Project Management Case Analysis

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1.0 Introduction

The purpose of this case study analysis is to investigate the Phoenix Pay System, which is the federal pay system renewal project for the Government of Canada. This is part of "Transformation of Pay Administration Initiative (TPAI). In this brief, timelines and goals of the project will be examined and then a deeper analysis will be conducted showing problems or effective strategies to work around issues. (Wikipedia, n.d.)

2.0 Background

The government of Canada started an initiative in 2009 to replace a very old system with a new system. This system was responsible of paying thousands of employees in several departments and agencies. The goal of this new automated system is to decrease the amount of labor required to maintain the system and reduce costs by almost $80 million a year. (Wikipedia, n.d.)

The initiative was split into two projects. One was to (Pay Consolidation Project) centralize payment processing for a number of departments in Brunswick and the other project was (Pay Modernization Project) to upgrade to a new payment software. The initiative had a budget of $310 million approved by previous Prime minister Stephen Harper's cabinet and took about seven years to complete. (House of Common, 2018)

In 2011, the public service and procurement Canada who were responsible for this initiative awarded a contract to IBM to customize PeopleSoft (a commercial software) and set it up to meet government's needs. In general, there are 3 main stakeholders besides the contractor/vendor. The Public Services and Procurement Canada who led the design of the Phoenix pay system and operating the pay center in New Brunswick where advisors handle the initiation and termination of employees' payments. (House of Common, 2018)

The second main stakeholder in this initiative was the Treasure Board of Canada Secretariat TBS which handles hours of work and regulates payment and other terms and conditions of employment. The third stakeholder was the Federal Department and Agencies who were responsible of ensuring their human resources processes and strategies align well with the Phoenix system. The Phoenix Management Team were: Brigitte Fortin and Rosanna Di Paola. (House of Common, 2018)

Initiative Timeline

Time	Action
2009	Federal government decides to update its 40 years old payroll system.
2011	IBM awarded a contract to implement the new Phoenix system
2014	Government takes responsibility in training users instead of relying on IBM recommended system
2015	• A contract is awarded for the construction of the pay center in New Brunswick while staff are working in two temporary centers and handling 72000 payroll stubs.

	• IBM suggests postponing the delivery because of critical issues with the system.
2016	• Some privacy issues brought up as public servants had access to thousands of personal employees' records. • Almost 3000 payroll employees were laid off as the Phoenix payroll system rolls out in a few department and agencies. • Thousands of employees are not getting paid and complaints are increasingly reported. • The Public Service Alliance of Canada minister calls the situation unacceptable. • An emergency meeting is held and more workers are hired to deal with the mess. • A new budget of about $25 million is announced to fix the system which was increased later to up to $50 million. • IBM blames government for taking over training. • Unions suspends filing against government.
2017	• Laid off payroll clerks rehired to help with fixing the Phoenix system. • New extra funding is approved by the liberals.

(Bradbury, 2017)

3.0 Current state

The development and implementation of the Phoenix pay system was a huge failure and it is very hard to blame one person. This is a huge and complex still ongoing initiative that had multiple stakeholders and hence it is almost impossible to point the finger to one person. First of all, this tells us and shows a lack of accountability in federal government which has probably contributed to this faulty system. This aligns well with our findings and observations in this course when we noted that one of the characteristics of working in government either provincial or federal is that there will never be a culprit to blame if something goes wrong, as opposed to that in the private sector. (May, 2018), (Ireton, 2018)

Thousands of federal employees did not receive their pay checks, and one would wonder where is the senior management in all of this disaster. From the beginning there were serious issues with the system that the executives overlooked and perhaps thought that they could be addressed later. Unfortunately, when the system was launched, it could not perform critical pay functions such as retroactive payments. (May, 2018)

This happened when the executives initially decided to reduce the scope of the initiative which had put the system's functionality at risk. Dropping critical payment functions was a bad practice and a risky plan from the executives pushing just to make the system go live by its target date. It is a mystery, however, that these decisions were made especially that there were a number of

stakeholders involved and who could have made a change in this. Reports mention that in government there is a culture that promotes good news and discourages bad news, hence the project management team was confident, minimized risks and had always provided optimistic briefings. (House of Common, 2018)

The other huge problem is that the Phoenix system was not fully tested despite warnings of experts and the vendor IBM who recommended to postpone rolling out the system. It was reported that 30% of the supposed functions were either removed or deferred and 20% did not pass testing. These are huge red flags and again for the same reason of meeting deadlines, the executives simply decided to cancel pilot testing. On the other hand, the Phoenix system has encountered major privacy breaches since its implementation. Personal information such as names, date of birth, home addresses and payments were made accessible to other staff who did not need to see this information. Treasury Board of Canada Secretariat admits that this is a concern and the executives seem to not have complied with security, privacy protection and accessibility polices. (House of Common, 2018)

In terms of change management, the project management team did not take into account future changes to the system and it is very absurd to think that the system is static and will stay intact over the forthcoming years without any changes. Oracle the vendor of PeopleSoft was said to stop supporting this software by 2018. This is bad news because PeopleSoft was the software and infrastructure that IBM is customizing to meet the government needs. Unfortunately, the management team did not have enough measures put in place to accommodate the new changes in the future which could jeopardize the system's long term viability. This just tells us that a contingency plan was not well formed because such scenarios were never considered which is a terrible step to take. (House of Common, 2018)

In terms of collaboration and cooperation, many departments and agencies were left out of the picture in regards to reviewing or approving of functionality of the system; to ensure that it meets their needs. There was some sort of exclusion instead of transparency between those running the initiative and other stakeholders. Not only that but the executives did not follow recommendations to allow departments to test the system and run both the old and the new system in parallel before going full deployment. (House of Common, 2018)

Further, the system was just not ready, and representatives from other departments and agencies were simply not consulted. Unfortunately, there was no oversight of the project independent of the management team which reported only to the executives. Thus, the deputy minister who is supposed to be responsible of the delivery of an effective project did not receive any project status information. Internal audits of the project were intended and considered but were never actioned. This, could have helped give the deputy minister a chance to review the project and voice different decisions. (House of Common, 2018)

In general, reports indicate that the executives were well aware of the serious issues within the system including some security and privacy concerns. The executives knew that the system would not be able to perform important functions and explicitly stated "really needed to go live in full by April 2016 because the compensation advisors had already been given their notices." It was very

clear to them that the system was not ready to go live and have been given enough information and warnings not to go that route. (House of Common, 2018)

Despite that, they prioritized time and cost over the functionality of the system. They basically broke the basic balance of the project's triple constraint theory. The scope constraint was significantly reduced and functionalities were omitted. Not knowing the importance of the scope of the project and its components is very challenging. What is even more challenging is being able to juggle the three interdependent constraints. This initiative could have benefited from a more coherent team but the entire initiative seemed disconnected at places. (House of Common, 2018)
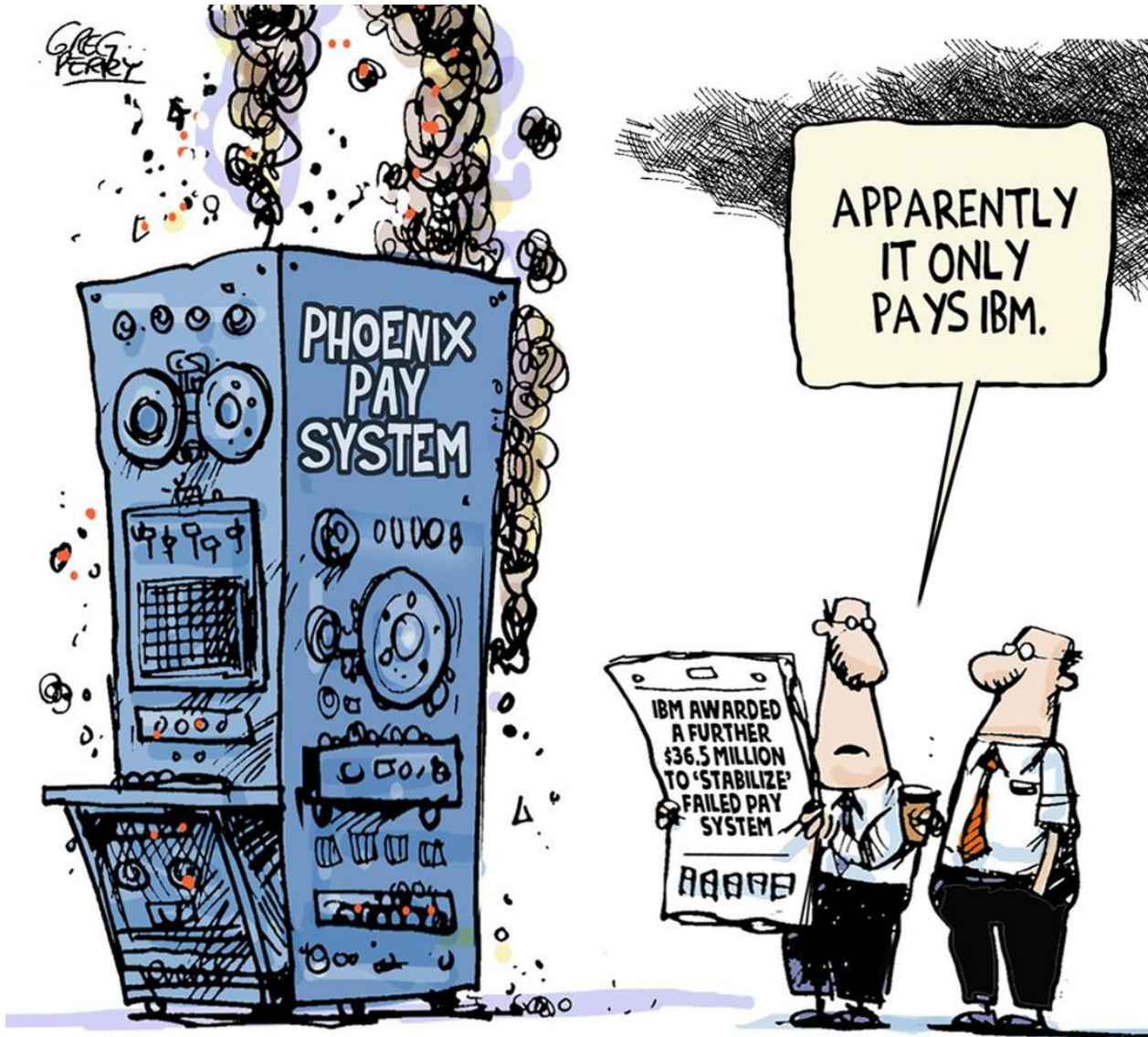
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4.0 **Lessons learned**

"It needs to be led from the top. The leaders need to model the fact that failures are okay as long as they're flagged early. A failure such as Phoenix is not okay because nobody caught it and nobody said anything until it was too late", said Goss Gilroy's Sandy Moir during a Senate hearing. (May, 2018)

The federal payment system is very complex and it was IBM that captured this complexity when it compared the Government of Canada pay system with that of the rest of the industry. This complexity needed to be addressed before diving into the implementation of an IT solution. Therefore, one of the lessons learned from the Phoenix system is to always define the scope and sub-scopes of a project and its components. For instance, a project could be divided into discrete projects where areas of change are defined within each sub project. This is not to create a divide among the projects but more to enhance interdependence of the composing parts. (House of Common, 2018)

The complexity of the pay system was not fully understood end-to-end and instead portions of the system were apparent or understood by only a few people. This is why the Phoenix system failed as it needed to rely highly on the collaboration of a wide range of users but unfortunately users of the new software were never considered as a change in the project. In general, a good practice in project 6management is to have a roadmap illustrating the initiative objectives, goals, timeline, risks, stakeholders, roles, deliverables and the various components. (House of Common, 2018)

As mentioned before, it is very important to know and note down how the discrete projects are intertwined and interconnected. This is because viewing the initiative holistically would have addressed many of the issues that the Phoenix system failed to address. Although a road map would illustrate projects as discrete, the whole initiative would be seen holistically, bringing risk management and change management into the picture. The is the second lesson learned from the Phoenix system. (House of Common, 2018)

Third lesson learned is to assign accountability for a huge nation-wide initiative to a single minister and a single deputy head. As mentioned before, there was no oversight of the project independent of the management team in the Phoenix initiative, and therefore taking responsibility for performance is very important. This should include the following: (House of Common, 2018)

- Clarifying roles and responsibility of all stakeholders.
- Setting clear objectives, goals and expectations.
- Expectations should be within capacity of the party in discussion.
- On-going transparent and credible reporting of the status of the project.
- Continuous review and feedback on performance, difficulties and status of the initiative is recommended.

In the Phoenix pay initiative, the accountability framework was clearly incomplete which was evident by the exclusion of deputy heads from the picture and hence, they were not aware of most of their responsibilities, of the changes made or the risks posed by these changes. Also, as mentioned before that the government promotes good news and just being generally positive. Thus, head deputies were not needed in briefings according to the executives. (House of Common, 2018)

Furthermore, what happened in the Phoenix initiative was that there was no single body for overall accountability for the whole transformation of the initiative. In fact, the public service and procurement Canada were granted the accountability to execute the initiative on behalf of the government of Canada, however, they were not able to exercise full authority and instead appeared to fall to the Public Service Management Advisory Committee for concerns and updates. In general, there needs to be an overall accountability and one option to do that is assign a single department/agency to be the lead in this. (House of Common, 2018)

"There was no oversight of the project independent of the management team which reported only to the executives" as mentioned before. To further comment on this, there seemed to be a number of established teams and committees that were supposed to work and collaborate together but that did not simply happen. Some of these teams are: (House of Common, 2018)

- Senior Project Advisory Committee (SPAC)
- Risk Management Oversight Committee (RMOC)
- Executive Management Team Change Agent
- Network External Advisory Committee TPA
- Union Management Committee (TPAUMC)

These teams were established for a good number of reasons. One of them is to have an overall governance that reflects the whole initiative. In fact, it is a good practice for any project or initiative to have a broad range of stakeholders that collaborate for the best of the project in hand. (House of Common, 2018)

Another lesson learned is that in order to deliver a successful product especially handling a complex and huge IT initiative, it is recommended to have an oversight body that monitors risks, issues, budget, schedule, scope and the overall status of the initiative. This means adding a third eye that is independent from the regular teams of the initiative and who can provide objective feedback and advice. Often time, this is going to be a third party who has international and comparable experience that can be part of the initiative oversight team. (House of Common, 2018)

This third party would provide independent evaluations of the progress of the initiative and most importantly would report to the head deputy and senior governance body. In the case of the Phoenix system, independent reviews were delivered, however, performed by internal project

management staff and were very technical. This was ineffective and did not address any of the significant issues of the project. (House of Common, 2018)

The final lesson learned from the Phoenix pay system is to integrate change management early on and take it seriously. An initiative especially a nation-wide project should be open to any changes in the future. This is important because it is a huge investment for the future as it will save everyone a lot of cost, time and effort. Just as discussed before, one example of resisting change was neglecting the fact the PeopleSoft(Software) is not going to be supported any more by Oracle (the vendor). Despite that, there were no reported plans to upgrade the system. (House of Common, 2018)

Eventually and from personal experience working in the public sector, there always seems to be a disconnect between upper management and the people who are actually doing the work. If upper management would not take their experts and technical teams seriously then how is it expected that an initiative would deliver successfully!

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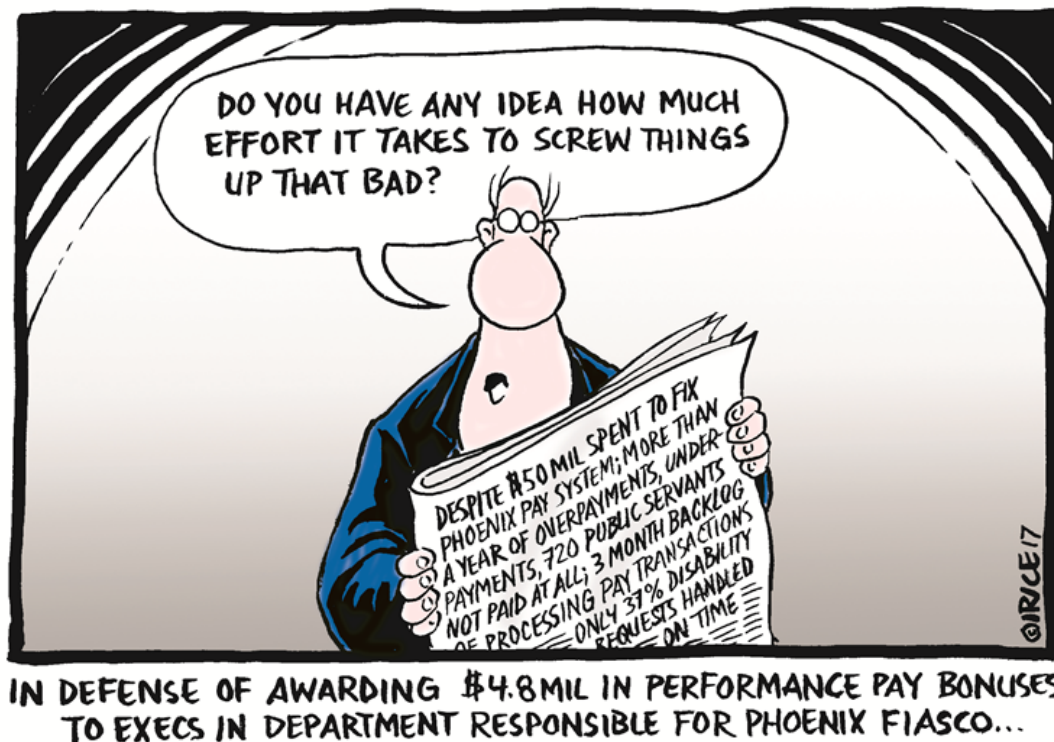
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