

# Submission to the Public Accounts Committee

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## Inquiry into the Acacia Digital Patient Record System

**Submission by:** André Snoxall

**Date:** 2 December 2025

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## Executive Summary

This submission provides evidence regarding the governance, planning, delivery, and benefits realisation challenges that have affected the Core Clinical Systems Renewal Programme (CCSRP) which was responsible for delivering the Acacia Digital Patient Record System in the Northern Territory.

Key points:

- The Programme Management Plan (PMP), developed in accordance with MSP and PRINCE2, was never effectively adopted or used.
- Project plans for the component projects were never completed, leaving the programme without defined baselines, measurable outcomes, or effective reporting.
- Governance was confused, clinically disengaged, and IT-centric, with the Deputy CE of DCDD positioning himself as both “sole supplier” and “programme sponsor,” contrary to accepted programme governance principles.
- Stakeholder engagement was restricted by management direction, which prevented discovery, workflow analysis, and clinical ownership.
- The proposed functional group (phased) delivery model was agreed but never implemented as intended; FG0 (read-only EPR) was abandoned, FG1 remains incomplete, and FG2–5 are materially unplanned.
- The Benefits Realisation Strategy, formally reviewed with NT Health, was never embedded or used, and a later proactive benefits-led adoption programme was shut down.
- The programme failed to learn from other jurisdictions — including South Australia’s publicly reviewed ePAS failure — and staff were actively discouraged from engaging with other TrakCare jurisdictions.
- A sustained negative internal narrative about NT Health ICT capability undermined operational readiness and has contributed to the failure to transition Acacia into proper BAU management, despite it being used operationally.
- As a result, Acacia remains in a hybrid, high-risk state being operated by a programme team not structured or equipped to provide long-term production support.
- Funding for ongoing support and maintenance of the solution has not been ringfenced or transferred to the NT Health ICT support team.

The submission concludes that CCSRП experienced systemic governance and leadership failures, lacked disciplined planning, did not follow best practice, and failed to learn from well-documented lessons in other jurisdictions. A benefits-led, clinically-governed digital transformation approach remains essential for the Northern Territory to achieve the outcomes originally promised.

## 1. Introduction

I welcome the opportunity to provide evidence to the Public Accounts Committee regarding the Acacia Digital Patient Record System and its associated programme, the Core Clinical Systems Renewal Programme (CCSRP). My contribution is based on my direct involvement with CCSRП and my experience leading major electronic patient record (EPR) programmes in the UK, Middle East, and Australia.

I was engaged in late 2018 to develop the Programme Management Plan (PMP) for CCSRП using the Managing Successful Programmes (MSP) methodology and PRINCE2 principles. I later developed the Benefits Realisation Strategy and subsequently worked on benefits-driven adoption planning within NT Health (2022–23).

## 2. Background and Role

### 2.1 Initial Engagement (2018–2019)

My responsibilities included:

- development of the **Programme Management Plan (PMP)** as the foundational governance and delivery framework;
- development of the **Benefits Realisation Strategy** for CCSRP;
- advising on the quality, completeness, and alignment of project-level plans;
- supporting NT Health in preparing for a benefits-led transformation.

The Benefits Strategy was reviewed and agreed by NT Health senior management but, like the PMP, was never implemented, cascaded, or embedded.

### 2.2 Later Engagement (2022–2023)

I later worked with NT Health executives to design a benefits-driven **adoption and readiness programme** to prepare clinicians, operational services, and digital teams for Acacia. This forward-looking work was not supported by DCDD, which proposed instead a retrospective benefits study to be completed after implementation.

## 3. Governance and Accountability Failures

### 3.1 Misaligned governance roles

Governance across the CCSRP was characterised by:

- unclear delineation of responsibility between DCDD and NT Health;
- insufficient clinical involvement;
- governance meetings that prioritised reporting optics rather than progress;
- feedback and concerns being routinely ignored.

Critically, the Deputy CE of DCDD positioned himself as both **sole supplier** and **programme sponsor**. According to MSP, the sponsor must represent the organisation accountable for realising benefits — in this case NT Health — not the IT delivery arm.

### 3.2 Absence of a Properly Functioning and Independent PMO

A further structural weakness in CCSRP was the absence of a **properly constituted, independent Programme Management Office (PMO)**. 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.

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.

Within CCSRP, the PMO did not function in this way. Instead, the PMO and related governance structures:

- 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.

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.

## 4. Planning Deficiencies

### 4.1 Programme Plan not adopted

The PMP — the programme's foundational document — was never formally endorsed or used by NT Health or DCDD. It was effectively sidelined.

### 4.2 Project plans not completed

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.

I raised concerns directly with the Deputy CE of DCDD in 2019, emphasising that **a failure to plan is a plan for failure** and repeatedly highlighted the challenge regarding lack of planning in ensuing years.

### 4.3 Restrictions on engagement with NT Health

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.

## 5. Delivery Model and Functional Group Approach

### 5.1 The impractical “big bang” model

The initial plan for a single-day, whole-of-system go-live was unachievable. I proposed a phased approach based on **Functional Groups**, which was formally accepted by both DCDD and NT Health.

### 5.2 Functional Group sequence and status

The proposed sequence:

- **FG0 — Read-Only EPR** (risk reduction, early value)
- **FG1 — Patient Administration**
- **FG2 — Orders & Results**
- **FG3 — Medication Management**
- **FG4 — Clinical Documentation (Primary Care)**
- **FG5 — Patient Portal**

However:

- FG0 was never properly implemented.
- FG1 remains incomplete; CareSYS is still required in Emergency Departments.
- FG2–5 have not been adequately planned or resourced.
- Budget depletion makes future functional delivery uncertain.

## 6. Benefits Realisation Failures

### 6.1 Benefits Strategy ignored

The Benefits Realisation Strategy, developed with NT Health, was never embedded in:

- governance,
- decision-making,
- reporting,
- clinical engagement, or
- readiness assessment.

### 6.2 Benefits-led adoption approach rejected

The 2022–23 benefits-led adoption programme, designed to reduce clinical risk and prepare the workforce, was halted by DCDD in favour of a retrospective study funded through DCDD to be delivered by Menzies School of Health Sciences.

## 7. Failure to Learn from Other Jurisdictions

### 7.1 Lessons from South Australia's ePAS Project

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.

### 7.2 Discouraged engagement with other TrakCare jurisdictions

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.

## 8. Cultural and Structural Barriers

Recurring cultural issues included:

- dismissive attitudes toward clinical concerns;
- limited transparency;
- decision-making dominated by technical rather than clinical priorities;
- reluctance to consult expert resources;
- an environment where challenge was unwelcome.

These factors created a fragile and insular programme culture.

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## 9. Organisational Dynamics and Operational Readiness

### 9.1 Negative internal narrative regarding NT Health ICT

A sustained internal narrative developed within CCSRP suggesting that NT Health's ICT capability — including the current **Health and Human Services Agency Business Systems Group (HHSABSG)** — lacked the competence to manage the Acacia system.

This narrative:

- undermined confidence in operational ICT staff;
- discouraged collaboration;
- created organisational tension;
- was never supported by an independent capability assessment.

### 9.2 Failure to transition Acacia to BAU

Because of this narrative and governance behaviour:

- Acacia has **not been handed over** to NT Health for normal production management;
- the programme continues to operate the system in a quasi-BAU state;
- there is no clarity on operational ownership or accountability;
- standard BAU processes (release management, change control, incident management) have not been fully embedded.

This hybrid model is **unsafe, unsustainable, and not fit for long-term digital health operations**.

### 9.3 Removal of NT Health Operational Funding and Failure to Establish a BAU Budget

At the outset of CCSRP, several million dollars were removed from the NT Health operational budget to help finance the programme. This reallocation was made on the clear understanding that the funds would be **returned to NT Health** when Acacia transitioned into steady-state operations, and that they would form the **recurrent support and maintenance budget** required for BAU operation of the system.

Despite key parts of Acacia being used operationally:

- these funds have **never been made available** to support BAU;
- no additional recurrent funding stream has been identified;
- DCDD has no clearly established additional BAU budget to support the system;
- essential operational roles and processes remain unfunded.

This situation has materially contributed to:

- the inability to transition Acacia out of the programme;
- the forced continuation of a programme-run pseudo-BAU model;
- the absence of stable operational capability, governance, and accountability;
- increased clinical and operational risk;
- inability to realise sustained benefits from the investment.

The Committee may wish to examine the financial governance arrangements underpinning the CCSRP, including the transfer and non-return of these funds and the impact this has had on NT Health's capacity to operate its core clinical systems.

#### 9.4 Leadership Transition and the Need for Transparency Regarding Funding Decisions

A further issue that the Committee may wish to examine relates to the **governance and transparency of the financial arrangements** surrounding the reallocation of NT Health operational funding to CCSRP.

As outlined in Section 9.3, several million dollars were transferred out of the NT Health operating budget at the commencement of CCSRP, with the stated intention that this funding would be returned to finance the recurrent BAU operation of Acacia. This has not occurred.

In the context of these financial arrangements, it is relevant to note that:

- the senior executive responsible for these funding decisions within DCDD — first as Deputy Chief Executive and later as Chief Executive —
- **subsequently assumed the role of Chief Executive of NT Health**, the organisation from which the operational funding was originally removed.

This leadership transition, in itself, does not imply impropriety. However, it **creates a governance environment in which rigorous transparency and independent scrutiny become especially important**, particularly because:

- the funding has not been reinstated to the NT Health operational budget as originally indicated;
- Acacia has not transitioned to BAU, partly because NT Health lacks the recurrent funding base that was expected to be restored;
- the rationale for withholding the funding has not been clearly articulated to operational leaders or programme stakeholders;
- the financial arrangements are not visible in publicly available documentation;
- decisions made under one portfolio now directly affect the budget capacity of another portfolio led by the same executive.

These circumstances may give the appearance — rightly or wrongly — of a lack of transparency or the potential for **conflicted decision-making**, particularly when viewed alongside the programme's failure to transition Acacia to NT Health and the absence of a funded BAU model.

The Committee may therefore consider it appropriate to examine:

- **the original agreement** regarding the transfer and return of operational funding;
- **the current status** of the funding and why it has not been returned;
- **the governance and documentation** that supported these decisions;
- whether NT Health's new leadership has full visibility of the commitments made prior to the leadership transition;
- whether internal oversight mechanisms functioned effectively; and
- whether the funding arrangements contributed to the continued reliance on a programme structure to operate a live clinical system.

This is not a comment on individuals, but rather a reflection of the importance of clear governance, financial transparency, and independent oversight when senior leadership roles span both sides of a complex inter-agency funding arrangement.

## 10. Conclusion

My experience leads me to conclude that CCSRP and Acacia have been significantly affected by:

- structural governance flaws;
- failure to adopt foundational programme and project planning;
- poor clinical and operational engagement;
- non-adoption of agreed benefits frameworks;
- incomplete and compromised functional delivery;
- failure to learn from other jurisdictions, including the well-documented SA ePAS failures;
- active discouragement of cross-jurisdictional learning regarding TrakCare;
- a counterproductive internal narrative undermining NT Health ICT capability;
- failure to transition the system into stable BAU operations.

I provide this submission in the interest of supporting greater rigour, transparency, and clinical alignment in future digital health programmes in the Northern Territory. I would be willing to provide further detail or appear before the Committee if required.

## RE: Congratulations and some suggestiuons

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From Electorate Spillett [REDACTED]

To Andre Snoxall [REDACTED]

Date Thursday, 9 January 2025 at 10:07

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Good Morning

On behalf of the Hon Lia Finocchiaro, Member for Spillett, thank you for your email below.

Your correspondence has been forwarded to the Office of the Chief Minister for consideration.

Kind Regards,

[REDACTED]

**Electorate Officer**

**Lia Finocchiaro MLA**

**Member for Spillett**

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**From:** Andre Snoxall [REDACTED]  
**Sent:** Sunday, January 5, 2025 6:08 PM  
**To:** Electorate Spillett [REDACTED]  
**Subject:** Re: Congratulations and some suggestiuons

**CAUTION:** This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Good evening Chief Minister,

As one of Australia's pre-eminent leaders in the effective delivery and adoption of electronic patient record systems I am keen to understand how governments deal with monumental failures such as that of the CCSRP/Acacia program.

So this is a follow up to the email attached to which I have never received a considered response, in particular in relation to the Acacia (CCSRP) investment with Intersystems Corporation.

It seems to be quite public knowledge that DCDD and NT Health have spent all of the \$320,000,000 (THREE HUNDRED AND TWENTY MILLION DOLLARS) of public funding that has been received by DCDD to replace the 5 legacy computer systems (Caresys, CCIS, PCIS, CWS and Medchart) with the Intersystems TrakCare solution.

The current status is that TrakCare (Acacia) is in partial use to replace limited CareSys functionality at Royal Darwin and Palmerston Hospitals, Katherine and Gove hospitals but remains unusable by the Emergency Departments and is not used at all except as a last-resort reference source for clinicians in Alice Springs and Tennant Creek. The system has not yet been deployed to remote, community, corrections or primary care sites apart from some limited usage in renal services.

There is no timeline, milestones or deliverables documented for retirement of any of the legacy systems and, in effect, a sixth system (TrakCare) has been added to the plethora of computer systems that we, Australian taxpayers, fund to support government health services. I note that this will result in significantly increased costs rather than any reduction in same. And further, will negatively impact the NT Government's financial position. It is a matter of puzzlement that, with more than twenty five years of experience delivering supporting such systems, and despite having

taken the trouble to relocate to Darwin to support the NT Government my advice has been continually ignored with regard to potential rectification of the issues . The current DCDD culture that puts sparing political blushes or protecting the reputation of the senior executives above protecting the interests of patients is one that stifles inconvenient truths being spoken to power, that silences whistleblowers and that ultimately puts patient safety at risk.

I am told that there are is no evidence of a documented pathway to termination of the Acacia projects (despite the lack of funding) and no quality gateways, timeline, tasks, or milestones documented to monitor progress on the path to DCDD closing out this piece of work.

I did not receive a response to my previous email (below). Are you able to clarify specifically:

- Which of the original business case objectives has been delivered?
- When will the remainder of the business case objectives be delivered?
- What has the investment of our public money on this program actually achieved in terms of benefits to the Northern Territory?
- Will there ever be a clear accounting for the expenditure of public funds?
- Who is being held to account for the outcomes of the Acacia projects?
- When will we understand the lessons learned?
- What are the risks of not funding the Acacia development further?
- What are the plans to deal with the legacy systems that are still in use and, it seems, are unlikely to be replaced? When will this work start?

André Snoxall GAICD

Email: [REDACTED]

Phone: [REDACTED]

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**From:** Electorate Spillett [REDACTED]

**Sent:** 03 September 2024 5:01 AM

**To:** Andre Snoxall [REDACTED]


**Subject:** RE: Congratulations and some suggestiuons

Good Afternoon,

On behalf of the Hon Mrs Lia Finocchiaro, Member for Spillett, thank you for your email dated 31 August 2024.

Your email has been sent to the office of the Chief Minister for consideration.

Kind Regards,

  
**Electorate Officer**  
**Lia Finocchiaro MLA**  
**Member for Spillett**

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**From:** Andre Snoxall   
**Sent:** Saturday, August 31, 2024 9:23 AM  
**To:** Electorate Spillett   
**Subject:** Congratulations and some suggestiuons

**CAUTION:** This email originated from outside of the organisation. Do not click links or open attachments unless you recognise the sender and know the content is safe.

Lia, congratulations Lia on your recent win in the NT Election.

I anticipate that you will be looking closely at opportunities to improve the financial performance of some of the NT government departments and wondered if you had considered the somewhat moribund performance of the Department of Corporate and Digital Development over the past 6 years or so and how this might be improved.

ACACIA

You will recall that the DCDD was given responsibility for managing the Acacia (Core Clinical Systems Replacement) Program with an original budget (including the budget for the medication management components) of more than a quarter of a billion - \$259 million - dollars. My understanding is that expenditure is now projected to be more than \$320 million dollars with no clear plan or milestones evident to demonstrate a path to rectify issues or finalise delivery.

It has not gone unnoticed by many that this program is yet to deliver an acceptable patient administration system capable of replacing the Caresys system in the Top End hospitals, let alone

patient administration solutions at Alice Springs and Tennant Creek. The Emergency Departments at Royal Darwin and Palmerston Hospitals do not appear to be any closer to accepting the ACACIA solution, and until this happens, Caresys cannot be decommissioned and savings cannot be made.

The ACACIA program has also not yet delivered even a prototype of the promised medications administration and electronic medical record functionality in the hospitals and primary care settings (necessary to replace the other legacy systems in use) and it seems highly unlikely given the current and past rates of progress and success that any of these new functionalities will be delivered within the current budget. It would be amusing if it were not so sad to note that the original plan was to enable decommissioning of five legacy systems and to replace these with one ACACIA solution. However there are now 7 solutions in use (including the ACACIA read-only system) and no prospect of replacing any of them or the paper records that are still being used at 5 hospital sites within the coming two or three years.

Indeed, if the South Australian experience is any indication (you will probably be aware that a similar program in SA remains incomplete ten years after initial budget approval and that the final cost is likely to be between two and three times the initial approved budget) it is likely DCDD and NT Health will be requesting much more money if they are allowed to proceed with the current cadence of delivery.

Of concern as a past senior executive in the public health sector is that the NT Health Strategies as published since 2016 have made no mention of ACACIA or its significance in enabling the current or future plans for the NT Health organisation. This reflects to me an ambivalence in NT Health toward the investment, and a failure on behalf of the stewards of the program resources (DCDD) to engage NT Health in the design and delivery of a solution that will have strategic and operational value. The oversight, governance and steering of the effort appear to be fatally flawed.

## SERPRO

Program delivered late, over budget and of lacklustre quality. Poorly accepted by police and unlikely to live up to expectations.

## MACHINERY OF GOVERNMENT CHANGES

The centralisation of IT capability from the public-facing agencies to DCDD was completed with an almost obscene haste, with very little planning and what appears to be a complete lack of meaningful benchmarks for success.

Any such centralisation should have been expected to produce significant efficiencies, measurably improved quality of services and clear reductions in cost over a period of time.

As an observer it is not apparent that this has occurred in any meaningful way.

Agencies continue to use essentially the same technologies they were using 6 years ago, in many cases paying extremely high monthly fees for desktop equipment that has not been replaced or upgraded in that time (some estimates are that more than 50% of the desktop equipment in Agencies has not been replaced for 6 years or more).

Server-hosting costs (which should have decreased as a result of the economies of scale offered by MoG) have in fact increased and remain un-competitive with those costs that would be incurred if a more contemporary arrangement were pursued with private sector providers.

Staff who had business facing roles in their respective agencies but who worked under the oversight of IT management were transferred to DCDD where their skills were not used effectively - this resulted in either a loss of these skills to the NT as staff left for careers elsewhere, or the same staff applying for roles back in the agencies and being replaced with IT technical staff in DCDD. This has driven costs up on both sides of the fence and resulted in churn and inefficiencies.

Indeed in NT Health the organisation has commenced rebuilding a "Health Informatics" capability in house with the appointment of two doctors into senior IT roles and assembly of a team of IT staff in the CCIO's Department who are striving to fill the gap that was created with the transfer of essential business-facing skills and personnel to a DCDD that had no concept, or willingness to understand, the pressures, challenges and need to innovate to survive in the healthcare sector.

## KPIs, ACCOUNTABILITY AND COLLABORATION

DCDD in its current form is a non-viable organisation that is costing and will continue to cost the taxpayers of the Northern Territory dearly. An arguably good idea that has suffered from a lack of planning, inadequate leadership, and an over reliance on hyperbole and virtue signalling rather than meaningful measures of success.

The organisation lacks meaningful Key Performance Indicators, has a poor understanding of the need to innovate and a very poor track record of program and project management (in fact there is little understanding of the difference between a program and a project and this should be considered a major red flag).

Inside the organisation there is a culture of bullying and cover-up and a complete lack of any sort of meaningful discussion, debate or ethics of continual improvement and learning.

I strongly urge you to take a closer look.

Developing and delivering shared services requires planning and a pragmatic and common-sense approach. Delivered effectively the opportunity is available to effectively streamline processes, enhance efficiency, and achieve tangible results. However, effective and meaningful collaboration, inclusion and communication amongst peers and other stakeholders is necessary if the opportunity

is to be realised to deliver public services that positively impact the lives and well-being of the community.

DCDD has the opportunity to craft innovative solutions and build strong relationships however the leadership of shared-service transformation initiatives through leveraging technology to improve service delivery has been squandered in recent years.

Information systems and technology should drive operational excellence, enable strategic decision-making, and enhance the overall quality of services. This has not occurred and electronic patient records systems have never been in a more fragmented state, Enterprise Resource Planning systems have stagnated, and Human Resources systems are also in stasis. There has been little, if any advancement of the digital reform agenda under the Labor Government.

The NT Government has a critical role in building stronger communities and supporting service delivery across the regions through effective use of Agencies such as DCDD.

I do hope the CLP will take a more proactive role in ensuring that the Department of Corporate and Digital Development is managed and led effectively to deliver to the promise that it should be capable of.

...André

André Snoxall GAICD

Email:

Phone:

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# Proposal for Strategic Support in Maximising NT Health's Digital Transformation and Contribution to Budget Repair

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From Andre Snoxall [REDACTED]  
To Minister.fyles@nt.gov.au  
Date Tuesday, 21 November 2023 at 16:24

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Dear Ms Fyles,

I hope this message finds you well.

As an experienced professional in healthcare IT and digital transformation, I am reaching out to discuss how my expertise could significantly benefit NT Health and the NT Government, especially in leveraging technology solutions provided by the Department of Corporate and Digital Development (DCDD).

While DCDD is making commendable efforts within its capabilities, my proposal is to work directly with NT Health, ensuring that the products and services delivered are optimally utilised and aligned with the strategic healthcare goals of the Northern Territory and the budget-repair strategy of Cabinet. My international experience, including successful stints in NHS England, NSW Health, Qatar Primary Care, and Sidra Hospital, has honed my skills in not just implementing technology solutions but ensuring they are seamlessly integrated into the healthcare setting for maximum impact.

The crux of my approach lies in caching, mentoring and supporting organisational executive teams to work collaboratively, providing and enabling:

**Strategic Guidance:** Assisting NT Health in aligning DCDD's technology solutions with their strategic objectives and clinical needs.

**Value Realisation:** Ensuring that the digital tools and systems provided by DCDD translate into tangible benefits for NT Health, both in terms of patient outcomes and operational efficiency.

**Cultural and Organisational Transformation:** Fostering a culture within NT Health that embraces digital innovations and adapts to new workflows effectively.

**Leadership and Change Management:** Providing leadership in change management to ensure sustainable adoption of new systems and practices across NT Health.

My focus would be on empowering NT Health to become a sophisticated recipient of DCDD's products and collaborative partner in realising value from machinery of government changes, enhancing the overall effectiveness and efficiency of healthcare delivery in the Northern Territory.

I would be honored to have the opportunity to discuss this in more detail with you at your convenience and explore how I can contribute to the advancement of healthcare in the Northern Territory.

Thank you for considering my proposal. I look forward to the possibility of making a meaningful impact in this vital sector.

Warm regards,

...*André*

André Snoxall GAICD

**Email:** [REDACTED]

**Phone:** [REDACTED]