How to set up a Project Management Office (PMO):

Outline by ERSME

11 May 2012

Table of Contents

TABLE OF CONTENTS **2**

1. INTRODUCTION **3**

About ERSG *3*

2. THE PROJECT **4**

Establishing a PMO at a Company *4*
Challenge *4*
Strategy Approch *4*
Basic Company Project Information *5*
Models used by ERSME to Develop PMO *6*

3. THE ERS PMO: Proposed Outline by ERSME **9**

ERSME Project Management Office *9*
Infrastructure *11*
PMO Manager *11*
Progress-tracking Manager *12*
Service Team Manager *12*
Reporting *13*

4. CASE STUDY 1: Brisbane Medical City: **16**

ERSME Project Management Office *16*
Summary *18*

5. CASE STUDY 2: – THE NEW LATROBE HOSPITAL **19**

Standards from the Start *20*
Success *21*
Consequences *22*
Establishment Project Office *22*
Benefits *23*
Typical Reports Produced by the Project Office *24*
The CPN for the Commissioning & Relocation Sub Project *24*
Project Steering Group Report *24*
Milestone Gantt Charts *25*
Milestone Tables *26*
Task Reports *26*
Cost Profiles 27

1. INTRODCUTION:

About ERSG

ERSG is an international management consulting firm, committed to improving overall operational effectiveness for Fortune 500 companies around the world. The firm's main areas of focus include operations excellence, manufacturing, quality, customer service, research and development and supply chain management.

With its "hands-on" approach philosophy, the company has achieved tremendous success in delivering quantifiable and value-driven results for its clients in a variety of industries, including petrochemical, healthcare, life sciences, general manufacturing, high-tech and financial services.

All of ERSG's support programs are ISO 9001 certified. ERSG currently employs over 400 professionals worldwide.

For additional information, please contact:

Troy O'Connor, Operations Director

Easy Risk Solutions Middle East Ltd
GCH Business Center
Fifth Floor, Al-Falak Building,
King Abdulaziz Street, 31952
Kingdom of Saudi Arabia

Mobile: 0558 769 379
Tel. + (61 7) 3325-0034
Fax. + (61 7) 3325-2946

troy@ersgltd.com

www.ersgltd.com

2. THE PROJECT:

Establishing a PMO

In April 2012, a company engaged (RFP) ERSG to help develop and implement an Operations Excellence Project Management Office (PMO). This included defining the organizational structure of the office and identifying the areas for improvement within the hospital facilities.

Challenge

The company was seeking professional services related to the creation of a Project Management Office (PMO) which will include the development of internal Operations Excellence (OPEX) capabilities as per ERSG's strategy for this type of project.

Strategy/Approach

ERSG will structure the project with the client concerns in mind and developed a project plan that focused on building an Operations Excellence Department from the ground up under the control of a Project Management Office.

Starting with developing the department, the organizational structure and governance guidelines will be established and implemented.
The following steps will be taken:

- Job descriptions for the OpEx Department roles were created
- Recruiting support for department was given
- Onboarding of new hires
- Training of department
- Project Management Training
- Identify project roadmap for current and new projects

ERSG will set up a full PMO on site at the company to meet all current and future project outcomes.

Basic Project Information

Submitted:

The Company is one of the largest medical cities in the Middle East, which consists of the main hospital, women's Hospital, children's hospital specialty and hospital rehabilitation. In addition to multiple medical centers are hospitals.

The company has a program building Major Unit forms part of a strategy of long-term growth and intends to manage the company's establishment of a project management office for the control and management of this project.

Basic information:

Some of the projects of the current and planned for 2011:

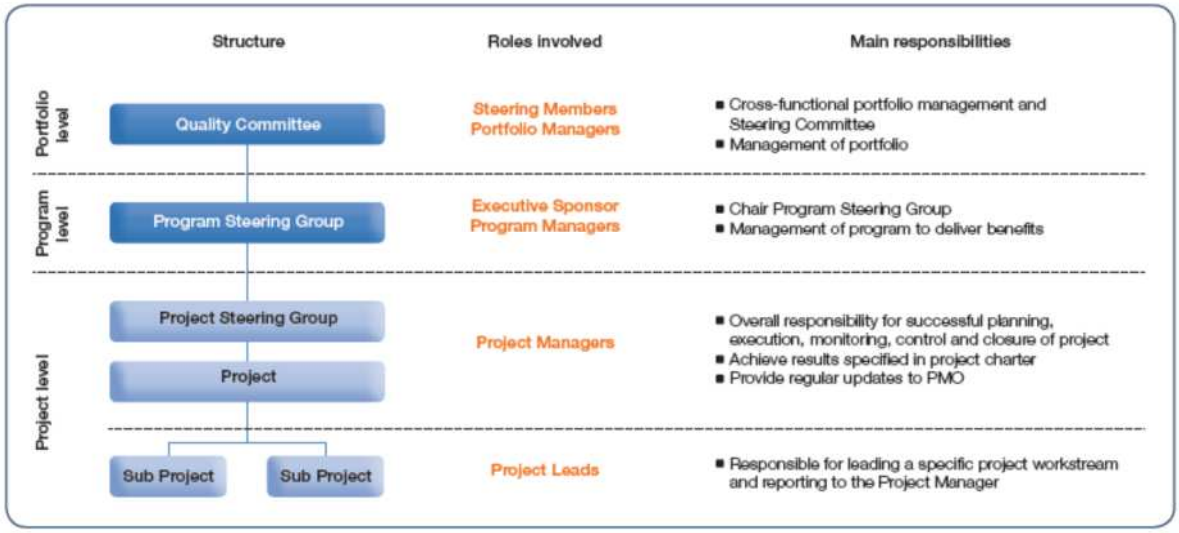
Building	**Situation**	**Space (M 2)**	**Value (Almost)**
Outpatient clinics			
Tumors			
Neurological Sciences			
Laboratories			

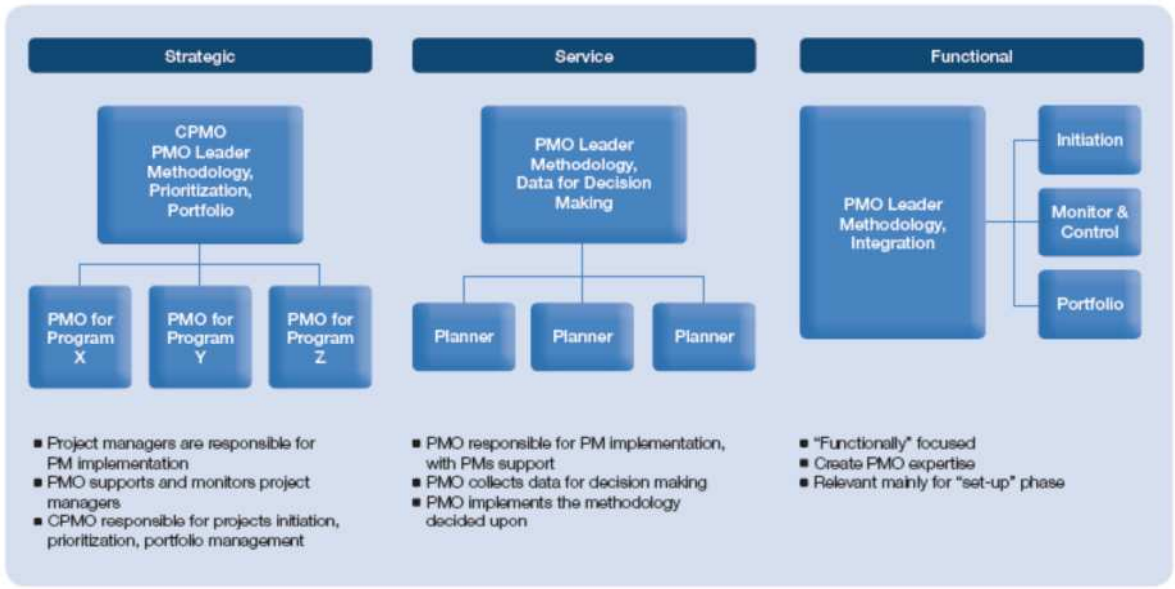
In addition to the projects mentioned above, there are a number of six major projects under construction and nearing completion and several large SME.

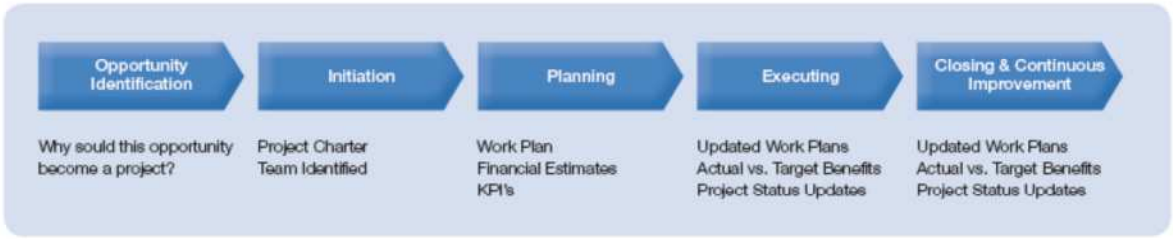
Requirements Program management center :

ERSG will provide a program management office to manage the companies projects in a fully effective way relating to the management of time, cost and quality of construction, and avoid serious problems that occur in these areas usually.

Models used by ERSME to Develop a PMO

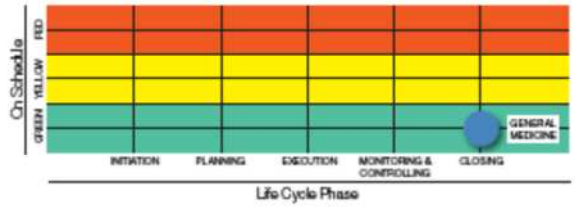






Project KPI Dashboard: Motality Index

Project Name	Project Manager	Due Date	On Schedule	Matric: Target	Matric Current	Life Cycle Phase	Upcoming Milestone
PORTFOLIO: MORTALITY INDEX							
DEPARTMENT: Medicine							
SECTION							
GENERAL MEDICINE							
HOSPITALIST							
CARDIOLOGY							
HEMATOLOGY / ONCOLOGY							
DEPARTMENT: Surgery							
SECTION							
BURN TRAUMA CRITICAL CARE							
ENDOCRINE & SURGICAL ONCOLOGY							
VASCULAR SURGERY							
SURGICAL TRANSPLANTATION							
CVTS							
NEUROSURGERY							
OPHTHALMOLOGY							
ORAL SURGERY							
ORTHOPAEDICS & ORTHO PODIATRY							
OTOLARYNGOLOGY							
PLASTIC SURGERY							
UROLOGY							
DEPARTMENT: Pediatrics							
SECTION							
DEPARTMENT: OB / GYN							
SECTION							
OB							
GYNECOLOGY							
GYNECOLOGICAL ONCOLOGY							



Legend

Next Upcoming Milestone

- High probability of not reaching next milestone
- Medium probability of not reaching next milestone
- Low probability of not reaching next milestone

On Schedule

- ≥ 2 weeks behind schedule
- < 2 weeks behind schedule
- on schedule

Project Life Cycle

INITIATING (I), PLANNING (P), EXECUTING (E)
MONITORING & CONTROLLING (M & C)

The ERSME Project Management Office: Proposed Outline by ERSME

To focus and drive a business transformation effort, a strong project management discipline is needed. ERSME will establish a Project Management Office at the company that will steer a business transformation by spearheading performance improvement measurements as well as traditional project monitoring efforts for all current and new projects.

Business transformation is a complex undertaking with millions of dollars invested in such projects, health organizations are eager to define the characteristics that ensure success. According to the Gartner Group, one of the critical elements is the presence of a centralized project management competency. Indeed, Gartner has estimated that without such a discipline, over 70% of projects suffer from time or cost overruns.

For an organization to maintain the performance advantages gained from clinical / business transformation, it must create a culture of accountability with a focus on sustainable improvement. This culture can be created by providing a structured way to track progress against goals, examine project status and interim results, and use this information to drive the overall organization to expected results. The set of tools used to drive focus and results within an organization is called the project management office (PMO).

The ERSME Project Management Office

An effective PMO operates as a centralized authority to oversee and coordinate single or multiple projects and or multiple initiatives. It flags conflicts in timing, resources, staffing, or information that can jeopardize the ultimate completion and cost of complex projects.

The PMO's authority goes beyond problem identification, however, to create problem-solving forums among the owners or, if needed, refer problems to those with the authority to act. Importantly, the PMO ensures that issues that can jeopardize the timing and success of the project are resolved so that the critical path for the project is protected (see Figure 1).

The **fully functional ERSME PMO** will be the repository for all analyses and quantifications of expected benefits (performance, operational, technological, and financial). This group of analyses collectively is called the business case and provides the rationale for the project.

Since setting up of a PMO and clinical transformation is composed of numerous initiatives, the charters and work plans for each of the initiatives are monitored and controlled from the PMO as well. The **PMO acts as the central hub** in all communication around the project. Status reports and issue management are handled consistently, so that executives have confidence that they are judging the progress and issues of different projects by common standards.

One of the main benefits of clinical transformation is the shift in organizational culture that can accompany the project. Knowledge transfer is therefore a major component of activity. After the end of the clinical transformation, the reports, skills, and techniques used to keep the project on track can be transferred to operational managers to enable them to focus on key components that drive the overall success of the endeavour.

Some of the specific responsibilities of the ERSME PMO will include the following:

- Communicates the prioritization of initiatives and projects to all constituencies
- Monitors change requests with timing implications across initiatives
- Monitors work plan variances
- Tracks progress and outcomes across initiatives, actively working to ensure realization of the expected benefits
- Creates and presents project-level status reports to executives based on initiative-level reports
- Sets the standards for use of automated project management tools and coordinates training on tools
- Approves change requests with time or budget implications (with leadership committee involvement for significant changes)
- Facilitates communication flow between and among initiatives.
- Generates ad hoc financial analysis (determinations of productivity or non-labour budget variances)
- Monitors initiative staffing commitments to ensure no project budget overruns

Infrastructure

While the specific structure of the PMO must reflect the company's individual requirements, there are roles and responsibilities that must be undertaken for all situations.

The PMO operates as a central communication, monitoring, and control hub for the clinical transformation project. It has a reporting relationship to the leader- ship team, which in turn exercises overall direction for the project, and recommends actions to the board of directors.

For the PMO to function effectively, certain roles and functions must be staffed. Depending on the size and complexity of the clinical transformation project, this **typically requires three to six full-time employees for the duration of the effort**. Figure 2 is an example of a typical organizational chart for a clinical transformation PMO.

PMO manager:

The PMO manager is typically a seasoned individual with significant knowledge of the health system and its reporting structure who is assigned full time to this central role for the duration of the clinical transformation project. This position assumes direct responsibility for all deliverables and for monthly monitoring or progress for all initiatives within the overall project. It is the PMO manager's responsibility to maintain communication and provide key updates and information to both the leaders of individual initiatives and the health system leadership.

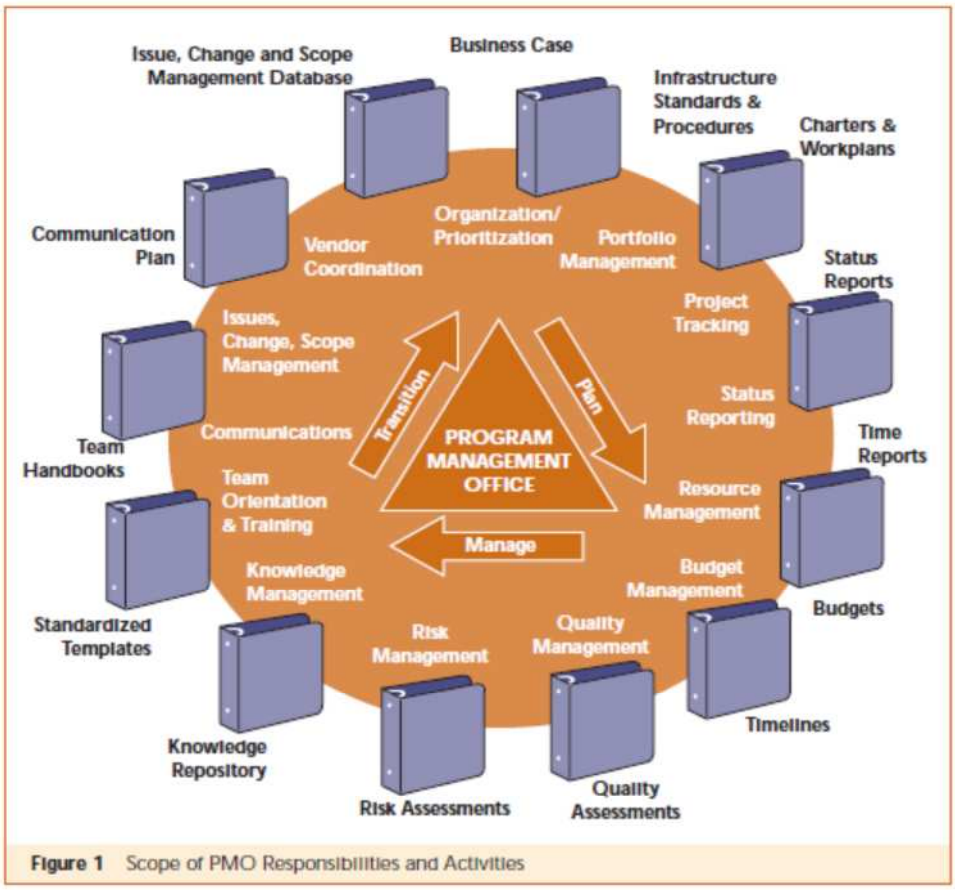


Figure 1 Scope of PMO Responsibilities and Activities

Progress-tracking team manager:

The progress-tracking team manager should have a familiarization with health system financial and management reports or accounting processes. The role of this position is to assume responsibility for the collection, analysis, and reporting of financial progress toward targets as well as monthly quality indicator reports. On larger projects, this position oversees the work of the scheduler and value trackers to create reports on each project initiative for review and integration by the PMO manager.

Service team manager:

The service team manager reports to the PMO manager and is responsible for ensuring that the project has appropriate human resources and administrative assistance, as well as appropriate communications efforts with constituencies. Such activities might include consistency and adequacy of staff on the various initiatives, as well as overseeing any contracts needed by the initiatives team to support their work. On larger projects, this position would oversee the work of the communications coordinator and the knowledge and training co-ordinator.

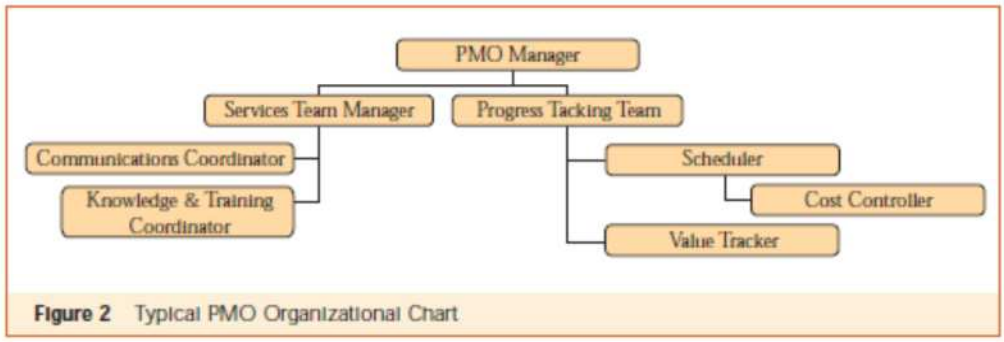


Figure 2 Typical PMO Organizational Chart

Reporting

The PMO's ability to focus the organization is directly related to its ability to monitor and control the various initiatives that make up the larger clinical transformation project. Specific project management methods and tools are used to create this discipline and ability. Figure 3 illustrates that reporting begins at the initiative level of the project. Information of various types is rolled up to create both detailed and executive level reports. This is the reason that the ERSME PMO must be empowered to serve as the centralized body with the authority to establish reporting standards, and to verify the consistency and accuracy of initiative level reports.

Some of the types of reports used by the PMO include:

Status reporting and issue management.

Status reports pro- vide clear and concise updates on specific tasks and deliverables. They are also used to escalate issues when appropriate to higher levels of the organization for resolution. Additionally, these reports are used to identify and report on project progress relating to budget, schedule, and performance; report on activities with delayed starts or completions; and report on current and anticipated deliverables.

Risk management and quality assurance.

Risk management and quality assurance reports are used to ensure that deliverables are produced on time, and with expected benefits. Figure 4 represents an example of a risk assessment report. Ongoing risk assessment reports keep the PMO informed of the progress of each initiative, highlighting problem areas because many of the initiatives are interrelated, the risk assessment report facilitates the PMO's early intervention, thus preventing a domino effect through other initiatives of the project.

Quality assurance is the ongoing review of deliverables from the individual initiative teams at certain critical junctures. Through use of a consistent set of criteria at these junctures, movement to new phases of work occurs when the needed foundation work has passed a quality review.

Scope and change management:

When initiative teams are in the midst of their work, scope issues always come up. The PMO monitors change requests and accepts recommendations for initiative leaders. By requiring consistent reporting on desired or requested scope changes, the PMO can serve as a for- mal review and control point. If the scope or change request is approved, the PMO then has the responsibility of reflecting the change in overall project and to oversee that individual project managers reflect changes in individual initiative work plans and other documentation.

Executive reports:

The most summary level of information is that which is prepared for executives. The purpose of these reports is to keep leaders fully informed of overall progress, especially with regard to potential or existing problem areas. In this way, leaders are in a position to understand the ongoing progress on the project and to intervene in a timely manner when needed. Figure 5 summarizes a dashboard report, used for such reporting.

Financial and operational assurance reports:

Often after reviewing the executive reports, both executive leadership and directors will want to drill down into the drivers/reasons for the lack of progress within specific initiatives. For instance, if patient care is not realizing the staffing efficiencies desired, they will want to understand which departments are driving these variances. A productivity report is a common tool used to help both executive leadership and director's focus on specific departments. An example of another report reflecting specific departments is the supply chain expense utilization report. This report allows one to determine which departments are responsible for supply expense variances.

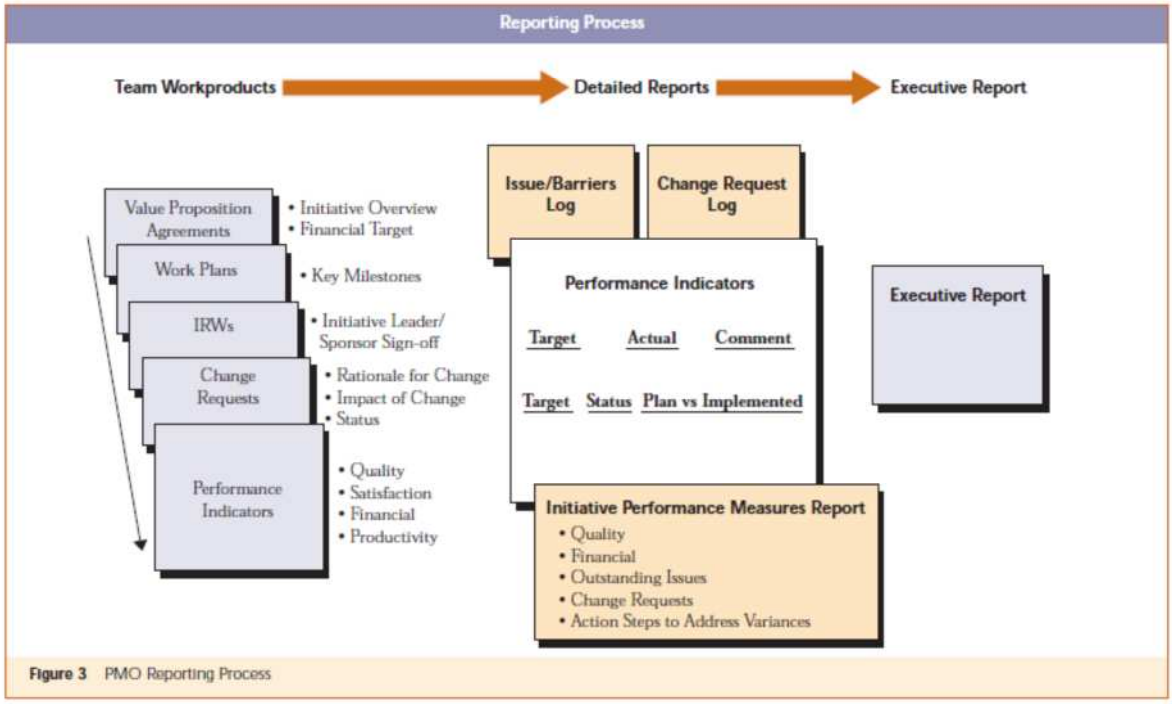


Figure 3 PMO Reporting Process

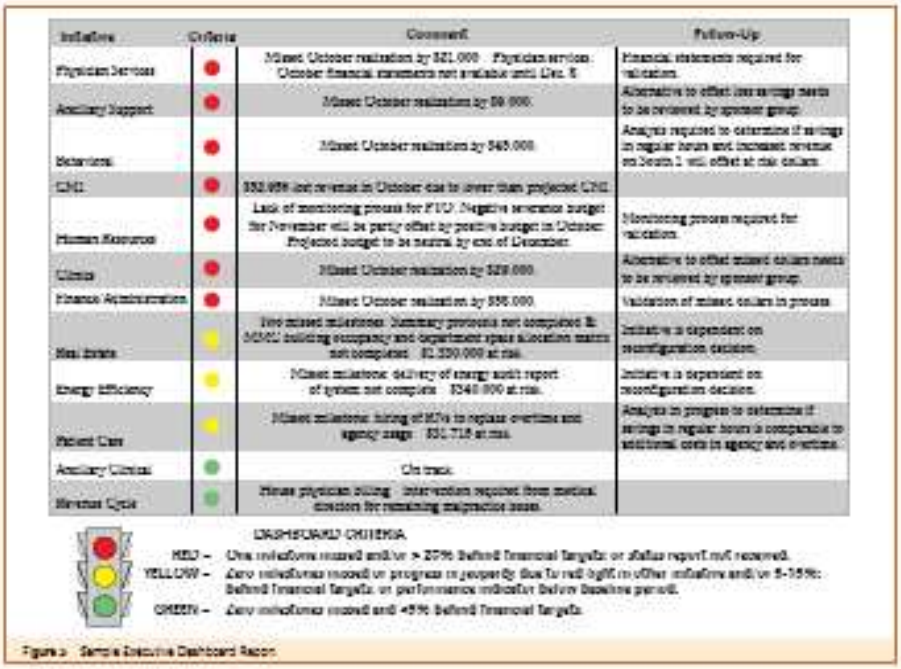


Figure 2 Sample Executive Dashboard Report

Case Study 1: Brisbane Medical City

For one health system, using a PMO resulted in changes in project design and management that, while subtle in nature, were significant in impact. In this situation, the health system involved three entities in its clinical transformation project:

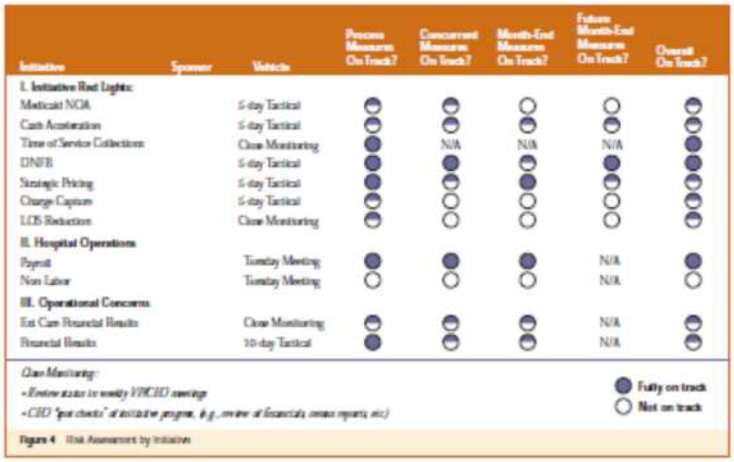
1. its existing executives and department managers,
2. a technology vendor, and
3. clinical transformation consultants.

The PMO was the central authority through which issues, project plans, timelines, dependencies, and deliverables were tracked, documented, and managed for these multiple groups. The health system appointed a PMO manager who had the responsibility for integrating and synchronizing the project plans from each application/design team.

The health system, very cognizant of the fact that the project management office would not replace or be confused with project management, designed a model to ensure one would complement the other. The goals and objectives of the PMO were consistent with the project's overall goals and objectives and were designed to ensure consistency of performance through the establishment of planning, reporting, controlling, quality and risk management, and knowledge capture standards.

One example of this process involved the creation of a single, comprehensive electronic medical record. To avoid the proliferation of medical records in which many of the documents were electronic but others (received from sources outside the health system) remained paper-based, a design team recommended that all hard-copy documents be scanned to create electronic versions. While this future state design offered many benefits, the current capacity of the health system to undertake the level of scanning required achieving this goal constituted a change in the scope of the project. The PMO worked with the current project managers, the clinical transformation consultants, and the technology vendor to create a scope change document that supported the business case for the recommendation.

This process gave leaders the information they needed to make a decision based on the quantification of benefits and costs. In a non-PMO controlled environment, such a change may have created operational barriers since the recommendation may not have been formalized during a window of time in which solutions were still changeable

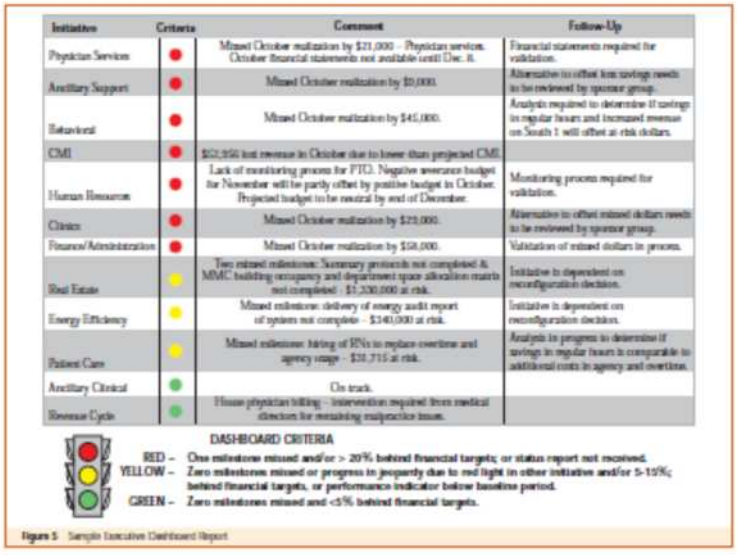


Initiative	Sponsor	Vehicle	Process Measures On Track?	Concurrent Measures On Track?	Month-End Measures On Track?	Future Month-End Measures On Track?	Overall On Track?
I. Initiative Red Lights:							
Medicaid NOA		5-day Tactical					
Cash Acceleration		5-day Tactical					
Time of Service Collections		Close Monitoring		N/A	N/A	N/A	
DNFB		5-day Tactical					
Strategic Pricing		5-day Tactical					
Charge Capture		5-day Tactical					
LOS Reduction		Close Monitoring					
II. Hospital Operations							
Payroll		Tuesday Meeting				N/A	
Non Labor		Tuesday Meeting				N/A	
III. Operational Concerns							
Ext Care Financial Results		Close Monitoring				N/A	
Financial Results		10-day Tactical				N/A	

Close Monitoring:
•Enter reason in weekly VHCHD meeting
•CHD "post checks" of initiative progress, (e.g., review of financials, census reports, etc.)

● Fully on track
○ Not on track

Figure 4 Risk Assessment by Initiative



Initiative	Criteria	Comment	Follow-Up
Physician Services		Missed October realization by $21,000 – Physician services. October financial statements not available until Dec. 8.	Financial statements required for validation.
Ancillary Support		Missed October realization by $9,000.	Alternative to offset lost savings needs to be reviewed by sponsor group.
Behavioral		Missed October realization by $45,000.	Analysis required to determine if savings in regular hours and increased revenue on South 1 will offset at-risk dollars.
CMI		$22,950 lost revenue in October due to lower than projected CMI.	
Human Resources		Lack of monitoring process for PTO. Negative severance budget for November will be partly offset by positive budget in October. Projected budget to be neutral by end of December.	Monitoring process required for validation.
Clinics		Missed October realization by $29,000.	Alternative to offset missed dollars needs to be reviewed by sponsor group.
Finance/Administration		Missed October realization by $58,000.	Validation of missed dollars in process.
Real Estate		Two missed milestones: Summary protocols not completed & MMC building occupancy and department space allocation matrix not completed – $1,200,000 at risk.	Initiative is dependent on reconfiguration decision.
Energy Efficiency		Missed milestone: delivery of energy audit report of systems not complete – $340,000 at risk.	Initiative is dependent on reconfiguration decision.
Patient Care		Missed milestone: hiring of RNs to replace overtime and agency usage – $31,715 at risk.	Analysis in progress to determine if savings in regular hours is comparable to additional costs in agency and overtime.
Ancillary Clinical		On track.	
Revenue Cycle		House physician billing – intervention required from medical director for remaining malpractice issues.	

DASHBOARD CRITERIA

RED – **One milestone missed and/or > 20% behind financial targets; or status report not received.**
YELLOW – **Zero milestones missed or progress in jeopardy due to red light in other initiative and/or 5-19% behind financial targets, or performance indicator below baseline period.**
GREEN – **Zero milestones missed and <5% behind financial targets.**

Figure 5 Sample Executive Dashboard Report

In another example, the implementation of computerized physician order entry (CPOE) originally assumed the use of two different, existing laboratory information systems at two facilities in a hospital system. During the design phase of the project, the actual cost of creating two sets of interfaces and two sets of system maintenance efforts was

revealed to be higher than originally estimated. The PMO monitored an “issue” for project management.

Four alternatives were considered:

1. Continue to use both laboratory systems and interface both of them with the new clinical information system
2. Continue to use both laboratory systems with upgraded interfaces
3. Convert one hospital’s laboratory information system to the larger hospital’s system
4. Migrate the larger hospital’s system to the smaller system

The result was a recommendation for investment in a single lab system, from the larger hospital, to be used across the sys- tem. While this decision resulted in additional, up-front capital investments, the savings accruing from reduced interface build and a single maintenance effort made the investment well worthwhile. The PMO provided a coordinated approach to measuring, recording, and reporting the value of this issue to the health system executives.

Summary

The PMO concept integrates performance improvement measurements and traditional project monitoring and reporting with behavioural and training concepts. This creates a culture of accountability.

In this way, the PMO finishes the transformation represented by the integration of clinical process redesign and information system design.

Case Study 2 – The New Latrobe Regional Hospital

The original LRH hospital was a registered public hospital under the Victorian Health Services Act 1988 and functioned as part of the Victorian Department of Human Services.

The diseconomies in the structure of the old LRH resulted in the Victorian State Government (through its Infrastructure Investment Policy for Victoria) to create a new health service facilities in the Latrobe Valley to be provided via a Build, Own & Operate model of private sector service delivery.

This new facility was constructed at a greenfield site at Morwell East Victoria, and was being built by Multiplex Constructions Pty Ltd and is operated by Australian Hospital Care Ltd (AHCL) Victoria's largest and Australia's second largest private hospital group.

Even though the new LRH is managed privately, it operates as part of the Victoria public health care system and is the Regional Referral Hospital for Gippsland. The funding for the new LRH will continue to be based on the current methodology for Victorian public hospitals i.e. Casemix funding.

In January 1997 the Victorian Government signed contracts with Australian Hospital Care Limited (AHCL) to build the new privately owned hospital to provide hospital services to public patients. An integral part of AHCL's bid was to assume immediate management of the existing public facilities during the construction phase of the new facility.

A Transitional Management Agreement (TMA) was developed to enable Australian Hospital Care Ltd to introduce itself to the staff and the local community and to ease the transition into the new facility. It was thought that this period would allow the new management to commence not only the structural changes that were inevitable but also commence work on the cultural changes that would be necessary.

I am sure you would agree that it would be a difficult enough task to manage a large and complex organisation over multiple sites. To do this and to undertake the complex and difficult task of bringing about cultural and structural change and at the same time become actively involved in the construction of a new Hospital was always going to be a big ask. It was the acknowledgment of these unreasonable demands on the Executive that led to the decision to seek the support of external consultants with expertise in project management. MPI Pty Ltd was appointed to assist with the project and one of our first decisions was to establish a Project Office.

The function of the Project Office was to carry out the planning, scheduling and project management of the move from the original three campuses to the new location so that it became operational from 1st September 1998. There were significant contractual imperatives for this to occur. During the initial phase of the project the role of the project office was expanded to provide support services to the builder and the introduction of an Issues Management system as well as Milestone Reports.

During this transitional period it was imperative that the contracted level of health care services to the community is maintained by the existing LRH. Through the Project Office the project schedule was managed to ensure that this was the case.

Standards from the Start –

As one of Australia's leading Healthcare services provider - AHCL understood that acceptance of the vital need for quality project management was a critical factor in the establishment of its new facility, the Latrobe Regional Hospital.

And, according to its senior management, the use of project management disciplines aided by effective project management software played a significant part in the successful opening of the new Latrobe Regional Hospital five weeks ahead of schedule and on budget.

The go ahead to start building the new Latrobe Regional Hospital was given in 1996 and, from the beginning; all efforts were directed contractually towards an opening date of 1st September 1998.

Under Executive Director Stuart Rowley, the construction of the new LRH was a Greenfield start-up operation. A major complication was that at the same time the old LRH hospital had to continue operations and convert from a public hospital management to a private hospital management model. All this occurring across three campuses up to 25 km. apart, with the new site located within the same area.

A relationship was established with many of the Heads of Department in the old LRH who then delegated unit managers to form "working parties" to cover all the aspects of the relocation of the old hospital and all its services from three campuses to the new campus. All this work had to be carried out in addition to regular duties.

Considerable executive management energy was focused on hitting the contract date target by establishing a Project Steering Group at AHCL's corporate office and so every part of the project was evaluated according to its Criticality to the readiness and ability to open on time. The steering group was made up of representatives of Silver Thomas Hanley (the architect), Multiplex (the builder); the Victorian Department of Human Services the Quantity Surveyor, an Independent Certifier; members of the Establishment Project Office, the Corporate Risk Manager as well as the Executive Director of LRH, Mr Stuart Rowley. Regular "go - no /go" reviews were conducted, this ensured that all of the staff involved with the project knew what was occurring with the project as well as what was expected of them. Extensive training sessions in the new practices and protocols were also given and formed an important part of the project plan.

Success

"A major factor in the successful opening of the new hospital "Stuart Rowley explains, "was the early implementation of quality project management processes

and standards." The chosen project planning software was Micro Planning International's X-Pert for Window (XPW). It uses a variety of "views" of project data, including Gantt charts and Critical Path Networks and is particularly strong in resource modelling, tracking and scheduling, as well as Earned Value Performance Management.

The old LRH initial priorities were to make the company's first high-level plans more robust and, crucially, to validate plan dates. The project management consultants because of its ease of use selected the software, and because its reporting and plan consolidation capability allowed the rapid pin-pointing of "hot-spots" (e.g. resource deficiencies) that required attention if the contracts launch date was to be met.

Consequences

"At start-up we were not well equipped technologically and by establishing the EPO we were able to develop a positive project based culture. The emphasis on good project management undoubtedly contributed to the team working and a "can-do" attitude amongst staff," says Stuart Rowley.

Within LRH today, cross departmental projects are the norm with the three Care Programs now well in place with marketing, finance, Y2K compliance and IT activities becoming ever more inter-related. The LPMG Project Office (colloquially known as the EPO) mainly manages these, which is based at the hospital. The processes that were developed during the establishment of the new hospital have become a de facto standard and are used by some of the major “Corporate Projects" within the AHCL group of hospitals.

Establishment Project Office

A central unit - the Establishment Project Office (EPO), supports project management throughout LRH. This performs the function that in many organisations would be handled by a Programme Manager. Typically, this type of function will take high-level project plans from operating departments and help to anticipate and resolve potential resource conflicts, using the company's overall

business objectives as the benchmark to determine priorities.

However, at LRH, the EPO also works closely with the AHCL Corporate Project Managers. Although project sponsors were ultimately responsible for delivering the project's business benefits, the Corporate Project Managers are expected to drive their projects forward proactively.

The EPO works through the Corporate Project Managers to apply "best practice" standards in project management across AHCL.

Typically, this involves encouraging the sharing of expertise amongst the company's pool of project managers and "mentoring" new entrants to the project management profession. In addition, the EPO sought to ensure consistency in the way elements of the project management process were handled throughout the organisation, all of which helps to build an effective project management culture.

Benefits

According to Stuart Rowley, the development of a project management culture via the EPO has brought significant benefits to LRH. The primary one being the defined involvement of all parties (users and developers alike) in the planning process - they are actively encouraged to challenge the assumptions on which the plans are based.

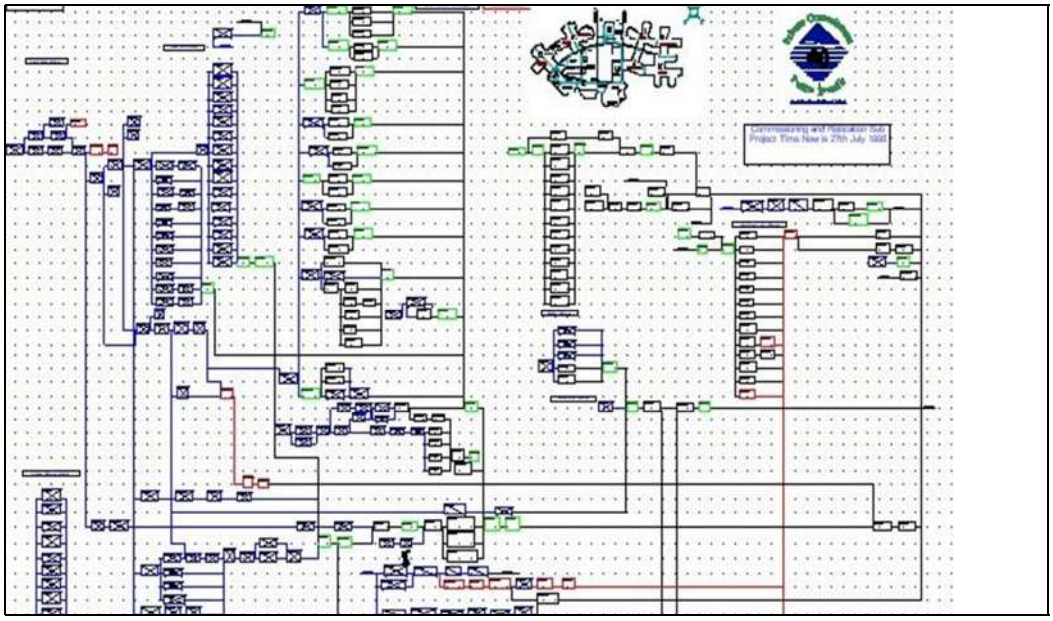
Additionally, the EPO is generally advised well in advance of a project's inception, so that plans can be aggregated early and resource profiling and forecasting carried out with far greater sophistication.

"Above all", says Stuart Rowley, "we have a continuous feedback loop whereby Micro Planner plans are produced in great detail for the first phase of a project, with plans for subsequent phases being refined according to experience. This process is continued beyond project completion into subsequent planning, to establish an on-going cycle of project improvement."

Typical Reports Produced by the Project Office

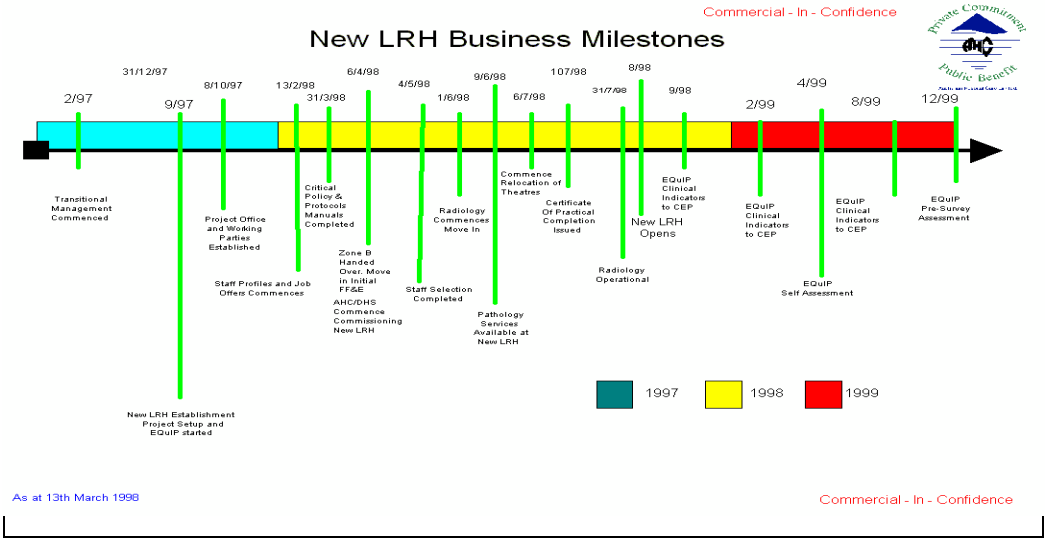
The following reports illustrate the typical information provided to corporate management;

The Critical Path Network for the Commissioning and Relocation Sub project



The above critical path network shows the relationship between the tasks involved with the commissioning of the new hospital and relocation tasks from the old hospitals campuses. Where a task has been achieved it is shown crossed out. Also included in this diagram is a small scale layout of the new hospital.

Project Steering Group Report

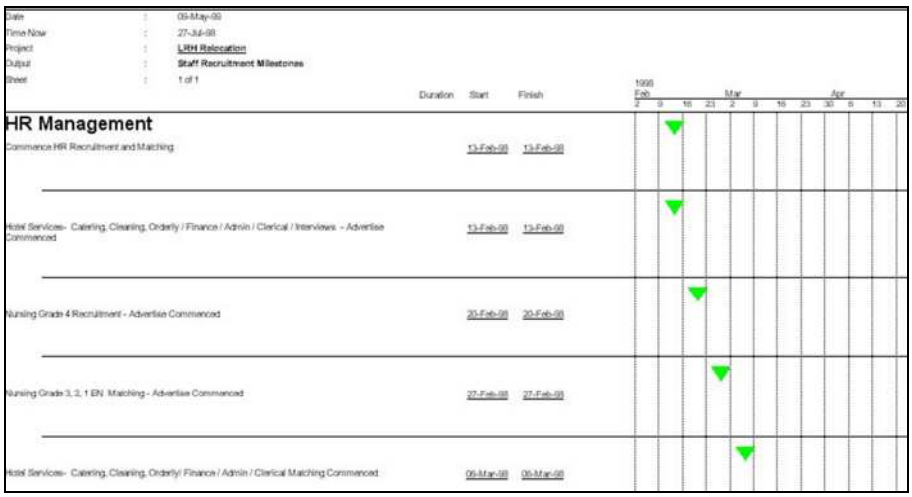


This report was specifically designed (it became colloquially known as the “Arthurgram” so named after the chairman of the Project Steering Group) to provide a high level summary of the most critical as well as the most important milestones within the project.

As can be seen it spans the total project from the commencement of the Transition Management Agreement in 1997 to the AHCS EQuIP certification requirement date at the end of 1999.

As the project progressed the “Arthurgram” was updated each fortnight to highlight the current project status.

Milestone Gantt Charts



This report was designed for the HR manager and provided the HR department with their specific milestones, which had to be met in order to ensure that sufficient staff would come through from the old system to the new system.

It was produced in Gantt form, which provides a rapid visual picture of the major milestones and their relationship in time. However some managers preferred the data in the form of a table, which is shown below

Milestone Tables

Title : Milestones for Catering
Project : LRH Relocation
Commercial - In - Confidence

Date : 09-May-99 Time Now : 27-Jul-98 Sheet : 1 of 1

Task Id	Description	Baseline Date	Achieved Date	Schedule Date	Variance
Catering					
LRH23001	Catering Department - Relocation Plan Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23002	Menu Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23017	Equipment Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23027	Staff Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23036	Staff Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23057	Plant Assessment Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23090	HACCAP Commenced	06-Apr-98	06-Apr-98	06-Apr-98	0:0
LRH23082	Rosters / Protocols Commenced	14-Apr-98	14-Apr-98	14-Apr-98	0:0
LRH23077	Computers Commenced	04-May-98	04-May-98	04-May-98	0:0
LRH23089	Operating New and Existing Kitchens Commenced	11-May-98	04-May-98	04-May-98	+5:0
LRH23099	Standards For Measure	11-May-98	04-May-98	04-May-98	+5:0

Task Reports

Date 18-Jul-95 Commercial - In - Confidence
Time Now 27-Jul-98
Project LRH Relocation
Output Pathology Certificates Task List
Sheet 1 of 1

Task Identity Task Description

LRH98012 **Certificate - Fire Hydrants & Hose Reels - Installation/Flow Rates**
Budgetted Cost:
Actual Cost to date:
OccupancyPermit Est. Rem. Cost
Scheduled dates: 17-Jun-98 17-Jun-98 Dur: 1:0 Balance from previous report:
ColinABrown Actual Progress 17-Jun-98

LRH98013 **Certificate - Mechanical Systems Comply Drawings,BCA & Codes**
Budgetted Cost:
Actual Cost to date:
Est. Rem. Cost
Scheduled dates: 17-Jun-98 17-Jun-98 Dur: 1:0 Balance from previous report:
Actual Progress 17-Jun-98

LRH98014 **Certificate - Glass installed to AS 1288 (1994)**
Budgetted Cost:
Actual Cost to date:
Est. Rem. Cost
Scheduled dates: 17-Jun-98 17-Jun-98 Dur: 1:0 Balance from previous report:
Actual Progress 17-Jun-98

Many of the various unit managers utilised the standard task report format, which shows the name of the task, it's duration, when it is scheduled to commence and finish as well as cost analysis information. As progress occurred the actual progress date was also entered which enabled the project office to monitor actuals against planned dates. The report shown above was the most commonly used one during the day to day management of the project.

Cost Profiles

The report below shows the results from the Performance Baseline Management process. The project was managed using EVPM techniques and the planned budget and actual cost profiles are shown as S-Curves.