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Communication of Strategy as Prerequisite to Strategy Implementation

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Abstract
Information on strategy must be disseminated for staff to understand their role in the strategy implementation. This exploratory study looks at the level of strategy information dissemination of a market leader in the highly competitive health sector in Nairobi, Kenya. Strategy is non-uniformly disseminated with a significant difference between perception and actual strategy knowledge

Keywords: Strategy communication, strategy implementation, perception of strategy

1. Introduction

In general, strategy implementation literature quotes an abysmal implementation rate, even when the strategy formulation is good. However, most of the information is from opinion pieces and very little empirical evidence. Whatever the case, the general feeling is that implementation rate of well formulated strategy is between 10 and 30% (Raps, 2005). Failure to implement strategy is as a result of both poor strategy formulation as well as poor execution.

Strategic response of a firm depends on the environment and internal structure of the firm. This environment-structure-strategic response can be classified in to specific archetypes (Miller & Friesen, 1978). According to market based approach, strategy is about taking advantage of the market and the changing environment to exploit resources within the control of the organisation and according to the resource based approach, strategy is about acquiring new resources and competencies to exploit existing or anticipated markets.

On the contrary, a business based approach to strategy management takes both the market-based approach of strategy (by exploiting specific market properties and segments) as well as the resource based approach of marching resources and key competencies to the existing markets to deliver on strategy. This approach recognises specific ways of developing and implementing strategies that factors in the combined approach of market based view and resource based view. The process recognises the role of leadership in determining the implementation process based on resources, culture and market condition (Acur & Bititci, 2004). It recognises that leaders are the drivers of strategy, either unilaterally or in a shared manner, and in doing so, that it is at the leader's discretion to communicate the strategy (Waldersee & Griffiths, 2004).

Whichever way one looks at it, strategy is about the future and therefore about change. At the beginning of change, employee uncertainty is at its highest. Employee seek constant convincing reasons and affirmation for the change (Kim, et al., 2011). Antecedent to change supportive behaviour is organisational commitment and social relationships at work. The perception by the employee on how much the organisation cares for their welfare is important in intrinsic staff motivation. It results in reciprocal and discretionary effort by the employee (Chong, et al., 2011). One cannot build social relationship at work without communicating the intentions.

Change has two sides – what is being changed and the people undertaking the change. What is being changed is influenced by the content of the strategy and the process of implementing the change. Both the content and process are influenced by the context of the strategy – the operating environment. This can be relatively static or highly dynamic. Of late, the context has been highly volatile. Strategy control is composed of strategy implementation process control and strategy content control. Strategy implementation is based on certain assumptions on the environment and competition. These assumptions may change. Content control is about tracking these assumptions for both validity and change. Content control is thus influenced by the dichotomy of assumption and knowledge which in turn is influenced by the rate of environmental change. To reduce the risk, firms use rapid results initiative (which is similar in spirit to pilot testing or concept testing) or phased sequence implementation. On the other hand, firms may use lobbying or scenario mapping to track and respond to environmental changes (Muralidharan, 2004). On the other hand, the people undertaking the change are either the leadership or the led. Permeation of vision (or lack of it), lack of strong teams and lack of committed leadership are responsible for failure of change process. These elements founded on strong leadership to rally all to a common purpose as well to develop the necessary structure and release the required

resources are the corner stone of quality change process (Hansson & Klefsjö, 2003).

In aligning business to strategy, the employee alignment is critical. This applies both to senior as well as to junior employees. Employee alignment is founded on trust which starts with empowering employees with knowledge. Employees' knowledge build-up is in turn founded on communication (Chong, et al., 2011). It is important to reduce strategic misalignment in order to achieve strategic congruence in strategy implementation. Staff strategic commitment is facilitated when workers are informed about the strategy. It behoves leadership to improve staff strategic knowledge with strategic information by communicating to staff orally and in writing. Special attention should be paid to long established staff as they tend to be more resistant to change (Gagnon, et al., 2008). Staff who have been won over, not only have less resistance to change but are also more motivated. Employees doing more than what is minimally required (discretionary effort) may confer a competitive advantage (Boswell, et al., 2006).

Unique and inimitable skills on their own do not confer competitive advantage. There is distinct and clear role that motivation, specifically intrinsic motivation, play in converting the unique skills in to a competitive advantage.

Intrinsic motivation can be hedonic, where one is motivated by being engaged in enjoyable, self-determined, and competence-enhancing behaviour or normative where one is motivated by engaging in behaviour that is compliant with norms and values.

This motivation (intrinsic and extrinsic) can be influenced by HR practices of reward and recognition, job design and socialisation norms and thus impact the interest alignment. Reward-based systems affects extrinsic motivation, task based systems affect hedonic intrinsic motivation, and identity-based systems affect normative intrinsic motivation. Socialisation norms are limited to the extent of the organisation's values.

Empowerment is bi-directional. The individual empowering has to do so actively whereas the individual being empowered must have the perception of being empowered. Intended outcome of empowerment is to further the goals of the organisation. However, empowerment also has an effect on the individual. Empowered individual has less role ambiguity and reduced conflict. Empowered individuals are more motivated, report higher satisfaction rates and are more loyal (Bryman, et al., 2005)

The degree of interest alignment has a direct bearing on economic rent. Interest alignment can be increased through manipulation of the influencing factors to achieved sustainable competitive advantage (Gottschalg & Zollo, 2007).

However, there is a distinct possibility that workers may focus on low priority goals or put their discretionary effort on the wrong things. It is important, therefore, for workers to know the strategies and goals to the same depth as the people who set them. This affects both junior as well as senior staff. Indeed it is perhaps even more important for non-executive workers to understand the strategy (Boswell, et al., 2006).

Strategic demands are evolving. Managers' capabilities to meet the demand should also be evolving in tandem (Kerr & Jackofsky, 1989). Institutional alignment with managers has usually relied in recruitment as a measure of ensuring fit. Managers' alignment to strategy through management development has not been used much. Development of a manager is through communication and information sharing. Whereas both experience and demographic similarity contribute to informal structure information sharing, only experience similarity contributed to formal structure information sharing (Preston & Karahanna, 2009).

Communication, sometimes referred to as interaction has been empirically found to be one of the fundamental success factors linked to successful strategy deployment. Severally, communication has been incorporated under culture or methodology. For example, it is often overlooked that change management and communication is a central part of the balanced scorecard approach (Kaplan & Norton, 2001).

As workers become more mobile between one organisation and another, commitment of workers is that to policies (and therefore values) that to the organisation itself. Employee commitment and alignment to an organisations policies is influenced by attitude, role clarity and role conflict. Commitment to policy in turn affects motivation and discretionary effort of employees (Foote, et al., 2005).

The behavioural consequence that an employee experiences in the past and present significantly informs the willingness to take risk and thus their creative effort in the future. Further this also influences the employee response in a similar situation in the future (Dewett, 2004).

Employees are directly and usually immediately affected by every decision by the board. The law acknowledges employees in the principle-agency perspective. It gives full recognition to the shareholders and other regulatory stakeholders. Employees are only protected by law in terms of safety, fairness and equity but not in terms of decision making. Employees do not appoint directors and do not formulate policies. Employees are not represented in the annual general meeting or board meetings. All these is the preserve of the shareholders. It is argued that this is because of the risk undertaken by the shareholders. Whereas many

shareholders are able to diversify and minimise their risk through portfolio management, employees cannot do the same. Because of this, employee shoulder the highest risk (Lewis, et al., 2004). Employees must be more involved in decision making rather than simply in execution. Shared knowledge and shared information are antecedent in effective strategy implementation. Whereas formal structure to develop interaction contributed to exchange of information, social systems of knowing (informal interaction) is not contributory (Preston & Karahanna, 2009). Thus communication about strategy implementation has to be structured and formal process. Increase in commitment to the strategy should be through the participation of the strategy making process (Kerr & Jackofsky, 1989). Poor communication of strategy to lower levels was only second to a reward and recognition system that is not aligned to strategy implementation as reasons why strategy implementation fails. Indeed of the reasons for failed strategy implementation, almost all were indirectly linked to poor communication of the strategy (Čater & Pučko, 2010).

2. Methodology

This exploratory case study is conducted in Nairobi, Kenya at a 280 bed private, not for profit, university teaching hospital that offers secondary and tertiary clinical care. The hospital is the market leader in the highly competitive industry by market share and is second in the market by revenue generation. The hospital was conveniently selected. The study, conducted as an audit and was administered through a questionnaire that captured basic demographic information as well as the study questions utilising both closed and open ended format.

2.1 Sample Design

The main objective of the sample design was to capture the views and experiences of the respondents (employees). The survey design adopted for the study was quota sampling where the population was first segmented into mutually exclusive sub-groups. Thereafter purposive sampling techniques was used to select the respondents. The survey administration targeted presentation from all divisions. The targeted sample was 324 at 5% margin of error. A 63% response rate was achieved.

2.2 Survey Instrument

The Strategy Survey questionnaire constituted of four main sections namely; [A] Personal Information section (demographics), [B] awareness and ability to state the strategy, [C] levels of understanding and [D] Open ended section. Section A, B and C were closed ended utilizing nominal (dichotomous); yes/no options followed by a 5-point Likert scale where 1 is strongly disagree and 5 is strongly agree. The last section [D] utilized open-ended items to explore respondents' opinions more thoroughly.

2.3 Data analysis

The analyses were based on data received from all respondents that participated in the survey. The software used for analysis was SPSS v.22.0. The data was statistically treated, using both descriptive and inferential statistics. The data was initially serialized, coded (for the open ended sections) and entered using Microsoft Excel® which was then exported into SPSS program for analysis.

Descriptive statistics mainly focused on 'mean'; with the scores converted to indicate average percentage (i.e. mean score recorded relative to the optimal score) as such, the higher the average percentage, the greater the degree of satisfaction. Within the descriptive framework, the data has been further analysed on the basis of employees' characteristics. Inferential analysis used non – parametric Chi- squares test of independence.

3. RESULTS

3.1 Sample profile

Sample profile is as provided in table one, providing a summary of the sample composition by various categories. The proportion of females who participated in the survey was slightly higher by 1% as compared to males.

Table 1: Sample profile

Gender	
Male	49.5%
Female	50.5%
Contract terms	
Permanent	73%
Contract	27%
Age (years)	
18 - 24	7%
25- 34	54%
35 - 44	28%
45 - 54	8%
55+ (and over)	3%

Years of Service	
Less than 1yr	17%
1 - 2 yrs	23%
3 - 5 yrs	27%
6 - 10 yrs	16%
11-20yrs	10%
Over 20 yrs	7%
Level of staff (Applicable to Hospital Staff)	162
Line Staff	77%
Manager	12%
Section Head	10%
Chiefs (Nursing, Medical staff, Operations, Finance)	1%
Level of staff (Applicable to Faculty)	18
Resident	50%
Senior Instructor	28%
Instructor	6%
Assistant Prof	6%
Associate Prof	6%
Professor	6%

Table 2: Sample Profile

Division	
Nursing	37%
ICT	13%
Facilities Management	7%
Pathology	6%
Medical Services	6%
Diagnostic Imaging	5%
Medical College	4%
Finance	4%
Human Resource	4%
Pharmacy	3%
Rehabilitation Services	3%
Radiation Oncology	3%
Not Indicated	2%
Dental	1%
MMD	1%
Internal Audit	1%

3.2 Analysis

The analyses section of this report present responses to the questions, indicating how frequently the different responses were offered. It is observant that some interpretive commentary has also been included in order to clarify or add meaningful context to the reported responses. This approach to reporting the findings is designed to provide the reader the essence of the findings in a handy and comprehensible format.

3.3 Level of Awareness

The study sought to find out the level of awareness and the ability to state and/or write the Hospital mission, vision, strategic plan, core values and the annual departmental objectives. The highest proportion of 93% was indicated regarding awareness towards Hospital mission followed closely by the awareness about the hospital vision with a proportion of 92%. Core values followed as indicated by 82% of the respondents. The least awareness was to the hospital strategic plan at 39%. On the other hand ability to state or write down the above was quite low depicted by low proportions

ranging from a low of 21% (with regard to Strategic plan) to a high of 55% (with respect to the ability to write down the hospital vision).

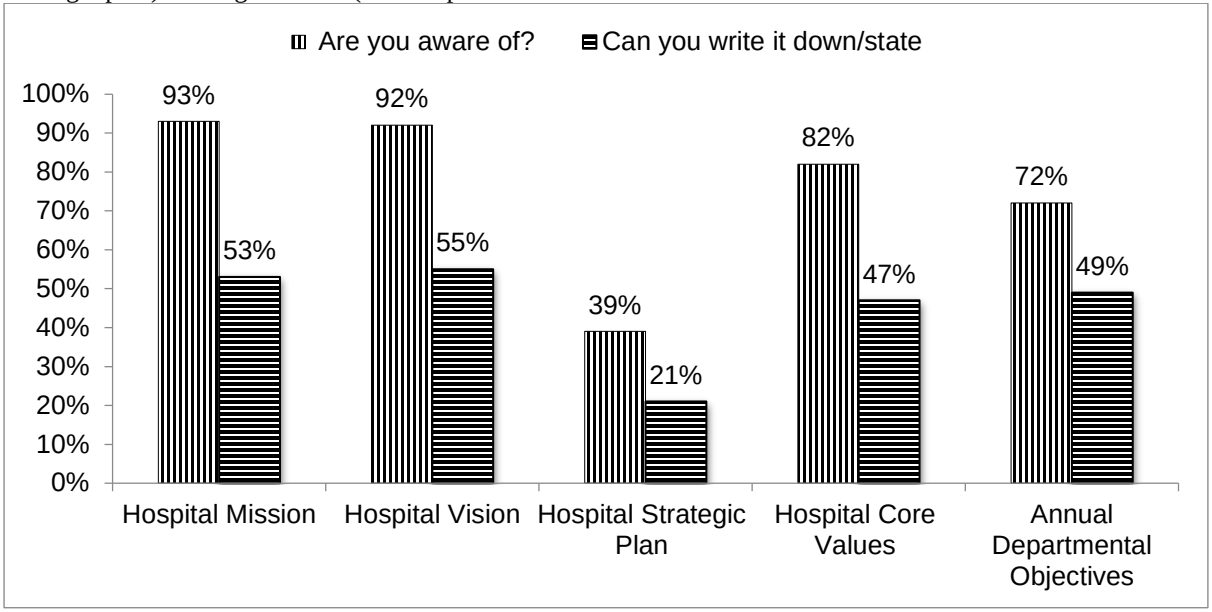

Figure 1: Staff Awareness

In addition a chi –square test of independence was carried out to assess relationship between the awareness and ability to write or state each component.

Table 3: Summary of Chi-square test of independence results

	Pearson Chi-Square	df	Asymp. Sig. (2-sided)	Phi
Hospital Mission; Awareness * Ability to write/state	18.053	1	0.000	0.298
Hospital Vision: Awareness * Ability to write/state	17.828	1	0.000	0.296
Hospital Strategic Plan : Awareness * Ability to write/state	76.768	1	0.000	0.615
Hospital Core Values : Awareness * Ability to write/state	38.493	1	0.000	0.435
Annual Departmental Objectives : Awareness * Ability to write/state	69.736	1	0.000	0.586

*Findings indicate that each component assessed was significant at $\alpha = 0.05$.

Hospital mission; level of awareness vs ability to state/write indicate a p=0.000 <0.05, hence significant and we conclude that there is an association between the level of awareness and ability to write the hospital mission. A further analysis indicate a moderately weak association (Phi=0.298).

Hospital vision; level of awareness vs ability to state/write indicate a p=0.000 <0.05, hence significant and we conclude that there is an association between the level of awareness and ability to write the hospital vision. A further analysis indicate a moderately weak association (Phi=0.296).

Hospital strategic plan; level of awareness vs ability to state/write indicate a p=0.000 <0.05, hence significant and we conclude that there is an association between the level of awareness and ability to write the hospital strategic plan. A further analysis indicate a moderately strong association (Phi=0.615).

Hospital core values; level of awareness vs ability to state/write indicate a p=0.000 <0.05, hence significant and we conclude that there is an association between the level of awareness and ability to write the hospital Core values. A further analysis indicates a moderate association 0.435 between the two variables.

Hospital Annual Departmental Objectives; level of awareness vs ability to state/write indicate a p=0.000 <0.05, hence significant and we conclude that there is an association between the level of awareness and ability to write the hospital Annual Departmental Objectives. A further analysis indicates a moderate association 0.586 between the two variables.

3.4 Level of Understanding

Six items were utilized to assess the level of understanding of the same components by asking

the respondents to indicate their extent of agreement on the 5 point Likert scale. Table 4 and 5 presents the results. The scores were average rating per each item. Looking at the overall scores, the rating ranges from a low of 3.48 to a high of 4.52 out of the optimal 5 points. The highest level of rating is in regards to understanding the hospital vision, followed by the mission and the core values recording 4.52, 4.49 and 4.38 respectively. On the other hand the lowest scores were recorded in respect to understanding how staff's work contribute to the achievement of hospital strategy, leaders' communication of hospital strategy, knowledge of the hospital's strategy, and senior leaders clear communication on vision and strategy attaining 4.22, 3.87, 3.52 and 3.48 respectively.

Table 4: Average ratings on the level of agreement by gender and staff employment status

	Total	**Gender**		**Staff**	
		Male	**Female**	**Permanent**	**Contract**
I understand hospital vision	4.52	4.54	4.48	4.58	4.27
I understand hospital mission	4.49	4.53	4.45	4.54	4.26
I understand hospital core values	4.38	4.36	4.39	4.45	4.07
I understand how my work contributes to the achievement of hospital strategy	4.22	4.18	4.25	4.36	3.78
Leaders communicate progress in achieving hospital goals	3.87	3.81	3.9	3.96	3.54
I know hospital Strategy	3.52	3.63	3.39	3.67	3.11
Senior leaders have communicated a clear vision and strategy on how this vision will be achieved	3.48	3.61	3.33	3.5	3.39
Overall rating (mean)	**4.07**	**4.09**	**4.03**	**4.15**	**3.77**

Disaggregating the results by gender indicates a higher level of understanding by males (4.09) as compared to females (4.03). Permanent staff's level of understanding (4.15) was higher as compared to the staff on contract (3.77). Looking at the tenure, the staffs who have worked for more than 20 years (4.55) understand more as compared to the other age groups least being those who had worked for a period of between six and 10 years (3.80). Allied staff depict a higher understanding (4.29) as compared to the other categories).

Table 5: Average ratings on the level of agreement by year if service and staff category

	Years of service at the Hospital						**Staff category**		
	< 1	1 - 2	3 - 5	6 – 10	11-20	> 20	Clinical	Allied	Support
I understand hospital vision	4.55	4.46	4.64	4.38	4.56	4.82	4.44	4.63	4.49
I understand hospital mission	4.59	4.33	4.63	4.31	4.67	4.82	4.39	4.63	4.45
I understand hospital core values	4.41	4.27	4.52	4.25	4.44	4.9	4.36	4.56	4.32
I understand how my work contributes to the achievement of hospital strategy	4.33	4.08	4.39	3.96	4	4.73	3.97	4.37	4.32
Leaders communicate progress in achieving hospital goals	4	3.89	3.95	3.62	3.63	4.27	3.63	3.98	3.94
I know hospital Strategy	3.53	3.73	3.69	3.14	3	4.44	3.2	4.06	3.37
Senior leaders have communicated a clear vision and strategy on how this vision will be achieved	3.56	3.76	3.73	2.92	3.18	3.9	3.17	3.83	3.44
Overall rating (mean)	**4.14**	**4.07**	**4.22**	**3.80**	**3.93**	**4.55**	**3.88**	**4.29**	**4.05**

3.5 Staff suggestions/comments

Respondents were asked to identify the areas of excellence and the areas of improvement within the strategy in an open ended mode. Figure 1 present the results (responses ≧ 5%). The highest percentage of mentions was "the provision of health care services at 20%", followed by enhanced communication through staff forums.

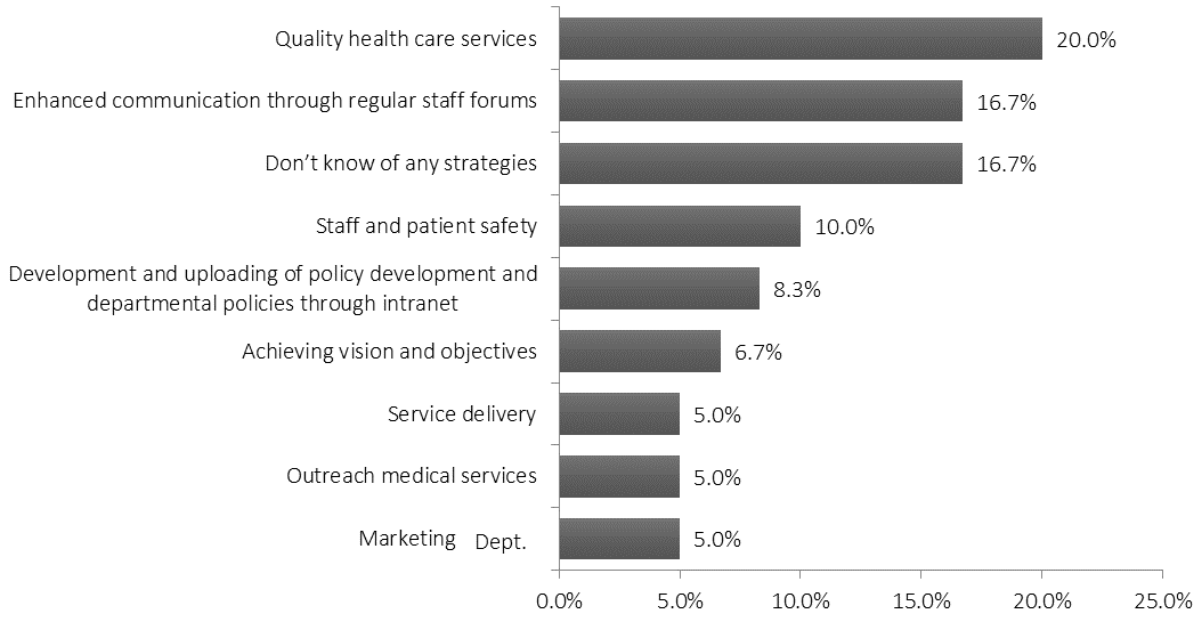

Figure 2: Areas of excellence in communication of strategy

In addition, respondents were requested to state the areas of improvement in an open ended mode. The responses (≥ 5% have been presented in figure 2). The comment with the highest number of responses was in regard to involvement of staff during the strategy formulation (34%) followed by rigorous conduction of staff awareness through forums, seminars and training.

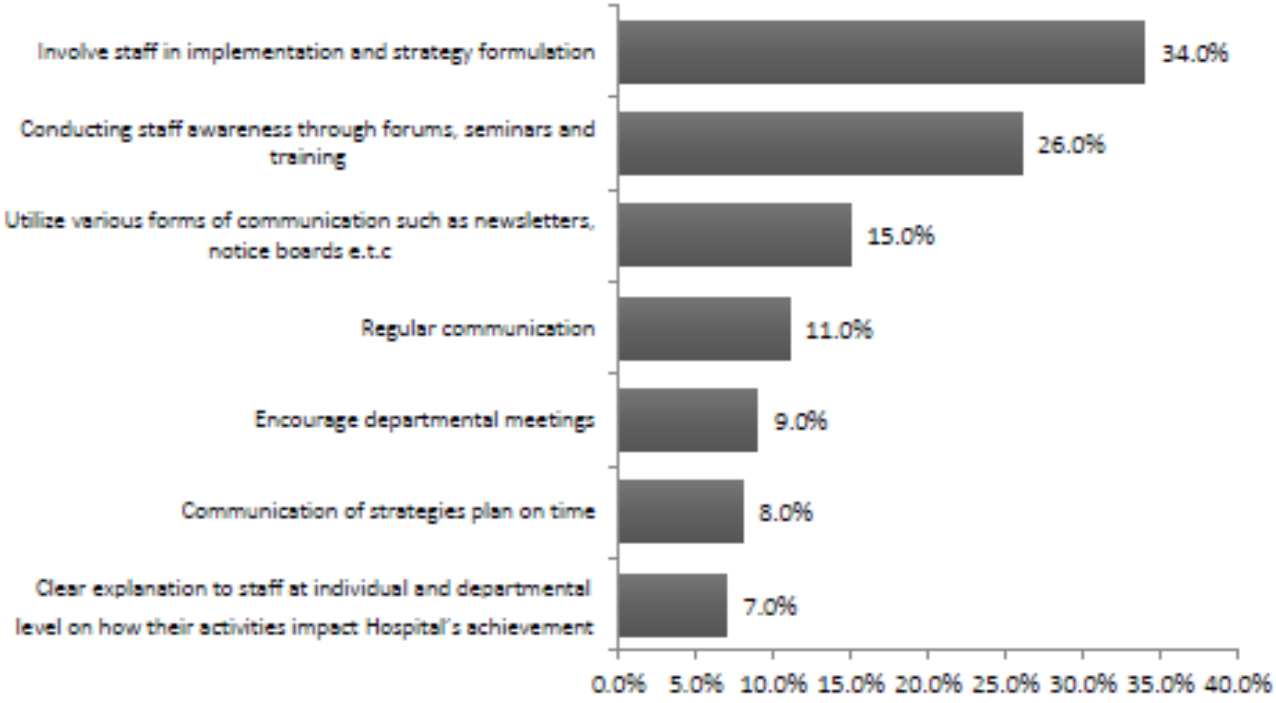

Figure 3: Areas of improvement regarding communication of strategy

4. Discussion

Whereas the overall awareness of mission and vision is high, the knowledge of institutional strategy was very low. Indeed even awareness of the cascaded departmental surgery is low. This implies implementation of the strategy is very difficult where staff are not aware of what that strategy is. It has been argued that staff awareness is not always a pre-requisite of strategy implementation. This is more so when the nature of the strategic change is of a technical-structural type. In such a case a unilateral approach to change is then more effective. Unilateral approach to change is more top-down, instructive and directive.

The premise is that behaviour and attitude will follow practice. On the other hand, when change is behavioural-social, then a more shared approach to change is then more effective. Shared approach to change is more participatory, consultative, and consensual, The premise in this case is that change in attitude is a pre-requisite to sustainable change in behaviour. (Waldersee & Griffiths, 2004). Changes, especially those related to strategy implementation are rarely singular. This argument that change management is situational though convincing does not address the situation where the nature of change is mixed. Indeed, part of the strategic change in the hospital involved both structural changes as well as behavioural change. The leadership in the Hospital did not set out to deliberately implement strategy through the unilateral process. On the contrary, the intention of the hospital was that of a shared process of change. One would therefore have expected a more consultative approach and that more staff would have aware of the strategy. Even unilateral process implementation of change does not preclude the staff awareness of the strategy. Indeed the unilateral and shared approach of change implementation may illustrate polar ends of a continuum of change process. A significant proportion of the hospital staff are not aware of the either the hospital strategy or of the departmental strategy. In spite of this, the hospital is a market leader in a highly competitive market. There could be various reasons for this, including historical success lingering on to the present. However, it is also possible that there exists a mixture of strategic implementation approach where in some, there is a shared approach and while in others there is a unilateral approach.

It is clear that the communication is important in the strategy implementation process. But communication is not necessary a formal passing of information between a recipient and a receiver. Strategy alignment could be done through the deliberate and defined performance measurement. Individual's goals are aligned to the strategy of the organisation. Goals are discussed and agreed upon by the individual employee and their immediate senior. Consensus is reached. In this way communication has taken place (Raisanen & Bjornstrom, 2007). In this way it is possible that staff have been inculcated in a participatory manner in to strategy without them being fully aware that this has happened. Whereas, this is possible, evaluation of the hospital performance management system was out of the scope of this study.

The number of staff who assumed that they knew the mission, vision, strategy and values drastically dropped when they were asked to write these down. This is illustrative in that communication means different things to different people as well as the difference between perception of knowledge and actual knowledge of the strategy.

It is also possible that there is a critical threshold of number of staff who need to be aware of a strategy for it to be successfully implemented and that this threshold was met in this hospital, hence the success.

The number of staff who were aware of the departmental strategy were larger than those who were aware of the hospital strategy. It is also possible that departmental strategy that is cascaded from the institutional strategy has a higher impact on strategy implementation

Lastly, even though the study was conducted on a market leader, it is possible that the performance of the hospital is still below its maximum potential and that perhaps if the strategic information was more widely disseminated, then the hospital would have done even better.

5. Conclusion

This exploratory case report illustrated interesting patterns of strategy information dissemination in the hospital. It also pointed out a discrepancy between perception and actual knowledge of strategy. In spite of incomplete dissemination of information, the organisation was still a market leader.

6. Limitations of Study and future areas of research

The methodological limitation of the study was with regard to non-response to the study and non-response to some questions. The former affected the achieved sample which was 63% of the targeted. The latter was with regard to non-responses to particular questions; to mitigate this limitation, the non-responses were excluded from the analysis.

The study assumed that strategy information dissemination leads to strategy implementation. There is opportunity to undertake empirical research in this area as the literature is mainly of observations and opinion pieces

The study assumed that the hospital being a market leader was attributed to strategy implementation. Success of a firm may be due to multiple reasons of which strategy implementation may be only one of them.

Future research may have to take a wider approach to determine the multiple factors and their individual and collective contribution towards the success of a firm. Additional areas of future research is whether a critical threshold of staff who the strategy exists for strategy implementation to be successfully.

A study in identifying existence of a continuum of strategy implementation process between unilateral and shared process would be of value rather than to

assume that the two processes are mutually exclusive

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