Is HRD a driver for employee engagement?
A critical literature review and qualitative study in the UK health sector.

Author…. Claire Valentin
The University of Edinburgh

Keywords: Employee Engagement; NHS: Qualitative study
Introduction
This study critically explores the contribution of HRD to employee engagement (EE), based on a review of literature and a small qualitative investigation within a health service organization. The paper makes a contribution to the literature on EE and HRD through a review of literature which summarises key debates on EE and HRD, and also draws on literature from other domains, including human resource management (HRM), management and organization studies, and psychological literature on ‘work engagement’. The paper reports on an empirical study carried out with staff in a UK health service organization. The qualitative study sought staff perceptions of EE, and explored whether learning and development could contribute to EE. The paper provides theoretical insights and empirical evidence to explore the implications for HRD theory and practice.

The theme for this study arose out of an expressed organizational interest in finding out more about EE in the organization (‘NHS Med’), in response to results of a staff attitude survey.

The study was based around the following research questions:
1. Is the concept of employee engagement used in a Health Service context? If so, what are the meanings and purposes of the concept of employee engagement in a health service context?
2. What are the drivers for and barriers to employee engagement in NHS Med?
3. Do formal and informal learning processes have a role in contributing to employee engagement?
4. If so, how can organizations develop support for formal and informal learning process to contribute to employee engagement?

The study found that the construct of EE was relevant to the health service context, but needed to be contextualised. A range of drivers and barriers to EE were identified. Staff broadly agreed that opportunities for learning and development could enhance engagement, but that these could not be seen in isolation from other drivers and barriers to EE. A range of factors to support learning could be relevant to EE. Another notable finding was that of the
locus of engagement, which seemed stronger at the team and work group level than at the level of the overall organisation. Overall EE was identified as complex and contextual.

**Employee engagement and HRD in the health sector**

Definitions of EE encompass emotional, cognitive and physical aspects of experience and behaviour. EE is broadly conceived as a combination of - commitment to the organization and its values, a willingness to help out colleagues, motivation, job satisfaction and discretionary effort by employees, (a willingness to ‘go the extra mile’ for the employer) (CIPD, 2008; Gatenby et al., 2009). Examining the construct from an HRD perspective, Shuck and Wollard (2010) define EE as ‘an individual employee’s cognitive, emotional, and behavioural state directed towards desired organizational outcomes’ (2010: 103). EE is more than factors such as job satisfaction or motivation alone (CIPD, 2008). Engaged employees are committed to organizational goals and values, whilst at the same time achieving personal satisfaction and feeling ‘psychologically connected’ to their work (Bakker et al., 2011a: 4–5). EE has been conceived as a conceptual framework incorporating engagement as a personal trait, the state of engagement, and engagement as behaviour (Macey and Schneider, 2008).

The related term ‘work engagement’ (WE) incorporates three dimensions of the experience: Vigour - high levels of energy and mental resilience; Dedication- a strong involvement in one’s work coupled with a sense of significance and pride; and Absorption - the experience of full concentration and being engrossed in work (Fairlie, 2011: 509). Workers should feel positive about their work, and experience it as something that is ‘stimulating and energetic and something to which they really want to devote time and effort (the vigour component)’ (Bakker et al., 2011a: 5). They feel dedicated to their work as something significant and meaningful, and engrossed and fully absorbed when engaged in work (Bakker et al., 2011a).

‘Job resources’ such as social support from colleagues and supervisors, have been positively associated with WE (Bakker and Demerouti, 2008). Positive emotions experienced by engaged workers transfer engagement to others in the work team, creating a positive team climate, and increased performance amongst team members (Bakker and Demerouti, 2008; Bakker et al., 2006).
In recent years there has been an increasing amount of interest in EE and HRD. Recent HRD studies have looked at antecedents to EE (Wollard & Shuck, 2011), EE from the employee perspective, (Shuck, Rocco, & Albornoz, 2011), EE and Leadership, (Shuck & Herd, 2012), and how to link theory and scholarship to current practice (Shuck & Reio Jr., 2011), to note a few examples.

HRD practices such as training and employee development are argued to be major drivers of engagement. This encompasses both formal training opportunities, and development interventions such as secondments and coaching, as well as personal development plans (PDP), induction programmes, and career development opportunities (Robinson et al., 2007; Seijts and Crim, 2006). Features commonly associated with a strategic approach to HRD are associated with EE, such as integration of HRD initiatives with organizational strategic aims and with HR practices (vertical and horizontal alignment) (Brewster, Higgs, Holley, & McBain, 2007; Garavan, 2007; Robinson, Hooker, & Hayday, 2007; Seijts & Crim, 2006). Support from both line managers and senior management are argued to be important drivers for EE (e.g., Alimo-Metcalf, Alban-Metcalfe, Bradley, Mariathasan, & Samele, 2008).

‘Relevant engagement practices range from supporting individual personal and professional development; support for staff to gain professional qualifications; skills development; management development programmes; induction programmes; work shadowing, job rotation and secondments; professional development portfolios and career planning; supporting communities of practice; formal training and on-the-job learning (Valentin, 2013).

Within a health service context there has been increasing interest in EE. In the UK this takes place within the context of the process of ‘modernization’ in the public sector, which has seen a drive for improved performance, and a focus on the management of organizational culture. Support for learning and workforce development and continuing professional development (CPD) is a key factor in many recent initiatives in the health sector, promoted by government, and professional bodies (Murphy, Cross, & McGuire, 2006; Sheaff & Pilgrim; 2006). The modern health care context is characterized by an environment of change and uncertainty, giving rise to a need for flexibility and innovation (Davies and Nutley, 2000). Sambrook notes an environment of ‘rapid, discontinuous change, accompanied by new internal structures, such as strategic business units and service level agreements’ (2001: 172). ‘Modernization’ has seen a drive for improved performance, and the focus has been on the
management of organizational culture and improving learning, and close external monitoring. Policy developments emphasize short-term financial targets and contracts, which have resulted in corresponding changed psychological contracts with staff (Davies and Nutley, 2000). These policy developments have resulted in increased bureaucratic complexity, creating systems of upward accountability, and weakening of professional authority, resulting in contradictory organizational effects; the NHS is now both more bureaucratized and more marketised, ‘it is neither fish nor fowl’ (Sheaff and Pilgrim, 2006: 9).

There are a range of studies around engagement, and the related concepts of commitment and the psychological contract in the NHS. In the UK, the Institute for Employment Studies (IES) published a first report on EE in 2004, entitled ‘Drivers of Employee Engagement’ based on research in over 40 companies in the private and public sectors (Robinson, Perryman & Hayday, 2004). They then tested the findings in the UK NHS. Alimo-Metcalfe et al (2008) studied health service managers, and argue that attitudes to work, particularly job satisfaction, are good predictors of organizational performance, measured in terms of productivity and profitability. Boaden et al (2008) conducted a study for the UK Department of Health, on ‘Improving health through human resource management’, which looked at how HRM can influence performance in NHS organizations, focusing particularly on issues of ‘engagement and alignment’. In this study, issues associated with ‘training’ and ‘career development’ were encompassed within a model of strategic HRM.

A recent report by CIPD and PPMA (2012) on Leading culture change-employee engagement and public service transformation argues that employers need to build a new psychological contract with staff. This should be underpinned by ‘greater flexibility for individuals, skills and employability development opportunities, as well as good-quality people management and leadership to compensate for lower levels or reward and job security’. They argue that ‘employee voice is key to service transformation’.

Despite its widespread popularity in practice, the construct of EE is contested; subject to competing interpretations, and definitions overlapping with constructs such as commitment, motivation, empowerment and organizational citizenship behaviour (OCB). There is an over-emphasis on the positive aspects of EE for both organizations and individuals. In practice, engagement takes on the identity of a ‘folk’ term, with imprecise definitions (Macey and Schneider, 2008). Practitioner models of engagement (Zigarmi et al., 2009) tend to be under-
researched and anecdotal (Shuck, 2011). EE can refer to both role performance and an affective state, and also a disposition or trait (Macey and Schneider, 2008). The different aspects of EE, for example cognitive engagement, emotional engagement and behavioural engagement, are sometimes identified as separate and sometimes merged (Shuck and Wollard, 2010).

Methodology

‘NHS Med’ is an umbrella organization covering several local authority areas in the UK, which includes a range of health service provisions, including several hospitals, general practice (GP) and community medical services.

A qualitative approach was taken to the study, which incorporated semi-structured interviews with health service learning and development (L&D) and HR professionals; focus groups with NHS Med staff; and document references. 52 staff participants took part in 10 focus groups. These were nurses and allied health professionals such as physiotherapists, radiographers and occupational therapists. Participants worked in a variety of clinical settings within NHS Med, in different institutions, and in the community. Three of the focus groups were held with administrative staff including medical secretaries.

The study took a social constructionist perspective to understanding organizational behaviour, which focuses on subjective consciousness, on the way people make sense of the world, especially through sharing experiences with others via the medium of language (Easterby-Smith, Thorpe, & Jackson, 2008). A specific focus in this research was on listening to voices of staff. The interview and focus group is a shared experience of creating meaning, or providing insight into multiple realities of the social world.

All focus group and most interviews were recorded on a voice recorder, and transcribed. A small number of the interviews were recorded by the interviewer taking notes. Transcript data was subjected to a thematic analysis, with use of computer aided qualitative data analysis software (CAQDAS), using Dedoose, an online mixed methods data analysis system. Study of the transcripts and recordings generated a range of codes, which were applied to the transcripts by defining text excerpts to each code. This built upon the themes that had been determined out of the research questions, and developed from the review of literature. Thus codes emerged partly from studying the data, and partly from pre-determined focus around
the research questions. Analysis started with a close inspection of the data, to generate a conceptual description (Rapley, 2011). The researcher listened to the recordings whilst reading the transcripts, to seek a fuller exploration of the data. Participants’ words were explored and explanations sought for underlying or broader concepts and themes. Key themes emerged in three broad areas: views on employee engagement, the organization as a place to work, and learning and development. A coding frame was developed based on these three themes. These were ordered as root codes and ‘child codes’, which allow more detailed coding within an overall code area. These were used as a way of thematic ordering of data, not so much sub-codes in a hierarchical sense, but a way of categorizing the different aspects of a theme. Two similar coding frames were constructed, one for data from the focus groups and one from the interviews. Table 1 show the coding frame and indicates the number of text excerpts recorded overall.
<table>
<thead>
<tr>
<th>Root Code title</th>
<th>Child Code title (if applicable)</th>
<th>Code Descriptor</th>
<th>Reason for code</th>
<th>No. of excerpts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Engagement comments</td>
<td></td>
<td>General comments on EE</td>
<td>Participants asked to comment on concept of EE.</td>
<td>84</td>
</tr>
<tr>
<td>Familiar with the term EE</td>
<td></td>
<td>Are participants familiar with the term EE, and other terms they use. Measurements of EE.</td>
<td>To find out what people knew about the concept of EE and identifying similarities and differences.</td>
<td>21</td>
</tr>
<tr>
<td>Barriers to EE</td>
<td></td>
<td>Comments on what gets in the way of EE</td>
<td>Understanding the barriers and drivers to EE were a goal of the research</td>
<td>55</td>
</tr>
<tr>
<td>Drivers of Engagement</td>
<td></td>
<td>Comments on things that facilitate EE</td>
<td></td>
<td>49</td>
</tr>
<tr>
<td>Locus of Engagement</td>
<td>General comments</td>
<td>What people say about the locus of engagement</td>
<td>An emergent theme from the focus group discussions, also appears in the literature</td>
<td>11</td>
</tr>
<tr>
<td>Engaged with co-workers/team</td>
<td>Locus of engagement is with co-workers or the team</td>
<td>This was mentioned a lot in the discussions</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Engaged with the organization</td>
<td>Locus of engagement is NHS Med</td>
<td>EE literature suggests that EE is with the organization goals.</td>
<td></td>
<td>23</td>
</tr>
<tr>
<td>Engaged with the patients</td>
<td>Locus of engagement is patient care</td>
<td>An emergent theme</td>
<td></td>
<td>28</td>
</tr>
<tr>
<td>NHS Med</td>
<td>Views on NHS Med</td>
<td>Views on NHS Med, as the employing organization.</td>
<td></td>
<td>67</td>
</tr>
<tr>
<td>The NHS</td>
<td>Comments on the NHS, history etc.</td>
<td>Views were expressed on the wider context of the NHS</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>The current climate</td>
<td>Cuts etc</td>
<td>Also includes the policy framework</td>
<td>An emergent theme</td>
<td>85</td>
</tr>
<tr>
<td>Targets.</td>
<td>Working to targets, often set by Government, e.g. waiting times. An emergent theme.</td>
<td></td>
<td>45</td>
<td></td>
</tr>
<tr>
<td>Workload, pressure</td>
<td>Comments on workload and pressure</td>
<td>An emergent theme</td>
<td></td>
<td>52</td>
</tr>
<tr>
<td>Organizational change</td>
<td>Comments on organizational change</td>
<td>An emergent theme</td>
<td></td>
<td>11</td>
</tr>
<tr>
<td>Change management</td>
<td>Comments on how change is managed</td>
<td>An emergent theme</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>Comments on management</td>
<td>Comments on management and managers</td>
<td>An emergent theme, also features in the literature of EE</td>
<td></td>
<td>64</td>
</tr>
<tr>
<td>Not being listened to</td>
<td></td>
<td>An emergent themes</td>
<td></td>
<td>18</td>
</tr>
<tr>
<td>Criticisms of management</td>
<td>Comments critical of management and managers</td>
<td>An emergent theme</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Bullying</td>
<td></td>
<td>An emergent theme</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Teams</td>
<td>Comments on teams, multidisciplinary working etc</td>
<td>An emergent theme</td>
<td></td>
<td>14</td>
</tr>
<tr>
<td>Learning and Development</td>
<td>General comments on learning and development</td>
<td>Obtaining views on L&amp;D was one goal of the research</td>
<td></td>
<td>152</td>
</tr>
<tr>
<td>Mandatory training</td>
<td>Comments on mandatory training</td>
<td>An emergent theme</td>
<td></td>
<td>53</td>
</tr>
<tr>
<td>Informal learning, sharing</td>
<td>Comments on informal learning, sharing, creativity</td>
<td>An emergent theme</td>
<td></td>
<td>36</td>
</tr>
<tr>
<td>Management development</td>
<td>Comments on management development</td>
<td>An emergent theme</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>IIP</td>
<td>Comments on Investors in People</td>
<td>An emergent theme</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Resources</td>
<td>Comments on resourcing L&amp;D e.g., finances, absence cover</td>
<td>An emergent theme</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>SHRD, managing L&amp;D</td>
<td>Comments on managing L&amp;D and SHRD</td>
<td>An emergent theme</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Skills</td>
<td>Comments on skills, what use the organizations makes of skills, skills training.</td>
<td>An emergent theme</td>
<td></td>
<td>37</td>
</tr>
</tbody>
</table>

Table 1. Data analysis coding frame
Findings and discussion

The findings report that the term ‘EE’ was not generally used by focus group respondents, but staff recognised the component aspects, and could see its relevance for the health sector. Engagement was seen to be multidimensional and complex, and may differ for different groups of staff. From the perspectives of the field research, the concept of EE actually provided a useful shorthand, which staff readily adopted as the starting point for critique. So although the term may not be entirely appropriate, and have connotations with staff governance, the meanings within it were deemed very pertinent.

In terms of drivers for engagement, comments of staff in focus groups seemed to concur with the research into EE. Engagement was seen as a two-way relationship between employer and employee (Robinson, Perryman, & Hayday, 2004). Staff agreed that factors which could contribute to engagement included such HRD-relevant aspects as open, two-way communication; engaging leadership styles; career development and training; coaching and mentoring (4-Consulting, 2007; Macleod and Clarke, 2009). The supportive role of work colleagues seemed to be a major driver of engagement (Bakker, Albrecht & Leiter, 2011). Staff also recognised the role of supportive managers, so the idea of ‘engaging managers’ seems to be borne out (Alimo-Metcalfe et al., 2008). Interviewees also recognised the importance of line managers in creating a climate for engagement. Organisational contextual factors such as the behaviour of managers impacted upon engagement.

Staff generally felt enthusiastic about opportunities to engage in training, and sharing knowledge and experience. Being encouraged to learn new skills, line management support for development, opportunities for training, assessment of training needs, and time to engage in training all were seen as positive in respect of EE, as were less formal development opportunities, such as secondments, coaching, multidisciplinary working and special projects (Robinson et al., 2007).

Whilst there is evidence that HRD can contribute to EE, there are a number of barriers cited, which touched on the psychological contract, job satisfaction, and stress. Specific concerns over HRD included: issues around time and resources; relevance of training; dislike of online delivery; opportunities for professional development; lack of support from managers; lack of
IS HRD A DRIVER FOR ENGAGEMENT?

recognition or reward for undertaking training; and lack of opportunities to practice skills in
the workplace.

The team or work group can be viewed as being a prime ‘locus of engagement’ or target of
commitment (Meyer et al., 2004), through processes of ‘social identification’ (Latham, 2007),
and as a source of organizational support (Bishop et al., 2000). This suggests that the team
can serve as a ‘driver’ of engagement. A group can also be considered a community of
practice, in which construct meaning when they interact with one another in working life, and
with technologies and tasks, and learning emerges from social interactions (Molbjerg
knowledge and creating intersubjective understanding within a ‘community of meaning’. The
findings suggests a role for the team as a locus of engagement, as well a locus for learning.
Social learning theory suggests that people construct meaning when they interact with one
another in working life, and with technologies and tasks, and learning emerges from social
interactions. Knowledge is public not private, ‘in the sense that people use publicly accessible
symbolic tools (myths, concepts, stories, narratives, rituals, traditions, procedures) for
communicating, collaborating and interacting with others ‘ (Molbjerg Jorgensen, 2011: 110).
The process by which a problem comes to be framed is also a process of creating
intersubjective understanding in a community ‘in which members come to share a set of
practices, knowledge about those practices, about one another, and about how to address new
situation….interpretation, then, rests on a community of meaning’ (Hatch and Yanow 2003:
68). Tacit knowledge is shared among members of an interpretive community.

Engaged employees are said to feel commitment to organizational values and to be motivated
to contribute to the success of the organization. Whilst staff expressed a certain distance from
the wider organization, they also had a very clear sense of their role and goals as
professionals, which would seem to be largely in accordance with espoused organizational
values and objectives. From their own perspectives, which were all that could be assessed in
this study, they described being mostly engaged in their day-to-day work, in varying degrees.
It was not possible to assess their work performance from this research. However, staff
expressed strong professional values about patient care and caring about their work, and
feeling supported by colleagues. Even for those who express aspects of disengagement, such
as a lack of willingness to work extra hours, there seems to continue to be engagement with
the actual work. In some respects they seem engaged despite the organization.
From a definition of WE, Bakker et al. (2011: 4–5) write about employees who invest themselves fully in their job roles, ‘who are proactive and committed to high performance standards’. This is what the organization desires from staff, in the context of meeting targets for quality of care. Meaningful work is a contributor to engagement (Fairlie, 2011) and most of the work that staff are engaged in the sense that their work appears to have meaning for them.

There was some evidence of staff disengagement. As defined by Kahn (1990: 694) personal disengagement is ‘the uncoupling of selves from work roles; in disengagement they will withdraw and defend themselves physically, cognitively, or emotionally during role performances’. Some staff said that they were reluctant to stay on and work extra hours, but there is no way of assessing from this study if their work quality is affected. But this seems at the very least a ‘precursor to disengagement’, if it is correct, as claimed by Attridge (2009), that employees who are disengaged can have a disproportionate impact on others in their team, which can serve to undermine more engaged co-workers. Robinson et al. (2007) comment on the cost of disengagement to the economy – but what is its impact on patient care?

It is appropriate at this point to refer to the research questions.

1. Is the concept of employee engagement used in a Health Service context? If so, what are the meanings and purposes of the concept of employee engagement in a health service context?

It appears from the review of literature that the concept of EE is being increasingly used in the health service concept. However there remain considerable areas of debate over EE as a construct, and the related but necessarily interchangeable construct of WE. Whilst the adoption of EE ideas in a practice context is widespread, caution is needed in its adoption. Engagement, if we assume that it does exist as a separate construct to motivation or commitment, or a combination of these and other constructs, is not something that can be simply switched on by management interventions. It is individual, contextual, and multifaceted. Organizations can do some things to provide opportunities for engagement to occur, but they cannot really control it.
In terms of practice and approaches there does not appear to be substantial difference between the application of EE in different sectors. Practices such as supportive management, training and development, communication, feedback and a general environment of fairness would seem to be appropriate aims for most organizations. However this suggests more of a focus on ‘full engagement’, which focuses equally on the interests of staff as individuals as well as on the requirements of the organization (Robertson and Cooper, 2010). This is in itself a challenging perspective. The idea of locus of engagement also seems significant, in that employees may identify more with their team or work group than the larger organization.

2. What are the drivers for and barriers to employee engagement in NHS Med?

This research highlighted a range of possible drivers and barriers to EE in NHS Med. Due to the nature of this inquiry, the results from the fieldwork must be treated with caution. They should rather be regarded as points to consider further, or discussion starters. The organization needs to ‘practice engagement’ as well as just ‘speak engagement’. For example, if the organization thinks it is important for managers to act as ‘engaging managers’, then it needs to consider further how to support and also reward appropriate management behaviours. It is also necessary to consider how far the organization can expect staff to increase engagement in times of financial stringency. Organizations need to pay attention to the psychological contract.

3. Do formal and informal learning processes have a role in contributing to employee engagement?

The findings in the literature review suggest that opportunities for formal and informal learning are integral to EE. This was also borne out in the fieldwork. Staff generally felt enthusiastic about opportunities to engage in training, and sharing knowledge and experience. They suggested that appropriate opportunities for training and development, and less formal learning, did support their engagement. This suggests that both formal L&D activities, ranging from training courses to supporting PDPs, and less formal opportunities, such as support for communities of practice, do contribute to the factors that are implied under the umbrella term EE. However it was not a blanket acceptance of all training. Much of the mandatory training, for example, was accepted with reluctance, but could not really be considered to contribute to EE.
4. If so, how can organizations develop support for formal and informal learning processes to contribute to employee engagement?

The review of literature suggested a range of learning and development interventions that organizations can make to support EE. These were generally also suggested or agreed with in the fieldwork. Training and development practices, and management and leadership development are significant. The perspective of strategic HRD seems to in fact encompass much of what is suggested under L&D contribution to EE.

In term of L&D, both the wider NHS and NHS Med support a wide range of initiatives and practices for learning and development. As for most organizations in time of pressure, training and development is often viewed as a cost and subject to cutbacks.

Conclusion
Bowles et al., (2012) note that complex organizations such as those in the health care sector have many sub-cultures, depending on a range of factors such as geography, sector, values, mission (Bowles et al., 2012). In the NHS there may be different cultures in relation to the varied healthcare professionals who have their own ethical standards and codes with which they need to comply. As Bolman and Deal (2008) note, organizations are complex, surprising, deceptive, and ambiguous, have multiple and sometimes competing goals, and ‘are open systems dealing with a changing, challenging, and erratic environment. (Bolman and Deal, 2008: 3).

HRD may appear to be a contributor to EE through support for formal and informal learning processes. However, staff experience is contextual and individual, and EE is a complex construct and not something that can simply be ‘switched on’. More consideration needs to be given to the multidimensional aspects of EE. The challenges faced by staff may not be fully explained within an EE construct, and organisation internal and external contexts need to be considered.

References


