to changing from big bang implementation to implementation by functional groups.[266]

5.94 In summary, the Committee identified 4 major cost revisions associated with Acacia away from the initial program budget of $242 million: $17 million in 2016, $63.4 million reprioritisation to Acacia in 2022, $6 million reprioritised away from Acacia in 2023, and $12 million in additional appropriations in 2025. The major cost driver has been the unexpected extent of time the program has run and the associated need for staffing of the CCSRP. Significant drivers of the extension to the program schedule include the commissioning of Palmerston Hospital, revision of the implementation plan, COVID-19, InterSystem's delivery to schedule, and extensive customisation of TrakCare to meet NT Health requirements.

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[264] Rod McDonald, Submission No. 9, p. 3.
[265] Rod McDonald, Submission No. 9, p. 4.
[266] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.

6 Issues Raised During Implementation

6.1 The Treasurer instructed the Committee to identify any issues raised during implementation of the system, including:

- when the responsible Minister was notified of these issues
- how long it took for these issues to be resolved, if they were resolved at all, and
- the cost of resolution.

6.2 This Chapter examines evidence provided to the Committee which responds to this element of the Inquiry Terms of Reference, broken down into 4 sections:

- ministerial notification of issues throughout the program
- major issues that have had a broad impact within NT Health
- other technical issues raised by submitters
- concerns regarding the resolution of issues in the program.

6.3 Issues previously discussed or discussed later in the report, such as delays caused by the COVID-19 pandemic or the status of FG2-5, are not repeated in this Chapter.

Ministerial Notification

6.4 The Committee heard that DCDD reported on Acacia quarterly to Cabinet, and that Chris Hosking PSM, when CEO of DCDD, met fortnightly with the Minister for Corporate and Digital Development where any relevant issues were raised. Dates of additional out-of-cycle briefings to relevant Ministers were also provided to the Committee. These matters are explored in further detail below.

Regular Procedures

6.5 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, advised that DCIS/DCDD reported quarterly to Cabinet throughout the life of the program, including when issues arose within the program associated with the schedule or funding:

> In terms of advice that was provided through to ministers, when the initial Cabinet decision to approve the program was delivered as part of the May 2016 budget, there was an obligation placed on DCIS at the time to report quarterly to Cabinet. That is still happening. That Cabinet reporting has been happening every quarter like clockwork.
>
> There has been a number of different ministers over that period of time, obviously—we had several changes of government in that time. Ministers have been kept very well briefed along the way. Certainly, in all the years I was accountable for delivery of the program it was a standing agenda item on my regular meetings with my minister. We reported openly, fulsomely and transparently to Cabinet on a quarterly basis.
>
> When we would run into delays in timing related to things like the pandemic or others, or where it has been a requirement to augment the funding because it

> was taking longer and therefore costing more—those are not decisions made by ministers, those are decisions made by public servants such as myself. Certainly, the responsible ministers were advised at every step along the way. We maintained a complete open book with that.[267]

6.6 He further explained that he personally met with Ministers on a fortnightly basis, and Acacia was routinely discussed during these meetings:

> throughout the life of this project in my time as the accountable officer for delivering the project, which was both as the deputy CE and the CE of DCIS and later DCDD, Acacia was a standing agenda item with our minister meetings. We generally meet with the minister once a fortnight. If we were working through a significant change such as that at the time, it would have featured in the conversation. The decision obviously traversed those governance committees that you refer to that are set out in our proposal there.[268]

6.7 When asked about reports to Ministers regarding risks to patients or clinical concerns (discussed later in this Chapter), Chris Hosking PSM advised the Committee that these issues were raised, but that they did not develop until after Acacia had been deployed. He said that:

> It was certainly part of the issues for consideration in any briefing, and I realise there has been a fair bit said about that publicly. It was not until the system was actually deployed and implemented in the use of clinicians that those sorts of questions arose, but they were discussed with various ministers. I think by the time the system was being used broadly by our clinical workforce, it was more towards the tail end of that time period. Certainly, it would have been discussed with Minister Uibo and more recently with Minister Edgington, who has had detailed briefings on this. I do not think it would have manifested in the briefings to earlier ministers because the project was not at that stage at that time.[269]

6.8 Additionally, Chris Hosking PSM explained that details regarding specific clinical concerns were not provided to ministers:

> When I was briefing the minister I might make a general reference to some issues of clinical safety that had been raised and being addressed, but I would not get into the specificity of it. Generally they are quite complex and would often require a clinician to interpret. Generally that level of detail would not feature in a briefing to a minister. The fact that there were concerns being raised on the shop floor absolutely would have been discussed, but the specificity of a particular clinical workflow or something would not have formed part of that discussion.[270]

6.9 The Committee notes that, despite Chris Hosking PSM's advice that clinical concerns did not develop until deployment, the Committee has received advice from other stakeholders that clinical concerns regarding the functionality and safety of Acacia had been raised through governance channels for years ahead deployment of FG1 to RDPH. In particular, the AMA NT told the Committee that:

> Multiple sources indicate that clinicians and potentially project staff had raised serious concerns about system flaws, usability problems, and potential risks between "two to four years" before the disastrous ED implementation in November 2023. These warnings were reportedly not adequately addressed or

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[267] Department of Health, Committee Transcript, 17 February 2026, p. 5.
[268] Department of Health, Committee Transcript, 17 February 2026, p. 15.
[269] Department of Health, Committee Transcript, 17 February 2026, p. 5.
[270] Department of Health, Committee Transcript, 17 February 2026, p. 6.

resolved; instead, mitigation strategies such as additional training, user supervision, and workarounds were proposed for known risks like medication chart deletion. Issues identified years earlier were allegedly still present when the system went live in the EDs.[271]

Additional Briefings

6.10 The Committee was informed that additional briefings were provided to the relevant Ministers on several different matters:

> the departments briefed either or both Ministers for Health and Corporate and Digital Development on the following occasions in relation to the Program:
>
> (a) 18 June 2021 in relation to postponement of the Katherine Go Live of Acacia 1.0 due to COVID-19 delays;
>
> (b) 14 November 2021 in relation to further postponement of the Katherine Go Live of Acacia 1.0 due to COVID-19 lockdowns and lockouts in Katherine and Darwin;
>
> (c) 28 July 2022 in relation to the upcoming Katherine Go Live of Acacia 1.0 on 29 July 2022;
>
> (d) 18 October 2022 and 9 November 2022 in relation to the shortfall in the Program budget, and the solution from internal reprioritisation of DCDD's and NT Health's existing budget appropriations;
>
> (e) 22 November 2022 in relation to the upcoming Gove Go Live of Acacia 1.0 on 25 November 2022;
>
> (f) 16 December 2022 on the general background to the Program and the status of its delivery;
>
> (g) 28 August 2023, 20 October 2023, and 10 November 2023 regarding the upcoming Royal Darwin and Palmerston Hospitals Go Live on 11 November 2023; and
>
> (h) 28 December 2023, 13 January 2024, 17 January 2024, 25 January 2024, and 20 March 2024 regarding the issues identified in the RPDH EDs and the reversion to CareSys to enable remediation works to be undertaken.[272]

Major Issues

6.11 Three major issues have been identified and raised with the Committee:

- a patient data breach in 2018-19
- theatre scheduling issues in FG1 in 2023
- emergency department issues in FG1 in 2023.

2018-2019: Patient Data Breach

6.12 The AMA NT and Royal Australian and New Zealand College of Psychiatrists (RANZCP) advised the Committee that there was a privacy breach in 2018-2019

[271] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[272] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 43-44.

where identifiable patients records were provided to InterSystems. The AMA NT explained the event to the Committee:

> During the initial design phase, NT Health transferred identifiable patient health records to the software vendor, InterSystems. While the exact number is contested, reports indicate over 3,000 identifiable records (out of a larger batch of 50,000 records exchanged between NTG departments) were shared with the vendor. This data included highly sensitive clinical information classified as "very-high or high clinical risk," such as psychology reports, psychiatric facility visits, records of pregnancy terminations or stillbirths, and electroconvulsive therapy records.[273]

6.13 As the RANZCP highlighted, the impact of such a leak can have a significant impact on patients and their privacy, including those seeking mental health care:

> Upholding the privacy of all patients is paramount, but confidentiality in record keeping is particularly important for mental health patients, who often face stigma. Disclosure of medical records may make people feel ashamed and can impair treatment and recovery. If an individual's history of mental illness and treatment becomes public or falls into the hands of a third party, this may result in serious personal and professional consequences.[274]

6.14 Beyond immediate impacts to the patient, AMA NT also submitted that the breach of privacy had a wider harm by reducing patient trust in the health system:

> breaches erode patient trust in the health system's ability to protect their privacy, which is an essential component of overall patient safety and wellbeing.[275]

6.15 The Departments provided the Committee more information regarding this event. They advised the Committee that in 2018, to facilitate InterSystems mapping NT Health processes to replicate in Acacia, program staff requested that NT Health provide templates of forms and questions. These were supposed to be deidentified:

> the Program undertook a process of content collection, in which staff were invited to send example templates of forms and reports they used on a day-today basis so that those could be built in the Acacia system instead. Program staff specifically requested that examples not include any patient information, or that any information was deidentified. Those materials were shared with Program staff internally within the NT Government's secure environment by a number of methods (e.g. email, hard copies, USBs, SharePoint). Overall, approximately 50,000 digital items (e.g. .docx, .pdf. and .xlsx files) were shared with Program staff.[276]

6.16 However, whilst in the process of sharing this data with InterSystems in 2019, program staff noted that some data included identifiable patient information. Sharing was halted and an audit was undertaken by DCDD's internal Data Control Management Team. They examined which files with identifiable patient information had been shared internally and with InterSystems. Access to data was revoked from users who did not form a part of the Data Control Management Team.[277] Ultimately,

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[273] Australian Medical Association Northern Territory, Submission No. 1, p. 12.
[274] Royal Australian and New Zealand College of Psychiatrists, Submission No. 6, p. 2.
[275] Australian Medical Association Northern Territory, Submission No. 1, p. 20.
[276] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 7.
[277] Department of Health and Department of Corporate and Digital Development, Submission No. 14, pp. 7-8.

the audit determined that InterSystems had been provided access to 31 files with identifiable patient information:

> Following a comprehensive review and risk assessment, it was determined that of the approximately 50,000 files shared internally with the Program staff, approximately 427 files were found to contain identifiable patient data. Of the 3,000 files which had been uploaded to the SharePoint and were accessible to InterSystems, only 31 were found to contain identifiable patient data.[278]

6.17 However, DCDD told the Committee that 'Each document that contained patient data could include a number of individual patients.'[279] In total, thousands of instances of identifiable patient data were transferred:

> NT Health determined that, in the documents, there were:
>
> - 7,698 instances of an individual patient name and hospital reference number (HRN)
> - 15,657 instances of an individual HRN only (+/- date of birth or non-name identifier)
> - 27,261 instances of individual name only (+/- non-HRN identifiers).[280]

6.18 The Departments advised the Committee that data provided to InterSystems were stored on servers in Sydney and remained in Australia. The departments also told the Committee that the contract with InterSystems required InterSystems to comply with the *Privacy Act 1988* (Cth) and the Information Privacy Principles contained within the *Information Act 2002* (NT).[281]

6.19 In response to this breach, InterSystems deleted all files with identifiable patient data, NT Health reported the breach to the Ombudsman/Information Commissioner, the Departments developed a Data Governance Framework, and implemented training for staff:

> Since that time, the Departments have developed and implemented additional controls to strengthen the governance of data received by Program staff throughout the deployment of Acacia. Those include the creation of a specific Data Governance Framework, supported by clear policies, procedures and training for the gathering and handling of sensitive documentation by Program staff.[282]

6.20 The Information Commissioner advised the Departments that notification of patients regarding the breach was at the discretion of the CEO of NT Health:

> We met with the Information Commissioner, and it was determined that it was the discretion of the Department of Health chief executives on whether or not patients needed to be advised because it was not considered a formal data breach, because the people within the department, so within the CCSRP team, and within InterSystems would have access to that information, just not in the

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[278] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 8.
[279] Department of Corporate and Digital Development, *Answers to Questions Taken on Notice,* 19 March 2026, p. 1.
[280] Department of Corporate and Digital Development, *Answers to Questions Taken on Notice,* 19 March 2026, p. 1.
[281] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 8.
[282] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 14.

way that we received that information. We had access to that information through all of our test systems that have production data in them.[283]

6.21 The Committee notes that staff involved in resolving this issue are a part of the existing DCDD staffing levels, and so would have incurred no additional costs.

2023: RDPH Theatre Scheduling

6.22 In their April 2025 submission, the Departments told the Committee that significant work was undertaken to revise theatre scheduling prior to deployment in RDPH:

> During the early stages of consultation in relation to theatre scheduling functionality, clinicians and schedulers identified a number of functional issues in the TrakCare system which were not aligned with clinical procedures in the Territory, and which had the capacity to impact user efficiency.
>
> Extensive consultation was undertaken with surgical clinicians and scheduling staff to identify the key areas requiring enhancement. InterSystems subsequently carried out a substantial redevelopment of the theatre scheduling functionality, aligned with the reported user issues and requirements, with key improvements including:
>
> (a) Improving visibility of theatre sessions and booked patients over extended scheduling periods.
>
> (b) Enhanced ability to transfer bookings between theatres, days and facilities.
>
> (c) Improvements to the workflow to better manage pre-admission appointments, wait lists and surgical bookings.
>
> (d) A graphical view of expected theatre capacity.
>
> (e) A streamlined function to transfer patients between facilities.
>
> (f) Ability to record additional information following a patient's death.
>
> (g) Developing capacity to send information to patients via SMS.
>
> (h) Improving outpatient scheduling, to allow a view of multiple appointments across the facilities.
>
> (i) Additional outpatient follow-up functionality to support transfers across facilities and manage patients waiting for follow-up.
>
> Following this redevelopment, comprehensive testing and validation was conducted to ensure that the revised functionality met clinical and operational requirements. In July 2023, two User Acceptance Testing sessions were conducted with 16 clinicians across the Territory to evaluate the updated theatre scheduling functionality prior to its implementation in hospitals. The enhanced functionality was accepted by clinicians and the Acacia theatre scheduling function has since been successfully deployed across Royal Darwin and Palmerston Hospitals, Katherine Hospital and Gove District Hospital.[284]

6.23 Despite these efforts, internal documentation highlighted that the CCSRP understood that theatre scheduling in Acacia would still be a more complex and time-consuming process than in CareSys. Because of this, they planned on funding 4 full-time equivalent (FTE) to support the operation of the theatre scheduling team:

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[283] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 27.
[284] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 11.

> The current functionality in CareSys is quite bespoke and users are able to 'drag and drop' and operate the system with ease. Key scheduling staff have been heavily involved in the design and testing of the new system functionality and have expressed concern that the new system will be slower to use.
>
> Considerable time and effort have gone into enhancing Acacia 1.0 to provide a better user experience however the prevailing view is that the work is able to be done more expediently in the old system and the transition to Acacia will slow things down. It is accepted that this will in fact be the case, at least initially. The Acacia program will be funding an additional 4 FTE to address this resourcing impact for a period of time (there are around 10 FTE across the Territory that undertake this function).
>
> It is expected that this resource impact will dissipate over time as theatre schedulers become more proficient in the use of the new system. In order to determine whether there is a longer-term resource impact to manage it is appropriate to capture baseline data now, while the legacy systems are still in day-to-day use.[285]

6.24 Indeed, the resource implications for theatre scheduling following deployment of FG1 appear to be extensive. The AMA NT told the Committee that booking times for patients has increased significantly, from 5 minutes in CareSys to anywhere between 18 and 40 minutes in Acacia. Nor has staff familiarity with the system resulted in any significant resource impact dissipating:

> The existing workflow to book or re-book a patient for an operation took around five minutes. Elective patients that cancel or "do not attend" take approximately 18 to 25 minutes to rebook for theatre. In worst case examples, this process can take 30 to 40 minutes. The interface has been described as clunky and non-intuitive, with only marginal time gains since the system was introduced and familiarity with the system was gained.[286]

6.25 In addition to increased booking times, the AMA NT told the Committee of other issues arising from Acacia within theatre scheduling, including:

- next-of-kin import mismatches
- deceased patients being booked in for surgeries
- removal of Aboriginal and Torres Strait Islander status from patients.[287]

6.26 They advised that resolution of some of these issues requires manual audit of patient data:

> Next-of-kin import mismatches seem to be the hardest to rectify. For reasons that remain unknown, Acacia has imported the incorrect next-of-kin for patients in an unpredictable manner. This is a manually corrected process and the issue is usually identified when the reported next-of-kin is uncontactable…
>
> Deceased patients being booked for operations is an issue that was raised with us. It is unclear how this is occurring. A manual audit process has been instituted to correct the issue (a common solution to issues raised by health practitioners that remain unresolved via the risk management systems). The manual audit requires checking the patient's record across legacy systems to ensure they are

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[285] Core Clinical Systems Renewal Program, *Acacia Digital Health Transformation: Proposal to Menzies School of Health,* July 2023, p. 8.
[286] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 3.
[287] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 3.

> not deceased and typically takes approximately two minutes per patient. Auditing is done on a weekly basis which totals >100 patients. This is a slow process because if a patient is accidentally "deceased" and then "un-deceased", not all of the existing record is restored and workload is significantly increased.[288]

6.27 Beyond resource implications for the theatre scheduling team, these issues create risks for patients:

> the NT has the highest rates of domestic and family violence (DFV) in the country. It is not uncommon for a next-of-kin to be a perpetrator of DFV and the disclosure of medical information to this person would not be acceptable or safe for the patient…
>
> removing Aboriginal & Torres Strait Islander status from a record… is not acceptable from a clinical standpoint given the importance of culturally safe person-centred care in the NT… this is critical information that affects evidence based care for the diagnosis of rheumatic heart disease, coronary artery disease and gestational diabetes screening.[289]

6.28 Despite the stated intention that DCDD would fund staff to support theatre scheduling, it does not appear to the Committee that this has occurred. The Committee asked the Departments how many staff had been hired across RDPH to maintain system functionality upon the introduction of Acacia and how much this had cost. The Departments' answer appears to specify that funding was only associated with the ED rollback, stating, 'DCDD $4.2 million - ED Rollback'.[290]

6.29 Nonetheless, the AMA NT told the Committee that additional theatre staff have been employed to enable the system to continue functioning post-deployment of FG1:

> 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.[291]

6.30 On this basis, it appears to the Committee that these additional scheduling and auditing resource requirements have not been met by the CCSRP. Accordingly, although the exact cost is unclear, it appears likely that ongoing costs to maintain functionality and patient safety as a result of Acacia have been absorbed into NT Health's operational budget.

2023-2025: RDPH Emergency Department

6.31 The highest profile implementation issue occurred following the deployment of FG1 at the Royal Darwin and Palmerston Hospital (RDPH) Emergency Departments (EDs). Thirty-four separate issues were identified by clinicians, InterSystems and the CCSRP.[292] On the basis of these issues, the decision was made to rollback

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[288] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 3.
[289] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 3.
[290] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 19.
[291] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 3.
[292] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 13.

Acacia to CareSys within the RDPH EDs. Rollback occurred on 20 March 2024. Issues experienced by clinicians within the ED were multifaceted. AMA NT highlighted some of the different technological faults:

> Clinicians reported "multiple system freezes" occurring shortly after the ED go-live, requiring escalation to the highest levels of DCDD. Another critical issue involved the system locking up when multiple clinicians attempted to access the same patient's record simultaneously, a common necessity in team-based emergency care…
>
> A major theme was that the system actively hindered rather than helped clinical workflow. Staff reported that Acacia significantly slowed down their access to basic patient information, including identifying patients needing care. It was described as "cumbersome," "not fit for purpose" for the ED environment, making clinical services "inefficient," and rendering established workflows "worse" [293]

6.32 A particularly significant issue faced within the ED was the clinical dashboard. As AMA NT explained, the dashboard did not provide clinicians sufficient visibility when treating patients:

> Issues with the Emergency module were… many and numerous, with the main issue being around “visibility”. It was difficult to see where patients were in the department and to maintain a mental model of where the workload or severity was. The interface failed to clearly display the patient location and acuity across the department, creating a lack of awareness for senior clinicians and posing a serious patient safety risk.[294]

6.33 This meant that clinicians were unable to access high-level information with ease, because ‘The system's interfaces were… poor, hindering clinicians' ability to quickly find critical information in emergency situations.[295] Efficiency of use was elaborated on by Chris Hosking PSM, who explained that many features of FG1 required more extensive navigation than clinicians were used to:

> people being able to do a thing in two clicks instead of five or on one screen instead of three. It is some of those efficiencies that allow people to stay on top of their client—patient—workloads when things are really busy in real time, particularly those middle-level, fairly senior doctors who supervise the work of junior doctors. That is where the pain point was.[296]

6.34 Additional issues included FG1’s inability to accommodate healthcare practices required in the NT, including those due to bed pressures:

> Furthermore, the system struggled to support essential, albeit undesirable, local practices like "double-bunking" (placing two patients in one ED bay due to capacity pressures), indicating a potential mismatch between the system's design assumptions and the operational realities of the RDPH ED. As a workaround to losing clinical notes, clinicians were forced to temporarily type notes up in alternate applications (e.g. Notepad) and then copy/paste unformatted text into Acacia.[297]

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[293] Australian Medical Association Northern Territory, Submission No. 1, pp. 10.
[294] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 3.
[295] Australian Medical Association Northern Territory, Submission No. 1, p. 11.
[296] Department of Health, Committee Transcript, 17 February 2026, p. 23.
[297] Australian Medical Association Northern Territory, Submission No. 1, pp. 10-11.

6.35 The Committee heard that as a result of these issues, upon deployment of FG1, wait-times in the RDPH ED increased significantly (see Chapter 7 for more detail on this matter).[298] The AMA NT further advised that the deployment of Acacia had broadly negative impacts on clinicians' stress, workload, and ability to deliver care:

> The usability and technical issues directly translated into increased workload and inefficiency for clinical staff. NT Health officially acknowledged that some Acacia workflows in the ED "impacted the workload of staff due to volume and complexity of presentations". This aligns with the clinician survey results, where majorities reported the system made their service inefficient and their workflow worse. The difficulties encountered necessitated workarounds and potentially increased cognitive load on clinicians operating in already high-pressure environments.[299]

6.36 The AMA NT told the Committee that the deployment of FG1 had a sustained and detrimental impact on clinicians, with the majority of staff having negative experiences using Acacia:

> A staff survey conducted in December 2023 painted a stark picture of user dissatisfaction: 85.7% felt the system was below or well below expectations, 83.7% found it made their service somewhat or very inefficient, and 86.7% stated it made their workflow a little bit or much worse. Anecdotal comments from staff labelled the system "terrible" and "unusable," noting continued reliance on parallel paper-based processes and other non-integrated digital systems, undermining the core goal of a single, unified record. At its worst, senior staff specialists in NT emergency departments stated that they would resign if the system was not made fit for purpose, due to the ongoing harm to patients.[300]

6.37 The personal impact of delivering care in this environment was elaborated on by Dr John Zorbas, President of the AMA NT in the public hearing:

> 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.[301]

6.38 Despite concerns from AMA NT regarding the impact that FG1 deployment had on patient safety, the Committee was advised by Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine at Royal Darwin Hospital, that no actual clinical harm occurred because of FG1 implementation:

> …when the emergency department went live in Royal Darwin… there was some delays. There was some benefit and there was some risk. I do not think it was direct harm to patients, but there were some areas it took a longer time to assess the patients because you were getting used to the new system. The system needed to be redesigned. As for clinicians' concerns; they were worried about the patient safety as opposed to actual safety concern. So any delay in

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[298] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 4-5; Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 16-17.

[299] Australian Medical Association Northern Territory, Submission No. 1, pp. 12-13.

[300] Australian Medical Association Northern Territory, Submission No. 1, p. 11.

[301] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 2.

> assessing a patient in the emergency department could potentially harm, but does not mean that harm was done.[302]

6.39 Dr John Zorbas, President of the AMA NT, strongly contested the notion that there had not been any patient safety issues:

> 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.[303]

6.40 However, Dr John Zorbas explained to the Committee that NT Health's statement could be technically true whilst simultaneously not reflecting the actual status of the situation:

> 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 [(ISR)] 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.[304]

6.41 Several underlying causes of these issues have been identified by submitters and discussed with the Committee. For example, the Departments advised the Committee that the deployment of Acacia to the RDPH EDs was challenged by four key factors: negative effect on productivity, long-term resource and bed pressures, additional information burden, and impact on staff morale.[305] In particular, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that workload pressures were significant during the deployment of FG1 at RDPH:

> I think the fundamental thing that tripped us over with emergency was not that the software did not work. The software worked. As I said, this system is deployed in a thousand hospitals worldwide; it is being used in emergency departments everywhere. How we practise emergency in Darwin is pretty strained. You would have seen we were in code yellow about a week ago. I think we had 120 people in an ED designed for 60. We always sail pretty close to the wind there because our capacity is constrained. We are in an old hospital and we are incredibly busy.[306]

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[302] Department of Health, Committee Transcript, 17 February 2026, p. 6.
[303] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 2.
[304] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, pp. 2-3.
[305] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 41.
[306] Department of Health, Committee Transcript, 17 February 2026, p. 23.

6.42 Because of the workload pressures, Deloitte's *Top End Pre-Go-Live Assurance Review* highlighted internal concerns that training had been insufficient to prepare users for the deployment of FG1:

> It was acknowledged that current training participation rates were low and training uptake was slow due to Code Yellows, staff shortages and not having a revised go-live date (which has since been announced). It was expected that rates would accelerate the closer the go-live date got and there was enough time to get "enough" people trained before go-live…
>
> Documented in all governance forums and raised in every stakeholder meeting, there is a broad understanding that staff shortages pose a risk to the Top End go-live. Code Yellows have limited staffs' ability to conduct training, run engagement activities (like communications and floor walkers) and conduct testing.[307]

6.43 Some of these concerns were specific to the ED, and linked to a late development of ED functionality:

> ED will not start training until the system is functionally ready. They have committed to fully support training (through staff engagement, overtime etc.). Most stakeholders were confident that ED would be able to complete training however some were concerned there was not enough time.[308]

6.44 However, by the time that FG1 was deployed, the Departments told the Committee that training uptake in RDPH was 'above target at 81%'.[309] In particular, the Departments advised that 'Eight weeks of face-to-face training was specifically made available to ED staff.'[310] That said, the Committee notes that no training was provided to ED staff regarding the dashboard adopted 2 days prior to go-live:

> The PowerBI dashboard was only a viewer and the movement of patients were conducted in Acacia therefore additional training was not required. The PowerBI dashboard was to provide situational awareness.[311]

6.45 Internal documentation additionally highlighted that the RDPH EDs were more reliant on digital support tools than other areas of the RDPH prior to the deployment of FG1. This meant that there was a greater 'change impact' experience by ED clinicians.[312]

6.46 Further, the Committee understands that not all ED features deployed in RDPH were tested in previous deployments. The proposal to deploy FG1 first at KDH, followed by GDH, was in part to apply learnings from deployment in the smaller

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[307] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, p. 20, 24.

[308] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, p. 20.

[309] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.

[310] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.

[311] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 12; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.

[312] Core Clinical Systems Renewal Program, *Acacia Digital Health Transformation: Proposal to Menzies School of Health,* July 2023, p. 7.

hospitals prior to deployment at RDPH and ASH.[313] However, the Departments told the Committee that not all ED features had been used in preceding hospitals:

> Katherine and Gove EDs do not use the full ED solution used in the RDPH and ASH EDs due to their small size and lower necessity, lower volume of patients, and lower acuity of care.
>
> There were no features that were scaled back. There were some features that Katherine and Gove ED chose not to use as they were not required for their processes and patient load…
>
> There were pieces of functionality that Katherine and Gove were not using such as internal consults, bed requests and inpatients in ED. These were implemented in RDPH ED. [314]

6.47 Additionally, the Departments advised that differences between the deployed versions of FG1 in KDH and RDPH had occurred due to updates to the system between deployments. Accordingly, FG1 deployment at KDH and GDH was not a 1:1 model for the deployment of FG1 at the RDPH EDs. Additional functionality was utilised in RDPH not used in prior deployments, and system updates were also incorporated:

> there had been a number of releases deployed between the hospital go lives which resolved previous defects, delivered system enhancements and also potentially introduced additional defects.[315]

6.48 Although not equivalent to experience in real-life conditions, the Committee notes that internal documentation highlighted that Site User Validation Testing (SUVT) was planned to occur prior to implementation of additional functionality:

> Site User Validation Testing will be conducted prior to each site implementation to ensure the system is configured and setup to support the site (i.e. floor plans, user lists, clinics, etc.). Any functionality that was outstanding and not tested prior to the Katherine implementation will also be tested as part of the Site User Validation Testing[316]

6.49 The Committee notes that several submitters also told the Committee that a contributing issue to the problems experienced within the RDPH EDs was that deployment of FG1 at the RDPH EDs occurred with defects known to the CCSRP, that had been previously raised by clinicians but not resolved. This matter is discussed later in the Chapter in the section ‘Resolution of issues’.

6.50 Remediation and resolution of the ED issues occurred over a protracted period. These matters and the cost of the rollback are discussed in detail in Chapter 7.

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[313] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p.11; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.

[314] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 11-12.

[315] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 11-12.

[316] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-04 – Core Clinical Systems Renewal Program, Revised CCSRP Functional Group 1 Schedule,* April 2022, p. 1.

Other Technical Issues

6.51 A range of more discrete technical issues have also been raised with the Committee throughout the course of the inquiry. These include:

- medical chart overwriting
- locked records
- patient loss
- episode limits
- access for non-government organisations.

Medical Chart Overwriting

6.52 The AMA NT submitted to the Committee that 'medication charts [were] being inadvertently deleted when patients were transferred from the ED to inpatient wards.'[317] The AMA NT explained the risks of this:

> The potential for medication charts to be deleted upon transfer fundamentally undermines data integrity and creates a high risk of medication errors, such as missed doses, incorrect medications, or wrong dosages. This negates one of the key potential safety benefits of [electronic medical records], which is improved medication management.[318]

6.53 The Departments explained the underlying issue, advising the Committee that when an existing inpatient is transferred to the ED a new 'episode' (a phase of treatment) will overwrite a pre-existing episode:

> The triage nurse may not recognise that they have an inpatient 'episode' already active in Acacia. When they create a new one, that automatically sends a prompt to the electronic medication management system, eMMA, to replace the existing medication charts with a new one. In doing so, eMMA overwrites their existing medication charts.[319]

6.54 The Departments told the Committee that a permanent resolution to this problem cannot be made within the current software constraints that are created by the use of eMMa. Instead, FG3 is necessary to permanently resolve the issue.[320] However, the Departments advised the Committee that they have established a workaround to mitigate the risks of this issue occurring:

> the Departments have implemented effective workarounds which prevent the medication charts from being deleted by triage staff selecting *"Internal Transfer"* when patients with an active inpatient episode are admitted to the Emergency Department, rather than creating a new one.[321]

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[317] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[318] Australian Medical Association Northern Territory, Submission No. 1, p. 20.
[319] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 5.
[320] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 5.
[321] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 6.

Locked Records

6.55 The AMA NT also raised an issue with the Committee regarding patient records being locked:

> Another critical issue involved the system locking up when multiple clinicians attempted to access the same patient's record simultaneously, a common necessity in team-based emergency care…
>
> A specific near-miss or potential incident was described involving a critically injured patient with severe head trauma, where accessing their essential clinical information from the transferring hospital via Acacia took over an hour due to system issues (locked records). This delay in accessing critical information in a time-sensitive emergency clearly poses a direct patient safety risk.[322]

6.56 The Departments advised the Committee that, by design, two users may not edit the same patient's records simultaneously. This is to prevent data being lost. However, a clinician may view a patient's record whilst another is editing it. The Departments told the Committee that locked records occur when a clinician does not close a record when ending their edit of the record.[323] In order to resolve this issue from occurring and prevent locked records, the Departments have made two key changes:

> the Program staff have implemented two specific system changes to mitigate the risk that clinicians will be delayed in their ability to contribute to a patient record due to the record remaining locked for editing:
>
> (a) *First,* the layout of the Acacia screens have been modified such that many aspects of a patient record will automatically open in view-only mode when clicked, with edit mode accessible by clicking a button. This reduces the likelihood that a user not intending to edit the record will unintentionally restrict it for editing by opening the record in edit mode.
>
> (b) *Second,* system permissions have been conferred on Hospital Resource Coordinators, Nurse Navigators and Team Leaders, who are hospital employees available 24 hours per day, 7 days per week at each tertiary hospital in the Northern Territory, to forcibly unlock a patient record for editing.[324]

Patient Loss

6.57 The AMA NT also told the Committee that patients were being 'lost' in the system.

> clinicians have approached us confidentially with concerns that Acacia is "losing" patients, with upwards of 3,000 patients identified as having their outpatient appointments or surgeries "lost" by Acacia, resulting in manual error control and ultimately an inability to verify that this critical issue has been rectified.[325]

6.58 The Departments told the Committee that this was not a technical issue but instead was due to staff failure to follow new workplace procedures:

> Previously, before Acacia 1.0 was used, clinicians would give patients a slip of paper at the end of their outpatient appointment which they were instructed to

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[322] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[323] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 9.
[324] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 9.
[325] Australian Medical Association Northern Territory, Submission No. 1, p. 20.

> put into a specific tray. That tray was monitored by administrative staff, and the slip of paper would indicate when the patient needed to be followed up, if at all. This created a risk that patients would lose or forget to place their slip of paper in the tray.
>
> Now, with Acacia 1.0, after the completion of an appointment with a clinician, the clinician has the opportunity to digitally confirm that a follow up is required with the patient, the date on which the follow up is required (e.g. 1 month, 3 months, 6 months), and then a free text box into which the clinician may enter specific notes. That then prompts the administrative officers in Acacia to book the follow up appointment for the patient, removing the need for the slip of paper and digitising the process.
>
> Unfortunately, due to the change in business processes, that step is occasionally being missed by the clinician and booking officers are therefore not being prompted to book the follow up appointment, nor do they know when to book the follow up for.[326]

6.59 The Departments also told the Committee this was occurring in triaging:

> A similar change occurred with the triaging of referrals in outpatients. Previously, clinicians would sift through the referrals (paper), and place post-it notes on the top regarding when the patient needed to be seen: for example, if the matter referred was urgent and the patient needed to be seen as soon as practicable, or if appointments could be booked in a few days or weeks. Those papers and post-it notes would then go the administrative staff, who would book the appointment accordingly.
>
> Now, with Acacia 1.0, that triaging is done within the Acacia environment, where clinicians can read each referral, and digitally mark it as being urgent, semi-urgent, etc, and list when the patient needed to be seen. That referral then automatically prompts the administrative staff to book that patient accordingly. However, if that digital triaging is not done, then there is no trigger to the booking team as to when to book the patient.[327]

6.60 In response, the Departments have delivered training and guidance to address these issues.[328]

Episode Limits

6.61 The Committee also heard from the AMA NT that they had been advised that there was a limit of 100 episodes of care per patient. The Committee was told that this was an insufficient number of episodes for long term care. Further, the Committee was advised that the workaround provided to mitigate this issue was to establish a new patient profile, which carried significant risks in itself:

> 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

[326] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 6.
[327] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 6.
[328] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 6.

> 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.[329]

6.62 The Committee asked the Departments about this issue. The Departments refuted the evidence provided by AMA NT and told the Committee that there was no episode limit. They instead explained there had been performance issues following FG1 deployment in KDH:

> There is no episode limit in Acacia. A performance issue was experienced during the Katherine FG1 implementation where patients with over 1000 episodes had a loading delay. This was resolved immediately.[330]

Non-Government Health

6.63 The Committee heard from the Australian Nursing and Midwifery Federation Northern Territory (ANMF NT) that they were uncertain which healthcare workers should have access to Acacia. They noted that agency Remote Area Nurses (RANs) were unable to access Acacia and were unsure whether limitations on Agency staff extended to urban areas.[331] Similarly, the RANZCP told the Committee that many psychiatrists do not have access to Acacia:

> Further, despite a majority of psychiatric care being delivered in community settings, Acacia in its current form does not support or capture community-based services. It also lacks integration with key partners such as NGOs and Aboriginal Corporations, creating a systemic blind spot that risks perpetuating health inequities in rural and remote communities, particularly for Aboriginal and Torres Strait Islander peoples.[332]

6.64 The Committee was advised by Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, that the non-government health sector were not envisioned to be a part of Acacia:

> The non-government health sector were never part of the scope of Acacia because they are not part of government. There are legislative and policy impediments to us letting them on our system. Obviously, there would be some value in the longer term being able to have a single joined-up clinical information system across the Territory, particularly as we continue to transition remote primary care clinics to community control. I think currently there are about 67 under community control and I think we have about 46 left on our books, but that transition is a slow process and needs to be done carefully. Generally the non-government clinics use a different platform called Communicare. We do take some data feeds from them for the purposes of national reporting against funding KPIs and those sorts of things, but we do not take their clinical information into Acacia as part of our database.[333]

6.65 Contrary to this position, the Committee observes that the community portal functionality of FG5 is designed to facilitate the integration of non-government healthcare:

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[329] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 3.
[330] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[331] Australian Nursing and Midwifery Federation, Submission No. 4, p. 1.
[332] The Royal Australian and New Zealand College of Psychiatrists, Submission No. 6, pp. 1-2.
[333] Department of Health, Committee Transcript, 17 February 2026, p. 6.

> …the Acacia system has the capability to provide what we call clinical portals so that if you were someone who came into Gove Hospital and had some form of clinical procedure but your follow-up care was being provided by Miwatj at Yirrkala, the clinician at Miwatj could have scaled-down access to come into the system, see just the information that they are allowed to see—your discharge summary and your medication schedule and those sorts of things—so that all clinicians are working to the one core true set of information, that one clean record which is important. At the moment, we do that manually; we send them a discharge summary and other things.[334]

6.66 The Committee also notes that the Departments themselves in describing the Acacia program indicate that all healthcare services in the Territory will have access to Acacia:

> **A fully integrated electronic clinical information system across the Territory**
>
> Once fully implemented, Acacia will operate as a single integrated clinical information system across primary, secondary and tertiary care settings in rural, remote, community and hospital environments.
>
> In practical terms, the integrated system will enable clinicians to access and contribute to a single patient record from any hospital, clinic or community care centre across the Territory. This electronic health record will be maintained in real-time, meaning that record entries such as pathology test results or clinical notes made by a clinician in a hospital will be instantly accessible to a remote area nurse or general practitioner in a remote community.
>
> The Northern Territory will be the first jurisdiction in Australia to provide this end-to-end clinical information to all healthcare providers, accessible across the entire health system at the time and place of care delivery.[335]

6.67 The Committee notes that, if non-government healthcare is to be excluded from access to Acacia, then departmental communications should be careful not to overinflate the extent to which *all* healthcare providers in the Territory will be able to access Acacia.

Resolution of Issues

6.68 Many submitters told the Committee that the process for raising and resolving issues was not transparent or effective. This section considers this matter both prior to deployment (for example, through UAT and SUVT processes) and following deployment (through ticketing).

Preceding Deployment

6.69 Prior to deployment of an FG, several different phases of testing and quality assurance occur. These include UAT and SUVT, lessons learnt assessments, independent stage-gate reviews, and clinical safety cases and Go/No-Go packs. Each provides an opportunity for clinicians to raise issues with the program. However, the Committee heard that in some instances issues raised with the CCSRP were not addressed prior to deployment, and in some cases, even when

[334] Department of Health, Committee Transcript, 17 February 2026, pp. 6-7.
[335] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 12.

that issue had been raised multiple times. These matters are discussed further below.

Issues Raised in UAT and SUV

6.70 UAT is a key mechanism to ensure that software meets the needs of clinical users, defined by the Departments as a 'software testing process in which end users test the new system in place to ensure it meets their needs and expectations, and to identify issues, before it is deployed at large'.[336] SUVT ensures that the software is appropriately configured for particular sites. [337]

6.71 The Committee was told by the Departments that extensive UAT and SUVT occurred. For example, the Departments told the Committee that in advance of FG1 deployment in KDH, UAT was undertaken across the NT (as discussed in paragraph 3.25—3.27).[338] Following postponement of the KDH deployment due to the COVID-19 pandemic, additional UAT was undertaken.[339] The Committee asked for further information regarding UAT and SUVT processes and procedures. The Departments highlighted the key features of both procedures, advising that UAT occurred following production release, whereas SUVT was site specific:

> The Program provides test documentation, including Testing Strategy and Plans. UAT occurs when the FG functionality is released to Production for the first time, not tied to individual sites. Site Validation checks site configurations before implementation but does not re-validate functionality. Both testing and site validation are part of approved implementation plans overseen by governance groups.[340]

6.72 However, the Committee heard from some stakeholders that UAT in the 'target environment' was insufficient.[341] In particular, some stakeholders told the Committee that issues identified in UAT and SUVT were not always resolved. For example, the AMA NT told the Committee how some clinicians who raised safety issues during these processes were told that no changes would be made to resolve their identified issues:

> 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.[342]

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[336] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. iv.
[337] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 9-10.
[338] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[339] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[340] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 9-10.
[341] Australian Medical Association Northern Territory, Submission No. 1, p. 18.
[342] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 4.

6.73 Accordingly, the Committee also asked the Departments what conditions enabled a 'pass' during UAT, and whether UAT occurred in the context of workflows or patient journeys. The Departments advised the Committee that:

> A pass means no defects are found during scenario or use case testing. After the first UAT, all further tests are performed by analysts using those same scenarios.
>
> UAT occurred using workflows in the system context given some steps in a workflow are completed outside of Acacia. [343]

6.74 The Committee also asked the Departments whether any UAT reports had outstanding actions or resolutions at time of go-live in any hospital. The Departments confirmed there were outstanding actions or resolutions but did not specify how many or what severity these outstanding actions were.[344] The Committee asked the Departments a similar question regarding SUVT reports. Further, if there were outstanding actions or resolutions at the time of go-live in any hospitals, the Committee asked how many there were. The Departments told the Committee that in most deployments there were outstanding issues identified in SUVT, but that in all cases governance committees had determined that workarounds mitigating clinical risks were satisfactory to enable deployment.

> Every IT system implementation and release update inevitably includes some residual defects (bugs). During the decision-making process for system releases and go-lives, NT Health evaluates and determines the acceptable threshold of defects.
>
> Below are the outstanding defects in Production at time of go live. Noting that at each go live the defects were present in Production and there for other sites.

	Big Rivers	East Arnhem	Top End (full hospital)	[Central Australia and Barkly]
Sev 2	0	0	9	10
Sev 3	51	8	109	114
Sev 4	6	1	36	12
Sev 5	0	0	0	89

> Note: Sev is the severity of the risk. Severity 1 is the highest risk and severity 5 the lowest. [345]

6.75 The Committee also asked the Departments what processes exist to ensure that issues raised by clinicians through UAT and SUVT are addressed prior to go-live.

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[343] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 10.

[344] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 10.

[345] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 9.

The Departments told the Committee that issues and their associated mitigating workarounds are assessed individually:

> Each defect is assessed individually to determine if the workaround is adequate. Not all defects will be fixed before an implementation.[346]

Issues Raised from Preceding Deployments

6.76 The Departments told the Committee that KDH was selected as the first site of FG1 deployment because 'a critical part of the subsequent deployments was reviewing and learning from the Go Live at Katherine Hospital to better inform those deployments.'[347] The Committee understands that similar logic underpinned the timing of the GDH deployment.[348] The Departments explained that issues identified following go-live of FG1 at KDH were resolved *in situ*:

> As expected with any large ICT system replacement, a number of further issues were identified by users following the Go Live, particularly in the theatre scheduling and outpatients teams. Those issues were addressed with the Acacia system in situ, with support provided by Program staff and InterSystems product specialists to workshop, test and implement fixes.[349]

6.77 In contrast, the Departments told the Committee that no major issues were reported as a result of the GDH deployment of FG1:

> On the morning of Saturday, 26 November 2022, Acacia 1.0 went live at Gove District Hospital. No significant issues were reported, and the deployment was smooth.[350]

6.78 Facilitated by the lessons learnt from deployment in KDH and GDH, the Departments advised that significant revisions occurred prior to deployment of FG1 in RDPH. They explained some of these reconfigurations in detail:

> Prior to Go Live, a number of significant enhancements were made to Acacia 1.0, particularly in the ED-to-inpatient patient journey workflow, and the theatre scheduling functionality. Those improvements were identified as necessary following the Katherine Hospital Go Live, and by the Top End Implementation Working Group. Whereas Katherine Hospital could safely manage Acacia 1.0 while those improvements were made in place, they were required prior to the Royal Darwin and Palmerston Hospitals Go Live given their significantly higher bed pressures compared with the smaller regional hospitals. Those improvements included:
>
> (a) enhanced identification and prompting of patients with similar names;
>
> (b) including the ability to search and manage patients using their localities and suburb information across waitlists and appointments, to allow more efficient management of patient travel and attendance for care;

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[346] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 9-10.
[347] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[348] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p.11; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 23.
[349] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 24.
[350] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 24.

> (c) complete restructure of the ED-to-inpatient functionality to ensure correct representation and efficient management of patient care and clinical responsibility;
>
> (d) enhanced bed management functionality to support management of patients across facilities; and
>
> (e) rebuilding the theatre scheduling functionality to allow schedulers and clinicians to manage patients through booking and subsequent admission of the patient for surgery.[351]

6.79 As a result of these revisions, the scheduled implementation was pushed back to November 2023:

> Those functionality enhancements were required to be thoroughly tested, validated, and assessed in User Acceptance Testing scenarios. In addition, recurrent Code Yellows at Royal Darwin and Palmerston Hospitals and staffing pressures limited the pace at which preparatory work for the Go Live could be completed. For those reasons, the Go Live was postponed to November 2023.[352]

6.80 However, the Committee heard views from other stakeholders that some issues identified during the KDH and GDH deployments of FG1 were not remediated in advance of the deployment of FG1 at RDPH. For example, AMA NT and ANMF NT highlighted that there were issues identified upon deployment at KDH and GDH that were not resolved prior to deployment in RDPH. ANMF NT told the Committee they were aware of:

> Issues within Acacia, which were supposed to be fixed when rolled out in say Gove, prior to being rolled out at Royal Darwin Hospital, were not fixed.[353]

6.81 Similarly, the AMA NT told the Committee that:

> Feedback from Katherine District Hospital highlighted a number of these workflow concerns that were ignored or not dealt with appropriately prior to the rollout in Royal Darwin & Palmerston Hospitals. It should have been well known that these issues would occur in RDPH given the feedback provided from KDH.[354]

6.82 The AMA NT specifically told the Committee that the same issues identified and escalated to the CCSRP following deployment in KDH and GDH caused issues at RDPH following deployment:

> The implementation then encountered profound difficulties upon its introduction into the high-volume, high-complexity environments of the Royal Darwin and Palmerston Hospital (RDPH) Emergency Departments (EDs) in November 2023. These issues spanned technical stability, clinical usability, workflow integration, and data governance.
>
> Frustratingly, several of these issues had been identified by clinicians in KDH and GDH, but were not acted upon. Clinicians across all sites have told us that the responses from support staff post-implementation were incredibly

[351] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 24-25.
[352] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 25.
[353] ANMF NT, Submission No. 4, p 1.
[354] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 4.

> patronising, and issues of significant clinical risk (including direct harm to patients) were treated with the same urgency as minor useability issues.[355]

6.83 Further, whilst the Departments acknowledged that issues had occurred during the FG1 deployment at KDH, the AMA NT emphasised that the issues were of such significance that, in their opinion, they required Ministerial notification:

> While the initial "go live" stage of the Acacia rollout appeared to proceed relatively smoothly in smaller regional sites like Katherine Hospital and Gove District Hospital , very clear clinical concerns began to become apparent in this first week of operation… critical feedback was provided from KDH staff in August 2022, and again was serious enough to require the attention of the Minister.[356]

Gateway Reviews

6.84 The Departments told the Committee that the CCSRP undertook independent gateway reviews throughout the life of the program. The Committee notes that use of stage-gate reviews was a key recommendation of the 2014 PAC *Management of ICT Projects by Government Agencies* and commends this practice. The Committee requested and was provided the stage-gate reviews conducted in 2015 and 2018. The Departments told the Committee that stage-gate reviews were also undertaken prior to deployment in KDH, RDPH, and the RDPH remediation:

> Independent assurance reviews were conducted prior to the following implementations:
>
> - Katherine FG1
> - Top End FG1
> - RDPH ED FG1 Reimplementation[357]
>
> The findings from these reviews did not warrant postponing the scheduled go-live dates.

6.85 The Committee also requested and received the RDPH stage-gate review. The scope of the Top-End assurance review was:

> - The planning and execution strategy for the FG1 implementation including the approach, user training, site plans, critical decision timeline, communication plan and other relevant documentation.
> - The planning for the cut-over and stabilisation period including back-out plans, performance monitoring, problem resolution plans and other relevant documentation.
> - Top End sites readiness, stakeholder engagement and business readiness to adopt and effectively use the new clinical system
> - Review of the planned implementation of documented lessons learnt.[358]

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[355] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[356] Australian Medical Association Northern Territory, Submission No. 1, pp. 10-11.
[357] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 10.
[358] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, p. 5.

6.86 The Departments advised that none of the KDH, RDPH or RDPH remediation stage-gate reviews found issues warranting postponement of any go-live.[359]

Go/No-Go Decisions

6.87 Before implementation in each location, a clinical safety assessment was undertaken to examine the clinical risks and provide a foundation on which to assess whether go-live should continue:

> Clinical Safety Cases were prepared and included as part of the governance go live prerequisite packs used to inform the go / no go decision for each implementation. These packs were considered by all the governance groups: [Implementation Working Group], CLG, PIC and PSC before the final decision was taken to proceed to go live. [360]

6.88 These formed part of the Go/No-Go packs provided to governance committees ahead of Go/No-Go decisions. These packs extensively evaluated the risks of deployment and mitigation strategies in place, including workarounds. Upon request, the following Go/No-Go packs were provided to the Committee, alongside their associated clinical safety case:

- FG1 Katherine Implementation
- FG1 Gove Implementation
- FG1 Top End Outpatients Implementation
- FG1 Top End Remaining Services Implementation
- FG1 Central Australia and Barkly Renal Implementation
- FG1 Alice Springs Corrections Implementation
- FG1 Alice Springs and Tennant Creek Implementation
- FG1 RDPH Emergency Departments Reimplementation.[361]

6.89 As Dr Andrew Bell, Chief Clinical Information Officer, explained to the Committee, it is not possible to eliminate risks associated with deployment. There are risks associated with deployment simply by virtue of being a major change in the operation of a complex system:

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

[359] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 10.
[360] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 10.
[361] Department of Corporate and Digital Development, *Attachments to Answers to Questions Taken on Notice,* 19 March 2026.

> monitor and improve the level of risk as you go forward. It has been quite a rigorous process[362]

6.90 Instead, as Grace Johnson, Program Director of the CCSRP, told the Committee these packs enabled governance committees to assess the level of risk associated with deployment and assess whether the risk of deployment was greater than or lesser than governance committees' tolerance for risks:

> They were all raised, as part of that go/no-go pack, they are all documented and written in there. That go/no-go pack traverses through all of those governance forums up to the steering committee which has the chief executives across the Department of Health, DCDD and Treasury.
>
> Then, as part of that, there is a decision by NT Health on what risk they will tolerate and what risk they will not tolerate. We obviously do that as part of a formalised process. NT Health, every second of every day, are assessing clinical safety risk, so they have a tolerance that they then decide on whether or not it is something that they are going to accept or not.[363]

6.91 Grace Johnson further advised the Committee that each subsequent deployment was able to build on and learn from prior deployments, including the actual level of risk associated with particular issues:

> Leading into implementation, as part of what we call a go/no-go decision, Chris mentioned we usually traverse all those governance groups in 24 hours. However, what we also do is before every implementation, a clinical safety case and a clinical safety assessment is conducted about what we are implementing. Though it is the same system that gets implemented across each of the hospitals, there are nuances on how it is used, depending on the hospital, so that clinical safety case is then updated as part of each of those implementations, with lessons from what occurred in the previous one—both what worked well and things that might have been degraded and rated lower. It was also things that we thought would only be a low clinical safety risk but actually turned out to be bigger, and any further mitigations that we put in place as well. All of those things were tracked and raised through our governance groups in various different forms, depending on when they were raised.[364]

6.92 However, the AMA NT told the Committee that the decision-making within these Go/No-Go decisions did not adopt an appropriate level of risk tolerance and instead appeared to agree to go-live whilst knowing of unacceptably high levels of risk:

> The potential for serious adverse events was clearly articulated and formed the basis for the necessary decision to suspend its use in the EDs. The history preceding the ED rollout raises questions about the project's approach to risk. Concerns being raised years in advance and known risks being mitigated through workarounds and training rather than fundamental fixes suggest a potential acceptance or normalisation of operational risk and thus an accepted threat to patient safety. Proceeding with the ED go-live despite these unresolved issues indicates that either the severity of the risks in the high-pressure ED environment was underestimated, or that pressures to adhere to timelines or budgets may have overshadowed safety imperatives. Relying on human adaptation to compensate for system deficiencies created a fragile

[362] Department of Health, Committee Transcript, 17 February 2026, p. 20.
[363] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 25.
[364] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 25.

> implementation that ultimately failed when subjected to real-world clinical stress, directly impacting patient safety.[365]

6.93 The Top End Remaining Services Go/No-Go pack explains that there were outstanding clinical concerns regarding the deployment of FG1 in RDPH. For example, it reported that ED UAT participants expressed 'strong concerns with the workflows in Acacia.'[366] ED UAT acceptance of the solution was 'conditional' on increased resourcing.[367] Similarly, the Go/No-Go pack included information that Theatres UAT participants expressed:

> strong concerns with the workflows in Acacia, especially when compared to CareSys. Feedback includes comments such as 'workflow too long', 'too many screens', 'time consuming'. This mirrors the feedback from users in earlier UAT cycles.[368]

6.94 Review of the Top End Remaining Services Go/No-Go clinical safety case indicates that there were 35 risks outstanding, with zero having a high residual rating, 7 having a medium residual rating, and 28 with a low residual rating.[369] However, beyond risks, defects and unit specific issues were also identified in the Go/No-Go pack. As noted above, there were 9 severity 2 defects, 109 severity 3 defects, and 36 severity 4 defects identified prior to go-live.[370] Theatre Scheduling issues were also identified, with 3 closed, 8 to be resolved prior to go-live and a further 12 open and to be resolved following go-live.[371] Accordingly, the Committee asked the Departments whether there were, prior to Go-Live of FG1 in any hospital, any clinical safety issues or formal challenges to FG1 raised with senior project staff or the project sponsor that sought to or were justification for halting deployment. The Departments told the Committee that:

> During the clinical safety case assessments, CCSRP conduct thorough risk determination, provide detailed descriptions of inherent risks, and establish clear go/no-go prerequisites.
>
> Risk-based decisions are evaluated by governance groups and consistently assessed against the inherent risks associated with not proceeding to go-live.
>
> Therefore, there have been clinical safety issues raised with FG1 however they are incorporated into the Clinical Safety Cases and assessments for each go live. These documents include the mitigation actions required.[372]

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[365] Australian Medical Association Northern Territory, Submission No. 1, p. 21.
[366] Core Clinical Systems Renewal Program, *Functional Group 1: ED to IP Patient Flow User Acceptance Test Summary Report,* September 2023, p. 5.
[367] Core Clinical Systems Renewal Program, *Functional Group 1: ED to IP Patient Flow User Acceptance Test Summary Report,* September 2023, p. 5.
[368] Core Clinical Systems Renewal Program, *Functional Group 1: Theatres Scheduling User Acceptance Test Summary Report,* July 2023, p. 5.
[369] Core Clinical Systems Renewal Program, *Functional Group 1 – Clinical Safety Case – Top End Inpatients Go Live,* November 2023, p. 11.
[370] Core Clinical Systems Renewal Program, *Top End Implementation Working Group – FG1 Defect Report*, November 2023, p. 7.
[371] Department of Corporate and Digital Development, *Theatre Scheduling Issues Report*, September 2023, p. 1.
[372] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 11.

6.95 The Committee further enquired whether any outstanding actions identified through UAT or SUVT caused issues upon deployment. The Departments did not specify whether any caused issues in their response to the Committee:

> While some of these items could have caused problems at go-live, the defect report accepted by governance groups and approved by the Steering Committee for the go/no-go decision, includes recommended workarounds.[373]

6.96 The Committee notes that go-live at RDPH was endorsed by Royal Darwin Hospital implementation group, membership of which included senior ED representation[374] The Committee observes that ultimately the decision to proceed with deployment is a question of risk tolerance. Although many clinicians may personally have been unwilling to tolerate the risks associated with deployment, it appears to the Committee that proper procedures and processes were followed.

Post-Deployment

6.97 The Committee heard that the existing resolution mechanism for issues identified within Acacia following deployment are ineffective. There are two systems for identifying and reporting issues with Acacia: Riskman and Jira. Riskman is maintained by NT Health, whilst Jira is maintained by DCDD.[375] Dr Andrew Bell, Chief Clinical Information Officer, told the Committee that all issues raised by clinicians must be logged in RiskMan:

> We have a system within the Health department of reporting any clinical risks and any incidents that are identified. They are all logged. They come up through our clinical safety team. There is work between the clinical safety team and my office to analyse all those risks as we go forward with Acacia, look at how we further mitigate any risks that were known about and we find have not been adequately mitigated or any new risks that emerge as we take on a new system.[376]

6.98 However, AMA NT told the Committee that the 2 different incident and risk management systems are not sufficiently integrated:

> When raising issues to Acacia staff, clinicians are being directed to RiskMan (the risk management system of NT Health). However, these incidents fail to progress as they are retained by NT Health and not DCDD.[377]

6.99 Both AMA NT and Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer in DCDD, told the Committee that there are extensive numbers of open tickets from clinicians seeking rectification or optimisation of Acacia which have not been dealt with.[378] For example, Kara Joyce told the Committee that there are more than 1000 outstanding tickets logged in Jira:

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[373] Department of Corporate and Digital Development and Department of Health, *Responses to the Written questions – 13 April 2026,* 13 April 2026, p. 9.
[374] Department of Health, Committee Transcript, 17 February 2026, p. 23.
[375] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 1.
[376] Department of Health, Committee Transcript, 17 February 2026, p 20.
[377] Australian Medical Association Northern Territory, Submission No. 1, p. 19.
[378] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 2; Kara Joyce, Submission No. 11, p. 2.

> The program uses a ticketing management system, Jira, to log and track issues. However, issues have not been managed effectively; there are currently 1,081 unresolved tickets relating to the delivery of Acacia 1.0 across all sites, with the oldest ticket dating March 2021, still sitting untouched. This reflects the long-term mismanagement of basic systems to deliver the product and explains the questionable quality of the implementation so far; as well as the feedback received from end users regarding the lack of training, guidance, and support.[379]

6.100 The Committee also heard that there is a lack of clarity regarding clinical requests for rectification or optimisation. Dr John Zorbas, President of AMA NT, told the Committee that staff are not clear how requests are handled or who makes the decision to progress a request:

> 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.[380]

6.101 Further, Kara Joyce told the Committee that clinicians have been asked to identify potential optimisations of Acacia, but that InterSystems are not obliged to deliver optimisation re-configurations:

> There are currently >1000 open tickets associated with Acacia that require an action from the program. Many of these are enhancement requests. The program has not only failed to managed expectations about Acacia being an out of the box solution but actively encouraged stakeholder to identify enhancements… From its inception the vendor was clear that they would not deliver or consider enhancements that didn't have a clinical safety impact. The messaging to the business was contrary to this and much work was done by program staff and stakeholders to define enhancements.[381]

6.102 AMA NT also told the Committee that rectification of issues are not prioritised by the extent of the clinical risk to patients:

> Clinicians across all sites have told us that the responses from support staff post-implementation were incredibly patronising, and issues of significant clinical risk (including direct harm to patients) were treated with the same urgency as minor useability issues. *It was, and remains clear, that the current project is unable to stratify clinical risk from the project by either likelihood and impact, which places Territorians directly in harm's way.*[382]

6.103 The Committee asked the Departments to clarify the division of responsibilities between InterSystems and the CCSRP regarding customisation of TrakCare into Acacia. They told the Committee that:

> InterSystems handles all customisations for their product. NTG uses the Australia/NZ edition of TrakCare, with some NT-specific custom features. CCSRP configures TrakCare for NT Health but cannot create customised views.[383]

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[379] Kara Joyce, Submission No. 11, p. 2.
[380] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 5.
[381] Kara Joyce, Submission No. 11, p. 2.
[382] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[383] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 6.

6.104 On this basis, the Committee understands that InterSystems is responsible for writing or modifying TrakCare code, whilst the CCSRP is responsible for configuring the settings and features within TrakCare to align it with NT Health business practices. The Committee asked the Departments about decision-making processes and associated authorities regarding optimisation, rectification, or enhancement requests from clinicians. Outlining the decision-making process, the Departments told the Committee that:

> All requests to modify Acacia production, currently utilised by hospital staff, undergo an assessment process that involves input from stakeholders and a structured decision-making process.
>
> a. The decision process depends on the size and impact of the change: single team changes are decided by the relevant delegate, while broader impacts go to the appropriate governance group.
>
> b. Affected areas must be consulted.
>
> c. For core system changes, [InterSystems] leads decisions at the global or regional level. CCSRP handles certain configuration changes that only affect NT.
>
> d. [InterSystems] runs several global and regional projects annually to review and update system functions. While some customers contribute input, not all are involved. All customers can submit product suggestions to [InterSystems] teams for consideration in their projects.[384]

6.105 Accordingly, 'core code' issues must be rectified by InterSystems.[385] This can mean engagement with 'multiple global and regional [InterSystems] teams.'[386] Where InterSystems are involved in the resolution of an issue, an extended timeframe may result from the need for the update to considered by different global and regional teams. Further, updates made by InterSystems are deployed at fixed times, in 6 scheduled updates per year:

> the vendor does updates throughout the whole year. Our vendor in particular does six updates a year, whether that is introducing new features in the system or fixing any issues in it. Those are just naturally in those updates throughout the whole year.[387]

[384] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 6.
[385] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 6.
[386] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 18.
[387] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p.33.

7 Impact and Cost of the Rollback

7.1 The Treasurer instructed the Committee to identify the impact to the health system, and the cost, of any rollbacks/suspensions of using the software in hospitals that occurred during implementation. This Chapter examines evidence provided to the Committee which responds to this element of the Inquiry Terms of Reference. The deployment of Acacia was suspended and rolled back only in the ED of RDPH, between 20 March 2024 and 13 November 2025. In all other areas any issues with the Acacia system have been resolved *in situ*.

Timeline of Rollback in RDPH EDs

7.2 A key timeline of events is outlined below:

- 11 November 2023: FG1 deployed in inpatients, including the ED.
- November 2023:
  - Workshops held between ED, InterSystems, and CCSRP[388]
  - InterSystems staff shadowed ED clinicians[389]
- 5 December 2023: the Director of Emergency Medicine at RDPH briefed the CCSRP on the impact of Acacia within the ED[390]
- 14 December 2023: a joint workshop was held between the CCSRP, InterSystems, and the RDPH ED[391]
- 18 December 2023: the PSC met and was updated on issues in the RDPH ED and discussed options for resolution, including formal introduction of the possibility of a rollback[392]
- January 2024: the PSC met weekly to discuss rollback[393]
- 24 February 2024: the PSC agreed to roll back to CareSys in the RDPH ED[394]
- 20 March 2024: FG1 was rolled back in the RDPH ED to CareSys.[395]
- 13 November 2025: Remediated FG1 was redeployed in RDPH ED.

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[388] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 41.
[389] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 41.
[390] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 14.
[391] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 14.
[392] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 14.
[393] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 14.
[394] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 14.
[395] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 42.

7.3 The Committee notes that the AMA NT advised that discussion regarding rolling Acacia back began earlier than the formal introduction of rollback as a remediation option on 18 December 2023:

> Once live, critical problems manifested rapidly, with serious issues reported within 35 hours, and discussions regarding a potential rollback commenced barely a fortnight later.[396]

7.4 Following the decision to rollback, risk assessments and safety reports were undertaken to assess the clinical risks associated with returning to CareSys in the RDPH and to identify methods of mitigating those risks:

> A clinical safety report had to be developed to capture any risks being introduced as part of the rollback as well as identify possible mitigations. [397]

> A clinical safety report was developed as part of the RDPH ED rollback to CareSys that identified 13 clinical safety risks. These were accepted as part of the decision to rollback to CareSys. The Clinical safety report outlines the risks and proposed mitigations.[398]

7.5 Additionally, software integration was required to facilitate the reintroduction of CareSys. The Departments outlined some of the preparatory work undertaken:

> Extensive planning and preparation was required to operate both patient administration systems within one facility including the synchronisation of data between CareSys to Acacia to ensure inpatient clinicians had access to their patient's information from ED. New integrations were also required between CWS, Acacia and other NT Health systems given CareSys integrations had been disabled to allow for Acacia integration.[399]

7.6 The remediation project was deployed in full to the RDPH in November 2025. The Committee notes that AMA NT consider the remediated dashboard to still be of lesser clinical use than that provided by CareSys:

> [Dashboard visibility] has been rectified somewhat but it required a concerted effort from the Acacia team over several months, but remains an inferior replacement of the previous low functioning system. The cost of this exercise was likely incredibly high and completely unnecessary, had early consultation and codesign and/or user acceptance testing been done with emergency medicine doctors prior to the rollout.[400]

Impact of the Rollback

7.7 A range of negative impacts of the deployment of FG1 in RDPH were outlined in Chapter 6. The rollback of FG1 to CareSys mitigated those issues in the RDPH ED, including additional staff stress, data integrity issues, and oversight of patients in the ED ward.

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[396] Australian Medical Association Northern Territory, Submission No. 1, p. 11.
[397] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 14-15.
[398] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 17-18.
[399] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 14-15.
[400] Australian Medical Association Northern Territory, *Supplemental Information, 22 July 2026,* p. 3.

7.8 Additionally, the Committee received specific evidence that the rollback improved wait-times in the ED, resulted in issues associated with have two different patient administration systems running concurrently, and delayed subsequent phases of Acacia being developed and deployed. These matters are discussed further below.

Wait-Times

7.9 The AMA NT told the Committee that the rollback of Acacia to CareSys had a positive impact on the wait-time performance of the RDPH ED, due to the poor performance of FG1:

> There is a correlation between wait times and the rollout/use of Acacia, which can be found in NT Health reporting and national safety & quality databases such as the Health Roundtable… The initial rollout of Acacia is clearly demonstrated by the rapid deterioration of performance… When Acacia was rolled back and CareSys was switched back on, the performance immediately returned to baseline levels.[401]

7.10 The AMA NT explained this impact with reference to information from the Health Roundtable regarding category 1 (immediate) and 2 (within 10 minutes) triage performance of the Royal Darwin Hospital between April 2022 and March 2026. The relevant charts are provided in Figures 1 and 2. AMA NT explained that deployment of Acacia corresponded with a sharp decrease in the performance category 1 triages at the Royal Darwin Hospital ED, to 20%. However, upon rollback the performance of the ED returned to its previous performance of 100%. A similar pattern was evident in category 2 triage performance:

> The purple line demonstrates RDH's performance over time. The initial rollout of Acacia is clearly demonstrated by the rapid deterioration of performance, with Cat 1 performance falling from 100% to 20% and Category 2 performance falling from ~40% to ~10%. When Acacia was rolled back and CareSys was switched back on, the performance immediately returned to baseline levels. You can then see the repeat deterioration in performance when Acacia was re-enabled later in the time period.[402]

7.11 The statistics provided by AMA NT align with patterns in wait times provided by the Departments at the RDPH EDs over the same period, as outlined in Table 4. Here, evidence from the Departments indicate that deployment of FG1 corresponded with an increase in both the average wait time to be seen and the longest wait time to be seen. During the rollback period, these figures reversed, with a shorter average wait time to be seen and longest wait time to be seen, compared to the deployment period. That said, the Committee notes that deployment of FG1 corresponded with a *decline* in the average time from inpatients admission to transfer out of the ED and rollback corresponded with a longer average time from inpatients admission to transfer out of the ED than the deployment period. The Committee notes its concerns that in both datasets the wait-times in the RDPH EDs have increased again following deployment of the remediated version of FG1.

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[401] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 4.
[402] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 4.

Figure 1: Triage Performance – Category 1[403]

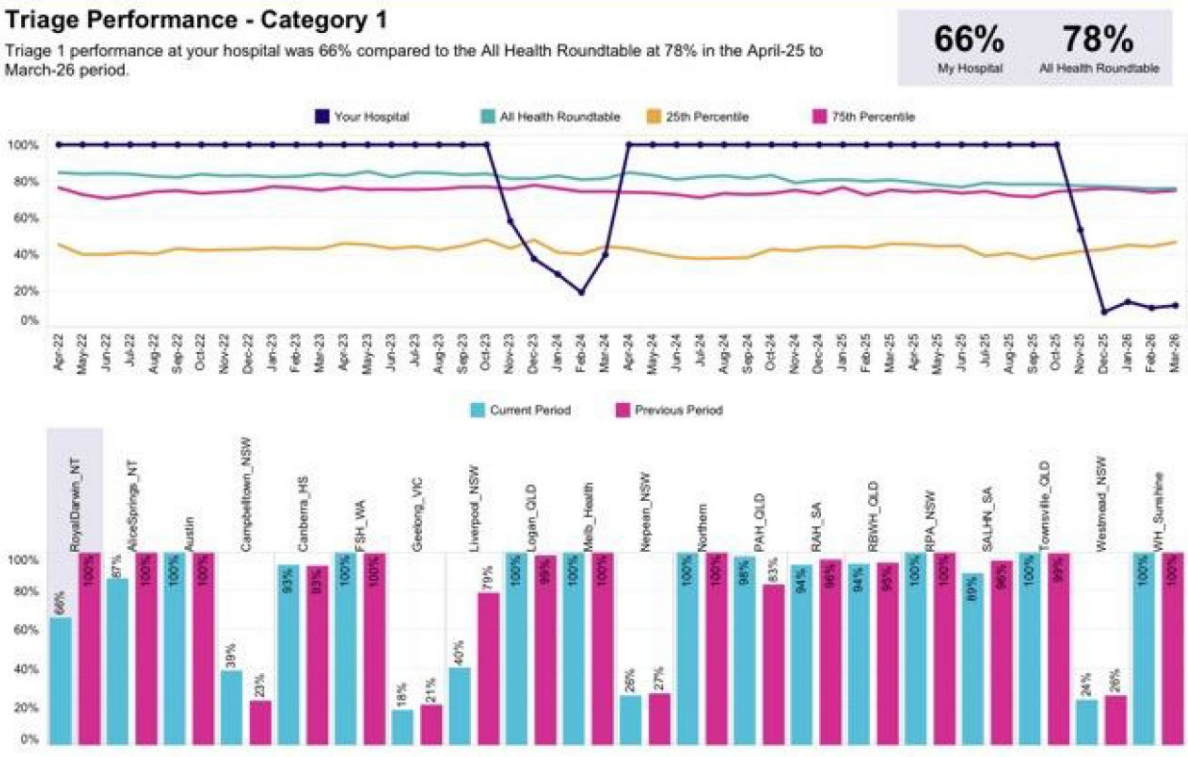
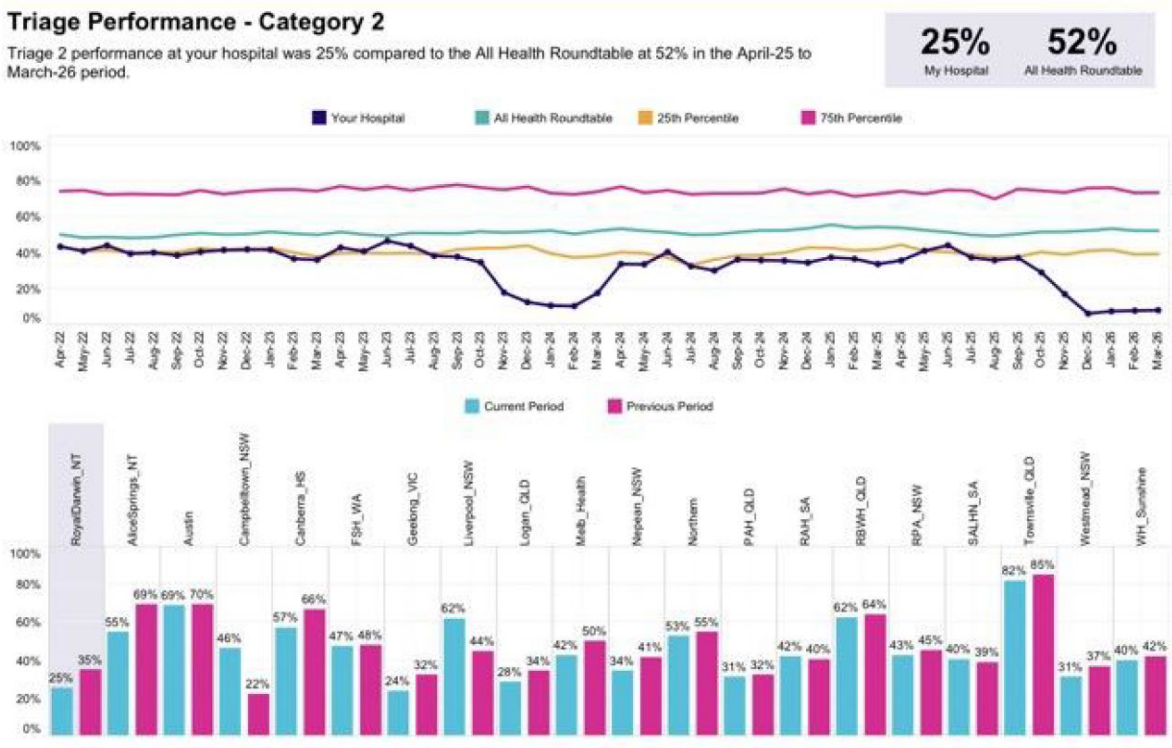


Figure 2: Triage Performance – Category 2[404]



[403] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 5.

Table 4: Wait Times at the RDPH Emergency Departments[405]

Time period	Average time waiting to be seen (mins)	Longest wait time to be seen (mins)	Average time from in-patients admission to transfer out of ED
2021/2022 financial year	61.5	1109	387
2022/2023 financial year	73.8	1793	349
Deployment (November 2023 - March 2024)	109.0	3428	205
2024/2025 financial year	83.7	1932	300
Re-deployment (Nov 2025-Feb 2026)	130.5	3612	161

Dual Patient Administration Systems

7.12 The Committee heard that there were negative impacts associated with maintaining two different patient administration systems at RDPH concurrently (CareSys and FG1 of Acacia). In total, 74 Riskman issues were raised in relation to the maintenance of dual patient administration systems over the course of the rollback.[406] Internal documentation demonstrates that the impacts were varied:

- RDPH ED admin team will have to continue to use two patient administration systems when registering and managing patients presenting to the emergency departments.
- The 'ghost' patients appearing in the Clinical Workflow System (CWS) will continue due to existing inpatients being admitted in ED when they already have an inpatient episode in Acacia.
- Issues being experienced with the synchronisation will continue to increase given the system was not built to be used in this manner.
- Increased data corrections workload will continue due to dual patient administration systems being used.[407]

7.13 A particular issue highlighted by the Departments was the need to have multiple inpatient episodes for a single patient:

> The main clinical safety risk that arose was having two inpatient episodes at the same time for one patient. This resulted in issues with documenting against the correct episode in CWS which is where clinicians write documentation as well

[404] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 5.
[405] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 16-17.
[406] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 18.
[407] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-21: Functional Group 1 (FG1) ED Remediation Project– Shedule* [sic], August 2024, p. 3.

> as eMMa medications being attached to the wrong episode or not having a current eMMa chart. This would often result in CWS showing a patient was still in the hospital even though the patient had been discharged.
>
> This resulted in inpatient clinicians not being able to trust the patient lists in Acacia, CWS or eMMa. This meant patients were not seen by a medical team for a day or were not provided with their medication.[408]

7.14 Accordingly, as highlighted by the AMA NT, it should be noted that the decision to rollback Acacia to CareSys did not *eliminate* clinical risks.[409] Instead, it exchanged one set of clinical risks for another. The clinical safety report undertaken to assess the risks of running two patient administration systems highlighted its own scope limitations, including that that it did not assess if the rollback would change the current level of clinical safety risk, as the decision to rollback had already been made:

> - Unlike a Clinical Safety Case this is NOT intended to make safety claims that control measures have been taken to reduce risks to an As Low As Reasonably Practical (ALARP) or a tolerable risk level to proceed to Go-Live.
> - The re-introduction of CareSys has been accepted by the agencies as a mitigation option for issues and problems using Acacia in the RDPH ED's. An argument that this will provide an acceptable level of risk mitigation, and therefore identify a change in the current level of clinical safety risk, is beyond the scope of this document.
> - This report does not include a comprehensive clinical risk assessment for the cutover activities [the re-introduction of CareSys and plans for this data transition across the 2 systems]. The planning and requirements to undertake this task are still under discussion and development, however this cut over is a high-risk activity for any introduction of a health information system, involving multiple manual processes, data migration and synchronisation
> - Some stakeholder groups may have been underrepresented in workshops due to the short notification and staffing shortages.
> - Time constraints did not facilitate evaluation of the effectiveness of controls or a comprehensive risk identification and assurance processes such as testing or workflow validation. This includes the integration with other systems; a significant cause of both clinical safety and business risk.[410]

7.15 The AMA NT told the Committee that clinicians were of the view that the risks associated with the use of the legacy system were lesser than those associated with the use of Acacia:

> it is important to acknowledge that legacy systems also carry inherent patient safety risks, often related to lack of integration, reliance on paper components, and potential for transcription errors. Staff have reported that these known risks of the legacy system were considered significantly less immediate or severe than the new risks introduced by Acacia in its problematic state. Any system

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[408] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 17-18.

[409] Australian Medical Association Northern Territory, Submission No. 1, p. 21.

[410] Northern Territory Government, *Clinical Safety Report- Reintroduction of CareSys to RDPH Emergency Departments*, February 2024, pp. 5-6.

> transition, including the rollback and the eventual reimplementation, also introduces transient risks that require careful management and monitoring.[411]

Program Schedule

7.16 Remediation at the RDPH ED had direct flow on effects to the deployment of FG1 in ASH and TCH, which ultimately occurred in August 2025:

> The decision in March 2025 was to not delay the Central Australia and Barkly FG1 implementation any further and instead to reimplement Acacia into RDPH ED after the CA&B implementation. Note that the same staff and contractors were required for each implementation so they could not have been achieved concurrently.[412]

7.17 Additionally, clinical and technical resources spent developing the remediated solution for FG1 further impeded progress on development of later FGs.[413] The Departments advised that the timeline impact of the remediation project on the deployment of FG1 to ASH and TCH was 10 months:

> The Central Australia and Barkly FG1 could have been implemented 10 months earlier if the RDPH ED rollback and remediation had not taken place.[414]

7.18 However, the Committee notes that this estimate of deployment at ASH and TCH in November 2024 is a year delayed from the schedule outlined in March 2023—the last full schedule provided to the Committee from before the remediation project—which planned deployment in these locations in November 2023.[415] This suggests that delays additional and separate to the remediation project occurred that impacted the ASH and TCH deployment of FG1.

Cost of the Rollback

7.19 The primary cost of the rollback was the establishment of the 'Central Administrative Hub' (CAH). Second order costs exist in the need for InterSystems and the CCSRP to prioritise work on the remediation project instead of progressing further FGs. The Committee notes that it also appears that the remediation project was rescoped, which substantially increased the extent of time that remediation works were required, with flow on effects on staffing costs and progress on later FGs.

Central Administrative Hub

7.20 Because the rollback required the RDPH to utilise two different patient administration systems concurrently, the CAH was established to integrate Acacia and CareSys:

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[411] Australian Medical Association Northern Territory, Submission No. 1, p. 21.
[412] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 19.
[413] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.
[414] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.
[415] Department of Corporate and Digital Development, *CCSRP Roadmap: Re-baselined Schedule*, March 2023, p. 1.

> The temporary suspension of Acacia in the Royal Darwin and Palmerston Hospitals EDs has led to a dual-system environment, in which 90% of the Royal Darwin and Palmerston Hospitals continued using Acacia while ED reverted to CareSys while further improvements were made. Immediate work was required to ensure seamless operation of the two systems, by manual data entry and document handling, so that a patient's journey through the hospital was not interrupted and patient safety could be preserved.[416]

7.21 The cost of running the CAH was initially $0.13 million per month, with a total projected cost of $1.5 million.[417] However, the cost of the CAH increased over time in two ways. Firstly, the initial projection was based on a February 2025 remediation date.[418] Ultimately, remediation was not deployed until November 2025, meaning the CAH was required for an additional 8 months. Additionally, the CAH appears to have been expanded. In April 2025 the Departments advised that the CAH consisted of 20 staff:

> a Central Administrative Hub **(CAH)** was stood up within the Royal Darwin and Palmerston Hospitals comprising 20 trained staff on a 24 hour, 7 days per week service. A team leader has been overseeing staff located in:
>
> (a) Palmerston Regional Hospital;
>
> (b) Royal Darwin Hospital Triage Unit;
>
> (c) Royal Darwin Hospital ED flight deck; and
>
> (d) Royal Darwin Hospital Patient Flow Unit.[419]

7.22 However, in April 2026, the Departments advised that there were 25 staff in the CAH:

> A Central Administration Hub of 25 staff had to be established, recruited to and trained in both CareSys and Acacia processes, to manually synchronise data between CareSys and Acacia in real time.[420]

7.23 It is unclear how long the CAH was ultimately maintained for. The Departments advised that the CAH was the only direct cost to the CCSRP associated with the suspension and rollback.[421] They further advised that the CAH was disestablished on 13 November 2025, upon the reintroduction of Acacia to the RDPH ED.[422] However, they also appear to have told the Committee that staff costs required to maintain functionality due to deployment of Acacia were related only to the ED rollback, and were expected to continue until April/May 2026.[423]

7.24 As of April 2025, running the CAH had cost $2.1 million:

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[416] Department of Health and Department of Corporate and Digital Development, Submission No. 3 p. 42.
[417] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-21: Functional Group 1 (FG1) ED Remediation Project– Shedule* [sic], August 2024, p. 3.
[418] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-21: Functional Group 1 (FG1) ED Remediation Project– Shedule* [sic], August 2024, pp. 2-3.
[419] Department of Health and Department of Corporate and Digital Development, Submission No. 3 p. 42.
[420] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 15.
[421] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 44.
[422] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 15.
[423] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 19.

> The only direct cost to the Program incurred as a result of the temporary suspension is the ongoing maintenance of the Central Administrative Hub (**CAH**), which is staffed 24 hours per day, 7 days per week. The operation of the CAH has required 20 FTE at around the AO4 level, at a cost of $2.1 million since inception.[424]

7.25 By April 2026, the Departments advised that the total cost of hiring staff to maintain system functionality related to the ED rollback was $4.2 million.[425] All staffing costs for the CAH were funded from the CCSRP.[426]

InterSystems

7.26 As previously discussed, InterSystems is paid when they achieve agreed milestones. Accordingly, the Departments advised the Committee in April 2025 that there have been zero direct costs to the program payable to InterSystems associated with the rollback. Instead, InterSystems bear all additional costs at their own expense:

> The contract with InterSystems is predicated on a milestone-based payment arrangement, in which InterSystems is paid per delivery of each development milestone, not per time period. For that reason, all the ED remediation works to the TrakCare software have been undertaken at InterSystems' own expense. Whereas software vendors might typically seek a contract variation to account for the additional costs incurred, InterSystems has not done so and has borne these additional costs.[427]

7.27 However, the Committee notes that in April 2026 the Departments advised that $2.7 million in costs have been payable to InterSystems for 'enhancements'.[428] Although they did not specify what these enhancements were, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that the remediation project had involved '170 enhancements to workflows'.[429]

Remediation Scope

7.28 Although it appears to the Committee that the time spent working on the remediation project would have substantially impacted the cost of the program, the Departments advised the Committee that these costs are not quantifiable:

> In addition to direct costs, there are further indirect costs due to the associated changes to the Program schedule, though these cannot be precisely quantified.[430]

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[424] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 44.
[425] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 19.
[426] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 15.
[427] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 45.
[428] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[429] Department of Health, Committee Transcript, 17 February 2026, p. 23.
[430] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 45.

7.29 The Departments told the Committee that 34 issues were identified that required remediation, and that completion of remediation was scheduled for the September 2025 quarter:

> Ultimately, 34 separate issues were identified which needed to be addressed to materially improve the use of Acacia 1.0 in the Royal Darwin and Palmerston Hospitals EDs. A number of options were considered to enable the ED remediation project to take place, including enhancing Acacia 1.0 in situ, or reverting to CareSys while enhancements were made.
>
> … The remediation work that was identified in early 2024, and re-introduction of Acacia into the Royal Darwin and Palmerston Hospitals EDs, are on track to be ready for Go Live in the September 2025 quarter.[431]

7.30 However, later advice provided to the Committee explained that the 34 separate issues identified as in need of resolution were identified in November 2023. Of these, 23 were resolved and delivered throughout January and February 2024. The remaining 11 outstanding issues were delivered in May 2024.[432] Remediation works 'identified in early 2024' appear to be separate to the 34 issues that necessitated the rollback in March 2024. Supporting this, in their January 2026 submission, the Departments told the Committee that, ultimately, 170 remediation enhancements were made:

> Approximately 170 remediation requirements were identified. Most of those related to the visual representation of clinical information on the screen, in a way in that clinicians were familiar with, and which enabled them to have "situational awareness" of what was happening across patients in the Department at any one time.[433]

7.31 Accordingly, it appears to the Committee that the remediation project expanded significantly in scope following the decision to rollback Acacia in January 2024. The Committee observes the Departments did not mention the scope of the project when asked about the key drivers of the time required to complete the ED remediation project. Instead, the Departments outlined three contributions to delays. Firstly, they explained that the extent of time required to remediate the RDPH ED was partially due to how InterSystems delivers software updates. The Departments told the Committee that the remediation necessary required changes to TrakCare's 'core code'.[434] These changes are made by InterSystems.[435] Accordingly, the Departments advised that an extensive process was necessary to re-engineer the system, in conjunction with InterSystems:

> TrakCare is a global product that has an Australian version. Changes requested by RDPH ED required core code changes in the system. These required

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[431] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 41-42.
[432] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 13.
[433] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 3.
[434] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 18-19.
[435] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 6.

> engagement and changes to be made by multiple global and regional [InterSystems] teams.[436]

7.32 The Departments then told the Committee that the remediation was first scheduled for February 2025. The delay from February 2025 to April 2025 was caused by the need to wait for InterSystems' set release schedule to amend TrakCare's core code. However, upon release, the second driver of delays were issues identified with the revised product:

> Changes to TrakCare code are made available to regional [InterSystems] teams through releases (rather than continuously). The teams would receive part of the release from the global team prior to being able to make the regional changes. Once the code changes occurred the changes were demonstrated to the ED stakeholders through multiple proof of concept sessions. The above process occurred over a 6-month period.
>
> The RDPH ED reimplementation of Acacia was originally planned for February 2025 however was postponed to April 2025 due to issues experienced in receiving the changes through the above ad hoc process (receiving specific code changes as they became available, rather than waiting for a system release).[437]

7.33 These matters were further articulated in an internal document released to the Committee. This document also indicates that the remediation project was expanded to include remediation to KDH and GDH EDs. Further, they outline that remediation in these locations was scheduled to occur in October 2024 but was delayed because of the identified issues:

> Together with the vendor (InterSystems(ISC)), CCSRP had planned to implement enhancements to Katherine and Gove District Hospital Emergency Departments towards the end of October 2024, with Royal Darwin & Palmerston Hospitals being rolled out in February 2025. Due to the multiple ad hoc releases of key functionality, the project team encountered significant defects and clinical safety issues which lead to the decision to not release the functionality and the delay in delivery to RDPH.[438]

7.34 Thirdly, the Departments advised that the delay to remediation of the RDPH EDs from April 2025 to November 2025 was because of issues with the remediated solution that were identified in March 2025. Subsequently, the CCSRP made the decision to prioritise the deployment of FG1 to ASH and TCH in August 2025, ahead of remediation of FG1 at the RDPH EDs.[439] Internal documents highlight that issues identified in March also had an impact on the deployment of the remediation of FG1 at the EDs of KDH and GDH, deployment of which was further delayed from March 2025 to April 2025.[440]

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[436] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 18.

[437] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 18-19.

[438] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-28: Functional Group 1 (FG1) ED Remediation Project – Revised Shedule* [sic], August 2024, p. 1.

[439] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 18-19.

[440] Core Clinical Systems Renewal Program, *CCSRP Governance Committees - Briefing Paper: Central Australia and Barkly Implementation Schedule*, May 2025, p. 1.

7.35 The Committee queries why the expansion in the scope of the remediation project in terms of the number of enhancements and locations of deployment was not raised by the Departments when the Committee asked about the causes of delays in delivering the remediation project. As discussed above, the remediation project diverted resources that would otherwise have been used to implement FG1 at the ASH and TCH at an earlier date, and further progress FG2-5. Noting that the key driver of program costs is elapsed time, it appears to the Committee that the near 2 years spent remediating FG1 were likely costly. As such, the expansion of remediation requirements, and the associated elapsed time and costs, appear an important feature of the ED rollback.

8 Current Status and Outstanding Steps

8.1 The Treasurer instructed the Committee to identify the current status of implementation against the original staged project plan and the outstanding steps and cost required for project completion. This Chapter examines evidence provided to the Committee which responds to this element of the Inquiry Terms of Reference. As previously discussed, when first funded in 2016, it was envisioned that the CCSRP would be developed and implemented in 5 years.[441] The original implementation plan would have seen Acacia deployed in a series of 'regional big bangs' followed by a secondary deployment of the community portal feature across the whole NT. Under this plan, Acacia would have been deployed in:

- Katherine in October 2019
- Darwin in May 2020
- Alice Springs in September 2020
- Tennant Creek in January 2021
- Nhulunbuy in April 2021.[442]

8.2 The community portal would have been deployed across the NT in June 2021, and the project would have been closed off by September 2021.[443] However, in December 2019 the implementation plan was changed to deploy Acacia in stages by FGs, on the following dates:

Table 5: Phased Implementation Deployment Dates[444]

Functional Group	Hospital/Region				
	Katherine/ Big Rivers	**Gove/ East Arnhem**	**Darwin and Palmerston/ Top End**	**Tennant Creek/ Barkly**	**Alice Springs/ Central**
FG0	June 2020 – November 2020				
FG1	November 2020	December 2020	March 2021	December 2020	February 2021
FG2 & FG3	October 2021	April 2022	September 2021	April 2022	March 2022

[441] Department of Health, *Annual Report: 2015-16,* p. 2.
[442] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[443] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 16.
[444] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

Functional Group	Hospital/Region				
	Katherine/ Big Rivers	**Gove/ East Arnhem**	**Darwin and Palmerston/ Top End**	**Tennant Creek/ Barkly**	**Alice Springs/ Central**
FG4	September 2021 – June 2022				
FG5	May 2022				

Current Status Against the Original Staged Implementation Plan

8.3 No elements of Acacia were deployed to the original 'regional big bang' program schedule. Of the 6 FGs in the revised phased implementation plan, only FG0 was deployed to the initial program schedule. FG1 has now been implemented, behind schedule. FG2 and FG5 are in development, with some features of FG2 nearing, or at, deployment. FG3 and FG4 have been deferred pending further funding. The current status of each FG is discussed further below.

Functional Group 0

8.4 Deployment of FG0 was scheduled to be rolled out across the Northern Territory from June to November 2020.[445] In their April 2025 submission to the Committee, the Departments advised that deployment was completed by October 2020, one month ahead of schedule.[446] However, in their January 2026 submission the Departments indicated that works continued into 2021:

> Functional Group 0, the Electronic Patient Record (EPR), which was completed in 2020-2021.[447]

8.5 As outlined in Figure 3, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG0 was to provide the following functionality:

Figure 3: Functional Group 0[448]

FG0 - Read-only Electronic Patient Record (EPR)

- Provides an aggregate read-only view of all 6 legacy data systems
- Read-only EPR enables Providers access to clinical information via Acacia
- Acacia access is available on appropriate desktop and handheld devices
- Maintained up-to-date with legacy systems (refer *Appendix D – Prioritised data set)*
- Enriched progressively as deployment and adoption proceeds
- Validate Wi-Fi coverage

[445] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.
[446] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 28.
[447] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[448] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 18.

8.6 Some submitters raised concerns with the Committee that FG0 did not achieve its full objectives. André Snoxall, former CCSRP contractor, advised that he had been informed that FG0 was 'not fully operating.'[449] He further specified that:

> 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.[450]

8.7 The Committee also heard that some healthcare workers have had issues accessing the EPR. In their April 2025 submission, the ANMF NT told the Committee that some agency nurses do not have access to information in Acacia:

> Acacia is used by Doctors and some remote area nurses (RAN). Agency RAN staff in remote do not have access to Acacia. ANMF NT are uncertain as to whether agency nurses don't have access to Acacia only in remote or whether this is NT wide...
>
> Acacia is definitely used for sourcing documents. It is meant to be the 'source of truth' for allergies over PCIS which is the remote NT system, for all clinics, to also be superseding PCIS. PCIS remains the primary system used by nursing staff. Agency staff do not have access to Acacia. [451]

8.8 AMA NT similarly queried whether community-controlled health organisations in regional and rural NT could access the EPR.[452] They also advised that some clinicians do not have access to the EPR:

> 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.[453]

8.9 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, gave the Committee an overview of the functionality of FG0 following its deployment, including in regional and remote communities. The Committee notes that FG0 sought to deploy a read-only EPR. It did not aim to deliver a read-and-write record:

> Functional Group 0, which was a read-only version of the system, took a feed from all our old systems into Acacia, so someone like me who grew up here and has a long patient history in our systems—a clinician anywhere, whether they are at RDH or out in the bush, could pull it up and look at it and see My Health Record over a longitudinal period, my medicines and surgeries I have had and any other contact I have had with the public health system... previously they would have had to go to a bunch of different systems and probably did not actually have access to those systems because they were not authorised users of them. If you are a doctor at Royal Darwin Hospital you do not necessarily have access to the systems used in the bush.[454]

8.10 The Departments further explained the functionality of FG0 in detail, again highlighting that the read-only EPR access is available Territory-wide:

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[449] Adelphos AI, Committee Transcript, 3 March 2026, p. 12.
[450] Adelphos AI, Committee Transcript, 3 March 2026, pp. 11-12.
[451] Australian Nursing & Midwifery Federation Northern Territory, Submission No. 4, p. 1.
[452] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 8.
[453] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 8.
[454] Department of Health, Committee Transcript, 17 February 2026, p. 8.

> FG0 delivered the Acacia Read Only Electronic Patient Record (EPR). The EPR contains real time and historical data from CareSys, CWS, PCIS, CCIS and MedChart / eMMa.
>
> It provides clinicians a view of the full patient history of treatment at NT Health facilities including visits at remote and primary health care clinics, mental health clinics and all NT Health hospitals. The EPR provides access to certain clinical documentation contained within the above systems without individuals needing access to each system. This is not something clinicians were able to see previously.
>
> The Read Only EPR also provides access to patients' My Health Record, Territory Kidney Care record, pathology and radiology results.
>
> Since implementing FG1, all NT Health clinicians can now see hospital presentations as they occur instead of relying on notifications from hospitals. The data recorded in the hospitals is visible to users who are currently not using Acacia FG1 (eg in remote health clinics) through their FG0 Read Only EPR access.[455]

Functional Group 1

8.11 Deployment of FG1 was scheduled to start in KDH in November 2020 and be complete by March 2021, with the final deployment in the RDPH.[456] Compared to the original staged implementation plan, deployment of FG1 was extensively delayed. Deployment in KDH did not occur until July 2022. The most recent deployment of FG1 occurred in RDPH on 13 November 2025. Table 6 outlines the full range of delays associated with implementing FG1:

Table 6: Deployment of FG1 Against the Original Staged Implementation Plan[457]

Hospital	Initial phased implementation deployment date (December 2019)	Actual deployment date	Months delayed
KDH	November 2020	July 2022	+20
GDH	December 2020	November 2022	+23
TCH	December 2020	August 2025	+56
ASH	February 2021	August 2025	+54

[455] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 20.

[456] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

[457] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 46; Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.

Hospital	Initial phased implementation deployment date (December 2019)	Actual deployment date	Months delayed
RDPH	March 2021	November 2023	+32
RDPH EDs	March 2021	November 2025	+56

8.12 With the remediation of FG1 in the RDPH EDs in November 2025, the Departments advised the Committee that the deployment of FG1 is complete:

> Acacia is now utilised 24 hours per day, 7 days per week by over 6,000 clinicians across the Territory's six hospitals, as well as in every renal dialysis facility. The successful, Territory-wide implementation of Acacia 1.0 has allowed the retirement of the Territory's highest-risk legacy system, CareSys, and is delivering clinical benefits at the point of care.
>
> Functional Group 1 of the Program is now complete.[458]

8.13 As outlined in Figure 4, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG1 was to provide the following functionality:

Figure 4: Functional Group 1[459]

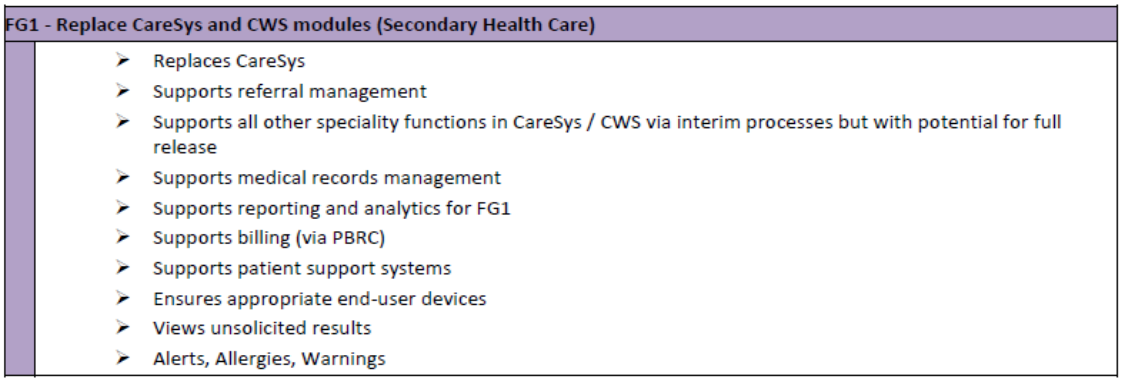
FG1 - Replace CareSys and CWS modules (Secondary Health Care)

- Replaces CareSys and CWS including User Defined Screens
  - Patient Administration System (PAS) module
  - ED module (triage)
  - Theatre module (pre/intra/post-op process)
  - JCCB modules and functions
  - Labels and bar-codes
- Supports referral management
  - Scheduling and wait-list management
  - Supporting OPD operational business
- Supports all other speciality functions in CareSys / CWS via interim processes but with potential for full release
  - Discharge summaries
  - Speciality letters
  - Speciality maternity information (e.g. birth registration)
  - Speciality Allied Health
- Supports medical records management
- Supports reporting and analytics for FG1
- Supports billing (via PBRC)
- Supports patient support systems
  - Transport
  - Interpreters
  - Diet ordering
- Ensures appropriate end-user devices
  - Barcode readers, Workstations on Wheels (WOWS), printers etc.
- Views unsolicited results
- Alerts, Allergies, Warnings

[458] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[459] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 18.

8.14 However, it appears that FG1 was later rescoped. By March 2023, internal documents no longer described FG1 as replacing both CareSys and CWS, instead only noting it as a replacement of CareSys. This is outlined in Figure 5:

Figure 5: Functional Group 1 – March 2023[460]

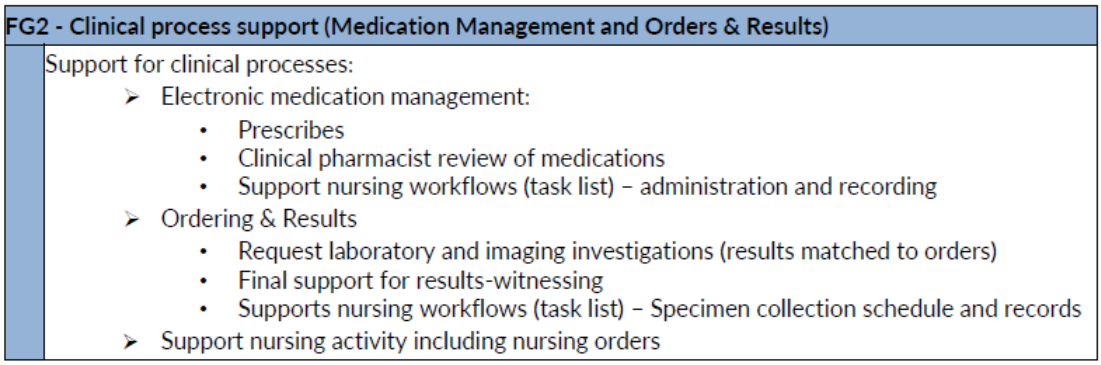


8.15 As discussed in Chapter 6, some submitters consider that FG1 has not delivered the outcomes anticipated upon implementation.

Functional Group 2

8.16 Implementation of FG2 was scheduled to start in RDPH in September 2021 and be completed by simultaneously deploying FG2 in GDH and TCH in April 2022.[461] Compared to the original staged implementation plan, deployment of FG2 was—and continues to be—extensively delayed. As outlined in Figure 6, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG2 was to provide the following functionality:

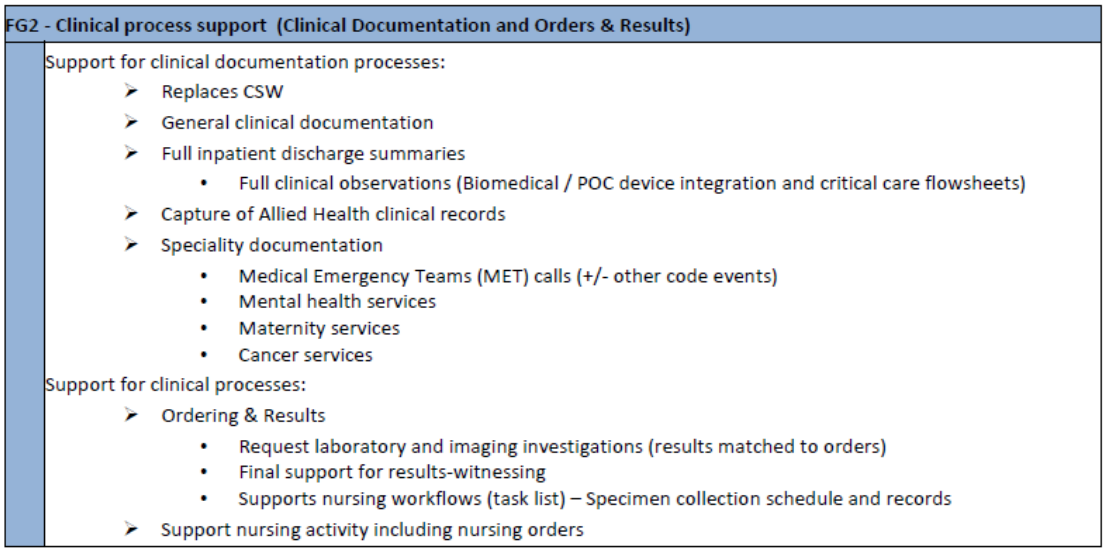
Figure 6: Functional Group 2[462]



[460] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, p. 4.
[461] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.
[462] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 19.

8.17 However, the substance of FG2 and FG3 were later swapped so that FG2 would implement clinical documentation reform instead of medication management. Additionally, it appears that the scope of FG2 was amended to absorb the replacement of CWS, which was initially planned for FG1. By March 2023, FG2 sought to implement the functions outlined in Figure 7:

Figure 7: Functional Group 2 – March 2023[463]



FG2 - Clinical process support (Clinical Documentation and Orders & Results)

Support for clinical documentation processes:

- Replaces CSW
- General clinical documentation
- Full inpatient discharge summaries
  - Full clinical observations (Biomedical / POC device integration and critical care flowsheets)
- Capture of Allied Health clinical records
- Speciality documentation
  - Medical Emergency Teams (MET) calls (+/- other code events)
  - Mental health services
  - Maternity services
  - Cancer services

Support for clinical processes:

- Ordering & Results
  - Request laboratory and imaging investigations (results matched to orders)
  - Final support for results-witnessing
  - Supports nursing workflows (task list) – Specimen collection schedule and records
- Support nursing activity including nursing orders

8.18 As of April 2026, the Departments told the Committee that, at a high-level, FG2 would:

> see the retirement of Clinical Workstations as well as clinical paper documentation. The replacement of clinical paper documentation (particularly forms) will be an ongoing process that will be handed over to the [business as usual (BAU)] team to continue.[464]

8.19 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, further explained the functionality of FG2 in a public briefing:

> there is a whole lot of other functionality native in Acacia which we currently do manually on paper-based forms and other manual workflows, so Functional Group 2 is about opening up that native functionality and putting it in the hands of our clinicians…
>
> The short answer to Functional Group 2 is about providing digital functionality for things that we currently do in hospitals manually today and that will improve efficiency and data accuracy and a whole bunch of other things.[465]

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[463] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, p. 4.
[464] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 21-22.
[465] Department of Health, Committee Transcript, 17 February 2026, p. 8.

8.20 A particularly important element of FG2 is the enablement of additional digital functionality within the healthcare system. Currently, paper records are extensive within the healthcare sector:

> All areas of the hospitals still currently use paper as electronic Acacia clinical documentation is being implemented as part of FG2. There are aspects of clinical documentation being captured in Acacia FG1 by renal clinics, ED, theatre and maternity units however the remainder of the documentation is captured on paper and in CWS.[466]

8.21 Because of increasing digitisation in FG0 and FG1, information must be captured in one format and transcribed to another to integrate the paper and electronic records:

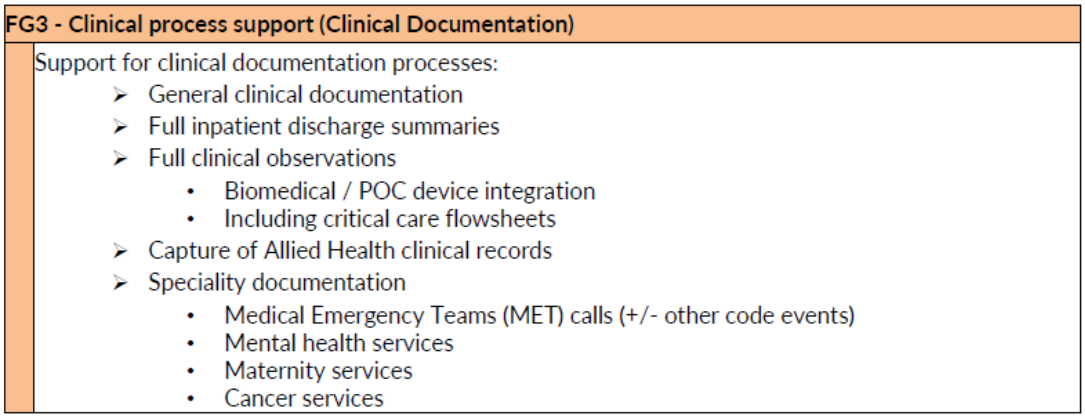
> There is information that is captured by one user group on paper and transcribed into Acacia by another user group. This will be transitioned out as part of the FG2 implementation.[467]

8.22 Functional Group 2 is currently in the solution build stage.[468]

Functional Group 3

8.23 Implementation of FG3 was scheduled concurrently with FG2. It was to be first implemented in RDPH in September 2021 and planned to be completed in April 2022.[469] As with FG2, FG3 has been extensively delayed. As outlined in Figure 8, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG3 was to provide the following functionality:

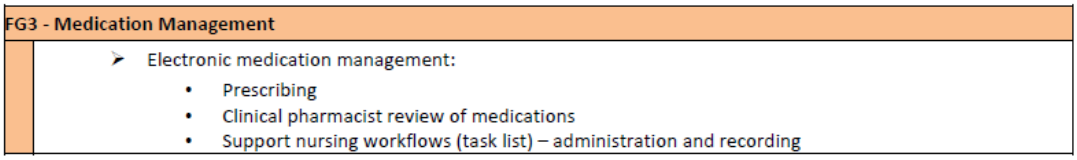
Figure 8: Functional Group 3[470]



[466] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[467] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[468] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[469] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.
[470] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 19.

8.24 However, as noted above, the substance of FG2 and FG3 was swapped so that FG3 implemented medication management instead of clinical documentation. By March 2023, FG3 sought to implement the functions outlined in Figure 9:

Figure 9: Functional Group 3 – March 2023[471]



8.25 In a public briefing, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, explained to the Committee that FG3 would replace MedChart:

> We have an old digital medicines system called MedChart which is in scope to be replaced. It is not integrated with Acacia; it sits off to the side, so you have to hop into there to have a look at MedChart. Acacia takes a feed from it, but the workflows are not integrated, so you can see the patient's medicines in Acacia, but you cannot work in the medicine space, so our pharmacists or others will use that. Functional Group 3 will see that replaced again with what is native functionality to Acacia. Acacia has a medicines management module. Functional Group 3 is about moving across from MedChart to that fully integrated medicines management module within Acacia, bringing another facet of functionality into the core single system.[472]

8.26 Functional Group 3 is currently in the solution build stage.[473] However, delivery of FG3 has been 'deferred pending funding availability.'[474] Because of this, the Departments advised that 'aspects [of the solution build] need to be revalidated given the time the project has been on hold.'[475]

Functional Group 4

8.27 Implementation of FG4 was scheduled to be complete by September 2022.[476] As with FG2 and FG3, progress on FG4 has been extensively delayed. As outlined in Figure 10, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG4 was to provide the following functionality:

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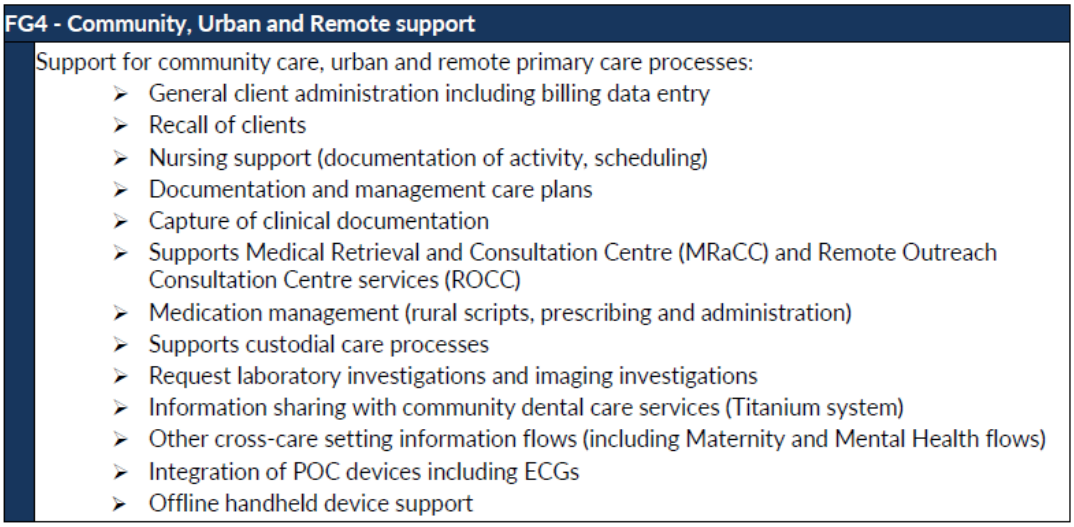
[471] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 23-03: Revised Implementation Schedule,* March 2023, p. 5.
[472] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[473] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[474] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.
[475] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[476] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

Figure 10: Functional Group 4[477]



8.28 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that:

> Functional Group 4 will see Acacia rolled out to remote primary care clinics and urban primary care clinics. Urban primary care clinics are pretty straightforward because they operate a bit like a GP clinic. It is fairly routine levels of care, whereas out in the bush the complexity of the care managed in those clinics is almost comparable to a hospital environment in some cases because we have very sick people with complex care needs. It is fairly unique to the Northern Territory; you do not see that level of complexity across 46 government clinics in other states in Australia. The software will need some more work in order to do that.[478]

8.29 Functional Group 4 is currently in the planning stage.[479] However, delivery of FG4 has been 'deferred pending funding availability.'[480] Because of this, 'some aspects [of the planning] need to be revalidated given the time the project has been on hold'.[481]

Functional Group 5

8.30 Implementation of FG5 was scheduled to be complete by May 2022.[482] As with FG2, FG3, and FG4, this has been extensively delayed. As outlined in Figure 11, which is extracted from the December 2019 *Acacia Deployment and Adoption Strategy*, FG5 was to provide the following functionality:

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[477] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 19.
[478] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[479] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[480] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.
[481] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 12.
[482] Department of Corporate and Information Services, *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 12.

Figure 11: Functional Group 5[483]

Client to Service information sharing (Client Portal) External Provider Access
Client Portal: ➢ Web portal that will enable clients/patients/consumers to directly access context specific health information about themselves ➢ Patient feedback tools (e.g. surveys on discharge and care ratings) ➢ Notifications from Acacia (e.g. upcoming appointment times) ➢ Access to health education information ➢ Storage of information relating to joint decisions about care ➢ Additional broadcasting options for messages to clients/patients/consumers about outages, outbreaks, warnings, health promotion, events, etc. External Provider Access: ➢ Will allow authorised external health partners access to information pertinent to the provision of direct care, appropriate for the shared care arrangements in place with NTG (as per the patient permissions/consent)

8.31 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that FG5 consists of:

> portals by which either providers like a non-government health service or a patient can access the system in a controlled and scaled-down way where they only see the bits they are allowed to see, and access the patient record. That forms part of the work that we are working on at the moment.[484]

8.32 The Committee understands that FG5 is currently in a very early stage of development at the start of the planning phase.[485]

Outstanding steps

8.33 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that the Departments have further plans to deliver on the outstanding elements of the program:

> There is still more to do and we have some moderate capacity to keep progressing some of the subsequent phases. There are some that are yet to be completed related to non-hospital care in areas such as remote primary care in the bush. We also have a digital medication system that is in scope to be replaced with the medications management functionality that is native to the Acacia system.[486]

8.34 In April 2025, the Departments advised the Committee that work on FG2, FG3, FG4 and FG5 was 'well progressed' and implementation of these FGs would not be as difficult or prolonged as the deployment of FG1:

> Importantly, much of the preparatory work for the deployment of Functional Groups 2-5, primarily including the procurement and configuration of the relevant parts of the TrakCare software, has been proceeding in parallel to the work done to date and is well progressed. The completion, testing, training and

[483] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 20.
[484] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[485] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 12.
[486] Department of Health, Committee Transcript, 17 February, p. 4.

> deployment of the remaining functional groups will not require the same time nor investment as to date.[487]

8.35 The Committee asked the Departments for an explanation of why remaining FGs would not require as much time or investment. The Departments told the Committee that user familiarity with FG1 means that training requirements will be lesser and FG5 activities are relatively simple. The Committee observes that the Departments' response does not substantively address the Committee's question regarding the time and investment required to deploy FG2-4:

> FG1 is the foundation for FG2, FG3, FG4 and FG5 as it implemented all the patient administration processes which will be used across all functional groups. From an implementation perspective, end users are already trained in the use of Acacia, and therefore only need to be trained in the new functionality as it becomes available. Therefore, the training requirements are much reduced.
>
> FG5 will provide access to data already in Acacia. Therefore, the only activity required relates to the policy settings for accessing this data, the setup activities to implement the policy and education regarding the use of Acacia for new users (eg external health services such as St John, Aboriginal health services). There is no new functionality introduced as part of FG5.[488]

8.36 The 2019 *Acacia Deployment and Adoption Strategy* broke the lifecycle of the Acacia program down into 4 stages. The stages of the CCSRP were planning, solution build, transition to operational services, and deployment:

> The CCSRP program lifecycle is divided into four stages, which are further defined by phases within each stage (refer *Appendix B – CCSRP stages and phases*). Three stages will focus on delivery, those being:
>
> 1. *Solution Build* (current stage) - where most of the foundations will be delivered, the solution developed, and Acacia and other supporting systems designed and made production-ready3.
>
> 2. *Transition to Operational Services* - as Acacia is deployed, operational support capability will be transferred to Operational Services. Once complete the portal will be delivered, access to the legacy systems for update will be removed and program closure activities will commence.
>
> 3. *Deployment* - where Acacia is deployed and adopted by NT Health personnel, and benefits can begin to be realised by *NT Health* management.
>
> The 'Transition to Operational Services' and the 'Deployment' stages will run concurrently.[489]

8.37 Each stage had a number of phases within it. For example, the solution build stage was broken down into 5 phases: IPS, design, solution confirmation, build and configuration, and testing. Stages and phases are visualised in Appendix B of the *Acacia Deployment and Adoption Strategy,* replicated in Figure 12. Stages are in blue and phases in green:

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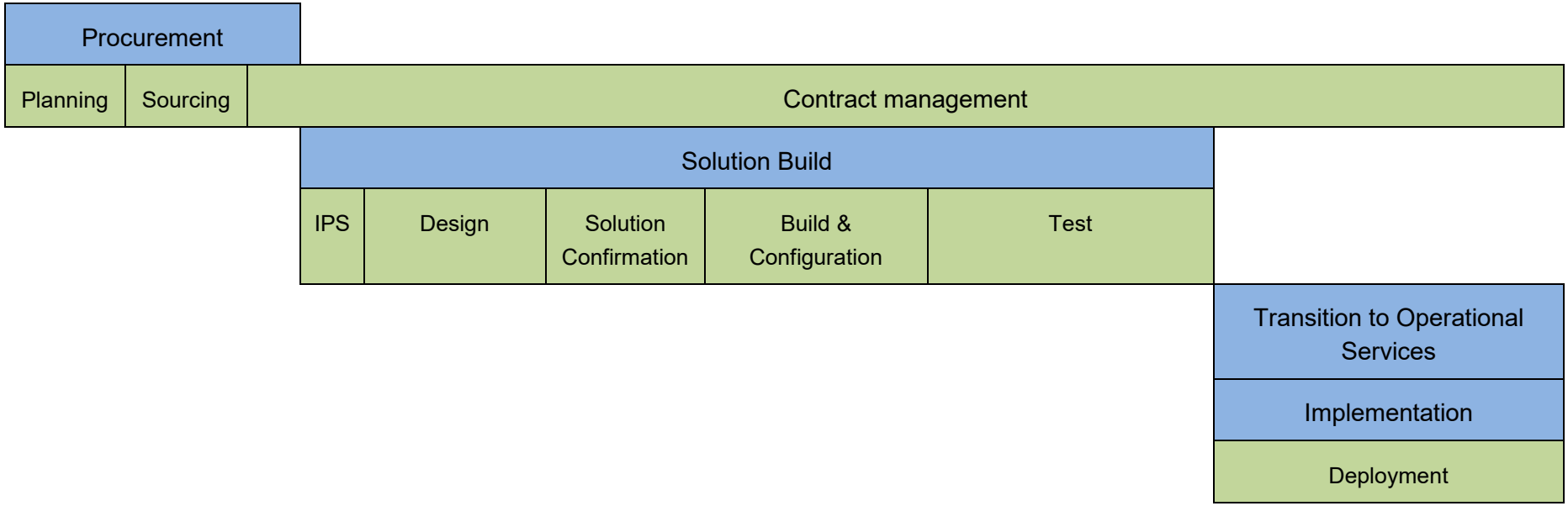
[487] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 26.
[488] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[489] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 14.

Figure 12: CCSRP Stages and Phases[490]



[490] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, p. 36.

8.38 To better assess the extent of work required to complete the program, the Committee asked the Departments how far through IPS, design, solution confirmation, build and configuration, and testing FG 2-5 were. In their response to the Committee's question, the Departments did not refer to the specific phases. Instead, they referred to broad stages of work. Because of the lack of information provided to the Committee by the Departments, the Committee is unable to assess with specificity how extensive the outstanding work required for each functional group is:

> FG2 is in the solution build stage with the first phase of functionality to commence implementation mid-2026.
>
> FG3 is in the solution build stage however aspects need to be revalidated given the time the project has been on hold.
>
> FG4 is in the planning stage however some aspects need to be revalidated given the time the project has been on hold.
>
> FG5 is at the start of the planning stage.[491]

8.39 However, the Committee notes that the *Acacia Deployment and Adoption Strategy* projected two main peaks of work effort and support required to fully deploy Acacia, as outlined in Figure 13. This figure seeks to visualise the amount of work effort and support required to implement Acacia, broken down by different clinical systems Each colour in Figure 13 roughly represents a FG, although the Committee notes there is no representation of FG5 and the estimate predates the apparent rescoping of FG1 to exclude the replacement of CWS and the corresponding expansion of FG2 to include the replacement of CWS:[492]

- Green represents FG0
- Orange represents FG1
- Red represents FG2 and FG3
- Blue represents FG4.[493]

8.40 Accordingly, Figure 13 indicates that FG0-3 combined represent roughly half the amount of work effort and support necessary to fully implement Acacia. The remaining half was projected to consist of FG4, which seeks to replace PCIS and CCIS. The Committee notes that to date only the EPR and CareSys have been replaced, represented by the green and orange sections of the first distribution of work effort and support. Accordingly, it appears to the Committee that based on the CCSRP's own projections, there is significant work remaining to complete. Indeed, it appears on the basis of these projections that the outstanding work is even greater than that complete. Outstanding steps for each functional group are further explored below.

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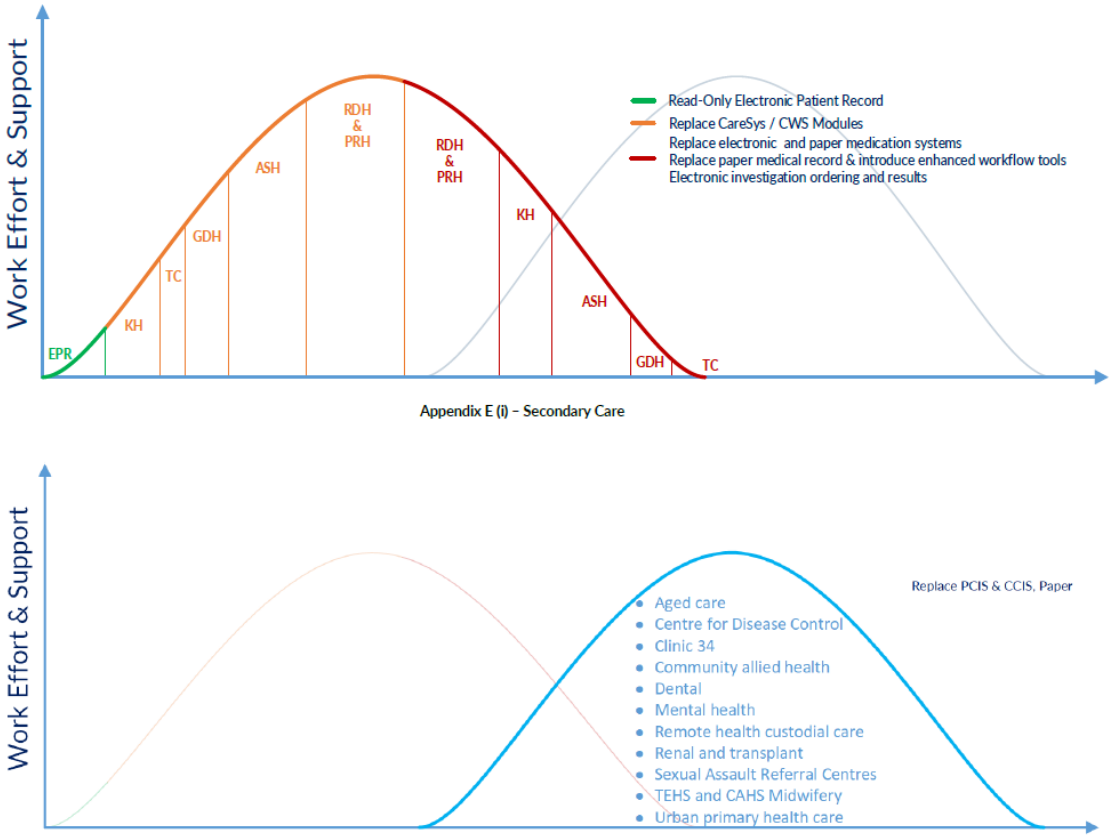
[491] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[492] *Core Clinical Systems Renewal Program*, *Program Schedule Revision - Adjustment due to impact of COVID-19,* November 2020, p. 12.
[493] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy,* December 2019, p. 39.

Figure 13: Deployment and Adoption Work Effort and Support[494]



Functional Group 1

8.41 The Departments' January 2026 submission informed the Committee that CareSys had been 'retired':

> the successful, Territory-wide implementation of Acacia 1.0 has allowed the retirement of the Territory's highest-risk legacy system, CareSys [495]

8.42 However, the Committee heard from other sources that CareSys is still in operation. André Snoxall, former CCSRP contractor, advised that CareSys 'is still in place, still costing the Northern Territory money and there is no clear plan for decommissioning it.'[496] Similarly, Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, told the Committee that CareSys could not be decommissioned without compromising other functionality:

> Even after the deployment of Acacia 1.0 into all hospitals, Caresys remains in use for both read access & backend patient registration functionality & cannot be decommissioned. In order for this to occur the Enterprise Master Person Index (EMPI) needs to be working. EMPI is running on the server but not actually

[494] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy,* December 2019, p. 39.
[495] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[496] Adelphos AI, Committee Transcript, 3 March 2026, p. 12.

> doing anything. This allows the program to report that this product has been implemented however the majority of the scope is outstanding.[497]

8.43 Further, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, made comments suggesting that CareSys had not been decommissioned and was instead 'off to the side':

> Getting that system into our hospitals and into the hands of users and getting CareSys retired and off to the side...[498]

8.44 Accordingly, the Committee asked the Departments whether Caresys had been decommissioned. The Departments did not specify whether it had been 'decommissioned', but instead advised that while CareSys was no longer used clinically, it had not been 'retired':

> CareSys has been withdrawn for daily use by hospital staff to capture patient information.
>
> Central Australia and Barkly information for July and August 2025 was captured in CareSys and is needed for 2025-26 reporting.
>
> CareSys also contains the Client Master Index which controls a patient's demographic details. This is currently used for all NT Health systems however is in the process of being replaced by the Enterprise Master Person Index. Once this project is complete, CareSys will be retired.[499]

8.45 As such, the Committee understands that whilst no longer used operationally, CareSys is yet to be retired and decommissioned. The Committee observes that the Departments' clarity in discussing this matter has been insufficient.

Functional Group 2

8.46 As discussed previously, FG2 is 'in the solution build stage'.[500] Implementation of FG2 will occur differently to FG1. Instead of being deployed in whole, FG2 will be deployed sequentially across several phases:

> One of the good things is we can do that gradually bit by bit. You do not need that big bang wallop like we had with Functional Group 1 where you have train everyone and have Go Live on a certain day. You could release that functionality to different clinical cohorts or different parts of the Territory based on need, and that work is happening now. [501]

8.47 Exemplifying this, in their January 2026 submission the Departments advised that some elements of FG2 had been deployed in renal units in 2025:

> Certain of the features of Functional Group 2 have been deployed into the Central Australian Renal Units (in February/March 2025) and the Top End Renal Units (in June/July 2025).[502]

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[497] Kara Joyce, Submission No. 11, p. 3.
[498] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[499] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[500] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[501] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[502] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.

8.48 The Committee understands that deployment of FG2 has been split into four phases. These were outlined to the Committee by the Departments:

> FG2 has four main phases:
>
> A – Early Clinical Adoption providing clinical documentation including notes, diagnosis and a priority workbench.
>
> B – Orders Communications providing clinical orders (such as pathology and radiology orders), results viewing and patient journey boards.
>
> C – Clinical Summaries providing clinical handovers, discharge summaries and inpatient clients.
>
> D – Advanced Clinical Adoption providing care plans, flow sheets, clinical observations, critical care and theatre documentation.[503]

8.49 The Departments told the Committee that no schedules have been approved for FG2 or FG3:

> The last schedules developed for FG2 and FG3 were set before the RDPH FG1 was implemented and there have not been further FG2 and FG3 schedules approved...[504]

8.50 The Committee asked the Departments to specify the dates by which different elements of FG2 are planned to be deployed. The Departments did not specify these dates in their response, but did tell the Committee that implementation would begin in mid-2026 and CWS would be replaced by June 2027:

> Timeframes are being worked through in conjunction with NT Health however the replacement of CWS is anticipated for June 2027…
>
> FG2 is in the solution build stage with the first phase of functionality to commence implementation mid-2026.[505]

8.51 Internal documents highlighted that FG2 and FG3 were required to be deployed concurrently to mitigate clinical risk:

> To reduce clinical risk, it was determined to deploy FG2 and FG3 simultaneously at secondary care sites. The clinical impacts of deploying FG2 and FG3 in a phased deployment are summarised in *Table 3 – FG2 and FG3 deployment.*

Clinical impact area	**Impact**	**Current system risk**
Transition of patients/clients between hospitals – one on legacy, one on Acacia	• Medical records in differing systems. • Users will have to review Acacia Read-only EPR and be able to review all care provided within Acacia.	• Paper records do not migrate between hospitals. • Medications are ceased on discharge, clinicians re-use previously prescribed

[503] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 22.
[504] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.
[505] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 22-23.

	• Medication records are disconnected, increased risk to double dose on transfer between facilities	medications to populate Medication Chart, information on last dose available
Transition of patients/clients between a hospital using Acacia and a NTG Primary Health Clinic – PHC on legacy system or non-NTG health clinic	• Discharge summary is generated with full documentation within Acacia and this allows for a faster generation of discharge summaries.	• Discharge summary is manually generated, information being imported automatically from eMMa and manual imported from other sources.
Transition of patients/clients between a hospital and a NTG Primary Health Clinic –on Acacia	• Full access to treatment information provided in either facility, allowing continuity of care	• Patient care information is not available within a single application.[506]

8.52 On this basis, the Committee asked the Departments what the clinical risks are of deploying FG2 without FG3. The Departments advised that more work is necessary to understand this:

> Parts of FG2 require information from FG3 such as discharge medication being available in the discharge summaries. FG2 and FG3 not being implemented simultaneously will mean that additional work is required to understand the impact of medication requirements for FG2.
>
> The Acacia Deployment and Adoption Strategy outlines the clinical impacts to delivering FG2 and FG3 simultaneously at secondary care sites prior to the primary site (Katherine Hospital before Royal Darwin Hospital) given the transfer of patients between the hospitals.
>
> This is being taken into consideration with the planning of FG2 and will need to be included in the planning of FG3 sequencing. [507]

8.53 The Committee notes with concern that the Departments have advised that FG2 will begin to be implemented in mid-2026.[508] Understanding the impact of deployment of FG2 without FG3 should be a priority for the Departments.

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[506] Core Clinical Systems Renewal Program, *Acacia Deployment and Adoption Strategy*, December 2019, pp. 30-31.

[507] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 22-23.

[508] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.

Functional Group 3

8.54 As discussed previously, FG3 is 'in the solution build stage however aspects need to be revalidated given the time the project has been on hold.'[509] Several stakeholders emphasised the complexity of FG3. For example, former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, explained that because FG3 deals with medications, it requires great care:

> … medicines is really complicated. It is one of the areas that needs incredible precision. You need to be very, very careful. Without sounding trite, errors in medication kill patients, so you need to be really careful. That is a separate body of work.[510]

8.55 Further, André Snoxall argued that extensive clinical engagement will be necessary to ensure that FG3 functions well in different clinical contexts, and that comprehensive training will be necessary to uphold patient safety:

> [FG2 & 3] 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.[511]

Functional Group 4

8.56 As discussed previously, FG4 is in the 'planning stage'.[512] This means that the entire solution build stage remains to be completed, including IPS, design, solution confirmation, build and configuration, and testing. Stakeholders have similarly advised the Committee that there is extensive outstanding work to be completed on

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[509] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[510] Department of Health, Committee Transcript, 17 February 2026, p. 8.
[511] Adelphos AI, Committee Transcript, 3 March 2026, p. 12.
[512] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.

FG4. For example, Rod McDonald, who worked on FG4 as a CCSRP contractor, advised that the outstanding steps to complete FG4 were extensive.

> 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.[513]

8.57 Similarly, André Snoxall argued that FG4 would likely require equal effort, or more effort, than that already expended deploying FG0 and FG1.[514] This aligns with the information identified in the *Acacia Deployment and Adoption Strategy* and represented in Figure 13, which outlines that FG4 would require as much work effort as the previous FGs combined.

Functional Group 5

8.58 As discussed previously, FG5 is 'at the start of the planning stage'.[515] FG5 is at a very early stage of development.[516] Accordingly, almost all activities required to implement FG5 are yet to occur, including IPS, design, solution confirmation, build and configuration, and testing.

Cost of program completion

8.59 In April 2025 the Departments advised the Committee that they had undertaken detailed financial modelling which indicated that completion of the program would require additional funding and time:

> Detailed financial modelling undertaken by the departments suggests the cost to fully deploy all five functional groups and deploy the Acacia end-to-end system across the Territory will require additional funding. The departments forecast at least 24- 30 months (2- 2.5 years) of further work would be required to complete the Program.[517]

8.60 However, when the Committee asked DCDD what the expected costs to complete the program were, Catherine Weber, the CEO of DCDD, advised they had not considered future costs:

> the total budget for the program at this stage is $335m. We have not done any estimates on what would be required to complete the whole program. That would be the subject of a future potential budget submission if we are invited to put one forward.[518]

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[513] Rod McDonald, Committee Transcript, 3 March 2026, p. 18.
[514] Adelphos AI, Committee Transcript, 3 March 2026, p. 12.
[515] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[516] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 12.
[517] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 46.
[518] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 4.

8.61 The Committee further queried this point, asking what the projected costs for full deployment of FG2, FG3, FG4 and FG5 would be, as well as the projected timeframe for completion. The Departments advised they would consider this in the future:

> This will be estimated as part of a future business case to complete the program and will exclude the FG2 and FG5 activities that will be completed in 2025-26 and 2026-27.[519]

8.62 The Committee notes that the initial advice provided to the Committee in the Departments' April 2025 submission appears to be at odds with the Departments' answers provided in 2026. The Committee also notes that in February 2025, the Treasurer referred to financial modelling that suggested that completion of the program in full would cost an additional $127 million more than had been spent on the program already.[520]

8.63 Because of the lack of information provided to the Committee by the Departments, the Committee is unable to determine the total costs of program completion. However, some discrete costs are identifiable. The total costs payable to InterSystems if the remaining functional groups were deployed in full at all sites would be $6.54 million in licensing fees, $9.72 million in milestone payments, and $4.28 million per year for annual product support over the life of the contract, subject to CPI increases.[521] Additionally, in the following sections the Committee outlines costs to date of each FG and any existing funding sources that may be drawn upon to implement the remaining steps.

Functional Group 2

8.64 As of 12 March 2026, of the total program spend of $319.6 million, $5.5 million has been spent on FG2.[522] In their January 2026 submission, the Departments suggested that the existing budget would be insufficient to fully deploy all elements of FG2:

> A core team of the Program's most highly skilled project professionals continue to work towards the deployment of Functional Group 2 - Clinical Documentation. Elements of Functional Group 2 will be delivered based on NT Health's clinical priority areas. This will support further transition to digital workflows, removing paper-based processes in key areas, and will allow the retirement of the Clinical Workstation (CWS) legacy system.[523]

8.65 However, at the public briefing in February 2026, Grace Johnson, Program Director of the CCSRP, disputed this advice by stating that FG2 would be complete within the existing $335 million program budget:

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[519] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[520] Treasurer, *Responsible action to repair the budget and rebuild the economy*, February 2025, https://territorystories.nt.gov.au/10070/987788.
[521] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 1.
[522] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2.
[523] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.

> The $335m that will be FG0 and FG1 which is complete. It is projected that FG2 will be completed and that FG5 will be commenced. The outstanding at the end of the $335m should be the completion of FG5, which is the portals; the FG3, which is the medication system; and then FG4, which is the replacement for the primary, community and mental health and [alcohol and other drugs]—outside of the hospitals essentially.[524]

8.66 Based on the information provided in their January 2026 submission, the Committee asked the Departments which elements of FG2 would not be able to be deployed within the current budget. The Departments told the Committee in April 2026 that full replacement of paper records will not be completed by the CCSRP, nor within the program budget. Instead, the DCDD ABS—HSS budget would need to be expanded to absorb these ongoing costs:

> The replacement of clinical paper documentation (particularly forms) will be an ongoing process that will be handed over to the BAU team to continue…
>
> There are thousands of paper clinical documents used within NT Health hospitals. These will not all be replaced by June 2027 and will transition to a business-as-usual process between DCDD and NT Health.
>
> Additional resources would be required within the DCDD ABS team to be able to continue to replacement of clinical documents.[525]

8.67 When asked, the Departments did not specify how much would be required to complete FG2.[526]

Functional Group 3

8.68 As of 12 March 2026, of the total program spend of $319.6 million, $11.1 million had been spent developing FG3.[527] The Committee notes that the electronic medication management project was provided $18 million in funding. The Departments confirmed that all $18 million of that funding has been spent.[528] Additional funding is necessary for any additional work to be carried out.[529] When asked, the Departments did not specify how much would be required to complete FG3.[530]

Functional Group 4

8.69 As of 12 March 2026, of the total program spend of $319.6 million, $2.0 million had been spent developing FG4.[531] Additional funding is necessary for any additional

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[524] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 34.
[525] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 22.
[526] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[527] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2.
[528] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 2.
[529] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.
[530] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[531] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2; Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.

work to be carried out.[532] When asked, the Departments did not specify how much would be required to complete FG4.[533]

Functional Group 5

8.70 As of 12 March 2026, of the total program spend of $319.6 million, only $91,000 had been spent developing FG5.[534] The Departments do not expect to be able to complete FG5 with the current budget.[535] However, work 'will be commenced'.[536] Noting that the Departments have stated that FG5 is only 'at the start of the planning phase', it is unclear where the funding for FG5 development is to be allocated from. This is because the Departments advised in April 2026 that the $63.4 million in reprioritised funding had not been allocated to FG5:

> The $63.4 million was allocated to the overall Program budget so was spent on FG1, RDPH ED Remediation, FG2 and aspects of FG3 and FG4. It was not tracked separately to the rest of the Program funds.[537]

8.71 Nor was FG5 mentioned when the Committee asked the Departments for detail on what the additional funding provided in Budget 2025-26 had been allocated towards, identifying only FG2:

> Delivery of FG2 to replace clinical documentation in CWS and paper clinical documentation in the hospitals with electronic documentation.[538]

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[532] Department of Corporate and Digital Development and Department of Health, Submission No. 14, p. 5.
[533] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[534] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2; Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[535] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 34.
[536] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 34.
[537] Department of Corporate and Digital Development and Department of Health, *Questions – 13 April 2026,* 13 April 2026, p. 3.
[538] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.

9 Further Findings and Recommendations

9.1 In addition to the discussion in the previous chapters, the Committee has identified several other issues that are associated with multiple different elements of the Terms of Reference, rather than tied directly to a single line of inquiry. These primarily relate to the effectiveness of the program governance, the recurring delays to the program schedule, and therefore the overall cost of the program. In this context the following issues are discussed:

- program budget
- the future of Acacia
- governance
- schedule delays, timeline slippage, and reporting
- workplace culture.

9.2 The Committee notes that some submitters and witnesses were not willing to appear on the public record to share their experiences of Acacia and the CCSRP due to fears they held regarding the likelihood of retaliation against them in their professional lives. The information provided to the Committee by these witnesses and submitters support the concerns and issues raised in evidence on the public record, which are detailed throughout the remainder of this Chapter.

Program Budget

9.3 The Committee has been advised by the Departments on several occasions that the total program budget is $335 million.[539] The individual cost elements in Table 7 have also been confirmed by the Departments as 'form[ing] part of the funding and reprioritisation decisions associated with the Acacia program budget':[540]

Table 7: Individual Cost Elements of the Program Budget[541]

Date	Source	Cost element
May 2015	Budget 2015-16	$10 million
May 2017	Budget 2017-18	$259 million
October 2022	Internal reprioritisation	$63.4 million

[539] Department of Health, Committee Transcript, 17 February 2026, p. 4; Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 34; Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 2.

[540] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 2.

[541] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 2.

Date	Source	Cost element
July 2023	Internal reprioritisation	-$6 million
May 2025	Budget 2025-26	$12 million
Total:	**$338.4 million**	

Committee's Comments

9.4 The Committee is concerned that the individual elements of the program costs do not align with the $335 million total program budget. Specifically, the sum of the individual figures provided to the Committee—each of which have been confirmed as contributing to the total program budget—is $3.4 million greater than the stated total program budget. The Committee asked the Departments to explain the difference between the sum of the individual costings and the total program budget. The Departments explained that:

> The… difference between the Public Accounts Committee's calculated total… and the approved program budget of $335 million is explained by… $3.4 million in repurposed digital contingency funding, which is not included in the approved Acacia program budget.[542]

9.5 Following clarification, the Departments confirmed that the digital contingency funding was repurposed *into* the Acacia program:

> The $3.4 million digital contingency funding was repurposed into the Acacia project program budget.[543]

9.6 The Committee observes that additional funding being repurposed into Acacia does not resolve the issue of more funding being associated with Acacia than the approved program budget indicates should be. Instead, additional funding exaggerates this issue. Additionally, the Committee queries how the $3.4 million in additional funding can simultaneously be 'repurposed into the Acacia project program budget' whilst being 'not included in the approved Acacia program budget.'[544] It is of further concern to the Committee that this $3.4 million in funding was only revealed to the Committee following several rounds of questioning, rather than in the Departments' submissions or briefings to the Committee.

9.7 The Committee also has unresolved questions regarding the $18 million in funding associated with the electronic medication management project (see paragraphs 5.54—5.58). Whilst the Departments have advised that the $18 million in funding

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[542] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 3.

[543] Department of Corporate and Digital Development and Department of Health, *RE: DCDD response - Correspondence from the Chair of the Public Accounts Committee - Acacia Digital Patient Record System*, email correspondence, 17 July 2026.

[544] Department of Corporate and Digital Development and Department of Health, *RE: DCDD response - Correspondence from the Chair of the Public Accounts Committee - Acacia Digital Patient Record System*, email correspondence, 17 July 2026; Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 3.

associated with this project was always a part of the $259 million funding allocated in May 2017, the business case for the project was only approved in June 2018. It is unclear why funding was attached to this project prior to the business case being approved.

9.8 The Committee also notes that figures provided to the Committee regarding the 2022 reprioritisation of $63.4 million differs from information provided to the Auditor-General for the Northern Territory, which was reported as $61 million (see paragraph 5.14).

9.9 Accordingly, the Committee cannot reconcile the figures provided by the Departments as associated with Acacia with the value of the total program budget. Continued uncertainty regarding the total program budget is of deep concern to the Committee. As such, the Committee recommends that a financial audit of the program be conducted. This audit should include, but not be limited to, determination of the actual program budget and expenditure.

Recommendation 1

The Committee recommends that the Government commission a financial audit of the Acacia Digital Patient Record System ICT program.

The Future of Acacia

9.10 As discussed throughout this section, the Committee has considered at length the appropriate future of Acacia, including the realised benefits to date, ongoing clinical risks, and anticipated but not yet achieved benefits. In addition to these matters, the Committee's views are based on and reflect the concerns discussed in later sections of this Chapter regarding program governance, timeline slippage, and workplace culture.

Realised Benefits, Ongoing Clinical Risks, and Anticipated Benefits

9.11 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that Acacia 'has been a resounding success.'[545] Further, he argued that extensive benefits have been achieved:

> We have gone from a 1930s pushrod engine to a modern Tesla. That is the quantum leap we have taken in terms of modern technology…
>
> The number one benefit in the proposal for this investment was around improving health outcomes for Territorians, which I think we are really poised now to do. We are already achieving that through what we have done [546]

9.12 One such identified benefit is the data reporting capacity of Acacia. The Departments told the Committee that the legacy systems could not accurately store, analyse or report on important health data (see paragraph 2.13). The Committee asked the Departments whether Acacia allowed for the full capture and reporting of

[545] Department of Health, Committee Transcript, 17 February 2026, p. 3.
[546] Department of Health, Committee Transcript, 17 February 2026, p. 21.

data necessary for mandatory reporting. They advised the Committee that there are no data reporting limitations:

> All the data required for funding (IHACPA - Independent Health and Aged Care Pricing Authority) and the Commonwealth (AIHW Hospital Data) for hospital reporting is captured within Acacia as the source system and extracted to the data warehouse for reporting. Mandatory statutory reporting is not managed within Acacia as it is managed through the NT Health Data Warehouse.[547]

9.13 Additionally, the Committee notes the 12 clinical testimonials included in the Departments' submission, from various sectors within the healthcare system.[548] These testimonials were strongly supportive of Acacia and provided a range of insights into the benefits they had experience as clinicians from using Acacia. Some of these comments are included below:

- 'We have been using Acacia for more than 2 years now and its extensive benefits have been outstanding to the service.'[549]
- 'Acacia, even in its initial stages, is already improving patient care by improving visibility of patient movement and capacity for planning'[550]
- 'Acknowledging that this experience is not the same for all streams, Acacia has improved the management of patient flow across RDPH.'[551]
- 'In my opinion, the current functionality available to Acacia users is a significant improvement compared to our legacy infrastructure (Caresys).'[552]
- 'Acacia significantly enhances perioperative care by providing timely, integrated, view-only access to the Electronic Patient Record (EPR) and Patient Administration System (PAS).'[553]
- 'Implementing Acacia at full capacity will improve cancer care in the Top End.'[554]
- 'I am writing to share my positive experience and highlight the benefits of the Acacia 1.0 system, based on my usage across various sites in the Northern Territory'[555]

9.14 Despite these positive views, the Committee notes that many of the projected benefits of Acacia have not been achieved. In particular, the Departments' April 2025 submission highlighted the benefits of an NT-wide integrated system, which have not been realised:

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[547] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[548] Department of Corporate and Digital Development and Department of Health, Submission No. 3, pp. 77-100.
[549] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 77.
[550] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 79.
[551] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 89.
[552] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 91.
[553] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 93.
[554] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 95.
[555] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 96.

> Once fully implemented, Acacia will operate as a single integrated electronic clinical information system across primary, secondary and tertiary care settings in rural, remote, community and hospital environments.
>
> In practical terms, the integrated system will enable clinicians to access and contribute to a single patient record from any hospital, clinic or community care centre across the Territory. This electronic health record will be maintained in real-time, meaning that record entries such as pathology test results or clinical notes made by a clinician in a hospital will be instantly accessible to a remote area nurse or general practitioner in a remote community.
>
> ….In the context of the Territory's unique healthcare landscape, a single, integrated [electronic medical record] will substantially enhance the capacity for early intervention, coordination and continuity of care, discharge planning, and follow-up care, across the Territory.

9.15 Further—and crucially—of the four legacy systems, only CareSys has been replaced. Nor has eMMa, the 5th core clinical system in scope of the CCSRP, been replaced. Whilst the Departments advised that CareSys was the 'highest-risk legacy system', it is clear to the Committee that the risk of continued reliance on the other legacy systems remain significant.[556] For example, the medical chart overwriting issue discussed in Chapter 7 will persist as this has been caused by 'a fundamental structural difference between Acacia and eMMa.'[557] More broadly, as the Departments described to the Committee, closure of the program following partial completion of FG2 would mean that eMMa, PCIS and CCIS will continue to be in clinical use, with the following associated risks:

> The key risks include:
>
> • Sentinel events occur due to IT system failure
>
> • Adverse clinical outcomes occur due to unavailable, incomplete or incorrect essential clinical information at point-of-care delivery
>
> • Reduced operational effectiveness due to IT systems not supporting efficient work practices
>
> • Reduced operational effectiveness due to IT system failure
>
> • Failure to collect revenue due to IT systems not supporting efficient work practices.
>
> PCIS and CCIS are owned by NTG therefore are no longer supported by the vendor. There is a higher reliance on integration between PCIS, CCIS and Acacia which would not be required if PCIS and CCIS were retired.
>
> Work to update the servers on which these systems operate on is underway. This activity will assist with mitigating the stability of the systems however does not remove this risk. eMMa would also need to be upgraded as it currently cannot be integrated with other systems including Acacia.[558]

9.16 The Committee also heard that extensive customisation of TrakCare has created ongoing risks for the long-term sustainability of Acacia. Kara Joyce told the Committee that the more extensive configurations that are made to align TrakCare

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[556] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.
[557] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 24.
[558] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 23-24.

to NT Health needs, the more likely that future updates delivered by InterSystems will create bugs within the system:

> The project team ignored advice from the vendor and created a highly customised product which increases the likelihood of 'bugs' with each release. There are 6 releases per calendar year meaning they have created a system that will be challenging for NT Health to maintain on top of their current workload.[559]

Future Activities

9.17 The Committee understands that, as discussed in Chapter 8, the Departments are currently in the process of planning, configuring and deploying FG2 and FG5. FG2 is being delivered in 4 phases, some of which are anticipated to be completed within the existing budget. FG5 is in a very early planning stage and while work will be commenced, it will not be completed on it within the existing budget. Additional work on FG3 and FG4 will require additional funding. Chris Hosking PSM was extremely positive about the future of the program:

> The number one benefit in the proposal for this investment was around improving health outcomes for Territorians, which I think we are really poised now to do. We are already achieving that through what we have done, but the potential to extend that into the bush will make an enormous difference to those people who need it the most. You will see that accelerate at a rate of knots now—that is exciting
>
> It is a bit of a pivotal moment here, because we are looking at the project in the rear-vision mirror, as it were, at some of the things that potentially could have gone better or that have thrown up question marks or flags along the way, but the future trajectory is really bright. I am excited for what we are going to achieve. [560]

9.18 The Committee heard various proposals from stakeholders regarding the future of Acacia. Several clinical testimonials in the Departments' submission argued in favour of continued deployment of Acacia or identified anticipated benefits of future deployments. For example, one clinician explained that:

> The Alan Walker Cancer Care Centre has long now adopted certain aspects of the Acacia system that are operational, such as patient scheduler, outpatient follow up requests, chemotherapy bookings and triaging referrals. This has allowed us to have electronic trail and optimise some of our services.
>
> However, given that the full adoption of the system has been delayed, we are restricted in its use, and we are still bound to use the old patient record systems. We utilise the various legacy systems for different purposes: Synapse to access x-rays, CareSys to access results and correspondence letters, and Mosaiq for our internal documentation and chemotherapy prescribing. As a result, we are now using four different software that complicate and delay our already heavy clinical workload and increase the risk of an error. The full rollout of Acacia will simplify our work, considerably.[561]

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[559] Kara Joyce, Submission No. 11, p. 3.
[560] Department of Health, Committee Transcript, 17 February 2026, p. 21.
[561] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 95.

9.19 Dr Andrew Bell, Chief Clinical Information Officer of NT Health, emphasised to the Committee that the best thing to do to mitigate the ongoing risks of the legacy systems is to retire them:

> I really do want to emphasise that the biggest thing we can do to lower the risk of our systems at the moment is to retire the ones that are clunky and we were having difficulty supporting.[562]

9.20 Similarly, Dr John Zorbas, President of AMA NT, told the Committee that the existing state of the clinical IT systems in the Northern Territory was untenable, due to the ongoing risks of the legacy systems. In his opinion, further works were required:

> 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.[563]

9.21 In later comments to the Committee, the AMA NT reiterated that the current state of Acacia was untenable and advocated for use of Acacia only as a patient administration system:

> The AMA NT stated that the worst position we could find ourselves in is the situation we find ourselves in today: a partial rollout with no clear path forward. Acacia has come at an inexcusable cost to date and the amount of healthcare that we have had to forego resourcing because of the gargantuan cost of Acacia is unacceptable.
>
> In health IT, a PAS (Patient Administration System) manages hospital logistics and patient details, like names and appointments. A CIS (Clinical Information System) manages actual patient care and medical data, like test results and doctor notes. The simplest path forward, at a high level, would be to retool Acacia to serve only as a simple patient administration system (PAS). This would allow areas of NT Health to seek appropriate clinical systems at the level of departments, divisions or health services.[564]

9.22 Several stakeholders recommended that an independent external review or audit of the program be undertaken.[565] Similarly, Kara Joyce told the Committee that the program needed re-baselining, independent of the CCSRP:

> I do not think that CCSRP can deliver that; it needs to be re-baselined… 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. [566]

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[562] Department of Health, Committee Transcript, 17 February 2026, p. 20.
[563] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 4.
[564] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 6.
[565] André Snoxall, Committee Transcript, 3 March 2026, p. 11; Rod McDonald, Committee Transcript, 3 March 2026, p. 14.
[566] Kara Joyce, Committee Transcript, 3 March 2026, p. 21.

Committee's Comments

9.23 It is clear to the Committee that the program has not delivered against the benefits outlined in the business case and has failed to achieve the objectives on which the investment decision was made. Significant clinical risks associated with potential failure of the legacy systems remain and a single integrated system across different levels of care across the NT has not been deployed. Accordingly, the Committee agrees with stakeholders that the current status of Acacia is not tenable. There remains a need to replace the existing legacy systems within the NT's healthcare sector. However, on the basis of advice received regarding the extent of issues faced in the program so far, and the extensive work still required to achieve further deployments, the Committee is not confident that Acacia is the right solution to replace these systems.

9.24 The Committee is also of the view that, as discussed in its *Inquiry into the Darwin Ship Lift Project,* business cases should be 'continually updated throughout the development and decision-making process to include the best information available, while taking into account whole-of-life cycle considerations.'[567] This point has also been previously made by the Department of Treasury and Finance and the Auditor-General of the Northern Territory.[568] Whilst it appears to the Committee that several different appropriate opportunities have arisen for such re-evaluation—such as prior to the adoption of the phased implementation approach or the deployment of FG1—so too is this point in time opportune for re-evaluation. With the completion of FG1, a significant milestone has been reached. Before any further funding is given to the program beyond the existing $335 million funding, the benefits and costs of future work should be re-evaluated.

9.25 However, the Committee does not believe that the CCSRP is the right team to further progress any future reform. It is clear to the Committee that the culture within the program has had a significantly detrimental effect on the successful delivery of Acacia in relation to both deadlines and budget. Further, it appears to the Committee that CCSRP leadership has failed to appropriately use program management methodologies, or more broadly, understand the complexities of the program necessary to successfully deliver the program. Accordingly, the Committee is not confident in the accuracy of any anticipated costs or timeframes for future delivery projected by the CCSRP.

9.26 As such, the Committee recommends that strict cost controls are implemented, whereby any future funding is subject to an independently prepared business case, not conducted by the CCSRP. Noting the concerns raised with the Committee regarding clinical involvement in decision-making to date and the need for clinical buy-in for any future reform, the Committee emphasises that any future business cases must involve rigorous clinical engagement and identify improved governance

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[567] Australian Government Department of Finance, Developing a Business Case, accessed 16 October 2025, https://www.finance.gov.au/government/commonwealth-investment-framework/commonwealth investments-toolkit/developing-business-case.

[568] Public Accounts Committee, *Inquiry into the Darwin Ship Lift Project*, October 2025, p. 74.

structures for future work programs that facilitates enhanced clinical decision-making.

Recommendation 2

The Committee recommends that strict cost controls are implemented whereby any additional funding is subject to an independently prepared business case that:

(a) is developed following rigorous clinical engagement,

(b) provides an enhanced governance structure which facilitates clinical decision-making, and

(c) identifies the cost, objectives, benefits and implementation time frame of any proposed future work to be undertaken in relation to the Acacia Digital Patient Record System.

9.27 Further, the Committee believes that the scope of works within the existing $335 million envelope of funding needs to be reprioritised. In particular, the Committee disagrees with the Departments' approach to FG5. The Departments told the Committee that they plan on commencing work on FG5, but do not anticipate completing it within the existing budget. Noting that FG5 is at the 'start of the planning stage' and as of April 2026 had only $91,000 of resources spent developing it (see paragraphs 8.32 and 8.70), the Committee believes that work on FG5 should stop. Additional investment in functionality that will not be completed is a poor financial decision. Instead, the Committee believes that the existing funding should be utilised to deliver cost savings to NT Health and configure FG1 to work as a standalone patient administration system.

9.28 Firstly, the Committee understands that, because of the deployment of Acacia, some units within NT Health have been required to hire additional staff. These staff are needed to maintain levels of functionality and clinical safety that existed with the legacy systems, but that have been disrupted by Acacia. It appears that in some cases these costs are expected to be ongoing, with no timeline for remediation to address the causes of the costs (see paragraphs 6.23—6.30). The Committee considers that accepting a permanent increase to the ongoing operational costs of NT Health is a poor use of resources. Instead, it believes that a more appropriate course of action is to address the root causes of the ongoing costs. On this basis, the Committee recommends that NT Health identify all ongoing FTE that have been employed within NT Health in order to maintain previously existing levels of functionality and safety, such as manual system auditing, and that the Departments undertake or commission the necessary remediation to eliminate the need for the identified ongoing FTE costs.

Recommendation 3

The Committee recommends that, as a matter of priority, DCDD and NT Health:

(a) identify all additional ongoing FTE costs in NT Health resulting from the deployment of the Acacia Digital Patient Record System that are

currently required to maintain previously existing levels of functionality and safety, such as manual system auditing, and

(b) undertake the necessary remediation of the Acacia Digital Patient Record System to eliminate the need for the identified additional ongoing FTE costs.

9.29 Further, the Committee believes that existing funding within the $335 million funding envelope that has not yet been spent should be utilised on the assumption that no further funding is to be granted to the program. As such, the Committee recommends that remaining funds should be prioritised to configure FG1 to enable it to work as a standalone patient administration system integrated with the remaining legacy systems on an ongoing basis, including any requisite enhancements to replace existing workarounds that may, upon long-term use, cause patient safety issues. Following this, any remaining funds should be prioritised on work that can be completed, deployed, and provide clinical benefits within the existing funding envelope of $335 million. The Committee notes that this may include some phases of FG2.

Recommendation 4

The Committee recommends that, within the existing program budget, DCDD undertake work to:

(a) ensure the existing deployed functionality of Acacia is fit-for-purpose,

(b) deliver enhancements outlined in Recommendation 3, and

(c) prioritise additional features that can be completed within the scope of the existing budget.

Governance

9.30 The Committee heard that the governance of the program was not always effective. Fundamentally, this is evident through the program cost overruns and the schedule delays. However, throughout this inquiry submitters and witnesses have also highlighted specific governance issues that they have argued hindered the effective and timely delivery of the Acacia program. These include governance structures and the relationship between the client and delivery agencies, change management processes, and benefits management and realisation. Additional governance concerns regarding the workplace culture of the CCSRP are discussed later in this Chapter.

Governance Arrangements

9.31 The Departments provided a comprehensive set of documents explaining the governance arrangements of the program. These included the governance pathways and escalations, including the PSC, PIC, and CLG, and the various Specialty Working Groups, Implementation Working Groups, NT Health

Governance Committees, and Internal Program Working Groups.[569] This is extracted in Figure 14.

9.32 The Departments also provided the Committee the Terms of Reference for each of the PSC, PIC, and the CLG, as well as the membership of these committees.[570]

9.33 The Committee considered evidence regarding the membership of the senior governance committees. The Committee heard from the former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, that in an attempt to ensure clinical representation on the CLG, its effectiveness was undermined through membership size:

> … as part of our three-layered governance structure, we had a clinical leadership group where at one point we had around 40 clinicians, which is probably too many people to have an effective committee but it was very inclusive and representative and had every clinical discipline and north and south regions represented. They got to review all the material. That clinical leadership group had a pivotal role to play in the training and education that went into getting people ready to use the system.[571]

9.34 The Committee also considered the expertise and balance of membership of the PSC. The Committee notes that both DCDD and NT Health were well represented on the PSC. Further, the Chief Executives of the agencies co-chaired the PSC.[572] Full membership included:

- both CEOs of the Departments
- the Program Implementation Committee Co-Chairs (a Deputy Chief Executive from both Departments)
- the Clinical Sponsor (NT Health)
- the Under Treasurer of the Department of Treasury and Finance
- the Senior Program Manager of CCSRP (ex-officio)
- the CCSRP Governance Lead (ex-officio).[573]

9.35 The Committee notes that the PSC membership had no independent ICT expertise. However, the PSC was able to invite independent advisors to attend meetings, without decision-making powers:

> The Committee may invite an independent advisor, agreed by both Co-Chairs, to attend meetings as an observer. An advisor should have significant experience in health service delivery, digital health and clinical systems. Any such advisor may provide input and guidance to assist the Committee and the Accountable Officers, but has no decision-making role.[574]

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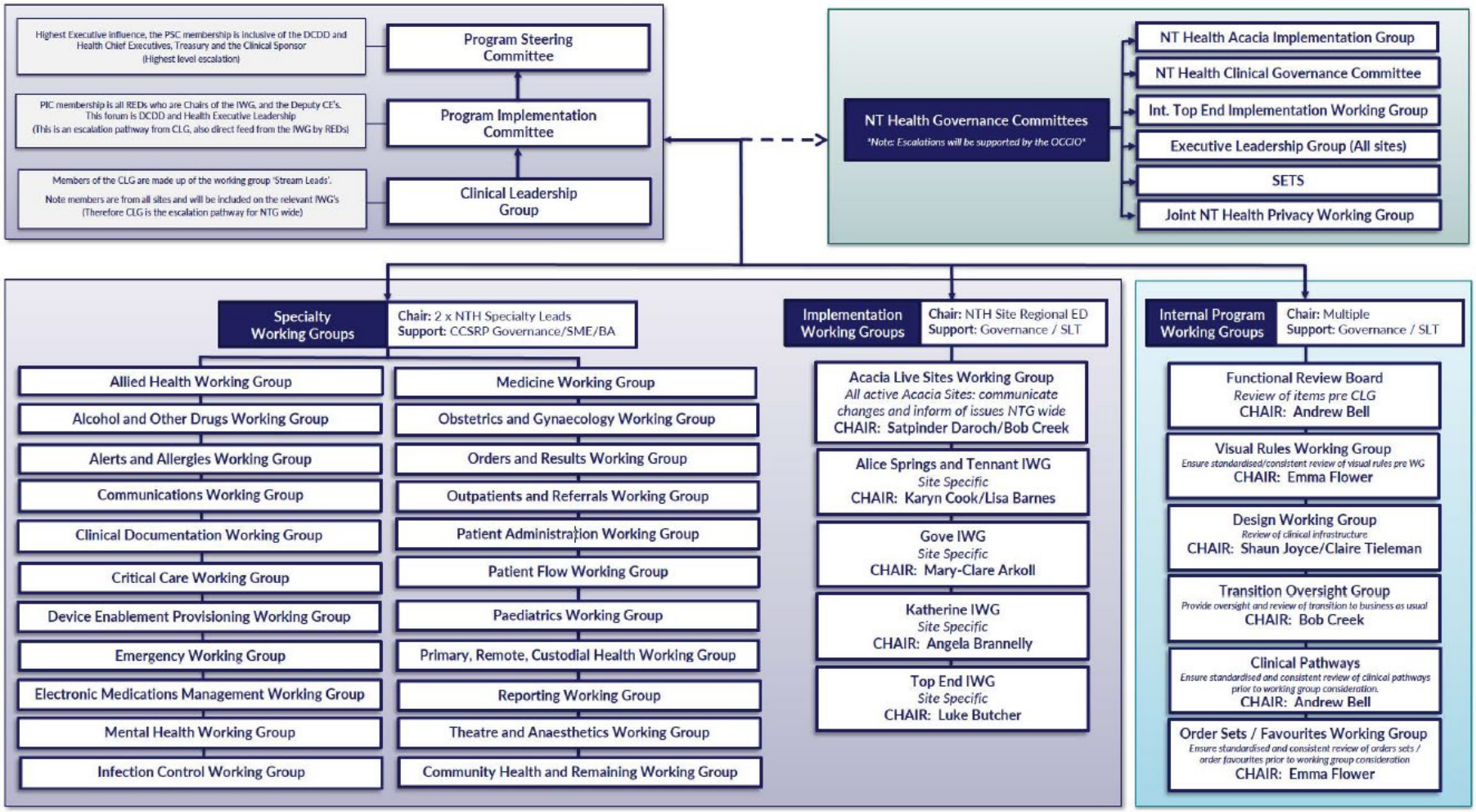
[569] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 55.
[570] Department of Health and Department of Corporate and Digital Development, Submission No. 3, pp. 56-74.
[571] Department of Health, Committee Transcript, 17 February 2026, p. 9.
[572] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 61.
[573] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 61
[574] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 61

Figure 14: CCSRP Governance Pathways and Escalations[575]



[575] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 55.

Delivery-Client Agency Relationship and the Centralised Delivery Model

9.36 The Committee understands that the relationship between the delivery and client agencies is incredibly important to the effective governance of a complex program such as Acacia. As Catherine Weber, CEO of DCDD, told the Committee:

> The concept of that partnership between the business agency, in this case Health, and the delivery agency, in this case DCDD, is paramount. The strength of that relationship is really important. The need for that business agency to engage from the outset is really important and to commit time and resources to it. We can produce an IT system, but we do not know what their business is; only they know what their business is, but they do not understand IT systems. It is a crucial partnership.[576]

9.37 However, over the course of the Inquiry, the Committee heard of a troubled relationship between NT Health and DCDD. It is the Committee's understanding that this has harmed the delivery of the program. For example, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that early in the life of the program the relationship between NT Health and DCDD was fractured:

> …making sure that those two agencies are working constructively and harmoniously together is really important for these projects to be delivered well. I say today on the record today that I think that is operating very well at the moment. We are working extremely well together. The level of engagement and collaboration between our agencies is rock solid.
>
> That was not always the case. Certainly, in the early days of the program there were some tensions.[577]

9.38 Stakeholders advised that one reason for this was that NT Health had expected to run the program and control its budget. However, Acacia became the first centrally delivered program managed by DCIS/DCDD on behalf of a client agency: upon approving the business case, Cabinet gave control of the program to DCIS.[578] As Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee, this was unexpected:

> For a whole range of reasons, I think the decision to vest accountability for the project with DCIS, not NT Health, caught everybody by surprise, including me. I remember saying, 'Well, hang on a minute. Is that what that decision really means?' It was the right decision, and I stand by that one today. But it took a period of adjustment, and I think people worked through that.[579]

9.39 Because of this decision, DCDD has controlled the program funding throughout the life of the program. Further, the CEO of DCDD became the program sponsor:

> The program sponsor is the DCDD chief executive. That generally contemporary project management methodology, the sponsorship follows the money. Because the funding is vested to DCDD to deliver, it is published in their budget and reportable in their annual report.[580]

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[576] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, pp. 34-35.
[577] Department of Health, Committee Transcript, 17 February 2026, p. 9.
[578] Department of Corporate and Information Services, *Annual Report 2015-16,* 2016, p. 4; Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 13.
[579] Department of Health, Committee Transcript, 17 February 2026, p. 9.
[580] Department of Health, Committee Transcript, 17 February 2026, p. 8.

9.40 The AMA NT told the Committee that funding control held by DCDD created tensions between the agencies. It also suggested that funding control resulted in a misalignment of priorities throughout the program:

> The placement of budget control with the IT agency (DCDD) rather than the primary clinical user agency (NT Health) contributed to tensions and misalignment of priorities during implementation. This disconnect between the planned governance model and its operational effectiveness played a key role in the challenges that unfolded during the project.[581]

9.41 Indeed, the Committee heard from several stakeholders that DCDD has had an undue influence on key decisions within the program.[582] An example of this was given to the Committee by André Snoxall:

> 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.[583]

9.42 The Committee heard from some submitters that the centralised delivery model, where DCDD delivers programs and projects on behalf of a client agency, should be reviewed or unwound. Dr John Zorbas, President of AMA NT, told the Committee he believed that the program would have been more successful if it had been managed directly by Health.[584] Similarly, Kara Joyce told the Committee that in some other jurisdictions Health IT reform has been led by Health itself, and the NT should consider the same:

> Perhaps Health would be a better driver. If we look at other jurisdictions, a lot of successful programs are clinically led… 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.[585]

9.43 Further, André Snoxall told the Committee that tensions between the agencies have been further exacerbated by DCDD's adoption of an advisory role regarding how agencies should use technology:

> 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.[586]

9.44 André Snoxall was critical of this development, arguing that DCDD should not advise agencies in how they should use technology but rather seek to deliver outcomes for their client agencies, as requested by those agencies:

> 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

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[581] Australian Medical Association Northern Territory, Submission No. 1, p. 5.
[582] André Snoxall, Committee Transcript, 3 March 2026, p. 10; Rod McDonald, Committee Transcript, 3 March 2026, p. 16.
[583] André Snoxall, Committee Transcript, 3 March 2026, p. 10.
[584] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 7.
[585] Kara Joyce, Committee Transcript, 3 March 2026, p. 21.
[586] André Snoxall, Committee Transcript, 3 March 2026, p. 13.

> agency, not within DCDD. What has happened in DCDD is they moved all [the advice on how agencies should use technology] 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.[587]

9.45 In contrast to other stakeholders, the CEO of DCDD, Catherine Weber, told the Committee that the centralised system remained the best model for delivering IT projects and programs in the Territory:

> The strength of the centralised system cannot be overstated. It is really important, that concentration of expertise. It is not possible to have the level of expertise in individual agencies that you need to run a big ICT project or even a medium-sized IT project.[588]

9.46 The Committee heard from Chris Hosking PSM and Greg Connors, Deputy Chief Executive Officer, Digital Services, DCDD that the relationship between DCDD and NT Health is now much improved.[589] Indeed, the Committee notes that in 2022 the Departments were awarded a Chief Minister's Award for Excellence in the Public Sector for Excellence in Cross-Government Collaboration and Partnerships.[590] However, positive perceptions of the relationship were not held by all stakeholders. For example, Kara Joyce, former CCSRP Project Manager, Business Analyst and Clinical Informatics Officer, told the Committee that she feared that 'we have reached a point where there is zero trust in the program to deliver'.[591] Further, AMA NT told the Committee that the relationship between the agencies does not 'encourage proactive and innovative change'.[592] In contrast, the Committee heard that ABS—HSS (the BAU unit within DCDD) has a better relationship with NT Health than the CCSRP.[593]

Escalation of Issues Through Governance Layers

9.47 As described by Grace Johnson, Program Director of the CCSRP, the extensive network of governance committees facilitated escalation of clinical issues from specialised medical disciplines or regions through to senior decision-makers:

> Underneath that CLG layer, we had 35 working groups that were made up by the business in their individual areas. For example, we had an emergency department working group, maternity, primary healthcare, medications—all of those different areas within NT Health, not just the hospital but also the primary, remote and mental health and [alcohol and other drugs]. They were the forums for NT Health staff to flag those risks and issues, either business related,

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[587] André Snoxall, Committee Transcript, 3 March 2026, p. 13.
[588] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 35.
[589] Department of Health, Committee Transcript, 17 February 2026, p. 9; Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 35.
[590] Northern Territory Government, Chief Minister's Awards for Excellence in the Public Sector, https://chiefministerawards.nt.gov.au/award-winners/award-winners-2022.
[591] Kara Joyce, Committee Transcript, 3 March 2026, p. 21.
[592] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 5.
[593] André Snoxall, Committee Transcript, 3 March 2026, p. 11.

> implementation related or clinical safety related. Then they would be managed either in those groups or escalated up through the governance pathway.[594]

9.48 Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine at Royal Darwin Hospital, told the Committee that every issue raised through clinical governance pathways was documented and addressed, even if it was not possible to resolve every concern:

> Every concern raised—I chair a clinical leadership group meeting, which is the frontline clinicians governance group which reports to the Program Implementation Committee, which involves executives as well as clinicians, and then to the program steering group. Issues were raised through the governance. Every issue is documented and tracked. Obviously not all the problems can be solved, but all the things are documented and addressed as best as possible at the time.[595]

9.49 However, the Committee heard from the AMA NT that some escalation pathways were not effective due to a lack of committee meetings and attendance:

> reports emerged that clinicians felt their significant concerns, raised years prior to problematic rollouts, were not adequately addressed or resolved by the project leadership. This implies that the input mechanisms, such as the working groups, may not have translated into effective action or appropriate prioritisation within the higher levels of project governance. We have reports from clinicians of some working groups being composed of "effectively" one person, with multiple meetings cancelled or held in absence of a majority.[596]

9.50 When the Committee asked at what stage clinicians raised concerns about patient risk related to Acacia, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, advised the Committee that this occurred after deployment in Royal Darwin Hospital, in November 2023:

> Generally, when we first had some fairly strong representations around it, it was after the deployment into Royal Darwin Hospital in November 2024 [sic]. Mostly those concerns were raised from the emergency department within Royal Darwin Hospital. I want to make the point on the *Hansard* that is not borne out by our clinical safety metrics, so some of those statements have been very broad and not substantiated by evidence. Nonetheless, when you hear them in the public domain they are cause for concern and they concern the public, so we take those things very seriously. Generally, where there have been issues around patient safety, they have come through that emergency medicine subset.[597]

9.51 In particular, Chris Hosking told the Committee that no patient safety issues arose during the implementation of FG1 at KDH and GDH:

> Implementation to Katherine Hospital and Gove Hospital—there have not been any direct patient safety issues. Obviously, any new system we implement there will be a change of workflow and people will have challenges, but there have not been direct patient consequences from Acacia or documented any clinical incidents. We monitor clinical incidents very carefully—that is our passion, so we do that to improve patient care, not to harm patients.[598]

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[594] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 25.
[595] Department of Health, Committee Transcript, 17 February 2026, p.6.
[596] Australian Medical Association Northern Territory, Submission No. 1, p. 5.
[597] Department of Health, Committee Transcript, 17 February 2026, p.5.
[598] Department of Health, Committee Transcript, 17 February 2026, p.6.

9.52 However, the Committee has heard from other stakeholders that clinical concerns had been ongoing well prior to the deployment of Acacia in RDPH ED, and issues were more widespread than only in the EDs. For example, the AMA NT told the Committee that:

> Multiple sources indicate that clinicians and potentially project staff had raised serious concerns about system flaws, usability problems, and potential risks between "two to four years" before the disastrous ED implementation in November 2023. These warnings were reportedly not adequately addressed or resolved; instead, mitigation strategies such as additional training, user supervision, and workarounds were proposed for known risks like medication chart deletion. Issues identified years earlier were allegedly still present when the system went live in the EDs.[599]

9.53 The AMA NT also told the Committee concerns regarding ED functionality had been raised as early as 2019 at the CLG:

> One source alleges that the CLG was made aware in August 2019 that Acacia would not be suitable for an ED environment in any form presented by Intersystems and CCSRP, and one assumes a competent governance structure would have escalated this to the attention of both Chief Executives and the Minister.[600]

Program Management Office

9.54 André Snoxall told the Committee that the Program Management Office (PMO) did not function in the way that it should have. He told the Committee that a PMO should act as an independent assurance body for the program:

> In major public-sector programmes, a PMO should:
>
> - act as a non-partisan source of truth,
> - ensure probity,
> - uphold methodological and reporting standards,
> - protect the integrity of planning and baselining,
> - ensure risks and issues are escalated transparently,
> - validate whether decisions align with programme objectives and approved benefits,
> - and provide independent assurance to the Senior Responsible Owner (SRO) and governance bodies.[601]

9.55 However, he advised the Committee that in practice the PMO was aligned with the priorities of DCDD and did not ensure rigour in determining project plans, escalate clinical risks, or comply with program management methodologies:

> While a PMO existed in name at times during the programme, it did not operate in accordance with accepted programme governance practice and lacked the independence required to provide impartial oversight… Instead, the PMO and related governance structures:

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[599] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[600] Australian Medical Association Northern Territory, Submission No. 1, p. 10.
[601] André Snoxall, Submission No. 7, pp. 4-5.

- were aligned closely with the priorities and positions of DCDD leadership;
- did not provide independent challenge;
- did not ensure compliance with MSP/PRINCE2 principles;
- did not enforce planning discipline or require completion of project plans;
- did not ensure that risks raised by NT Health or clinical stakeholders were transparently recorded or escalated;
- and did not act to ensure that programme governance was balanced, evidence-based, or objective.[602]

9.56 The effect of this was to enhance the influence of the CCSRP rather than ensuring that the CCSRP were effectively managing the program:

> This alignment had the practical effect of making governance partisan, rather than impartial — a significant deviation from best practice for high-risk, clinically significant transformation programmes. In this environment:
>
> - concerns raised by NT Health stakeholders were often dismissed or reframed;
> - risks affecting clinical safety or service delivery were not given appropriate prominence;
> - reporting tended to reflect the narrative required by DCDD leadership rather than an objective account of progress;
> - and decision-making lacked the independent scrutiny that should characterise a public sector digital transformation programme of this scale.
>
> A PMO's purpose is not to "take sides," but to provide independent, methodical oversight that protects the programme, the public investment, and ultimately the health and safety of patients and staff. This essential function was not fulfilled within CCSRP.[603]

9.57 Kara Joyce also told the Committee that a member of the CCSRP senior management was moved into the PMO role following complaints about that member's behaviour in the program.[604] This also suggests to the Committee a lack of independence within the PMO.

Engagement of NT Health Leadership

9.58 The Committee heard evidence that NT Health executive leadership did not sufficiently drive Acacia during some periods of the program. For example, André Snoxall spoke of a 'lack of ownership, driving and leadership from the Health department.'[605] Kara Joyce emphasised the need for Acacia to be driven, top-down, from NT Health leadership.[606]

9.59 Internal documents reveal similar concerns. The Deloitte *Top End Pre-Go-Live Assurance Review* highlighted concerns that some members of NT Health executive

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[602] André Snoxall, Submission No. 7, p. 5.
[603] André Snoxall, Submission No. 7, p. 5.
[604] Kara Joyce, Committee Transcript, 3 March 2026, p. 22.
[605] André Snoxall, Committee Transcript, 3 March 2026, p. 9.
[606] Kara Joyce, Committee Transcript, 3 March 2026, p. 21.

leadership were not driving Acacia deployment. Partially, this was attributed to difficultly balancing driving the reform program whilst having concerns regarding the delivered solution. In contrast, the review highlighted that clinical leadership was engaged:

> There is a perception that some hospital executives are not adequately engaged, don't fully understand the solution or program and are not actively leading go-live activities (e.g. communications, training, benefits, etc.)…
>
> Some senior stakeholders expressed difficulty balancing their role of program advocacy while managing risk and ensuring the solution is fit-for-purpose
>
> It was noted in multiple interviews that clinical leadership were engaged and supporting the go-live as best they can given the circumstances[607]

9.60 Secondly, the Deloitte *Top End Pre-Go-Live Assurance Review* identified issues of governance committee attendance and clarity of responsibility at both the PIC and the Top End Implementation Working Group. These concerns align with accounts provided by the AMA NT (see paragraph 9.49):

> A lack of attendance and unclear responsibilities of the Program Implementation Committee and Top End Implementation Working Group members, has resulted in decisions being challenged / re-prosecuted. Concerns were also raised that the executive team wouldn't understand the cutover process[608]

9.61 The Committee notes that Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, described the PIC as the 'engine room that does the doing and drives the delivery' of the program.[609] Accordingly, a lack of attendance at the PIC would undermine the effective governance of the program. The Committee asked the Departments what the extent of these issues were and what impacts they had on the program. The Departments told the Committee only of the impact in relation to the Implementation Working Groups:

> Key NT Health stakeholders were unable to attend the Implementation Working Group meetings. Significant overlap between the Program Implementation Committee (PIC) and the Working Group led to some duplicate discussions on issues and activities at the PIC.
>
> Decisions had to be pre-prosecuted at the PIC by members who should have been at the Implementation Working Group, where the decisions were endorsed. This issue was avoided in the Central Australia, Barkly, and RDPH ED reimplementation working groups after applying this lesson.
>
> Following completion of FG1 implementation, the roles and membership of all CCSRP governance groups have been thoroughly evaluated and adjusted.[610]

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[607] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, p. 12.

[608] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, p. 18.

[609] Department of Health, Committee Transcript, 17 February 2026, p. 21.

[610] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 8.

9.62 The Committee notes that no evidence of a lack of NT Health executive leadership regarding Acacia was provided in relation to the time period following Chris Hosking PSM's appointment as the CEO of NT Health in August 2024.

Committee's Comments

9.63 Following the Committee's 2014 *Management of ICT Projects by Government Agencies*, significant reforms were undertaken to improve ICT governance in the NT. However, the Committee notes that the *NTG ICT Governance Framework* has not been updated since July 2015, shortly after the Committee's report on the *Management of ICT Projects by Government Agencies*.[611] Associated documents such as the *ICT Governance Models: Guidelines for Agencies* are from 2016.[612] Review of governance practices should not only be precipitated by failures on the scale of the Asset Management System or Acacia. Indeed, the NT cannot afford for this to be the case. It is important that the NT adapts alongside evolving technological and governance practices.

9.64 As discussed in this section and later in the Chapter, it is clear to the Committee that the failures of the program to deliver on time on budget stem at least in part from failures of governance. As such, the Committee considers that the Government should review and revise the *NTG ICT Governance Framework* and associated agency guidelines to enhance governance practices. The Committee considers it likely that NT Health and DCDD will have identified internal governance issues and lessons learned from the Acacia program that should form a part of this review, as well as issues raised in this report. However, the Committee believes that this review should look more broadly and incorporate best-practice advancements in governance practices, as well as lessons learnt from other ICT program and projects run by DCDD on behalf of client agencies, such as SerPro.

Recommendation 5

The Committee recommends that the Government review and revise the *NTG ICT Governance Framework* and associated agency guidelines to enhance governance practices and incorporate lessons learned from the implementation of the Acacia Digital Patient Record System.

9.65 In addition, the Committee has identified some discrete areas of governance practice where it believes that enhancements should be made. These should be incorporated into the above review of the *NTG ICT Governance Framework* and associated agency guidelines.

9.66 One such area the Committee has identified is the membership of the PSC. The Committee observes that the governing arrangements do not appear to have provided the PSC sufficient ICT expertise to critically evaluate the success and

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[611] Department of Corporate and Information Services, *NTG Information and Communications Technology (ICT) Governance Framework*, July 2015.

[612] Department of Corporate and Information Services, *ICT Governance Models Matrix: Guidelines for agencies,* June 2016.

health of the program. Noting the client-delivery agency relationship that is required by the centralised delivery model, the Committee considers it important to have a third-party at the highest decision-making levels. Whilst in the case of Acacia the Under-Treasurer was represented on the PSC, the Committee believes that the PSCs would benefit from an independent *and* expert member. This would better enable critical analysis of the true state of the program, as this person would not be responsible to—or for—either agency. As such, the Committee recommends that as a part of the review of the *NTG ICT Governance Framework,* the *ICT Governance Models: Guidelines for Agencies* be updated to recommend that complex ICT programs and projects have an independent expert member on their PSC.

Recommendation 6

The Committee recommends that the *ICT Governance Models: Guidelines for Agencies* be amended to provide that membership of Steering Committees of complex ICT programs and projects include ICT experts independent of DCDD and the client agency.

Change Management

9.67 Change management is critical to the successful delivery of complex programs such as Acacia. As discussed by Deloitte in the context of Acacia:

> The CCSRP will impact clinicians from all areas of the system including medical, nursing, pharmacy and allied health as well as support and administrative staff. Workflows and business processes will transform, and extensive change will be experienced. This will require significant preparation to ensure that the workforce is ready to adopt the new solution. Engagement of these clinical and non-clinical stakeholders through a robust, well-resourced change management strategy that is linked to clinically validated measurable benefits is critical to developing a system that will be both acceptable to users across the NT Health continuum of care, and be capable of measuring and delivering on clinical performance goals.[613]

Clinical Engagement

9.68 Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, advised the Committee that an aim of the CCSRP was to ensure that clinicians were on board with the new software:

> …you do not want your clinical users, the people who are going to use this system for the next 20 years, feeling that it was chosen by the IT people and inflicted on them.[614]

9.69 Accordingly, the Committee heard that significant clinical consultation occurred in the early stages of this program to solicit system requirements. The CCSRP wanted to be clinically driven:

> …when we undertook the tender assessment process we had more than 50 clinicians involved in that, and that was really deliberate. We involved emergency doctors, surgeons, nurses and physiotherapists. Everybody that

[613] Deloitte, *Northern Territory Government – Assessment 2: Program Health Check*, May 2018, p. 20.
[614] Department of Health, Committee Transcript, 17 February 2026, p. 9.

> was going to use this system, we tried to get representation from all those different clinical categories and across the Territory to make sure our regions were included. Logistically that is a lot of work, but getting our clinical workforce involved in the selection of the product is really important…
>
> We pretty much adopted a first principle that said this program will be clinically driven and IT enabled so that clinicians will drive the program and the IT people will enable it. It will not be the IT people doing it to the clinicians, and we have maintained that view right through until today.[615]

9.70 Evidence examined by the Committee makes clear the extent of clinical engagement during the early years of the program. For example:

- In 2016, somewhere between 2,700 and 3000 clinical requirements were identified in more than 100 workshops with 600 clinicians, for the tendering process[616]
- In 2018, design and configuration workshops occurred with more than 350 clinical, administrative, and technical stakeholders[617]
- In 2018-19, 4800 detailed design requirements were identified in more than 600 system design workshops with more than 1500 NT Health clinicians.[618]

9.71 Unfortunately, it does not appear that this degree of clinical engagement was maintained throughout the life of the program. Several examples of this are evident within internal documents and submissions made to the Committee. For example, in late 2018 when it became clear that completion of the prototype deployment was unrealistic, the CCSRP developed a new schedule for the program without engaging with anyone from the NT Health:

> At the CCSRP PIC meeting held 25 October 2018, PIC members were provided with details of the work that the CCSRP had independently undertaken to develop a new approach and schedule.
>
> In developing the revised schedule no NT Health staff including clinical staff currently engaged in the program or the DoH Chief Information Officer were provided the opportunity to assist and to bring their expertise and awareness of any potential business impacts.[619]

9.72 Additionally, throughout the COVID-19 period where clinical workforce was not engaged with the CCSRP, work continued developing FG1. Accordingly, it appears that solutions were built without regular levels of clinical engagement. For example, internal documents suggest that revision to the Theatre Scheduling were undertaken without engagement with clinical theatre staff:

> Considerable work has been done with InterSystems to further enrich the functionality of the software code that will be delivered for FG1. The initial 'Katherine build' has been enhanced through the configuration and delivery of an additional 19 functional requirements uplifting complex workflows. This will

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[615] Department of Health, Committee Transcript, 17 February 2026, p. 9.
[616] Department of Health and Department of Corporate and Digital Development, Submission No. 3, p. 18; Department of Corporate and Information Services, *Annual Report 2016-17,* 2017, p. 40.
[617] Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, November 2018, p. 10.
[618] Department of Corporate and Information Services, *Annual Report 2018-19,* p. 39.
[619] Core Clinical Systems Renewal Program (CCSRP) *Program Implementation Committee Brief: Changes to the CCSRP Implementation Timeframe*, November 2018, p. 1.

> mean a more function rich solution will be delivered for Katherine, with capability that would have ordinarily have been delivered in a subsequent release of the software.
>
> Further work has also been progressed with the more refined Acacia build that will be required for deployment into RDH and PRH in late 2022. This time has been used to work with InterSystems and deliver 67 additional functional requirements including enhancements that will improve workflows in Theatre Scheduling. This is expected to be well received by clinical stakeholders in the Theatres functional stream.[620]

9.73 The extent to which the CCSRP ultimately diverged from their original goals of being a clinically driven program was highlighted by several submitters. André Snoxall told the Committee the program was 'clinically disengaged, and IT-centric', where decisions were 'dominated by technical rather than clinical priorities'.[621] Additionally, he told the Committee that CCSRP staff were prevented from engaging with NT Health to determine key features of the program:

> Management directives prohibited staff from engaging with NT Health stakeholders without prior approval. This limited:
>
> - requirements discovery;
> - workflow analysis;
> - confirmation of clinical needs;
> - effective change management planning.
>
> Such restrictions and a lack of effective engagement with healthcare managers made it impossible to deliver a clinically owned, clinically safe, operationally-relevant EPR programme.[622]

9.74 Similarly, the AMA NT told the Committee that 'failure of the project to capture frontline concerns was treated as tacit approval from the frontline.[623] Kara Joyce told the Committee that CCSRP assumes that 'no feedback is positive feedback'.[624] A lack of clinical engagement was also evident in advice provided by the Departments. In one case, the Committee asked the Departments what actions were taken to strengthen program control and delivery timeframes. They told the Committee that a key takeaway determined through lessons learned exercises was the need to include local NT Health management and clinicians in developing implementation schedules. The Committee considers that clinical engagement regarding implementation with those working where the software will be deployed is a clear matter of priority, and should not have been a lesson in need of learning:

> A lessons learned exercise was conducted after each FG1 implementation and the findings included in the close reports to inform future implementations. One key takeaway was that participation by onsite NTH management and executives in developing the implementation schedule was essential, for example to provide input on times when engagement or training would be challenging (such

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[620] Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, May 2022, p. 2.
[621] André Snoxall, Submission No. 7, pp. 3, 8.
[622] André Snoxall, Submission No. 7, pp. 6-7.
[623] Australian Medical Association Northern Territory, Submission No. 1, p. 5.
[624] Kara Joyce, Committee Transcript, 3 March 2026, p. 20.

> as school holidays, intake periods, or major events). This approach has helped to ensure that stakeholder engagement activities were not planned during periods when NTH staff would be unavailable.[625]

9.75 Consequently, as Greg Connors, Deputy Chief Executive Officer, Digital Services, DCDD, told the Committee, Acacia became inflicted upon clinicians:

> Our ability to succeed relies heavily on engagement from the client agency. I like to think it is something we are doing with them, not to them. In a lot of cases in a lot of ways with the Acacia program at times, because of the workload they were under because of the pandemic, it was something we were doing to them, and that is how it felt at times.[626]

Change Management Planning

9.76 The Committee also observes that it appears that change management planning and resourcing was insufficient in the early stages of the program. These issues are evident in independent reviews and program health checks provided to the Committee by the Departments. For example, Deloitte's review of the business case outlined that:

> The business case incorporates a relatively detailed description of the proposed implementation approach but does not provide a lot of detail on the proposed structure and approach to change and communications management.
>
> The CCSRP program will result in significant change and disruption to the existing work practices and systems. Ensuring that adequate focus and effort is applied to the necessary change (including training) and communication management activities will be critical to ensure that the outcomes of the program are successfully achieved.
>
> While there is an appropriate and significant proportion of the program budget devoted to change management, there is insufficient detail in the implementation plan as to how the change management program will be structured and delivered.
>
> **Recommendation**
>
> It is recommended that further detail regarding the proposed resourcing, structure and approach to change and communications management be included in the CCSRP business case document to provide Government with confidence that the critical change management aspects of the program have been appropriately considered and planned for.[627]

9.77 A stage-gate review conducted by Deloitte in May 2018 identified that, although progress had been made addressing this issue, resourcing remained inadequate:

> Interviewees applauded the recent on-boarding of a highly skilled, and experienced Change Management resource. Although there is one remaining vacant position to be filled in the Change Management team. The current resource allocation for Change Management is not adequate to support the change management, stakeholder engagement, change impact, clinical adoption, communication, and training activities required for the successful

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[625] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 8.

[626] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 35.

[627] Deloitte, *Department of Health – Core Clinical Systems Replacement Program (CCSRP) Business Case – December 2015 Stage Gate Review*, 18 January 2016, p. 9.

> program delivery for a large –scale clinical transformation program of this scope and complexity.[628]

9.78 Further, in a governance review undertaken by John Kost in 2019, similar concerns were raised regarding a lack of focus on change management within governance documents:

> I did have a chance to review the Terms of Reference for the Stage 2 governance overview, the Program Steering Committee, the Program Implementation Committee, the Stakeholder Reference Group, the Clinical Leadership Group, and the Clinical Governance Advisory Group. Overall, they are well written… However, I did notice that all of them share a similar and serious flaw. The "Outputs" described in all are about upward policy decisions and conflict resolution. None of them are about downward execution or change management issues – all vital to the success of a program.[629]

9.79 The Committee asked the Departments what actions were undertaken to resolve these issues. The Departments told the Committee that:

> The Change and Engagement Strategy and Change Management Plan were developed and approved in 2018 which outline the responsibilities of DCDD and NT Health.
>
> A change management, engagement and training team was established within CCSRP to work with NT Health to manage the change and engagement associated with each implementation. Lessons from each go live highlighted the importance of change and engagement being led by NT Health and supported by DCDD/CCSRP. These lessons were incorporated into the next go live which is evident with the successful go live of FG1 in Central Australia and Barkly.[630]

9.80 The Committee notes that by the time the Change and Engagement Strategy and Change Manage Plan were approved in 2018, extensive work had already occurred engaging submitters and seeking solution design requirements. The Committee considers that these important matters shaping clinical expectations of the solution should have been informed by a Change and Engagement Strategy rather than preceding it.

Clinical Expectations and Resolution

9.81 Indeed, the Committee heard that clinical expectations of the end-product of Acacia were not sufficiently managed. Specifically, the Committee heard from Kara Joyce that the CCSRP failed to appropriately manage clinical expectations regarding the extent that TrakCare would replicate the pre-existing functionality of CareSys:

> The program has not only failed to managed expectations about Acacia being an out of the box solution but actively encouraged stakeholder to identify enhancements. This is well documented with Acacia 1.0 Optimisation. From its inception the vendor was clear that they would not deliver or consider enhancements that didn't have a clinical safety impact. The messaging to the business was contrary to this and much work was done by program staff and stakeholders to define enhancements. Evidence of this can be found in request

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[628] Deloitte, *Northern Territory Government – Assessment 2: Program Health Check*, May 2018, p. 20.
[629] John Kost, *Review of Northern Territory Electronic Health Record Program Governance,* June 2019, pp. 2-3.
[630] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.

> for information (RFI) responses from the vendor and communications that were sent to NT Health Executives.[631]

9.82 Similarly, as discussed previously, Rod McDonald, former InterSystems employee and later CCSRP contractor, told the Committee that the Departments had not sufficiently sought to re-engineer NT Health business practices to better utilise the out-of-the-box functionality delivered by InterSystems. It appears that clinicians reasonably expected a product closely resembling CareSys:

> The overarching approach was for [InterSystems] to simply demonstrate the existing TrakCare functionality and then for DCDD engaged Subject Matter Experts (SMEs), drawn from the business, to document their requirements for how they would like the TrakCare solution to be enhanced/modified at a detailed User Interface level, and to better reflect the way existing legacy systems supported current work practices…
>
> their approach was effectively taking a COTS product down a path of significant customised development, rather than transforming their business practices to adopt the COTS product[632]

9.83 However, Rod McDonald also told the Committee that from InterSystem's perspective, they were not obliged to go through iterative rounds of extensive configuration, rather, they were obligated to fulfil the terms of their contract:

> 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'.[633]

9.84 This gap between clinical expectations and InterSystem's contractual obligations were discussed in Chapter 5 in relation to the customisation of TrakCare. As noted the Committee has heard evidence that this resulted in extensive customisation that has delayed the program. Nevertheless, FG1 was not delivered as a 1:1 model of CareSys. Whilst this is understandable from a technical perspective, apparent failure to manage expectations and re-engineer business practices meant that clinicians experienced a lack of resolution to the issues they identified when functionality was not delivered:

> 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.[634]

9.85 Similarly, internal documentation reveals a clinical view that InterSystems were unwilling to configure TrakCare as requested by clinicians. A finding of the *Top End Pre-Go-Live Assurance Review* was that:

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[631] Kara Joyce, Submission No. 11, p. 2.
[632] Rod McDonald, Submission No. 9, p. 3.
[633] Rod McDonald, Committee Transcript, 3 March 2026, p. 15.
[634] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 4.

> Although some stakeholders reported strong working relationships with the vendor there was also a perception that the vendor was inflexible and unaccommodating to meet the specific needs of Top End
>
> There is a belief that the leadership team did not have enough influence over the vendor to get the desired outcomes
>
> A concern was raised that turnover in vendor resources and potentially loosely defined contractual agreements around functionality may have led to commitments not being delivered and difficulty in communicating requirements, with frequent requests for more user stories…
>
> some stakeholders voiced frustration and a lack of trust towards the vendor for their ability to accommodate Top End's requirements with an out-of-the-box solution and there were misaligned expectations of what was demonstrated prior to build activities commenced and what has been delivered[635]

9.86 Exacerbating these issues, as discussed in Chapter 6, the Committee heard that the process for remediating and optimising Acacia is opaque and has left many issues unresolved for extended periods of time. Together, these matters have caused deep clinical apprehension regarding the CCSRP's willingness to engage with clinical concerns. As Dr John Zorbas, President of AMA NT, told the Committee:

> 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.[636]

Committee's Comments

9.87 The Committee believes that mismanagement of clinical expectations, insufficient business practice transformation, and failure to remedy issues raised during UAT or post-deployment have generated severe clinical frustration and concern regarding Acacia. The Committee notes that this has occurred whilst the program has simultaneously extensively customised the product to an extent that it has caused major program delays and cost overruns. A particular issue related to this matter has been that the existing mechanisms for clinicians to seek remediation of identified issues within Acacia appear opaque and ineffective.

9.88 The Committee has also heard that clinicians are unsure of who is responsible for delivering remediation, in what timeframe, or even if remediation is to occur. As noted previously (see paragraph 6.99), the Committee has been told that an extensive backlog of remediation and enhancement requests have built-up. Further, it appears that in some cases NT Health are absorbing the cost of additional staff to mitigate associated issues.

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[635] Deloitte, *Northern Territory Government – Department of Corporate and Digital Development – Core Clinical System Renewal Program (CCSRP) – Functional Group 1 (FG1) – Top End Pre-Go-Live Assurance Review*, September 2023, pp. 13-14.

[636] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 8.

9.89 The Committee asked the Departments what mechanisms NT Health has to hold DCDD accountable for the successful delivery of Acacia. The Departments advised that:

> Under the OneNTG model and the Administrative Arrangements Order, DCDD is responsible for the delivery of all NTG IT support and IT related projects. Service Statements set out the services to be provided, standards of service and respective responsibilities of DCDD and agencies.
>
> NT Health holds DCDD accountable for the delivery of Acacia through the Program Governance Committees which have representation from NT Health, DCDD and Department of Treasury and Finance.[637]

9.90 It does not appear to the Committee that these mechanisms were sufficient in the case of the CCSRP. In particular, the Committee observes that NT Health's representation on the PSC has not enabled effective delivery of the Acacia program to date. The Committee considers that it is important that in future, programs or projects run by DCDD on behalf of a client agency have clarity regarding delivery and agreed outcomes of projects and programs. There must be clear mechanisms by which client agencies can hold DCDD to account and seek remediation if agreed outcomes are not delivered. Accordingly, the Committee recommends that additional or stronger accountability mechanisms such as Service Level Agreements are implemented to ensure that the DCDD delivered solutions align with agreed program or project outcomes and standards of functionality.

Recommendation 7

The Committee recommends that the Government implement Service Level Agreements or an appropriate alternative, to include agreed outcomes and standards of functionality, between DCDD and client agencies for the operation of complex DCDD delivered ICT projects and programs.

Benefits Realisation

9.91 Internal documents demonstrate that benefits management and realisation planning were not sufficient in the early stages of the program. As a part of their review of the program business case, Deloitte highlighted that predicted benefits of a program must not be assumed to occur following deployment but must be actively managed to ensure genuine success:

> Realising the benefits associated with the implementation of new clinical systems does not follow automatically from successful systems implementations - effort is required to ensure that the intended benefits are actually realised and that their full magnitude is achieved. Effort is also required to track the level and timing of benefit realisation.
>
> Well planned projects devote effort up–front to benefits realisation planning so that as the project progresses, the baseline data that will be required for benefit

[637] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 15.

> measurement as well as the processes to measure and track benefit realisation are established as part of the project's implementation program.[638]

9.92 Deloitte's review of the program business case indicated that planning for benefits management and realisation had been insufficient to date:

> The draft business case identifies the potential benefits that are expected from the delivery of the CCSRP but does not provide any detail on a benefits realisation strategy and plan…
>
> **Recommendation**
>
> It is recommended that additional work is undertaken on the development of a benefit realisation strategy and plan to ensure that the Department and the NT Government are well positioned to realise the intended benefits of the CCSRP.[639]

9.93 Several years later in 2018, the same issue was identified and extensively discussed during a health check of the program conducted by Deloitte. An extract of their summary of observations, associated risks, and recommendations are included in Table 8 below.

The Committee asked the Departments what actions were undertaken to resolve these issues. Amongst other matters, the Departments told the Committee that:

> A Benefits Management Strategy and Plan were developed and approved in 2019.[640]

9.94 However, André Snoxall, who worked as a contractor with the CCSRP to develop the Benefits Realisation Strategy, told the Committee that 'The Benefits Strategy was reviewed and agreed by NT Health senior management but… was never implemented, cascaded, or embedded.'[641] Instead, the Committee heard that benefits realisation was considered within the program as a matter to consider post-deployment:

> 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.[642]

9.95 Indeed, the Departments told the Committee that the remaining actions taken in response to Deloitte's reviews was to plan to consider benefits after full implementation:

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[638] Deloitte, *Department of Health – Core Clinical Systems Replacement Program (CCSRP) Business Case – December 2015 Stage Gate Review*, 18 January 2016, p. 10.
[639] Deloitte, *Department of Health – Core Clinical Systems Replacement Program (CCSRP) Business Case – December 2015 Stage Gate Review*, 18 January 2016, p. 10.
[640] Department of Corporate and Digital Development and Department of Health, *Responses to the Written questions,* 13 April 2026, p. 5.
[641] André Snoxall, Submission No. 7, p. 4.
[642] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.

Table 8: Extract from Deloitte's Summary of Key Findings / Recommendations[643]

Observations	Highlighted risks	Mitigations/ Recommendations
Benefits Realisation • Very limited documented evidence of a plan for realising, monitoring, and evaluating clinical and/or financial benefits • Clear performance improvement targets have not been defined • Limited evidence to demonstrate how the key benefits (as defined in the business case and draft program management plan) are to be realised within the solution design and configuration (i.e. examples of where the software has been configured to realise key identified benefits) • Currently there are no mechanisms for the CCSRP project team to: o Link identified improvement opportunities to the current process and application design sessions o Ensure that the new clinical system build includes the collection of data needed to demonstrate that clinical and business benefit goals have been met	• Significant risk of failing to achieve the expected clinical and financial outcomes, if the business does not have a clear understanding of what the benefits are, and what is required to achieve those benefits • Inadequate benefits realisation planning may negatively impact end user clinical adoption, user satisfaction, uptake and ownership of the system	• Since benefits realisation is a shared responsibility between the program team and NT Health, it is critical to adopt a collaborative approach to agree upon and establish a set of meaningful metrics that measures the degree of impact of the clinical transformation on stakeholder organisations • It is recommended that the CCSRP in collaboration with NT Department of Health (DOH) design and implement a clinically validated benefits realisation plan that: o Provides a framework for measuring the enterprise wide benefits of the CCSRP (both clinical transformation and system implementation) at a patient, care delivery and Health Organisation level. o Includes a benefit target and realisation schedule and identifies key metrics and a risk assessment for each opportunity o Assigns benefit owners across the program team and NT Health with clear roles and responsibilities to capture, measure, and track benefits over time o Identifies detailed benefits metrics, as well as tracking activities and processes across the organisation • It is recommended that benefits realisation is linked with program governance and change management processes; as benefit owners are accountable for ensuring that projected benefits are enforced, sustained, and monitored • It is recommended that NT Health key stakeholders and the program team develop a robust benefits realisation strategy that includes the following benefit categories: o Bankable –can be quantified and have a financial impact due to cost savings or revenue gains o Non Bankable –can be quantified but no cash impact. Relate to improvements in productivity. o Qualitative –can not be quantified but have a positive impact due to improved impact, experience or reputation

[643] Deloitte, *Northern Territory Government – Assessment 2: Program Health Check*, May 2018, p. 15.

> Benefits were highlighted in the business case however it was noted through governance groups that these benefits would be experienced when Acacia had been implemented fully.[644]

9.96 Accordingly, in 2023, the Departments decided to outsource benefit assessment to the Menzies School of Health:

> A decision was made by the Program Steering Committee in 2023 to partner with Menzies to manage assessment of benefits. It was noted the immediate benefits would be experienced related to access to information however the full benefits would take many years to be realised.[645]

9.97 This July 2023 proposal to the Menzies School of Health focused consideration on an assessment of the ED, Theatre Scheduling, Maternity and Child Health and Renal Dialysis units.[646] They sought to engage Menzies School of Health to determine legacy system baselines and then measure changes associated with deployment of Acacia:

> NT Health and DCDD are seeking to partner with Menzies School of Health to commence a program of work to 1) baseline the current state within NT Health supported by legacy IT platforms and 2) establish a basis by which the value of the investment in Acacia can be tracked and measured in both quantitative and qualitative terms.[647]

9.98 Future planning for benefits assessment of additional elements of Acacia is still underway:

> An amount of $100,000 has been funded from CCSRP to date for the Menzies engagement. Discussions regarding the future funding model are currently underway with NT Health.[648]

Committee's Comments

9.99 The Committee does not consider outsourcing benefits assessment to Menzies School of Health to be a satisfactory substitute for active benefits management and realisation throughout the life of the program. Indeed, the fact that the proposal to engage Menzies School of Health was made in July 2023, several years after FG1 was first supposed to be deployed, suggests that it was a low priority for the Departments.

9.100 The Committee notes that benefits management and realisation activities work to ensure that the recipients of new technology experience genuine benefits from that technology. André Snoxall provided an example of the issues with not managing

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644 Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.

645 Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.

646 Core Clinical Systems Renewal Program, *Acacia Digital Health Transformation: Proposal to Menzies School of Health,* July 2023, pp. 7-10.

647 Core Clinical Systems Renewal Program, *Acacia Digital Health Transformation: Proposal to Menzies School of Health,* July 2023, p. 6.

648 Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 4.

benefits in the context of the EPR delivered by FG0, noting that it is unclear what parts of the solution work, and which parts do not:

> 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.[649]

9.101 The Committee notes that clinicians have expressed concerns that Acacia has not delivered on the projected benefits to their work or has delivered significant disbenefits.[650] The Committee considers that, if benefits management and realisation had been better valued by senior management throughout each stage of deployment, it is likely that clinical experiences of deployment would have improved over phases of deployment. An enhanced focus on benefits realisation was also recommended by the AMA NT:

> 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.[651]

9.102 The Committee observes that active management of benefits is required under the Treasurer's Directions ICT1.3.5, ICT1.3.6, and ICT3.1.2. In particular, ICT3.1.2 requires that processes be maintained for the realisation of benefits throughout the lifecycle of a project. Benefits realisation is not only an activity to be completed following completion of a project:

> Each agency is to provide benefits realisation measurements for the project lifecycle and develop and maintain processes for the realisation, measurement and reporting of benefits through the lifecycle.[652]

9.103 The Committee does not consider that the *NTG ICT Governance Framework* sufficiently reflects the need to actively realise benefits as set out in the Treasurer's Directions. The need to consider benefits is highlighted in the planning stage of projects and measurement of benefits is highlighted in the post-implementation review of projects.[653] However, benefits realisation does not feature in the implementation of a project itself, which is necessary for active management of benefits.[654] Accordingly, the Committee considers it would be appropriate to elevate the role of benefits realisation in the *NTG ICT Governance Framework*. As such, the Committee recommends that the ICT Governance Board be provided an explicit role

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[649] Adelphos AI, Committee Transcript, 3 March 2026, pp. 11-12.
[650] Australian Medical Association Northern Territory, Submission No. 1, p. 1; Australian Nursing & Midwifery Federation Northern Territory, Submission No. 4, p. 1; Royal Australian and New Zealand College of Psychiatrists, Submission No. 6, p. 1.
[651] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 8.
[652] Treasurer's Directions, ICT3.1.2.
[653] Department of Corporate and Information Services, *NTG ICT Governance Framework*, 2015, p. 13.
[654] Department of Corporate and Information Services, *NTG ICT Governance Framework*, 2015, p. 13.

in monitoring the ongoing benefits management and realisation over the lifecycle of projects and programs.

Recommendation 8

The Committee recommends that the role and functions of the ICT Governance Board, as set out in the NTG *ICT Governance Framework*, be amended to explicitly include monitoring of ongoing benefits management and realisation over the lifecycle of ICT projects and programs as set out in Treasurer's Direction ICT1.3.5, ICT1.3.6, and ICT3.1.2.

Schedule Delays, Timeline Slippage and Reporting

9.104 Extensive delays and timeline slippage have plagued this program. However, the Committee notes that program delay was often well justified, and in some cases, unavoidable. In particular, the COVID-19 pandemic was not predictable, nor able to be worked around. In other cases, such as the remediation of FG1, implementation was delayed due to identified issues regarding the functionality of Acacia and the risks to patient safety (see Chapter 7). More broadly, the Committee was advised by NT Health that one of the reasons for the significant delays was the program's focus on patient safety:

> One of reasons things took longer is we always had the philosophy of patient safety first, so we want to get it right. In most projects when the budget is under pressure people try to push through and take shortcuts, and we always made sure there were no shortcuts. We discussed everything at every meeting, so all the governance meetings I have been part of, including the program governance group, every decision has been met with patient safety in mind.[655]

9.105 Despite this, the Committee considers that more rigorous program management methodologies would have enabled stronger schedule control. Further, it appears that the current system of reporting has not enabled sufficient oversight of program timelines, facilitating long-term timeline slippage.

Program Management Methodology

9.106 The Committee has heard from several submitters that the delivery schedule for different elements of this program was often decoupled from actual progress in developing and configuring Acacia. In particular, Kara Joyce told the Committee that project management methodologies were not used. Instead, timelines were determined to align with CCSRP priorities:

> Program Schedules have never aligned to any project management methodology. Routinely, dependencies were removed to fit a desired go live date. A recent example was the go live for ASH/TC where the program promised delivery prior to EOFY in order to reduce the reporting burden for NT Health. This was never possible based off required activities however the schedule was altered to make it appear possible. Ultimately the go live date was pushed and

[655] Department of Health, Committee Transcript, 17 February 2026, p. 6.

> this resulted in unnecessary financial loss due to booked accommodation to support a June go live.[656]

9.107 Associated with this issue, André Snoxall told the Committee that, although a program plan for Acacia was developed, individual project plans for each project within Acacia were not. It appears that, in effect, the building blocks of the program were not appropriately managed. He highlighted issues associated with this:

> Without completed project plans:
>
> - no baselines for schedule, scope, or quality existed;
> - project engagement planning was non-existent;
> - there were no effective project communication plans;
> - resource planning was unsupported;
> - reports were based on shifting, unanchored schedules;
> - predictable programme risks were never mitigated.[657]

9.108 An example of the unanchored schedules was provided by Kara Joyce, who told the Committee that schedules were made without strong methodological rigour. When asked what input staff had on determining the schedules set by senior management, she told the Committee that:

> 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. [658]

9.109 In recent years, Kara Joyce also told the Committee that governing committees have been unable to hold the program to schedule because there was no schedule:

> For several years CCSRP board meetings have been conducted with no delivery dates against the project. Evidence of this can be found in meeting minutes. This is highly unusual and shows a lack of transparency and accountability.[659]

Oversight and Reporting

9.110 The Committee also heard that reporting mechanisms to enable oversight of the program schedule were ineffective.

Traffic-Light System

9.111 In particular, the traffic-light rating system for reporting on the status, health, and progress of the program failed to reflect the actual status of the program. Kara Joyce outlined how program re-baselining would, in-effect, erase past delays:

> 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

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[656] Kara Joyce, Submission No. 11, p 2.
[657] André Snoxall, Submission No. 7, pp. 5-6.
[658] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[659] Kara Joyce, Submission No. 11, p. 2.

> 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.[660]

9.112 Because of this, the actual status of FGs was not reflected in reporting:

> 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.[661]

9.113 A practical example of this issue is evident in internal documentation provided to the Committee. When reporting to governance committees in November 2020 on delays to the program schedule because of the COVID-19 pandemic, the CCSRP explained that:

> As a result [of the pandemic], the Program is no longer aligned to the delivery schedule approved by the PSC in December 2019 and is currently rated 'Amber' across all layers of governance reporting (this includes all CCSRP committees, NT Government ICT Governance Board (IGB) and the quarterly scorecard report to Cabinet).[662]

9.114 While in isolation the status is accurate, it does not appear to the Committee to reflect the true nature of delays to the program. At the time of the quoted document Acacia was originally planned to have been fully deployed in the 4 largest NT hospitals and most of its regions. Indeed, as outlined in Chapter 3, by this point the program had been delayed from a first deployment of the full suite in Katherine in October 2019 to July 2020, again to September 2020, and upon being further delayed to June 2021 the schedule had been completely revised to implement the program by FGs, with FG1 now being delayed from its first planned deployment in November 2020. Clinical resources had left the program to support the frontline healthcare system.

9.115 While having the benefit of hindsight, the Committee queries whether—having not deployed any functionality outlined in the business case after 4 of the 5 planned years of the program—an orange status reflected the true health and progress of the program. Instead, it appears to the Committee that re-baselining obscured the true status of the program. The Committee considers that if reporting mechanisms do not provide clear and consistent methods for assessing the health of the program, then they do not enable effective oversight by governance structures. The Committee is concerned to hear that multiple programs within DCDD (Acacia and SerPro) have been decoupled from effective oversight because of this issue.

Timeline Slippage

9.116 Further, internal documents provided to the Committee provide evidence of an apparent recurring issue where revised timeframes were discussed as original

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[660] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[661] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[662] *Core Clinical Systems Renewal Program*, *Program Schedule Revision - Adjustment due to impact of COVID-19,* November 2020, p. 7.

timeframes, obscuring the true extent of timeframe slippage and failure to meet key deadlines. For example, in the *Acacia Deployment and Adoption Executive Summary* the 'Big Bang (approved)' schedule is referred to as 'the original schedule that assumed a regional "big bang" deployment'.[663] However, as outlined in Table 9, this was not the original schedule. Instead, it was a revised schedule with some elements being a year behind the actual original schedule. Accordingly, when comparing the proposed timeline for the phased implementation plan against the erroneously labelled 'original' timeline, delays appear less than their true nature.

Table 9: Timeline Slippage Between the CCSRP Integrated Master Program Schedule and the Acacia Deployment and Adoption Executive Summary

Deployment	CCSRP Integrated Master Program Schedule (November 2018)	Acacia Deployment and Adoption Executive Summary (December 2019)	Months of obscured slippage
Technical go-live	August 2019	August 2020	+12
Katherine deployment	September 2019	September 2020	+12
Darwin deployment	May 2020	April 2021	+11
Alice Springs deployment	September 2021	August 2021	+11
Tennant Creek deployment	January 2021	November 2021	+10
Nhulunbuy deployment	April 2021	November 2021	+7
Personal community portal deployment	June 2021	November 2021	+5

9.117 Similarly, in a document titled *CCSRP Acacia Timeline – Key Dates,* presented to the Program Steering Committee in February 2025, the CCSRP recapped the key dates associated with the deployment of FG1 and the FG1 remediation project in RDPH. They explained that:

> FG1 went live in the Big Rivers, East Arnhem and Top End regions in July 2022, November 2022 and September/November 2023 respectively.
>
> In March 2024, the NT Health Chief Executive (CE) approved for the Emergency Departments (ED) across Royal Darwin and Palmerston Hospitals (RDPH) to revert to using CareSys, whilst the remaining services across RDPH continued to utilise Acacia. This rollback to CareSys was deemed interim to enable further enhancements and remediation to Acacia workflows to address feedback provided by ED stakeholders. An impact assessment of the RDPH ED rollback was undertaken, with the intended delivery of remaining FG1 functionality planned as:

[663] Core Clinical Systems Renewal Program (CCSRP), *Acacia Deployment and Adoption Executive Summary*, December 2019, p. 13.

- FG1 ED Remediation – deploy to East Arnhem and Big Rivers Region | 13 March 2025
- FG1 ED Remediation – deploy to Top End Region | 8 April 2025
- FG1 CA&B Renal Same Day Dialysis – deploy to Central Australia and Barkly Regions | 24 February 2025 (ASH), 3 March 2025 (TCH)
- Remaining FG1 – deploy to Central Australia and Barkly Regions | 27 June 2025.[664]

9.118 However, this timeline of events omits to mention the originally planned deployment date of the FG1 remediation project was February 2025.[665] The document instead positions the April date as the 'intended' date rather than a rescheduled date.

Current Schedule

9.119 Similar issues to those discussed above are still evident in the program today. For example, in April 2026 the Departments advised that no schedules have been approved for FG2 or FG3:

> The last schedules developed for FG2 and FG3 were set before the RDPH FG1 was implemented and there have not been further FG2 and FG3 schedules approved...[666]

9.120 However, the Departments also told the Committee that implementation of FG2 would begin in mid-2026 and CWS would be replaced by June 2027:

> Timeframes are being worked through in conjunction with NT Health however the replacement of CWS is anticipated for June 2027…
>
> FG2 is in the solution build stage with the first phase of functionality to commence implementation mid-2026.[667]

9.121 It is of concern to the Committee that implementation planning activities are occurring without program schedules having been developed. This reflects submitters' concerns that the program has lacked robust project management, including failure to adopt appropriate project management methodologies. Because of this, timelines and schedules appear to have been decoupled from the actual status of development and feasibility.

9.122 More broadly, the Committee observes that assessments of the success and future of the program appear disconnected from the reality of the program status. For example, in their April 2025 submission to the Committee, the Departments advised that implementation of FG2-5 would require less effort and cost than FG1 had:

> much of the preparatory work for the deployment of Functional Groups 2-5, primarily including the procurement and configuration of the relevant parts of the TrakCare software, has been proceeding in parallel to the work done to date

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[664] Core Clinical Systems Renewal Program, *Program Steering Committee: CCSRP Acacia Timeline – Key Dates*, February 2025, p. 2.

[665] Core Clinical Systems Renewal Program, *Program Steering Committee Briefing – Meeting 24-21: Functional Group 1 (FG1) ED Remediation Project– Shedule* [sic], August 2024, p. 1.

[666] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 7.

[667] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 22-23.

> and is well progressed. The completion, testing, training and deployment of the remaining functional groups will not require the same time nor investment as to date.

9.123 However, later information provided to the Committee indicated that only $2.0 million had been spent developing FG4 to date,[668] $91,000 on FG5, [669] and that both were only in the 'planning stage' rather than the solution build stage. It does not appear to the Committee that these FGs are 'well progressed'.[670]

9.124 Even following the Departments' January 2026 submission detailing that FG3 and FG4 have been deferred indefinitely pending funding availability, in February 2026 during the public briefing Professor Nadarajah Kangaharan, Acacia Clinical Sponsor and Co-Director of Medicine at Royal Darwin Hospital continued to speak as if the program was being completed:

> I am just saying that this is a really good investment. When we complete it, we will make a huge difference. In 20 years' time you will not talk about the cost; you will probably be much better off.[671]

9.125 Similarly, at the same briefing, Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, told the Committee that the future of the program was 'looking bright', despite effectively running out of funding:

> Functional Group 1 is complete; we are starting to get stuck into Functional Groups 2 and 5. I think the future for Acacia is incredibly bright.[672]
>
> It is a bit of a pivotal moment here, because we are looking at the project in the rear-vision mirror, as it were, at some of the things that potentially could have gone better or that have thrown up question marks or flags along the way, but the future trajectory is really bright. I am excited for what we are going to achieve.[673]

Committee's Comments

9.126 The Committee notes that the Digital Project Management Framework was updated in May 2026.[674] The Committee is heartened to see that this framework is derived from the PRINCE2 project management methodology. The Committee supports this improvement to project and program management practice within the NT. However, the Committee does not consider that this is sufficient to resolve the schedule and

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[668] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2; Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.

[669] Department of Health, *Answers to Questions Taken on Notice,* 12 March 2026, p. 2; Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.

[670] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.

[671] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 5; Department of Health, Committee Transcript, 17 February 2026, p. 21.

[672] Department of Health, Committee Transcript, 17 February 2026, p. 9.

[673] Department of Health, Committee Transcript, 17 February 2026, p. 22.

[674] Digital Project Services - Department of Corporate and Digital Development, Digital project management framework, May 2026, https://ntgov.sharepoint.com/sites/DPSHub/Shared/PMF/Framework/Digital%20project%20management%20framework.pdf

delivery issues identified. Opacity within the governance of a complex program such as Acacia inhibits effective and appropriate decision-making. Whilst this issue appears to have directly impacted Acacia's governance structures, the Committee notes that this would have similarly impacted the ICT Governance Board's ability to oversee Acacia.

9.127 The Committee considers that Acacia demonstrates a clear need to enhance the oversight of complex ICT programs and projects within the NT. Effective governance cannot be conducted with inaccurate information, or information that disguises the true status of the program. As such, to enhance the ICT Governance Board's oversight of complex ICT programs and projects, the Committee recommends that the Government review and enhance the effectiveness of existing reporting mechanisms relating to ICT programs and projects.

Recommendation 9

The Committee recommends that, taking into consideration the Committee's findings, the Government review the effectiveness of existing reporting mechanisms relating to the progress of ICT programs and projects with a view to enhancing the ICT Governance Board's oversight of complex ICT programs and projects.

9.128 Additionally, the Committee considers that it would be of benefit to the NTG to develop a single, universal program and project reporting framework that could be utilised across all government agencies. This would enable consistent and clear reporting across the NTG and enhance oversight of projects and programs in all agencies. Accordingly, the Committee recommends that government develop a cross-government reporting framework for all program and projects, with clear and consistent measures of progress and delivery.

Recommendation 10

The Committee recommends that the Government develop a cross-government reporting framework for all programs and projects.

Workplace Culture

9.129 Submitters to the Inquiry highlighted a harmful culture present within the CCSRP and the impact that this workplace culture had on the successful delivery of the program. The Committee notes that the experiences shared by submitters and witnesses in public align with the experiences of those who submitted confidentially to the Committee or spoke to the Committee in private hearings.

9.130 The Committee heard that the CCSRP had a 'toxic'[675], 'fragile and insular' culture.[676] Submitters advised the Committee that the toxic workplace culture was known to

[675] Rod McDonald, Submission No. 9, p. 4; Name withheld, Submission No. 10, p.1; Kara Joyce, Submission No. 11, p. 3.
[676] André Snoxall, Submission No. 7, p. 8.

and cultivated by CCSRP senior management.[677] For example, Rod McDonald told the Committee that 'Bullies were allowed to flourish'. Pointing to a specific example of this culture, Kara Joyce told the Committee that:

> 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 [them] were not acted on.[678]

9.131 The Committee also heard that senior leadership were unwilling to listen to issues raised by their staff and contractors.[679] André Snoxall recounted to the Committee his experience of senior management seeking to retain total control over the program:

> 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.[680]

9.132 Because of this, the Committee heard that the CCSRP had a culture 'that rewards obedience and punishes constructive dissent.'[681] In this latter vein, the Committee was also told that senior management took punitive action, or threatened punitive action, if staff continued to raise concerns.[682] For example, Rod McDonald recounted his manager's fear that they would be fired if he raised concerns regarding the program:

> 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.'[683]

9.133 Similarly, André Snoxall talked about his experience of being 'cancelled' for flagging concerns:

> 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.[684]

9.134 Some submitters told the Committee that senior leadership did not have suitable qualifications or experience to be in leadership positions within a complex ICT program.[685] For example, Rod McDonald linked workplace culture issues to the inexperience of the senior management team:

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[677] Kara Joyce, Submission No. 11, p. 3; Rod McDonald, Submission No. 9, p. 4.
[678] Kara Joyce, Submission No. 11, p. 3.
[679] André Snoxall, Submission No. 7, p. 8; Rod McDonald, Committee Transcript, 3 March 2026, p. 14; Name withheld, Submission No. 10, p. 1; Kara Joyce, Submission No. 11, p. 1.
[680] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.
[681] Kara Joyce, Committee Transcript, 3 March 2026, p. 19.
[682] Rod McDonald, Committee Transcript, 3 March 2026, p. 14; Adelphos AI, Committee Transcript, 3 March 2026, p. 10; Name withheld, Submission No. 10, p. 1; Kara Joyce, Submission No. 11, p. 1.
[683] Rod McDonald, Committee Transcript, 3 March 2026, p. 14.
[684] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.
[685] Rod McDonald, Submission No. 9, p. 4; Kara Joyce, Submission No. 11, p. 3.

> It is obvious that the inexperience and lack of appropriate qualifications for the management of the program led to individuals being placed under extreme stress. It resulted in those SLT members without the necessary skills reverting to bullying tactics to try and achieve what they believed was a sufficient outcome to be defended as success in their minds.[686]

9.135 Moreover, the Committee heard that senior management were not held accountable for failures of management or delivery.[687] Further, the Committee was told that hiring practices were linked to 'personal relationships' over 'organisational need':

> Restructuring decisions appeared to reflect personal relationships rather than capability or organisational need, further degrading culture and delivery outcomes. Decisions around who was kept at the end of 2025 funding envelop were not documented or based on a skills matrix. [688]

9.136 DCDD contested this position, telling the Committee that merit selection processes and market testing occurred for the recruitment of permanent staff and contractors:

> In terms of filling these positions, we do not just pluck them and go, 'Here, your turn'; there is a recruitment process that we go through. We test the market. In some cases we are testing the market for contractors and there is an onboarding process for those individuals. We put requirements out; we actually go and seek what we need to fill those positions.
>
> In the FTE, in the NT public service side of things, again there is a [job description] that goes to market, and we do an assessment—many, many applicants. We pick the best that we can out of that based on their capabilities.
>
> At all times we are getting the best people for those positions that we can. Their responsibilities and skill sets are… predicated on what the work is we have got coming.[689]

9.137 The Committee observes that issues with workplace culture within DCDD have been a recurring issue over several years. The results of the *NT People Matter Survey 2021, 2023,* and *2025* aligns with the experiences of submitters to the inquiry. A sample of the clearest issues have been reproduced in Table 10 below. These demonstrate that employee experiences of bullying and perceptions of improper conduct, recruitment and promotion issues, and lack of collaboration have not seen meaningful improvements over the last 5 years.

9.138 The Committee notes that Catherine Weber, CEO of DCDD, told the Committee that contractors do not contribute to the People Matter Survey, which is limited to permanent staff. Instead, contractors are expected to engage with their vendors if there are issues in the workplace:

> the staff satisfaction surveys are only undertaken by NTPS staff, so the contractors do not participate in that process. However, they have recourse to their employers who we call vendors—organisations that engage ICT professionals and then contract them out to us.[690]

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[686] Rod McDonald (Supplementary), Submission No. 16, p. 6.
[687] Kara Joyce, Submission No. 11, p. 3.
[688] Kara Joyce, Submission No. 11, p. 4.
[689] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 28.
[690] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 29.

Table 10: Results from the 2021, 2023, and 2025 People Matter Survey (DCDD)

Question/Statement	Percent agreed (strongly agree and agree)		
	2021[691]	2023[692]	2025[693]
Experienced bullying/harassment in the past 12 months[694]	22	15	16
I believe my organisation will take action as a result of this survey	50	59	54
I think it is safe to speak up and challenge the way things are done in this organisation	50	59	56
My organisation fairly considered recommendations from staff about how we could better operate	48	57	53
I am confident that I would be protected from reprisal for reporting improper conduct	60	67	61
I am confident that if I reported improper conduct in my organisation, it would be investigated in a thorough and objective manner.	57	62	59
People recruited to my organisation seem to have the right skills for the job	56	55	53
Recruitment and promotion decisions in my workplace are based on merit	51	56	54
My manager appropriately deals with employees who perform poorly.	48	50	51
There is good collaboration between my organisation and other agencies or organisations we work with	54	60	60
There is good cooperation between teams across our organisation	49	56	54

[691] Department of Corporate and Digital Development, *NT People Matter Survey 2021*, 2021, https://ocpe.nt.gov.au/media/documents/people-matter-survey-reports/2021/results/department-corporate-digital-development-pms2021.pdf

[692] Department of Corporate and Digital Development, *NT People Matter Survey 2023,* 2023, https://ocpe.nt.gov.au/media/documents/people-matter-survey-reports/2023/department-of-corporate-and-digital-development.pdf

[693] Department of Corporate and Digital Development, *NT People Matter Survey 2025*, 2025, https://ocpe.nt.gov.au/__data/assets/pdf_file/0006/1599765/dcdd-nt-people-survey2025.pdf

[694] Note: the specifics formulation of this question have changed in each iteration of the survey.

9.139 Contractors also provide feedback to DCDD upon their exit through the medium of their vendors, who may retain an ongoing relationship with the agency:

> [Contractors] are encouraged also to provide their feedback because that is valuable input for us about how we manage things and how we can improve. They would also speak with their employer. Those sorts of discussions would form part of our contract management discussions with those vendors…
>
> We operate a vendor panel—an ICT specialist panel I think it is called—which has many firms and individuals on that panel. We draw on different ones at different times. We do not necessarily end the contractual relationship altogether with a vendor; we might just cease or conclude that piece of work with that particular person that they have provided to us. [695]

Impact on Program Staff

9.140 The Committee heard that workplace culture issues had a severe impact on program staff. Most tragically, the Committee was told by Kara Joyce that the workplace culture with the CCSRP and associated failures of senior management led to the death of her brother, Shaun Joyce, a contractor with the CCSRP:

> 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.[696]

9.141 As Kara Joyce told the Committee, Shaun Joyce's death is emblematic of the experiences of staff within the program. The Committee heard from public and private submitters and witnesses alike that working on the CCSRP was an unpleasant, stressful, demanding, and often thankless experience. The Committee heard that failures of the program to meet deadlines resulted in additional pressure on staff already working extensive hours:

> The pressures that you as employee are under to deliver on these timeframes with a failing project, it can be very stressful.[697]

9.142 The Committee also heard of staff being let go with no warning or prior conversations regarding performance, in front of their colleagues:

> 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.[698]

9.143 Overall, the Committee heard that these tensions and pressures created a toxic working environment:

> 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

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[695] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 30.
[696] Kara Joyce, Committee Transcript, 3 March 2026, p. 19.
[697] Rod McDonald, Committee Transcript, 3 March 2026, p. 17.
[698] Kara Joyce, Committee Transcript, 3 March 2026, p. 20.

> trying very hard to improve their services and do their best. It was very demoralising.[699]

9.144 Whilst some staff were able to leave the program, other local staff could not due to limited job opportunities within Darwin. In other cases, the Committee heard that the CCSRP would block contractors seeking alternative employment:

> 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.[700]

Impact on Program Delivery

9.145 The Committee heard that failings of senior leadership and the toxic workplace culture had a range of detrimental impacts on the delivery of the program. Firstly, the Committee was told that the toxic workplace culture created a high level of turnover within the program.[701] This meant that over time institutional knowledge was lost and extensive resources were spent on recruitment and training. As explained by one submitter:

> The program started with well-meaning staff who had a wealth of knowledge, but over time a lot of these people were let go when they raised a concern that didn't align with the program's direction (with as little as a days' notice). Replacement resources typically didn't have as much knowledge, and required extensive onboarding, impacting delivery times or product quality. I think my team had worked with [six] different Project Managers in the [thirty] months I was there.[702]

9.146 Secondly, as discussed, the Committee heard that senior management were not willing to constructively engage with concerns or issues raised by staff. Alongside this, senior management did not proactively utilise expertise within the CCSRP:

> 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.[703]

9.147 Together, it appears this meant that serious challenges to program configuration and delivery were left unresolved, with decisions made by leadership without full clarity of the scale or complexity of the issues. The Committee heard that these factors harmed the delivery of the program because refusal to acknowledge concerns did not make the root cause disappear. Rod McDonald discussed this

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[699] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.
[700] Kara Joyce, Committee Transcript, 3 March 2026, pp. 22-23.
[701] Name withheld, Submission No. 10, p. 1; Kara Joyce, Committee Transcript, 3 March 2026, p. 22.
[702] Name withheld, Submission No. 10, p. 1. Note: number of managers and months change to preserve anonymity of the submitter. The spirit of the submission has been retained.
[703] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.

issue in the context of the capability gap between TrakCare and expectations of clinicians, saying that his concerns were:

> 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'.[704]

9.148 Because of this, the Committee was told that significant challenges impacting later FGs were deferred rather than addressed, impacting long-term timeframes:

> Many attempts were made within CCSRP to engage with [InterSystems] on making progress on the Functional Group 4 phase of the program (the replacement of CCIS and PCIS) – however none of these were successful
>
> The poor leadership within DCDD and the continued absorption of time and resource in the FG1 phase allowed [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 [InterSystems] down to the ground and allowed the program budget to be used up without exposing TrakCare to costly enhancements[705]
>
> 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.[706]

9.149 The Committee notes that the lack of reflection discussed by submitters was often associated with, or because of, the need to meet delivery schedules. For example, André Snoxall told the Committee that:

> 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.[707]

9.150 Similarly, Kara Joyce pointed out that staff concerns were not listened to because of desire to meet the program schedule:

> 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.[708]

9.151 Ultimately, the Committee heard that the toxic workplace and fears of retribution meant that people stopped raising issues, which undermined the quality of the delivery:

> the primary driver for project failings was due to poor executive leadership (Upper Program leadership and EPS). This resulted in a toxic workplace that had *extremely* high turnover, low morale, and excessive burnout. This had a

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[704] Rod McDonald, Committee Transcript, 3 March 2026, p. 15.
[705] Rod McDonald, Submission No. 9, p. 4.
[706] Rod McDonald, Committee Transcript, 3 March 2026, p. 15.
[707] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.
[708] Kara Joyce, Committee Transcript, 3 March 2026, p. 22.

> knock-on effect into poor performance, inordinate amounts of time spent on recruitment and training, and a far greater focus on people keeping their jobs over delivering a good product out of fear.[709]

9.152 Kara Joyce made a similar point when asked what the consequences would be for a person who raised issues with achieving a go-live date:

> 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.[710]

9.153 Thirdly, the Committee heard that, because people were hired without sufficient expertise and experience—whether in senior management or other levels—the work program was undermined. For example, Kara Joyce told the Committee that:

- 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.
- Many Senior Leaders possessed no relevant health or digital health experience and demonstrated limited ability to lead or manage staff. Their approach was reactive and not impartial[711]

9.154 Further, Rod McDonald told the Committee that inexperience within senior management meant that the program did not have the requisite expertise at the decision-making level needed to understand the key challenges the program was facing.[712] The Committee notes that this issue would have been exacerbated by the previously discussed lack of willingness of senior management to listen to and engage with concerns from elsewhere in the program:

> CCSRP lacked the business architecture expertise needed for a challenging software replacement exercise of this nature. The senior program managers within CCSRP did not have the experience to recognise that the adopted implementation strategy would lead to the outcome that has resulted to date. They were rigid in enforcing their approach as summarised above and were not prepared to be challenged by individuals within the program who raised concerns[713]

9.155 Fourthly, the Committee heard that the tight control that senior management sought to exert over the program meant that the CCSRP did not sufficiently engage with external advice or past experiences.[714] André Snoxall told the Committee that leadership prohibited CCSRP staff from engaging with other jurisdictions to learn

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[709] Name withheld, Submission No. 10, p. 1.
[710] Kara Joyce, Committee Transcript, 3 March 2026, p. 23.
[711] Kara Joyce, Submission No. 11, p. 4.
[712] Rod McDonald, Submission No. 9, p. 3.
[713] Rod McDonald, Submission No. 9, p. 3.
[714] Adelphos AI, Committee Transcript, 3 March 2026, p. 10.

from their experiences conducting relevant health care reform or the use of TrakCare:

> The 2018 public review of SA Health's ePAS project identified:
>
> - governance failures;
> - inadequate planning;
> - poor clinical engagement;
> - IT-centric thinking;
> - unrealistic scope;
> - absence of benefits management;
> - organisational resistance to acknowledging issues early.
>
> These findings closely mirror issues later seen in CCSRP.
>
> Despite the availability of this report — and its direct relevance — CCSRP leadership did not engage with its findings or embed them into programme planning….
>
> Acacia is based on InterSystems TrakCare, deployed in several Australian and international health systems. In CCSRP:
>
> - staff were discouraged from comparing notes with other jurisdictions in Australia;
> - attempts to understand proven approaches, configuration models, or governance lessons were not supported;
> - cross-jurisdictional learning opportunities were actively suppressed.
>
> This approach eliminated a major risk mitigation strategy and contributed to the repetition of known pitfalls.[715]

9.156 Finally, the Committee also questions the extent to which senior executive leadership have been involved in detailed operational matters of the program. This reflects submitters' concerns regarding the tight control over the program and unwillingness to rely on those with the appropriate expertise. The Committee heard from Chris Hosking PSM, former CEO of DCDD and then-CEO of NT Health, that he had personally reviewed 170 enhancements for the ED remediation project over the course of several months. Whilst this displays impressive commitment to the success of Acacia, the Committee queries whether senior executive leadership is best placed to consider clinical software workflows:

> to give you an example of how much finesse went into that, there were 170 enhancements to workflows. Andrew and I sat there for a couple of hours every Friday afternoon for months and worked through them with the senior emergency doctors. I have viewed and navigated every single one on screen myself. It was a painstaking process of working through that[716]

9.157 Kara Joyce summarised the interrelated governance issues and the effect they had on program delivery:

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[715] André Snoxall, Submission No. 7, p. 7.
[716] Department of Health, Committee Transcript, 17 February 2026, p. 23.

> The governance failures in Acacia are inseparable from the same leadership culture that failed to manage psychosocial risk and comply with NT Government's *Work Health & Safety (WHS)* laws. The behaviours are identical: suppressing risks, discouraging escalation, altering or avoiding mandatory documentation, ignoring specialist advice, rewarding compliance with political narratives over factual accuracy, and retaliating against staff who raised concerns.
>
> These cultural failures not only contributed to significant workplace harm but also produced a digital health system delivered without proper governance, safety processes, or technical accountability. The WHS failures and Acacia delivery failures are two outcomes of the same systemic breakdown…
>
> 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. The consequences have been financial, clinical, organisational, and human. Unless these systemic failures are addressed, the Territory will continue to carry a program that is unsafe, unsustainable, and unaccountable.[717]

Impact on Clinical Priorities and Staff

9.158 The Committee heard that the workplace culture within the CCSRP also impacted clinicians within NT Health. André Snoxall told the program cultural issues extended to 'dismissive attitudes towards clinical concerns', where governance was 'clinically disengaged, and IT-centric' and decisions that were 'dominated by technical rather than clinical priorities'[718] Indeed, André Snoxall told the Committee that he was not allowed to engage with NT Health:

> I was directed not to speak to Health, as were many other people on the program.[719]

9.159 The Committee was particularly concerned to hear from Kara Joyce that some individuals within the CCSRP sought to amend and minimise clinical concerns:

> Evidence indicates that members of the previous clinical safety team encountered repeated instances where non-clinical personnel, with no expertise in clinical safety or health informatics, intervened in and rewrote clinical safety artefacts. In doing so, identified clinical risks were down-played, re-characterised, or reframed to align with delivery or reputational objectives rather than patient safety imperatives. This interference fundamentally undermined the independence and integrity of the clinical safety function.[720]

9.160 The toxicity of the program and the associated culture of fear has also penetrated NT Health. The Committee heard from NT Health staff in private hearings who were unable to share their experiences on the public record due to fear of retaliation. The AMA NT also highlighted this point in their supplementary submission:

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

[717] Kara Joyce, Submission No. 11, p. 1, 4.
[718] André Snoxall, Submission No. 7, pp. 3, 8.
[719] Adelphos AI, Committee Transcript, 3 March 2026, p. 11.
[720] Kara Joyce, Submission No. 11.

> do not have faith in NT Health, DCDD, or whistleblower structures to protect them from retaliation.[721]

9.161 Further, AMA NT told the Committee that staff have been threatened with punishment for engaging with the AMA:

> Theatre staff have been accused of breaching their code of conduct for fictitious meetings with the AMA.[722]

9.162 The AMA NT also told the Committee in their initial submission that clinical staff had been told by NT Health to only provide positive comments in relation to Acacia:

> Staff have confidentially approached the AMA with concerns that they are being targeted when they raise clinical concerns with Acacia. This chilling effect is preventing the capture of the full extent of risks and near misses. Specific examples include requests to clinical staff to provide "only good examples" of Acacia in day to day use, to clinical leads assisting the Acacia team with a response to this very inquiry.[723]

9.163 Former CEO of DCDD and then-CEO of NT Health, Chris Hosking PSM, strongly refuted this:

> I will make strong remarks now. I absolutely reject any assertion that staff have been told only to make positive comments; that is simply not accurate. I am very conscious I am on *Hansard* when I say that, but I reject that outright.[724]

9.164 The Committee heard the CCSRP's lack of engagement with clinicians has driven the CCSRP and NT Health further apart, as some clinicians stopped seeing the value in engaging with the CCSRP:

> 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.[725]

9.165 The Committee heard from that there has been a lasting negative impact to clinical perceptions of Acacia as a result of their experience so far. For example, Kara Joyce told the Committee that she believed that clinicians 'have reached a point where there is zero trust in the program to deliver', which she considered 'really hard to get back.'[726] Similarly, AMA NT told the Committee that clinical staff continue to have negative perceptions of Acacia and it would be difficult to get buy-in to further reform:

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[721] Australian Medical Association Northern Territory, *Supplemental Information,* 22 July 2026, p. 2.
[722] Australian Medical Association Northern Territory, Submission No. 1, p. 19
[723] Australian Medical Association Northern Territory, Submission No. 1, p. 19
[724] Department of Health, Committee Transcript, 17 February 2026, p. 11.
[725] Kara Joyce, Committee Transcript, 3 March 2026, pp. 20-21.
[726] Kara Joyce, Committee Transcript, 3 March 2026, p. 21.

> 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.[727]

9.166 Dr John Zorbas, President of the AMA NT, further told the Committee that:

> 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.[728]

9.167 In contrast, Chris Hosking PSM told the Committee that feedback from clinicians is now 'overwhelmingly positive.'[729] Angela Brannelly, Regional Executive Director – Top End Regional Health Service, told the Committee that even clinicians in the RDPH are now 'doing well with the system and are happy using the system', although caveated that some concerns arise occasionally whilst they are on their 'change journey'.[730] Chris Hosking told the Committee that stakeholders providing evidence to the Committee regarding NT staff wellbeing were not well placed to know the concerns of staff:

> In my view, I think Ms Brannelly is far better placed to make observations about the wellbeing of her staff than the authors of those submissions. I think she is in a position where she has got that information. She manages that workforce of 5,000 people. I think they are a view and they need to be respected, and I respect that this committee must listen to that and take them into consideration, but I do not accept them.[731]

Committee's Comments

9.168 On the basis of the evidence provided to the Committee, it is clear to the Committee that the workplace culture within the CCSRP was harmful to staff. Additionally, beyond the details recounted in this report, the Committee has heard in private hearings accounts of behaviour from those in leadership positions within the CCSRP that are both distressing in nature and clearly unacceptable in a workplace.

9.169 The Committee is thankful to those who spoke to the Committee—both in public and in private hearings—for their insights into the program. The Committee is particularly concerned to hear the depth of responsibility that some submitters and witnesses have taken upon themselves, when, by all accounts they sought to elevate issues

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[727] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, pp. 6-7.
[728] Australian Medical Association Northern Territory, Committee Transcript, 3 March 2026, p. 4.
[729] Department of Health, Committee Transcript, 17 February 2026, p. 11.
[730] Department of Health, Committee Transcript, 17 February 2026, p. 11.
[731] Department of Health, Committee Transcript, 17 February 2026, p. 11.

and do the right thing by their colleagues and families, NT Health clinicians, and more broadly, Territorians.

9.170 The Inquiry Terms of Reference denotes the scope of the Committee's remit. These limit the Committee to consider matters related to the cost and delivery of Acacia, issues raised during implementation, impact of the rollback, and the current status of the program. It is clear to the Committee that the workplace culture of the CCSRP has impacted the cost and delivery of Acacia, but it is not the remit of the Public Accounts Committee to attribute the failings of the program to particular individuals. The Committee notes that both cultural issues and health and safety issues are directly within scope of other reviews that have been, or are being conducted by DCDD, NT WorkSafe, NT Police, and the Office of the Coroner.[732]

9.171 Nonetheless, the Committee is deeply concerned that the conditions that allowed the toxic workplace culture to flourish within DCDD—and more specifically, the CCSRP—could emerge again. It appears to the Committee that many of the workplace culture issues within the program stem from the high rates of contractors within the program. As previously discussed, around 80% of the workforce were contractors. This is an extremely unusual reliance on contractors compared to the rest of the NT Public Sector. Because of this, the Committee understands that daily rates enabled long hours of work without additional costs to the program. Further, the Committee understands that contract insecurity facilitated threats of retaliation due to the ease of ending a person's contract with the program.

9.172 Because contractors have insecure work, it is particularly important that they have recourse to appropriate complaints procedures and mechanisms when they do not feel they have been treated fairly in the workplace. However, in this case, the Committee is concerned to hear that the standard mechanisms for complaints were not sufficient. For example, Rod McDonald advised that he went to his vendor over workplace culture issues:

> 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.[733]

9.173 Further, Kara Joyce told the Committee that both herself and her brother, Sean Joyce, sought support from their vendor regarding options to leave the CCSRP:

> 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.[734]

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[732] Matt Cunningham, *Investigation confirms workplace misconduct before death of IT worker Shaun Joyce,* 29 May 2026, NT News, https://www.ntnews.com.au/news/investigation-confirms-workplace-misconduct-before-death-of-it-worker-shaun-joyce/news-story/524d4d75c6da4766921bfc23c93f992c

[733] Rod McDonald, Committee Transcript, 3 March 2026, p. 17.

[734] Kara Joyce, Committee Transcript, 3 March 2026, pp. 22-23.

9.174 Because of the uniquely concentrated levels of contractors within DCDD, the Committee considers that it is important that contractors are sufficiently aware of their health and safety rights and obligations within DCDD. Additionally, on the basis of the experiences shared with the Committee, the Committee considers that existing processes and procedures for contractors appear insufficient. As such, the Committee recommends that DCDD review its induction process for contractors to ensure that they are informed of their health and safety rights and obligations, and complaints processes and procedures.

Recommendation 11

The Committee recommends that DCDD review its induction process for all contractors to ensure that it includes information on contractors' health and safety rights and obligations and complaints processes and procedures.

9.175 Further, the Committee considers that there must be greater oversight and scrutiny of the experience of contractors within DCDD. The People Matter Survey facilitates an understanding of agency performance, including employee engagement and job satisfaction, across the whole public sector. As the results of these surveys are reported upon publicly, it provides a public accountability mechanism to drive senior leadership to adopt practices that enhance and improve the workplace. However, as contractors are not employees of the NT Public Sector, their experiences are not captured in the People Matter Survey. This has allowed the toxic workplace created within the CCSRP to develop without public knowledge or scrutiny. Accordingly, the Committee recommends that DCDD develop an annual survey mechanism for contractors within DCDD which reflects the People Matter Survey and for DCDD to publish the results of this survey in their annual report.

Recommendation 12

The Committee recommends that DCDD develop an annual survey mechanism similar to the People Matter Survey for personnel contracted by DCDD for a minimum of 6 months and publish the results in their annual report.

Concluding Comments

9.176 As evidenced throughout this report, the Committee has faced challenges understanding the CSSRP and Acacia, in part due to the clarity and quality of information provided by the Departments. For example, at times the Departments have provided contradictory answers to the Committee's questions. More concerningly, it appears to the Committee that at times the Departments have omitted information and failed to answer the Committee's questions in ways that have challenged the Committee's understanding of the program and ability to report to the Terms of Reference. The most serious examples of these are outlined below.

9.177 Firstly, as discussed previously, the Committee has had to make repeated requests for information from the Departments to clarify matters regarding the program budget that the Committee considers should have been proactively addressed by the Departments. For example, in neither submission to the Committee did the

Departments inform the Committee that $6 million was reprioritised from the Acacia budget to SerPro in July 2023. Indeed, in their 2025 submission, the Departments explicitly told the Committee that they were outlining 'each cost revision.[735] When doing so, they listed only the funding increase in Budget 2017-18 and the reprioritisation in October 2022.[736] It was only upon specific questioning from the Committee that the Departments advised that $6 million had been reprioritised from Acacia to SerPro, that this was associated with the program budget, and that this funding would not be returned to the program.[737]

9.178 Similarly, it was only upon several rounds of questioning that the Departments advised the Committee of $3.4 million in digital contingency funding that had been repurposed to Acacia.[738] The Departments explained that this repurposed funding 'is not included in the approved Acacia program budget.'[739] However, upon the Committee seeking clarification, the Departments told the Committee that it 'was repurposed into the Acacia project program budget.'[740] The Committee queries the distinction, and whether any other funding associated with Acacia falls outside of the approved program budget. Regardless, both matters are clear material revisions to the cost and funding of the program, relevant to the Inquiry Terms of Reference.

9.179 Determination of key information related to the Inquiry Terms of Reference only following repeated rounds of questioning has been a recurring issue. For example, the Departments advised the Committee that the 9-month delay to the program schedule in 2018 was due to the commissioning of Palmerston Hospital. This was explained as a key reason for the cost revisions.[741] However, upon further questioning it was revealed that there were 'two other delay factors at the same time (engaging contractors for CCSRP and system changes required for Primary and Remote Health Care)'.[742] The impact of these matters on the cost revisions were not previously explained by the Departments.

9.180 In another case, the Departments told the Committee that 'the successful, Territory-wide implementation of Acacia 1.0 has allowed the retirement of the Territory's highest-risk legacy system, CareSys.'[743] However, following information provided by a submitter that CareSys was still operational, the Committee asked for more

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[735] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 43.
[736] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 43.
[737] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 3.
[738] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 3.
[739] Department of Corporate and Digital Development and Department of Health, *Responses to Written Questions – 16 July 2026,* 16 July 2026, p. 3.
[740] Department of Corporate and Digital Development and NT Health, email correspondence (unpublished), 17 July 2026.
[741] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 38.
[742] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 5.
[743] Department of Health and Department of Corporate and Digital Development, Submission No. 14, p. 1.

information from the Departments. At this point, the Departments advised that, in fact, 'CareSys will be retired' in the future.[744]

9.181 At other points, the Departments have ignored Committee questions or failed to fully answer them. More broadly, answers provided to Committee questions have often been vague, lacking in detail, or very brief. These failures have had a material impact on the Committee's ability to comply with the Inquiry Terms of Reference. For example:

- **Cost and program budget:** the Committee asked the Departments whether the $18 million stakeholder in-kind costs provided by NT Health were included in the total spend to date for the program. The Departments did not answer this question.[745]
- **Impact to the health system:** the Committee asked the Departments how many staff have been hired to maintain system functionality as a result of the deployment of Acacia across RDPH. The Departments did not answer this question.[746]
- **Current status and outstanding steps:** the Committee asked the Departments how far progressed FG2-5 were through the IPS, design, solution confirmation, build and configuration, and testing phases of the solution build stage. The Departments told the Committee that they were variously in the planning or solution build stage, not specifying progress through phases.

9.182 The Committee has also received directly contradictory advice from the Departments. For example, in their April 2025 submission to the Committee, the Departments told the Committee that they had undertaken 'detailed financial modelling' of the costs and time to finish the program.[747] When the Departments were asked to provide detail on these estimates, DCDD told the Committee that 'We have not done any estimates on what would be required to complete the whole program'.[748] Upon further questioning on the same matter, the Departments told the Committee that 'This will be estimated as part of a future business case to complete the program'.[749] The Committee also notes that in February 2025 the Treasurer indicated that completion of the Acacia program in full would cost an additional $127 million more than the $320 million spent at the time.[750]

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[744] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 21.
[745] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 3.
[746] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 19.
[747] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 46.
[748] Department of Corporate and Digital Development, Committee Transcript, 17 February 2026, p. 34
[749] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 23.
[750] Treasurer, *Responsible action to repair the budget and rebuild the economy*, February 2025, https://territorystories.nt.gov.au/10070/987788.

9.183 Finally, at other points, the Departments appear to have omitted key information pertinent to the Inquiry. For example, in explaining the ED rollback at RDPH, the Departments told the Committee that '34 separate issues were identified which needed to be addressed to materially improve the use of Acacia 1.0 in the Royal Darwin and Palmerston Hospitals EDs.'[751] Shortly afterwards, the Departments advised the Committee that the 'remediation work that was identified in early 2024, and re-introduction of Acacia into the Royal Darwin and Palmerston Hospitals EDs, are on track to be ready for Go Live in the September 2025 quarter.'[752] However, the 34 issues initially referenced by the Departments were in fact resolved by May 2024, not the September 2025 quarter.[753]

9.184 The remediation work identified in early 2024 was distinct to that precipitating the ED rollback. By allowing the identification of the 34 issues in November 2023 and the completion of remediations in November 2025 to blur together, the scope of issues faced by the EDs appeared much lesser. Indeed, it was only through a second round of submissions opened almost a year later that the Departments told the Committee that 170 features had ultimately been enhanced, and only through requests of internal documentation that remediation to the KDH and GDH EDs were identified. Further, when asked directly what factors contributed to the repeated delays to the rollback, expansion in the scope of the remediation project was never mentioned.[754]

9.185 The Committee observes that submitters challenged the CCSRP on the grounds of their lack of transparency, obfuscation of issues, and lack of critical reflection on the true state of the program. It is deeply concerning to the Committee that these issues have, in the Committee's view, been reflected throughout this inquiry in the advice provided by the Departments to the Committee.

9.186 Combined, these tendencies have made it a challenge to fully understand the key decisions and issues faced by the program. Although the Committee is now satisfied that it understands the key challenges associated with Acacia, the Committee emphasises the need for Departments to provide fulsome and accurate accounts of events to the Committee. Further, when clarification is sought, it is vital that Departments answer the Committee's questions fully and frankly. All agencies must be accountable for their expenditure of public monies.

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[751] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 41.
[752] Department of Corporate and Digital Development and Department of Health, Submission No. 3, p. 42.
[753] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, p. 13.
[754] Department of Corporate and Digital Development and Department of Health, *Responses to the Written Questions – 13 April 2026,* 13 April 2026, pp. 18-19.

Appendix 1: Submissions Received

Round 1 Submissions Received

1. Australian Medical Association Northern Territory
2. Not for Publication
3. Department of Health and Department of Corporate and Digital Development
4. Australian Nursing & Midwifery Federation Northern Territory
5. Not for Publication
6. Royal Australian and New Zealand College of Psychiatrists

Round 2 Submissions Received

7. André Snoxall
8. André Snoxall – Supplementary Submission
9. Rod McDonald
10. Name Withheld
11. Kara Joyce
12. Not for Publication
13. Not for Publication
14. Department of Health and Department of Corporate and Digital Development – Supplementary Submission
15. Not for Publication
16. Rod McDonald – Supplementary Submission

Note: Copies of submissions are available here.

Appendix 2: Public Briefing and Hearings

Public Briefing

Darwin: 18 February 2026

Department of Health

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

Department of Corporate and Digital Development

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

Public Hearing

Darwin: 3 March 2026

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 Core Clinical Systems Renewal Program Project Manager, Business Analyst and Clinical Informatics Officer, Department of Corporate and Digital Development
- Bernard Yehuda: ex Lead Business Analyst, Core Clinical Systems Renewal Program, Department of Corporate and Digital Development

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Core Clinical Systems Renewal Program, *CCSRP Governance Committees - Briefing Paper: Central Australia and Barkly Implementation Schedule*, Department of Corporate and Digital Development, Darwin, May 2025, *(unpublished).*

Core Clinical System Renewal Program, *CCSRP Integrated Master Program Schedule*, Department of Corporate and Information Services, Darwin, November 2018, *(unpublished).*

Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 21-09 – Revised CCSRP Schedule – InterSystems Network Outage*, Department of Corporate and Digital Development, Darwin, September 2021, *(unpublished).*

Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-04 – Core Clinical Systems Renewal Program, Revised CCSRP Functional Group 1 Schedule*, Department of Corporate and Digital Development, Darwin, April 2022, *(unpublished).*

Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Briefing – Meeting 22-05: CCSRP Schedule Status*, Department of Corporate and Digital Development, Darwin, May 2022, *(unpublished).*

Core Clinical Systems Renewal Program, *CCSRP Program Steering Committee Meeting 22-11: Revised Functional Group 1 Schedule*, Department of Corporate and Digital Development, Darwin, November 2022, *(unpublished).*

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