



DProf thesis

The learning experience on an undergraduate blended learning healthcare management programme: an examination of knowledge and skills transfer to practice
Sanyang, S.

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Title page

The Learning Experience on an Undergraduate Blended Learning Healthcare Management Programme: An Examination of Knowledge and Skills Transfer to Practice

This project is submitted in partial fulfilment of a Doctorate in Professional Studies Health at Middlesex University.

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Glossary of Terms and Abbreviations

Academics: A collective term used in the study to refer to associate lecturers, lecturers, module leaders, senior lecturers, or programme or portfolio managers.

Antifragility: Define systems, people, organisations, or processes that not only resist shocks, volatility, or pressures but also benefit from them, growing more potent, more resilient, or more adapted as a result.

APEL (Accreditation of Prior Experiential Learning): a procedure by which individuals can acquire academic credit or recognition for learning outside typical educational environments - e.g., work experience.

Blended learning: A hybrid learning approach delivered in study centres/campuses that use structured virtual resources and weekly lessons or face-to-face seminars.

Case study design: A qualitative research approach for conducting in-depth examinations of a specific individual, group, organisation, or event in its real-world environment.

Chartered Management Institute (CMI): Professional body for managers and executives in the UK and worldwide. It offers programme accreditation, professional recognition and support to managers and leaders.

Communities of learners/learning: small learning communities where learners actively collaborate to share and acquire knowledge and capabilities and develop specialised graduate attributes for practice.

Communities of practice: People (informally) with a shared experience and passion for collaborating continuously to learn and share knowledge and skills that enhance their practice.

Employer focus group discussions (EFGD): Group interviews comprising students and graduates engaged in pilot or pre-testing the employer interview questions.

Employability: The preparedness for job opportunities, specifically after graduation.

Epistemology: Refers to the theory of knowledge and the relationship between the knower (i.e., the agent or researcher) and what is known (e.g., the context of their study or area of interest).

Evidence-based: Practices that are defined by a dedication to employing scientific proof, reasoning, and data to manage challenging issues and hurdles across various areas of practice/work.

Evidence-informed: Like evidence-based, it recognises that choices may need to be reached when there has yet to be a substantial amount of proof available or where evidence by itself may not adequately address the complex nature of the issue.

Explicit knowledge: Knowledge commonly available in textbooks, manuals, databases, and other structured libraries may be easily transmitted using words, symbols, numbers, or other expressive forms.

Focus group discussion (FGD): Group interviews comprising students and graduates engaged in a discussion led by interview questions and a moderator.

GDPR: Stands for General Data Protection Regulation

Graduate attributes: Refers to the information, abilities, skills, and personal characteristics that students are supposed to acquire during their studies and upon graduation.

HE: Higher education (sector) – Includes undergraduate and graduate degree programmes, professional certificates, and other types of advanced education.

HEIs: Higher education institutions – Universities, colleges, and specialised vocational schools are examples of HEIs. These institutions offer postsecondary education and award academic degrees. ‘HEI’ primarily refers to the institution in which the study was conducted.

HSc: Health and social care

Implementation science: An interdisciplinary field of inquiry that seeks to determine and improve how evidence-based interventions, programmes, guidelines, or practices are embraced, implemented, and maintained in real-world contexts.

Insider researcher: Someone who performs research for a group, organisation, or community to whom they belong or share a close relationship.

Knowledge: The understanding, insight, and exposure gained via experience, learning, observation, or study.

Knowledge economy: An economic system in which knowledge creation, dissemination, and application are crucial economic growth and progress drivers.

Knowledge translation: Transforming research results, knowledge, or evidence into real-world uses or regulations that benefit people, communities, institutions, or society.

Knowledge transfer and utilisation (KTU): Individuals engage in KTU by purposefully learning and adjusting their situatedness (i.e., knowledge, reasoning, or behaviour) to apply current knowledge, skills, and expertise in novel situations and environments.

Legitimate peripheral participation: Newcomers are gradually integrated into a community of practice by participating in peripheral activities that, over time, become more sophisticated and central.

Mode 1 & Mode 2: The framework proposes two distinct perspectives or techniques for generating knowledge (i.e., Mode 1, which is traditional and discipline-based and Mode 2, which is transdisciplinary, collaborative and context-driven).

Naturalistic generalisation: Associated with the transferability of a study's findings to similar situations, this is attained through thick description, which provides rich, thorough accounts of the research background, participants, and procedures.

Negative transfer: A scenario in which previously learnt knowledge, skills, or behaviours impede or impair the acquiring or performance of new knowledge, skills, or behaviours.

Neutral and transfer difficult to determine: Investigated the possibility of knowledge and skill transfer from the blended learning healthcare management classroom to practice and any existing curriculum mechanisms that may assist, impede, or impact transfer.

NVivo: A data analysis software for assisting researchers in organising, coding, analysing, and visualising qualitative data.

Pilot/pre-test: Formal practice runs to examine and (potentially) change the data-gathering plan, ensuring it closely fits the intended data-collection approach.

Positive transfer: This implies that participants (employers, academics, students, and

graduates) observed, perceived, or experienced knowledge and skill transfer from the programme to the workplace

Practice learning: This type of learning emphasises active participation, repetition, and application of knowledge or skills to achieve competence and mastery.

Proxy data collector: A person who gathers data on behalf of another party (e.g., on behalf of a principal investigator).

QAA subject benchmark: The framework provides rules for curriculum design, assessment, and programme evaluation procedures in the UK higher education sector. It also promotes consistency and standardisation across different fields of study.

QAA: The Quality Assurance Agency for Higher Education is a nonprofit organisation in the United Kingdom charged with maintaining standards and promoting the quality of higher education.

Qualitative research: A methodological approach used to examine and comprehend events in detail by studying subjective experiences, interpretations, and perspectives.

REC: Research ethics committee - a committee in charge of examining and approving research studies involving human beings to ensure that ethical criteria are met.

Reflexivity: Refers to the process by which researchers become conscious of and critically reflect on their preconceptions, biases, and viewpoints within the study process.

Rigour: Refers to the comprehensiveness, precision, and dependability of a study's methodologies, processes, and findings.

RPL: (Recognition of Prior Learning) - a process by which individuals can obtain academic credit or acknowledgement for the knowledge, skills, and competencies they have gained via earlier educational experiences such as job experience, volunteering, informal learning, or self-directed study.

Semi-structured interviews: A qualitative study methodology that combines preset questions with room for open-ended discussion with research participants.

Skills: Particular abilities, proficiencies, and strengths people build through study,

practice, and experience.

Social constructionism: The theory holds that individuals and organisations build and preserve their concept of reality via language, symbols, norms, and social activities.

Social constructivism: A philosophy that emphasises the significance of social interaction and cultural context in forming individuals' understanding and knowledge.

Social mobility: People or groups' ability to progress upward or downward in a society's social order over time.

Tacit knowledge: Refers to knowledge that is difficult to express, write down, or communicate to others by formalised or explicit means.

The Antecedents of Knowledge and Skills transfer: The framework (developed in the study) integrates findings from the data gathered with theoretical literature. It includes human variables within the programme and external organisational and social factors affecting transfer dynamics.

WHO: World Health Organization

Zero transfer: Refers to a scenario in which knowledge or skills obtained in one environment do not add to or affect performance in another.

Abstract

Background: Knowledge and skill transfer from higher education settings to the workplace is essential in supporting employment-ready graduates and the knowledge economy. The yearning for employability has significantly intensified post-COVID-19 as the UK government and universities examine further partnerships with employers to plug the skills gaps in the healthcare sector.

Aim: This study evaluated the knowledge and skills 'transfer direction' of a non-practicum-linked undergraduate blended learning programme to the healthcare management workplace.

Methodology/Methods: The qualitative study used a UK higher education institution (HEI) as a case study. Between December 2021 and June 2022, 28 purposively selected participants were recruited in the study. Focus group discussions (FGDs) and semi-structured interviews were conducted with the programme's students and graduates, employers, and academics.

Findings: Results revealed that the programme takes advantage of strengths such as curriculum design, communities of practice, and integrated and scaffolded content and resources in modules to emphasise and promote knowledge contextualisation and skill development for application to practice. The transfer outcome of knowledge and skills from the blended learning classroom suggested either a "positive transfer" or "neutral and transfer difficult to determine". Five of the 28 participants identified the need for practicums and a mechanism to follow-up and monitor graduate and student practice as a significant impediment to comprehensively determining whether knowledge and skills transfer from the programme is explicit, transparent, or even observable.

Conclusion: The paucity of studies on knowledge and skills transfer from blended learning healthcare management programmes to practice uniquely positioned this study to advance our understanding of knowledge and skill transfer from the classroom to the healthcare industry. Similar undergraduate curricula would benefit from formally incorporating practicums to enhance theory-to-practice application, student achievement and employability.

Keywords: *Blended learning, knowledge and skills transfer, evidence-based, communities of practice, non-practicum-linked, healthcare management practice.*

Chapter 1: Introduction

1.0 Introduction

Knowledge is a fascinating concept, yet how it is understood and perceived to be transferred and translated is up for debate (Chappell, 2021). This chapter provides the study background, context, scope, and motivation for undertaking this insider study. My interest in knowledge and skill transfer stems from my professional experience as a registered nurse, my work in social care management, and teaching health and social care (HSc) and healthcare management students in both work-integrated and non-work-integrated programmes. Despite pedagogical variations, both programmes emphasised the use of an instructional style that encourages students to demonstrate their contribution to health and care management practice through experiential learning.

My goal was to guide students through theoretical and practical experiences, allowing them to understand the relationship between the two better. Students enrolled on the work-integrate programme also completed 200 hours of work experience, leading to a portfolio of reflective statements, 'competency affirming' documentation, and feedback. Reflecting on the disparities between the two courses (programmes) piqued my interest in investigating the non-practicum-related undergraduate healthcare management programme's potential for knowledge and skill transfer to practice. Both curricula require individuals to demonstrate personal knowledge (Eraut, 2004) in a learning setting supported by a community (e.g., of practice) (Lave and Wenger, 1991). Eraut (2004) refers to personal knowledge as an intellectual resource demonstrated through prior experiential awareness, professional (healthcare) competence, and skills. Given my experience supporting a work-integrated programme and my interest in promoting professional development in higher education, a better understanding of knowledge and skill transfer, as well as how this could be supported across the undergraduate portfolio I currently oversee as deputy head of school, is imperative.

Nokes (2009) observes that transfer, or how knowledge obtained out of a particular endeavour or setting could be used in another, has typically been examined by authors like Barnett and Ceci (2002), Bransford and Schwartz (1999) and Perkins and Salomon (1992). Even so, most studies on knowledge and skill transfer from

healthcare-related training to the workplace focus on programmes and training that embed formal practicums (e.g., Greenhalgh and Russell, 2006; Slipicevic and Masic, 2012) or are situated in clinical practice (e.g., Dowson, 2019; Sousa et al., 2020). This study is uniquely placed to explore knowledge and skills transfer from a blended learning undergraduate programme (without a practicum) to the healthcare management workplace.

1.2 Purpose of Study

As an insider involved with managing a school within which the BA (Hons) Blended Learning Healthcare Management Programme sits, my experience is that the programme is designed with healthcare management knowledge and skills transfer in mind (Crawford et al., 2016). Also, with eight out of ten students in the HEI either in health and social care-related employment or with relevant work experience in similar fields when they embark on their studies with the university (Published HEI data, n.d.), the school is distinctively placed to implement the type of practice learning advocated by Nicolini (2012). This concerns having them practice applying theoretical concepts in the blended learning classroom while drawing on their professional experience (experiential learning) to make sense of it (ibid.). However, a systematic approach, such as insider research, is required to ascertain this. In this vein, the study aimed to assess if the programme of study facilitates the transfer of knowledge and skills to the workplace, as well as how explicit and transparent the transfer process is within the programme. Data was gathered through student and graduate focus group discussions and semi-structured interviews with academic staff and employers.

The BA (Hons) Healthcare Management Programme was initially designed for a distance learning audience. However, the curriculum was modified to implement the blended learning version in October 2016. The programme's origin inspired the current blended learning curriculum delivery strategy across the UK and Berlin study centres. In the past, the programme had positioned itself as a primary recruiter of students from widening participation backgrounds, who are more likely to be older and mature learners with moderate to significant work and life experience. Until now, this had worked well for the school and HEI, but as it continues to diversify its student

recruitment strategy (to attract a more diverse student base, such as younger students with limited or no healthcare work experience), it must consider how this will likely influence the programme’s expected practice orientation, especially the practicum absence’s impact on knowledge and skills transfer to practice. The figure below summarises student enrolment numbers in the blended learning programme as of November 2021, when the study data-gathering phase began. This number would have tripled as of September 2023, when this thesis was submitted.

| CourseExternalName | StudyMode | Completed | Enrolled | Total |
|--|--------------|------------|------------|-------------|
| BA (Hons) Healthcare Management | Blended | 435 | 67 | 502 |
| | Total | 435 | 67 | 502 |
| BA (Hons) Healthcare Management (Top-Up) | Blended | 239 | 1 | 240 |
| | Total | 239 | 1 | 240 |
| BA (Hons) Healthcare Management with Foundation Year | Blended | 251 | 52 | 303 |
| | Total | 251 | 52 | 303 |
| Total | | 925 | 120 | 1045 |

Figure 1 Programme Statistics (source: HEI student enrolment data November 2021)

1.3 Programme Situatedness and Delivery

The programme is delivered online through ‘Distance’ (DL) and ‘Blended Learning’ (BL). BL uses hybrid face-to-face synchronous and asynchronous Moodle-based activities, discussion forums and flipped classroom exercises. It employs technology and digital resources to create adaptable student learning circumstances and experiences (Panopto.com, 2019). “*Flexible learning...*” enhances “*...experiential...*” learning opportunities for learners, using an ‘anytime’, ‘anywhere’, ‘anyhow’ “*learning environment*” (Hamilton and Tee, 2013, p. 749). For my project intention, a point to note is that students enrolled in the blended learning programme commit to a 6-week roll-on, roll-off teaching block instead of the conventional semester model of 10–12 weeks (e.g., as with the DL delivery model). BL students only take on one module at a time using the block delivery approach, which consists of 8 hours of weekly face-to-face teaching and asynchronous activities supported by healthcare management lecturers, module leaders and senior lecturers.

This is further enhanced by rich module content produced in iLearn, a Moodle-based platform. Each module has up to ten lessons, activities, quizzes, expanded resources, discussion forums, formative feedback activities, and three distinct and complementary e-library hubs (e.g., enhanced EBSCO and ProQuest). Module core texts are housed in these libraries, supplemented by subject-specific databases, library blogs and linked sources. A mini study skills module and a careers and wellbeing portal – custom-made to scaffold fundamental academic skills and encourage employability and student well-being are also available and used in reinforcing learning.

The decision not to incorporate practicums in the programme was deliberate. Nonetheless, every effort was made to ensure that the supporting structures to supplement the programme delivery plan were scaffolded to keep current, diversified and practice and employability-facing. To illustrate, the use of comprehensive active learning strategies and resources such as case studies, simulated activities, role plays, flipped classrooms, synchronous and asynchronous discussion forum activities and external career support services. The distinctive mix of modules and scaffolded content incorporated into the curriculum has contributed to a learning environment that, in theory, should encourage collaboration in a 'community' (of practice) (Bandali et al., 2011). Also, the availability and application of current knowledge and information relevant to real-life case studies is an excellent technique to increase students' capacity to perform in practice scenarios (Cornelissen et al., 2011).

The HEI uses proactive employer-stakeholder consultation and feedback to inform programme development, validation, and enhancement of students' employability outcomes. This also extends to graduate employability initiatives such as job fairs, industry guest speakers and professional body accreditations. These are all crucial hallmarks for developing healthcare management knowledge and skills for graduate employability. The programme also has specific mechanisms to support graduate skill development, as demonstrated in the six module graduate attributes. The 'graduate attributes' are based on Bowden et al. (2000), with their achievement explicitly demonstrated through module outcomes and individual assessments. For instance:

- a) 'Effective Communication' (e.g., achieved through students communicating effectively, both verbally and in writing, using a range of media widely used in their relevant professional contexts),
- b) 'Lifelong Learning' (e.g., achieved through students managing employability goals, using the skills of personal development and planning in different contexts to contribute to society and the workplace).

(Bowden et al., 2000)

Besides the six attributes by Bowden et al. (2000), other essential graduate attributes covered in the programme include interpersonal skills and relationship management, ethical practice, professionalism, leadership and knowledge of information management and healthcare system(s) (see Chichirez and Purcărea, 2018; Slipicevic and Masic, 2012; Stefl, 2008). My research goal is to investigate if the programme's learning and teaching advance knowledge and skill transfer to the healthcare management workplace and if there is evidence to support this.

1.4 Professional Practice and Work Context

1.4.1 Professional Practice Overview

My path to professional practice began in 2004 when I enrolled in a State Registered General Nursing (RGN) Programme. My motivation for studying nursing was to work in a respectable and humanitarian profession. However, the first hurdle I had to overcome was gaining admission to the highly competitive and only School of Nursing and Midwifery programme in my home country. My career in nursing led me to work in clinical research with the Medical Research Council (MRC) in 2007 and social care management in 2013. In 2014, I had an opportunity to work in a full-time lecturing position in Higher Education.

1.4.2 Healthcare Practice Background

My healthcare work experience goes back over 15 years, from when I completed my initial RGN programme and worked as a staff nurse and unit in charge in a busy

outpatient department of a regional government hospital in The Gambia. The early opportunity in nursing leadership was unexpected. When I became a nurse-in-charge, I had only been in my position for six months. This was due to a severe shortage of RGNs in the healthcare industry. The significant attrition of nurses to the private sector and the 'global north' in pursuit of greener pastures has resulted in acute retention of qualified nurses in the country (i.e., The Gambia). While this is not new, Ayalew et al. (2021) argued that 'internal and external brain drains' still need to be resolved for healthcare services in sub-Saharan Africa to work better. Without proper context, this view may be an oversimplification of the problem. Haddad et al. (2022) insisted that even if the gap these health professionals leave is a concern, other factors are also to blame. To illustrate, poor incentives, a lack of highly qualified nurse educators, nurse burnout, and an inequitable workforce distribution (ibid.). As I examined the literature on the causes of the shortage, I became aware of a severe global shortage of nurses. This is particularly severe in Sub-Saharan Africa and Southeast Asia (WHO, 2022).

Although the reality in the Gambia (and Sub-Saharan Africa) differs from that in the United Kingdom, the pressures on nurses and the profession are comparable. For example, pressures to provide compassionate and person-centred patient care. McSherry et al. (2012) addressed this difficulty by stating that delivering caring, compassionate, and person-centred care is a major concern for the nursing profession in the United Kingdom and is still essential in all aspects of nursing practice.

Whilst working as (a nurse) unit in charge, I was also on secondment with the Medical Research Council as a staff nurse researcher on a double-blinded, double-dummy phase III clinical trial. Such drug trials include both placebo and active treatment approaches, with well-choreographed controls for drug administration to both groups to avoid observer bias (Marušić and Ferenčić, 2013). My experiences in healthcare leadership, clinical research, social care, and coordinating home care services catalysed my higher education (HE) work.

1.4.3 The HEI and Academic Roles

I currently work at a university launched over three decades ago, initially as a specialist distance learning partner of traditional universities (e.g., in South-East England and

Wales). Since its inception, it has constantly evolved and adapted itself to cater to the demands of providing higher education for students across the globe. The university currently has over 25,000 students enrolled in its programmes (in the UK and globally). I work in a faculty of business comprising ten schools. Before this, I served as co-interim head of the School of Business and Management (now the Faculty of Business) for about one year. In this role, I designed (together with my co-interim head) the new faculty's structure and composition. The faculty, created in October 2020, currently has over 17,000 students.

My current role is Deputy Head of the School of Health and Care. In this role, I oversee the undergraduate portfolio, which today includes over 2500 students and more than 50 faculty members. I also facilitate a level 7 Senior Leader's Rosalind Franklin (RF) Apprenticeship Programme for NHS (National Health Service) managers. The award is delivered through a franchising partnership between the HEI's School of Health and Care and the NHS Leadership Academy. The programme, which leads to a senior healthcare leadership qualification, is closely mapped to the NHS Multi-professional Framework for Advanced Practice in England (Health Education England [HEE], 2017) and is for titled managers in the NHS (e.g., doctors, matrons, and commissioning leads). Unlike the Leadership Academy's version, ours runs for just over a year, with apprentices expected to complete an End Point Assessment (EPA) with the Chartered Management Institute to gain an additional level 7 Strategic Management Diploma in Management and Leadership.

1.5 How is the Study Novel?

Most of the studies looking at knowledge and skills transfer from healthcare-related training to the workplace explore this in the context of programmes, curriculum, or training embedding formal work placements (e.g., Abu-Hijleh et al., 2004; Greenhalgh and Russell, 2006; Günay and Kılınç, 2018; Jackson et al., 2019; Robinson and Dearmon, 2013). My study is distinguished from previous research because it analyses and critically examines knowledge and skill transfer in an undergraduate blended learning healthcare management programme that does not formally include practicums. The study's originality stems from its investigation of knowledge and skills

transfer to the healthcare management workplace in an interdisciplinary programme setting that embraces a mix of resources and content from healthcare, social work, leadership, and business management.

Given that most previous studies focused on practice-learning, professionally oriented programmes such as nursing and clinically oriented courses (e.g., medicine), the findings of this study could address a gap in the literature by explaining how knowledge and skills transfer occur from blended learning healthcare management programmes that do not offer placements. When such programmes strike this balance, they will (arguably) increase student attainment and produce employment-ready and digitally savvy graduates for the sector. This is especially essential as the UK recovers from a COVID-19 pandemic and economic downturn (Elliot, 2022), partly caused by the war between Russia and Ukraine (Institute for Government, 2022).

1.6 Chapter Summary

This chapter discusses my professional situatedness, rationale, study purpose and context, and what makes the study novel. Key concepts that shaped the project's goal and knowledge contribution were briefly discussed. Following Chapter 1, the rest of the thesis is divided into chapters, each focusing on a different aspect of the study. To illustrate, the second chapter, Chapter 2, outlines the project terms of reference and critically examines crucial literature guiding the investigation.

Chapter 3 presents and justifies the research approach and data-gathering procedure adopted. Chapter 4 describes and analyses the project-related activities to support the study methodology. Chapter 5 expands on Chapter 4 by presenting and exploring the study's findings from the focus groups and semi-structured interviews. In this chapter, themes and sub-themes generated from the study are explored and categorised into a coherent theme structure using inductive coding.

Chapter 6 discusses the results of the study. The chapter interprets the findings in the context of relevant literature on knowledge and skills transfer. Chapter 7 is the last and responds to the study's research questions. It presents a conclusion drawing together observed themes from the findings and what they mean for the study's aims, research

questions and practice. It also offers recommendations for the HEI and the higher education sector. A reference list and appendices follow Chapter 7.

The next chapter (Chapter 2) presents the research questions, aim, objectives, and terms of reference (ToR) before critically reviewing seminal literature.

Chapter 2: Project Terms of Reference and Literature Review

2.0 Introduction

This chapter sets out the project's boundaries and provides a critical literature review that shapes the study's scope, purpose, and anticipated outcome. Later in the chapter, the theoretical framework that underpins the study is presented and critically analysed. Chapter 2 critically discusses vital concepts and seminal literature around knowledge and skills, knowledge transfer and utilisation (KTU) and associated terminologies.

2.1 Selecting Relevant Literature for the Study

Choosing the seminal literature for the study was both daunting and fascinating. This was due to the extensive literature on knowledge and skill transfer and the various pedagogical perspectives that inform it. There were three stages to the process. The first occurred during my Planning a Practitioner Research module (IPL4016). The literature from this phase influenced my proposal for my programme approval plan in March 2021. The second stage expanded on the literature gathered in 'phase one' to look for more specific literature for the literature review chapter. The third stage, which happened during the discussion of findings, solidified this even further. The following selection criteria determined which literature will inform this chapter: the study topic's relevancy, publication date, alignment with the study, and source reputation. In light of this, the following databases were chosen: Academic Search Complete, Taylor & Francis, British Medical Journal (BMJ), Sage, Elsevier Science Direct Freedom Collection, PubMed, Ebsco Host, Wiley Online, The King's Fund Library, Google Scholar, and Middlesex and my HEI's virtual libraries. All databases and virtual libraries include considerable literature on interdisciplinarity, transdisciplinarity, communities of practice, knowledge and skill transfer, student and graduate instructional pedagogies, and evidence-based and blended learning approaches. The search results were optimised using the following keywords and search parameters:

- Knowledge Or Knowing Or Information Or Wisdom
- Learning experience Or The experience of learning Or Knowledge acquisition
- Knowledge and skills transfer Or Knowledge utilisation Or Transfer of

knowledge and skills Or Knowledge translation

- Experiential learning Or Practice learning Or Tacit learning Or Situated learning
- Explicit learning Or Structured learning Or Formal learning
- Skills Or Employability Or Competency-based learning
- Work-integrated learning Or Practicums Or Placements
- Blended learning Or Hybrid learning Or Flexible learning
- Evidence-based Or Evidence informed Or Research informed
- Communities of practice Or Learning communities Or Communities of learning

While some of these searches were frequently merged to optimise results, conducting a separate search in each database usually provided me with an idea before reading reference lists to point me to other relevant sources. Once the database searches began, papers were saved in various OneDrive folders to serve as references for the chapter write-up. More than 25 folders (encompassing the project's terms of reference and associated concepts) were created to house data from database and virtual library searches.

2.2 Study Aims, Objectives and Research Questions

2.2.1 Aims

The study aimed explicitly to:

- a. Investigate whether a UK HEI's BA (Hons) Blended Learning Healthcare Management Programme facilitates knowledge and skills transfer to healthcare management practice.
- b. Critically analyse whether there is clear evidence of positive and explicit transfer of healthcare management knowledge and skills from the programme to the healthcare workplace.

2.2.2 Objectives

- Analyse how situated the blended learning programme is in supporting knowledge and skills development for use in the healthcare management

workplace.

- Determine whether there is positive and explicit knowledge and skills transfer from the programme to practice and what mechanism facilitates this.
- Evaluate stakeholders' perspectives (i.e., academic staff, students, graduates, and employers) of the programme's strengths, areas for improvement, and their alignment with knowledge and skill transfer goals.
- Suggest enhancements for further integrating knowledge-to-practice and the development of graduate skills within the programme, considering the implications for the HEI and comparable higher education programmes.

2.2.3 Research Questions

The following questions guide the study:

- How supportive is the BA (Hons) Blended Learning Healthcare Management Programme of knowledge and skills transfer to the healthcare management workplace?
- Is there clear evidence of knowledge and skill transfer to the healthcare management workplace and is the process transparent in the programme?

2.3 Project Boundary

This project's scope is limited to investigating how a blended learning healthcare management programme offered by a higher education institution (HEI) in the UK supports the transfer of knowledge and skills to healthcare management practice. The focus lies on foundational ideas like knowledge, employability, skills, evidence-based/evidence-informed, Mode 2 learning, knowledge-to-action, blended learning, knowledge and skills transfer, and knowledge transfer and utilisation.

2.4 Knowledge Episteme and Contextual Concepts

'Knowledge and 'knowing' and how this is best constructed is contested in some philosophical traditions (Demeritt, 2002). Despite this, "*knowing and knowledge*"

have been the subject “...of human inquiry from the ancient times...” (Bolisani and Bratianu, 2018, p.2), and renowned philosophers like Plato and Aristotle have contributed immensely to our understanding of it (Fink, 2012). Even so, Bolisani and Bratianu (2018) presented their perspective on the tenuousness of knowledge and the problems associated with a unified approach to its construction. The authors argued that while expecting a simple answer to what constitutes knowledge may be reasonable, theorists have yet to provide a holistic and universally accepted view (Bolisani and Bratianu, 2018). Plato, however, described knowledge as a logical and instituted belief held by people and existing within the three perceptions of ‘*truth*,’ ‘*belief*,’ and ‘*evidence*’ (Southerland et al., 2001). Contextualising this, Vejar (2021) suggested that truth often mirrors reality, with belief denoting the legitimacy of such truth and evidence exemplified in one's ability to ‘reasonably’ justify such a stance. While close to Plato's view, the Aristotelian epistemology argues that knowledge is theoretical, qualitative or performative. Debatably, this looks at knowledge generation, perception and utilisation mechanisms. Jean Piaget felt that people strive to gain a state of equilibrium with knowledge and knowing the environment and its contextualisation (Yardley et al., 2012). This is to say, we harmonise prior experiential learning and exposure to our environment sequentially to assimilate and accommodate information and new knowledge (see Kolb and Kolb, 2005). Also, the confidence to transfer this to other contexts when required and the conditions are suitable (see Eraut, 2008).

From my observation of the epistemic arguments on knowledge and associated theories, these could be discussed under the two major perspectives of: ‘Rationalism’ and ‘Empiricism’, with a third and less recognised theory, Critical philosophy, introduced much later (Vanzo, 2013). All three perspectives believe that knowledge is a justified true belief one has. The problem, as I see it, is that there is no singularity in how one can find this truth or validate true belief (see Neta and Pritchard, 2020). This notion does not, in my view, negate the position that both the two major perspectives of ‘Rationalism and Empiricism’ have their place in the epistemology of knowledge formulation (Webb, 2018), particularly in healthcare management. Even so, out of the two, the rational school of thought “...has traditionally been held...” in higher regard. This is despite orientalist theorising that

the “*empirical...*” view provides a more persuasive basis for an argument (Jacobs et al., 2016, p.9).

Despite the contested notions of what accounts for knowledge, The Open University (2020) suggested that it is a set of structured information and evidence contextualised to enhance understanding of a phenomenon, process, product, or occurrence. What this definition had yet to consider, however, is the epistemic differentiation between knowledge and belief and personal and organisational knowledge (Steup and Ram, 2020), which are sometimes indistinct factually and typically do not refer to the same things. Hage (2020) corroborated this view before suggesting that there should be a clear differentiation between individual knowledge, organisational knowledge, and macro institutional-level knowledge. The individual level is about one’s ability to conduct certain activities learnt or experienced within a specific context and social reality (Farnese et al., 2019). Illustrations include knowing how to read, managing a team, and cooking a particular meal (Steup and Ram, 2020). Nevertheless, crucial literature (e.g., Bolisani and Bratianu, 2018; Matricano et al., 2019) have noted personal knowledge’s role in contributing to organisational knowledge through the socialisation and social interaction of individuals in the organisation. This appears consistent with Nonaka's (1994) work on tacit and explicit knowledge in organisations.

From an organisational frame of reference, knowledge could be a means to produce tailored goods, services, and innovation (Gherardi, 2006; Gherardi, 2009; Matricano et al., 2019). To illustrate, what differentiates this from the macro institutional level for UK undergraduate healthcare management programmes (and broadly higher education) is that they tend to adopt or create specific graduate attributes woven into programme outcomes. This could be top-down when directly adopted from Quality Assurance Agency (QAA) subject benchmarks (see - QAA, 2022) into the programme concept and design. This could also be bottom-up when student, graduate, academic or employer feedback on sector skills needs primarily informs it. The allusion to standardised benchmarks, as with QAA subject benchmark statements (QAA, 2022), hinted at a drive to encourage the creation of resources and espoused knowledge, skills and attributes for graduate employability for

society's benefit (Hage, 2020).

Hage's description of the purpose of knowledge provides a hierarchical notion, which is reasonable and attractive from a conceptual perspective. Though it could be deemed controversial, the proposition of a hierarchical element does tacitly acknowledge the view that there is a symbiotic (i.e., maybe not so much of a hierarchical) relationship between efficient graduates from higher education, industry (i.e., the healthcare sector) and the (knowledge) economy (see Leydesdorff, 2013). This affirms Santiago et al. (2008), who explained that the post-compulsory tertiary education sectors in the EU were under heightened pressure to contribute to the knowledge base that adds value to member countries' economic growth and competitiveness. This was acknowledged in the European Union's Lisbon Strategy, which came into force in 2010. The UK was part of the EU during this period (ibid.).

Brockmann et al. (2011), unpacking the types of knowledge, argued that while in its substance, knowledge could be expressed in explicit or tacit terms, fundamental distinctions must be made when it comes to what constitutes it – e.g., declarative (theoretical) knowledge and procedural (practical) knowledge. Declarative knowledge focuses on 'factual' information, occurrences and empirical generalisations, which, in my view, has its place in learning in our blended learning classroom space. In comparison, procedural knowledge focuses on practice, routines, skills, and application (ibid.). Jacobs et al. (2016) corroborate the dichotomy of the two as distinct strands of knowledge, defining it as one's ability to 'know that' (i.e., indicative knowledge) against the ability to 'know how' (i.e., practical knowledge). Jacobs and colleagues' reasoning, particularly about the latter, has been affirmed and documented in Greek and Chinese Taoist philosophy (ibid.).

Moving this discourse further, the work of pragmatist philosophers like John Dewey enhanced and shaped our understanding as professionals. For example, Dewey observed a belief in an oppositional effect between 'knowing how' and 'knowing that' – for instance, some things work best when performed under certain conditions and in a certain way. Dewey deduced that 'knowing how' is instinctive and could become second nature to a professional (Dreon, 2019). In contrast, 'knowing that' requires

introspection and appreciation of an observed phenomenon (Jacobs et al., 2016). I will also add that there must be a willingness for the agent (i.e., practitioner) to engage fully with the introspection to derive maximum benefit – through professional growth and individual and organisational learning. The latter exemplifies Hannabuss (2000, p. 402), who observed that "*knowing that...*" we "*...do not know*" is a state of "*conscious incompetence*", which is an important place (i.e., for managers and organisations, as an example) to engage in continuing professional development, individual and organisational learning as well as asking for expert advice.

Back to tacit and explicit knowledge, in deconstructing Dewey's view further (see Jacobs et al., 2016; Dreon, 2019), 'knowing that' and 'knowing how' align closely with Polanyi (1958)'s differentiation of knowledge typologies into implicit and explicit knowledge (also see Nonaka, 1994). According to Polanyi (1958), explicit and tangible knowledge can be described as heuristics, whereas implicit (or inherent) knowledge is best captured and articulated through individuals' experiences and perceptions of their surroundings. Through his work with organisations, Nonaka deepened our understanding of the links between implicit and explicit knowledge. For instance, considering his investigation, Nonaka proposed a total of four types of knowledge transformation: (1) "*from tacit knowledge to tacit knowledge,*" (2) "*from explicit knowledge to explicit knowledge,*" (3) "*from tacit knowledge to explicit knowledge,*" and (4) "*from explicit knowledge to tacit knowledge*" (Nonaka, 1994, p. 18). Nonaka argued that knowledge and (professional) wisdom arise by way of a "*conversion between tacit and explicit knowledge*" (Nonaka, 1994, p.18).

2.5 Knowledge Transfer vs Knowledge Translation and Implementation Science: Similarities and Differences?

Jacobs et al. (2019, p.29) suggested expressions such as "*knowledge*", "*knowledge transfer*", "*knowledge uptake*", "*knowledge management*" and "*knowledge translation*", which began to "*...replace the 1980s buzzwords...*" such as "*information technology*" continue to influence thinking in organisations (including HEIs). To illustrate, in the UK health service, this is noticed with the introduction of a National Knowledge Service under Health Education England, which has now

morphed into the 'Knowledge for the Healthcare 2021-2026' strategy. The ambition of this strategy is that: *"NHS bodies, their staff, learners, patients and the public use the right knowledge and evidence, at the right time, in the right place, enabling high-quality decision-making, learning, research and innovation, to achieve excellent healthcare and health improvement"* (Health Education England, nd, p.6). This is also observed globally with SDG 4, which is mandated to ensure an 'inclusive and equitable quality education and promote lifelong learning opportunities for all' (United Nations, n.d).

In conducting this review, as I distilled the literature, I noticed knowledge transfer and knowledge translation were used synonymously in some of the literature. This led me to use 'Acronym Finder' (Acronymfinder.com, n.d) to see if that provides the required clarity. On 'Acronym finder,' however, I noticed that 'knowledge transfer' and 'knowledge translation' were represented by the same abbreviation – 'KT.' While significant overlaps and parallels exist between the two (Wensing and Grol, 2019), previous research underlines the differences (e.g., Graham et al., 2006; Khalid, 2016). As a result, misunderstandings arise over whether knowledge transfer, knowledge translation, and even a third-implementation science, at a more abstract level, share the same curiosity for knowledge transfer. As a result, their contributions have changed the scholarly community's lexicon for communicating knowledge-to-action (Graham et al., 2006; Straus et al., 2009). Prihodova et al. (2019) also directed us to the plethora of terminology used in the literature to refer to knowledge transfer and exchange-linked activities, which typically span from education or training to organisations and work environments. Nevertheless, Harrison and Graham (2021) added a further tangent by reasoning that the commonality in terminology reflects a desire to discuss, exchange, and share knowledge across settings, albeit through evidence-informed practice. Later in the chapter, I examine seminal literature (e.g., Kumah et al., 2022; McSherry et al., 2002) on the importance of evidence in facilitating knowledge (and skills) transfer to practice.

Still, terms such as knowledge transfer, utilisation, translation and innovation diffusion describe how knowledge is used and applied from its theoretical form to practice (Jacobs et al., 2016). Straus et al. (2009) observed different terminology in how nations

such as the United Kingdom and, more specifically, Europe use vocabularies such as implementation science or research utilisation to represent 'theory knowledge' application in other contexts (e.g., practice). Similarly, knowledge transfer, exchange and uptake, as well as knowledge translation, dissemination and diffusion, are more widely used in Canada, the United States, and other world regions (Straus et al., 2009). These tend to prefer and are interested in knowledge-to-action and evidence-based practices to enhance practice (Field et al., 2014).

Although Straus et al. (2009) advocated using knowledge-to-action (commonly associated with knowledge transfer) interchangeably and 'integratively', the literature revealed that there is a distinction between knowledge translation, knowledge transfer and implementation science (see Khalil, 2016). Despite the overtures in the literature about the distinctions between knowledge transfer, translation and implementation science (Graham et al., 2006), knowledge transfer and knowledge translation often overlap (Wensing and Grol, 2019). To elaborate further, implementation science is considered a subset and one of the domains of knowledge translation (Barwick, 2018). In the words of Wilson and Kislov (2022), implementation science is the systematic and purposeful process of addressing hurdles that prohibit or inhibit the adoption of evidence-based healthcare solutions. It is instrumental in bridging the 'know-do gap' (University of Washington, 2022) in healthcare practice. Therefore, evidence-based and informed practice are significant paradigms relevant to implementation science.

Delving further into what distinguishes knowledge transfer, translation, and implementation science, I have become convinced that at a granular level, both knowledge transfer and knowledge translation focus on the sharing of information, knowledge, or product from person to person (e.g., in the blended learning classroom), within and across organisations (e.g., healthcare institutions), via a recognised medium (Esmail et al., 2020). Implementation science, conversely, is concerned with the systematic elimination or minimisation of barriers to the absorption or transmission of evidence-based information or research (ibid.).

2.6 Defining Knowledge Transfer and Utilisation (KTU): Harmonisation Efforts

After reviewing and engaging with seminal literature on knowledge transfer, I realised that I needed to produce a phraseology that reconciled my appreciation for the (somewhat) blurriness that exists between critical knowledge transfer ideas (e.g., knowledge transfer, knowledge translation, and implementation science) and the confusion observed in the transfer literature and semantics. This understanding was required to lay the groundwork for my research, which included using clear and unifying language such as knowledge transfer and utilisation. In earnest, the intention to use such terminology becomes the foundation for a harmonious and consistent description of my desire to disclose the programme's knowledge and skill transfer direction (Harrison and Graham, 2021).

In line with Jacobs et al. (2016) and Esmail et al. (2020), this study uses 'knowledge transfer and utilisation' and 'knowledge and skills transfer' interchangeably to describe how knowledge and skills from the blended learning healthcare management classroom could be contextualised and consolidated by students and graduates for application to practice. Beyond harmonising the semantics in the literature, my decision to employ 'knowledge transfer and utilisation' was influenced by intuition and experience of the programme's teaching pedagogy. Despite lacking official practicums, the programme encourages practising theoretical knowledge in the healthcare management workplace.

I define 'knowledge transfer and utilisation (KTU)' in this study by drawing on Eraut and Hirsch (2007), Eraut (2008), and Paulin and Suneson (2012). KTU describes individuals intentionally learning and modifying their situatedness to apply existing knowledge, skills, and expertise to new contexts and situations. Based on the level of complexity and alignment with previously acquired skills and knowledge, as well as familiarity with the unique context of the application, the users (e.g., students and graduates) should be able to demonstrate that they can:

- a. Draw out and reflect on theoretically relevant knowledge and information – for example, with *“the context(s) of its acquisition and previous use”* in mind.
- b. Assess their cognitive understanding of the knowledge experienced and the

- situation, including the impact of *“informal social learning”* and community.
- c. Identify the knowledge and skills relevant to the application's context and new situation.
 - d. Determine the resources, tools and capabilities needed to aid the application,
 - e. *“Transform”* the knowledge and skills experienced to help make sense of the new situation.
 - f. Apply it by *“integrating with other knowledge and skills”* to unveil a new autobiographical lens - through which they analyse, inform, perform and communicate in the unique situation.

(Eraut, 2008; Eraut and Hirsch, 2007, p. 37; Paulin and Suneson, 2012)

2.7 Evidence and Knowledge Transfer

Transferring knowledge and skills from the blended learning classroom to healthcare management practice necessitates understanding the importance of 'evidence-based' and 'evidence-informed' approaches. To demonstrate its importance, I reference Plato, who defined 'evidence' as a vital component of one's perception and understanding of knowledge, how it is formed, and how it can be potentially synthesised for use in the workplace (Chappell, 2019; Southerland et al., 2001). However, putting evidence into practice is a challenging and laborious endeavour, and despite ongoing research on effective strategies, most healthcare practitioners continue to experience difficulties with it (Wye and McClenahan, 2000).

Pooler (2014) described 'evidence' as extending beyond the outcomes of established research programmes and is drawn from four essential sources: professional expertise, service users and care providers, and a professional's immediate surroundings. Evidence and 'evidence-based' are primarily rooted in evidence-based medicine (Babiker, 2012). There are many descriptions of evidence-based practice, among the earliest and most widely accepted of which was by Sackett et al. (1996). Nevertheless, a particular critique of Sackett et al.'s (1996) premise of evidence-based medicine is that it was overly focused on synthesising external scientific evidence alongside the healthcare practitioner's competence at the expense of the patient's

values, choices, and voice. Yet, Sackett et al. (1996) provided a valuable description of evidence-based medicine. He defined it as: *"the conscientious, explicit and judicious use of the current best practice in making decisions about the care of individual patients. The practice of" evidence-based "medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research"* (Sackett et al., 1996, p. 71).

There has been a proliferation of the term evidence-based in healthcare practice over the past few decades (Titler, 2008). Yet, McSherry and Warr (2010) emphasised that practitioners must be aware of its core elements to harness it effectively. Kumah et al. (2022, p. 4) crystallised this view by maintaining that healthcare practitioners should understand that *"evidence-based practice"* and *"evidence-informed practice"* are two crucial tangents required for applying evidence-related interventions into healthcare practice. In line with this, Titler (2008) suggested that, as a rule, 'evidence-based' facilitates transfer (e.g., from the learning environment to practice) through the following stages:

- a. *"Knowledge creation and distillation"* – through inquiry and arranging pertinent study results into actionable healthcare delivery *"products."*
- b. *"Diffusion and dissemination"* – through working together with *"professional opinion leaders and healthcare..."* institutions to spread knowledge as the foundation *"for action..."* to prospective beneficiaries.
- c. *"End user adoption, implementation, and institutionalization"* – the terminus of *"the knowledge transfer process"* aimed at convincing organisations, collaborators, and people to embrace and regularly apply *"evidence-based..."* *"...findings and innovation"* in their daily practices.

(Titler 2008, p.1-2)

Introspecting the stages detailed by Titler (2008), there is no indication that the stages were exclusionary of evidence-informed practice, which authors like McSherry (2007) stressed to be crucial to systematically using evidence-related interventions in practice (see Kumah et al., 2022). Nonetheless, I am increasingly convinced that Titler's position was that the transfer of knowledge to practice is supported more closely by

'evidence-based. Indeed, for a long time, healthcare practitioners have used the expression evidence-based, yet more recently, the phrase evidence-informed has been employed alternatively or in addition to it (Woodbury and Kuhnke, 2014). However, this view presents a new problem as it would appear to presuppose that the two are too similar or even the same to differentiate, adding to the confusion for practitioners (also see Cardoso et al., 2017).

Evidence-based practice is distinguished by its recognition and application of appropriate research evidence to practice (Titler, 2008). Unlike evidence-based practice, semantic differences about evidence-informed approaches exist in the literature, making it difficult to obtain a specific and universally accepted definition (Nelson and Campbell, 2017). Even so, 'Evidence Informed Practice' (EIP) *"is not simply a technical activity; it is influenced by personal and professional values and beliefs, and affected by wider political and educational contexts, policies, and changes"* (Nelson and Campbell, 2017, p.128). In the blended learning healthcare classroom, evidence-informed practice reflects the belief that research evidence is just one of many factors influencing decisions about providing a learning environment where students and graduates thrive by applying knowledge and skills to management practice. Thus, assessing students' learning preferences, career aspirations, broader industry developments and policies (ibid.), given the professional knowledge (of faculty), is situated to foster active learning methodologies that highlight theory-to-practice application.

Returning to the distinctions between 'evidence-based' and 'evidence-informed,' my position closely aligns with Kumah et al. (2022), who provided a helpful delineation between the two by postulating that evidence-informed practice is a systems-based strategy that includes the tenets of evidence-based practice as one of its components. Evidence-informed practice has a greater scope than evidence-based practice (Kumah et al., 2022; Rubin and Bellamy, 2022). Yet, beyond my position on the delineation of the two (i.e., evidence-based and evidence-informed), whereas authors like Cardoso et al. (2017) used evidence-based and evidence-informed practice in the same breadth, McSherry and colleagues (2002) and White (2019) suggested that evidence-informed practice is different from evidence-based practice. McSherry et al.

(2002) contended that the transition to evidence-informed care for the practitioner represents an acknowledgement of a shift from incoherent knowledge-based (healthcare) towards one in which healthcare choices are ordered, informed by meticulous monitoring and evaluation of therapies and working methods (McSherry et al., 2002; White, 2019).

Kumah et al. (2022) contended that the scientific community is divided on which of the two (i.e., evidence-based or evidence-informed) principles best facilitates the effective and uniform implementation of healthcare knowledge into practice. To illustrate, Melnyk and Newhouse (2014), McKendry (2015), and Melnyk (2017) inferred that evidence-based practice supports knowledge transfer and better application to healthcare practice. Conversely, McSherry et al. (2002) and Nevo and Slonim-Nevo (2011) hinted that evidence-informed practice makes a stronger case for equipping healthcare professionals with the knowledge and skills for the successful systematic implementation of evidence into practice. To this effect, I am led to deduce that evidence-informed practice allows students and graduates to leverage their access to the blended learning programme resources, online databases, careers portal and experiential learning case studies in the healthcare classroom to collaborate, reflect, and engage in a learning culture that encourages application in the real-world context of practice (also see Rubin and Bellamy, 2022).

It is vital to add that critics have questioned the very concept of evidence-based decision-making, arguing that due to the uncertain nature of evidence and the myriad of factors that might influence its adoption, the closest thing that could be expected was evidence-informed practice (Davies et al., 2008). While advocating for *“substituting the word “informed” for “based” in evidence-based – because of the connotations that practice knowledge and intervention decisions might be enriched by prior research but not limited to it...”* Epstein (2009, p. 224) proposed that we redefine the term *“evidence”* to include insights from mainstream *“post-positivist, interpretive research studies”* as well as *“program-specific practice-based research”* investigations undertaken by practitioners. Epstein (2009, p.224) argued that *“the idiographic insights that”* result from purposeful introspections on practices and the outcomes of the contemplation are compelling in also supporting phronesis (practise wisdom (see

Kinsella, 2010) or tacit knowledge application (see Nonaka, 1994) for practitioners.

Rather than viewing knowledge transfer as solely a scholar-led activity, the focus should, therefore, shift to conceiving it non-linearly in which investigators and users of the evidence (e.g., healthcare practitioners) equally have essential roles to assume, particularly in an environment of collaboration. As a result of this, the value of complex and multidisciplinary strategies would become apparent. The vocabulary would also naturally evolve from the transfer of knowledge (and skills) to more active and engaging terms, like "*knowledge mobilisation*" (Harvey and Kitson, 2015, p. 22), knowledge transfer and utilisation (KTU), among others.

2.8 Higher Education, Knowledge Transfer and Sustainability

Academic literature and the research community disagree on the "*nature of transfer*," the degree to which it occurs and "*the underlying mechanisms*" (Barnett and Ceci, 2002, p. 612). This is similar to contentions over what knowledge is and how it is best produced (Bolisani and Bratianu, 2018). The surfeit of terminology further complicates this about knowledge application and the potential for skills transfer to practice. To illustrate my point, 'knowledge transfer,' 'knowledge translation,' 'Mode 1 and Mode 2,' 'teaching for transfer' and 'transfer of learning' (e.g., Barnett and Ceci, 2002; Galoyan and Betts, 2021; Gibbons et al., 1994; Greenhalgh and Wieringa, 2011; Kubsch et al., 2020; Perkins and Salomon, 1999).

Perkins and Salomon (1999) stressed that knowledge transfer (e.g., from higher education to the healthcare workplace) exists within the broad theoretical domains of forward-reaching and backward-reaching. Examining the seminal concepts of Forward-reaching and Backward-reaching transfer, Fuchs et al. (2002) posit that Forward-reaching transfer occurs when students can (e.g., prospectively) think about explicit situations where the concepts learnt might be applicable during the initial learning exercise. However, Eraut (2008) argued that despite a significant segment of professional and vocational education developed with future (prospective) use in mind, there is evidence to suggest that there is a level of disappointment that this is only sometimes used to good effect by students (and graduates). For instance,

looking at it from an employability mindset, Purcell et al. (2017) noted how higher education graduates' increasing lack of certain professional graduate skills and competencies has resulted in low employer confidence.

Fuchs and colleagues (2002) also proposed that Backward-reaching transfer is observed when a person exposed to a new situation or problem reflects (back) on their autobiography and experience for connections and abstractions to help them make sense of the task at hand. Eraut (2008) maintained that success, in this case, would depend on how familiar the person is with similar contexts and their awareness and proactiveness to confront other challenges, such as the time commitment and the precise memory trail required to troll through previous knowledge to apply to the current situation. Alluding to the tests inherent to transfer, Eraut (2008) suggested that the challenge with the forward-reaching and backward-reaching approaches to knowledge transfer is that: "*when transfer is from*" "*programmes in Higher or Further Education...*," a problem arising is that a vast and somewhat irreconcilable gap could ensue "*...between the forward transfer discourse of higher education and the backward transfer approach expected in the workplace...*" It is important to note that "*...formal education tends to assume that simple recognition of what it teaches is all that is needed*" (Eraut, 2008, p. 14), but the question remains: Is this the case?

In partially responding to this provocative question and providing further context, Perkins and Salomon (1999) contested the notion of students seamlessly transferring knowledge from one context to another. This aligns with other literature (e.g., Dougherty, 2013; Hempenstall, 2019) but at odds with (Argote and Ingram, 2000), whose findings suggested that knowledge transfer is supported where it is within the organisation but less so across organisations. Nevertheless, Argote and Ingram (2000) looked at transfer from an organisational paradigm. Barnett and Ceci (2002) also noted the likelihood of transfer occurring when the same or similar performance change outcomes are used (Zelinski, 2009). For instance, we expect the knowledge our students engage with in the blended learning classroom to be applied across practice settings, which, by all indications, appears less straightforward than initially thought. It is essential to highlight that sustainable, effective knowledge flows

between individuals and within organisations tend to help deepen understanding and enhance skill development for personal and organisational success (Cabrera and Cabrera, 2005).

Luo and Lee (2015) provided a helpful distilling of the broad challenges with the success of transfers by urging that this may depend on whether the knowledge is explicit or tacit. The SECI model by Nonaka (1994) and Nonaka and Takeuchi (1995) provided a valuable explanation of the links between tacit and explicit knowledge by drawing our attention to knowledge generation as an ever-evolving process wherein a constant dialogue involving explicit and tacit knowledge surfaces that develops novel expertise and wisdom. In this case, emerging knowledge and learning become an immense source of benefit that could be expanded for individuals and organisations to apply to new frontiers and to their advantage. I find this interesting, as according to Perkins and Salomon (1999), students' knowledge is sometimes inert, passive and only called upon in direct response to specific tasks or situations.

Fuchs et al. (2002) and Dougherty (2013) predicted the following factors as having an impact on the success of transfers:

- a. A broad schema – which is defined as a comprehensive plan designed to shape the structures that underpin the type of problem students and graduates face – e.g., a diagram or mind-map created to identify and understand a problem to aid knowledge application and problem-solving (Powell, 2011).
- b. Becoming skilled at the art of problem-solving or following set rules.
- c. The awareness of linkages between earlier solved problems and new situations or problems,
- d. Classroom culture and instructional method.

Beyond acknowledging the challenges and facilitators of knowledge transfer, Eraut (2008) suggested that there are mechanisms (e.g., in higher education) that could be implemented to support students in applying the knowledge learnt to their practice appropriately. This support is crucial to aid meta-learning in the classroom to improve the knowledge and the competence base for practice (Hannabuss, 2000).

Hannabus (2000, p.403) provided a more profound perspective to this by observing that: *“meta-learning is where we acknowledge and use our learned knowledge of learning to help learning, arguably making learning richer...”*, *“...more personalised”* and in my view potentially more application-facing. Eraut (2008) added a different dimension to this by arguing that learning in education or training and learning in the workplace have their place in society. Indeed, one cannot supplant the other. Eraut thus concluded that:

- Learning oriented at using field knowledge for practice poses a significant challenge and is not a natural consequence of just learning theory knowledge on its own and practising separately,
- The learning needs both (the) time invested in it and (the) support provided, which (HEI) programmes rarely give any time for; instead of erroneously assuming there is a spontaneity that occurs with this,
- Key stakeholders (would) have given little thought to the process of learning and transfer, the type of support required and the absolute clarity about who is responsible for providing it.

(Eraut, 2008)

To put this into the broader context of the available literature and frameworks, such as Barnett and Ceci’s (2002) taxonomy of far transfer (Figure 2), there is potential for one to be able to make more sense of the situatedness within which transfer is located and the associated complexities to navigate. Although the model overtly focuses on how learning in schools could be applied in time and under different contexts, it helps enhance our understanding of the many magnitudes of transfer. This includes the information, concept or theory transferred and the setting or area to be applied. Also, what needs transmitting (i.e., the content) and when and where it is transferred (i.e., the context) – all this while being mindful of the distance of transfer along a continuum of near and far (Barnett and Ceci, 2002).

| A Content: What transferred | | | | |
|------------------------------------|--------------|-----------------------|--------------------------------|--|
| Learned skill | Procedure | Representation | Principle or heuristic | |
| Performance change | Speed | Accuracy | Approach | |
| Memory demands | Execute only | Recognize and execute | Recall, recognize, and execute | |

| B Context: When and where transferred from and to | | | | | |
|--|---------------------------|---|-----------------------------------|-------------------------------------|--------------------------|
| | Near ← | | | → Far | |
| Knowledge domain | Mouse vs. rat | Biology vs. botany | Biology vs. economics | Science vs. history | Science vs. art |
| Physical context | Same room at school | Different room at school | School vs. research lab | School vs. home | School vs. the beach |
| Temporal context | Same session | Next day | Weeks later | Months later | Years later |
| Functional context | Both clearly academic | Both academic but one nonevaluative | Academic vs. filling in tax forms | Academic vs. informal questionnaire | Academic vs. at play |
| Social context | Both individual | Individual vs. pair | Individual vs. small group | Individual vs. large group | Individual vs. society |
| Modality | Both written, same format | Both written, multiple choice vs. essay | Book learning vs. oral exam | Lecture vs. wine tasting | Lecture vs. wood carving |

Figure 2 The Taxonomy of Transfer (Barnett and Ceci, 2002, p.621)

Barnett and Ceci (2002) argued that the need for their model is essential in current times as there remains confusion about the transfer of knowledge across contexts. In their view, this is caused by a failure to determine the most critical dimensions along which transfer and related activities occur. In response to the failures, they philosophised that the ‘content’ element of transfer could be divided into various skill types existing along a continuum of “*specific*” to “*general*” performance and application. Correspondingly, the improvements that (e.g., professionals) show in their performing these skills are most effectively measured through the “*speed*,” “*accuracy*” of the task performed and ethical conduct – i.e., “*doing the right thing*” (Barnet and Ceci, 2002, p.62). Emphasis was also put on the fact that the skills existing along the continuum, no matter their level of complexity, should be able to be theoretically evaluated for “*recall*,” “*recognition*,” or “*merely prompted execution*” (ibid, p.62).

A critique of the framework is that the word choice associated with skills and knowledge demonstration, in this case, is based on lower cognitive skills (e.g., recall,

recognition, and basic application), which are less complex than higher levels of study in higher education. Also unclear is whether there would be a discernible change in outcomes when higher-order thinking, such as evaluation and synthesis, necessitates theoretical testing.

To elucidate the model further, Barnett and Ceci (2002) advocated that the 'content' of transfer could be further imagined as existing within the two axes of 'vertical' versus 'horizontal' transfer. The vertical transfer comprises learning and the adoption of a memory stratagem for deployment in a range of tasks that depend on it – that is, regardless of the associated complexity. The sticky point is that if the strategy is not adhered to, it is likely that the transfer will not materialise as intended. In contrast, horizontal transfers denote a situation where the transfer occurs between two tasks of similar levels of complexity (Barnett and Ceci, 2002). For the practitioner, this is more straightforward. The 'context' orientation of transfer is made up of a cluster of dimensions, including a "*knowledge domain*," "*physical context*," "*temporal context*," "*functional context*," "*social context*," and "*modality*" (ibid, p.623). Barnett and Ceci (2002) observed the following about the dimensions:

- *Knowledge domain*: Symbolises the knowledge base with which the skill is applied.
- *Physical context*: This is made up of macro- and micro-facets. The macro-element deals with whether the associated training and transfer are undertaken in an educational setting, research lab or home environment. For example, the blended learning classroom. The micro-element, in contrast, deals with issues such as whether the exact room is used and whether the same person assumes the facilitator and experimenter roles.
- *Temporal context*: Examines the time between the training and the testing or application of the knowledge. For example, applying theoretical knowledge learnt from one module to another or to practice immediately versus after a few months have passed.
- *Functional context*: Denotes the purpose for which the skill is enacted and the mentality it evokes in a person.
- *Social context*: Explains whether the skill was attained in a group in

collaboration with others or individually and performed alone. Barnett and Ceci intimated that this matters as the level of application for a skill learnt in a group might not be as fine-tuned and applied to good effect as one learnt individually. For example, collaboratively in a community of practice in the blended learning classroom.

- *Modality*: The final part of the transfer framework embodies a macro and micro-level, with the macro-level represented either visually or “*auditory*,” “*written*,” or verbally, linguistically or “*hands-on*.” The micro-level imbues task completion using, for example, assessments and output measurement strategies such as essays, reports, portfolios of tasks, and reflective blogs.

(Barnett and Ceci, 2002, p.623)

Barnett and Ceci’s model dwells on applying impartial assessments to ascertain the transfer (of knowledge and) skills. Unfortunately, this fails to consider subjective and tacit judgements, which impact successful transfers across contexts (see Nonaka, 1994). As a result, opportunities for participants to self-report and describe changing dimensions in their cognitive performance, including fewer disappointments or frustrations with failures and greater self-confidence in remembering everyday activities, were missed in the model (Zelinski, 2009). To contextualise this relative to my HEI, the blended learning classroom becomes a testbed for students to share knowledge and engage their cognitive and affective skills. In the process, they reflexively discuss changes they observe, such as increased confidence in engaging with theoretical literature, using appropriate semantics, and understanding how evidence-based learning could be used in their learning to support healthcare management practice. This is crucial to note as Barnet and Ceci (2002) believed that the possibility of transfer occurring hinges upon essential factors such as:

- a. The training of individuals about the general principles of the content (or codified information).
- b. The routine measures of the outcome mirroring the training provided.
- c. The task (to perform) requiring little recall or retrieval from the activity or task they were trained to conduct.

Another criticism against the model is that Barnett and Ceci (2002) could have been more forthright about whether their model existed on a rigid hierarchical content and context 'transfer' continuum. Without this clarity, the model is open to subjective interpretation. To illustrate how this is problematic, the model suggests that any duration for the transfer that occurs beyond immediate evaluation is “*far*” (Zelinski, 2009, p.6). The question then becomes how one could objectively qualify ‘far.’

HEIs (e.g., public and private universities), also known as third-level institutions – are imagined as having a third mission to them (Evers et al., 2020; Laredo, 2007). Broadly, the third mission is an association connecting universities and non-scholarly partners to develop, implement, and exploit university wisdom, capacity, and assets for society’s benefit (Compagnucci and Spigarelli, 2020). Evers et al. (2020, p. 60) elaborated that “*third-level institutions continue to be seen as drivers of knowledge that impact the economy and society through technology and knowledge transfer...*” and because of this, “*...policy-makers desire to see more research and technology from third-level institutions become more easily available to support economic development, firms, jobs and entrepreneurship...*”

To illustrate, the higher education sector, through its knowledge partnerships with the healthcare industry and government (see Etzkowitz and Leydesdorff, 2000) in the UK, fosters an adaptable knowledge economy that efficiently pools expertise across sectors (e.g., the graduate employment sector) to promote innovation in service and product development. Linked to this, successive governments in the UK have advocated for improved access to higher education for all to ensure that participation is widened to improve social mobility and the competitiveness of the UK economy (Bekrahndia, 2013). The yearning for increased access has meant higher education continues to be impacted by factors such as massification (Caillé and Vandenberghe, 2020), producing employment-ready graduates (Purcell et al., 2017) and the resilience to remain sustainable (Rossi, 2023). Hinting at the widening participation policy's social justice and equality predisposition, Vignoles and Murray (2016) commented on massification's transformative effect on individuals, groups, and access to higher education for the UK society. Through the massification of higher education access, for instance, my HEI has benefited from the proliferation of undergraduate

programmes, resulting in more student enrolments and increased profitability (Gedye and Beaumont, 2018).

Reflecting on my engagement and exposure to literature on massification – going back to when I was first introduced to it ten years ago, I must admit I had considered it a relatively new concept linked to new labour and the drive to widen participation in higher education in the UK (see Dearing Report, 1997 (Dearing, 1998)). However, as I immersed myself in the literature and introspected on it more deeply to reconcile the information I was exposed to, it became apparent that the social roots of massification predate the famous Dearing Report of 1997 (Dearing, 1998). Even more profound was that it had always been accompanied by some observed tension – an effect the UK higher education sector continues to experience, in my view.

Certeau, a French historian, poignantly surmised his view of massification by stating: *“The university must now solve a problem for which its tradition did not prepare it: the relationship between culture and the massification of its recruitment. The economic situation requires the university to produce a mass culture. Institutions break under this heavy weight...”* particularly as they grapple with the demand of dealing with the perpetual recruitment of students *“...whose mentality and future are...”* sometimes *“...alien to the present objectives of education”* (Certeau, 1974 (1993), p. 85). Building on Certeau, Caillé and Vandenberghe (2020) draw our attention to the fact that massification's consequences have become so firmly embedded in academia that we cannot disregard it. The tension has become that, as academics and managers, we are torn between supporting massification (e.g., its intense competition for students) and making sure we are recruiting students with the right mindset and motivation to study while balancing this all with the idea that the students are paying customers whose voice must be heard and their learning journey enhanced and experience excellent (Collini, 2016; Nixon et al., 2016; Parker, 2018).

High student enrolment numbers in HEIs resulting from massification have also raised concerns about how this has contributed to (unsustainably high) competition in the graduate job market (in some sectors) and the devaluing of certain university qualifications (Brown et al., 2008). Notwithstanding, this may not reflect the UK's health and social care sectors, which both confront significant personnel shortages that are

worsening (Bottery, 2022), particularly post-COVID-19 (Waitzman, 2022).

Beyond the opportunities and challenges presented by massification and its link to widening participation, social mobility and sustainability, even before the global pandemic (COVID-19) began in 2020, Atkins (2005) had asserted that the role of higher education in the knowledge economy and society was being scrutinised, particularly considering technological advances and their impact on learning (and career development) for students and graduates. Unfortunately, higher education had been too slow to fully embrace this to help propel it beyond resilience to antifragility (see Aven, 2014). The COVID-19 pandemic has exposed deficiencies in the sector, particularly the lack of preparedness for major incidents (Abi Jumaa et al., 2023).

This concern has intensified the need for collaboration between universities, technology industries and stakeholders like governments to make universities more sustainable. Rossi (2023, p.39) noted the importance of sustainability in higher education by linking it to the United Nations SDG 4 (Target 4.7), which sees sustainability as an essential factor for promoting equity, social justice, lifelong learning, and inclusive and graduate skill value-adding for students (and graduates) (United Nations, n.d). Also, the amplified funding challenges currently observed in the UK's higher education sector post-COVID-19 do not lead to a funding crisis comparable to the one the UK's higher education sector confronted in the mid-1990s - this was before implementing student tuition fees (Foster et al., 2023).

2.9 Employability: Bridging the Knowledge, Skills and Practice Gap

While not always obvious, Knight and Yorke (2003) suggested that the terms 'employment' and 'employability' are two distinct concepts. Nevertheless, the author, Cranmer (2006), was concerned about the possibility of defining employability in a universally accepted manner. Cranmer (2006) argued that different definitions exist in the literature. To illustrate, whereas Rothwell and Arnold (2007) linked it to vocationally relevant knowledge and skills, previous work encounters, and career planning qualities, Gedye and Beaumont (2018) associated it with the capacity to find employment, execute efficiently in the workplace, advance across employment opportunities or positions and possess the skills, knowledge, and qualities that allow

for this. Even so, to deepen our understanding, Knight and Yorke (2003) argued that employability is characterised by the preparedness for job opportunities after graduation, as opposed to graduate employment rates, which are influenced in the UK by data relating to whether graduates secure employment six months after graduation (i.e., graduate outcomes).

Perkins and Salomon (1999) argued that there is a general view that a core expectation and aspiration of (higher) education is to transfer knowledge and basic skills. This is based on the supposition that the knowledge transfer will take care of itself once we (educators) provide the knowledge, resources and environment for learning (ibid). Eraut (2008) agreed with Perkins and Salomon (1999) to an extent before protesting that while the process of knowledge transfer might be more straightforward where the practitioner is familiar with the new situation, it is very much a challenging affair where the familiarity is absent and the situation complex (ibid).

Knowledge transfer is not simply about engaging with relevant information; it transcends regular learning and emphasises how the skills and knowledge are 'transportable' (Perkins and Salomon, 1999) from one context (e.g., the blended learning classroom) to another (e.g., the healthcare management workplace). Notably, occupationally-oriented professional higher education programmes aim to produce individuals who can apply theoretical knowledge to solve complex operational problems arising from practice (Brockmann et al., 2011). Thus, efficient knowledge and skills transfer, specifically from education settings to the workplace, is expected and highly valued by employers (Harris et al., 2013). In line with this, the Pearson human skills most in demand capabilities for UK employers report suggested that human skills are currently in high demand in the UK economy, with employers demanding graduate capabilities like communication, organisational and teamwork skills. In addition, "*while technical skills and expertise remain vitally important for many roles...*," "*...there are clear gaps between existing skills capabilities...*" and future skills needs employers may have (Pearson, 2022, p. 3). The broader context here is that: "*the UK economy benefits from the growth of employers with an improved competitive edge*" and the much-needed workers with the right "*...knowledge-base...*" and skills to support organisational performance, growth, and quality (Harris et al., 2013, p.184).

The literature is ambiguous about the precise meanings of terms such as skills, competency, and knowledge (Flynn, 2014). Skills and knowledge, however, are closely linked, with skills constituting knowledge learnt in action (Organisation for Economic Co-operation and Development [OECD], 1999). Bolisani and Bratianu (2018) went as far as labelling skills as action-focused knowledge that is highly experiential and fostered by systematic task repetition. Skills, therefore, somehow reflect how knowledge gained is applied in practice; notably, this could be improved upon, perfected (or mastered) through repetition (Benner, 1982; The Open University, 2020). An example is healthcare management students conducting service user risk assessments as part of the care planning process following theoretical knowledge of models, evidence-based literature, and case studies. The definitions suggest that skills are a tangent of knowledge – a reasonable observation, especially if one agrees that knowledge exists within the two central dichotomic positions of 'Rationalism' and 'Empiricism' (see Jacobs et al., 2016; Vanzo, 2013).

To advance this argument, Brockmann et al. (2011) contended that in contemporary times, skills should be understood to be intently linked to competence, which is closely associated with employability. To shed light on this, Brockmann and colleagues (2011) theorised that to refer to someone as 'competent' would suggest they could undertake a specific skill to a desired minimum performance level. However, this becomes murky where competence denotes the performance of an act or job beyond the designated skill, markedly if it is complex and requires various skills. Finegold and Notabartolo (2010) observed that the two (skills and competencies) are so similar that they expressed their preference for using them reciprocally in their literature review on twenty-first-century competencies for employment. The Leitch Review of Skills (2006) contended that skills are competencies and expertise a person demonstrates in a specific line of work or professional dimension, and illustrations include communication, interpersonal, management and leadership skills in healthcare management.

Reflecting on the blurriness existing with the terminologies, I recognise the likelihood of reducing competence into a group of skills bundled together because of their close association (Brockmann et al., 2011). Chappell and colleagues (2003) insisted that

given the realities of the current job market, where employers are demanding greater flexibility from employees, the delineation of the meaning of skill and competency is quickly dwindling (Chappell et al., 2003). Over two decades since Chappell and colleagues' (2003) view, this has been further heightened by COVID-19's impact and labour force shortages in the UK's health and care sectors (Powell et al., 2022). Recognising the challenge with the delineation of skills and competence, Brockmann et al. (2011, p.15) surmised that a more straightforward differentiation of skills and competence is: whereas the former (i.e., skills) is usually associated with task performance, the latter (i.e., competence) often refers to "*a threshold level of performance of a skill in workplace conditions or a bundle of skills which may be applied to a complex type of task.*"

Brown et al. (2008, p. 16) proposed that there was evidence that organisations (e.g., HEIs and healthcare organisations) were in the habit of using different terminology to refer to skills. In my experience, healthcare organisations characteristically use competence as a more holistic terminology instead of skills. This is apparent with the NMC's (Nursing and Midwifery Council) standards for competence for registered nurses (NMC, 2019) and the HCPC standards of conduct, performance, and ethics (HCPC, 2018), which both emphasise the competency and performance benchmarks professionals registered with their organisation should adhere to and espouse. Brown and colleagues (2008) further suggested that employers increasingly have concerns about student and graduate employee performance. To the extent that despite the importance of qualifications as a measure of the "*hard skills*" candidates bring to the sector, employers are more concerned about the attainment and demonstration of behavioural competencies (i.e., "*soft skills*") like time management, using own initiative, collaborative skills among others (Brown et al., 2008, p. 16).

As noted earlier in the discourse, competence in the workplace is intricately linked to skills. However, the literature is blurry regarding how they are used and sometimes integrated (see Brown et al., 2008; Chappell et al., 2003). Given this concern, a more objective and cogent characterisation of competency is that it is a collective manifestation of a set of knowledge and skills that a particular profession values. Vitello and Greatorex (2022) also characterised competence as the capacity to

incorporate and employ pertinent context-specific skills, knowledge and psychosocial components such as one's conviction, principles, values and motives to perform in a particular area or field of practice reliably and successfully.

Vitello and Greatorex's (2022) definition provided a comprehensive perspective of the domains informing competence (i.e., knowledge, skills and the psychosocial). A critical place in their description was the embedment of the crucial behavioural aspects – which is quite interesting to note as competence, in my experience, is expressed within codes of practice or a spectrum of performance expectations and espoused professional values – often supported by organisations (also see Brown et al., 2008). Eraut (1998), in his seminal work '*Concepts of competence*,' claimed that not only is there an element of value judgement of quality and an accepted standard that is negotiated and socially situated with competence, but that this is enacted with employer needs in mind. Eraut (1998) notes that the challenge is that "*the organisation of work is different in different localities.*" Thus, the "*transfer of competence from one workplace to another*" could not always be guaranteed (Eraut, 1998, p. 130). This, for me, puts into perspective the increased impetus for the 'vocationalisation' (e.g., healthcare degree apprenticeships) of aspects of higher education through work-integrated learning-oriented programmes (Burns, 2021). We see this across the UK economy—to illustrate, the UK government's introduction of nursing associates and nursing apprenticeships (see Department of Health and Social Care, 2016) and current discussions to introduce similar ones for medical degrees. From a practical standpoint, this move would appear to be aimed at plugging shortages in nurse-patient ratios in England. At heart, they also help resolve the challenge of competency transfer (Eraut, 1998) as the staff are trained in the organisations and trusts they work and are familiar with.

As I reflect on the literature in this section, I conclude that the concepts and definitions of employability, skills and competence are by no means uniform across literature or even restrictive in their view of what a skill is and the nature this may assume in different practice contexts. I will, however, emphasise that the word 'skill', although increasingly (albeit loosely) used to denote specific skill sets – for example, communication, interpersonal, organisational and teamwork, is required for healthcare professionals to practice effectively. At the same time, they are also recognised as

transferable and adaptable across different practice settings (see Eraut, 2004). In demystifying this further, Brockmann et al. (2011) noted that “...*the range of abilities that can be described by the word ‘skill’ seems to have grown...*” over the past few years. However, “...*the term is still linked to the performance of tasks...*” and tasks are “...*typically a narrow range of operations usually linked to a larger action category such as a project...*” (p.15).

To belabour the point further, CEDEFOP (2008) articulated what it means for someone to be professionally competent by demonstrating specific employability skills. CEDEFOP (2008) explained that a critical distinction here is that the person can showcase an ability to apply learning outcomes experienced. That is, either through formal or informal means to new situations such as the workplace (Eraut, 2004). Unlike Vitello and Greatorex (2022), this description of competence by CEDEFOP (2008) has yet to attempt to present it from a holistic viewpoint of professional-body value judgement and labour market requirements. Nonetheless, it is essential to note that at its most basic level, it “... *denotes the potential of the individual worker to draw on multiple resources, including knowledge, know-how and social and personal qualities to deal with complex and unpredictable tasks and situations*” (Brockmann et al., 2011, p.19) that arise mainly in a practice setting.

2.10 Blended Learning and the Undergraduate BA (Hons) Programme

The interdisciplinary nature of the BA (Hons) Blended Learning Healthcare Management Programme ensures that its uniqueness is in its “*approach to learning...*”—*specifically, its ability to be “developmental because students...*” are required “*to learn to think critically...*” “*by acquiring knowledge of theories and ideas...*” about healthcare management as a practice and as business operation, “*they learn to assess what they had learnt critically...*” (Higgins, 2014, p. 67). At the same time, this resource base and experience are used to collaborate, transfer and apply to various practice situations (Taylor et al., 2010). There is also a plurality of knowledge creation from different parties with diverse experiences that is particularly important for synthesising and integrating knowledge for application beyond the classroom (Bidarra and Rusman, 2017; Evans, 1999; UNESCO, 1998).

Bowyer and Chambers (2017) lamented the paucity of literature on blended learning programme implementation in the UK post-compulsory education sectors compared to the United States (e.g., pre-COVID-19). Even so, blended learning is becoming increasingly prevalent in colleges, universities, and adult learning spaces (Graham and Halverson, 2023). This is true for the UK and beyond (ibid.). Blended learning programmes have excellent learning efficacy (Van Doorn and Van Doorn, 2014) and offer a suitable pedagogical structure for diverse student learning preferences and opportunities (Mansour and Mupinga, 2007). The pedagogical structure referred to is observed in my HEI's structured Moodle-based platform (iLearn), which offers blended learning students access to synchronous and asynchronous learning resources and activities.

Ganesan et al. (2002) also underscored the prominence of blended learning curriculum designs, particularly in being flexible to provide the basis for students to learn, engage (with peers) creatively, and improve their confidence to thrive beyond the classroom. However, Ngoasang (2022) intimated that a precursor to the successful amalgamation of the online and face-to-face aspects of blended learning is transformative course content, the availability of interactive and integrative technology-linked resources, a highly trained faculty, and an accessible and credible virtual learning environment (VLE). Knight and Yorke (2003) emphasised that this would warrant faculty providing comprehensive and integrative learning resources tailored to learners' needs and professional development aspirations. While Knight and Yorke (2003) emphasised this within a disciplinary orientation, the BA (Hons) Blended Learning Healthcare Management Programme adopts an interdisciplinary approach to curriculum delivery. Ivanitskaya and colleagues (2002) praised learning environments that encourage interdisciplinary learning as spaces of fertile ground for comprehensive knowledge integration to reveal links between theoretical information, practice situations and, more importantly, views spanning several domains of study (Ivanitskaya et al., 2002).

The uniqueness of blended learning lies in its combining e-learning, classroom instruction, and other modes of offering rich educational materials, information, assets, and tuition (Hamer and Smith, 2021). This situatedness grants students and graduates

increased independence and access while encouraging independent study and taking more responsibility for their educational experience (Wang et al., 2023). Studies have also shown the beneficial effect of blended learning curriculums in helping improve outcomes in students who would typically be at risk of withdrawal due to poor attainment (Hughes, 2007) and improvements in student and programme outcomes – for example, increases in overall student achievement and experience (Bowyer and Chambers, 2017).

Blended learning curricula are also notably recognised for encouraging flipped learning (Hamer and Smith, 2021), which Noe (2022) argued promotes the completion of assigned activities and reading before face-to-face classroom seminars to ensure the learning time is spent reinforcing and applying the theoretical knowledge and skills to practice. Tayebinik and Puteh (2013) discovered that combining online and face-to-face learning (e.g., as observed in blended learning) has enormous potential to promote adaptive educational experiences and social relationships through which learning and students' competence and skill evolution flourish. Also, Ashraf et al. (2021) explored the ICT (Information, Communication and Technology) aspect of blended learning and how this presents an opportunity for active learning strategy implementation in the classroom—in a way that makes diverse students and graduates' learning more satisfying and relevant to their wants, interests and employment quests. Indeed, blended learning sessions (e.g., in the programme under investigation) are not just imbued with a scaffolded curriculum and module content for enhanced cognitive processing (Van Laer and Elen, 2017) but integrated through experiences, theories and situated practice case explorations in the classroom (Schneider, 2012).

To elaborate on how the undergraduate blended learning healthcare management programme is experienced by students and graduates on the programme from a faculty perspective, the 17 modules of the programme are divided into three core themes for a coherent structure to the content and graduate skills coverage. These include: 'Professional Environment and Practice', 'Operations and Quality Management', and 'Leadership and Management.'

Modules under these themes are designed to support the development of healthcare sector knowledge and awareness and graduate skills such as communication

(interpersonal), leadership, teamwork (in integrated care settings), care planning, project management, critical reflection and lifelong learning. The knowledge and skills are explicitly embedded within the learning outcomes and graduate attributes in modules and summative assessments. Additionally, within each module, there is an opportunity for deeper immersive learning of the content and supplementary resources, self-managed by learners often working in small communities (e.g., synchronously in the classroom and asynchronously in online discussion forums) to synthesise and socially construct knowledge for transfer to practice. The HEI’s learning model (Figure 3), which follows a cyclic process, elaborates this succinctly. The model comprises the following stages: ‘acquire,’ ‘inquire,’ ‘discuss,’ ‘collaborate,’ ‘practice,’ and ‘produce’ (Miles, 2016).

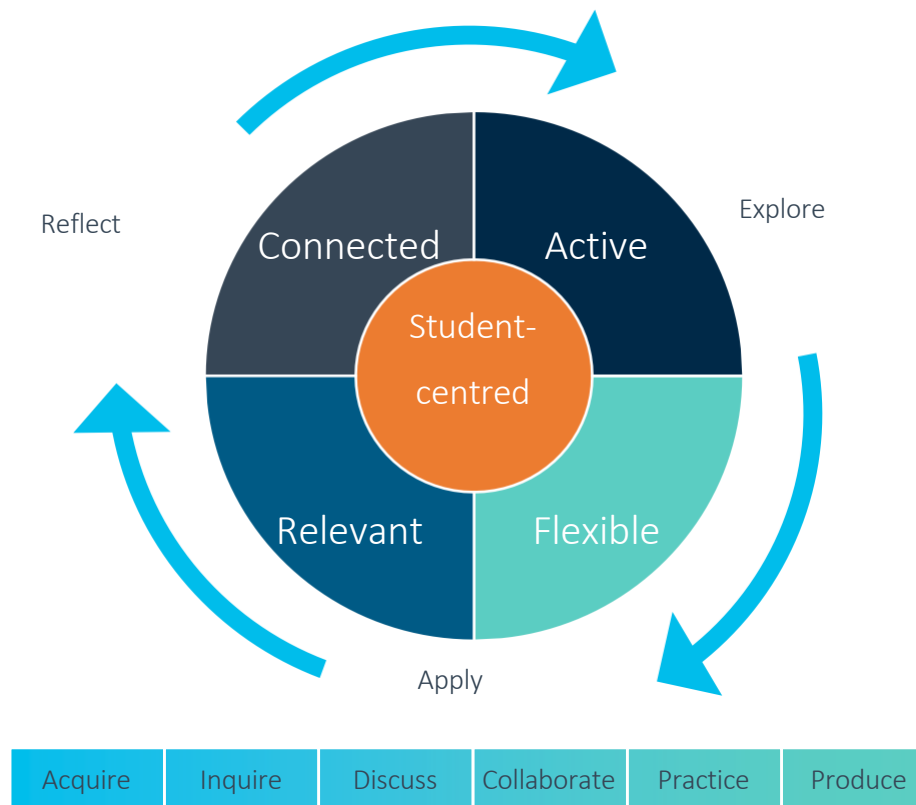


Figure 3 The HEI’s Learning Model (Miles, 2016)

The model suggests that crucial concepts and module information are explored via the online content, core texts, supplemental reading and in-class tutorial seminars for each module completed. Students also engage in online and classroom activities through

discussions with peers and academic staff. Differentiated tasks and formative feedback activities consolidate this. What makes the learning feedback holistic is its link to lesson content, discussion forums, formative feedback, and embedded self-appraised knowledge check tasks on the VLE.

After completing a module, when students submit work for summative assessment, they 'move on' to the next session or module. During this time, they are encouraged to reflect on their learning and feedback from a 'comprehension', 'knowledge production', 'transfer', collaboration and 'graduate skills' lens. The Health and Care Professions Council [HCPC] (n.d) contends that such reflection is a vital part of a health and care practitioner's life and contributes immensely to improving their work routine and quality of service delivery. There are further opportunities for skills development with the academic coach, study skills tutor workshops and tutorials, and external professional body resources (e.g., the Chartered Management Institute (CMI)) available to students.

2.11 Communities of Practice: Learning, Participation and Skills

Before getting into the topic of communities of practice, it is crucial to note an overlap and liminality between 'community of learners/learning or learning communities' and 'communities of practice' – which have a relationship but are not the same. Even though my evaluation of the undergraduate blended learning healthcare management programme was that it promoted a community of practice (the focus of my discussion in this part of the review), I contend that for the blended learning strategy to develop 'communities of practice,' students and graduates must first be part of a small 'learning community.

University College London [UCL] (2023) suggested that members of learning communities develop knowledge through interaction; they learn collaboratively as a social group by evaluating, negotiating, conversing, and sharing ideas while recognising divergent views and their diversity of thought. Beyond learning communities, Lave and Wenger (1991), the first to coin the term 'communities of practice' in their seminal work, referred to a community of practice as regularly

comprising a (small) group of individuals with shared interests and practices. Lave and Wenger (1991) noted a sociocultural element associated with communities of practice that fosters legitimate peripheral participation from learners. This is more distinct as learners evolve from novice outsiders (i.e., beginners) to developing the requisite knowledge and skills mastery (or proficiency) of an 'expert', which brings them into the core group (ibid.). Since introducing us to the concept of communities of practice, more studies have flourished – more so in traditional face-to-face learning environments than blended learning programmes (e.g., Azan et al., 2017; Hennein et al., 2022; Pyrko et al., 2017; Yukawa, 2010). Nicolini et al. (2022) contended that communities of practice should be best thought of as being made up of people (informally) who have a shared experience and passion for collaborating on an ongoing basis to learn and share knowledge and skills that enhance their practice. However, Li et al. (2009) argued that knowledge-sharing and meaning-making within the contexts referred to could happen formally and informally and do not require intentionality from learners (Lave and Wenger, 1991).

Pyrko et al. (2017) noted that it is naive to think that knowledge is 'effortlessly' transferred in these communities by actors who merely receive or absorb the knowledge from instructors and peers to apply it to their work. This is because communities of practice are premised on the assumption that learning is an active social endeavour (Lave and Wenger, 1991). Pittaway and Moss (2014) argued that socialising, for instance, allows learners (e.g., in a blended learning classroom) to widen their thoughts and viewpoints (e.g., on healthcare management), hence the ability to interpret them in unique ways. Lave and Wenger's acknowledgement hints at a bidirectional occurrence and the substitutability of the provider and recipient positions in the interaction (Angheloiu, 2020). Given this, Pyrko and colleagues (2017) argued that communities of practice provide a conducive environment where practitioners can reflect and reason together while drawing on and sharing tacit knowledge and learning from each other's perspectives and experiences. Nonaka (1994) hinted at the importance of tacit knowledge in communities and organisations. To illustrate, he indicated that organisational learning facilitates information acquisition, skill advancement, utilisation in real life and socialisation. For this to occur, however, informal communities must exist to socialise, collaborate, share tacit

knowledge and synthesise this in a way that makes it explicit in the organisation (see Nonaka, 1994).

Wenger (1998) described these communities as having similar 'practice biographies', working together on shared activities and enacting a situated resource base to aid their professional development. A study by Rovai and Jordan (2004) found that blended learning programmes fostered an enhanced feeling of community among learners compared to traditional or entirely online programmes. This is likely because there is a cultural component to the practice of communities, which (e.g., considering the diverse resources and platforms on blended learning) encourages legitimate peripheral participation by students (Lave and Wenger, 1991). However, Nicolini et al. (2022, p. 3) gave an intriguing comparison of how learning was perceived to occur in such communities in the past – that is, an impression that it was the “*newcomers...*” that “*...learn the tricks of the trade*” from more established community members. While this would allude to Lave and Wenger (1991), who distinguished the role of the core group from the peripheral group, it gives the impression of a unidirectional sharing of knowledge existing in a hierarchical power-laden structure.

An essential critique of communities of learning is that they have specific weaknesses, such as needing to fully account for how complex group dynamics and individual differences can deter communities' ability to manage shared knowledge. In line with this, “*...understanding of the power dynamics of communities of practice is essential to...*” developing “*...a full understanding of knowledge creation and dissemination*” (Roberts, 2006, p. 627). In contextualising the dynamics existing in communities, Fox (2000) reasoned that the uneven power associations manifesting within communities of practice, if not managed properly, may have an untoward impact on all parties. This is because core members who are afforded full involvement will have a more central role and are most likely to have a more significant say and impact on the negotiation of meaning and knowledge synthesis. From our programme's perspective, this means “*...peripheral community members...*” in the blended learning classrooms and within cohorts across the programme “*...may not necessarily develop beyond a position of peripheral participation*” (Roberts, 2006, p. 627). These learners are less likely to reach the same skill proficiency and competence level as core group members (ibid.).

Drawing on theories of knowledge and skills sharing and the broader social context of learning, Benner (1982) elaborated on the mechanism through which graduates and practitioners further develop their skills (e.g., in a community) in a graduated way. For instance, using the Dreyfus model of skill acquisition, Benner (1982) indicated how nurses, through their work situation, requisite translational care knowledge and skills, can develop their practice using a 5-point proficiency scale. Benner (1982) articulated the proficiency scale into a spectrum – i.e., from novice, advanced beginner, competent, proficient to the expert practitioner. Looking at both ends of the spectrum, Benner particularly noted that the expert practitioner, who at the zenith of their practice, embodies a holistic and outstanding self-assured performer who sees the whole in their actions and how this impacts all parts of the care they coordinate and lead (Benner, 1982). In contrast to the novice or advanced beginner, in my view, there is a level of knowledge synthesis for application within the community, which is transformative for the members who make it to ‘expert practitioner’ (Deakin University, 1994).

Furthermore, members of the community of practice are expected to demonstrate a level of personal and academic commitment and participation, like an implicit social contract. This should come from both learners and instructors to engender a self-assuredness and an antifragility (Klisanin, 2020) mindset about students’ ability to cope, plan, track, and appraise their learning to succeed (Johnson et al., 2018). Aven (2014, p. 182) suggested, “...*Taleb’s antifragility concept can be seen as an ideal state, where we are exposed to some level of variation and uncertainties but we are protected from adverse events.*” Students and graduates need an antifragility mindset as the healthcare management workplace is fraught with noteworthy challenges around funding, staffing, meeting service user needs through person-centred care, and working within an integrated and multi-cultural care system. Rainey and Gifford (2016) demonstrated that blended learning students from diverse backgrounds and experiences sometimes lack confidence in their knowledge and abilities in a way that I will argue that building resilience alone is not enough.

2.12 Theoretical Framework

Before I interrogate the Mode 1 and Mode 2 theoretical frameworks and the 'knowledge context' and 'social situatedness' Mode 2 especially is located (Gibbons et al., 1994), I give a brief historical perspective to help situate our understanding of how views of knowledge production have evolved from the nineteenth century onwards (Hammarfelt, 2012). Figure 4, which provides a helpful summary, shows the attributes of Mode 1 and Mode 2.

| | <i>Mode 1</i> | <i>Mode 2</i> |
|------------------------|-------------------------------|--|
| <i>Organization</i> | Disciplinary and hierarchical | Transdisciplinary and heterarchical |
| <i>Context</i> | Academic; specific community | Public; application based |
| <i>Quality control</i> | Academic | Social accountability; reflexive |
| <i>Setting</i> | The university | The university and non-university institutions |

Figure 4 Attributes of Mode 1 and Mode 2 (Hammarfelt, 2012, p. 54)

Klein (2004) argued that during the twentieth century, questions about knowledge and its production were discussed around disciplinarity (i.e., Mode 1). This has since moved on, during the 21st century (ibid), to multidisciplinarity (Blake et al., 2013; Zaman and Goschin, 2010) and later interdisciplinarity (Ivanitskaya et al., 2002; Klein, 2010; Repko and Szostak, 2017) and transdisciplinarity (Gibbs, 2015). The main promulgator of this movement was the need to solve complex scientific problems for the benefit of society (Chettiparamb, 2007; Repko and Szostak, 2017). With this evolution in mind, multidisciplinary learning advocates using different professional contexts, albeit not necessarily in an ordered and integrated manner, whereby they interact and affect each other (Repko and Szostak, 2017). The outcome experienced in this setting becomes a simple mixing of different disciplines (Blake et al., 2013), each of which partly exists in silo yet holds on to their specific ontological stance (Zaman and Goschin, 2010). Conversely, interdisciplinary learning promotes

the “*development of structural knowledge*” and the “*gradual progression in...*” “*metacognitive skills, critical thinking, and personal epistemology.*” This, together with a design of “*higher learning outcomes,*” contributes to a personalised “*integration and assimilation of knowledge transferable to other contexts, issues, or problems.*” (Ivanitskaya et al., 2002, p. 108).

Just over a decade ago, there was an appeal for multidisciplinary and interdisciplinary (programmes and) training of healthcare graduates in practitioner and management roles (Mishra et al., 2011; Nash, 2008). The blended learning healthcare management programme fully adopts the latter and has been applauded for supporting knowledge and skills convergence for practice and critical thinking and boosting graduate employability capabilities. Even so, Gibbs (2015, p.152) argues that “*the emergence of...*” another paradigm, the more recent of the former–‘transdisciplinarity’ was in “*...response to often-failed attempts of closed system, discipline-based approaches to solve complex social problems...*” and “*...ontological incongruities evident in discipline-based approaches. Such approaches are not confined to large, seemingly insurmountable social problems, but apply equally well to workplace issues, seemingly defying traditional managerial approaches...*”

I used the Mode 2 knowledge production framework (Gibbons et al., 1994), which incorporates elements of interdisciplinary learning while advocating for transdisciplinarity, as the theoretical foundation for investigating the learning experience in a HEI's undergraduate blended learning healthcare management programme. The study focuses on the programme's orientation for knowledge and skills transfer and whether there is clear, explicit evidence of transfer to the healthcare management workplace.

Despite criticisms about the lack of experimental evidence for the existence of Modes 1 and 2, Gibbons et al. (1994) made a significant contribution to the debate on knowledge production and the overlaps between science and research in post-compulsory education (Hessels and van Lente, 2008). Nowotny et al. (2003) claimed that their original notion of 'New Production of Knowledge' (i.e., Mode 1 and Mode 2) (Gibbons et al., 1994) sparked a fascinating debate within the scholarly community and society. Indeed, some in the scientific community reacted positively and regarded

it as an authentic portrayal of the situation in a postmodernist research world. Others, however, identified gaps and opportunities for the writers to present an expansive and sustained examination of the dynamics of science and society. To illustrate, the authors filtering what they were calling for was not legitimising the opinion that research scholarship was acquiescent to market forces and partisan agendas (Nowotny et al., 2003). The observations led to a second book titled *Re-Thinking Science: Knowledge and the Public in an Age of Uncertainty*, which attempted to address the criticisms and expand the breadth of conversation around some of the concepts. To clarify, they explored the unconcealed and nuanced intricacies between science and society (Nowotny et al., 2010).

In their second book (i.e., written by three of the original authors of Gibbons et al. (1994)), Nowotny et al. (2001) investigated why they needed to broaden their treatment of the missing aspects related to the complex social variations of Mode 1 and Mode 2. This time, they clarified their definition of society before providing a detailed analysis of the complex yet dynamic relationship between science and society due to Mode 2 (Nowotny et al., 2003). Nowotny et al. (2001) also highlighted observations of shifts in higher education, particularly from disciplinary science culture to research culture and orientation.

Still, Gibbons et al. (1994) acknowledged that Mode 1 is disciplinary, and it is from Mode 1 that Mode 2 was developed. The latter supports a plurality of approaches. Although the two continue to exist alongside each other, Gibbons and colleagues (1994, p. 16) noted how “...*The problems, projects or programmes on which practitioners temporarily focus constitute new sites of knowledge production which are moved into and take place more directly in the context of application or use.*” The blended learning programme environment is conceptualised as a site of knowledge production and graduate skill development. It creates the foundation for students and graduates to build the knowledge base and confidence to apply their learning to practice. Notwithstanding, Nowotny et al. (2003) discussed the challenges of managing this process by expounding that managing Mode 2 knowledge (for application) needs further dedication and attention in progressing knowledge to foster the development of professional careers, technical skills and individuals’ personal and

collective identities (ibid.). This is despite the sector's pressure to grapple with the massive proliferation of higher education (see Brown et al., 2008).

Nevertheless, Lawlor et al. (2015) argued that the root of Mode 2 recognises the role higher education plays in fulfilling a critical social concern – that is, ensuring that the "exogenous" external real world of community and knowledge generation and application supersedes "*internal knowledge production*" (Martin, 2017, p.82).

Reflecting on Mode 1 and Mode 2 as a framework, I refer to Fook et al. (2015), who draws our attention to what distinguishes Mode 1 and Mode 2 by advocating that the two should not be seen as entirely separate from each other but rather that Mode 2 evolves from Mode 1 and compliments it by recognising "*the situated nature of research and its embeddedness within...*" power relations. Looking at Mode 2 specifically as a philosophy, this is rooted in the belief that for higher education to continue to remain relevant, it must be responsive to society's needs and aspirations and relevant to governments' development programmes (Etzkowitz and Leydesdorff, 1997; Scholz, 2020). Despite the appeal of this as a theoretical framework, there are critiques. For example, Etzkowitz and Leydesdorff (2000) questioned if Mode 2 was anything new, given that its tenets strongly resemble approaches advocated for by pre-nineteenth-century science. Nevertheless, I posit that a fundamental difference exists between disciplinary science and Mode 2. For instance, whereas in science, peer reviews are the promulgator of individual actions aligned to criteria situated within discipline-specific intellectual interests (e.g., that of gatekeepers), in Mode 2, the context of the application is on the incorporation of different intellectual ideologies to progress the needs of society (ibid); also see the 'third mission' of higher education (Laredo, 2007) which elicit the place of higher education in society.

Nowotny et al. (2003, p.186) clarified that "*Mode 2 knowledge is generated within a context of application...*". This differs from endeavouring to explain the application process or even the transfer of the produced knowledge or skill. The "*...context of application...*" describes the overall "*...environment in which...*" "*...problems*" or situations arise for appropriate "*...methodologies...*" to be then "*...developed...*" (Nowotny et al., 2003, p.186). This and the clarification of expected "*...outcomes...*" herald the sharing and linking of theory to healthcare management practice through

case studies, simulated activities and flipped and experiential learning resources, content and support in the blended learning classroom.

Allen et al. (2011) also deepened our understanding of the type of learning experience in Mode 2 settings, where there is an integration of theoretical knowledge, case studies and workplace experiences to create new ways of understanding. For students enrolled in our blended learning healthcare programme and learning together with peers, the learning environment initially develops into a community of learning, eventually transforming into a community of practice. This includes students with different skills and work experiences (experientially learning) and working together as a community of prospective healthcare management practitioners (see Lave and Wenger, 1991).

Following reflections on the perceived weakness of Mode 2, Gibbons (2000) argued that there was a missed opportunity to interrogate the decadent social permutations associated with Mode 2 in their seminal publication (i.e., Gibbons et al., 1994). Gibbons noted how this gave the impression that they were making a case for applied science while, at the same time, providing a defence for relativism (Gibbons, 2000). Also, not discussing the more exhaustive social permutations presented another complication as it meant there was much resemblance with work undertaken by Latour, who had already suggested or even recognised a new dynamic relationship existing between science and society (ibid.).

Finally, both modes make a case for a form of knowledge production that recognises personal knowledge and contextual reflexivity and for Mode 2 (mainly) the broad societal context and relevance. Mode 2 is primarily situational, contextual, experiential, collaborative and supportive of knowledge produced in its application context (e.g., Gibbons et al., 1994; Nowotny et al., 2001; Nowotny et al., 2003), which the blended learning programme was designed to support in its curriculum delivery plan.

2.13 Chapter Summary

The project's boundaries, aims, objectives and research questions were explored in

this chapter. The chapter described and critically examined the literature on crucial project drivers and ideas such as knowledge and skill transfer, communities of practice and blended learning programme curriculum direction. The role of evidence-based and evidence-informed approaches in the transfer process was critically discussed to establish their influence on knowledge and skills transfer. Exploring these helped shed light on massification, sustainability, and the third mission orientation of higher education in society. Sustainability was especially framed through an antifragility lens, which suggests the conversation should move from building resilience for students and higher education to developing antifragility systems and processes and graduates with an antifragile mindset. Finally, the 'New Production of Knowledge' framework (i.e., Mode 1 and Mode 2 (Gibbons et al., 1994)) was also interrogated.

Chapter 3: Design and Methodology

3.0 Introduction

According to Mukherjee (2019), 'methodology' is a collection of practices and strategies highlighting the principles, skills, and general activities a researcher could adopt to support their research goals and methods. This chapter is prospectively written and describes and critically discusses the methodology and procedures underpinning the study. This chapter details and critically evaluates the techniques and procedures that support the study. It describes my plans for the study, the reasoning underlying specific methods, and how this supports the anticipated outcomes.

3.1 Philosophical Assumptions, Positionality, Approach and Design

3.1.1 Philosophy, Positionality and Methodology Connotation

Kivunja and Kuyini (2017, p. 1) explain that *“when we say that it...”* (i.e., research philosophy) *“...defines the researcher’s worldview, we mean that the abstract beliefs and principles that shape how a researcher sees the world, and how s/he interprets and acts within that world. It is the lens through which a researcher looks at the world...”* and *“...the conceptual lens through which...”* they investigate *“...the methodological aspects of their research project to determine the research methods that will be used and how the data will be analysed”* (Kivunja and Kuyini, 2017, p. 1).

The study uses a qualitative methodology. Recognising the impact of this early on formed an essential part of deep reflections undertaken to align my methods to my assumed insider research positionality. Finlay (2002, p. 210) contended that qualitative researchers attempt to unravel how their biographies link with the meaning-making accompanying the highly subjective *“...accounts of fieldwork...”* and are often concerned about the social context(s) being investigated (Willig, 2013). Kirpitchenko and Voloder (2014, p. 16) also added that qualitative researchers are *“...highly engaged...”* members *“...of the social world...”* they explore.

There is a general agreement that each qualitative method is distinct and typically

backed by a particular school of thought. Hence, a close association exists between a researcher's assumptions about phenomena, their adopted positionality and their planned approach (Daniel and Harland, 2017; Green and Thorogood, 2018). Whether acknowledged or not, a deep-seated theoretical position drives all research approaches, such as interpretivism, social constructivism and pragmatism (Salmons, 2015). This is particularly imperative for qualitative methodologies that attempt to unravel deeper meanings and associations (Forster, 2001), such as by exploring the knowledge and skills transfer orientation of an HEI's undergraduate blended learning healthcare management programme.

Saunders et al. (2015) assert that research philosophy explains our assumptions and beliefs about how knowledge is best developed. These assumptions, Saunders and colleagues (2015, p.124) observed, touch on things such as our view of "...*human knowledge (epistemological assumptions)*...", the "...*realities...*" we "...*encounter...*" ("*ontological assumptions*"), "...*extent and ways...*" our "...*own values influence*" the "...*research process (axiological assumptions)*" and adopted methods and the interpretation of findings. Niiniluoto et al. (2004, p.1) affirmed Saunders et al. (2015) while observing that positionalities and "*classifications of philosophical problems*" in knowledge building are numerous and distinct. Niiniluoto et al. (2004) also draw our attention to how this has had a contributory effect on the current "*division of philosophy into ontology (or metaphysics), epistemology, and axiology (ethics and aesthetics)*", which generally speaking "*still seems the most efficient*" way of delineating how knowledge is interpreted within various philosophical traditions (ibid, p.1).

Daniel and Harland (2017) argue that ontological and epistemological positions are discussed considerably in higher education research because they have a noteworthy impact on researchers' positionality, adopted methods and study outcomes. Ontology is "*the study of being,*" including the nature within which "*knowledge or reality*" exists, is construed and the organisation and explanation of the belief systems of the constituted knowledge or existence (Daniel and Harland, 2017, p.21). To enumerate further, Daniel and Harland (2017) noted how the critical difference between ontology and epistemology, which could be seen as opposite sides of the same coin, is that although ontology is mainly preoccupied with unpacking the nature of beliefs, interpretations and ideals about specific knowledge and ways in which that is known,

epistemology describes the systematic procedures, tools and techniques (i.e., resources) used in investigating the problem. Compared with ontology, the term epistemology (e.g., now generally used to refer to the 'philosophy of knowledge') appeared much later in literature and is regularly associated with unravelling the following questions: "*What is knowledge?*" Is it centred on "*sense of reason?*" Is it possible to attain complete "*certainty,*" "*What is truth?*" and "*Are there ultimate limits of knowledge?*"? (Niiniluoto et al., 2004, p. 4).

Hence, to illustrate my study's situatedness, the nature of reality (i.e., ontology) (see Blaikie, 2000) of the learning experiences on the BA (Hons) Blended Learning Healthcare Management Programme exists in a social world that acknowledges the existence of a rich and diverse healthcare knowledge and skills exploration in the blended learning classroom. Therefore, the study assumes that because healthcare management knowledge and skills are woven explicitly through the programme outcomes and across module-level graduate skills, students and graduates possessing personal knowledge and prior experience repertoires can leverage the learning in the classroom in a way that leads to the creation of new knowledge. The programme arguably takes advantage of this situatedness to encourage the development of the necessary theory, sector knowledge, and skills to support competency development (see Slipicevic and Masic, 2012; Stefl, 2008) and demonstration in the workplace.

Relativism—or, as alluded to above, to put it more broadly, a relativist social constructivist ontology guided my study. This was instrumental in helping decode the interpretive context of the learning experienced by students and graduates in the undergraduate blended learning healthcare management space. The perspectives of employers, academic staff familiar with the programme, and students and graduates provided an added lens for the knowledge and skills transfer orientation. Relativist ontologies hold that our images of the world are socially produced and cannot be viewed simply as "*reflections of how those things are*" (Forrester, 2010, p. 43). Guba and Lincoln (2005) also asserted that contrary to the realist position, relativist ontologies hold that reality about a given situation or phenomenon typically happens within various socially enacted views that cannot be examined and reduced to

causative effect relationships. This is particularly important, as noted by Thompson (2000), who characterised such settings (e.g., where relativist social constructivist ontology is observed) to be one of social interaction between—for example, students, graduates, academics, and the learning environment (also comprised of the healthcare workplace). The latter is where knowledge is produced and contextualised for transfer and application to management practice (see Gibbon et al., 1994).

I chose social constructivism as the study's research paradigm to emphasise and elucidate the philosophical inclination driving this investigation. However, before making this decision, I debated whether 'Social constructivism' or 'Social constructionism' best suited my project intention. Social constructivism is linked to the work of Berger and Luckmann in their book 'The Social Construction of Reality,' in which they acknowledge how their thoughts were shaped by philosophers like Shutz, Durkheim and others (Sica, 2015). Key literature suggests that 'Social constructivism' is more of an epistemology about the environment in which learning occurs than a learning theory (Hyslop-Margison and Strobel, 2008). Shunk (2012) also remarked how views expressed in 'Social constructivism' are closely linked with more modern development theories such as Bruner, Vygotsky and Albert Bandura's Social Learning Theory - all of which accentuate the significance of social intermingling in skills and knowledge acquisition (and production).

Nevertheless, to situate my positioning on a 'Social constructivism' epistemology and expound on what differentiates it from 'Social constructionism,' I explored and reflected upon associated liminal concepts such as constructionism and constructivism. To this effect, constructivism sees knowledge and knowing as neither absolute nor separable from the agent (i.e., the knower) (Ültanır, 2012). This is partly because students in constructivism are provided scaffolded information and given limited direction to engender an element of active learning and learning by discovery (see Bruner, 1960; Kirschner et al., 2006). Alanazi (2016) deepened our understanding by postulating that under "...*constructivism...*", learning is seen as "*a mental process and people learn from previously-built knowledge by building on that knowledge in collaborative environments...*" (Alanazi, 2016, p. 5). Constructivism focuses on students for most of the learning process, and this trait differentiates it from constructionism. In contrast,

constructionism primarily focuses on educators, the instruction provided, and the associated outcomes observed in the broader learning space (ibid.). Ackerman and Hilsenroth (2001) expanded this notion by suggesting that constructionism (e.g., by thinkers like Seymour Papert) also stresses individuals working together to create knowledge and artefacts. What could be deduced from similarities in the positionalities of the two – vis-à-vis their knowledge production propensity is that while constructivism emphasises the process in which learning occurs, constructionism concentrates on the instructional process observed in the learning environment (Alanazi, 2016).

Beyond ‘Constructivism’ and ‘Constructionism,’ ‘Social constructivism’ (i.e., the philosophy of choice adopted for this study) holds that learning builds on existing prior information (e.g., healthcare management theory knowledge, skills and experience). Moreover, through interaction with others (e.g., peers, employers and academics in the blended learning study space), a person may apply prior knowledge in novel ways, leading to distinct socially producible and culturally and historically relevant knowledge for application (Taylor, 2021). Conversely, ‘Social constructionism’ emphasises how psychological and social realities are formed through societal exchanges (Taylor, 2021). Mercadal (2020) also contended that ‘Social constructivism’ explains how naturally occurring social phenomena are performed and developed in a situated social and cultural environment.

Despite the semantic differences, ‘Social constructivism’ is sometimes erroneously referred to as ‘Social constructionism,’ which shares many of its features (Kim, 2001; Sommers-Flanagan and Sommers-Flanagan, 2018). Corroborating this, Andrews (2012) emphasised that in some of the literature, ‘Social constructivism,’ Social constructionism and even ‘Constructionism’ are used in contexts suggesting they mean the same thing. They are different in their direction on how knowledge (and skills) develop through intermingling with individuals who, as agents, also interact with and experience their environment. To illustrate, ‘Social constructivism,’ unlike Constructionism and Social constructionism, underscores the nature of knowledge and how it is enacted without simultaneously discounting the possibility of reality being objective and subjective (Andrews, 2012).

Social constructivism, although also regularly combined with Interpretivism, has its relativist worldview, which is that as we immerse ourselves in our surroundings to have a better understanding of issues or problems, we inadvertently develop and derive a deep and wide range of meanings (Creswell, 2007; Crotty, 1998). However, a common theme in Crotty (1998) and Creswell (2007) is that individual actors enact and agree upon meaning. Thus, the context of the lived experience must be considered (Andrews, 2012). This encourages us (practitioners and scholars) to seek to establish the associated intricacies rather than trivialise them into a set of categories, thoughts or information (Andrews, 2012). In short, the philosophy emphasises the significance of our situatedness and cultural context in helping us understand the society in which the phenomenon sought exists, thereby creating meaningful knowledge from that understanding (McMahon, 2007). The fundamental beliefs of 'Social constructivism' are:

- a) Reality is created by the actions we take as social beings, which is co-created by the people around us (i.e., society) and cannot be discovered because it would not have existed before that period (i.e., the social mediation).
- b) Knowledge is a product of interaction between individuals and is created from social and cultural factors to which one is exposed. From the above exchange, individuals can produce meaning to explain certain phenomena.
- c) Learning is facilitated by a social process beyond the individual level. It is not just about the passive development of behaviours and behavioural queues shaped by other environmental forces. It only becomes profound learning when the people involved are significantly immersed in related social activities (e.g., communities of practice).

(Kim, 2001; McMahon, 1997)

The three perspectives above on how learning and knowledge development (and production) are facilitated within 'Social constructivism' could be combined into four big-picture views. That is:

- An "ideal-based Social constructivism," which for our programme typically takes place during programme conceptualisation (i.e., after competitor higher

education provider course analysis to see what is out there, employer and stakeholder feedback, and higher education market skills gap research), programme development, and standardisation (of for example, schemes of work and lesson plans). All of these contribute to outlining the critical healthcare management theories, case studies, and activities to set the foundations for developing the knowledge and managerial graduate skills for practice.

- A “cognitive tools perspective” focuses on how, for example, our blended learning healthcare management students learn by engaging their intellectual skills and schemas to support knowledge and skills development and a range of cognitive tools to use in their current and future healthcare management practice.
- A “pragmatic or emergent approach” stresses that the use of ‘Social constructivism’ in moderating and managing our blended learning classroom environment should be contingent upon the need for it to be implemented. This puts subtle emphasis on dichotomising the individual learner's view of knowledge, meaning and understanding from that of the group,
- A “transactional or situated cognitive perspective” is the last, which focuses on the impact of the social relationships between our healthcare management blended learning students, the blended learning classroom and the broader healthcare management environment in shaping learning.

(Bredo, 1994, p.24-28; Prawat and Floden, 1994)

3.1.2 Research Approach and Design

As I conceptualised the purpose of this project undertaking, I reasoned and concluded that a qualitative research methodology would be more appropriate. Given my unique position, it was necessary to describe the perceptions of learning experiences, knowledge and skills transfer orientation and cultural nuances around learning in the blended learning classroom (also see Darling, 2016). In alignment with this, having the chance to give a voice to participants in expressing what they think is a privilege that brings with it a sense of indebtedness. Gibbs (2009) envisaged this indebtedness

by emphasising the information given by the participants, which, while helpful in having their voices heard, is an enormous gift for which researchers should be grateful.

3.1.2.1 Research Approach

As per Creswell (2014), research methods include researchers' strategies and procedures to accomplish predetermined project objectives. Three major research approaches exist in social science research: Qualitative, Quantitative and Mixed methods (Saunders et al., 2023). Although all three approaches are (arguably) in a continuum, with Qualitative and Quantitative at both ends of the spectrum, they should not be viewed as entirely rigid and contradictory in their approach to insider projects (Creswell, 2014). Neuman (2014) also suggested that a crucial thread in qualitative and quantitative methods is the systematic collation of data and observation of patterns to interpret metaphysical and social phenomena. Hitherto, there is consensus that the philosophies informing qualitative and quantitative approaches are explicitly different and set within constraints of specific epistemologies (Somekh and Lewin, 2011).

Unlike quantitative approaches, qualitative data gathering stresses the quality of interaction between participants and researchers and their lived experiences. Because of this, it is not uncommon for smaller sample sizes to be used (Willig, 2013). Holloway (1997) also asserted that qualitative research is especially interested in how people interpret and make meaning of the experiences in which problems arise and how various agents engage with this environment. Even so, Carlsen and Glenton (2011) noted how a distinctive feature of qualitative research is its ability to look at a topic in more depth using different data sources. This is down to their potential to exist within a socially "*...constructivist, symbolic interactionist, or other interpretive conceptual frameworks...*" (Cleary et al., 2014, p. 473).

Qualitative approaches are primarily known to engender the adoption of theoretical frameworks (like 'Social constructivism') to analyse and interpret social phenomena (Adams et al., 2014). This alludes to their incredible power to encourage multiple data sources to provide in-depth explanations of multifaceted research occurrences in real-

life contexts (Morgan et al., 2017; Tight, 2017). In comparison, designs such as quantitative cross-sectional approaches, although known for their scientific and methodical approach to data gathering, will not be a good fit for my study as they overtly focus on objectivism while mainly ignoring the context and lived experiences of participants (Somekh and Lewin, 2011), which is pertinent to my research aim. Indeed, the opportunity to interact with students, graduates, academic staff and employers in a natural setting puts me in a unique position to critically examine how situated the programme is, for instance, in fostering knowledge and skill transfer to healthcare management practice. Parahoo (1997, p. 143) shed light on this by arguing that: “...*the selection of a..*” research approach and “...*design is largely dependent on the belief and values of the researcher...*” “*the resources available (cost, time, expertise of the researcher), how accessible the respondents are...*” and arguably the value of their contribution to understanding the phenomenon under study.

3.2.1.2 Research Design

Yin (2017) suggested that every empirical study has an implicit, if not explicit, research design, and in its most basic sense, a study's design is the logical progression that connects its empirical findings to its initial research questions and, ultimately, to its conclusions. A research design also offers a methodical strategy for moving from one place to another, with ‘here’ being the collection of questions to be addressed and ‘there’ being some findings concerning these questions (ibid.).

“*Case studies offer in-depth contextual analyses of one or a few instances of a naturalistic phenomenon...*” – for example, “*a person,*” “*an organization,*” or “*a program*” (Tracy, 2019, p. 119). They provide a comprehensive analysis and description of one or more cases—an activity, process, company, group, person, or event—and have the propensity to showcase each of these using a boundary-defining definition of what constitutes a case (Christensen et al., 2015). It became apparent while implementing the study's terms of reference and selecting a suitable research design that case studies offer greater flexibility than other qualitative methodologies like grounded theory or phenomenology.

Two typical case study approaches are used in qualitative research. The first method, put forward by Stake (1995) and Merriam (2009), is based on the 'Social constructivist' paradigm, whereas the second, advanced by Yin (2012), takes a 'Post-positivist' stance (Hyett et al., 2014). My philosophical stance and view of case study designs from an epistemological standpoint is closer to that of Stake (1995) and Merriam (2009). The latter is one I related to beyond the rest. Adopting this philosophical premise and understanding the meaning or knowledge that students and graduates construct is paramount to my qualitative research (Yazan, 2015). To illustrate, my proposition was that knowledge is socially built and arises from students, graduates, academics and employers' social activities. Social reality is created and formed by the actors in my study, with a significant portion existing inside their minds (i.e., cognitive). As a result, there was a need for my research to be concerned with finding out culturally determined and historically situated explanations for the learning experience (as expressed by participants) in the blended learning healthcare management programme and how this situates it to support knowledge and skills transfer to practice (Yazan, 2015).

As I reflect on Yazan (2015), Stake (1995) and Merriam (2009), I noticed that something that is of extreme importance was that Guba and Lincoln (1994) suggested that case study designs usually approach enquiry from a relativist ontological perspective. This implies that the true extent of the construction of theory and practice knowledge and its potential transfer is highly contextual and complex. This surmise aligns with previous literature explored in Chapter 2 (e.g., Eraut, 2008; Nonaka, 1994; Perkins and Salomon, 1999) and the broad challenge identified in the literature with empirically evidencing knowledge and skills transfer, especially from a non-practicum undergraduate healthcare management programme.

Nevertheless, Polit and Beck (2012) provided reassurance by arguing that when researchers believe they have a limited understanding of a phenomenon, using a recognised research design (e.g., qualitative case studies) can help them characterise and deconstruct it. Polit and Beck (2014) expounded on this notion, stating that such designs apply when the necessary information is acquired directly from individuals with firsthand experience of the phenomenon (Bradshaw et al., 2017). Green and

Thorogood (2018) postulated that case studies are ideal designs for dealing with a research question requiring describing phenomena to understand their context. However, Somekh and Lewin (2011, p.53) protested that they could not be “*easily summarized as a single, coherent form of educational or social research...*” This is because as an “*approach to research,*” such designs have been “*fed by many different theoretical...*” branches – for instance, “*phenomenological social science...*,” “*social construction of knowledge...*” and “*medical or even criminological models.*” Notwithstanding, case studies are among the most recognised and versatile designs (Rashid et al., 2019). Unlike an experiment, where the researcher or a survey makes up the instances, a case study focuses on a small number of naturally occurring cases (i.e., in which several cases are investigated) (Hammersley, 1992a). As I consider the rationale behind my decision to select a case study design, I concur with Hammersley (1992a) and Green and Thorogood (2018) that my goal was to learn more about participants' learning experiences, opinions and perceptions, which necessitated a thorough investigation and (thick) description of their ‘lived’ experiences (see Geertz, 2008). This makes case studies a natural fit for my study. Yin (2003) elaborated that a case study should be used when one of the following conditions exists:

- a) The purpose of the study is to offer "how" and "why" explanations.
- b) Participant behaviour cannot be controlled.
- c) The scholar wants to cover contextual conditions because they are relevant to the phenomenon under study.
- d) The line separating the phenomenon and context is ambiguous.
- e) All these points are relevant to my project intention.

For Baxter and Jack (2008), nonetheless, once a researcher determines that their research issue is best addressed using a case study and the case and its boundaries have been established, they must consider the type of case study that will be conducted. Whether they want to discuss, investigate, or compare two cases will determine how they proceed (ibid.). My study primarily describes a case rather than comparing different situations for contextualisation. This makes it a descriptive case study (see Yin, 2003). Case studies are explanatory, exploratory, or descriptive (Yin, 2003). In line with Rabaa'i et al. (2009), I intended to use a single case design for the

study as I did not want to make a statistical-probabilistic generalisation or validate a hypothesis (Smith, 2017). This is not to say that qualitative research using case study designs cannot be generalisable. Indeed, Smith (2017) points out that the premise that qualitative investigations fall short of generalisability is incorrect. Because of this, the study describes the learning experience of an HEI's undergraduate blended learning healthcare management programme, especially its situatedness in supporting knowledge and skills transfer to practice. In this case, the strength of descriptive case studies is that they give investigators a detailed account of the event under investigation (Yin, 2003).

Yin (2017) suggested two essential types of designs for case studies. That is – a single case design (i.e., types 1 and 2) and a multiple case design (i.e., types 3 and 4). Single case designs are comparable to a single experiment, and many of the same factors that support choosing one experiment might also support picking a single case study (Yin, 2017). However, Baxter and Jack (2008) explained that researchers must determine whether using a single case design over multiple case designs will lead to a greater understanding of a phenomenon. My project intention was to adopt a single case design that uses a dataset or units from focus group discussions and semi-structured interviews involving the following stakeholders: students, graduates, academic staff and employers from the broader study population. This was necessary to help expose the learning experience on the programme and how healthcare management knowledge and skills are produced and contextualised for transfer. A cross-analysis of the different data sets would aid in triangulation, such that I could articulate it and give a voice to participants about their experiences of the programme and how this influences knowledge, skills, and graduate readiness for practice.

Yin (2017) proposed that single-case designs with embedded units are required when several analysis units are required in a study. While a case study may focus on a single institution or programme, the learning culture, student and graduate knowledge, programme characteristics, work performance, systematic data from academic staff and employers, and theoretical literature could all inform the embedded units (Yin, 2017). Baxter and Jack (2008) further observed that the ability to conduct such an in-depth study (e.g., using single-case designs with embedded units) only helps clarify

the phenomenon's situatedness. Even so, if too much emphasis is placed on the subunits and the broader holistic aspects of the initial case study are ignored, the case study itself would have changed its orientation and essence (Baxter and Jack, 2008). Therefore, I intended to focus on the holistic whole of the data and what this explicates regarding the study's aim. This reinforces the need to address and justify any shifts in my approach and explain how they relate to the originally articulated research intention (Yin, 2017). This is significant given that the most voiced concern and critique of single-case designs is the need for more methodological rigour and external validity (Willis, 2014).

3.5 Data Collection Method

Data collection involves understanding and describing an occurrence using information (Bradshaw et al., 2017). There are many reasons why data collection methods should be thorough. For example, the necessity for transparency about the ethical guidelines followed and the need for the replicability of my study (UK Statistics Authority, 2022). Additionally, it might offer guidance to others interested in utilising comparable methods (Leavy, 2020).

The study's data collection would begin with pilots of focus groups and semi-structured interview questions. This was scheduled to begin in late 2021. The data collection process is planned to be completed within six months. This would give me (the researcher) enough time to transcribe the data, get respondent validation on the transcribed data, and begin the NVivo analysis. Because the data collection phase was expected to occur under the COVID-19 pandemic limits, it was recognised that this would affect the proposed data collection schedule. To ensure a methodical approach, internal or insider participants (i.e., students, graduates and academics) were to be recruited in the study first to participate in semi-structured interviews and focus group discussions. A practical element of this planned approach is that the students and graduates were to refer me to their employers and make formal introductions before I formally invited them to participate in the study. The last data collection phase was with the external participants, the employers. Employer interviews were to conclude the data collection process. Face-to-face and virtual

(Zoom) focus group discussions and interviews were planned.

Before data gathering, Middlesex University and my HEI must provide formal ethics approval. This process would begin with completing Middlesex University's 'MORE forms' and using the documentation gathered to first submit an ethics application to my HEI's Research and Ethics Committee (REC). Once ethics approval is granted, I intend to recruit participants for the study by sending out formal invitation letters via email. Following affirmative replies to my invitation letter, more information about the study's aim, objectives, expectations, and possible outcomes was to follow. For instance, a comprehensive participant informed consent sheet (PIS).

Clarifications are to be made before formal recruitment is confirmed and an interview date is agreed upon. Consequently, formal recruitment will be contingent upon receiving signed consent from each participant. The willing expression of consent by a knowledgeable subject and sufficient information regarding the study are two essential and necessary stages to be included in the informed consent process (Nardini, 2014). The signed consent forms will be stored on OneDrive, with access given to my supervisors and the proxy data collectors. The proxy data collectors will support the data-gathering process to mitigate risks associated with the vulnerability of students, graduates and academics because of the power dynamics between them and me (the researcher) (Rosenstein, 2019).

3.5.1 Study Data Collection Protocol and Generalization

Unlike quantitative scholars, when gathering data, qualitative researchers are more concerned with the depth and richness of the data collected and their inquiry's naturalistic approach (which involves observing people in their natural environment) and less so about scientific generalisability, validity and reliability of findings (Flynn, 2021). The study intended to use a variety of data from key stakeholders and emerging themes to provide a detailed account of the learning experience of undergraduate blended learning healthcare management students and graduates and the programme's knowledge and skills transfer orientation. The reason for opting for a varied dataset is the concern that thin qualitative data that is ambiguous, shallow, and

bereft of consensus will lack the credibility and verifiability necessary to support the reliability of my findings (Flynn, 2021).

According to Merriam and Grenier (2019), interviews, observations, and artefacts are the primary data sources for qualitative research projects. Bradshaw et al. (2017) also alluded to this, noting that there are other methods to consider. To illustrate, focus groups and documentary reviews (see Colorafi and Evans, 2016). In this vein, my project would initially recruit approximately 25 participants. However, looking at the study population, I hope to surpass this number. Figure 5 provides context for the proposed data collection process. The figure also shows how proxy data collectors were necessary to ameliorate the relational power difference between the researcher, the students, graduates, and academic staff involved with the programme. The concern about power was that it could exercise undue influence on some of the study participants (Rosenstein, 2019).

To elucidate, I am part of the senior management team at the school where the study is to be carried out. This could impact the interest in participating in the study and the information participants share. Insider action researchers' access to data, opportunities to observe actions, and the decisions made by other organisation members regarding participation in the research will all depend on their degree of authority and influence within the organisation (Holian and Coghlan, 2013). Thus, Hilsen (2006) argues that those who occupy positions that can influence other people's lives must confront issues of power and responsibility and have moral accountability for the results of their choices and inactions. Even so, the role duality in insider action research can bring further uncertainty and role conflict. Because of this, ethical dilemmas frequently occur, especially for individuals in decision-making roles (ibid.). Hilsen (2006, p. 34) further belaboured this point by explicitly stating that: *"...because what we do matters, we have an ethical responsibility for the consequences of what we do and what we do not do, and this ethical responsibility is particularly imperative to..."* action research *"...because of the stated commitment to social justice. As long as we 'dare show our colours' in this way, we surely have to answer for how we live up to them..."*

Academics were to be recruited through the School of Health and Care Microsoft

Office 365 email group. I planned to send the research invitation letter to the Office 365 group site, which has over 50 academic staff registered. I intend to recruit at least ten academic staff. The academic staff in the study will be recruited across the following study centres: three in London, Birmingham, Manchester, and Berlin (Germany).

The study aims to attract and access employers who work with students and graduates of the programme. Recruitment will occur through direct requests during the first and second focus group discussions. Invitations (i.e., via emails) will be sent to student and graduate groups who respond to the initial email or express interest in the study, regardless of whether they participated in the first or second focus groups. The project plans to recruit up to five employers for the study, but if this is not possible, a minimum of three will be considered appropriate.

Aside from the data collection in the study, case study designs and qualitative investigations are not well known for their call for generalisation. This is because each case is unique and particular in its characteristics. Even so, my study envisioned making a case for naturalistic generalisation (i.e., transferability and fittingness of the findings for similar HEIs (Lincoln and Guba, 1985). This is to be facilitated by the comprehensive (thick) characterisation of the findings such that readers are adequately informed by their implications and the degree to which they support initiatives in similar higher education institutions (Johnson et al., 2020; Lincoln and Guba, 1985; Stake, 1978). Melrose (2009, p.2) argues *“that naturalistic generalization emphasises practical, functional application of research findings that intuitively fall naturally in line with readers’ ordinary experiences.”*

The phrase *“naturalistic generalisation,”* according to Melrose (2009, p.2), was first coined by Stake and Trumbull (1982), who felt that alongside learning through explicated generalisations, people acquire knowledge from abstractions they form during ordinary encounters, as well as from creators of literature, educators, and leaders in their daily experiences. Stake (1978, p.6) surmised that *“naturalistic generalizations develop within a person as a product of experience. They derive from the tacit knowledge of how things are, why they are, how people feel about them, and how these things are likely to be later or in other places with which this person is*

familiar.” “...These generalizations may become verbalized, passing of course from tacit knowledge to propositional; but they have not yet passed the empirical and logical tests that characterize formal (scholarly, scientific) generalizations.”

Lincoln and Guba (1985) broadened our understanding of naturalistic generalisation by linking it to ‘transferability’ and ‘fittingness’, which they argue exists on the same pedestal as naturalistic generalisations such that a claim generated in a particular setting (e.g., the HEI) is capable of being carried over to a different one (e.g., similar undergraduate higher education programmes in the UK), which it arguably harmoniously has a natural fit with as both exist within the same higher education landscape. My position about the potential for naturalistic generalisability is in line with observations by Lincoln and Guba (1985). Abma et al. (2020, p. 9) reinforce this reasoning by positing that the *“strength of naturalistic case study research lies in its rich and multilayered understanding of the singularity of a single case, using multiple reality constructions in a particular time-location-culture context.”*

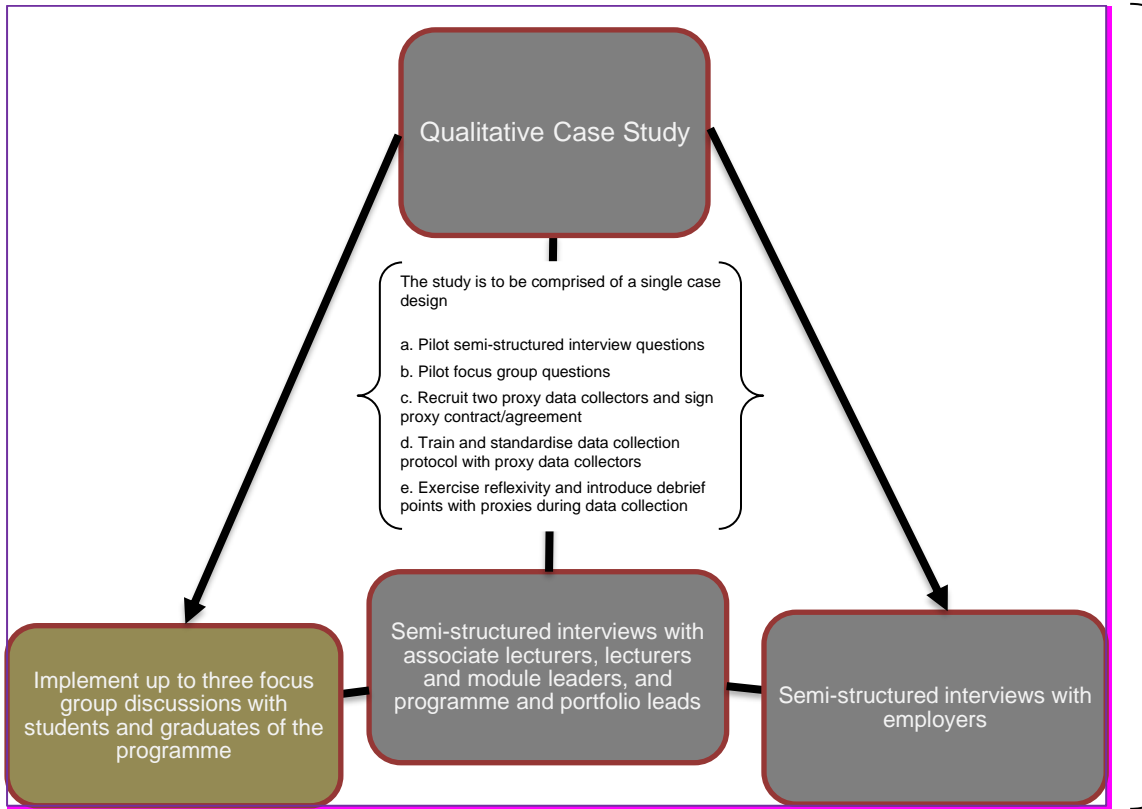


Figure 5 Proposed Methodology and Data-gathering Process

3.5.2 Study Pilot

Yin (2017) contends that it is essential to recognise that a pilot test is distinct from a pre-test and that the two have different objectives. To clarify the differences between the two, Yin observed that a pilot test is more instructive and aids in developing relevant research avenues; it may even provide mental clarification for a study's strategy (Yin, 2017). In comparison, the pre-test (e.g., on which this subheading principally focuses) serves as formal practice runs to examine and (potentially) change the data-gathering plan, ensuring it closely fits the intended data-collection approach (Hair Jr et al., 2019; Yin, 2017).

The project intended to conduct a pre-test for the data collection instruments (i.e., focus groups and semi-structured interview questions). I planned to use academic staff, students and graduates as pilot subjects in the academic interviews and focus group discussions. Furthermore, students and graduates who consented to introduce me to their employers were to form part of a third focus group discussion to review the employer questions. This is to ensure that the questions are relevant to the work managers do, review their appropriateness, and make sure they are not controversial enough to raise difficulty in their role or line of work or be construed by employers as a performance management tool.

The pre-tests will provide insight into the study instruments and the adjustments needed to boost their precision. Running this reinforces my belief that because qualitative interviews are subjective, I must take various precautions to ensure that the data collection instruments are appropriate for gathering valuable factual information to support plausible findings in my study. I also noticed that I needed to construct these precautions in my pilot test before collecting data for the primary research. (Gall et al., 2013). Well-executed pilot tests guarantee that the investigation and methodologies are accurate and trustworthy to give an investigation methodological rigour (Flynn, 2021). According to Bryman (2016), checking the interview schedule with a few friendly participants is appropriate before interviewing candidates. Malmqvist et al. (2019) indicated that quantitative health-related research in professions like nursing tended to favour pilot tests (pre-tests) more than other approaches. This, however, does not preclude their use in qualitative and mixed-method research (Janghorban et al., 2014),

as may be the case for my qualitative case study design. The activity of my pre-test is described in Figure 6 and discussed in more depth in the next chapter.

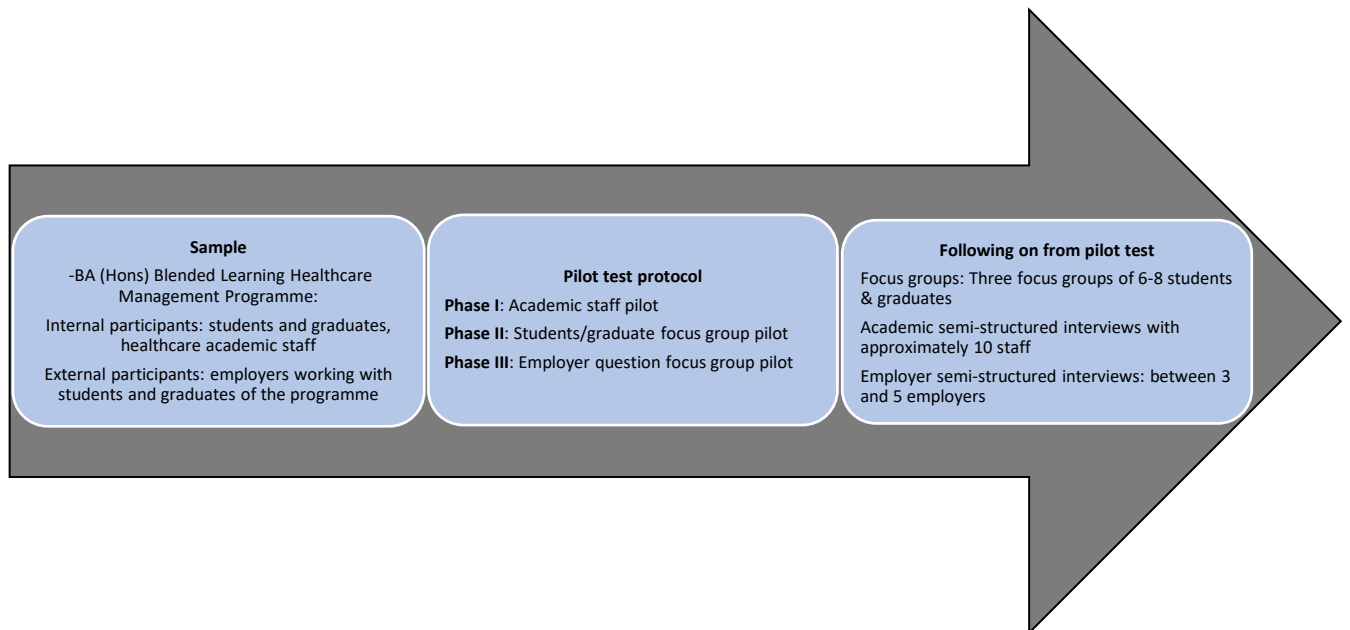


Figure 6 Planned Data Gathering Tool: Pilot

3.5.3 Semi-structured Interviews

Interviews involve collecting verbal and occasionally non-verbal information through direct interactions between the investigator and the subjects being examined (Gall et al., 2013). They are investigative interviews widely used in the social sciences to gather data for qualitative research. This allows for discovery while additionally permitting thematic inclinations to emerge as the conversation progresses, even though they frequently use a guide or approach prepared before the interview and focus on an important issue to offer a basic structure (Henriksen et al., 2022; Saunders et al., 2020).

Although I had considered face-to-face interviews (e.g., for academic staff), I mainly planned to conduct semi-structured Zoom interviews in the study. These were to be undertaken for the study's academic and employer data collection phases (Magaldi and Berler, 2020). Interview questions are expected to be structured around demographic and non-demographic questions. The demographic questions would

elicit patterns across and within 'participant groups' and the dataset. The non-demographic questions are to be open-ended and focused on the programme's strengths, potential knowledge, and skills transfer orientation to practice and considerations for areas for development. Flynn (2021) contends that although qualitative tools undoubtedly support structured interview questions and questionnaires, most qualitative interviews use open-ended inquiries and are semi-structured and in-depth. Like other data collectors, qualitative researchers strive to include as many specifics about the interview as possible (Flynn, 2021).

Structured interviews adhere to a set agenda, and every question is put to everyone interviewed in a specific sequence (Willig, 2021). The person conducting the interview cannot vary their question sequencing or diverge from it in any manner whatsoever (Hooley et al., 2020). Unlike structured and semi-structured interviews, unstructured interviews are interpretive and are not limited to a list of questions. During such interviews, the researcher's initial remarks are ordinarily broad, followed by more personalised and individualised questions for each interviewee (Saunders et al., 2020).

3.5.4 Focus Group Discussions (FGDs)

Focus group discussions are a form of group interview where questions catalyse the elicitation of participants' viewpoints and experiences (Stringer, 2014). According to Dunn (2005), focus groups and semi-structured interviews are ideal for promoting an open and "*honest*" discussion with study participants because they also allow researchers to corroborate the intended meanings and patterns emerging in the data (Somekh and Lewin, 2011, p. 62). All three focus groups are to be conducted, recorded on Zoom and later transcribed with the help of the Zoom recording transcript functionality.

Procedurally, in a focus group discussion, a moderator maintains a small, uniform group of participants concentrated on the discourse of a particular subject or issue, which is particularly beneficial for exploring concepts and learning in-depth details about how individuals see a problem (Christensen et al., 2015). Given this, the project intended that the first and second focus groups comprise six to eight students and

graduates. The study also envisaged the last focus group for the employer questions to have a similar number as the first two focus groups (i.e., 6-8). This is, however, contingent upon the level of interest expressed by students and graduates in introducing the researcher to their employers. The third focus group would aim to receive feedback from students and graduates about the employer questions.

Kitzinger (1995) suggested that most research studies only use a handful of focus groups. In contrast, others incorporate this strategy with other methods of collecting information (e.g., semi-structured interviews, as in my study) (ibid.). However, the ideal number of participants required for a focus group is contested, with some authors indicating 3–12, 6–12, or even 8–10 (Christensen et al., 2015; Elmendorf and Luloff, 2001; Graham and Bryan, 2022). This has led to criticism that focus groups are fraught with problems to do with representativeness, generalisation, sample size, and difficulty in establishing statistical significance (Elmendorf and Luloff, 2001). This might be the case for a researcher interested in quantifying their findings. However, my study does not attempt to quantify the learning experience of the undergraduate blended learning healthcare programme and its knowledge and skills transfer orientation to practice. So, I find this critique inconsequential to the purpose of my endeavour.

Nonetheless, I found the disagreement on the precise number that should make up a focus group problematic, as it is difficult to predict the exact number of participants I will successfully recruit for my study. To reconcile the concern about workable focus group numbers, I refer to Leavy (2020), who believes that evaluating the sample size depends on how in-depth and comprehensive the study is. This implies that the likelihood that the research will produce a more in-depth examination of phenomena increases with decreasing case numbers. Peek and Fothergill (2009) argued that while they had similar concerns in their study, they found focus groups with 3-5 participants were more efficient than the more extensive group interviews. They put this down to the small groups working better due to time limitations and the range of topics participants can discuss (also see Lobe et al., 2020). Kitzinger (1995) provided an interesting perspective by observing the tension in the literature in electing to recruit either a homogenous (focus group) of participants with similar experiences and backgrounds or those from a more diverse group. While both have their place in focus groups (Kitzinger, 1995), my study had no intentionality and pre-set notions around

choosing between a homogenous or diverse group of participants. Even so, I had anticipated that participants in focus groups would comprise diverse students and graduates of different ages, healthcare experience, race, level of study, and prior education. This diversity is apparent in the blended learning student population, which allows the study to analyse different views. Regardless, Morgan (1997) stressed the moderator's capacity to offer participants additional time to express themselves and engage in the discussion as critical to affording these diverse individuals a voice.

3.6 Sampling Technique

Using a sample of participants allows researchers to conclude a larger population from a smaller one—i.e., the sample (Bell and Waters, 2018). The extent to which the recruited group accurately reflects the community also affects whether such conclusions are valid (Lune and Berg, 2017). After deciding on a qualitative case study framework to examine the learning experience of the BA (Hons) Blended Learning Healthcare Management Programme and its knowledge and skills transfer orientation, it was crucial to consider sampling plans for various stages of my project (Flynn, 2021). Mohd Ishak and Abu Bakar (2014) hypothesised that qualitative researchers use sampling methods to allow them to act or gather information that deepens their understanding of a social occurrence. For instance, the programme's knowledge and skills transfer orientation and the potential mechanism by which this occurs from the blended learning classroom to healthcare management practice.

The two main categories of sampling methods are 'Probability' and 'Non-probability' sampling, and research investigators can extrapolate the sample's results to the sample population using probability sampling (Acharya et al., 2013; Neuman, 2014). Simple random sampling, systematic random sampling, stratified random sampling, and cluster sampling are all examples of probability sampling, predominantly used in quantitative research (Saunders et al., 2020). What differentiates this from non-probability sampling, which the study adopts, is that in probability sampling, the sample size is essential because random sampling from that frame would not solve the research problem if it were not suitably drawn from the population of interest (Acharya et al., 2013).

Convenience, purposeful, quota and snowball sampling techniques fall under non-probability sampling methods (ibid). Lune and Berg (2017) noted that non-probability sampling for a qualitative study provides access to groups that would otherwise be overly sensitive or difficult to reach. After reflexively exploring various non-probability sampling methods, I concluded that a purposive sample was the best fit for my study. This is because purposive sampling allows for identifying specific case categories for in-depth analysis (Palinkas et al., 2015). This sets it apart from methods like convenience sampling, which relies on accessibility while unintentionally making it difficult to reach adequate levels of in-depth comprehension (Neuman, 2014). I arrived at this choice because this is a sampling type where a researcher selects a sample to serve a specific purpose (Lincoln and Guba, 1985). For instance, the diverse participant groups I intended to recruit for my study include students and graduates of the programme, associate lecturers, lecturers and module leaders, programme managers and employers who broadly have experience with the programme, and the students and graduates work performance (also see Martinez-Mesa et al., 2016).

However, because of difficulties in establishing external validity, a concern about purposive samples is that they must offer representativeness (Barratt and Lenton, 2015). Conversely, Neuman (2014) claimed that while purposeful sampling does not provide representativeness, it is distinctive in that participant selection is based on the researcher's previous knowledge or professional judgement, which was essential for me as a manager with knowledge of the undergraduate blended learning programme and the HEI. Figure 7 summarises the planned sampling technique.

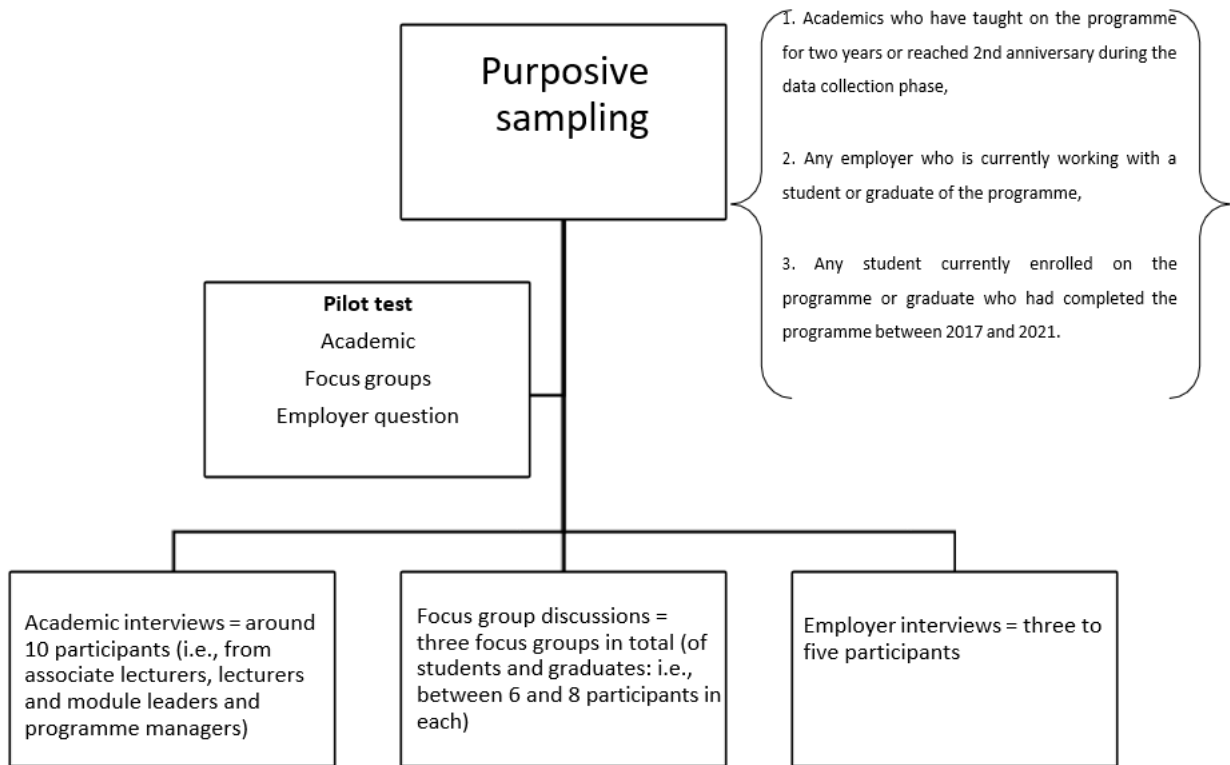


Figure 7 Planned Recruitment Strategy via Purposive Sampling

3.7 Data Analysis

The primary goal of qualitative studies is to find the factors or characteristics of a situation that “*makes a difference*” and are responsible for or significantly affect the issue under investigation (Stringer 2014, p. 93). Data analysis in qualitative studies takes different forms. It has a variety of methods for gathering, arranging, organising, analysing, assessing, and presenting—which makes them ideal for exploring attitudes, behaviour, perception, and nonverbal cues (Bergin, 2018).

3.7.1 FGD and Semi-structured Interview Transcription

Transcripts, or the interviewer’s inquiries and the interviewee’s precise answers, are frequently produced by researchers after interviews (Bergin, 2018). I had planned that the first stage of the analysis would include listening to and watching the Zoom videos of focus group discussions and recordings of semi-structured interviews. This was to

increase my familiarity with the data, as all three focus groups and the academic interviews are to be conducted by two proxy data collectors. As previously indicated, the study will create three types of data: student/graduate focus groups, academic interviews, and employer interviews (see Chapter 4, which goes into greater detail on protocol implementation). Transparency in my involvement in this process and the proxies' roles in maintaining my data integrity are essential. By involving proxies to collect data from participants associated with the HEI (I refer to these as insider participants earlier in the chapter), I demonstrate reflexivity that allowed the participants space to express their honest feelings and perceptions without being laden by the relative power difference existing between myself (the principal investigator) and them (insider participants in the HEI)(see Leavy, 2020). This will be pivotal in helping shape the NVivo codes, themes generated, and conclusions drawn from the study's findings.

3.7.2 Using NVivo for Analysis

Being honest with the participants is the most significant aspect of data processing and analysis in qualitative research, especially as my role involves listening to and hearing their voices to interpret and report on them (Sutton and Austin, 2015). The study will use NVivo 12 as an analytical tool, and the analysis will occur as the data is collected. The process shall be continuous, going from data gathering to analysis (i.e., across the three separate datasets) and back again until a thorough account is produced (Polkinghorne, 2005). NVivo is part of CAQDAS (Computer Assisted Qualitative Data Analysis Software) and tools (Harding, 2018). CAQDAS, like NVivo, is used to organise data collated during focus groups and semi-structured interviews (Nowell et al., 2017). It is essential to state that this would impact plans to adopt an inductive approach for my study's analysis. Inductive approaches support attempts by a researcher to construct a theory based on the evidence they have available from their data. This foundation is built primarily during data gathering and modified as the investigation progresses (Saunders et al., 2020). CAQDAS would aid in efficiently managing my qualitative data, given that it uses computer-assisted software to undertake coding. While this will not supplant my role in manually generating codes and finding patterns in the data, the NVivo software allows me to review the transcribed

data more thoroughly and code it well while being mindful of errors and duplications (Sinkovics and Alfoldi, 2012).

Parahoo (1997) proposed that the data analysis process in qualitative research begins during data gathering and continues after the field notes and tapes have been transcribed. As noted, in demonstrating reflexiveness, I planned to recruit proxy data collectors from other schools in the HEI to conduct the semi-structured interviews and focus group discussions with 'insider participants' (i.e., academic staff, students and graduates), respectively. Interviews with individuals within an organisation are a frequent method of gathering data in insider research (Fleming, 2018). This data would then be complemented by the 'outsider participant' (i.e., employers') semi-structured interviews, which I (the principal investigator) planned to moderate.

I had planned to conduct the initial NVivo coding and analysis by reviewing participant views and sharing them for respondent validation while at the same time constantly retelling myself to keep an open mind in using my insider perspective to engender a more in-depth and latent understanding of the data (Bergin, 2018). Insider researchers must be mindful of information bias (Fleming, 2018). For example, my understanding of the tendency to be partial or the preconceptions I hold about the potential outcomes of the study could skew my analysis (Burchett et al., 2020). Fox et al. (2007) added another dimension to this complexity by suggesting that insider research must also confront the immense challenge of navigating political interests and tensions associated with conducting equitable and ethical workplace research.

I planned to use Charmaz's (2006) coding framework to support my data analysis. Charmaz (2006) argued that coding is divided into three stages: initial, concentrated, and theoretical, and combining these three phases elevates analyses from a fundamental to an advanced, theoretical level. Embedding Charmaz's coding framework, I will exercise great caution to ensure that my initial coding is open, brief and as close to the data as possible (Flood, 2021) and precisely aligned with the broad areas covered in my guided interview questions. This is needed to typically allow codes to be affixed to data or sub-units observed in the data – for example, a statement, an idea or value judgement (Miles et al., 2019).

Braun and Clarke (2006, p.82) suggested that a pertinent question to ask concerning the coding of qualitative data for a thematic analysis is instituting the notion of “*what counts as a pattern/theme, or what ‘size’... a “...theme need to be?”* The answer must be linked to how often the theme emerges across various dataset parts. In reviewing and determining what accounts for a code in my study, I have decided not to be too bogged down in endeavouring to express this in percentage terms – for example, how frequently a piece of information must be present in my data before being considered a theme – as it typically is the case in content analysis (Babbie, 2020). This has the potential to be immensely useful, particularly in affording me the freedom to use my positionality as an insider with knowledge of the programme to develop codes using keywords, phrases and sentences from participant responses. I planned to start with line-by-line coding of the focus group and semi-structured interview data while being aware of the importance of exercising reflexivity so that continuous comparing of information across datasets draws latent contextual conclusions (Charmaz, 2006). Kiger and Varpio (2020) observed that constructivist thematic analysis often uses this to look for more underlying, hidden (latent) themes and interpretations in the data.

A related tangent to this is that using an inductive coding approach also ensures that my predetermined notions and expectations of the study did not impact the coding structure and theoretical framework that would emerge later. Braun and Clarke (2006) observed that information coded using inductive analysis does not attempt to fit the data into an established coding framework or the researcher's analytical preconceptions. Hence, what differentiates it from 'deductive analysis' is that the deductive approach is motivated by researchers' theoretical or analytical interests. Though it may offer a more in-depth analysis of a particular data element, it tends to result in a less thorough description (Braun and Clarke, 2006).

Since it is the first stage in interpreting data, initial NVivo coding is crucial in creating familiarity with my data (Alzaanin, 2020). For example, it could illuminate why starting with the ‘insider participants’ before looking at the ‘outsider participants’ would benefit my analysis. Although this approach would be partly down to practicalities around timelines with access to participants and data during data gathering, it is also intentional. I hoped this would reveal a pattern that supports the thick description of my

data (and findings) (see Geertz, 2008). It could reveal intricacies about the programme's orientation and existing mechanisms to support knowledge and skills transfer to healthcare management practice.

The In Vivo coding is to be used to preserve participant quotes and unravel, early on, overt cultural nuances existing within the 'insider participants' situated in the HEI. Following this, initial coding will be conducted before downloading the codebook to familiarise myself with the data. In Vivo coding will then aid in inserting codes into the data log using words or brief phrases from the participant's words (Miles et al., 2019). This initial coding process will likely generate a fair number of codes, requiring whittling down through merges and removing duplicates later (Stuckey, 2015).

The second 'analysis phase' involves focused coding activities (Charmaz, 2006). This phase aims to group the most important and common earlier codes under more general conceptual categories for developing theories (Alzaanin, 2020). However, to classify my data using focused coding wholly and accurately, choices over which initial codes offer the most analytical sense must be made (Charmaz, 2006). Thus, focused or selective coding is to be applied after I established the most prevalent and essential initial codes (Holton, 2010). To do this, I planned to create new code files to theme the data using critical lines of inquiry from the initial and frequent codes, interviews and focus group questions. First, related questions and units were to be themed together to create a central theme, and then words or phrases for the ones with less obvious similarities. After reviewing this several times, the expectation is that this process will further reduce and categorise the main codes under fewer codes for thematic analysis. Miles et al. (2019) assert that 'themeing' the dataset involves using extended thematic phrases to help with analysis. Themes are summaries of what is occurring, explanations of what is happening, or explanations of why something is done in the format prescribed by participants during interviews (Rubin and Rubin, 2012). As per Boyatzis (1998), a theme symbolises a logical order in a collection of data used to give the data comprehensive meaning and could be used with participant statements and descriptions (Jesson et al., 2011; Tight, 2017).

The following coding phase will determine the relationships between the theoretical or conceptual codes that emerged from the focused codes. Theoretical coding could be

used to accomplish this (Alzaanin, 2020). During theoretical coding, the research is elevated to a more abstract level while still examining the connections among the mental categories that have emerged through focused coding (Alzaanin, 2020). I planned to meticulously identify the core categories essential to comprehending the BA (Hons) Blended Learning Healthcare Management Programme learning experience and its knowledge and skills transfer orientation from the participants' perspectives. Because of this, as I developed the emerging framework in my research, I hoped to find that the basic categories I had been exposed to from the data had unravelled clear links during my focused coding. At this stage, all indications are usually based on constant comparisons across the data and a review of the fuller set of codes existing across the data to show that theoretical saturation was achieved. Theoretical saturation is envisaged by continuously comparing occurrences (and patterns) in the data (Holton, 2010).

More structured categories and thematic analysis will follow once codes are thoroughly reviewed and compared across the datasets. Categories are usually created from codes, and those with more comprehensive subjects could be made to characterise the data in a way that summarises it while preserving the richness, depth, and context (Seers, 2012). Clarke and Braun (2015) suggested that thematic analysis is a method used by qualitative researchers to classify, examine, and interpret the trends in a study. According to Joffe (2011), this analysis method is especially well-suited to my philosophical stance – 'Social constructivism', because it can show how a particular social construct emerges by analysing a broad range of data. Clarke and Braun (2015) underscored how they are also desirable for researchers using a variety of research approaches and paradigms. This is because it is not constrained or localised within a particular or singular context for research. This makes thematic analysis appealing to me as it allows for both practical and theoretical flexibility (Clarke and Braun, 2015)—for example, using my research design and approach to data gathering to generate findings contextually relevant to my HEI and the HE sector.

According to Clarke and Braun (2013), thematic analysis gives researchers a great deal of freedom in terms of:

- a) The types of research questions it can address, ranging from intimate accounts

of people's experiences and understandings to more general constructs in various social contexts,

- b) The types of information and records examined,
- c) The volume of data analysed,
- d) The choice of applied theoretical and epistemic framework and
- e) The ability to analyse information through inductive and deductive methods.

(Clarke and Braun, 2013)

However, the freedom that thematic analysis provides can also be seen as a disadvantage because it leads some people to believe it needs a more rigorous methodology (Clarke and Braun, 2013). Furthermore, the theoretical orientation of the work and the role of theory in the analysis must be stated in manuscripts to avoid the risk of thematic analysis being perceived as a method used indiscriminately and erratically (ibid). Kiger and Varpio (2020) also noted that the theoretical direction of the study and the function of theorising in the analysis must be stated clearly to avoid the risk of thematic analysis being perceived as an approach implemented inconsistently. The danger this poses is recognised in my study by the clear statement of my philosophical stance, positionality and how they have influenced my methodological choices. Figure 8 elucidates the proposed approach to implementing data analysis using NVivo.

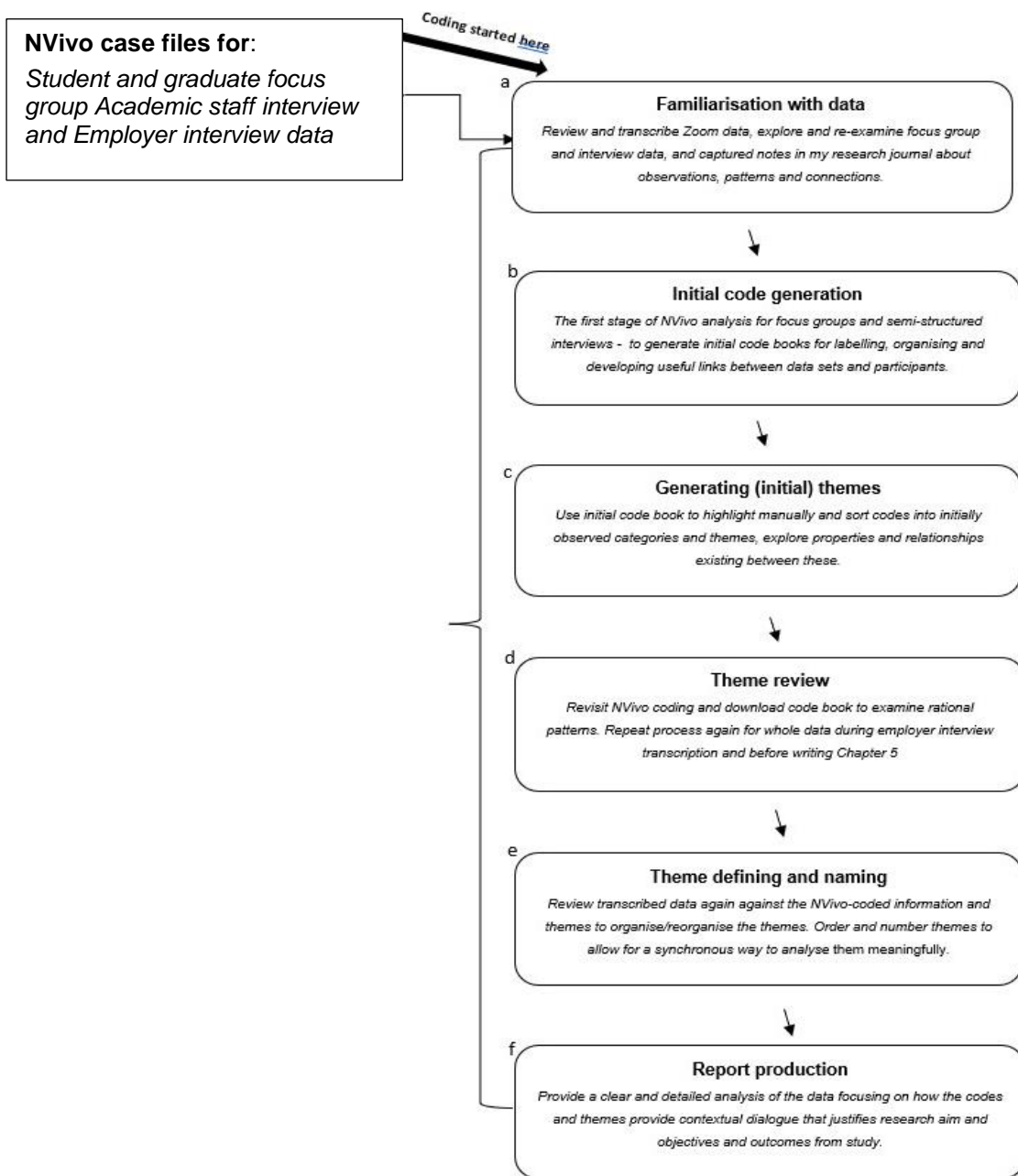


Figure 8 Planned Data Analysis Protocol (adapted from Braun et al. (2018) and Campbell et al. (2021))

3.8 Rigour and Credibility

While a validity and dependability lens are used to frame and assess quantitative research, rigour and trustworthiness are used for measuring qualitative research outputs (Cypress, 2017). A project intention like this is evaluated for its worth and quality by peers, experts, reviewers, and readers (Sutton and Austin, 2015). Yet, “to

be accepted as trustworthy...” it “...*must demonstrate that data analysis has been conducted in a precise, consistent, and exhaustive manner...*” – “...*through recording, systematizing, and disclosing the methods of analysis with enough detail to enable the reader to determine whether the process is credible*” (Nowell et al., 2017, p. 1). Flynn (2021) asserted that the degree to which an investigation provides a comprehensive approach, analysis, and reliability is referred to in the qualitative tradition as rigour.

In their ground-breaking work from the 1980s, Lincoln and Guba (1985) supplanted reliability and validity with the related concept of ‘trustworthiness’ in qualitative studies to deepen our understanding. Its four subcomponents are credibility, transferability, reliability, and confirmability (ibid.). These four roles each contained distinct methodical techniques that demonstrated the rigour of qualitative studies (Stahl and King, 2020). For example, maintaining a transparent audit record, performing member validation during coding and classifying, verifying with research participants, and conducting peer debriefing meetings (Lincoln and Guba, 1985). Lincoln and Guba’s (1985) defined criteria initially served as the foundation for developing standards and checklists before being abandoned in favour of principles. These criteria and checklists included a lengthy list of qualitative research procedures that were criticised since it was unclear which methods to use with which designs or what naturalistic inquiry was being evaluated (Morse et al., 2002; Nowell et al., 2017). Morse (2012) elaborated by conceding that this method was unsuitable and that norms had become the ‘biggest enemies’ of qualitative researchers.

Still, the rise of statistical software and advancements in computing systems and software in quantitative research to enhance rigour have often corresponded with challenges to establishing rigour in qualitative studies (Johnson et al., 2020; Morse et al., 2002). This is evident in how qualitative (as opposed to quantitative studies) lack the assurance of tangible figures and ‘P’ values (Morse et al., 2002). This sentiment has endured and become inescapable in the scholarly world, with prominent qualitative scholars asserting that validity and reliability are specific and relevant to quantitative investigations and not so much the case with qualitative research (Morse et al., 2002). However, Clarke and Braun (2013) argued that qualitative studies could not preclude validity. The authors surmised that, as an example, ecological validity is the most

frequently linked with qualitative studies out of the four prevalent types (e.g., construct, internal, external, and environmental) (ibid.). This type of validity encourages questioning whether a research's data-gathering context matches the real-world setting (and thus is relevant to real life) – and whether the findings could be applied to real-world settings (Clarke and Braun, 2013).

Given the possibility for bias sometimes arising from various types of qualitative design, such approaches should be undertaken with the highest level of rigour (Blaxter and Jack, 2008). Because of this, Baxter and Jack (2008) suggested that a researcher could incorporate several fundamental design components to improve their study's overarching quality or reliability when conducting a case study approach. They, for instance, noted that (insider) researchers like me who employ case studies ought to ensure that there is a presentation of sufficient information for readers (e.g., outside my organisation) to judge the reliability or veracity of my research undertaking (ibid.). Cypress (2017) affirmed this by proposing that the principles of case study approaches make it possible to incorporate many strategies that increase the verifiability of data. For instance, my study's triangulation of data sources or types will be a critical strategy to examine and investigate the multiple perspectives from numerous directions (or internal and external participant feedback). In line with this, Denzin (1970) "*identified four basic types of triangulation: data triangulation: the use of multiple data sources in a single study; investigator triangulation: the use of multiple investigators/researchers to study a particular phenomenon; theory triangulation: the use of multiple perspectives to interpret the results of a study; and methodological triangulation: the use of multiple methods to conduct a study*" (UNAIDS, n.d, p. 13).

Employing Denzin's framework, I focus on the first three (triangulation types) to explain how the current study will demonstrate rigour. For example, my study employs semi-structured interviews for academics and employers, focus groups for students and graduates, and a critical review of seminal literature about knowledge and skills transfer to respond to data triangulation concerns. More specifically, while collecting data, I (supported by proxy data collectors) planned to establish a respectful and amicable relationship with participants to promote trust and inspire them to be authentic in sharing their views, perceptions and thoughts. This will be made possible

by using proxy data collectors and setting the groundwork for an open-door communication policy within which students, graduates, academics and employers could engage with me to raise any concerns or clarify the rationale for my proposition to follow particular data collection protocols as it pertains to participant recruitment and the use and processing of their data. The Middlesex University code of ethics (including the PIS) and invitation letter would establish the work required, and this will be reinforced during the informed consent process, respective interviews, focus groups, respondent validation and the analysis and presentation of the data. A crucial element to (methodically) approach triangulation in this manner is that it allows me to reflexively immerse in the data using various sources during latent coding.

Investigator triangulation will be assured using two proxy data collectors. Proxies would conduct academic interviews for the academic staff recruited in the study and moderate the student and graduate focus group discussions. I had envisioned both data sets to complement employer interviews, which I planned to conduct as the last data collection strand—yet, because of the overlap between triangulation and member-checking (validation), Guba and Lincoln (1989) distinguished the two. Guba and Lincoln (1989) differentiated triangulation from member validation by claiming that triangulation concerns double-checking factual data. In contrast, member-checking protocols guarantee that the data gathered corresponds to the ones provided by participants (*ibid.*). In this case, my investigator triangulation was to extend to proxy and co-investigator data validation. Peer briefings with supervisors and proxies and constant review of my 'insider' reflective diary and field notes will also assist this process (Polit and Beck, 2014). To illustrate, I plan to share the transcribed data with proxy data collectors and my advisors for examination as the study progresses. While the proxies will not be involved in the data analysis stage of the study, they will simultaneously be involved in the respondent validation (i.e., member-checking) process as I confirm interview transcripts with participants. Birt et al. (2016) also assert that member checking is a method for examining the veracity of findings as participants receive transcribed results to verify their correctness and fit with their experiences. This is instrumental in reducing the potential for bias associated with data collection, reporting and analysis, especially as member verification is frequently listed (in the literature) among qualitative research authentication methods (Bygstad and Munkvold,

2007).

While I had imagined needing help to conceptualise theory triangulation in my study, I also noticed a crucial gap in knowledge that my study could fill. Most studies examined knowledge and skills transfer to healthcare management practice from programmes offering practicums (e.g., Casey et al., 2011; Mallidou et al., 2018; Scoble and Russell, 2003). Nonetheless, as I have reflected further, it has become clear to me that Modes 1 and 2 (Gibbons et al., 1994), as well as other knowledge transfer concepts and theories (e.g., Barnett and Ceci, 2002; Eraut, 2008; Graham et al., 2006; Perkins and Salomon, 1999), provide a completely different perspective on codified knowledge and experiential learning transfer in higher education settings. As a result of this disparity in opinion in the theoretical literature about knowledge and skill transfer, it has proven challenging to reconcile this within the framework of theory triangulation. Although triangulation (including theory triangulation) is linked with qualitative rigour, Richardson (2000) questioned whether we could use it to determine completeness in qualitative studies. Therefore, Richardson rejected the notion of a fixed position, suggesting that we crystallise instead of triangulate (ibid.). Indeed, we are encouraged to accept the idea of crystallisation because we know our reality has “*far more than three sides*” (Richardson, 2000, p. 934). This makes it possible to move away from thinking of anything as a rigidly fixed object in two dimensions and towards the idea of the crystal, which permits an unlimited diversity of shapes, substances, transmutations, multidimensionality and approach angles (Tobin and Begley, 2004). My study will combine various perspectives from my data and my insider and situational HEI and HE sector experience to deepen our understanding and the breadth of my qualitative findings through sequential contemplation, interpreting, and refinement in a way that encourages the development of a theoretical framework for knowledge and skill transfer, particularly in blended learning programmes that do not include practicums.

Even if methodological triangulation will not be as relevant as the other forms of triangulation in my study, by describing and defending my approach and methodological choices and the knowledge and skills transfer frameworks I use in my study, individuals with access to my research would have assurance in the inferences

I will arrive at (i.e., credibility) and that the findings and conclusion, without scientifically generalising them, could potentially be transferred from my HEI to similar undergraduate healthcare programmes and practice environments ('transferability').

The level of reflexivity to be exercised and the approach to inductively code the data would demonstrate "*confirmability*" in producing themes and findings that closely emerge from the experiences participants share with me. Lincoln and Guba (1985, p 290), Nowell et al. (2017) and Flynn (2021) all corroborated the view that a study's trustworthiness can be measured by how confident one is in their methods and results being accurate. This is almost akin to the internal validity measures used in quantitative research (Flynn, 2021).

3.9 Managing the Ethics Process

Since ethics is essential, ethical concerns should be anticipated and considered from the beginning of a research endeavour. This begins as soon as researchers start thinking about the scope of their study (Saunders et al., 2020). Sections 3.9.1 and 3.9.2 explore ethical considerations linked to the study in more detail.

3.9.1 Ethical Considerations

The guiding principles of ethics help an individual or organisation decide what is right or wrong (Passmore, 2015). In contrast, morals are a person's or a group's beliefs about good and evil (Bell and Waters, 2018). Bell and Waters (2018) observed that to prevent deliberate and unintentional harm to participants, researchers must conduct themselves ethically, treat participants equitably, and write up their results objectively. Clarke and Braun (2013) maintained that in addition to study practices, ethics should also include how we interact with participants, academic groups, and the general public.

Inference from the literature explored so far suggests that my behaviour in preserving the rights of participants and the integrity of my data is fundamental to ethical research (see Gray, 2014). Gray (2014) particularly highlighted how the conduct of researchers

must be morally defensible and consistent. In light of this, Walliman (2018, p.43) argued that adhering to stringent ethical protocols is so significant that researchers must not even entertain the idea of “...*shortcuts or...*” circumventing the process. Indeed, engaging in these actions will cause a discrediting of one’s work for lack of credibility (trustworthiness) and dishonesty (ibid.).

As an insider, I must be conscious of the moral issues that my positionality raises. Considering this, four significant issues that scholars need to consider and respond to were brought up by Galea (2009), and they include, for example:

1. The attributes that factor into my personality and the connection between myself as an insider and the subject of my research.
2. How will participant liberty, autonomy, and informed consent be implemented (in real life)?
3. How will my organisation and participant groups’ anonymity and security be guaranteed?
4. Who owns the rights to publish the data gathered in my study?

From the beginning of my project, I took great care to clarify the personal connections and boundaries between the participants and me to prevent ambiguity. The lines between participants and researchers can become hazy, primarily where they work closely together (Parsell et al., 2014). This haziness necessitates the need for clarity. Parsell and colleagues (2014) argued that it is crucial that the foundations of the methodology and mutually cordial relationships are not jeopardised and that any possibility of harm or exploitation (e.g., from my end) is recognised, curbed and managed. Proxy data collectors outside the programme and school will be used to mitigate the potential for exploitation and issues with participant honesty in the study. As noted early in this chapter, this also attempts to remedy the relative power difference between ‘insider participants’ and myself, the principal investigator.

Similarly, by outlining expectations, the invitation letters to participants will address participant liberty, autonomy and informed consent. For instance, an introduction to the study, expectations regarding proxy data collection and participant contribution, the participant withdrawal procedure, and the voluntariness of the study, among other

topics, are to be shared and covered during the focus group discussions and semi-structured interviews. According to Manti and Licari (2018), informed consent occurs when participants are sufficiently informed about the research and can understand the material, allowing them to consent to or deny participation willingly. However, one issue with informed consent is that information regarding what will be done during the study is sometimes offered in a way that participants need help to grasp. Another concern is that because qualitative research is exploratory, the researcher may need a more thorough understanding of all parts of their topic immediately. This makes it impractical for participants to give informed permission (Holloway, 1997), which is fully holistic (Flood, 2021).

Participants could ask questions about anything they felt was unclear in the study. Information about this will be explicitly added to the PIS. A key area of consideration in the planning of the study is understanding Middlesex University's code of ethics, which aims to assist scholars in undertaking inquiries as per the pertinent legal, moral, and professional regulations and criteria, irrespective of the study setting. As a researcher, I must seek ethical approval from Middlesex University's Research Ethics Committee before engaging in any data collection activity. The Middlesex University ethics approval process will be conducted in earnest and concurrently with the HEI's REC (Figure 9 outlines the planned ethics process).

Sharing the participant information sheet (PIS) and consent forms with proxies and advisors for sense-checking was another vital aspect of reflexivity that I would actively engage in to help acknowledge and expose some of the underlying and nuanced assumptions relevant to the project intention. This will benefit the proxies and allow me to reflect on them during data collection and analysis. It will clarify and maintain topical subjects of consideration in my research, such as 'bracketing' potential biases.

3.9.2 Insiderness: Tensions, Moral and Ethical Connotations

Middlesex and my HEI's ethical approval requires that the participants' and HEI's confidentiality be preserved under all circumstances. My research plans to address this by anonymising the institution and using diverse pseudonyms (for participants) to cater to the cultural diversity of my participant groups. Smyth and Holian (2008) believe

that for insider researchers, institutional anonymity and security present enormous challenges, not least because through the dissemination of project findings in their name, they inadvertently disclose the identity of their institution—that is, irrespective of whether they mention it. Nevertheless, Floyd and Arthur (2012) contend that organisational anonymity should have no significance for insiders as, despite attempts to maintain anonymity, a quick online search will make it possible to locate their organisation.

Still, to address the concern about anonymity, Floyd and Arthur (2012) suggested that insider researchers and doctoral students publish under pseudonyms or keep their theses confidential as a last option to preserve the anonymity of the participants. Since my research is part of an insider project geared towards genuinely enhancing our undergraduate blended learning healthcare management programme experience and its knowledge and skill transfer orientation, I do not need to use a pseudonym. Besides, Floyd and Arthur's suggestion (see Floyd and Arthur, 2012) of publishing under a pseudonym or keeping my thesis confidential would preclude proper recognition of my research and its knowledge contribution.

According to Gibbs and Costley (2006, p. 247), once the researchers are "*out in the field*", they may sometimes feel that because the ethical clearance was received at the beginning of their project, they no longer need to worry about such matters. Although the more stringent procedures (encapsulated in the ethical clearance process above) are necessary to protect participants' interests, Gibbs and Costley (2006) considered that an excessive focus on researchers just checking (or ticking) boxes could occasionally come in the way of engaging with more fundamental ethical questions. In line with this, reflecting on the steps I plan to take to ensure my study remains ethical, I have made intentional choices throughout this research process to ensure that participants' rights and voices are safeguarded and allowed to flourish. Nevertheless, as an insider, I entered the study with some assumptions and possible biases that I could not simply turn off. This would affect how I engaged with, analysed the data, and perceived the phenomenon under study. This is compounded by my working in a complex higher education setting with various stakeholder needs to navigate. Gibbs (2009) recognises this by noting that workplace learning exists within a socio-political

realm that can simultaneously be exploitative, complicated, explorative, social and creative.

Another tangent to consider is that Zoom-recorded data in my study will be kept confidential to prevent unauthorised access. This includes raw data from soft copies (e.g., Microsoft Word transcriptions of interviews and FGDs). All Zoom-recorded data will be held in the researcher's HEI Zoom account before migrating to Middlesex University's OneDrive. Each study team member with access (e.g., proxy data collectors and supervisors) will be authorised and credentialed in the standards and procedures for data storage and safeguarding outlined in the PIS, consent forms and other relevant documents (Rosenstein, 2019). For example, they would be advised to access or download Zoom videos on institutional laptops. My HEI's Zoom licence arrangement is also to be explored with the relevant authority to ensure that the data generated from the platform is managed to align with data protection laws and the study protocol (e.g., GDPR).

Once interviews are completed, the Zoom application will automatically share the recording with me. I planned to download interviews on my work computer and store them in my Middlesex University OneDrive for transcription and analysis. Participants will be notified that they can request access to the data for up to 5 years after study completion. All participant-held data will be destroyed after the fifth anniversary of data collection. Access to Zoom video recordings would stop for the proxy data collectors once the focus group and semi-structured interviews were completed and the data was moved to Middlesex University's OneDrive. They would only be accessible to me and my two supervisors.

Reflecting on the diversity of students in the programme, as most identify as non-white, a similar strategy to Flood (2021) will be adopted for 'bracketing'. Bracketing is a technique used to lessen the potential adverse impacts of preconceptions that could taint the research process (Tufford and Newman, 2012). This will be influenced by my recognising that, identical to the data collectors (myself and my proxy data collectors), a good number of the students, graduates and

academic staff are likely to identify as BAME (Black, Asian and Minority Ethnic)

(Gov.UK, 2021). Flood (2021) and Tuffour et al. (2019) remarked how they found it difficult to distinguish between their positions as Black people and researchers while working on their doctoral project data gathering and analysis. This was down to their yearning to maintain objective connections between them, the study, and its subjects, which they claimed was mentally taxing. Flood (2021) and Tuffour et al. (2019) asserted that they had to suppress their emotions through 'bracketing'. Similarly, I would have to put my preconceptions on hold during data gathering and analysis to report my findings constructively while presenting participants' voices objectively. This is particularly important given my positionality as an inquisitive and naive spectator who genuinely wanted to hear what the participants had to say about the programme's learning experience and knowledge and skills transfer orientation.

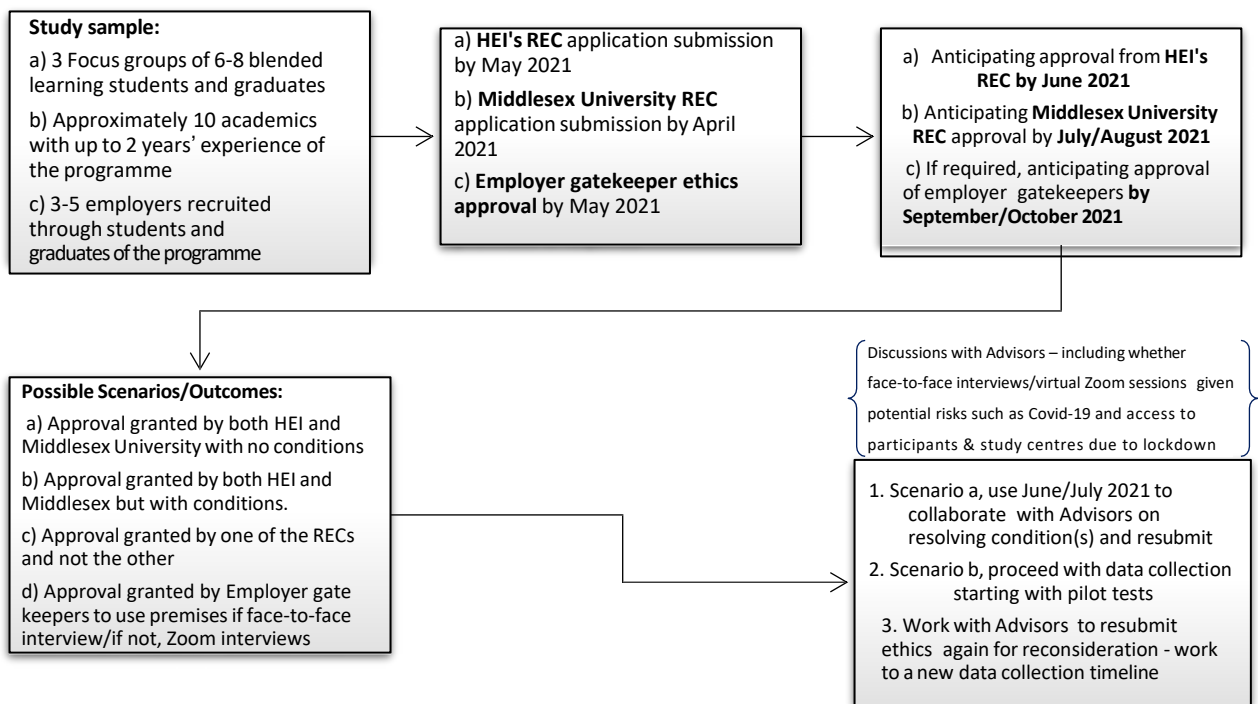


Figure 9 Planned Ethics Approval Process

3.10 Chapter Summary

This chapter examined the different methodological traditions that support qualitative inquiry and described how my study's situatedness within a relativist 'Social constructivist' paradigm establishes a credible proposition to shed further light on the

blended learning programme's knowledge and skill transfer orientation. Writing this chapter allowed me to explore and defend my planned methodological decisions and how they would give a voice to participants and illuminate findings for naturalistic generalisation (i.e., transferability and fittingness) (see Lincoln and Guba, 1985).

The chapter captures the trajectory of my project plan in a way that occasionally highlights the liminal space in which my leadership biography and project terms of reference operate. Throughout my journey of applying the techniques, some moments were liberating and perplexing, particularly as it pertained to deciding my positionality and how this contrasts with other paradigms, e.g., 'Social constructionism' (i.e., a term strongly associated with it). Ethical implications were also discussed, which I anticipated would be difficult to manage because I must obtain two distinct REC approvals—from my HEI and Middlesex University.

Chapter 4: Project Activity

4.0 Introduction

This chapter considers planned (i.e., as captured in Chapter 3) versus actual research activities in the study. It provides an overview of participant recruitment, data collection approaches, processes for gaining consent from study participants, ethical approval from Middlesex University, and my HEI's REC. Factors such as COVID-19 have had a significant effect on my study. As a result, I explored its impact on my data collection. I also examined and scrutinised data analysis measures that contributed to the themes generated in Chapter 5 and embedded an insightful introspection on the processes and efforts to mitigate the challenges experienced in the study.

4.1 Phase I: Pre-data Collection

Following talks with my supervisors and recommendations from Middlesex University's Research Ethics Committee about the power relations between students, graduates, academic teams and me, I decided against collecting first-hand data with this participant group. As a result, proxy data collectors from other departments at my HEI, who were considered 'outsiders' to the School of Health and Care, were hired to collect insider data. Furthermore, the risk of implicit coercion was deemed an essential element to consider as a privileged insider researcher (Fleming, 2018). These considerations informed the project's pre-data gathering phase and associated activities.

4.1.1 Deciding and Planning Participant Sampling

It is customary to include sample size and group demographic descriptions in a study (Leavy, 2020). One of the inclusion criteria for sampling in my research was students across levels 4-6 of a UK HEI's BA (Hons) Blended Learning Healthcare Management Programme and graduates who completed their studies between 2017 and 2021. The latter was because the blended learning programme was launched in 2016, and the first level 6 (i.e., 1-year top-up degree) graduates would have completed their studies in late 2017. Before this, the programme was only delivered through distance learning.

Also, 2021 was a cut-off point, as this corresponded with my Programme Approval Plan (PAP), ethics approval, and the study's data collection phase commencing.

First, I used the programme induction page to inform students about the project, intended outputs, and potential knowledge contribution before formally inviting them to contribute to focus group discussions. Following this, students who responded were provided with further information about the study, a PIS, a consent form and a debrief sheet. General emails to lecturers, associate lecturers and programme or portfolio managers reminding students about the study and how to express interest in joining focus group discussions also followed.

The second step entailed seeking access to the HEI's graduate spreadsheet for students who graduated between 2017 and 2021. I had to justify to the Data Protection Officer and the Awards Team the reason the data was needed and how it would be processed in line with the General Data Protection Regulation [GDPR] (2017) (Gov.UK, 2018). I understand the concern about GDPR; however, I was dissatisfied with the process because ethical approval and gatekeeper access had been given six months before my request. Another problem was that information sharing between the HEI's departments could have been more effective. Although the invitation letter sent to students and graduates generated much interest, most follow-ups afterwards to recruit into the study had only sometimes materialised, even with numerous reminders.

Academic staff recruitment was conducted through a Microsoft Office 365 email hub. The email hub serves as a shared space for academic staff at the school. The platform, which acts as a virtual community for sharing information, was used to invite lecturers to the study after gatekeeper and ethical approval were sought. The initial inclusion criteria were that academics would have had to have worked at the school for two years or more. This protocol had to be slightly adjusted to guarantee that those celebrating their second anniversary during the early stages of data collection were also considered for recruitment. This was required to ensure I could recruit more academic staff. Module leadership in the programme is assumed by lecturers, who are given anything between one and three modules to manage.

All participants who showed interest were recruited on the premise that if a participant

did not meet the inclusion criteria of two years but expressed interest, they would still be drafted into the pilot study (pre-test) alongside others who did. This enabled a broader range of responses and views. The pilot data from the four academic participants from this part of the study protocol was not included in Chapter 5's data analysis as some of the interview questions had to be modified following feedback from the pilot.

While three employers were primarily recruited through focus group discussions with students and graduates, I also received employer information from students who did not participate in either focus group 1 or 2. Although there is a subtle distinction between an 'employer' and a 'manager,' the two terms were broadly used interchangeably in the research. The employer recruitment information sent to students and graduates had a paragraph explaining that I was seeking to recruit employers and would like to be introduced to them. The proxy data collector performing the focus groups reinforced this message during the two focus group discussions. A crucial point for the students and graduates was that they would have the chance to review the employer questions to ensure they are appropriate, sensitive, and not constructed in a way that misreads them as performance management tools. A more implicit reason was to offer reassurance that the questions are uniquely about knowledge and skill transfer and do not lead in a manner that employers think of or use as checklists by which to measure performance. This was reinforced during employer interviews.

After discussing the request with employers, students and graduates shared their employers' contact details. I followed this up with emails to introduce myself and the study before sharing invitation letters (see Appendix 3). Once an acknowledgement and an expression of interest were received, a PIS, consent form, and a debrief sheet were sent. Following this, formal enrolment was only confirmed with the receipt of a signed consent form. I aimed to recruit a maximum of five employers, but this was challenging despite following up for six months with some employers. Recruiting participants for research can be challenging in any environment or population. Nevertheless, it is particularly challenging for healthcare professionals and managers, frequently impacted by job and time constraints (Browne et al., 2022).

4.1.2 Participant Recruitment

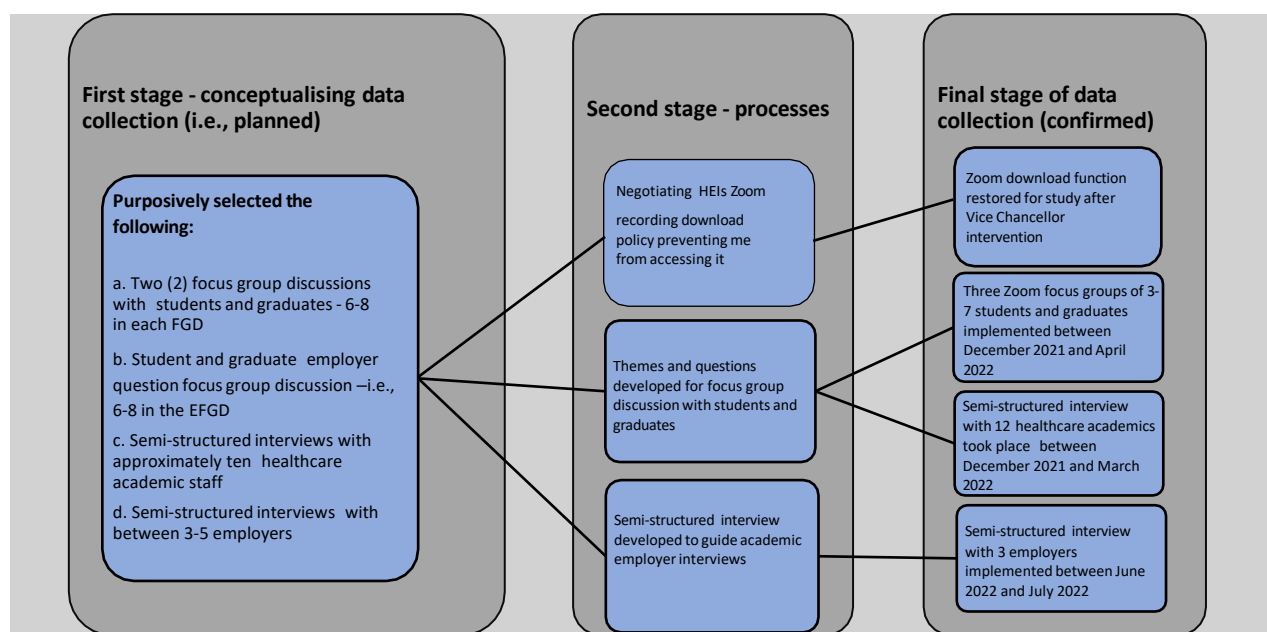


Figure 10 Participant Recruitment Stages and Challenges

The study recruited 28 participants (i.e., the total number recruited in FGD 1 and 2, academic and employer interviews). However, if participants were counted just for participation (including the two double-counted-for participating in more than one focus group and the pilots), the overall number of participants would be 35 (Tables 1–6). Also, the information from the two focus groups and academic and employer interviews suggests that the study attained theoretical saturation. Theoretical saturation determines when to stop sampling participants relevant to a category in a study. At this point, no new information is being discovered that would allow for a further definition of study characteristics (Saunders et al., 2018). As a qualitative research concept, saturation is the foundation of rigour in selecting a sample size. Even then, there was little guidance on achieving it outside of grounded theory (Hennink and Kaiser, 2022), which was an uncomfortable struggle for me, and it arose during discussions and reflections with my supervisors. As a result of my knowledge of the setting, I observed and analysed trends in my participants' replies, which eventually gave me confidence that I had attained saturation.

The research included two focus groups of 6-7 healthcare management students and

graduates. This group's participants were 18 or older, indicating that no minors participated in the research. The presence of students and graduates in respective focus groups provided rich data about the programme's knowledge and skills transfer orientation to the healthcare management workplace and whether this lends itself to an observation of explicit transfer.

The study semi-structured interviews and focus group discussions were conducted following a pilot of the academic interview questions in November 2021 and focus group questions in December 2021 (Tables 1–3). This involved 12 academic staff, 13 students and graduates (i.e., FGD 1 and 2 combined), and three employers (Tables 4–6). Leavy (2020) explains that it is helpful to enumerate researchers' methods to obtain their data. However, the employer interviews were the most challenging part of the data collection process. A minimum of three and a maximum of five employers were initially targeted for recruitment. The upper limit of five also ensured I accounted for dropout in participant numbers. After challenges with employer willingness to participate – mainly due to time constraints and work pressures, three employers eventually provided availability to be interviewed. The locations of the organisations they oversee are in the Southeast, the North and the Midlands (all of which are regions in England) (Table 6).

4.1.3 Study Instrument Development

Data for qualitative research are gathered using data-gathering strategies like interviews, direct observations, diaries, and observations, among others (Nassaji, 2020). Before conducting interviews or focus group discussions, I needed to carefully consider which data-gathering method would provide the proper evidence to clarify the learning experience in the HEIs blended learning healthcare management programme and how this juxtaposes with its knowledge and skills transfer orientation to practice (see Austin and Sutton, 2014). Focus groups are structurally like in-depth interviews in that they are comprised of open-ended questions designed to capture the in-depth experiences of participants (Rosenthal, 2016).

Three sets of interview questions were developed for data gathering. The first was for

the 'student and graduate focus group discussion questions,' and the second was for the 'academic interview questions.' The 'employer interview questions' that followed was the third. The initial version of the academic interview and focus group questions, developed in early 2021, only comprised open-ended interview questions. However, after discussions with my advisors, the recommendation was to add demographic questions. On reflection, I had not added demographic questions, given the concern that this would partly introduce quantitative data into my study. Nevertheless, I noticed that the demographic questions were crucial in creating my case classification in NVivo and providing further insight into response patterns. However, Morse (2008) provided reassurance that adding demographic questions should not be a concern as long as researchers make it known to their audience why certain groups were chosen (i.e., for what specific reason), how they ascertained when saturation was reached, and, if necessary, how rigour and verifiability of the findings were affirmed (see Chapter 3 where I deliberated on these).

Once I created a list of demographic questions to kickstart interviews, I divided them into two sections (i.e., sections A and B)—that is, to guide the data collector-participant interview or discussion structure. This was necessary to ensure that demographic and open-ended questions were separate during interviews and focus group discussions. Key themes linked to the research questions were also used to formulate a core set of open-ended semi-structured questions for section B. These questions featured across all interviews and focus groups to provide a context through which the NVivo thematic analysis could be loosely structured albeit inductively. The questions include 'expectations,' 'knowledge and skills covered in the programme,' 'knowledge to practice, suggestions for improving the programme,' and 'general perceptions about higher education.'

4.1.3.1 Recruiting and Collaborating with Proxy Data Collectors

Fleming (2018) hinted that research participants may be open to sharing detailed or confidential information and discussing matters with someone who understands their context. Nevertheless, the exact opposite could happen, where they feel insecure about sharing information because they are afraid of being judged or because honesty

influences their ongoing relationship with the researcher (ibid.). The concern around this and the relative power difference led to proxy recruitment to aid data gathering in this study.

Proxy recruitment for the study commenced during the ethical approval process—between September and October 2021. I approached the first set of proxy data collectors in early September 2021. However, both colleagues left the HEI to pursue opportunities elsewhere, even before we formalised the process and had proxy contracts signed. Although this set me back, it also made me rethink whether my expectation of using one proxy data collector for the academic interviews and the three student and graduate focus group discussions was realistic. After considering the time and effort required to complete the data collection, two proxy data collectors were recruited: one from the School of Leadership and Management (proxy 1 AM) and another from the School of Law (proxy 2PH). Proxy 1 (AM) is a senior lecturer responsible for looking after international partnerships (i.e., a ‘link tutor’) in his school, while proxy 2 (PH), a solicitor by profession, is a module leader, lecturer and PhD scholar.

Once an agreement was reached, relevant information, including a 'Fieldwork Code of Conduct', 'Research-Collaboration Agreement' and a PIS document, were shared on OneDrive (see Appendix 4 for the proxy collaboration contract). The first proxy-led data collection activities started with academic and focus group pilot tests, respectively. To illustrate, Proxy 1 (AM) conducted four pilot tests with the academics in November 2021. Before this, though, I organised training with him to explore the study intention, ethical considerations, data protection and the guided interview questions for academics. The same approach was replicated for Proxy 2 (PH) before the focus group pilot test. The pilot tests were followed by a debrief meeting to discuss feedback, data collection instruments and general observations. This process was particularly useful in informing further updates to academic interview questions.

The only difference with the post-focus group pilot debrief was that after the discussions, the students, graduates and proxy felt the questions were appropriate and would not require any change. Because no change was needed, data from the first focus group (FGD 1) pilot was analysed as part of the study. The proxies were also

valuable during the respondent validation process and member checking (see Birt et al., 2016; Polit and Beck, 2014), where they added to discussions about whether the transcribed data accurately represented the discussions and responses during interviews and focus groups.

4.1.3.2 Academic Interview Questions

Following the pilot (pre-test) feedback from the four academics and proxy 1 (AM), eight demographic and nine open-ended questions (for sections A and B, respectively) were eventually adopted for the academic questions. Before this, section A had seven questions, while section B had ten. The one question added to section A was:

“Beside healthcare management, do you teach on any other programmes in the University?”

This was required because some associate lecturers worked across different schools and faculties in the HEI. For section B, the question dropped was a duplicate of question 4 of the demographic questions. The question states:

“Could you explain how long you have been teaching on the BA (Hons) Blended Learning Healthcare Management Programme?”

For comparison, question 4 of section A stated:

“How long have you been a lecturer/academic on the BA (Hons) Healthcare Management?”

Both questions cover the same theme –the length of service or time spent as a lecturer on the programme. Also, having this as an open-ended question does not look to add any more value than the closed-ended question would do.

4.1.3.3 Focus Group Discussion of Employer Interview Questions

The employer interview questions were piloted differently through a student and

graduate focus group discussion, which I refer to in the thesis as focus group 3 or employer question focus group discussion (EFGD). If not appropriately explained to participants, the employer questions had the potential to give the impression that they were a student or graduate performance evaluation tool. This could be either overt or subconscious. Thus, focus group 3 allowed students and graduates to evaluate the employer questions before administering them. Before piloting the questions, I had seven questions in Section A covering basic demographic information and eleven in Section B (Appendix 8). Following on from the pilot, questions in Section B remained the same. It was Section A where changes were made (see Appendix 9). The following three questions were added following feedback from participants:

“What part of the UK is your organisation? Please specify, for example, if your organisation is in England, Scotland, Wales, or Northern Ireland. Also, specify the county or borough your organisation is in”

“How many students and graduates from the BA (Hons) Healthcare Management Programme have you employed and worked with over the past six years?”

“How long have you been working in management (including healthcare)?”

After reflecting on the feedback from the EFGD participants, two of whom have worked in leadership capacities in health and social care, adding these three questions was seen to be crucial in helping clarify employer situatedness in the light of their location and familiarity with students' and graduates' work routine and output.

4.1.3.4 Focus Group Discussion Questions

I developed the focus group interview questions alongside the academic interview questions. This was because academics, students, and graduates, as insiders of the HEI, have good knowledge of the programme and are, therefore, best placed to enunciate its learning experience and knowledge and skills transfer orientation to healthcare management practice. Section A of the interview questions was made up of six demographic questions. Section B comprised nine main and three additional questions for graduates (see Appendix 5).

Following the focus group pilot, the questions were kept as they were, as none of the participant feedback indicated a change in the tool. The slight change in the tool broadened the eligibility to cover graduands. The change was necessitated due to non-eligible participants (i.e., students) contributing to graduate questions exclusively set aside for graduates. This is despite the focus group moderator emphasising the eligibility criteria during discussions with participants. In retrospect, despite identifying the status of every participant on the recruitment spreadsheet shared with proxy data collector 2 (PH), it would have helped to create a separate list for him to use on the day. Nevertheless, despite this slight deviation from protocol, as I reflected more deeply on it, focus groups naturally encourage discussion among participants. For a data collector, it is difficult to track who had said what and whether you would expect a contribution from them on a subject of discussion. For the study, I defined graduates as students who have completed their studies or have officially graduated from the programme (Cambridge Dictionary.Org, 2023). The graduate questions did not add much depth to my analysis, as the level of participation was low.

4.1.3.5 COVID-19's Impact on Access to Participants and Data Collection

The data collection phase coincided with the COVID-19 pandemic and the subsequent lockdown. The pandemic caused significant upheaval in higher education. It spread after it began in Wuhan, China, in 2019. In March 2020, WHO proclaimed it a public health crisis of primary global concern due to its terrible consequences (Di Gennaro et al., 2020). This caught higher education providers off guard, causing in-person teaching to cease. Changes to online learning soon followed (Abi Jumaa et al., 2023). This heralded a disruption to learning (ibid) and research-linked data-gathering activities.

I had to change my data collection plans to online Zoom interviews instead of the (intended) face-to-face for some academic staff (see Appendix 12 for student and academic PIS). According to Pyhältö et al. (2022), the COVID-19 pandemic generally harmed doctoral research projects. The negative impacts are distilled down to impaired data access, eroding scholarly support networks, decreased availability of academic resources, poor work-life balance, and reduced well-being (ibid.). In-person face-to-face contact is considered one of the best ways to gather qualitative data. Even

so, there is little proof that a particular data collection medium is superior to the other as each has weaknesses and challenges that should be thoughtfully evaluated before adoption (Rosenthal, 2016). In light of this, I had to decide if remote data collection could achieve my research goals while maintaining the same depth as face-to-face, information quality, and participant security (Reñosa et al., 2021). Given the significance of data quality, the study also validated respondents' semi-structured interview transcripts and focus group discussion transcripts (i.e., the latter through moderator verification of FGD data).

Zoom provided much-needed convenience, but I discovered that remote qualitative data gathering was more complex than anticipated. Broadly, challenges, for instance, include difficulties with the internet, participants' technology awareness (i.e., technophobia), working out a way to seek ongoing consent (ibid), and maintaining privacy and data integrity (Boland et al., 2021)—all of which were important to my chosen methodology. It, however, conveniently presented me with an opportunity to recruit more participants in the proposed data collection timeframe cost-effectively while engaging a participant group in the HEI not previously accessed by other researchers. Yin (2009) observed that (case study designs) are well placed to enable insider researchers to explore a unique case or help reveal peculiar intricacies around cases (and participant groups) not previously accessed by other researchers. This broadly affirms Oliffe et al. (2020) and Boland et al. (2021), who corroborate the benefits of data collection tools like Zoom. Also, in a study by Archibald et al. (2019), the advantages of Zoom for data gathering outweighed its difficulties. For instance, Zoom's usefulness for collecting qualitative data that might supplement or expand the existing methodological options for qualitative researchers was indicated favourably by the researchers' and participants' overall pleasure with using it (Archibald et al., 2019). This resonates with me, as Zoom interviews allowed me quick access to the data before meeting with my two proxies post-interview or post-focus group for a debrief.

4.2 Ethical Approval

The study followed all guidelines and legal and regulatory standards for primary

research (e.g., Middlesex University and the HEI's code of ethics). Particularly noteworthy are rules and practices that emphasise the autonomy of the 'researched' and respect for individual rights, consent, and confidentiality. Wiles et al. (2005) contend that these regulations and mechanisms are in place to counterbalance the competing interests researchers must deal with, primarily to protect participants' interests and promote ethical behaviour (ibid.). These include Article 8 of the Human Rights Act (1998) and the Data Protection Act 1998 (updated to the General Data Protection Regulation [GDPR], 2017) (Gov.UK, 2018).

This study sought ethical approval from Middlesex University and the HEI's Research Ethics Committees (RECs). I began this process by reflexively engaging with literature on data sources my study would need, where and how best to access these, and the key considerations to make before soliciting formal ethics approval and gatekeeper access (see Somekh and Lewin, 2011). This happened while compiling my Programme Approval Plan (PAP) in 2020. I started gathering the documents for REC submission once approval was given to my programme plan in 2021. Guided interview questions (for focus groups and semi-structured interviews), PIS, consent forms, debrief sheet, gatekeeper letter, fieldwork code of conduct for principal investigators and proxies, and research collaboration agreement documents were among the documents included.

Institutional ethics approval, the first stage of formal ethics application, started with the HEI. This began when I had informal conversations with the HEI's REC secretary, who guided me on the documentation and processes to follow to maximise the chances of securing a successful REC approval outcome. On May 2nd, 2021, after receiving advice and direction about the forms to use and documents required to support my application, I submitted the necessary documentation to the committee. Following this, I received correspondence from the secretary on May 4th to suggest the committee would seek advice from the chair about whether the proposal could go ahead for formal REC review. Finally, on May 14th, I received confirmation of REC approval without conditions (see Appendix 9).

Following institutional REC approval, I completed the Middlesex Online Research Ethics (MORE) forms to kickstart the ethics approval process. However, after

submitting my ethics application – a few months later, some complications emerged. The problem was that, besides the HEI's REC approval evidence, a gatekeeper letter was required from the Head of School of Health and Care in my HEI. However, following a restructuring, the line management structures in our newly created faculty had changed. Securing the gatekeeper letter from my new line manager was somewhat seamless, even though the whole process had delayed the ethics approval process by another few weeks.

The second phase involved the formal Middlesex University REC application. This was the part I found to be the most difficult because it required much reflexivity, determination, patience and a learning mindset to see it through. The REC had requested that I clarify my data-gathering strategy and provide further evidence to support my informed consent procedure. Wiles et al. (2005) noted that these are all critical dimensions of the ethics submission process. Before applying, I had a couple of meetings with my supervisors to explore timelines, gather documentation to submit, and clarify the REC approval process. In all, I submitted twenty-eight documents to support my application. These include the ones initially offered to my HEI but are not limited to that. To illustrate, also submitted were a fieldwork code of conduct for proxies, a conflict-of-interest form, a data protection checklist and declaration form, a gatekeeper letter, a participant invitation letter, and separate participant information sheets for employers, students, graduates, and academics. The initial REC application was submitted on April 30, 2021. REC (and supervisors) provided initial feedback in May/June 2021, along with a request for resubmission. Clarification on the data collection protocol and proxy collaboration agreement was then provided, along with additional information and updated documentation. Ethical approval was finally given on September 6, 2021.

The study population comprised adults over the age of 18. There was no cognitive, sensory sensitivity, or capacity issue. This was an important consideration linked to the Mental Capacity Act of 2005, which offers an extensive mechanism for decision-making for individuals (aged 16 and older) who cannot make their own decisions (NHS Health Research Authority, 2021). This made participant verbal "affirmatory" agreements easier (i.e., before each semi-structured interview and focus group

discussion). The verbal affirmation of consent before interviews aligns with Kadam (2017), who asserted that informed consent should be a process, not just a one-time signature on a form. Clandinin and Connelly (2000) reinforced this stance by proclaiming that it is insufficient to assume that a contract of informed consent obtained at the beginning of a study covers the entirety of the study. My reflexivity heightened my awareness around issues such as researchers occasionally failing to appreciate that consenting to a research study does not constitute a legal contract in which participants are non-faithfully expected to see things through to completion (Rosenstein, 2019).

Reflecting on the ethics process, I recognise the significance of addressing the REC's concern by providing clear, unambiguous information about the study and its purpose (Walliman, 2018) through the PIS, invitation letters, data collection and consent forms. The participants' rights to consent to participate in the study and their ability to withdraw at any moment without repercussions were emphasised at this stage. Barrow et al. (2022) emphasised the importance of this by arguing that research participants have the right to be informed that they are being studied, to understand the type of study in which they are participating, and to be aware that they can leave at any time without giving a reason.

4.3 Phase II: Intra-data Collection and Analysis

This phase presents a synopsis of the steps undertaken during data gathering and the study's implementation of specific protocols. It sets the groundwork for data analysis and the discussion of findings. An important point about this phase is that after expressing interest, completing consent forms, and after interviews and focus group discussions, I shared a thank-you note with participants for taking the time to participate in the study. This note of appreciation aligns with the concept of gratitude advocated by Gibbs (2009). Tables 1-6 reveal who participated in the study, where they were located, the phase of data gathering, and the proxy data collector involved. This part and chapter do not cover the complete participant profile or demographics in Chapter 5.

4.3.1 Piloting Study Instruments

Tables 1-3 provide summary information about participants who took part in the various pilots, which is expanded upon with detailed demographic data in Chapter 5. As noted in the project activities discourse earlier in the chapter, the data collection phase started with a pilot (or pre-test) of the data collection instruments. This took place in different stages between November 2021 and April 2022. The first stage, the academic (pilot) interviews, occurred between November 3rd and 26th and recruited four lecturers (Table 1). Proxy 1 (AM) conducted it. The information from this did not form part of the final data analysis. The reason for its non-inclusion was that, following the pilot, a few of the questions on the instrument required reviewing and modification. Christensen et al. (2015) reinforced the significance of this trial test in ascertaining the pertinence of my data collection tools and pre-emptively resolving adverse issues with the credibility and specificity of such instruments.

The second part was the student and graduate focus group pilot. This was conducted in December 2021. Seven students and graduates participated (Table 2). Proxy 2 (PH) moderated the focus group, lasting just over one and a half hours. Following reviews of the focus group recording and reflective deliberations with PH initially and supervisors, the pilot was adopted as the first focus group (FGD 1). The reason for its inclusion in my analysis was that the students, graduates, and PH affirmed that the questions were clear, cogent and relevant to the intended outcomes outlined in the participant information sheet. This decision is supported by Flynn (2021), who observed how pilot tests' short investigation procedures are instrumental in offering feedback to a more extensive research endeavour.

The third stage of the pilot involved reviewing the employer interview questions with two students and one graduate (i.e., a total of three participants) (Table 3). These two students and one graduate provided their employer contact details and introduced me to them. Nonetheless, for a long time during my analysis, I grappled with whether this number (i.e., three participants in a focus group) fits the threshold of what would account for a pilot. Flynn (2021) provides their general perspective on pilots by postulating that pre-testing appraisal tools and conducting scaled-down versions of more extensive research investigations are pilot studies. Nevertheless, the most

profound literature that helped reassure me was Peek and Fothergill (2009), who observed that small focus groups of between 3 and 5 participants were efficient and suitable for data collection. Lobe et al. (2020) noted that these groups are efficient because they are dexterous in exploring various topics, even within a short time.

The third phase of the pilot was conducted in April 2022. The reason for this was because of the challenges experienced in recruiting employers. Again, the focus group was moderated by PH. Feedback from this helped immensely in improving the interview questions for employers. What I found especially useful from this phase were the suggestions made by participants about potential changes that were required to some of the questions. For example, they argued that the question about employers' locations needed clarifying (see 4.1.3.3 for further context). Tables 1-3 are presented below:

| <i>Participant (pseudonym)</i> | <i>Academic job role</i> | <i>Study Centre</i> | <i>Interviewer</i> |
|---------------------------------------|---------------------------------|----------------------------|---------------------------|
| Nancy | Lecturer/Module leader | Birmingham | Proxy 1 AM |
| Armando | Associate lecturer | London | Proxy 1 AM |
| Kobi | Associate lecturer | London | Proxy 1 AM |
| Josie | Lecturer/Module leader | Manchester | Proxy 1 AM |

Table 1 Participant Details for Academic Pilot

As highlighted above, the academic staff pilot (Table 1) was not analysed as part of the data in the study. This is because the pilot feedback led to changes to the questions.

| <i>Participant (pseudonym)</i> | <i>Student/graduate</i> | <i>Pilot</i> | <i>Interviewer</i> |
|---|--------------------------------|------------------------|---------------------------|
| 1. Chanice | Graduate | Student/graduate pilot | Proxy 2 – PH |
| 2. Kathy | Graduate | Student/graduate pilot | Proxy 2 – PH |
| 3. Mandy | Graduate | Student/graduate pilot | Proxy 2 – PH |
| 4. Mark | Student | Student/graduate pilot | Proxy 2 – PH |
| 5. Abi | Student | Student/graduate pilot | Proxy 2 – PH |
| 6. Tilda | Graduate | Student/graduate pilot | Proxy 2 – PH |
| 7. Emma | Graduate | Student/graduate pilot | Proxy 2 – PH |

Table 2 Participant Details for Focus Group Discussion Pilot

The student and graduate pilot (Table 2) was analysed as part of the data in the study. Because the pilot feedback had yet to lead to changes to the questions, it was used as part of my data (i.e., as FGD 1).

| <i>Participant (pseudonym)</i> | <i>Student/graduate</i> | <i>Pilot</i> | <i>Interviewer</i> |
|---|--------------------------------|------------------------|---------------------------|
| 1. Chanice | Graduate | Student/graduate pilot | Proxy 2 – PH |
| 15. Garry | Student | Student/graduate pilot | Proxy 2 – PH |
| 16. Dame | Student | Student/graduate pilot | Proxy 2 – PH |

Table 3 Details of Employer Question Focus Group

The employer question focus group pilot (Table 3) was not analysed as part of the data in the study. This is because the pilot feedback led to changes to the questions.

4.3.2. Implementing Focus Group Discussions (FGDs)

Access to students in the school was through the programme induction page, which also serves as one of the main communication hubs for programme teams to

communicate with students. However, despite ethical approval from Middlesex University and HEI REC and gatekeeper access, the HEI's Awards and Graduation team (who oversee the data) initially declined my request to access the school's graduate data from 2017 to 2021. This was granted after further consultation with the HEI's Data Protection Officer. I used email as the principal route of contacting and recruiting graduates in the study. Data protection measures at this stage included using blind carbon copy (Bcc) to send a collective introductory message inviting them to the study (see Appendix 3 for the participant invitation letter).

FGD 1 and FGD2 were conducted over two months—between December 1st, 2021, and February 2nd, 2022, with sessions on average taking 60 and 150 minutes. Christensen et al. (2015) observed that focus group meetings are typically between one and three hours long and taped using audio or video. Thirteen students and graduates took part in the FGDs (Table 4). The moderator (PH) skilfully engaged all participants in the FGD, which was crucial, as the same level of detail for individual interviews should be devoted to focus group discussions (Kitzinger, 1995; Flynn, 2021).

In addition, the questions were structured to narrow the topic of discussion to my study. Bell and Walters (2018) assert that focus groups could be fully unstructured, requiring little to no researcher participation, or structured, with pre-written questions and checklists. The structure of my questions meant that I focused on themes in my data that could be triangulated across the dataset. Even so, I exercised caution to ensure there was flexibility for the moderator to prompt students and graduates further and allow them space and time to express their 'voices.' This approach confirms Bell and Waters (2018), who argued that the goal of focus groups is for participants to interact with one another, be open to hearing different points of view, possibly come to an agreement on aspects of the subject or disagree on others and give the topics that interest or matter to them a thorough discussion (Krueger and Casey, 2002).

The role of the researcher in all this shifts from interviewer to moderator or facilitator, leading Clifford et al. (2010) to refer to it as a non-directive, flexible approach to eliciting information during data gathering. According to Brannick and Coghlan (2007), the responsibilities of an insider researcher also include active participation in all phases

of data collection and passive observation of the phenomenon under investigation. While I did not personally moderate the focus group and academic interviews, the Zoom recordings brought me close to the data in a way that felt like I was present.

| <i>Participant (pseudonym)</i> | <i>Student/graduate</i> | <i>Focus Group</i> | <i>Interviewer</i> |
|---|--------------------------------|---------------------------|---------------------------|
| 1. Chanice | Graduate | Focus group 1 | Proxy 2 – PH |
| 2. Kathy | Graduate | Focus group 1 | Proxy 2 – PH |
| 3. Mandy | Graduate | Focus group 1 | Proxy 2 – PH |
| 4. Mark | Student | Focus group 1 | Proxy 2 – PH |
| 5. Abi | Student | Focus group 1 | Proxy 2 – PH |
| 6. Tilda | Graduate | Focus group 1 | Proxy 2 – PH |
| 7. Emma | Graduate | Focus group 1 | Proxy 2 – PH |
| 8. Garry | Student | Focus group 2 | Proxy 2 – PH |
| 9. Lumia | Student | Focus group 2 | Proxy 2 – PH |
| 10. Barry | Student | Focus group 2 | Proxy 2 – PH |
| 11. Omo | Student | Focus group 2 | Proxy 2 – PH |
| 12. Zubayda | Student | Focus group 2 | Proxy 2 – PH |
| 13. Samantha | Graduate | Focus group 2 | Proxy 2 – PH |

Table 4 Details of Focus Groups 1 and 2

4.3.4 Semi-structured Interviews

4.3.4.1 Implementing Academic Interviews

Academic interviews took place between December 6th, 2021, and March 10th, 2022, lasting between 18 and 45 minutes. The nature of discussions in interviews was exploratory, with the proxy data collectors able to ask follow-up questions and clarifications. Both proxy data collectors (AM and PH) supported the academic interviews. This allowed me to reflexively observe differences in approach and

interview style and whether this contributed to deepening discussions between the interviewers and interviewees.

As I found during the study, interviews have numerous benefits, including exploring reasons and feelings, pursuing ideas, and examining responses in ways a poll can never do. Such reactions are ideal during response delivery. For example, vocal inflexion, facial expression, hesitancy (including laughter) (Bell and Waters, 2018; Gall et al., 2013) and uncertainty expressed with remarks like 'I should have seen these questions before', 'Have I answered that question, okay?' Things that I would argue a written reply may hide. Interviews take time to complete (and transcribe), and I could only interview a few individuals at a time. Other interview challenges include bias, problems with response analysis, and formulating interview questions (see Bell and Waters, 2018).

I intended to recruit around ten academic staff for the study. However, the study sparked much interest, with up to 16 potential participants expressing interest. The high uptake was due to the trusting and compassionate relationship I have built with the academic team in the school. This is especially true as I have contributed immensely to developing the school and the academic teaching staff. Also, using the Office 365 email group offered a level of precision that, in my observation, took more work to replicate for student and graduate focus groups.

To ensure that my approach to deciding who would participate in the main study was transparent, I enrolled the first four people who expressed interest in the pilot (pre-test). Three of these would have qualified for the main study because they met the inclusion criteria of having up to two years of experience teaching on the programme or would have reached their second anniversary during the early stages of the data collection process. The remaining twelve were recruited for the semi-structured interview (Table 5).

Following the November pilot, a few questions were changed after participants and proxy 1 (AM) felt they were repetitive. All academic interviews were conducted via Zoom, with the Zoom meetings created by me and invitation links and interview information sent via email to participants and proxies.

Proxies were also added as co-hosts to ensure they could run the meeting without my presence as the meeting host. With my host rights, all Zoom videos were only shared with me, the Zoom account holder. This meant that giving proxies and co-hosts access was not a data management issue because they would not have necessarily received interview recordings. The same was true for the recording of the focus group discussions. Table 5 summarises the participant's information, including the study centre where they are based and the proxy who interviewed them.

Following the first set of academic interviews, a crucial decision was to enlist proxy data collector 2 (PH), who oversaw focus group discussions, to conduct the remaining interviews for the academic staff. What prompted this was my concern that the first set of academic interviews conducted by proxy 1 (AM) were shorter than anticipated, and I was concerned about the depth of conversation. This is especially true given that Proxy 1 (AM) had previously taught the healthcare programme before joining the School of Leadership and Management three years ago. Using proxy data collector 2 (PH) ensured I had a comparator to review the length of interviews, discussion depth and overall participation levels. What was reassuring was that there was no significant difference despite the two differing interviewing styles.

| <i>Participant (pseudonym)</i> | <i>Academic's role</i> | <i>Study Centre</i> | <i>Interviewer</i> |
|---|---|----------------------------|---------------------------|
| 1. Jamela | Lecturer/module leader | Birmingham | Proxy 1 – AM |
| 2. Umaro | Lecturer/module leader | London | Proxy 1 – AM |
| 3. Katherina | Associate lecturer | London | Proxy 1 – AM |
| 4. Daniella | Associate lecturer | Manchester | Proxy 1 – AM |
| 5. Emebo | Associate lecturer | London | Proxy 1 – AM |
| 6. Sara | Associate lecturer | Birmingham | Proxy 1 – AM |
| 7. Peter | Associate lecturer | Birmingham | Proxy 1 – AM |
| 8. Randolf | Programme manager | Birmingham | Proxy 1 – AM |
| 9. Jade | Associate lecturer | London | Proxy 2 – PH |
| 10. Leah | Programme manager | London | Proxy 2 – PH |
| 11. Ethan | Senior lecturer (and portfolio manager) | Berlin | Proxy 2 – PH |
| 12. Ron | Lecturer/module leader | London | Proxy 2 – PH |

Table 5 Details of Academic Semi-structured Interviews

4.3.4.2 Implementing Semi-structured Interviews for Employers

Unlike focus group discussions and academic interviews, I conducted employer interviews. These interviews, like the academic semi-structured interviews, followed a similar format. The only distinction was in the questions. For example, open-ended employer questions tended to delve into the healthcare management sector, management skills and knowledge, strengths and areas for development on the programme.

Students and graduates who expressed interest in participating in the study and those who participated in either focus groups 1 or 2 helped facilitate this. Before providing me with the employer's information, students and graduates consulted their employers for permission. This process initially identified up to seven potential employers. Even so, after numerous exchanges and prompts, only three eventually provided availability to be interviewed (Table 6).

Three separate days were scheduled for interviews. Before scheduling interview dates, I shared the programme website with information about the programme so employers could better see the programme’s learning intention and outcomes. This would have ensured they were fully acquainted with the programme’s scope, teaching and assessment strategy, the theoretical knowledge and graduate skills it promotes, and ‘claims’ to develop. On average, interviews lasted anywhere from 30 to 45 minutes.

| <i>Participant (pseudonym)</i> | <i>Manager/Director/Supervisor</i> | <i>Organisation’s location</i> | <i>Interviewer</i> |
|--------------------------------|------------------------------------|--------------------------------|------------------------|
| 1. Tamika | Service Manager | London | Principal investigator |
| 2. Moses | Managing Director | Manchester | Principal investigator |
| 3. Layla | Service Manager large Charity | Birmingham | Principal investigator |

Table 6 Details of Employer Semi-structured Interviews

4.4 Data Analysis

The first semi-structured interviews were conducted in December 2021, formally kicking off the data collection and analysis phase. The stages involved are discussed further below.

4.4.1 First Stage

Microsoft Transcribe was used as a tool for data transcription in the study. The transcribe tool turns an audio conversation into a written transcript that separates each speaker. It does this while allowing a researcher to save the entire transcript into a Microsoft Word file or cut and paste it into an existing document (Microsoft.com, 2023). My first step in transcribing the data was downloading and saving the interview and focus group discussion videos in mp3 format. At this stage, the data were organised into three subfiles: employer interviews, academic interviews, and student and graduate focus groups.

The size of the files determined the speed with which the data was transcribed. For example, semi-structured interviews had quick audio to Microsoft Word transcription speed of under 4 minutes. In contrast, focus group data took longer (i.e., up to 10 minutes) to convert from audio to text. Before saving the original transcription, I added time stamps and speaker differentiation or identification choices. This was necessary to ensure that information was not attributed to the wrong person in FGDs.

The drawbacks to software like Microsoft Transcribe include that it is only available to those with premium user accounts, such as institutional subscriptions (Microsoft.com, 2023). For me, a difficulty was that the software could not recognise participants by name and therefore used, for example, “speaker one” and “speaker two” to denote participants. I had to painstakingly format the transcribed text and listen to the recording several times to identify and attach names (i.e., pseudonyms) to the right participants. Another challenge experienced (e.g., with FGDs) was that it sometimes attributed wrong words or statements to participants. Addressing these further prolonged the data transcription process. On reflection, however, it was worth it as it gave me a wholly different perspective of the data I was initially detached from because I was not involved in collecting it first-hand as principal investigator.

Despite the challenges with Microsoft Transcribe, I had the first version of the data transcription to share with my supervisors for review. I also shared semi-structured interview transcripts with proxy data collectors and participants involved in semi-structured interviews. This meant all participants involved in semi-structured interviews (i.e., academic staff and employers) could review transcripts for accuracy. Instructions were provided about how to let me know if they would like to add to or challenge the accuracy of the transcribed data. A similar process was implemented for the three focus groups, except that the focus group transcripts were shared with the moderator to review for accuracy and validity. While I had considered extending this to the students and graduates of FGD 1 and 2, it would have been challenging as the transcribed FGD documents were at least 6500 words. The data validation process is a vital component of this stage, as Bell and Waters (2018) noted when they argued that interviewers could say whatever they want (i.e., fabricate data) if their transcribed data is unavailable to crucial stakeholders like participants.

4.4.2 Second Stage

After adding participant pseudonyms and formatting, the next step was to listen to the Zoom recordings while going through the transcribed text line-by-line. As previously stated, integrity is critical at this point. This was done several times for each interview and focus group to ensure that transcription errors, such as incorrect wording, unclear speech attributions, or misspellings, were corrected. Another reason for repeating the line-by-line transcription was to ensure that information such as laughter, silence, pauses, and other expressions were captured and added to transcripts as needed. This enabled a more thorough evaluation of the data.

Nonetheless, I found this process time-consuming, with each interview, focus group transcription and review requiring between one to two and three to four hours, respectively. Transcriptions started early during data gathering. The process lasted for around nine months. Researchers could expect to put in at least 4–8 hours of work per hour of interviewing if they are responsible for the transcription themselves, but this time could increase considerably in some studies (Bell and Waters, 2018; Sutton and Austin, 2015).

4.4.3 Third and Fourth Stages

The third phase was to separate the demographic data from the open-ended questions for the semi-structured interviews and focus group discussions. This was necessary to ensure that the demographic questions did not add another layer of complexity to the coding process, which was to come later. Interviews and focus groups comprised up to 15 pages; removing the demographic questions meant the page volume had reduced significantly. A spreadsheet was created for the demographic questions across all the samples. This formed the basis for the categories of data added to the spreadsheet. This became a valuable source file to refer to when creating case classifications in NVivo during coding.

The fourth phase of the transcription was to proofread the transcribed information again and remove the timestamps now that I was familiar with the data. At this point, it was necessary to remove the timestamps because I discovered that leaving them in

my data had not helped me better understand the data. To ensure NVivo makes sense of my data, I had to reformat the questions using the Microsoft Word heading function with each question. This was an attempt to assure a degree of standardisation that would help NVivo recognise questions and commonalities between case files. The transcribed data was then saved in a new folder and was ready to be imported into NVivo for early coding.

Stage four also included generating codes for the open-ended questions in NVivo after importing the transcribed files. In some instances, NVivo coding was conducted (simultaneously) as the case classifications for each dataset. Reflecting on this process, NVivo functioned as a hub to upload all the data in one place to facilitate my coding, categorisation and theme formation. The initial themes developed amounted to eight. However, after immersing myself in the data analysis and using coding stripes to track duplication, I realised there were repetitions and crossovers across the main themes and some of the sub-themes generated. This needed addressing by revisiting themes and sub-themes to cleanse the data further. Using NVivo coding stripes was quite beneficial at this time. Chapter 5 delves deeper into the six major themes identified in the study.

4.5 Project Write-up

My project write-up was the final part of this project intention, and it offered me an opportunity to reconcile observations and connections in my study in a way that was only noticeable after I undertook the data analysis. This gave me an insight into the degree of precision required to select the literature relevant to my study's context.

I discussed completing chapters 1-3 with my supervisors before my data analysis commenced. Immersing myself in the analysis as the data was gathered gave me a better understanding of how my project concepts had evolved – from an abstract thought guided by predetermined aims and objectives. It also allowed me to apply the data gathering processes, even while grappling with dilemmas such as having my HEI Zoom video download functionality stopped due to organisational policy and the delays this caused to my data transcription and analysis process.

The most challenging segments of my project report were Chapter 3 Methodology, Chapter 5 Analysis and Chapter 6 Discussion. These chapters were chunky, required excellent reflexivity, took longer to complete and were particularly important in verifying the appositeness of my methods and study findings, particularly as they pertained to rigour, integrity, credibility and the transferability of findings. Gerrish and Lacey (2009) maintained that while qualitative investigators should be curious and immersed in their conclusions, they should also ensure that they honestly account for their results without bias.

Like everything else (e.g., the increased pressure of managing portfolios in higher education), the writing process sometimes felt rushed, owing to work obligations and projects I supervised as Deputy Head responsible for overseeing undergraduate programmes and a student population numbered over 3000 as of September 2023.

4.6 Chapter Summary

The chapter examined, among other things, participant recruitment processes, data collection, instrument design, pilot testing and implementation, the impact of factors such as COVID-19 on my project and the procedures for obtaining ethical approval. The project tasks were divided into pre-data and intra-data collection phases. Pre-data collection examined processes adopted to lay the groundwork for the data collection and analysis. Intra-data collection and analysis starts with the formal data collection and analysis phase and extends into the thesis write-up.

As I summarise the chapter, I share my thoughts on the methods utilised in designing the project, the plans set in place at the start of the study and their implementation, and how reflexivity was used throughout the process. My role as an insider researcher steeped in my HEI's inner workings was emphasised. This allowed me to reflect on and contextualise participant feedback while giving them a voice. Also, as I engaged with the data gathered, I noticed that the material before me frequently appeared fragmented. While I could not claim a 'eureka' moment with this during the initial phases of my write-up, I recognised that as I became more familiar with the data, I would likely see a more precise picture emerging that should allow me to further

condense the main themes and sub-themes into a logical and coherent structure.

Chapter 5: Findings

5.0 Introduction

In this chapter, I share my research findings, which initially discuss the demographic details of the study participants. This information contributes to the contextual discourse by describing the characteristics of the different participant groups. Demographic questions comprised closed and open-ended questions that helped establish basic facts that illuminated the context of each participant. The second part pooled, displayed, and thematically analysed responses to open-ended, semi-structured interview and focus group questions. Frameworks proposed by Braun et al. (2018) and Campbell et al. (2021) guided my thoughts and decision-making during the thematic analysis.

I watched the Zoom videos and read the transcripts several times to become acquainted with the focus group and interview data. This was to review the data and rework it to allow me to develop themes relevant to the study. I checked my research diary and supplementary documents for comments and reflections throughout this procedure. Following this, preliminary codes informed a draft codebook developed for comparison later. The third stage of the process was the creation of initial themes, which included a code book to allow for the manual highlighting and sorting of themes and sub-themes to establish relationships. The theme evaluation, which included revisiting NVivo codes to create rational patterns, followed an iterative process (see Appendix 10 for the code book). Theme definition, naming, and report production followed and continued into the writing of this chapter (see 5.2a for an illustration of NVivo code contribution to generating themes and sub-themes).

5.1 Demographic Data

Researchers commonly collect demographic data to characterise the participant population in their investigations, and qualitative studies, like quantitative studies, convey data using stories, table-like layouts, and graphs (Connelly, 2013). The graphs and tables below outline the study's primary demographic data (Tables 7–15).

For ease, the tables present datasets separately for each participant group. Examples

include academic interviews (Table 7), student and graduate focus groups (Tables 11 and 13), and employer interviews (Table 15).

5.1.1 Demographic Profile – Academic Interviews

| <i>No.</i> | <i>Name</i> | <i>Age group</i> | <i>Gender</i> | <i>Ethnicity</i> |
|------------|-------------|------------------|---------------|---------------------------|
| 1. | Daniella | 48-54 years | Female | White |
| 2. | Emebo | 55 and above | Male | Black African |
| 3. | Ethan | 41-47 years | Male | Mixed (White and Chinese) |
| 4. | Jade | 34-40 years | Female | Black African |
| 5. | Jamela | 34-40 years | Female | Black African |
| 6. | Katherina | 55 and above | Female | White |
| 7. | Leah | 55 and above | Female | White |
| 8. | Peter | 41-47 years | Male | White |
| 9. | Randolf | 34-40 years | Male | White |
| 10 | Ron | 48-54 years | Male | Black African |
| 11. | Sara | 41-47 years | Female | Asian |
| 12. | Umaru | 41-47 years | Male | Black African |

Table 7 Age, Gender and Ethnicity - Academic Interviews

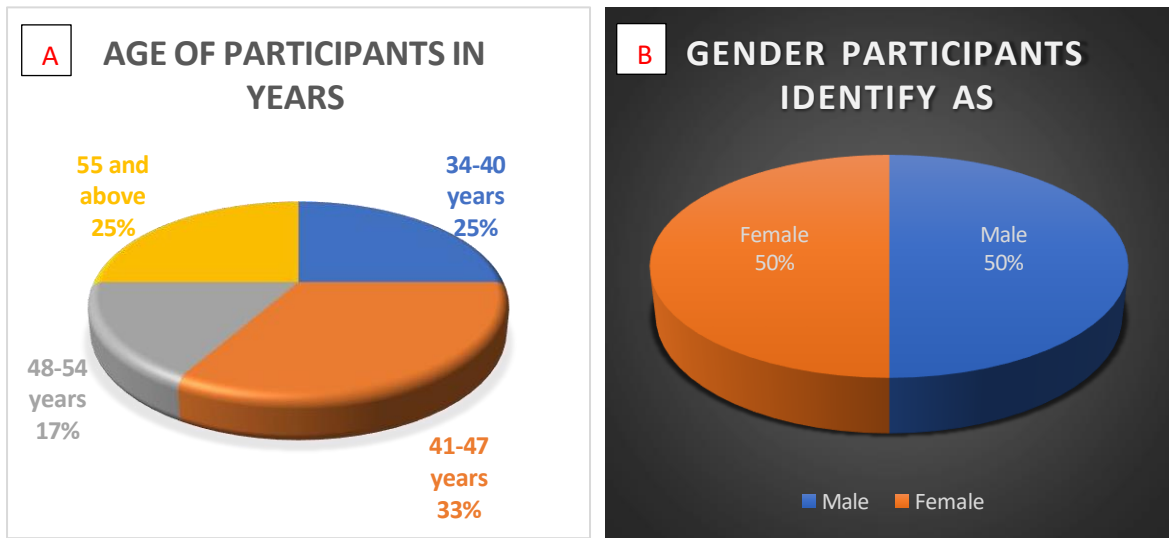


Figure 11 Age and Gender of Academic Participants

The participants in the study ranged in age from 34–40 years old to 55 and older. The 41–47-year age group was, by far, the most represented in the research, accounting for 33% (n = 4) of the study sample (Table 7 and Figure 11). The 48–54-year-old age group had the fewest participants, with only two (17%). The remaining age groups had comparable values. Furthermore, with a 50% split, male and female academics were equally represented in the research. This was fascinating to observe because it was unexpected. With 42% each, the ethnicities most represented in academic interviews were Black African and White. Asian and other mixed ethnicities only accounted for 8% each.

| No. | Name | Role | Module leading experience | Current number of modules |
|-----|-----------|---|---------------------------|---------------------------|
| 1. | Daniella | Associate lecturer | Never | Not Applicable |
| 2. | Emebo | Associate lecturer | Never | Not Applicable |
| 3. | Ethan | Senior lecturer (also manages Academic Enhancement and Quality) | Previous | Not Applicable |
| 4. | Jade | Associate lecturer | Previous | Not Applicable |
| 5. | Jamela | Lecturer and module leader | Current | 3 |
| 6. | Katherina | Associate lecturer | Never | Not Applicable |
| 7. | Leah | Programme manager | Previous | Not Applicable |
| 8. | Peter | Associate lecturer | Never | Not Applicable |
| 9. | Randolf | Programme manager | Never | Not Applicable |
| 10. | Ron | Lecturer and module leader | Current | 3 |
| 11. | Sara | Associate lecturer | Never | Not Applicable |
| 12. | Umaru | Lecturer and module leader | Current | 3 |

Table 8 Role and Module Leading Responsibility

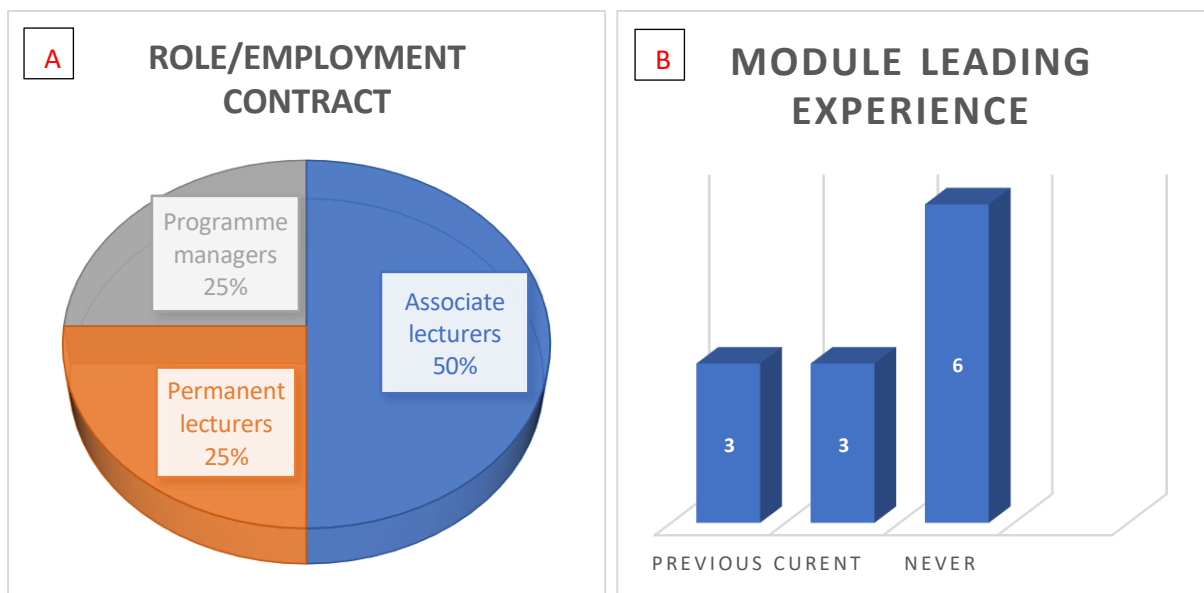


Figure 12 Role and Module Leading Responsibility

Three of the twelve academic participants (Ethan, Leah, and Randolph) were senior lecturers and managers in the school with portfolios spanning 'Academic Enhancement and Quality', 'Apprenticeships', and 'Postgraduate' studies, respectively. There was an even split between participants who worked as permanent (academic) staff members and associate lecturers (Table 8 and Figure 12). Although permanent lecturers conduct module-leading responsibility, three associate lecturers had previously led modules in the school. This is immensely helpful in providing an in-depth understanding of teaching modules and what it takes to manage and coordinate module delivery teams and resources. The findings also affirmed that, on average, module leaders lead up to three modules.

| No. | Name | Programme teaching experience | Study centre | University (HE) lecturing experience |
|------------|-------------|--------------------------------------|---------------------|---|
| 1. | Daniella | 2-3 years | Manchester | 3-4 years |
| 2. | Emebo | 1-2 years | London | 1-2 years |
| 3. | Ethan | 1-2 years | Berlin | Over 7 years |
| 4. | Jade | 5 years | London | Over 7 years |
| 5. | Jamela | 3 years | Birmingham | 3-4 years |
| 6. | Katherina | 2-3 years | London | 3-4 years |
| 7. | Leah | 5 years | London | 5-6 years |
| 8. | Peter | 2-3 years | Birmingham | Over 7 years |
| 9. | Randolf | 2 years | Birmingham | 1-2 years |
| 10. | Ron | 5 years | London | Over 7 years |
| 11. | Sara | 2 years | Birmingham | 5-6 years |
| 12. | Umaru | 4 years | London | 3-4 years |

Table 9 Study Centre, Programme and University Teaching Experience

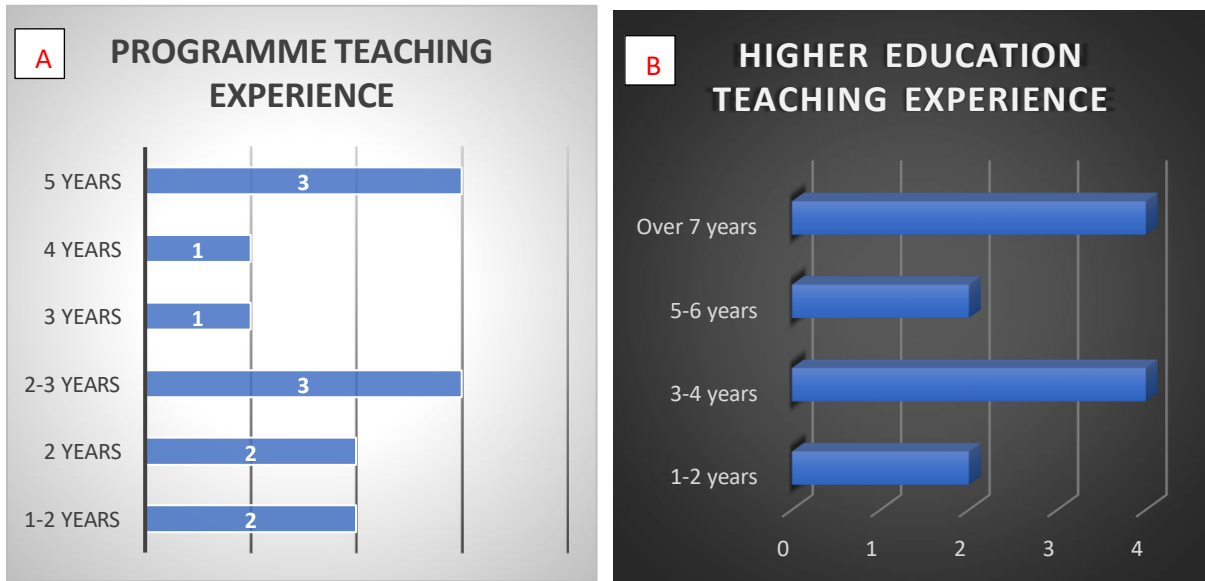


Figure 13 Programme and Higher Education Teaching Experience

Participants have instructional experience ranging from 1-2 years to 5 years on the programme. For relationship development, this still makes the group a young team. Fifty percent of the academics had taught the programme for at least two years and up to five years. Compared to the participants' higher education teaching experience, it is noteworthy that 67% (8 participants) have experience ranging from just over three years to more than seven years. London was also responsible for half of the academic participation in the research (Table 9 and Figure 13). Despite this, all study centres were represented, including Berlin, a smaller centre with fewer academic employees than the UK study centres.

| No. | Name | Statement best describing academic experience |
|-----|-----------|---|
| 1. | Daniella | <i>A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice.</i> |
| 2. | Emebo | <i>A practitioner-academic actively working in a recognised professional role.</i> |
| 3. | Ethan | <i>A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice.</i> |
| 4. | Jade | <i>A practitioner-academic actively working in a recognised professional role.</i> |
| 5. | Jamela | <i>A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice.</i> |
| 6. | Katherina | <i>An academic neither actively participating in academic scholarly activity nor working in a recognised professional capacity.</i> |
| 7. | Leah | <i>A practitioner-academic who has not worked in a recognised professional capacity for over 2 years.</i> |
| 8. | Peter | <i>A practitioner-academic actively working in a recognised professional role.</i> |
| 9. | Randolf | <i>A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice.</i> |
| 10. | Ron | <i>A practitioner-academic actively working in a recognised professional role.</i> |
| 11. | Sara | <i>An academic neither actively participating in academic scholarly activity nor working in a recognised professional capacity.</i> |
| 12. | Umaru | <i>A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice.</i> |

Table 10 Academic Staff Professional Work Experience

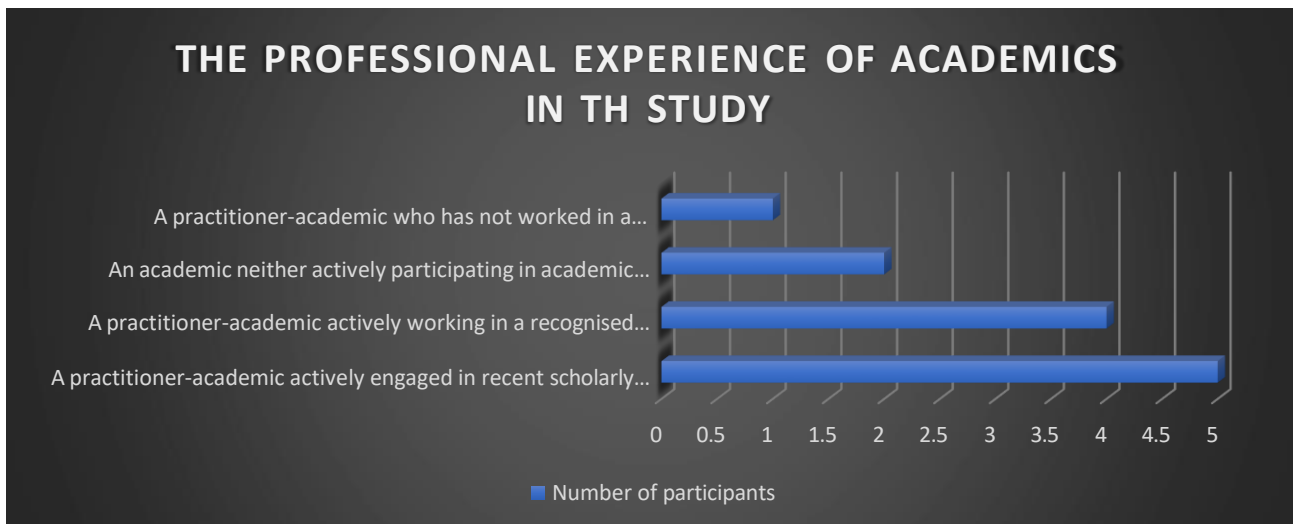


Figure 14 Professional Experience of Academics

When asked how they would like to describe their professional experience, 75% of

academic participants identified themselves as either ‘practitioner-academics actively engaged in recent scholarly activity related to healthcare practice’ or ‘practitioner-academics actively working in a recognised professional role’ (Table 10 and Figure 14). This is significant in proportion since most students enrolling in the degree have moderate-to-substantial health and social care employment experience that they bring to the blended learning healthcare management programme.

5.1.2 Demographic Profile – Focus Group Discussion 1 and 2 Combined

| No. | Name | Age group | Gender | Ethnicity |
|------------|-------------|------------------|---------------|----------------------------|
| 1. | Abi | 50 and above | Female | Black British |
| 2. | Barry | 34-41 years | Male | Black African |
| 3. | Chanice | 42-49 years | Female | Any other Asian Background |
| 4. | Emma | 50 and above | Female | Black British |
| 5. | Garry | 26-33 years | Male | Black British |
| 6. | Kathy | 42-49 years | Female | Black African |
| 7. | Lumia | 50 and above | Female | White |
| 8. | Mandy | 50 and above | Female | Black African |
| 9. | Mark | 42-49 years | Male | Black African |
| 10. | Omo | 26-33 years | Female | Any other black background |
| 11. | Samantha | 50 and above | Female | Black British |
| 12. | Tilda | 50 and above | Female | Black British |
| 13. | Zubayda | 50 and above | Female | White |

Table 11 Age, Gender and Ethnicity of FGD Participants

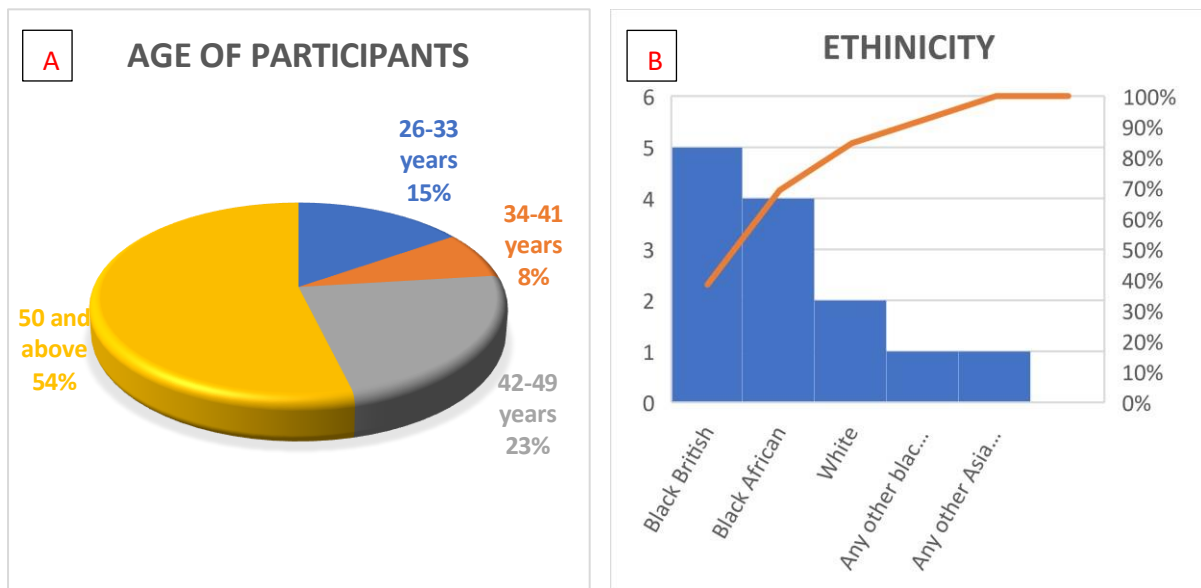


Figure 15 Age and Ethnicity of FGD Participants

Only three students and graduates in Focus Groups 1 and 2 identified as male; hence, 77% were female. Over 50% of participants were 50 years or older. This information sheds light on their experience in health and care delivery in the UK and beyond. The Black British group (i.e., five of them) had the highest ethnic representation in the study, followed closely by the Black African (i.e., four) and White groups (i.e., two). Any other Black or Asian background—together, these two groups comprised 15% of participants (Table 11 and Figure 15).

| No. | Name | Status | Highest qualification before enrolment | Work experience |
|-----|----------|----------|--|-----------------|
| 1. | Abi | Graduate | NVQ 4/5 | More than 10 |
| 2. | Barry | Student | BTEC HND Level 5 | 4-6 years |
| 3. | Chanice | Student | BTEC Extended Diploma Level 3 | 1-3 years |
| 4. | Emma | Graduate | BTEC HND Level 5 | More than 10 |
| 5. | Garry | Student | BTEC HND Level 5 | 4-6 years |
| 6. | Kathy | Graduate | Access to Nursing/Healthcare Level 3 | 4-6 years |
| 7. | Lumia | Student | BTEC Extended Diploma Level 3 | 1-3 years |
| 8. | Mandy | Student | BTEC HND Level 5 | 1-3 years |
| 9. | Mark | Graduate | BTEC HND Level 5 | More than 10 |
| 10. | Omo | Graduate | Access to Nursing/Healthcare Level 3 | More than 10 |
| 11. | Samantha | Graduate | BTEC HND Level 5 | More than 10 |
| 12. | Tilda | Student | NVQ 2/3 | More than 10 |
| 13. | Zubayda | Student | NVQ 2/3 | More than 10 |

Table 12 FGD Participant Status, Work Experience and Highest Qualification

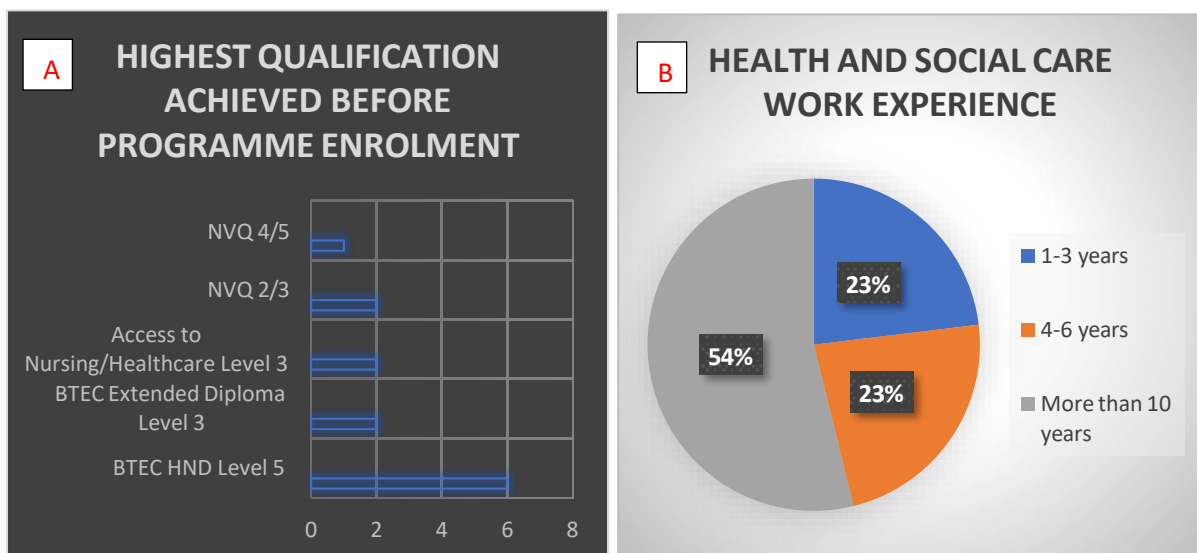


Figure 16 Highest Qualification and Work Experience

Student representation in the study was 54%, slightly higher than graduate representation (46%). Data on the highest qualification obtained before course enrolment revealed that 46% of those who enrolled did so after earning their BTEC Level 5 HND in Health and Social Care. This group would have enrolled in the 1-year degree top-up pathway after their request for credit exemption through Accredited Prior Credential Learning (APCL) was granted. Qualifications such as the NVQ level 4/5 (8%)—which would indicate that the candidates have achieved or are working towards obtaining their CQC registered manager status—were also listed as qualifications with which participants enrolled in the course. The remaining categories, i.e., NVQ 2/3, L3 Access to Nursing and Healthcare, and BTEC Extended Diploma, showed a percentage score of 14% each (Table 12 and Figure 16). All participants in the study were working in health and social care or a related field, with the least amount of experience being 1-3 years and 4-6 years (i.e., 23% in each case), respectively. The remainder (i.e., 54%) have more than ten years of experience in the sector.

5.1.3 Demographic Profile – Employer Interviews

| <i>No.</i> | <i>Name</i> | <i>Age</i> | <i>Gender</i> | <i>Job title</i> |
|------------|-------------|--------------|---------------|--------------------------------|
| 1. | Layla | 55 and above | Female | Service Director Charity |
| 2. | Moses | 55 and above | Male | Managing Director and Owner |
| 3. | Tamika | 55 and above | Female | Service Director |

Table 13 Age, Gender and Job Title of Employers

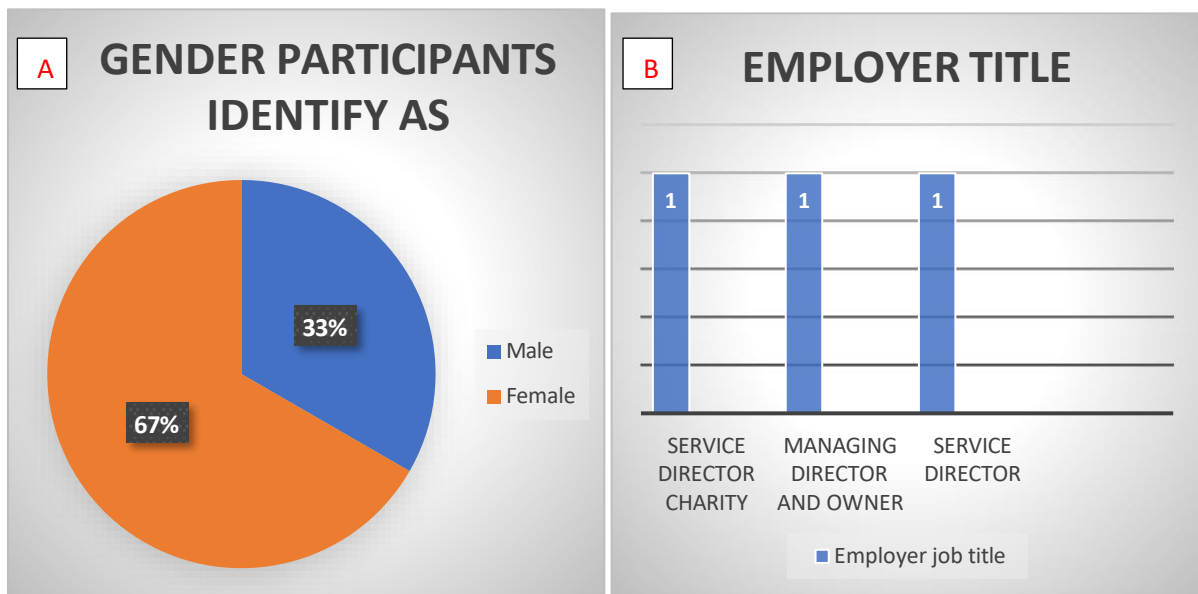


Figure 17 Gender and Employer Title

The employers recruited for the study were all 55 and older. There were 67% women and 33% men. Two managers (67%) have job titles that imply they are service directors, albeit one is in social care and the other is in the voluntary/third sector (Table 13 and Figure 17). The employer, who claimed to be the managing director and owner, operates a franchised home care business.

| No. | Name | Management Qualification/s | Management Experience | Sector and Organisation Location |
|------------|-------------|--|------------------------------|--|
| 1. | Layla | CMI Level 5 Certificate in Management and Leadership | 9-12 years | Large Charity – Birmingham and West Midland area |
| 2. | Moses | MBA, MA Strategic Marketing and NVQ Level 5 | 5-8 years | Care Services - home care – Manchester |
| 3. | Tamika | NVQ Level 5 and Registered Nurse (RN) | 21-24 years | Care Services - care home – South-East London |

Table 14 Management Qualification, Experience and Organisation

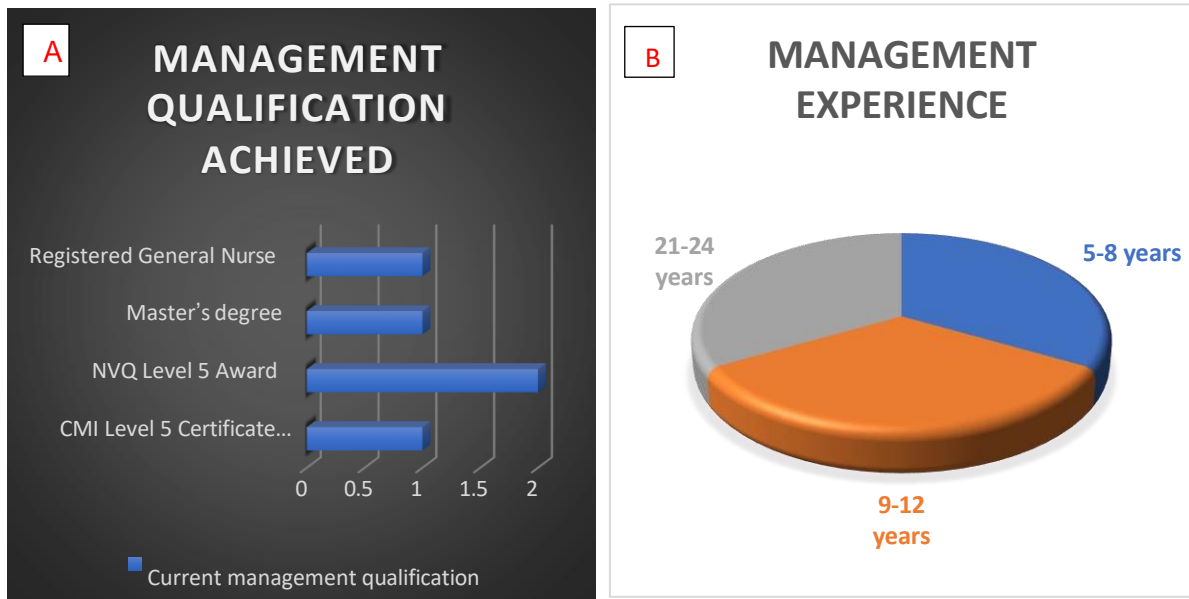


Figure 18 Management Qualification and Experience

Employers' organisations and work locations are across three English regions: Birmingham, London, and Manchester. While Tamika and Moses run smaller organisations, Layla works for a large charity serving a sizeable catchment area, including Birmingham, Coventry, Cumbria, Kirklees, Leeds, Lincolnshire, Milton Keynes, and Northumberland.

The managers' educational backgrounds and skills range from an NVQ Level 5, a CMI Level 5 Certificate in Management and Leadership, and a Registered General Nursing qualification to an MBA and an MA in Strategic Management. The employer with the least experience (between 5 and 8 years) had the highest qualification and had previously managed projects in the construction industry before working in care (Table 14 and Figure 18). Tamika and Moses, unlike Layla, are formally dually qualified, having completed two separate courses linked to their care management work.

| No. | Name | Programme students and graduates employed | Other higher education students and graduates | Organisation's recruitment strategy |
|-----|--------|---|---|---|
| 1. | Layla | 3 | 6 | Indeed, and adverts in local papers |
| 2. | Moses | 1 | 2-3 | Indeed, Facebook advertising, Google Ads and links with organisations |
| 3. | Tamika | 2 | 7 | Job Centre |

Table 15 Employers' Recruitment Strategy, Students/Graduates Employed

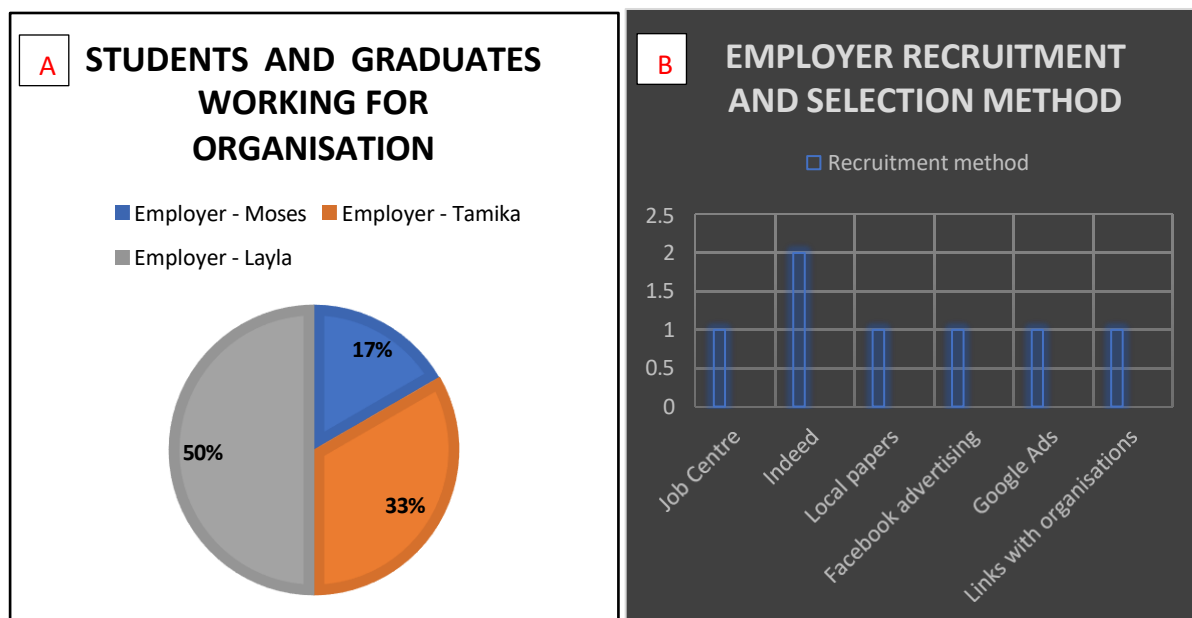


Figure 19 Student and Graduate Working for Organisation and Employer Recruitment

The distribution of BA (Hons) Blended Learning Healthcare Management students and graduates across the three organisations reveals that 50% of them work for Layla's company. Moses employs the fewest students and graduates (17%, or one student) (Table 15 and Figure 19).

Also, despite only hiring through the Job Centre, Tamika employs the highest number of higher education students and graduates (i.e., seven). With six students, Layla

closely trails. Despite using more recruitment channels, Moses' organisation had the fewest number of higher education students and graduates working for them.

5.2 Generated Themes

Themes generated from the study are presented and contextualised in this section – in line with the study's situatedness.

5.2a Context and Illustration of Theme Generation

Following data analysis in NVivo, I generated six main themes from the study. Participant quotes aided the discussion of the themes and sub-themes emerging from the study. The participant quotes were also instrumental in showing links and connections between participants' thoughts and views. The NVivo summary codebook tables in the chapter summarise these to provide a reasonable basis for understanding how main themes interact with sub-themes across the whole dataset. I have added a fuller thematic code book in the appendix section for further information (Appendix 10).

I illustrate below an example of how I reviewed, coded and used a participant quote to aid the development of one of the themes and sub-themes discussed later in the chapter. The illustration is linked to a question participants were asked (in the focus group) about their expectations of the programme when they sought enrolment. In her response, the participant indicated:

“My reason to choose the healthcare programme [...], I was a nurse, even in my country, so I have plenty of years of experience, and, uh, I would like to have the knowledge to be a good manager, be able to provide the best care for the service users and support, uh, the team, the staff [...]. My expectation is [...] more information about the safeguarding, the CQC [...], policy and legislation”
(Zubayda, 50 and above, student, focus group 2).

The remark highlights the students' prior experience and information and addresses their expectations of the programme. The expectations broadly involve leadership expertise, service management, and other sector-relevant transferable skills, such as regulation. After assessing the student and graduate focus group and employer data

sets, which had questions about expectations of the programme around the time of enrolment, I created theme one (see Table 18) to categorise the codes together with similar ones. I then observed that there were 35 codes under the theme. This demanded further sub-theme structuring for a deeper examination and coherent reporting. I noticed that students and graduates appeared to have slightly different expectations of the course than employers. Following this, I created two unique sub-themes for theme 1, “sub-theme 1: employer expectations” and “sub-theme 2: student and graduate expectations.”

I initially categorised Zubayda's perspective under “sub-theme 2: student and graduate expectations”, which it naturally fitted under. However, I still had twenty-four codes under this sub-theme to analyse and determine the best way to interpret and report. Again, after an in-depth examination of the dataset, I realised there was a further opportunity of further categorising the codes for “student and graduate expectations” into two additional sub-themes: “employment, self-improvement, and applying learning to practice” and “Leadership, management, and other transferable skills.” After developing these two new sub-themes, I concluded that Zubayda's comment best falls under the “Leadership, management, and other transferable skills” sub-theme. I reviewed these later as my analysis ensued (using my reflexivity and NVivo coding stripes) to ensure I had not duplicated it elsewhere in the thematic analysis.

The following were the main themes generated from the findings (see Figure 20):

- i. Knowledge, characteristics, skills and employability expectation*
- ii. Strengths*
- iii. Length of stay with employer and reason*
- iv. Knowledge, skills and transfer to practice*
- v. Suggested improvements*
- vi. The current higher education landscape*

5.2b Taxonomy of Themes with Associated Sub-themes

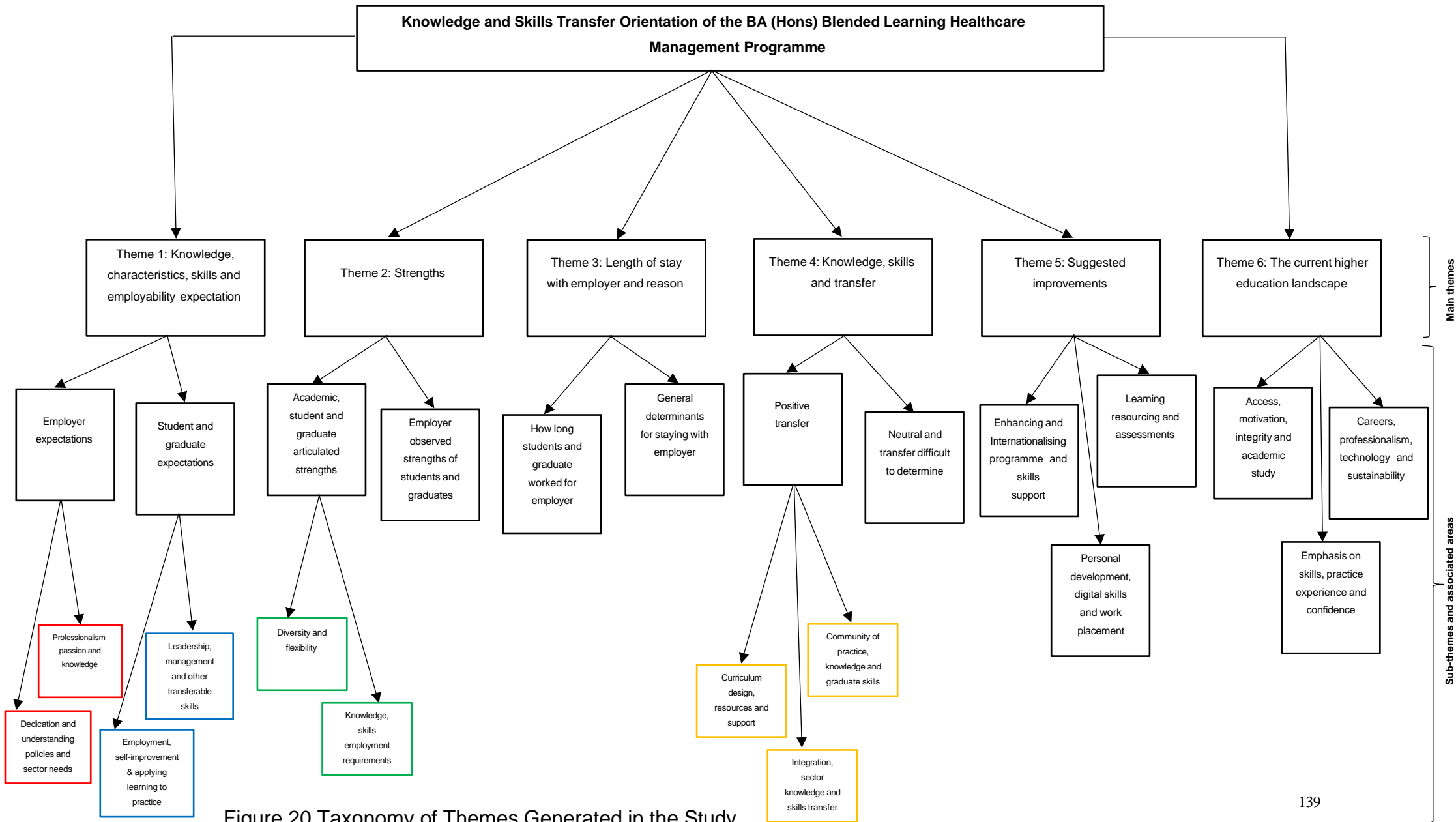


Figure 20 Taxonomy of Themes Generated in the Study

5.3 Theme 1: Knowledge, Characteristics, Skills and Employability Expectation

| Theme and Sub-theme name | Files | References |
|---|----------|------------|
| Knowledge, characteristics, skills and employability expectation | 5 | 35 |
| <i>Sub-theme 1: Employer expectations</i> | <i>3</i> | <i>11</i> |
| Dedication and understanding policies and sector needs | 3 | 5 |
| Professionalism, passion and knowledge | 3 | 6 |
| <i>Sub-theme 2: Student and graduate expectations</i> | <i>2</i> | <i>24</i> |
| Employment, self-improvement and applying learning to practice | 2 | 8 |
| Leadership, management and other transferable skills | 2 | 16 |

Table 16 Theme 1 Summary

Table 16 provides a summary of theme one and its associated sub-themes. This is a core theme in the study. The theme underscores two areas: a) the knowledge, characteristics and skills employers expect of graduates and students from the programme; b) the knowledge, characteristics and skills expectations students and graduates have of the programme – particularly before and during programme enrolment. These are a central part of the graduate employability skills espoused by the healthcare management sector (see Stefl, 2008).

5.3.2 Sub-theme 1: Employer Expectations

Employers identified students, programme graduates and higher education graduates' readiness to work in the health and social care sector as an essential factor for them. I have discussed the sub-themes forming the theme below, starting with 5.3.2.1.

5.3.2.1 Sub-theme 1a: Dedication and Understanding Policies and Sector Needs

As a sub-theme, this is one of the most significant in its association with employer expectations. Moses contends that dedication and understanding of regulator and sector expectations are essential to him when employing students and graduates with healthcare management knowledge and qualifications. To explain his reasoning with specific reference to the student in his care organisation, he stated:

“Yeah, she's very driven and dedicated, you know, she spends her own time learning more. [...] what would be important to us and the learning is that they come out, you know, understanding [...] the key lines of inquiry, and what CQC is looking for and how to make sure we've got the evidence to support, you know, the five key lines of inquiry that we are, uhm, inspected against. Uhm, yeah” (Moses, 55 and above, managing director and owner, home care service, employer).

Tamika coined professional dedication differently, relating it to students' commitment and dedication to their higher education study. She also mentioned how much commitment to one's education may be extended to imply that a healthcare student has strong organisational skills for managing their work-study life.

“The other thing I look for, which may be is how serious are they with their education. Some [...] student [...] are doing 40/50 hours a week. I don't encourage that here and your students that I have seen, the two [...] I don't know what your programme entails, but they will tell you: ‘No, I don't want more than two days,’ even get them to do three days [...], they'll say No, I've got to submit my module, and I have to meet deadlines [...]. People in management need to show [...] and develop certain skills like organising themselves, and these are skills [...] I look for and forms my opinion about people [...].” (Tamika, 55 and above, service director, mental health care home, employer).

On the other hand, Layla highlighted a unique concern with higher education students and graduates who struggle to demonstrate flexibility and the skill to contextualise knowledge in a way that allows them to apply their learning to practice fully. Layla's contention is particularly the case when dealing with practical workplace challenges. She stated:

“[...] whatever degree or whatever you're doing, uhm, a book is very good, you know, the books are great, and what we learn in university is fantastic, but when you get on the actual ground, when you're [...] working on the ground [...] sometimes the books are not always right, or there is a level of correctness there, but life isn't always as it seems, is it? So, I think people need to be able to adjust that and be flexible in their thinking to think, well, okay, I learnt this, but in this situation, it doesn't quite work.” (Layla, 55 and above, service director large charity, employer).

While flexibility and adaptability were central to Layla's expressed frustration, she also suggests reflexivity and phronesis as necessary components for transferring

knowledge from theory to practice scenarios.

5.3.3 Sub-theme 1b: Professionalism, Passion and Knowledge

Professionalism, passion, and knowledge of healthcare management work were expectations all employers expressed as being important to them. While citing an example of our student Garry, who had an intention of working in healthcare-related policy decision-making after completing his degree, Tamika explained:

“[...] things I tend to look for the first thing is the passion [...] people do some courses because it's readily available I tend to look for their passion in healthcare management [...]. Now, the other things that I look for its [...] their seriousness – their understanding of what they really wanted to do [...] (Tamika, 55 and above, service director, mental health care home, employer).”

When prompted to clarify what she meant by ‘seriousness,’ a term she referred to while articulating her expectations of employees, Tamika explained how she associates this with professionalism. To elaborate, she suggested:

“Is something linked to professionalism and when I say professionalism [...] so in terms of their seriousness, it's about their profession, understanding boundaries, developing communication skills, what to say, what not to say, your role, what is expected of you, and you know managing a group of people, managing service users [...].” (Tamika, 55 and above, service director, mental health care home, employer).

Moses added to this by understandably saying that his attribute expectations of managers differ from those of care workers hired to do personal care chores. He said:

“Yeah, if we're looking for someone, it will tend to be a senior role or a management role. Uhm, I would look out for someone who understands the Health and Social Care Act and its requirements, not necessarily the details of the Act, but you know, their responsibilities with regards to regulation and compliance with the [...] key lines of inquiry from the CQC [...]. So, uhm, knowledge and [...], you know, management potential, intelligence, you know, to be able to read and write properly, [laughs].” (Moses, 55 and above, managing director and owner, home care service, employer).

Layla raised expectations similar to Moses's about the essential knowledge and skills she would expect from students and recent graduates. For example, knowledge of the setting, CQC requirements, and safeguarding, among others, yet it was worth noting that, just like Moses, Layla also mentioned basic academic skills like written communication as being especially important to her. She said:

“[...] basic things that, you know, that they can actually, you know, write a decent letter or a report; so those are the things that I look for.” (Layla, 55 and above, service director large charity, employer).

Layla also highlighted that understanding and applying person-centred care and a supportive leadership style is crucial to her as an employer. She clarified this by adding that what is essential for her is knowing that employees incredibly efficiently care for vulnerable service users in their care. She indicated:

“I interviewed a manager for our care home, uhm, about three or four years ago, and one thing that really stood out, [...] they genuinely want to look after the people that we [...] are responsible for. [...] What really stood out to me was the genuineness of him of wanting to care for our residents, but also the caring of the staff as well [...]. (Layla, 55 and above, service director large charity, employer).

5.3.3 Sub-theme 2: Student and Graduate Expectations

Codes under this sub-theme affirm the diverse knowledge and skills expectations students and graduates have about the programme. I coded the information under this sub-theme within broad views of expectations expressed before and during programme enrolment. To illustrate, all candidates said unequivocally that they joined the programme with certain expectations of what the programme would support them in developing as managers. Students' and graduates' expectations are further discussed below under two more sub-themes: “Employment, self-improvement and applying learning to practice” and “Leadership, management and other transferable skills.”

5.3.3.1 Sub-theme 2a: Employment, Self-improvement and Applying Learning to Practice

Participants indicated that the theoretical knowledge and skills developed through the programme, as well as the practice experience and simulation of the healthcare management workplace in the classroom, are crucial in boosting overall employment opportunities. Exploring participant feedback associated with this theme, I observed that Mark believed the programme was central to helping him secure work in the healthcare industry. He indicated the following:

“Yes, I was hoping to have, uhm, easy employment opportunities in the [...] healthcare industry. That was what I was hoping for and, and definitely [...] I was able to get employment easily.” (Mark, 42-49 years, student, focus group 1).

While emphasising the importance of assuming a manager persona and recognising his responsibilities as a government (student loan company) funded student, Barry noted how his experience of the programme aligns with notions he had about it beforehand, especially when it came to meeting deadlines, applying oneself to practice deriving maximum benefit from the programme.

“[...] The moment I joined the programme, I felt that I was already a manager because [...] when I'm being paid to do something, that means I have a responsibility right there [...]. That entails my time [...] keeping, making sure I meet deadlines, making sure I do well in my assignment, making sure I work with my team in class to help them, and they helping me to reach my full potential [...] I was very determined to ensure that I take something valuable with me [...], that I'm ready for employment [...].” (Barry, 34-41 years, student, focus group 2).

Garry offered a detailed appraisal of his experience studying the programme, claiming that his initial expectations had been surpassed. He highlighted how the theory learnt had married with his practical experience working in a mental health service delivery. This would also support Garry's employer (i.e., Tenny) in her assessment, which shows that Garry continued to display the healthcare management knowledge, skills, and attributes that she would expect of a healthcare management trainee. Garry stipulated the following:

"[...] To be honest, it prepared me more than I expected it to with the wide, with the vast range of knowledge through the modules and the practical experience from working and different situations arising [...]. The theory side - getting the knowledge from, from even one of the modules Meeting the Needs of Service Users, so many modules I can name, and it just expanded my knowledge, [...]. I'm not looking at a local level anymore; I'm looking at situations [...] on a global level [...]; it overprepares you; you just have to be ready to put in the work." (Garry, 26-33 years, student, focus group 2).

Reflecting on her personal experience of the impact of COVID-19 on their learning, Lumia expressed how she found the self-improvement opportunities offered by the programme to boost her career readiness and confidence to such an extent that, despite the COVID-19 pandemic and disruptions she experienced, she now has more clarity about where her future career plans lie. She stated:

"Uhm, how was I hoping it would prepare me for future employment in healthcare management [...] I was hoping that I could, as I went to learn and progressed from year one to year two to year three, I actually decided that I would like to work in resources, uhm, which this programme prepares you for [...]." (Lumia, 50 and above, student, focus group 2).

5.3.3.2 Sub-theme 2b: Leadership, Management and Other Transferable Skills

With regards to this sub-theme, while participants' comments were unique in their manner of articulation, it appears to show that all participants had a preconceived notion about how the programme would assist them in acquiring specific knowledge or skills that would help them progress (professionally) in their work. To illustrate, Emma contended:

"Yeah, I was expecting [...] to gain knowledge and skills to manage, uhm, care homes." (Emma, 50 and above, graduate, focus group 1).

Emma expressed her expectations about the broad knowledge and abilities to help her manage a care facility. Despite this, Tilda and Mark, for example, had specific knowledge and capabilities in mind. Tilda stated:

"I mean, when I came in for the course, I was expecting to improve on my

communication and team working with my colleagues and even with the, uh, customers that we are supporting.” (Tilda, 50 and above, graduate, focus group 1).

Tilda's view was similar to Mark's. Unlike Tilda and Emma, however, Mark associated this with critical thinking and the application of knowledge to practice. He stated:

“Uhm, for me, OK, yeah, I was trying to improve my, uhm, critical thinking [...] so that I can [...] transfer it into uhm practical skills [...]” (Mark, 42-49 years, student, focus group 1).

Although this might be obvious given that the programme is a healthcare management programme with a specific focus on leadership training, several participants indicated that they expected the programme to assist them in building capacities for leadership. As an example, a participant named Kathy expressed the following viewpoint:

“To improve on my leadership skills and interpersonal skills at a professional level.” (Kathy, 42-49 years, graduate, focus group 1).

Kathy's view about enhancing her interpersonal skills was affirmed by Chanice, who noted that she expected to develop specific transferable skills linked to healthcare management practice - for instance, communication and management skills. Lumia also corroborated Kathy, Mark and Chanice. Nevertheless, she reflected on the overall influence of the undergraduate programme on widening her managerial horizon. As a result, she posits that she was encouraged and invigorated to revisit the course materials to ensure she could immerse herself and study them again to consolidate her understanding of management practice.

“[...] I expect to learn more about leadership skills, but I learned a lot more than that. I've just completed my third year [...], and I think I'm going to have to revisit my first and second-year notes [...] [laughs] because there was so much to learn, and it was really interesting, but at the end of the day, you need to revisit to get the full, uhm, benefit of all that you learnt [...] there was so much, it was absolutely packed and very interesting so, and enjoyable, mostly.” (Lumia, 50 and above, student, focus group 2).

Zubayda referred to her experience working as an overseas-trained clinician who had

hoped that by enrolling in the programme, she would develop management knowledge and skills to deliver individualised care while collaborating with other critical stakeholders in regulated care. Abi's view crystallised this and what most other participants expected of the programme – that is, about the knowledge, skills and employability aspects, and how this connected with her belief of what the programme offered her as she embarked on a career change. She observed:

“I wanted more knowledge of the healthcare industry because I come from a different background, and I wanted to, uhm, change my career totally, so I wanted more information on what goes on in the, in the healthcare sector. I mean, obviously being, uhm, a leader already in the field that I was in. So, it just helped me to improve more on all of what everyone has said [...]. Also, because I wanted to set up, uhm, in the future, have a company with my kids; so, and they were already in the healthcare sector, so I wanted to [...] see what part of the healthcare sector could actually work in.” (Abi, 50 and above, student, focus group 1).

Samantha suggested that having a management qualification at the end of their studies motivated many learners to join the programme, as this is what distinguished them from non-graduates. Samantha reinforced notions raised by other participants (e.g., Omo) about her lack of formal qualifications before joining the programme. This suggests that she expected the programme to support her in proving her professional standing while giving her transferable skills to leverage additional job opportunities in the sector. In line with this, Samantha further acknowledged the positive effect studying the programme had on her.

“[...] Uhm, I had already been in management for 13 years and, [...] we had a change of management that got rid of us, because I wasn't qualified, so my main aim for coming in there was to get a qualification as a manager. I decided [...] I will need to go and seek knowledge in the health industry. So, I took up [...] work on the side to gain an insight into it and the knowledge from the course actually helped propel me to the next level, which was gaining insight into the CQC aspect that my colleague already mentioned and uhm, the care [...] management.” (Samantha, 50 and above, graduate, focus group 2).

5.4 Theme 2: Strengths

| Name | Files | References |
|---|-----------|------------|
| Strengths | 17 | 51 |
| <i>Sub-theme 1: Academic, student, and graduate articulated strengths</i> | 14 | 44 |
| Diversity and flexibility | 10 | 17 |
| Knowledge, skills and employment requirements | 11 | 27 |
| <i>Sub-theme 2: Employer observed strengths of students and graduates</i> | 3 | 6 |

Table 17 Theme 2 Summary

A significant number of codes were associated with this theme. As a theme, it brings together the strengths of the programme as viewed by students, graduates, and the academics interviewed in the study, together with the strengths employers saw in students and graduates. This data is crucial in serving as a conduit between Theme 1, knowledge, characteristics, skills and employability expectation; Theme 4, knowledge and skills transfer to practice; and Theme 5, suggested improvements. The sub-themes are discussed in further depth below (see 5.4.2 onwards).

5.4.2 Sub-theme 1: Academic, Student and Graduate Articulated Strengths

When I asked the participants situated as insiders relative to the organisation (i.e., the HEI) what they thought the programme's strengths were, I noticed a difference in how students and graduates articulated this compared to associate lecturers, lecturers, and others with programme and portfolio management responsibilities (e.g., senior lecturers and programme managers). Although both groups were insiders in the organisation, it was not surprising that their understanding of the programme's strengths differed. For instance, academics typically have at least two years of programme teaching experience, giving them familiarity and a deeper understanding of the undergraduate programme curriculum intention and resources. I derived the following three sub-themes from the 'Academic, student and graduate articulated strengths': "Diversity and flexibility," "Knowledge, skills and employment requirements."

5.4.2.1 Sub-theme 1a: Diversity and Flexibility

Several participants named the diversity of the blended learning healthcare student

community, the breadth of the programme and the module material as qualities of the programme. According to the findings, these attributes, together with the programme's flexibility, are reasons for its appeal. To illustrate, Randolph attempted to assist us in grasping the nature of the blended learning programme's faculty support and how this interacts with the diversity of the student population on the course. He noted:

“[...] the teaching team is great. The teaching team, as it is very patient, very good with students, uh, very good with being clear [...]; we have a diverse population of students [...]. I will say the other great thing of our programme is the diversity of students because we give access to university to a lot of students that would struggle in a normal university because they wouldn't have, for example, the possibility to attend classes that are taught. For example, [...] where a remote working is not possible and the third [...] is our blended learning teaching method.”
(Randolf, 34-40 years, programme manager, Birmingham study centre).

Ron emphasised the flexibility of the blended learning model and how this, along with the breadth of the content, offers fertile ground for in-class discussion (in communities), knowledge exchange, and skill demonstration—all of which allow for the development of relevant employability skills. Ethan added to this discussion by clarifying Ron's view on how the programme's strengths are observed from an academic's vantage point. He alluded to the highly collaborative blended learning environment where there is a diversity of thought and ideas to contextualise the learning for application. Ethan stated:

“[...] it really gives a good introduction to a lot of different topics, uhm, and a bit of a taste into lot of different, uhm, fields and jobs as well. I think that a lot of the material that gets covered on the programme [...] there's a big focus on practice and implementing theory and knowledge into practice [...], and I think having that is really essential to [...] our programme that this link from going beyond just learning theory [...] and gaining knowledge [...]. So not only do they learn [...] a lot of background knowledge about different fields, but they also get to understand and appreciate [...] how [...] theories might be applied across many different types of jobs [...].” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Considering Ethan's comments about the programme's distinct interdisciplinary qualities, Leah's perspective validates a similar viewpoint. As an example, Leah suggested that the core strengths of the programme are that:

“[...] it has a broad, uhm, range of modules [...] dealing with people who are in need of care as well as managing and leading [...] services.” (Leah, 55 and above, programme manager, London study centres).

Lumia went as far as to name areas, in her experience, where she believes the programme's strengths have been exemplified – for example, in assisting her to comprehend the magnitude of healthcare organisations such as the National Health Service and how the global scope of healthcare affects healthcare at the local level. She said:

“I actually found that it made me take a look at the bigger picture. I mean I never really realised how huge the NHS was as an organisation, number one, and number two it taught me to think of the bigger picture because we were learning about global health care and how it relates to us as individuals [...]” (Lumia, 50 and above, student, focus group 2).

5.4.2.2 Sub-theme 1b: Knowledge, Skills and Employment Requirements

This sub-theme was referred to significantly more than sub-theme 1a: “Diversity and flexibility” (see Table 19). Higher education curricula, such as the BA (Hons) Blended Learning Healthcare Management Programme, have broad learning outcomes and graduate attributes to enhance learners' knowledge, skills and healthcare management attributes for their specific sectors. As a result, it was predictable that several of the strengths mentioned by students, graduates, and academics appear to confirm this as a significant quality of the programme.

To elaborate, Daniella suggested that the programme has a distinct viewpoint and focuses on healthcare management, which supports graduate skill development. She also reasoned that lecturers had a personal effect in supporting students to recognise and develop the right skills for practice. The enablers to this support, she argued, were the module resources, which were specially designed to arouse the curiosity of students. She stated:

“I think that they all obviously have a healthcare or health and care and a management focus, uhm, so they help to develop those particular skills and understanding, regardless of the student's background [...] I've just been teaching

the Skills for Learning in Care module [...] so you know it talks about a range of soft and hard skills, it talks about transferable skills. It talks about skills required in healthcare, and we discuss the skills that the students have got and the skills [...] that are transferable.” (Daniella, 48-54 years, associate lecturer, Manchester study centre).

The role of instructors was particularly significant in advancing confidence and motivating learners. For instance, Garry described how inspiring he found some of his instructors in setting expectations around learning through discovery and further research. These educators tended to be particularly inventive and adept at directing students, drawing on their professional knowledge and the innate desire that students have to succeed. Garry said:

“[...] I had some fantastic lecturers who never gave me the answers, but they encouraged me to find the answers myself [...] so we can discuss. There is one particular lecturer that I will never forget. She said: I know the answers already, but I want you lot to read ahead of class to challenge me, so I will learn something new. Bring something new into the discussion and every week I always read ahead of class to bring something new to the discussion [...]. Even though we were online, it was some of the best times I had because everyone was reading ahead of class and with the modules, and it was just fantastic.” (Garry, 26-33 years, student, focus group 2).

The reference to the lecturer and the students reading ahead and bringing something new to the classroom for discussion referred to a ‘Social constructivist’ orientation of the learning environment where actors collaborate to create knowledge jointly. Also, Garry’s allusion to “being online” suggested this would have been during the COVID-19 lockdown period when the HEI transitioned to online learning before offering a hybrid face-to-face and online as the UK Government eased the lockdown.

Emebo confirmed Daniella’s view of strengths by stating that the curriculum covers specific essential themes, and the strength is how this content is provided in chunks to scaffold healthcare management knowledge and practice skills for students and graduates. He observed:

“I think the key strengths of the programme are that it [...] is able to inform students about key themes in healthcare management, uhm, and that the modules are very bite-sized and easy [...]. So, I would say it covers some of the basic, you know,

concepts and themes in healthcare management, and it's done in such a way that students who [...] often do not have huge amounts of formal education behind them, are able to digest the [...] key ideas.” (Emebo, 55 and above, associate lecturer, London study centres).

Lumia coined the strengths she had examined by suggesting that the scope of learning she experienced transcended knowledge of healthcare management in the UK. This suggests the holistic nature of the programme content, learning outcomes and resources. Lumia said:

“[...] like an extensive overview it's really good because you have like a huge, much bigger picture of what's going on in the healthcare industry both here home in the UK and globally. So, you could basically go anywhere in the world with your healthcare management degree and make a difference.” (Lumia, 50 and above, student, focus group 2).

Lumia's view suggests that this usually has a personal impact on individual learners and their development of practice confidence. Kathy appears to agree with this contention by stating that her view on quality-assured processes and methods had heightened since her completion of the programme. She noted:

“Uh, I would say on my side [...] it gives you a chance to be able to do things in a quality way and where you used to do things differently. Now you do them differently, [...].” (Kathy, 42-49 years, graduate, focus group 1).

Doing things differently, as cited by Kathy, suggested an enhancement to the practitioner's autobiography. Based on his nurse practitioner background and recent social care management experience, Peter's perspective was that, besides the programme's strengths, graduates also achieved a level 6 management qualification, which is higher than a level 5 manager qualification. The backdrop here is that the level 5 manager qualification has long been recognised as the gold-standard vocational qualification for CQC-registered managers in regulated care in the social care sector. He indicated:

“[...] The CQC require that, uhm, registered managers have at least a level 5 qualification in management. Uhm, obviously, this course provides that, and I think, as I've been teaching on the course, I think, uhm, the realisation that there's an awful

lot of, I mean the [...] focus on management which also looks at, as I say things like budgetary skills, uhm, team organisation and management specifically, I think that's a real strength. [...] I mean obviously it provides a level 6 management qualification which is above the basic you need to take up a registered manager post.” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

Chanice confirmed the programme's knowledge and skill development focus by sharing her experience of enrolling in the programme while working in the prison service and how the knowledge gained from the programme supported her decision to work in health and social care. She indicated:

“ [...] I was a prison officer in the beginning, uhm, haven't got no knowledge so, my managers three years later, and I was planning [...]; 'Assessment and Planning' and [...] then she was asking me all the time, this is the Governor of the prisons, how did you get this knowledge [...]. Same too applied in the second year, I left the prisons, and I got the job [...] – Age UK team, this is the home from discharge team [...] The manager was asking where did you get this knowledge from. I said I just completed [laughs] BA Healthcare Management.” (Chanice, 42-49 years, graduate, focus group 1).

Barry, who joined the programme before working in healthcare management, suggested that students were likely to notice the potential for knowledge and skill development opportunities from the programme to practice. His personal experience securing a position in health and social care, where his line managers quickly recognised his skill set and work performance, confirmed this. He declared:

“ [...] When I went into my first managerial role, I was, uhm, still studying, and what response I got was [...] my colleagues, my team, some of my managers, my director started coming to me and asking me what are you studying again because they were quite shocked [...]. I was very proactive and knew how to like [...] approach [...] everything, and they are like, what are you studying? Ah, okay, that's really useful, yeah [laughs] [...].” (Barry, 34-41 years, student, focus group 2).

Ron and Katherina supported Daniella's view about the transferable skills developed by the programme. Nevertheless, Katherina does this while spelling out her experience of some of the challenges some students face with basic academic study skills. To illustrate, she said:

“It develops so many, very many transferable skills and, in particular, in the management role so many students that come in who are working in management and often they have very little writing skills [...] it rounds up their transferable skills. And also, it helps them understand and apply evidence-based practice, and I think that's a really important part of modern healthcare [...].” (Katherina, 55 and above, associate lecturer, London study centres).

Given the significance of evidence in supporting practice and knowledge transfer, it was interesting to note Katherina’s comment about the knowledge being evidence-based. Nevertheless, Ethan also described the strengths, looking at them more outwardly from the professional body links and accreditations the programme has in place with organisations like the Chartered Management Institute (CMI). For example, the links with CMI offer students full membership access to their resources and the opportunity to apply for chartered managership at programme completion. This offers further professional growth and career advancement prospects. Ethan asserted:

“I think the breadth of the programme is the big strength that we cover such a [...] broad scope of different topics, and [...] secondly, I think the link with the professional bodies, The CMI, and now we have partnerships with other organisations, I think that's a big strength that stands out, uhm, from our programme [...] for career progression [...].” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

5.4.3 Sub-theme 2: Employer Observed Strengths of Students and Graduates

Some of the employers were aware of the programme’s strengths. Others believed this was limited, especially as they saw themselves as outsiders relative to the HEI. The theme "Strengths" included all facets of the programme and those demonstrated by students and graduates in the workplace, which were helpful in interrogating and giving a fuller context of perceived strengths.

I reflexively framed conversations with employers during interviews to ensure they could articulate strengths beyond what the programme explicitly stated on its website and in its documentation – which they could relatively easily access. In this manner, an additional question was posed to employers to encourage them to offer further clarifying feedback. For instance, they were allowed to discuss the variations in

graduates' and students' contributions in the workplace before and after programme enrolment (or even completion).

I categorised participant feedback on this minor theme into two subheadings (i.e., instead of more sub-themes). I classified it in this manner because the level of participant responses generated would indicate that a robust discussion could be contained under one main sub-theme even without more sub-themes.

5.4.3 a Commitment, Confidence and Determination

According to the findings, commitment is an important personal characteristic of practice for students and graduates to show in their line of work. The result alluded to its importance in settings like healthcare management, where workers implement care for vulnerable users of care, who primarily rely on them to design and help them meet their activities of daily living. Working as a manager in such environments would necessitate confidence and a resolve to meet service targets and needs despite resource limitations.

Four references were made to 5.4.3a, making it one of the most critical employer-observed strengths mentioned by employers. Tamika illuminated the positive work contribution of the HEI's students and graduates in comparison to other higher education students and graduates she had met by suggesting the following:

“[...] The two students that I have come across from your university are different and I think other universities running this programme needs to look outside the box to see what your university is doing well [...] Your students are completely different from the ones that I have seen. [...] I don't know, I think your university, [pause], I, I think, I don't know what you are doing well that your students are [laughs], I don't know, I don't know, but they are quite different [...]” (Tamika, 55 and above, service director, mental health care home, employer).

Reflecting on the interview with Tamika, the positive difference referred to about our two students was their commitment and assertiveness. Even so, Layla suggested that knowledge and skill development (i.e., to support one's confidence in practice) and growth opportunities are significant to her as a manager. She did this by elucidating

how Gemma meets the criteria of the perfect employee for her organisation – particularly as it pertains to the strengths she brings to her team. She said:

“I’d say after enrolling and starting the programme is the confidence, I’ve really seen a difference in Gemma’s confidence already. I mean, she was already a confident lady anyway, uhm, but she’s very, she’s a very quiet woman who doesn’t, uhm, she’s not forceful at all, uhm, but if she has an opinion, she’ll give it to you [...]. So, uhm, you know, she’s more forthright and, uhm, oh, also very happy to share what she’s learning with us [...] and to talk to us about it [...].” (Layla, 55 and above, service director large charity, employer).

Moses went further to add that, beyond commitment and dedication to the organisation, which are both crucial strengths, the students would need to show a level of competence for him to have trust that they could fulfil their role. To illustrate, Moses said:

“Yeah, dedication, commitment to the organisation, uh, you know, for me, I know I can trust them and leave them to it, uhm, and things would not be missed, important things that might affect our sort of compliance [...] [statement incomplete].” (Moses, 55 and above, managing director and owner, home care service, employer).

5.4.3b Eagerness to Learn and Knowledge Demonstration

With only two of the employers referring to this sub-heading (i.e., 5.4.3b), Moses offered a helpful reflection on Dame (i.e., the student working for him) and the skills she had displayed in articulating herself, applying a holistic view to a situation, and presenting a coherent description. An ability that he associated with a good healthcare manager's attribute. This led him to conclude that Dame has a bright future ahead of her. Moses stated:

“I mean, she always had potential before, but her knowledge is much better now. Uhm, again, I don’t know how much of it is from experience, how much of it is from the learning, but from what I understand, she’s quite a strong contributor in class. She has a dedication to what she’s doing, uhm, and I guess when you’ve got that, and yeah, I mean she writes very well, she can analyse the situation and present a case quite strongly [...]. I think she will be quite good as a future manager.” (Moses, 55 and above, managing director and owner, home care service, employer).

Moses' opinion implied that establishing cause and effect between, for example, Dame's current level of competence and the knowledge and skills she is exposed to on the programme in this circumstance would be difficult. Nonetheless, he was eager to point out that the comments he had received about the student's performance in class seemed to confirm that she had grown and matured in her academic writing, analytical abilities, and knowledge of requirements.

Tamika also disclosed the knowledge she noticed students from the programme demonstrate in their delivery of care services. In addition, she emphasised that higher education programmes' knowledge and practice orientations require close alignment if students and graduates are to derive meaningful learning by applying theory to practice. However, comparing our programme with similar higher education programmes, she remarked that our programme offers this alignment, thus making it a core strength. She asserted:

"[...] So, what I see as being their strength is there is no conflicting information from what you are teaching them and what they are seeing, so in my own opinion, I think their programme is very detailed [...]. I give you one example: one of your students did a module on budgeting [...] during supervision when we got to, do you have any other thing? And he said, yes, I've been working in the admin and this budgeting side of it I don't see it, and I said yes, as a manager [...] the onus is for you to set your budget to your directors and I took him through the process of it and I remember very well that student saying yes it's exactly the same thing we had in the classroom [...]." (Tamika, 55 and above, service director, mental health care home, employer).

5.5 Theme 3: Length of Stay with Employer and Reason

| Name | Files | References |
|--|----------|------------|
| Length of stay with employer and reason | 3 | 10 |
| <i>Sub-theme 1: How long student or graduate worked for employer</i> | 3 | 3 |
| <i>Sub-theme 2: General determinants for staying with employer</i> | 3 | 7 |

Table 18 Theme 3 Summary

Theme 3 was a theme I grappled with, particularly in deciding where it best fitted in my analysis. The question that inspired it was shaped, in part, by the employer

question pilot, in which students and the one graduate involved with the EFGD suggested adding a "why" to the question would provide a contextual basis for the second question on the employer open-ended questions (i.e., Section B) and be valuable as an extension to question 2. Question 2 stated: *"Could you explain how many BA (Hons) Healthcare Management Programme students or graduates you have employed or worked with over the years?"*

Following feedback from the EFGD pilot and my making sense of the quantitative and qualitative elements associated with the feedback, I felt it was essential to include it in this section of the analysis because it provided a basis for understanding the true extent to which employers knew employees well enough to comment comprehensively on their employment before enrolling in the programme, while studying, and potentially after graduating.

Another conclusion drawn from it was whether decisions made by students, graduates of the programme, and higher education graduates in general about staying with an employer or seeking opportunities elsewhere are because of the potential newfound knowledge, skills, and abilities participants derive from studying healthcare management or other less obvious reasons for employers and the higher education sector to reflect on.

5.5.2 Sub-theme 1: How Long Student or Graduate Worked for Employer

According to the data, students typically worked for employers for at least one year and up to ten years. The candidate, who worked for a year, had previously worked for the social care organisation before she left and returned to work in a middle management role. This would seem to be a reasonable amount of time for employers to get acquainted with their employees—well enough to comment on their work output and the knowledge and skills they see in their day-to-day work.

To illustrate, Layla (the third employer to be interviewed) suggested that Gemma has worked for her for over five years. She stated:

"Gemma is worked for us for: I'd say five years plus." (Layla, 55 and above, service director large charity, employer).

Dame, who worked for Moses, had worked for over one year. This is a combination of her previous employment and her current role as compliance lead. Before this, she had worked for them and left to go elsewhere before returning as compliance lead. Moses suggests:

“Uhm, she worked for us previously for about a little over a year, but she's re-joined, uh, this uhm, April.” (Moses, 55 and above, managing director and owner, home care service, employer).

The students who have worked for Tamika have done so for a combined period of around 13 years. This would show a reasonable staff retention rate. I explore the potential reasons for this further in 5.5.3. Tamika indicated:

“The other one [...] has worked for about 10 years, and the second person has worked for about 3 years plus.” (Tamika, 55 and above, service director, mental health care home, employer).

5.5.3 Sub-theme 2: General Determinants for Staying with Employer

Employer feedback showed that some students and graduates tended to stay with employers because of their reputation or the supportive environment they provided. For instance, Moses associated their reputation with the quality of care they provide, the pay offered to staff, and their refusal to accept 15-minute flying visits or homecare allocated slots. Moses' quote below gives context to the general determinants that influence the decisions of students, graduates (of the programme), and higher education graduates (in general) to stay with employers. He asserts:

“[...] We're part of a big franchise group, and our philosophy is about quality care, uh, we don't do sort of 15-minute calls or council type contracts, uhm, because it doesn't pay enough, so we charge a good price and hopefully pay a reasonable amount to keep our staff. Uhm, I think generally, yeah, it's a quality organisation to work with.” (Moses, 55 and above, managing director and owner, home care service, employer).

Tamika provided a different and fascinating perspective, which appeared to confirm the feedback from the student working for her organisation (i.e., Garry). I separated

the feedback into reasons before graduation and post-graduation. What was fascinating about the feedback was that, with current recruitment pressures and a shortage of healthcare workers, employers would be fighting hard to retain highly qualified staff like healthcare management graduates. This does not appear to be the case with Tamika's workplace, which actively supports graduates to take the next step in their careers. Even so, a counternarrative to this is that this may have a hugely positive impact on encouraging loyalty from students who witness such goodwill from the employer. In line with this, Tamika argued:

"The reason why they stay with us before graduating: they are able to marry what you are teaching them to what they are seeing here [...]. That tends to help them a lot because what they are teaching them in the classroom when they come to the practical side of it, they [...] see and understand it, so it helps them to complete their modules. [...]. Normally, they stay till the end of their programme and then [...] the organisation [...] assist them by channelling them to the right place[...] to get a graduate job, like in the NHS." (Tamika, 55 and above, service director, mental health care home, employer).

When I questioned the employers about higher education students and graduates more broadly and what factors led them to the decision to stay or leave, all three provided thoughtful comments. Layla explained that they stayed for under three years, indicating a lost opportunity to potentially harness the knowledge, skills, and creativity (e.g., long-term) graduates would have contributed to the organisation. Layla shared the following:

"Uhm, I couldn't honestly tell you the answer to that [...], but I'd say two or three years, and then they're ready to move on to pastures new, should we say." (Layla, service director large charity employer).

Layla also indicated that this will be mostly true for graduates rather than necessarily students. What is unclear is whether these graduates would stay in healthcare management practice or whether '*pastures new*' would indicate moving to other sectors.

Moses also mentioned a problem that the social care industry continues to grapple with: finding suitable graduates to work in the field and how this has made recruiting

and retaining graduates challenging. Judging from Moses' earlier comment, it is safe to deduce that pay in the sector and clear career progression routes may be contributors. Another potential contributor appears to be that a CQC-registered manager status requires a level 5 vocational award for regulated care. Unfortunately, there is a less clear direct route to CQC-registered manager status through higher education qualifications. This would partly clarify Moses's suggestion later (in theme 6) about the lack of robustness, especially with the verifiability of the academic integrity of portfolios (assessments) submitted for the NVQ level 5 vocational award. Moses indicated:

“I’m saying we haven’t had a lot; I mean [...] I’m hoping the latest one stays, you know, and progresses their career with us.” (Moses, 55 and above, managing director and owner, home care service, employer).

When prompted about why he (Moses) thinks students and graduates especially tend to stay or move on to new opportunities after their programme completion, he explained that if the current student (Dame) decides to leave, her decision would be driven by career progression. Moses explained:

“I mean, if she leaves, it will be to pursue career opportunities elsewhere. Yeah.” (Moses, 55 and above, managing director and owner, home care service, employer).

5.5 Theme: 4 Knowledge, Skills and Transfer to Practice

| Name | Files | References |
|---|-----------|------------|
| Knowledge, skills and transfer to practice | 17 | 87 |
| <i>Sub-theme 1: Positive transfer</i> | 16 | 71 |
| Curriculum design, resources and support | 4 | 8 |
| Community of practice, knowledge and graduate skills | 9 | 18 |
| Integration, sector knowledge and skills transfer | 15 | 45 |
| <i>Sub-theme 2: Neutral and transfer difficult to determine</i> | 6 | 16 |

Table 19 Theme 4 Summary

This was the theme that received the most mention in the entire study. It is central to the project's intention because it brings together the perspectives of students, graduates, associate lecturers, lecturers and module leaders, programme managers, and employers. As a core theme, it comprised two seminal sub-themes: "Positive

transfer" and "Neutral and transfer difficult to determine." The sub-themes are covered in greater detail below, beginning with 5.5.2.

5.5.2 Sub-theme 1: Positive Transfer

This was a significant theme in the study as seventy-one of the eighty-seven references to theme four (see Table 21) comprised the positive links and attributions participants alluded to about how the programme contributes to knowledge and skills development and transfer to healthcare management practice. The sub-theme comprises the following additional sub-themes: "Curriculum design, resources and support," "Community of practice, knowledge and graduate skills," and "Integration, sector knowledge and skills transfer," – which describe the parts of the programme resources, content and tools ("what?"), and the mechanism ("how?") of the transfer of knowledge and skills (if evident) from the blended learning classroom to healthcare management practice. The sub-themes are analysed below.

5.5.2.1 Sub-theme 1a: Curriculum Design, Resources and Support

Participants emphasised the importance of the curriculum structure, support and learning resources in building the base for learning and establishing conditions and the learning environment by which students and graduates could connect theory knowledge to practice. To illustrate, Mark observed the links within the programme content, resources and outcome – which findings suggest has an overt and obvious level of scaffolding and wrap-around support for students. Mark made the following statement:

*"I think it, uh, relates from one module to another as you are going on, you gain more knowledge and how interconnected this whole programme is up to the end."
(Mark, 42-49 years, student, focus group 1).*

Chanice expanded on Mark's thought by focusing on crucial lesson content she had received from the modules and how the embedded order helped her develop a level of familiarity across modules that, at face value, sometimes appeared to be heading

in different directions. Chanice's response hinted at discordance with Mark's perspective about the coherence of the programme's module content. However, this expounded on the different modules and their emphasis on supporting specific knowledge and skill development, not a lack of coherence.

Sara and Emebo also referred to the suitability of the resources offered to students through the HEI's virtual learning platform. This is critical for understanding theoretical information and improving healthcare management knowledge and skills. Findings showed that case study discussions and synchronous and asynchronous activities and assessments support knowledge and skills development. While Sara raised a point about low student engagement (in her groups) with this content sometimes, Emebo noted the problem is not the learning platform as this has sufficient interactivity embedded in it. He also highlighted the learning he (as faculty) derives from the resources in every module he has taught and how valuable and professionally enhancing this is. He asserted:

"[...] I think iLearn is a very interactive tool, and that's a good thing about it, uhm, and yeah, using the discussion forum, particularly this last module I've just completed. [...] Every module, I sort of learn a new trick, so [...] they're all very useful tools and their ways of [...] keeping students engaged, and you're hoping that they are picking up things to apply [...] We can participate that sort of live, you know."
(Emebo, 55 and above, associate lecturer, London study centres).

Samantha noted that learning happens in an environment where the focus is not just on theoretical knowledge but on the sharing of experience between students and the skills and graduate attributes needed to support employability. A key point to note is the implied notion that not only are the resources available, but that students access them under the tutelage of an experienced lecturer and within a community learning from each other. Samantha suggests:

"Yeah, the materials are all there, the lecturers, uhm, show you how to research, and you studied with other people who happen to work in different domains, we did group work, we all brought knowledge together and, uhm, learn from each other, so, it was all there. They even taught us how to write our CVs, interviewing skills – all was there, they had seminars, they had workshops, they did everything for us."
(Samantha, 50 and above, graduate, focus group 2).

Examining what Samantha said about lecturers 'showing' students how they conduct research provoked further introspection as I searched other parts of the results. The provocation was because other parts of the findings and literature in Chapter 2 (e.g., Etzkowitz and Leydesdorff, 2000; Bruner, 1960; Allen et al., 2011) indicated that the role of higher education is to support independent learning through self-application and learning by discovery if necessary. Even so, Lumia provided reassurance that students in higher education are required to demonstrate independence and ownership of their studies. This alludes to and reinforces the significance of independent learning in higher education programmes. Lumia contended:

"[...] Everything was there, and at university, you're not at school; your teacher is not going to chase you around with a ruler telling you what to do all the time. It's up to you as a student, uhm, to take from the blended learning course what you want, [...], it's up to us to [...] use the resources that have been given to us." (Lumia, 50 and above, student, focus group 2).

Lumia also raised a curious point most HEIs are beginning to confront – an increasing number of students having to deal with the uncomfortable tension of balancing work and life commitments with university education. She observed:

"[...] as I said before, when you in the workplace, and you got to support yourself at the same time as you're doing your degree, it's not as easy as that; you've really got to like - go the extra mile [...]." (Lumia, 50 and above, student, focus group 2).

Sara also noticed how balancing work and other personal commitments has often affected students, who need help dedicating the time required to review all the recommended learning resources. Sara also thought that the COVID-19 pandemic exacerbated this even further. She offered the following assertion:

"[...] I think it's the time they don't have because the four hours of lectures plus they're working plus family commitments [...]. It's not everybody, but I know if I've got 15 students, I know only five or six will actually sit down and go through the stuff which is there on the iLearn [...]. Obviously the COVID didn't help anybody." (Sara, 41-47 years, associate lecturer, Birmingham study centre).

5.5.2.3 Sub-theme 1b: Community of Practice, Knowledge and Graduate Skills

As a theme, “Community of practice, knowledge and graduate skills” accentuates how the learning on the programme supports experiential learning through learning communities of students who share and exchange ideas and experiences to support knowledge application to practice. The emphasis is on how learning occurred in modules taught in the undergraduate blended learning programme. There is a broad link to specific premises around expectations of developing small learning communities where learners actively collaborate to share and acquire knowledge and capabilities and develop specialised graduate attributes related to healthcare management practice.

Using the COVID-19 lockdown period in the UK in 2020 as an example, Abi set the context for the discussion of this theme by noting how the shift to exclusively online learning from blended learning was critical in fostering a spirit of community and an understanding of multidisciplinary working. She emphasised this significance considering the challenges transitioning to online had presented them with.

“The blended classroom, uhm, experience is very good because [...] you have that feeling of working as [...] an MDT [...]. We had a mixed, uhm, experience because we did have the blended [...] but then COVID set in, so [...] we were now [...] individuals on their own online. So, you get that feeling, but then when you are now working online, and you're trying to work as a group [...], you can see how miscommunication happens [...].” (Abi, 50 and above, student, focus group 1).

Ethan implied that the community derives maximum benefit from this learning environment because the students can leverage the learning to promote knowledge sharing and transfer in a physical undergraduate blended learning environment.

“Being there in person, I think, really adds a huge, uhm, additional dimension for them to be able to apply the skills, uh, and the knowledge that they're learning [...] sometimes, maybe even in a simulated, uhm, environment that they wouldn't otherwise be able to do it if it was just distance learning.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Findings showed that what makes the learning community experience rich and helpful is that students come from various complementary backgrounds and professional

experiences. Lumia articulated her thoughts below:

“Everybody in my class, and I was part of two separate classes, and [...] without exception I would say, [...] was working in health and social care already - be that in different, uhm, spheres [...]. Whether it be a mental health worker or, uhm, a support worker in social care or social worker or care assistant in health care, uhm, or even [...] hospitals, some of my colleagues were working for the NHS already. So, you know that experience that they already had, uhm, helped all of us [...].”
(Lumia, 50 and above, student, focus group 2).

Daniella affirmed Lumia’s view on the diversity of the blended learning environment. She posited that the learning methods of asynchronous discussion forums and synchronous face-to-face sessions are the two main facilitators of knowledge transfer in the community. However, she raised an intriguing issue concerning learners who are enrolled in the programme but do not have prior health and care work experience. This is a critical issue to reflect on, as it could have ramifications for the learning of students and graduates enrolled in a healthcare management degree that does not provide students with practicum opportunities. She stated:

“We have students from all sorts of different experiences [...]. Some of them already working as managers. [...] uhm, so I think that the blended learning approach in terms of the face-to-face learning and what they’re doing on iLearn, uhm, is really helpful for them, but I think a lot of it they get through discussion and examples and real-life examples in the classroom and through, uhm other people coming in - external speakers [...].” *(Daniella, 48-54 years, associate lecturer, Manchester study centre).*

Findings alluded to how learning in a community of learners and practitioners is uniquely helpful in improving awareness of one's skills, abilities, and opportunities for future growth. The shared knowledge could increase students' capacity to apply themselves (i.e., their knowledge and skills) across multiple healthcare practices while improving their self-image and employment options.

“[...] you gain so much from working in a blended environment to the point that when you go out there, sometimes you don't always remember what you're being taught, but you remember what you have shared with someone or what someone has shared with you, and you're able to carry that into the work environment [...]. Topics that you've done, all the assignments that we've done, they might not be

practical, but they've given us scenes of what happen within the healthcare industry [...]. It's broadened your horizon [...], it allows you to identify your weaknesses [...], it's open up doors, open up things that had been hidden. That hidden knowledge [...] to know that yes, I'm competent at this, I can do this [...].” (Abi, 50 and above, student, focus group 1).

The quote by Abi succinctly summarises how learning in a community of practitioners intersects with making tacit experiential learning evident so that it helps contextualise and illuminate explicit codified knowledge for application. Randolph expanded on Abi's thought by providing information about how the tacit (implicit) learning experienced in the blended learning classroom is intentional in its attempt to bring together students to share healthcare management work experience. He asserted:

“[...] we need to think about tacit knowledge, so really the knowledge that we learn only when we are with other people and our students [...] are with the tutor but also with people, that [...] have work experience or are working; so there is whole lot of an opportunity to like share these knowledge that cannot really be written, [...] that cannot be put into words, but it is deriving from its interaction between students and [...] the tutor.” (Randolf, 34-40 years, programme manager, Birmingham study centre).

Ron went even further to describe the nature of the social interaction between 'members of the community', the platforms and resources that aid the sharing of socially situated knowledge and experience, and the contributions made by key stakeholders during this highly collaborative blended learning classroom setting. Ron said:

“[...] there are a lot of students with [...] knowledge around healthcare, and some of them are already in, uhm, strategic positions, managerial positions. [...] the blended learning approach gives a forum for them to, uh, interact. [...]. It permits them to create, uhm, say, groups: classroom groups, WhatsApp groups and other forums [...] where even the lecturer is involved. So, transferring knowledge from one person to another, bringing in and sharing knowledge, understanding more, going back again [...]; the shared knowledge, is recycled.” (Ron, 48-54 years, lecturer and module leader, London study centres).

Jade also hinted that there is evidence of the transfer of knowledge from the programme. This is her synopsis, and while it may appear linear and occur between

the theoretical knowledge learnt and the practice context, it could occur vice versa (as suggested by Ron), whereby the students also come back with experiences from practice to support the theory knowledge exploration in the classroom. She even cited how student feedback had shaped her view of why the programme fosters knowledge and skill transfer from communities of learning in the blended learning classroom to the workplace.

“Uh, we do have students who [...] work and come back with these experiences [...], told me the programme has really helped them, and they have now become deputy managers, and they're looking to become managers where they work [...] they do say the course is [...] very detailed and very helpful, so it's, it helps them to apply knowledge into practice. [...] what they learn from the classroom and what they have online on iLearn prepares them, I think it prepares them, and they are able to transfer what they have learnt, [...] into their healthcare management practice.” (Jade, 34-40 years, associate lecturer, London study centres).

Lumia highlighted the programme's employability opportunities and how immersing oneself in the learning experience appears to be an essential element of the employability skill development predisposition of the programme.

“The knowledge and skills that we learnt about in our degree covered every area, uhm, that would give us the employability skills we need as healthcare management, [...], I was happy with it [...].” (Lumia, 50 and above, student, focus group 2).

Exploring his view on employability, Mark also cited the diversity of learners and support within the blended learning classroom as crucial areas that exercise great power in building the confidence that aids graduate employability and the opportunities for knowledge and skills transfer to healthcare management practice.

“So, from the support you get from the classroom itself, by knowing people from different areas, different background; that, uhm, increases your [...] confidence and somehow you can gain competency from that [...] that can be transferable to your workplace.” (Mark, 42-49 years, student, focus group 1).

5.5.1.2 Sub-theme 1c: Integration, Sector Knowledge and Skills Transfer

This theme proved significant to the study's research questions as it brought together feedback alluding to the programme direction to support knowledge and skill transfer to healthcare management practice. Despite not knowing what to expect upon joining the programme and releasing their first module and the anxieties this came with, Barry explained how integrating the contents and resources felt to him and his peers – from a user perspective.

"I was a bit nervous from day one first module [...], not knowing what to expect [...]. As time went on, from module two to module three going into second year, I noticed, and I think my colleagues said the same we all thought that the modules were linked, and it became more like a revision, but more like, uhm, researching more into our previous modules so, uhm, it became, for me [...] a lot of research and the expectations were becoming higher [...]." (Barry, 34-41 years, student, focus group 2).

Furthermore, to further clarify our understanding of this theme, Daniella commented on the breadth of the curriculum by asserting that each module had a unique focus on management skills needed by students and graduates to operate effectively in different healthcare settings. She advised:

"Each of the modules really, uhm, do focus on skills required by managers who may be working in health or care and, uhm, it really does kind of focus on what particular skills the[...] students might need [...] It's quite a broad subject because a manager in health and care the role could be very, very different from one organisation to another [...] it doesn't kind of just focus on, say, the NHS or one aspect of it. So, it keeps it very broad." (Daniella, 48-54 years, associate lecturer, Manchester study centre).

Kathy's view broadly corroborated Daniella's about the breadth of the curriculum. Kathy especially noted the synergistic effect between the content and resources in their drive to support leadership skill development. Kathy posited:

"I think it was great. You get to see different areas and then how they interconnect to make you or to give you good leadership skills." (Kathy, 42-49 years, graduate, focus group 1).

Abi also confirmed the synergy observed in the programme. However, she pointed out

difficulties she experienced with students calling and texting her for support with clarifying content and signposting to resources. This was linked to her role as a student representative, whom other students unofficially relied on (in her group) to provide academic guidance and support. There was an expectation here that as a core group member, she was also expected to be a study buddy to everyone in her whole group.

The challenge with this role is that because it is developed informally by the group and resides in a liminal leadership space, it is difficult for the HEIs, despite the help they would usually provide for students, to recognise the difficulties and worries that this would have caused for the learner. A counterintuitive argument is that she needs to be just as assertive in drawing boundaries with her peers. However, this simplistic view ignores group culture, personal values, and shadow systems existing in organisations. Abi asserted that:

“[...] the modules were interlinked [...] the integration of the programme itself was really, really good because you were able to take knowledge from one module and use it in another module and when [...] you had lecturers that would ask questions, uhm, about things that were done, then you could see the link within the healthcare system. [...] I mean, yes, there were times when it was difficult, [...] especially when I had other students always calling or, uhm, texting me [...].” (Abi, 50 and above, student, focus group 1).

Samantha mentioned the modules that were directly knowledge and skills supportive of practice and how they had buoyed her healthcare experience. She remarked:

“[...] The Care Planning module, for instance uhm, taught you what you look out for when you are about to draw a care plan for an individual [...]. There was Budget Planning, which sort of gave an eye opener into how, uhm, funds are allocated for primary care, CCGs, and even the hospital [...]. Inter-Agency Working, which teaches you how to work with each other [...]. All the modules were interrelated, and they were straight-on answers to the things that we face at work.” (Samantha, 50 and above, graduate, focus group 2).

Lumia raised a pertinent point referred to earlier by Sara about the challenge students face in maintaining the right balance between their day-to-day work commitments and university studies. This is relevant as all students and graduates in the study were

either currently actively working in health and social care (including management) or had done so in the recent past. Lumia especially voiced her observation about the difficulty she had experienced finding the right balance between work and studies. She said:

“The only thing that I wished I had done is not work so much in my job as I did whilst I was doing my degree because I couldn't give my degree the full attention it deserved. Uhm, my typical day starts at, between 7:00 and 8:00 in the morning and it will end up like between 10 and 11 at night. [...] and so, I lost the plot a bit [...]. If you sit down and you practice reflective thinking, that helps you to, uhm, tie things up, and it was like a light bulb coming on sometimes because [...] you think ah well okay, I know that, and that relates to that [...].” (Lumia, 50 and above, student, focus group 2).

Umaru attempted to explain the mechanism through which the integration takes place on the programme before heralding knowledge consolidation for transfer. He observed:

“[...] the module [...] are designed in such a way to identify those knowledge and skills required, uhm, by a healthcare manager and the learning outcomes of the modules are also designed to develop those skills [...]. So, within the in-class teaching [...], there's a push to use active learning in order to make sure [...] the knowledge is ingrained in the students; they are able to participate and practice what they learn. They learn theories, but they also learn how to practice it through various activities, discussion and so on.” (Umaru, 41-47 years, lecturer and module leader, London study centres).

Leah provided a timely reminder about how she uses her professional experience working in the health and social care sector and the programme's resources to support learners in applying and potentially transferring theoretical knowledge to practice. She explained:

“[...] Well, particularly talking about my own experience because I've worked for a long time in the sector, uhm, there's a lot of linking that I do in my teaching between the theoretical, the concepts, the ideas, and how we actually see them in practice, [...] how we apply them in practice. So [...] within some of the modules there's; well, no, most of them there is an aspect of, uhm, using case studies and using particular examples from, uhm, practice anyway to apply them [...] I think that it is also supported a lot by the teaching.” (Leah, 55 and above, programme manager, London study centres).

Randolf coined his thought differently to Leah while referring to similar exercises and case scenarios used (i.e., use of problem-based learning) in lectures requiring learners to simulate the role of healthcare managers faced with difficulties that need resolving. However, in his summary, what is significant is the involvement of lecturers, particularly their use of professional experience to support application and transfer, as touched upon by Leah. Leah posited:

“We do exercises [...] so this is very relevant to put the students in the shoes of a healthcare manager role and [...] our lecturers, a lot of them have a lot of professional experience, which is very important. Of course, to share with the students and allows them to learn very much about what happens, uh, what to do in the workplace [...].” (Randolf, 34-40 years, programme manager, Birmingham study centre).

Developing knowledge and skills related to the work requirements of the healthcare sector was viewed as a crucial aspect of employability and graduate outcomes. Ethan provided a new dimension to Umaru's perspective by underlining the distinction between modules targeted towards social care and health service management and their contribution to specific sector knowledge and skill development. This perspective also allows us to understand Daniella's input on the programme's level of integration. Ethan indicated:

“Yeah, I think having individual modules that focus on quite specific topics that are kind of within certain fields [...] I think having those distinction between the modules really helps to, uhm, create this link within that scope rather than just kind of learning about healthcare manager at multiple different aspects at the same time. I think having these kind [...] of deep dives into particular topics can really help, uhm, to create this link between a knowledge and the skills.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Jade's feedback illustrates the suitability and usefulness of some crucial modules supporting sector knowledge and skills that allow students and graduates to demonstrate effective communication, collaborative working abilities, and leading and managing change, resources, and quality. She observed:

“The way our modules are [...] they are designed in a way that, uh, they all have, uhm, leadership skills embedded in them [...]. I look at modules such as, uhm, Communication and Collaboration [...]. These modules do have, uh, the content

which helps our student to, uh, acquire knowledge and skills that will help them to be more competent, efficient and effective, uhm, in their roles as healthcare managers.” (Jade, 34-40 years, associate lecturer, London study centres).

Assessments play a focal role in contextualising theory knowledge to practice and reinforcing the transferable skills employers in the healthcare sector look out for during the recruitment and selection of healthcare managers. Samantha exemplified this in her view by noting that there is a bridging of theory and practice experienced by students in the programme, which brings integration and sector relevance to the fore. She asserted:

“Yes, because is bridging the gap between theory and practice.” (Samantha, 50 and above, graduate, focus group 2).

Katherina’s view provided an elaborate frame of reference supporting Samantha’s opinion. Her thought further explained what the programme does to verify the evidence of the theory-to-practice orientation, even if students don’t always recognise it as that. She contended:

“[...] they are tested through linking theory to practice; so, I would say yes, and even if they wouldn’t know what label to put on it [...] that is what they would have, a good understanding by the end of it - that the knowledge, skills, yeah and competency.” (Katherina, 55 and above, associate lecturer, London study centres).

Jamela specifically observed the vital role assessments play in supporting knowledge and skills development and evidencing the transfer to practice that follows when she explained:

“Depending on the assessment as well and how well the student is doing, but [...] most of the assessment is linked to how, uh, managers can perform in their role.” (Jamela, 34-40 years, lecturer and module leader, Birmingham study centre).

For the students and graduates in the study, the transfer of knowledge and skills to healthcare practice appeared straightforward. However, it is not clear if their responses would have been different if they had no experience working in healthcare. To illustrate, Mandy explained the following:

“Blended learning really helped and because you, you got the time to do things at your own time. So, it give us the time to research more [...], so we are learning the theoretical part from the uni, and you are transferring the skill in a practical way at the workplace.” (Mandy, 50 and above, graduate, focus group 1).

Emma validated Mandy’s opinion by hinting at how she initially lacked an appreciation for the transferability of the knowledge and skills gained from the programme. Even though she had not negated the two-way nature of the experiential learning from the learning environment to practice and vice versa, Emma particularly emphasised a one-way transfer from the blended classroom to practice. She expressed these thoughts in the below quote:

“[...] you don't really know until you are actually in employment because it was only when I was actually at work I realised, I said, oh my God, we were taught so well. When you're on the programme to me, you know, I'm just doing, I'm studying. It didn't really mean; it didn't really relate to anything you know for me until actually I got to the workplace. OK, I just saw that everything we were taught was so relevant to the workplace; we were really very well taught.” (Emma, 50 and above, graduate, focus group 1).

While underscoring the flexibility the blended learning programme provides healthcare students (e.g., to foster the integration of resources and problem-based learning), Jamela also stated that most, if not all, of the students she had met work in the healthcare industry, and those who don't generally end up working in the field during their studies; several of these students eventually advanced to managerial positions. She suggested:

“[...] Most of the students that I've known [...] they've been working in care already or [...] end up joining care. I know a student who had no, uh, knowledge [...], but as I speak now, they actually are in a high position in care. [...] it does actually help because they're not attending every day. [...], they can use the other time to apply what they're learning.” (Jamela, 34-40 years, lecturer and module leader, Birmingham study centre).

Ron provided a more vivid representation of the back-and-forth situated learning orientation between the learning environment and workplace (i.e., in the programme and across modules) and the impact this has on skills and competency development

and the transfer of knowledge to practice when he stated:

“It helps, you know, support the knowledge transfer because they learn they go to work, they come back, they experience, they practicalise it. They work, they come back, share what they did, they learn from others and then they go back again. So, it's a kind of a circle that goes on. And while they're learning, they're practicalising what they're learning, and they're coming back with such experience [...], and they can now go back to perfect it.” (Ron, 48-54 years, lecturer and module leader, London study centres).

Kathy expressed how the programme's transferrable skills and knowledge had influenced her experience. She noted how her viewpoint had shifted because of her experience with the programme. Mark builds on this, explicitly commenting on the emotions evoked when he suddenly realised that whatever he had been taught was highly contextualised and relevant to his practice.

“It's very clear. Yeah, it has linked properly [...]. When we were doing it in the programme [...], you don't understand it as it should be, but when you go into the field [...], that's the time [...] it really links, and it makes you feel that you've learned something in the course and which makes you [...] say very happy [...]. It has that interlink between the job and what you have learnt.” (Mark, 42- 49 years, student, focus group 1).

Omo provided an example from her practice, during which she observed how knowledge and skills from the programme were crucially applied to support the needs of service users. She examined her knowledge of how her practice of self-application and professional wisdom had transformed, allowing her to actively advocate for a particular service user at the point of need.

“[...] I was dealing with a situation with one of my service users – safeguarding. So, what I learned with my, one of my lectures when I was doing one of my modules would help me to use that knowledge and, uh, step forward [...]. Because before [...] it's not like I will ignore it, but probably I wouldn't know which kind of action or where to go.” (Omo, 26-33 years, student, focus group 2).

Employers working with students and graduates usually observe them in real-time in the workplace, and due to this positionality, their feedback on their work output and performance relative to the evidence of healthcare management knowledge and skills

transfer has the potential to be immensely valuable. In this vein, Layla provided an interesting perspective when she discussed the context of Gemma's work and the opportunities provided for her to share knowledge from the programme with her team and colleagues. She said:

"[...] She shares a lot of what she, uhm, learn. We have team meetings, uhm, with her colleagues because [we] there are four of us within forensic care. Uhm, so, we'd have like monthly team meetings, uhm, it's not always on the agenda for Gemma to discuss what she's working on at the time, but we might just, in general, say, or how're things go in and what are you working on this term [...]." (Layla, 55 and above, service director large charity, employer).

Beyond sharing beneficial knowledge that supports transfer and skills application in the workplace, Moses referred to Dame's improved understanding of CQC requirements. He explicitly inferred that the role of her education (on the programme and experience) was significant in giving her the perspective she has on matters to do with quality in care provision. Furthermore, this understanding was evident in Dame's contribution to the employer focus group pilot (i.e., EFGD). Moses said:

"[...] We had to, uh, submit our provider information return, which used to be something the CQC asked for, uh, before an inspection now they asked for it every year. I gave her that look over, and she, she put some fantastic points in there, so her understanding of the requirements, understanding of what the questions are asking, and looking for in terms of evidence is quite good, but that'll [...] be a mix of education and experience [...]." (Moses, 55 and above, managing director and owner, employer).

It was interesting to note how Moses alluded to the influence of education and (practice) experience on Dame's improved understanding. While not explicit, Moses' inference affirmed a non-unidirectional linear link between learning from the blended learning programme and practice experience.

To add another dimension to our understanding, despite raising concerns about some higher education students finding it difficult to transfer knowledge and skills to the healthcare workplace, Tamika confirmed that she had witnessed evidence of the transfer of knowledge and skills from the students and graduates of the undergraduate healthcare management programme. Tamika articulated her view as

follows:

“In terms of what they have been taught and transferring that (your students that I’ve come across) have been able to do that, but some students are not [...]. Your uni, the students that I have seen, yes, they do, and they are a pillar of support for staffs working on the floor, they pass that that knowledge and when they are not sure, they ask question which is good.” (Tamika, 55 and above, service director, mental health care home, employer).

Layla's view broadly aligned with Tamika's. However, she also noted Gemma's challenge in sharing and transferring her knowledge and skills as a service user advocate outside her organisation (e.g., in the NHS). The difficulty was that, as an outsider advocating for service users admitted to NHS facilities, expectations, work culture, and resistance were complex organisational factors she constantly had to navigate to ensure that the voice of her service users was heard and, in the process, display evidence of healthcare management knowledge and skills transfer. Layla quickly added that even within these constraints, there was evidence of Gemma's core transferable skills in navigating this complex work environment, like negotiation, assertiveness, and stakeholder interest awareness. Layla observed:

“She's not able to, uhm, probably use all the skills that she is learning at the moment because she works [...] in a forensic, uh, hospital, uhm, [...] we are there as independent mental health advocates. So there is only so much that she can do, uhm, but what she does do, uhm, probably not always taken that well by some staff there because we are seen as outsiders, [...] to the organisation, is that she shares her knowledge, uhm, but she'll do it [...] very subtly, uhm, which is part of the job as an advocate really is trying to, uhm, advocate with the [...] NHS about people [...].” (Layla, 55 and above, service director large charity, employer).

5.5.3 Sub-theme 2: Neutral and Transfer Difficult to Determine

Neutral and transfer difficult to determine was a minor sub-theme under theme 4. The sub-theme explored participant feedback about whether there was evidence in the programme to show that there was potential for the transfer of knowledge and skills from the blended learning healthcare management classroom to practice and the mechanism (if any) existing within the curriculum to facilitate, further or even negatively impact transfer. For ease, I have discussed this under two further subheadings – that is, 5.5.3a “Transferability and competency assessment challenges” and 5.5.3b

“Absence of placements hampers transfer appraisal.”

5.5.3a Transferability and Competency Assessment Challenges

This subheading explored whether the programme's conceptualised knowledge and skills are transferrable to practice by students and graduates. While positive transfer returned the most themes in the study, a few of the participants alluded to the difficulty in determining if there is definitive evidence that the transfer of knowledge and skills is transparent and fully observable in the absence of practicums. For instance, Daniella noted the difficulty with establishing whether healthcare management competency could be verified where the teaching faculty is not in the workplace to observe this in person in the performance of students and graduates. She mentioned:

“I think in terms of competency, it's more difficult to assess, although we can, uhm, include that in the graduate attributes, and we can consider things like communication skills and emotional intelligence [...]. Uhm, but I think [...] that's much more difficult to assess if you're not in that workplace with them.” (Daniella, 48-54 years, associate lecturer, Manchester study centre).

Peter corroborated Daniella's view about the shape placements could assume, specifically in helping prospectively observe students' workplace output and capability in expressing requisite healthcare management graduate attributes. To surmise the students' and graduates' ability to demonstrate their application of the knowledge and skills from the programme to practice, Peter noted:

“[...] because we don't have that practical component, I think it's really difficult to assess. [...] I think it's easier to assess almost two or three years down the line after students have graduated to see how they applied their knowledge. I would say without having that placement components; it's difficult to assess. I think some students do a really, really good job of illustrating the application of skills in context scenarios, and uhm, you know assignments that they write, other students, much less so [...].” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

Peter further qualified his view by noting that a further dimension to consider is that only a few students he had encountered in the Birmingham study centre worked in management positions in healthcare. As a result, he asserted that:

"[...] some students have got fantastic experience and are able to apply the things that we're talking about to that context. I think the other thing is that a lot of students aren't necessarily in managerial roles [...]." (Peter, 41-47 years, associate lecturer, Birmingham study centre).

Similarly, Emebo was also uncertain to a greater degree about the programme's ability to fully demonstrate knowledge and skills (including competence) transfer to the workplace holistically. Nevertheless, he provided examples of modules in which students can transfer the skills they learn and their management knowledge to other situations, such as practice. He stated:

"I think it does to a certain degree, but to what degree it does so effectively, I don't know [...] I think it does, [...] we have certain [...] modules which, which focus on, you know, particular skills [...] and, you know, do transfer knowledge but, yeah, here again, the links are not always explicit [...]. When you're thinking about it you need to also think about it in terms of some modules are better at it than others. You know, I think I would say OK if you're looking at the Communication and Collaboration [...]." (Emebo, 55 and above, associate lecturer, London study centres).

Following Emebo, Leah also emphasised that more work was needed to ensure skills and competency and their application are better understood so that the programme team is most capable of responding to concerns about skills and competency demonstration and application. She said:

"This is an area where it probably needs more work, uhm, because obviously skills and competency are things that actually, uhm, you cannot necessarily judge in terms of, uhm, what people say in a classroom, uhm, and what people know in the way of their knowledge. So, I suspect that it would probably need more work on it." (Leah, 55 and above, programme manager, London study centres).

5.5.3b Absence of Placements Hampers Transfer Appraisal

"Absence of placements hampers transfer appraisal" was mentioned the same number of times as 5.5.3a "Transferability and competency assessment challenges." I presented this part as a subheading (i.e., under 5.5.3) rather than a sub-theme. There were substantial crossovers between 5.5.3a and 5.5.3b for these to be discussed as separate sub-themes. Structurally, to make it easier to follow the discussion, I have

reported these in the manner I did.

Emebo indicated that the connections between knowledge, skills, and competency requirements of a healthcare manager did not explicitly appear in the programme for him. He also cited questions students had asked as reasons that reinforced his opinion. He mentioned:

“So, if we're thinking in terms of if the modules itself make apparent the link between knowledge and skills covered and the competency required of the healthcare manager, I would say no. I think sometimes students ask me questions that suggest [...] it is not clear to them that there is a clear apparent link between what they're learning in class and the competency required for [...] healthcare management. [...] What I'm saying is not that it doesn't exist, but I guess the students might not appreciate it. I thought it's not explicit.” (Emebo, 55 and above, associate lecturer, London study centres).

Abi's opinion on whether the relationship is apparent resembles that of Emebo. To explain, whereas Emebo believed the relationship was not apparent, Abi felt the same way, but only at the beginning of the programme. To reconcile the difference between the views, the missing piece for Abi was that the practice or placement opportunity was missing for her as a student to organically create those connections between the theoretical knowledge and their links to practice at the beginning of their study. This is evident in her view that all they learned in class was theoretical.

“Initially, it wasn't transparent [...]. I'm not just talking from my point of view; I'm talking from the point of view of other class members [...] and then gradually, as they got into the course, they now began to see the link on how they could use it [...]. I do think it was down to each individual and their understanding because, like [...] both speakers have said, you won't know what you have learnt until when you go into the field because everything that we have learned was theory. We did not actually, unless you are already in the field and you were actually working in healthcare, you were not able to put what you have learned into, into practice [...].” (Abi, 50 and above, student, focus group 1).

Chanice also confirms the theory-laden nature of the programme, such that despite the diversity of her peers and groups of service providers in her practice, she felt scared and lacked the confidence to apply the theoretical knowledge. Nevertheless, she discussed how she treasured the opportunity to work in a blended learning space

with diverse people where peers learned from each other. On the other hand, Leah elaborated on the notion of more linkages, as suggested by Emebo and Abi. Her point of view was intriguing because, while she acknowledged the difficulties in coordinating placements, this might be a critical component in establishing a deeper awareness of the situatedness of the transfer setting. She expressed herself as follows:

“I suppose, uhm, I would see one of them as being going down the route of perhaps much more linkage [...] and students being involved in actually delivering healthcare, even if it's not management, uhm, and so that we would know that they are applying those skills [...]. I hesitate to say it, uhm, but I suppose it might be valuable to [...] either insist that students are in a role in health and social care, uhm, whether it's paid or unpaid doesn't matter, or that there is a potential for placement and [...] hesitate to say placements because I think that uhm, they take an awful lot of organising, but I think that, actually, that would probably support the whole part of the skills and competency. We'd be able to have, uhm, much more understanding of that.” (Leah, 55 and above, programme manager, London study centres).

Compared to other HEIs, Garry believed placements are critical to the programme's process of connecting knowledge, skills, and healthcare management graduate competency to practice. He thought offering this would distinguish the curriculum from comparable programmes from other HEIs. He noted:

“[...] to be honest, the theoretical side [...] is perfect, for me anyway, I think it's good, but the only thing [...] is like in traditional universities, like say you study health or social care [...] in second year they will give you like a placement to enhance your knowledge. Like even if we had a placement like a two, three months [...], or during the summer, we had a placement, and we're learning managerial skills from top health and social care [...].” (Garry, 26-33 years, student, focus group 2).

Peter stressed the need to see placements as an essential component of the support system for guaranteeing all students' (employability) success on the programme. He implied that, without exception, this would provide students with an egalitarian experience in which they could apply theoretical knowledge to healthcare management practice. He suggested:

“Although the vast majority of students on the healthcare management programme are actually working, usually as support workers, somewhere in practice or in advocacy or related disciplines, I have come across some students who've sort of

started out doing a healthcare management course and they haven't got any practical experience. Uhm, now that often changes as they sort of moved through because it's often an intention, but I think somebody who didn't have any practical experience of working within the healthcare sector [...] might really struggle, and we used to have something in nursing called a management placement, where essentially, students would shadow a manager.” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

5.6 Theme 5: Suggested Improvements

| Name | Files | References |
|---|-----------|------------|
| Suggested improvements | 16 | 57 |
| <i>Sub-theme 1: Enhancing and internationalising programme and skills support</i> | 8 | 19 |
| <i>Sub-theme 2: Learning resourcing and assessments</i> | 8 | 15 |
| <i>Sub-theme 3: Personal development, digital skills and work placement</i> | 12 | 23 |

Table 20 Theme 5 Summary

This theme delves into the enhancements recommended by the study participants. The sub-themes attributed to it were divided into three primary areas: "Enhancing and internationalising programme and skills support", "Learning, resourcing, and assessments," and "Personal development, digital skills, and employability." Theme 5 broadly relates to other primary themes such as Theme 1, Knowledge, characteristics, skills and employability expectation, Theme 2, Strengths and Theme 4, Knowledge, skills and transfer to practice. For instance, exploring the knowledge, characteristics, skills and employability expectations together with the programme's strengths and knowledge, skills and transfer orientation to practice brings to the fore suggested improvements for the programme team and HEI to consider for a better student experience.

5.6.2 Sub-theme 1: Enhancing and Internationalising Programme and Skills Support

Due to their familiarity with the programme, internal participants (i.e., insiders) in the study provided feedback about how it could be enhanced to provide an improved learning experience for students. This includes augmenting the programme induction, embedding more wraparound academic skills support, and adding a more international

tilt to the content and resources to accommodate the needs of the international students enrolled on the programme – for example, students studying in the HEI's Berlin study centre. These students learn in a country whose healthcare leanings and models differ from the UK.

Umaru proposed that the programme team rethink the depth with which topics and skills on the programme are addressed in future. These were related to some graduate employability skills managers must display in their day-to-day roles and responsibilities. Umaru observed:

“Uhm, well, I don't think there's any that is not being covered but is probably to the extent that they are being covered or how well they are being covered. [...] I don't think we are paying as much attention to communication skills - developing the students communication skills, presentation skills, uhm, and stakeholder engagements skills. [...] while there are modules that touch on those, we haven't really developed them properly.” (Umaru, 41-47 years, lecturer and module leader, London study centres).

Ron implied that Umaru's suggestion should be of utmost importance to the curriculum management process and managers, particularly given that his observation has been that some students experience challenges, demonstrating the level of communication he would associate with third-year management students as an example. He noted:

“[...] Some people would come up to final year and maybe the language used in assignments, the way is [...] constructed you still find some issues [...]. Some people come to class, but they don't talk. They're shy about their language [...]. My point again is, uhm, can more practice, 'practicals' be applied, you know, like [...] presentations [...] so practice [...] communication. You can't be – say, a manager [...], and you can't express yourself very well [...]. You must be able to transmit whatever you have in your head at that level [...].” (Ron, 48-54 years, lecturer and module leader, London study centres).

In referring to the need to enhance how core (or essential academic study) skills assistance is delivered to students, Daniella stated that another significant area she believes the curriculum might improve is building IT skill competencies for students and graduates. This viewpoint is broadly consistent with other academic participants, who called it 'digital skills.' Daniella also described the COVID-19 study period as challenging for students studying on Zoom. As a result, while reiterating her

observation about students hiding (during Zoom sessions) and not participating as much as others, she indicated that (as a long-term strategy) frequent one-on-one personal tutorials may be a tactic for bringing these students into the fold of conversations. The only issue is when students decide not to accept the offer or fail to attend such appointments. She asserted:

“I think key improvements for the whole programme might include [...] some kind of IT skills [...]. I think [...] some kind of tutorials for students so that you have [...] one-to-ones with them on a regular basis [...] because it's sometimes easy, particularly with the way things are at the moment on Zoom, for students to hide.[...] also, I think embedding academic skills [...] within their timetable for the first year [...] into the programme more so that students [...] reach some kind of academic skills competencies so that they're not just relying on the students to access the academic skills tutors.” (Daniella, 48-54 years, associate lecturer, Manchester study centre).

Programme inductions offer an opportunity to set expectations for students and share resources to help them understand their roles and responsibilities as independent learners in higher education. In addition, the roles, responsibilities and support offered by the different university departments. Jamela expressed her frustration that sometimes students don't take the responsibility of accessing and reviewing core programme resources, like programme handbooks, seriously enough, which tends to be detrimental to their studies. Jamela felt programme inductions could do with further enhancement to reinforce expectations and signpost to relevant resources. She asserted:

“I think [...] when the student starts, [...] in the first week, I know they do have, uhm, their induction, but I don't think it's enough. I think they need to have more like an orientation kind of, uhm, sessions. [...] it has to be mandatory; where they can, uhm, learn few basic things [...], especially about understanding the importance of having like [...] the programme handbook – a lot of students have no idea that all the information they're asking is in the handbook [...].” (Jamela, 34-40 years, lecturer and module leader, Birmingham study centre).

Katherina suggested that the programme is playing catch up in some way regarding the topic of academic study skills support. Yet, the wrap-around academic skills support students have access to now, including gaps in inducting students into the academic community, are being addressed gradually. She articulated her feelings

about this by stating the following:

“When I first arrived [...], I was concerned about a lack of skills support or the type of students [...] with their wide-ranging experiences or lack of experiences. But I do feel that that gap is being plugged, uhm, and is recognised [...]. I still think there's more to be done in that area. Uhm, the skills module, I think, is so important and personally, I think [...] in the past it's been too focused on CV and interview technique.” (Katherina, 55 and above, associate lecturer, London study centres).

Still, on improvements, Ethan suggested the programme consider how students studying in blended learning centres outside of the UK engage with the curriculum resources. He came at this from both a position of concern and opportunity. With a UK-centric resource base, students studying outside of the UK might need help to reconcile the content, and broadening the resources also helps UK students better understand the global citizenship graduate attribute associated with healthcare management. He said:

“[...] We've been talking a lot about [...] having more of an international perspective on the programme, uhm, because as you know, we have centres outside [...] the UK as well, uhm, and also just raising awareness to UK students around international issues is something pretty beneficial, uhm, especially fields like public health and, and global health.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Reflecting on her experience of the "Research and Final Project" module, Omo raised concerns about the problems she experienced with her supervision. She pointed out the skills challenges, confusion and concerns experienced in receiving adequate guidance from the dissertation support team. Despite this, she noted how excellent her supervisor was once they were eventually assigned to her. Omo stated:

“I don't know if this is going to be relevant, but [...] on my dissertation, [...] I think this should be more organised because, uh, to the last minute is when they provided a supervisor [...]. So even you email to the team [...] they don't give you a correct answer or do not advise you [...].” (Omo, 26-33 years, student, focus group 2).

An observation of the group dynamics at this stage was interesting in that while one participant (in the same focus group) appeared to provide a defence of the supervision

process as commensurate with other HEIs, another attempted to expound on the broader context (e.g., COVID-19 pandemic) of the period during which they had their final project supervision going. To illustrate, Samantha indicated:

"[...] I have researched even the mainstream universities because I did feel that way as well but what I found out was, you [the student] will always need to be ahead of time because supervisors do not provide you with enough supervision because it's a tertiary institution they expect you to do your research. Please don't wait for them; do not wait for them." (Samantha, 50 and above, graduate, focus group 2).

Lumia, on the other hand, particularly noted the impact COVID-19 had on her ability to maximise her supervision experience and how this experience (i.e., COVID-19), while broadly impacting the experiences of other students in her group who also reported a less satisfying experience, puts them in good stead when they progress to complete their master's degree or in their place of work. In short, she was more sympathetic in her defence of the HEI. She asserted:

"I think that if it hadn't been for the coronavirus and all upset that have caused, everything would have been better. I think, because we weren't going to campus and we had no physical interaction, [...] it was just much more difficult. For me, my supervisor and I hardly engaged at all, but at the end of the day, it was my fault because, like Samantha said, you've got to be the one; it's your dissertation, you've got to be on top of it, so you have to start right at the beginning, and that was a mistake I made. I left my [...] queries and everything else too late, but at the end of the day, almost everybody in my class was unhappy about supervisors and the dissertation [...], but at the end of the day, you learn from all these things, you learn from it, so if you go onto a master's degree, it stands you on very good stead [...]." (Lumia, 50 and above, student, focus group 2).

The "Research and Final Project" module is run in six-week blocks of three-hour weekly workshops. This module includes theoretical material to assist students in completing their ethics and research proposal ideas. Nonetheless, from all three perspectives, the module would need enhancing to change how students interact with it. Jade, who manages and delivers the "Research and Final Project" module workshops in the school, also recommends that the managers revisit the coordination of the module delivery. She stated:

"I would emphasise on the research side, on giving, on paying more attention when

it comes to, uh, Research Projects [...]. I think we need to improve on that and, and, and maybe come up with strategies that will help to, uhm, consider the Research Project as a module and not just like, uh, having them as workshops.” (Jade, 34-40 years, associate lecturer, London study centres).

Umaru, one of the research and final project module leaders, agreed with Jade that the workshops in their current form are voluntary, which means that students who do not attend them may still have their final project module released to them. These students often struggle as they usually lack a fundamental comprehension of research methods. He indicated:

“Another thing I would also want to engage, uhm, or see changed would be improvements in the, uh, dissertation module. So, I think that should have a dedicated module of its own where the students can start to learn about the rudiments of the dissertation or through the process with the support of a dedicated teacher or lecturer and allocated time where they need to attend classes rather than workshops which are voluntary.” (Umaru, 41-47 years, lecturer and module leader, London study centres).

5.6.2 Sub-theme 2: Learning Resourcing and Assessments

This was the least mentioned of the three sub-themes under the "Suggested improvements" theme. It was mentioned fifteen times in all. The spectrum of comments on this issue includes module and programme delivery methods, assessment management systems, and diversity.

Referring to the six-week teaching block structure of – one module at a time, Emebo advised that a long and thin module experience, in which the modules are delivered over a more extended period (e.g., over a conventional semester of 10-12 weeks), might relieve lecturer strain, particularly with meeting marking turnover deadlines. He stated:

“[...] I think maybe the modules need to be a bit longer [...]. I think, yeah, they need to be slightly more in-depth, maybe. [...] marking places, a lot of pressure [...] I find it really hard to do, [...] proper marking in the sort of the timescales we are given [...].” (Emebo, 55 and above, associate lecturer, London study centres).

Correspondingly, Mark and Abi shared a similar concern as Emebo about the

pressures and effect the 6-weekly block system has had on them as students. Yet, Mark explained that despite the challenges in his first year, things improved as he progressed across the different levels of study. Mark indicated:

“[...] my first year because of the six weeks [...] it was a bit of a struggle, but as time goes on, uhm, I become used to it, so, uhm, the second year is fine. Third year is fine. [...] but the first year, I think they should make it a bit easy, or they start it with easy modules. I know they always, uh, try to relate modules from module to another module, but I think to make it easier, a bit easier in the first year [laughs].”
 (Mark, 42- 49 years, student, focus group 1).

Abi, too, felt pressured by the six-weekly delivery schedule. Her perspective complemented Mark's in that it addresses the assimilation and metacognitive processing of the codified knowledge shared in the learning environment. Abi added:

“[...] like Mark said, I mean it's not just the first, second, third year, but I think throughout the programme itself, [...] to teach a particular module in six weeks you are really, really rushing people and sometimes, I mean in the first year I felt I've been taught so much, but then I felt like I wasn't taught anything because it was rushed. Didn't have time to [...] assimilate and digest and [...] most of the people I spoke to they felt like that.” (Abi, 50 and above, student, focus group 1).

Leah suggested that the focus of the composition of some of the modules would also require further consideration for future development. She argued that more focus is needed on healthcare than on the business side of healthcare management. This calls for more focus on the practitioner and practice aspects of healthcare. She asserted the following:

“Uhm, [...] I think it does have a tendency to, uhm, favour much more, uhm, what I would call ‘businessy type’, uhm, ways of looking at health and care and I, I suppose I feel that I would like to see more, uhm, emphasis on delivery of service and [...] meeting the needs of service users [...] which would bring a bit more balance [...] in terms of being aware that we are working with people.” (Leah, 55 and above, programme manager, London study centres).

Unlike Leah, Katherina focused on the upkeep of module content and resources rather than their integration across the programme. She contended that it is vital to review and analyse module information regularly to ensure the content is relevant and current.

She also provided her personal experience teaching a particular level 5 module (i.e., Health Promotion), which she believed was a significant advancement from level 4. This was noteworthy considering Mark's statement about making level 4 modules more straightforward for students.

There is also the concept of pinned and paired modules, which Abi referred to in her feedback; while implemented, this concept, it seemed, had not always worked as well as it was hoped, particularly for students who join the programme at specific enrolment cycles, such as February and April, when the first set of pinned and paired modules would have run. Katherina shared the following:

“Some of the material doesn't change that regular, but some of them do, particularly when you're talking about things like NHS plans [...] You know, that's the sort of thing, so there's a couple of modules that need to be kept a closer eye on, so I would suggest that [...]. I did think that the level 5 module was too big a step for the students, but that's now been brought to level 4 [...]. I do think that more skills needs to be really drummed into them at an early stage so that by the time they get to level 5, they are better prepared.” (Katherina, 55 and above, associate lecturer, London study centres).

Abi also alluded to Mark's concern regarding the difficulty level of some initially completed Level 4 modules. However, based on the feedback, Abi was more concerned about how some of the modules that were supposed to be introduced first in terms of synchronising concepts and creating basic knowledge blocks were completed later than they should have been. This would imply a risk of disrupting the integration that some participants saw as a fundamental strength of the programme. Abi stated:

“Some modules that should have been put at the beginning of the year; you're going on from 1 module to another, you're realising hang on a second, this module should have been done before this module because the ending of this module leads onto another module. [...] it's like you're putting [...], the cart before the horse [...]. So, the way modules are planned and situated within the programme itself, they need to look at.” (Abi, 50 and above, student, focus group 1).

Ethan, one of the portfolio managers and senior lecturers in Berlin expressed his thoughts about assessment modality and practice on the programme by emphasising

the significance of assessment diversity in assisting graduate skill development. Ethan's comments were prompted by a recent programme revalidation, which came after the undergraduate blended healthcare management periodic subject review in late 2021, which I co-managed and coordinated as Deputy Head and Principal Lecturer responsible for programme development. The revalidation was implemented to refresh and update the modules and the programme. Despite this, the core areas of coverage and subject benchmarks informing programme knowledge, skills, and attributes of the curriculum stayed the same, and practicums still form no part of the updated programme version. He explained:

“Uhm [paused]. I guess there's a lot that we've already been discussing in the recent, uh, recent revalidation [...]. The key things really that have come out of that are or that I've been involved in especially is, is one: [...] thinking about the assessments that we give, having more diversity, in terms [...] of the assessments [...] to try to develop a more diverse [...] set of skills, uh, in the students, to make them more engaging as well and [...] also thinking about academic malpractice as well which is something that I have worked on.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Sara, Katherina, and Peter mentioned the need to look at assessments throughout the programme. Sara believed there was sometimes a haziness between module material and assessments, which students occasionally highlighted with her. This, in general, would raise slight concerns about 'teaching to assessment', which had been implied by Emebo, who expressed concerns about the pressures brought on by the 6-week delivery timetable. Nevertheless, responding to the concerns about diversity and academic integrity raised by Ethan, Katherina suggested the following:

“Yes, I would like to see less emphasis on 3000-word essays, which I think are a very one-sided form of assessment and not necessarily particularly useful either, and I would like to see Moodle used more for good quality [...] assessment. Yeah, because [...] you're more able to check that the student is doing the work themselves [...]. There are problems with ghost-writing which they are with every university. It's hard to identify, and it's much more likely to pick up whether there's a problem [...] if you're bringing them in for something.” (Katherina, 55 and above, associate lecturer, London study centres).

Peter even went as far as arguing that digital resources may be valuable in

encouraging the type of assessment variety (and authenticity) Ethan and Katherina were calling for. He asserted the following:

“We could have e-portfolios for assessments. For example, using things like ‘Wakelet’ [...]. I think we could do more because at the moment, uhm, you know, the vast majority of assignments are written assignments, and I think we could get more creative in terms of, uhm, presentation assignments or, [...] more sort of e-portfolio type stuff [...].” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

Ron viewed resourcing differently when he proclaimed that the programme should be more outward-focused. This is because of the changing dynamics of higher education, where significant changes have been observed over the past couple of years – not least with the impact of widening participation, student recruitment and experience. Ron argued that the programme team and HEI, in general, need to be agile to respond to what he feels competitors are doing differently that is making a difference for them. For example, how to support adult learners as they settle into higher education and help change their mindset to one of resilience and an understanding of the benefits their contribution would have on society.

5.6.3 Sub-theme 3: Personal Development, Digital Skills and Work Placement

This was the sub-theme most frequently referred to under the ‘Suggested Improvement’ theme. Personal development goes hand in hand with professional development, with the two having a symbiotic effect on each other. Digital skills are also becoming more visible as a core skill to support management work in health and social care (Skills for Care, 2016). As a sub-theme, it closely interacted with the “Learning resourcing and assessments” sub-theme. To illustrate, “Learning resourcing and assessments” is an essential precursor to personal development, and students and graduates leverage the theoretical knowledge and skills from the blended learning classroom to support transfer and utilisation in the healthcare workplace.

Randolf had a favourable outlook when he mentioned how fantastic his students were. This alluded to their innate wisdom and personal and professional experiences. He

remarked this while highlighting IT skills as an asset for students. To help solidify his view, he also attempted to link personal development opportunities to student confidence. He indicated:

“I think maybe a bit more about IT skills. I think that it will be useful, and second, I think personal development because I think that many times our students are great, but they don't know it, so they lack confidence. So, these types of skills that are related to personal development, I think that would be very helpful for them.”
(Randolf, 34-40 years, programme manager, Birmingham study centre).

Explaining why IT skills are essential graduate employability skills for the current health and social care management workplace—a sector our students and graduates work in or would be hoping to go into, Peter said:

“[...] I mean, if you're really, really, positively IT literate, then I can see how that would give you [...] positive opportunities [...]. I actually think, you know, the digital side of things, I think, is really, really important, and I think that is something that could be enhanced within the course.” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

Like Randolf and Peter, Daniella also mentioned that some students struggle with different IT skills required for their coursework. She posited:

“I think in particular, IT skills [...] some students really struggle with basic IT skills, so [...] I think that needs to be embedded much more into the [...] programmes and looking at different types of [...] IT, most of them can [...] use a word document, but uhm, beyond that [...] some of them are not able to [...]. So, we look [...] at, uhm, artificial intelligence and how [...] knowledge about that is going to be needed much more.” (Daniella, 48-54 years, associate lecturer, Manchester study centre).

Also offering his thoughts on the subject, Ethan agreed with Daniella that digital skills are essential for students, particularly in making them more employable. He mentioned:

“I think digital skills is the big one [...]. Uh, [...] I think there's some digital skills that [...] could be really beneficial to them in the job market. [...]; not currently at least, uhm, our big focus of the programme.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

To elaborate on the difference in IT skill proficiency observed between the student groups, Jamela explained how she had noticed a difference between students who joined the 4-year foundation programme and those who joined the 3-year degree programme. She argued that a marked variation in IT skill proficiency is observable. She remarked:

"[...] I do find a lot of students have no idea [...] how to use 'Word' and things like that. So, I personally spend a lot of time teaching students [...] to navigate around 'Word' document. Hmm, so, I think they do need, uhm, IT skills, just basic [...]. I think if the student starts with, uh, Foundation year, uhm, they're OK because I think in, in Foundation Year, they [...] cover some of the, uh, things [...]." (Jamela, 34-40 years, lecturer and module leader, Birmingham study centre).

Continuing with the sector and employability theme, Emebo suggested that additional work was needed to ensure the curriculum displayed stronger links to the health and social care sector. He observed that the challenge with this sometimes is that the programme content draws on examples from other countries and geographical locations, such as the US, instead of the UK. He asserted:

"I think the BA Healthcare programme needs to make more explicit links with the health and social care sector. [...] there should be much clearer links between the, uh, uhm, the key actors in sector, [...] from the ministry to, [...] different hospitals and care homes. [...] a lot of our examples and theories come from the States, and there's nothing wrong in learning from the States, but we need to have something that is really local and embedded [...]." (Emebo, 55 and above, associate lecturer, London study centres).

What could be implied from Ethan's feedback was that the further work required (and as highlighted by Emebo) to make links to the sector and graduate skills more apparent is why students often ask about connections between the lesson content, resources and employability. Embedding this, Ethan noted, would be crucial for enhancing personal and career development opportunities in the programme moving forward. Ethan indicated:

"[...] I think on the programme as a whole, [...] a question, I often get it from students, is to think about what kind of jobs they would, uh, apply for, especially the students in in Berlin. They're not really sure about what to look for when they graduate [...] what kind of jobs they would be, uhm, eligible for, and so I think that integrating that, uhm, somehow within the actual curriculum would be really helpful

*[...] – integrating case studies where they might look into certain roles or positions.”
(Ethan, 41-47 years, senior lecturer, Berlin study centre).*

Barry supported Ethan's view by discussing specific employability skills for students and graduates. He wanted to see the curriculum incorporate this more deeply in its official instruction. While this was accessible as part of the university's broader support services, adding it, particularly in formal teaching resources, would offer additional value for students and graduates, particularly with employability in mind. To illustrate, he referenced supporting them with interview preparation, CV writing, and directing students to job websites. He also hinted at the increased tie to practice, indicating some placement opportunities to support their learning journey further. He contended:

“I think at the end of the day, we are being prepared to go out there and deliver, so, uhm, for me, I think there should be more, uhm, inclusion as to what is going to happen in the real world than just [...] come into class and teaching.” (Barry, 34-41 years, student, focus group 2).

According to Chanice, Mark, and Abi, the programme provided enough theoretical knowledge. However, they believed that opportunities for practicalising the knowledge and skills were required. This does not imply they were not already in practice or had no experience providing care; instead, the lack of a practicum option on the degree had resulted in a less holistic managerial experience for them. Abi agreed with Chanice and Mark on the possibility of placements, or "work attachments," as Mark (student, focus group 1) put it. Abi asserted:

“Doing the practical side of it would have been, uhm, beneficial not just to those that are in the industry, but also to those that are new to the industry. Is nice to be an all-rounder to see things from [...] different angles, so then, and then it gives me a better picture [...]. That will afford you to be a better manager to those that you are going to manage in future.” (Abi, 50 and above, student, focus group 1).

This view mirrors the following teaching faculty: Jade, Peter and Sara, who, although they referred to placement opportunities differently in their feedback (e.g., apprenticeship offers and internships), all believed it would add value to the graduate

skills and competency development for healthcare management practice.

Peter's feedback captured the views they all expressed and espoused when he asserted:

"[...] I wonder whether as a part of the final year [...] some sort of internship, some sort of opportunity to, even if it was one day, a week or something for students to have that opportunity to go and [...] I mean, there are a variety of placements, and it could be something that potentially students could set up themselves. Uhm, but I think it could actually be assessed as a sort of reflective piece, a sort of developmental piece." (Peter, 41-47 years, associate lecturer, Birmingham study centre).

This aligned with the suggestion by Garry to have a placement organised for the students in their second or third year of studies or even as part of their summer work. Employers like Tamika added their voice on the issue of placements by stating that the programme would do well to embed this for students. She asserted:

"I think that there is need for your programme to be able to accommodate your students to be able to have practical [...] experience. So certain hours [...] should be set aside, just like social workers you know, and nursing students [...]. They have that, uhm, they have such hours where they get to see the practicality of it. I think your programme should involve that, and that will make it more robust." (Tamika, 55 and above, service director, mental health care home, employer).

Moses deepened our understanding of what is most important to him as an employer in a social care field struggling with recruitment, retention, and funding challenges. He mentioned:

"I think, uh; generally, I can say our priorities are one to obviously survive and grow as a business, so [...], it's got a range of skills, including marketing [...], networking and business development [...]. Also, from a care point of view, understanding the requirements of the Act, and the key lines of inquiry, and what a CQC inspector will be looking for. [...] if all that's in there, in part, I think, uh, you know, it would be very useful." (Moses, 55 and above, managing director and owner, home care service, employer).

5.7 Theme 6: The Current Higher Education Landscape

| Name | Files | References |
|---|-----------|------------|
| The current higher education landscape | 15 | 32 |
| <i>Sub-theme 1: Access, motivation, integrity and academic study</i> | 7 | 15 |
| <i>Sub-theme 2: Careers, professionalism, technology and sustainability</i> | 7 | 9 |
| <i>Sub-theme 3: Emphasis on skills, practice experience and confidence</i> | 5 | 8 |

Table 21 Theme 6 Summary

The sixth theme investigated participants' beliefs, expectations and views about higher education in general. This elicited fascinating input from internal (insider) and external participants. The feedback ranged from access to higher education to students' motives for enrolling in higher education, academic integrity, career advancement, and professionalism. The theme comprised three sub-themes. They are as follows: "Access, motivation, integrity and academic study", "Careers, professionalism, technology and sustainability", and "Emphasis on skills, practice experience and confidence" (see Table 23).

5.7.2 Sub-theme 1: Access, Motivation, Integrity and Academic Study

Feedback from the participants showed that access to higher education is an important indicator of social mobility. In recent years, much attention has been placed on universities' roles in promoting equality, diversity and inclusion (Costley et al., 2021), particularly among traditionally under-represented groups such as those from BAME communities (see National Union of Students [NUS], 2019). While this has aided the widening participation agenda, the right motivation to study is critical in delivering positive graduate outcomes and progression, continuation, and retention targets, all essential benchmarks for HEIs.

Furthermore, studying in higher education entails adhering to academic traditions and exhibiting intellectual property integrity. The problem is that the growth of essay mills and (now) Artificial Intelligence (AI) technologies capable of assisting students in cheating appears to breed grounds for alarm in the study.

Regarding access to higher education, Chanice discussed how important it was for

higher education students to have at least a level 3 vocational qualification or some experience working in healthcare management. She noted that this is to prevent struggling students from soliciting contract cheating services.

“If someone come into higher education, they should have at least [...] NVQ level 3 or at least [...] doing [...] healthcare management.” (Chanice, 42-49 years, graduate, focus group 1).

Abi was, however, quick to point out that her experience of having joined the programme from ‘Foundation Year’ was that, while she could attest to the existence of tests (e.g., diagnostic and initial assessments) on the programme, the criteria for entry into higher education should flexibly reflect ‘diversity’ and (the entry criteria) should not preclude others without particular qualifications. This view provides a counternarrative to Chanice’s and reinforces the message of widening participation as envisaged in the Dearing Report (see Dearing, 1998). She contended:

“They have the foundation level and [...] I know, uhm, they do screen [...]. Even though I had studied, I mean I came back through the foundation level. [...] but then again, just like Chanice said, some people may not have that, but they’re willing to, you know, work hard.” (Abi, 50 and above, student, focus group 1).

Randolf also explored access, but mostly from a university fee affordability perspective. This is important to reflect upon, as he intrinsically linked it to individual (student and graduate) growth and social mobility. He said:

“I think that the tuition fees now are very expensive for students, so they are a big burden on families, and I think that, in general, this is not a good thing for social mobility [...], for people that are trying to, of course, have new opportunities and to grow.” (Randolf, 34-40 years, programme leader, academic interview).

Emebo appeared to frame his response to the question about higher education improvements with the HEI in mind. He observed that the institution must ensure that it shows flexibility in responding to the challenges faced by students. This, he argued, could be achieved through their reflecting on key obstacles this unique set of students face as mature learners who, while at work, also have parenting and other responsibilities to contend with. He asserted:

“Xxxxx University needs to think [...] much more carefully about the needs of the particular group [...]. They [...] shouldn't imagine that they're working with the 18-year-old students who [...] have no other, you know, commitments or concerns. [...]. The people who we provide education for are [...] unique clientele, [...] largely immigrants [...], many of whom do not have many years of formal education [...] are working full time, with children, uh, with long hours [...].” (Emebo, 55 and above, associate lecturer, London study centres).

Not restricting access to higher education means people, regardless of age or experience, could embark on it to support their personal growth and career advancement. This diversity of experience and personal knowledge is what Jamela feels she values the most in higher education. She indicated:

“I think [...] the good thing with Higher Education is you can get it at any stage, [...]. I think to me as a teacher, uh, it helps me as well sometimes when I'm discussing something historically, if I have an advanced student in terms of age, they kind of bring in, uh, you know, some wisdom – a mixture of, uh, knowledge within the classroom [...]. I've got a student who is going to be 60 [...] very soon, and they're full of knowledge.” (Jamela, 34-40 years, lecturer and module leader, Birmingham study centre).

Abi noticed the influence COVID-19 had on higher education learning in general. She did this while focusing on the significance of individuals having the correct motivation and mindset to study in higher education. Abi said:

“I think individuals should come in with an open mind. They should come in as a blank canvas. Come in to know that it's not an easy road, [...] it's very difficult [...] I've gone through ups and downs, highs and lows, I mean, I've even had COVID thrown in the mix, but we've had two years of, uhm, learning online, so they should be prepared to work [...] very hard, especially when you come in as an adult learner.” (Abi, 50 and above, student, focus group 1).

Abi was channelling her frustration about the motivation and attitude that some students bring to higher education and how, at the extreme, this has an untoward impact on the learning experience of other students who are fully committed to the process. Abi's feedback below confirms this:

“When you're studying higher education, know that you're not coming in to waste your time, and you're not coming in to waste the time of the people that are

teaching you. You're coming in to learn and concentrate [...], you're a student.”
(Abi, 50 and above, student, focus group 1).

Tamika questioned what she thought about higher education given the current challenges it faces with dealing with the abuse of programmes which have enormous potential to transform graduates into professionals. This led her to the conclusion that some students are on professionally oriented programmes in which they have enrolled for all the wrong reasons. She said:

“[...] What I have observed is that, not from your university, I have friends, I have neighbours, and I've had students that have worked with us in this place and have moved on, and [...] some of them have [...] claim to have done this courses either they don't complete it or many of them most especially not the younger ones, many of them go for it because of the money.” (Tamika, 55 and above, service director, mental health care home, employer).

Alluding to the challenge COVID-19 had presented higher education providers, Daniella especially commended the HEI's decision to continue providing students with a choice to attend lessons face-to-face or stay online (i.e., hybrid approach learning offer) after the first COVID-19 lockdown in 2020. This flexibility that higher education providers in the UK and beyond offered was crucial in easing students' worries and concerns about missing their studies and qualifications. She observed:

“I was pleased to see that [...] 'Xxxx University' [...] were going to continue the 'Your Degree, Your Way,' because I think a lot of students were really worried about having to come back into the classroom [...].” (Daniella, 48-54 years, associate lecturer, Manchester study centre).

Tamika suggested that academic integrity (the use of essay mills particularly) in higher education has become so pervasive that she has interacted with students who unabashedly acknowledge their role in using such services to complete assignments for them. Employers are increasingly concerned about academic integrity and its impact on graduate knowledge, skills, and output. Tamika remarked:

“I've had neighbours who have done this courses and [...] would not even believe they passed through the four wall of a university [...], there is no reflection of that management programme, so that's [...] time, energy, knowledge, everything wasted. [...] I met a lady who was coming from a night shift, and she was telling me

how she pays - is it 70 pounds or 100 pounds to get her modules done [...]? I was interested in what she was saying, but I have very low opinion of her.” (Tamika, 55 and above, service director, mental health care home, employer).

Having studied and achieved both vocational and academic qualifications, Moses reflected on the dichotomy he had observed with plagiarism (i.e., the intentional copy, use and claiming ownership for work without proper attribution to its source (Pears and Shields, 2022) and how safeguards are put in place to address academic integrity within vocational and higher education settings. He explained that, compared to higher education safeguards, he did not believe vocational qualifications, such as NVQs, were robust enough to demonstrate an individual's learning and competence. He surmised:

“[...] I have a view of NVQs that I don't think they are that great [...] I've seen people copy and paste stuff off the Internet with no sort of referencing or anything [...] and get through [...] and I think that's not really learning, whereas your courses are [...] formal and you know properly assessed [...]. I think at that level [...] I would have more faith in what's coming out of them. Not that I don't support NVQs [...].” (Moses, 55 and above, managing director and owner, home care service, employer).

Tamika's view about plagiarism and use of essay mills particularly, more generally, appears to partly dispute Moses' view, who had confidence in the procedures, criteria, and systems that higher education providers use to enrol students and ensure that they abide by safeguards to maintain the rigorous academic culture. The latter is even more pertinent with the advent of AI assignment writing tools like ChatGPT.

“I think you know; I think universities have systems and procedures that you know cover that off quite well, I mean it's an opinion I have [...].” (Moses, 55 and above, managing director and owner, home care service, employer).

5.7.3 Sub-theme 2: Careers, Professionalism, Technology and Sustainability

The sub-theme was referred to nine times by the participants. As a sub-theme, it emphasises the opportunities for career advancement that higher education provides students and graduates. Increasing professional body accreditation – for example, the

Chartered Management Institute (CMI) has become significant in helping HEIs respond to much-needed enhancements to graduate outcomes and support them in succeeding in a competitive job market. Digital skills and an understanding of technology form a core part of upskilling management and healthcare leadership students and graduates ready to operate in complex healthcare systems.

Kathy hinted at an essential role of higher education – that is, it offers a route by which students and graduates could progress in their careers and fulfil their growth and development aspirations. She indicated:

“I think it's something that helps people to progress further where you would have been stuck; however, [...] you have to know what you want to take out from there.”
(Kathy, 42-49 years, graduate, focus group 1).

Moses also provided an employer’s perspective on recruitment pressures for managers and opportunities for career progression within the health and social care sector. He also acknowledged that, in future, developing further collaborative partnerships with higher education providers may be a strategy that could enhance how they recruit managers into their services. He asserted:

“If they want a career in care [...], with an ageing population, the industry is growing, there are vacancies, and it's really hard to recruit registered managers at the moment [...]. These people can come in and be in a fast track to senior management position; maybe what we can do as employers is coming in and talk to them, you know, address the students at a careers event or something; say this is what we do this is how it works if you want to you know [laughs].” (Moses, 55 and above, managing director and owner, home care service, employer).

Ron alluded to the challenge the massification of higher education has brought—specifically, making the job market a competitive place for students and graduates. Yet Moses’ experience would suggest that the pressure brought on by the massification of higher education is not as impactful in health and social care compared to other sectors. Ron argued:

“Gone are the days when you finish your higher education, and you come out, and people just come hunting for you, you know [...]; things have changed.” (Ron, 48-54 years, lecturer and module leader, London study centres).

Ron further attempted to put his view into perspective by arguing that sustainability-wise, higher education has always had a leading role in society that would require re-examining. Although this partly alludes to Moses' view on links between industry and higher education, this is a fascinating thought, especially considering the exorbitant cost of higher education, which Randolph saw as an impediment to social mobility in the UK. Ron suggested sustainability could be framed in line with reduced funding and increased pressure on universities to provide value for money for students while remaining competitive. He asserted:

“Cuts in higher education means that, uh, higher education are forced to be, uhm, self-sufficient [...]. So, they all apply business methodologies to acquire, uhm, students, funds and so on. The dilemma is if you don't acquire students [...], even if they are not as qualified [...], then of course, that is where we have problems [...].”
(Ron, 48-54 years, lecturer and module leader, London study centres).

Despite pressures to be sustainable and competitive, Leah hinted that maintaining professionalism within higher education should remain central. The implication is that this should include ensuring the faculty teaching students have professional experience under their belt that is relevant to the subject specialisation. This would mitigate the skills and competency transfer gaps for programmes focusing solely on healthcare management theory and delivery without a placement offer. She suggests:

“My take on higher education is very much from a kind of dual professional's, uhm, stance really, and [...] in many ways I see myself probably much more as a deliverer of health and care services, or you know, a health care professional [...] I think that actually, particularly [...] in relation to, uhm, these kinds of degrees, where actually is about delivery, uhm, that we need many more people who have got a background in the kinds of services that we're teaching about.” (Leah, 55 and above, programme manager, London study centres).

Sara's view appears to expand on Leah's remark – in that, if you have faculty with the right practice experience, it will appear this makes the contextualisation of learning to aid application on the side of learners and graduates more straightforward. Sara indicated:

“There's no point [...] teaching them okay these are the models we have [...], but they're not able to apply those.” (Sara, 41-47 years, associate lecturer, Birmingham)

study centre).

Even so, Umaru remarked that we must remember that higher education provides excellent prospects for students and graduates. He advised that professionalising some programmes offers a tremendous scope for mapping it to learners' and graduates' employability aspirations. He observed:

“I think Higher Education in general, uhm, [...] is great, but it's, it needs to, especially for some courses, [...] become more [...] professionalised. There needs to be a drive towards making it more professional. So, for example, you have, uhm, a degree like healthcare management, uhm, there isn't really any direct or regulated route that, uh, for a profession that it takes you to [...].” (Umaru, 41-47 years, lecturer and module leader, London study centres).

Moving beyond professionalising higher education and exploring the impact of technology on it, Peter thought that the COVID pandemic appears to have taken us ten years forward in terms of technology. Ron's perspective on higher education's sustainability makes Peter's observation about digital technology and higher education a valid concern. This is especially the case with resilience and antifragility in mind. Peter asserted:

“I do think that uhm, there are big challenges in terms of digital, uhm, and I think [...] to some extent, I think 'Xxxxx University' are ahead of the game, but [...] as a relatively smaller university, perhaps the investment in technology hasn't always been able to be there [...]. [...] danger is that [...] unless we can continue to sort of step up and move on and really develop that digital side [...], the danger is that 'Xxxxx University' ends up behind.” (Peter, 41-47 years, associate lecturer, Birmingham study centre).

5.7.4 Sub-theme 3: Emphasis on Skills, Practice Experience and Confidence

Participant feedback informing this sub-theme emphasised vital skills such as communication as essential in healthcare management practice. This, along with appropriate managerial practice experience and confidence, placed students and graduates in an ideal position to showcase the attributes to stand out and thrive in the graduate labour market.

Tamika used an illustration to discuss why healthcare management skills such as communication are essential to a practitioner's work performance. She stated:

"[...] There is need for them to address their communication skill [...]. For a student who is in management he needs to have that skill [...] to be able to manage her team effectively and understand how to communicate with them in a simple language that they will understand [...] We had a visit, and one of the inspectors commended [...] one of your students in terms of consent [...] I think he was trying to do a test [...]." (Tamika, 55 and above, service director, mental health care home, employer).

Layla relayed how the student (Gemma) who worked for her had several excellent leadership qualities, such as determination and diligence, making her an asset in her organisation. Nonetheless, she observed that:

"Probably her biggest weakness is she works too hard, puts everybody else first, uh, which sometimes is a weakness, because you have to know when to stop when to rest, but uhm, she just carries on and on and on; she's a very determined lady." (Layla, 55 and above, service director large charity, employer).

It appeared there was scope for Gemma to continue improving on her assertiveness, which is an essential attribute of a manager. Having reflected on his experience working with both younger and older, more mature students, Moses also explained that what he noticed was that experience plays a significant role in how they go about delivering care to service users.

"[Sighs] [...], the one we've got now is not a [...], young student, she's, is in early '30s so [...] she's had quite a bit of good experience in care in various organisation settings so, but with others, it might be just to, uh, with younger ones, maybe a lack of experience in business, and [...] taking responsibility." (Moses, 55 and above, managing director and owner, home care service, employer).

Ethan hinted that while codified knowledge and its acquisition are essential, higher education needs to move away from this to produce more employment-ready graduates. He said:

"I think there is [...] this old idea of just, uhm, knowledge acquisition, but rather thinking about higher education as a, as a vehicle for supporting people to get into the job market and not just to, to learn about scholarly, uhm, material. [...] I think to

move away from because, uh, yeah, more practical, uhm, and maybe a bit less academic.” (Ethan, 41-47 years, senior lecturer, Berlin study centre).

Ethan’s view would appear to underline the importance of practice skills and the urgency for application to be a forethought during teaching. Jade agreed with this position when she asserted the following:

“I would say it should be more practical than theoretical. Yes, we can embed more practice into our teaching and learning.” (Jade, 34-40 years, associate lecturer, London study centres).

Layla elaborated on the importance of practice experience when she highlighted what she saw as the need for common sense in some managers applying themselves in practice in a way that shows adaptability. She suggested that more common sense is applied in how some higher education students and graduates use policy and procedures. Underneath the surface, something interesting she pointed out was how what drives this, at times, is a lack of confidence in showing creativity to solve issues arising in the workplace and ethical dilemmas. She said:

“So, we will find maybe [...] we’ve got a very, uhm, a new manager with us at the moment, who [...] if she doesn’t know about something, she will refer to the policy and procedure. Implementing the, as I say, with common sense and not just the book says we do this, so we do that, you know, I really noticed that with the, the young managers [...]” (Layla, 55 and above, service director large charity, employer).

Tamika mentioned some weaknesses she had observed with confidence and assertiveness and explained how these disadvantaged higher education students and graduates in the sector.

“The weakness that I have observed is lack of confidence. You see, your students can learn everything in the encyclopaedia, but there are certain, practicality of it they can’t learn anywhere unless they’re hands-on. [...] I remember when they started, they lacked that confidence [...]. As a manager, you have to be assertive [...], but you also have to be like a kind of authority in what you do that was lacking [...]” (Tamika, 55 and above, service director, mental health care home, employer).

Tamika also raised an interesting point about practicalising theoretical knowledge and

the contributions employers could make to supporting learners' practice and graduate development experiences. This would suggest an employer-university relationship that supports work experience linked to management skills. Tamika said:

"[...] I have seen many [...] people from various university with this kind of certificate they are still working as support workers, and that's because they don't have the privilege of working with an organisation that will support them all the way. So, there's need for your [...] universities that does this programme to incorporate [...] the practical side of it; if not, they'll just be producing students who have the degree but are doing 'dirty jobs' and I tell you [...] the industry need people like them [...]." (Tamika, 55 and above, service director, mental health care home, employer).

While the term 'dirty jobs' appears problematic, it refers to graduates continuing to work in the operational day-to-day care delivery even with a level 6 management qualification – a higher qualification than the NVQ Level 5 (CQC) Registered Manager Qualification.

5.8 Reflections on Using NVivo for Data Analysis

Learning to accomplish a qualitative analysis with NVivo differs from having a comprehensive understanding of the software (Woolf and Silver, 2017). This is essential because there are many more intricate NVivo components I would have desired to become more acquainted with before beginning my analysis. Yet, knowing how to import my data, use case classification, coding functionality, and coding stripes were all important in assisting me in conducting a thorough investigation.

Exposed to NVivo, my first observation was that whilst it was easy to use, the software was prone to crashing and freezing, making it time-consuming to contend with at times. However, as I reflected more deeply on this, this was likely down to my accessing the software remotely on a VPN (virtual private network). My HEI licence also expired when I began data analysis, which exacerbated things as it took a few days to sort this out. Elliott-Mainwaring (2021) also recognised similar limitations and issues with NVivo in their study.

I used my HEI's NVivo (version) 12 instead of the version 12 Pro, which Middlesex

University offered. However, I noticed little disparity between the two versions once I looked at the differences. I could not use version 12 Pro due to IT administrator restrictions and embargoes on software downloads on official HEI portable devices like laptops. Even so, I saw the learning opportunity this presented for me as a leader responding adaptively in a 'systems leadership' environment, especially when things do not go to plan (Lichtenstein and Plowman, 2009).

Before my analysis, I had read about other research projects that used NVivo. I found that as a computer-assisted qualitative data analysis software (CAQDAS) (Saunders et al., 2023), NVivo had excellent agility in organising and categorising data (Dhakal, 2022) and supporting a more substantial audit trail for my study (Welsh, 2002). I imagined it as a tool qualitative researchers would use to upload data to sort and label with 'little to no effort.' However, after attending some workshops (organised by Middlesex University and QSR International, now known as Lumivero (Ken State University, 2023)), it became clear that I needed to learn how to code because my role during this phase is that of an active agent seeking to assess, make sense of, and coherently organise the data for reporting (see Dollah et al., 2017; Welsh, 2002). To elaborate, *"NVivo has no buttons for..."* identifying *"themes or..."* for comparing *"the meaning of a statement in one context rather than another"* (Woolf and Silver, 2017, p. 23).

Reflecting on the study's themes, NVivo was crucial in offering a platform to store my data. It allowed me to connect with it holistically and efficiently apply line-by-line coding while categorising and structuring the data under broad themes. For example, this was critical in my initial generation of more than 200 codes from three independent datasets: student and graduate focus group discussions and academic and employer semi-structured interviews.

What was crucial to note is that NVivo did not take over my role as the researcher, responsible for discovering patterns, similarities, and differences in the data and bringing them together logically to highlight my participants' perspectives. Indeed, I had to carefully consider the codes, categorise them, reveal the emergent themes, and double-check that they accurately reflected the data. Also, I returned to the categorisation regularly to re-read and verify that it was consistent with the overall

study aims and research questions. This process continued even as I wrote the closing chapter of my report and reviewed my study's fit with findings in the broader literature. This was arduous, but it gave me confidence that I had achieved a holistic understanding of my data and the picture portrayed by my findings.

5.10 The Antecedents of Knowledge and Skills Transfer Framework

This framework (Figure 21) was inspired by Mode 2 knowledge production (Gibbons et al., 1994), which directed our thoughts to the idea that learning and knowledge production could exist within a highly interdisciplinary, contextualised, inclusive, and application-facing space as well as Graham et al. (2006)'s knowledge to Action Framework, which provides an in-depth and effective system for adopting evidence-based practices in healthcare organisations. The latter emphasises the importance of knowledge development, action cycles, and contextual variables in fostering effective evidence-based practice implementation and sustainability. The two were appealing as they complement each other in their approach – i.e., from looking at knowledge transfer from a generic perspective (Gibbons et al., 1994) to more precisely in the healthcare management workplace (Graham et al., 2006).

The framework is a model of all the different aspects of the findings, supported by theoretical literature, that interacts, from the most distinctive human variables existing within actors such as students and graduates in the blended learning classroom to the organisational and social variables outside the classroom. These factors significantly impact knowledge and skills transfer to healthcare management practice. They accomplish this by acting as either contributors or barriers. In short, I would describe it as a transitional framework between Modes 1 and Mode 2. It occurs before Mode 2; therefore, it directs our attention to aspects that must be considered in order to promote efficient knowledge and skill transfer to the healthcare management workplace. The factors are often latent and not always evident to actors, making it difficult for them to fully perceive or appreciate the magnitude of their influence on defining the type and impact of the transfer experienced.

The specific contextual variables are highly situation-relevant, and their shape will vary from one organisation (e.g., education provider) to the next. These determinants

are recognised and recognisable by actors, and their implementation is changeable to develop and strengthen links between theoretical knowledge and practice application. Another element of this level is that when work experience accounts for placements, it allows for trial and error for skill and competency proficiency. When it comes to employers' assessments of how well students and graduates can apply explicit healthcare knowledge and skills to management practice, the transfer outcome, whether 'Positive' or 'Neutral and transfer difficult to determine', stands at the top of the iceberg. The only time this does not manifest as an iceberg is when theory and practice are fully integrated (e.g., through placements or the expert practitioner with noteworthy practice experience). Also, employers have specific practice mentors (i.e., formal or informal) versed in the learning outcomes as they are with expectations of the programme and competencies and graduate attributes the programme seeks to develop and support.

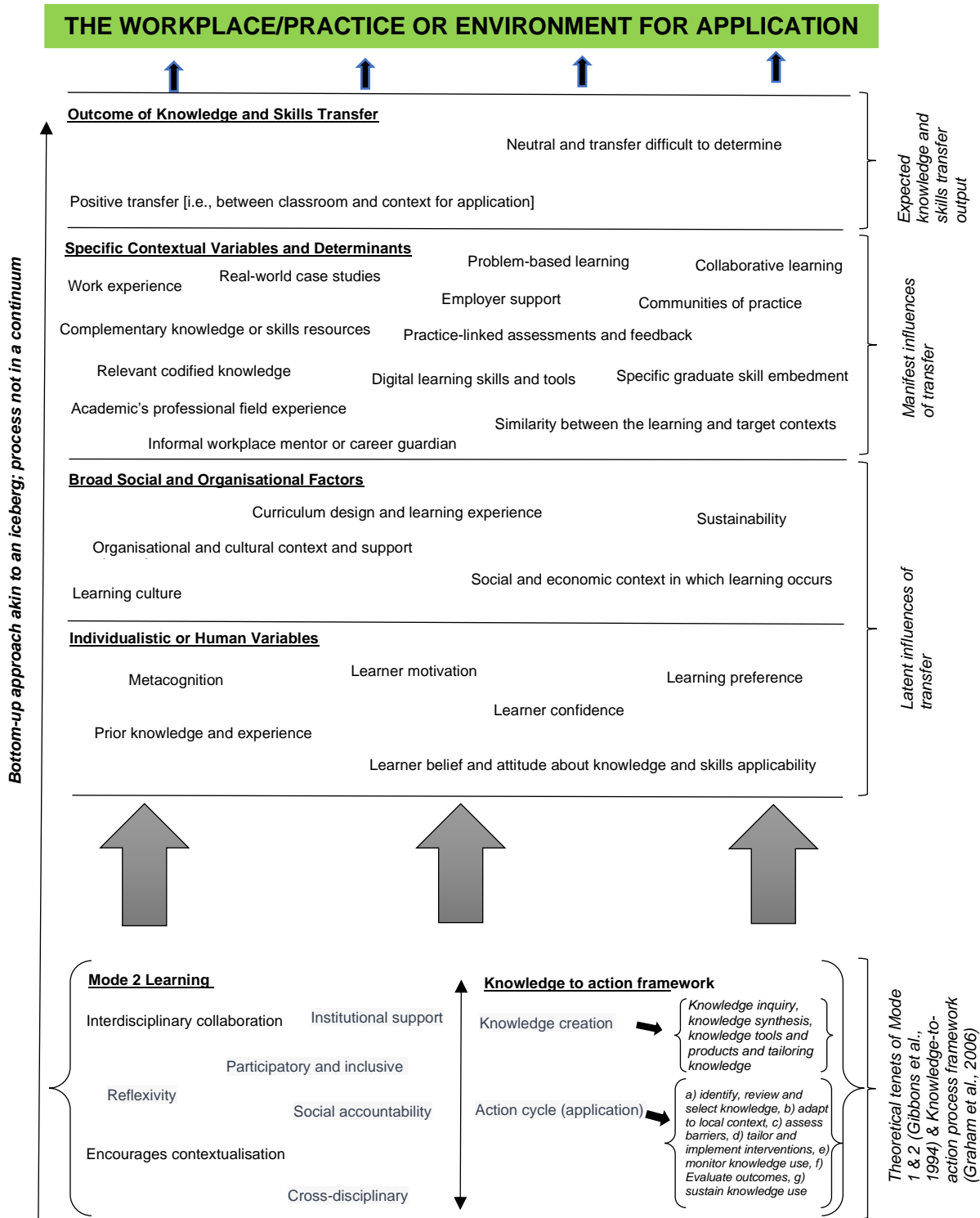


Figure 21 The Antecedents of Knowledge and Skills Transfer Framework in Higher Education; adapted from Gibbons et al. (1994) and Graham et al. (2006))

5.11 Chapter Summary

The findings presented semi-structured interviews and FGD data from 28 participants recruited in the main study. Data collected from insider participants – academics with portfolio management responsibilities and teaching on the programme and students and graduates of the programme, was presented first in the demographic data before exploring employer data. This was crucial in observing how the views of the insider participants interacted with those of the employers – the last group to collect data from in the study. The integrative analysis involved open-ended and thematic codes, which gave a sense of coherence across the views that shaped the main themes of the study.

Chapter 6: Discussion

6.0 Introduction

I began this project by formulating the following research questions:

- *How supportive is the BA (Hons) Blended Learning Healthcare Management Programme of knowledge and skill transfer to the healthcare management workplace?*
- *Is there clear evidence of knowledge and skill transfer to the healthcare management workplace and is the process transparent in the programme?*

The interviews and focus groups conducted in the study yielded crucial information that served as the foundation for the discussion in this chapter. This chapter will explore these themes, sub-themes, and supporting literature in further depth.

6.1 Theme 1: Knowledge, Characteristics, Skills and Employability Expectation

Students and graduates enrol in higher education, expecting to develop knowledge and skills that provide a pedestal for employment and a career. This theme explored expectations from the perspectives of students, graduates, and employers.

Employability in this theme, at its most basic, refers to a collection of skills that enable a person to find and keep a job, which is critical for both organisations and employees (Trought, 2017). Organisations with employable staff remain competitive, and employable individuals thrive in their careers (van der Baan et al., 2022). Programmes, such as the undergraduate blended learning programme, are designed from the conceptual stage to embed codified knowledge, skills, and competencies that support and develop the graduate skills necessary to operate effectively in healthcare management practice. The curriculum managers collaborate with employers and associated professional organisations to determine the industry graduate skill gaps most relevant to employers. As an example, consider its relationship with the following organisations: Skills for Care, The Institute of Health and Social Care Management (IHSCM) and The Chartered Management Institute (CMI).

This relationship is especially pertinent in the current health and social care context, where, post-COVID-19, the sector continues to experience acute workforce shortages. In the UK, this has led to patients being unable to obtain necessary treatments for acute and chronic medical complaints (Wickens, 2023). Correspondingly, worldwide healthcare worker turnover has worsened because of the excessive strains on the health and care workforce over the last three years (Poon et al., 2022). Inflationary pressures have exacerbated this, affecting the NHS and the living situations of health and social care personnel in the UK (Wickens, 2023). The theme is divided into two main sub-themes, presented and discussed below.

6.1.1 Sub-theme 1: Employer Expectations

Graduates now discover that having a degree is simply a prerequisite for employment, yet they must also provide other value-added experiences, abilities, and traits. The recent economic difficulties have exacerbated the gap between graduate demand and supply (Gedye and Beaumont, 2018). In line with this, employers had confident expectations of students and graduates. These expectations were associated with how they could demonstrate specific knowledge and skills linked to healthcare management work.

The views employers expressed suggest that expectations are not always that students and graduates should be able to demonstrate advanced and complex knowledge and skills such as budgeting, project management and strategic management. Recent Pearson research on the most in-demand capabilities for UK businesses indicates that graduate competencies such as communication, organisational and teamwork skills are essential to employers (Pearson, 2022). This finding is at odds with the sector, where compelling motivation, the capacity to think strategically, manage projects, and have good organisational skills are referred to as essential skills for healthcare managers (Skillsforcare, nd). Even so, there was an uneven split between knowledge, personal attributes, and sector-linked technical skills, with sector-linked technical skills given more importance. The sub-themes below expound on these in more detail. Sub-theme 1 is explored below, starting with 6.1.1.1.

6.1.1.1 Sub-theme 1a: Dedication and Understanding Policies and Sector Needs

Dedication and altruism are vital attributes that healthcare practitioners are expected to demonstrate (Cao et al., 2023). This is especially true for managers coordinating healthcare delivery. Kim et al. (2006) underlined the importance of dedication in healthcare by stating that care professionals are intensely driven and dedicated to giving the best possible care to their patients. They are already accustomed to ongoing experimentation and novel information driving change in care delivery (ibid).

Although dedication was associated with personal attributes, students' and graduates' understanding of policies and sector requirements was also linked to the expectations to demonstrate in the workplace. Employers alluded to how dedication is necessary for developing a deeper appreciation of learning and self-development linked to lifelong learning. Moreover, coining dedication through the lens of the commitment students had shown to their learning in higher education provided an interesting perspective.

Purcell et al. (2008) observed that individuals have varied reasons for picking their main course of study. When applying to higher education, most people choose their specialism because they like learning the field of study or the course's subject matter. Nevertheless, their second primary motivation was that they needed the programme for entry into a specific profession (ibid.). Showing dedication (or commitment) to one's study implies a better acknowledgement of the organisational skills needed to manage the competing priorities of working part-time or full-time in healthcare while studying. What is unclear is if this would have been the case if the students were working with employers as part of a structured placement embedded within the curriculum.

Specific reference was made to external stakeholder processes, such as the CQC regime of inspection and the critical lines of inquiry, which was thought-provoking as this would appear to indicate that sectors linked to delivering regulated care have it as a crucial priority for students and graduates (who are part of vital internal stakeholders) to have excellent working knowledge and understanding of regulatory requirements. Service users value care services delivered to meet their needs at an

excellent, safe, efficient, and suitable standard, which the regulators ensure is happening (Kim et al., 2006).

Furthermore, external consumers in (regulated) care delivery include patients, relatives, local authorities and regulators. How these external stakeholders (e.g., CQC and Monitor—the latter for the NHS) operate requires students and graduates to demonstrate reflexivity in adopting theoretical knowledge and evidence-informed practice in their workplace. Hence, it often presents unique opportunities, professional dilemmas and ethical considerations for prospective healthcare managers. In light of this, employers expressed concern about the difficulty healthcare management students and graduates have applying themselves and their learning to solve complex workplace challenges.

Improving skills and talent is critical for encouraging growth, both as a contributor to productivity and as a means of accelerating technological development (see Valero, 2021). According to Ivanitskaya et al. (2002), interdisciplinary learning (as seen in the programme) has a significant impact on assisting learners in developing an in-depth awareness of relationships between contexts (e.g., in the classroom and workplace) through the juxtaposition of relevant and ordered knowledge to enhance knowledge exchange valuable for academic scholarship and the knowledge economy. This benefits students and graduates who are progressing towards skills proficiency (National Research Council, 2012) and specific higher education graduate skills relevant to employer needs (Kolmos, 2016). This highlights the importance of reflexivity in fostering adaptation and self-awareness while applying theoretical information from study learning environments. While related to reflexivity, adaptability and flexibility are essential employability qualities (Trought, 2017). Thus, the ability to watch and reflect upon social interactions involving oneself and others is known as 'reflexivity' (Cunliffe, 2016). Archer (2012) also described it as a consistent use of the mental ability that people share to evaluate themselves concerning their social circumstances and vice versa. In the words of Archer (2007) and Archer (2012), reflexivity arises from students, graduates, and healthcare managers' constant internal dialogues.

6.1.1.2 Sub-theme 1b: Professionalism, Passion and Knowledge

Knowledge and professionalism are two symbiotically linked concepts, with passion arguably manifesting explicitly as a product of both embodied in a healthcare manager. Finding ways to project professionalism in practice is appealing for those who use and provide care, with a greater emphasis on relationship-based care, reciprocity, and partnership working underpinned by a philosophy of 'doing with' service users, clients and co-workers rather than 'doing to them' (Scottish Government, 2012).

Employers emphasised the importance of students and graduates demonstrating their values and the desire to imbue professionalism. What was interesting was that professionalism was also discussed alongside passion and the restraint to work efficiently in health and care management. To deepen our understanding, The Health Service Commissioner for England (2011) noted that technical ability, appearance, reputation, faith level, feelings for others, understanding, empathy, patience, conduct, verbal and nonverbal communication, an inclusive and non-judgmental attitude, and suitable physical contact are characteristics of professionalism. To emphasise how central it is to care provision, it was noted that many of the complaints made by service users and carers concerning their care are based on a lack of or inconsistency in portraying and expressing these traits. Professionalism demonstration in one's practice requires healthcare managers to know their area of professional practice (ibid). To illustrate, employers referred to specific knowledge and skills such as communication, professional boundaries and role awareness, basic academic skills and managing people and relationships. Some employers hinted at their expectation of the programme, which is that, without exception, it should provide the foundational structure and resourcing for students to develop this knowledge and skills.

To expound on how work and learning (i.e., from a professionalism and knowledge demonstration lens) are linked, WHO stressed the importance of interprofessional learning, which is when learners from two or more healthcare disciplines collaborate to gain knowledge with, from, and about one another to improve collaboration and care delivery. Nevertheless, Lave and Wenger (1991) revealed that, in the complex workplace, learning progresses from legitimate peripheral involvement to more central positions over time. Consequently, the formal instruction in skills and knowledge that

precedes the actualisation of what is learnt in the work environment must be evidenced to enable this shift. One of the employers associated professionalism with both learning and work. However, work is typically associated with creating or doing things to earn a living, whereas learning is more associated with school and what occurs before working (Baerheim and Ness, 2021). This places work and learning into two distinct categories (ibid.). Baerheim and Ness (2021) noted a need for more profound knowledge about how learning takes place in interprofessional health teams of students and graduates in the workplace.

Passion can be described as a strong predisposition towards an endeavour that people (or professionals) like (or love), value (and so find essential), and devote time and energy to (Vallerand et al., 2010). Therefore, passion for a profession like healthcare management is a state of mind characterised by a powerful and positively motivating sentiment, an inner propelling effect, and devoting one's total concentration to meaningful service coordination and management work (ibid). Whereas passion was viewed as an essential factor for working in healthcare management, some studies have shown stress in the workplace, working conditions, opportunities for learning, relationships with others, individual achievement, and the feeling of being trusted and valued all influence work passion (Luo et al., 2014; Sun et al., 2009; Wang et al., 2013). Other research also demonstrated a significant negative association between work passion and work unhappiness, planned turnover (e.g., Blankertz and Robinson, 1997), symptoms of burnout (Swetz et al., 2007) and emotional weariness (Green et al., 2013). What can be deduced from these is that, while passion is crucial in healthcare management practice, there is a careful balance to maintain, as it could potentially negatively impact a manager's job satisfaction.

6.1.2 Sub-theme 2 Student and Graduate Expectations

Students' and graduates' expectations of the programme were mostly linked to knowledge, experience, qualifications, career development, or graduate employability concerns. The sub-themes informing theme 2 are further explored below, starting with 6.1.2.1.

6.1.2.1 Sub-theme 2a: Employment, Self-improvement and Applying Learning to Practice

Employment and employability are slightly different terminologies. For instance, '*employability*' is defined as readiness for graduate employment, which differs from graduate employment rates, which, in the UK, are led by information regarding whether graduates find work six months after graduation (Knight and Yorke, 2003). In a study conducted by Elias and colleagues (2021), findings showed that the degree to which learners used the knowledge and abilities obtained as undergraduates in the course of their most current employment varies from highly specialised and directly relevant to their employment (e.g., with medical and healthcare programmes) to broad in scope and transferable across a variety of professions and work contexts (e.g., social policy) (Elias et al., 2021). Recognition of personal and professional improvement needs and opportunities that engender programme graduate attributes and theory knowledge application to practice is crucial to management practice. While students and graduates referred to specific knowledge and skills the programme permeates to aid employment, reflecting more deeply on their responses, it became apparent that what they refer to – for example, 'getting employment easily after enrolling on the programme' as expressed by Mark, was a reference to espoused employability skills.

Nevertheless, the employment references raised a thought-provoking question about what exactly employability means and what it looks like for the individuals (and organisations) associated with the programme. Williams (2021, p.21) used the analogy of: "the question today isn't 'Can you do the job?' but 'Will you do the job?'" to explain what employability looks like for organisations. He noted that employers seek proof of 'employability,' which is about one's attitude, behaviour, and personal traits, not their qualifications, abilities, and experience. The highly employable recruit can show that they can be a dependable team player and that they will be an invaluable contributing part of the organisation they are joining, in addition to a list of talents and job experience (Williams, 2021).

However, Cranmer (2006) pointed out the difficulty of pinning down a universally accepted definition of employability. This, he argues, is down to the fact that various

definitions exist in the literature (ibid.). Gedye and Beaumont (2018) argued for a more holistic view by stating that there is universal agreement, per se, that employability entails the elements that follow: the ability to get work, perform well within work, move between jobs or roles, and have the skills, knowledge, and traits that enable this. This view recognises the knowledge, skills and personal traits as necessary prologues for potential employees. Rothwell and Arnold (2007) reinforced this view by suggesting that vocationally pertinent knowledge and skills, previous employment experience, and career management abilities are influential internal employability variables for managers.

To add context, Slipicevic and Masic (2012) observed that Interpersonal skills (i.e., leadership and relationship skills, helping, and delegating), relationship management (i.e., information gathering and management, and change management), analytical skills (i.e., technology management and quantitative data analysis), and action skills (i.e., goal setting, entrepreneurial, and action-taking abilities) are the four main types of healthcare management skills managers are expected to demonstrate in their practice.

According to the student and graduate feedback on expectations, assisting students to enhance their graduate employability skills has been a significant plus of the healthcare management programme. This mirrors an employability-enhancing trend in higher education in OECD countries since the 1990s (Gedye and Beaumont, 2018). To illustrate, this could be seen in crucial policy directives such as the Dearing Report of 1997 (Dearing, 1998) and more recently in independent reviews such as the Wakeham review, which was an impartial inquiry into the availability of science, technology, engineering, and mathematics (STEM) degrees and job prospects for graduates (Gov.UK, 2016).

Nonetheless, these key government strategies, among others, have also contributed to the massification of undergraduate courses (including in healthcare), with higher education enrolments in courses like ours at an all-time high, notably pre-COVID-19 (see Gedye and Beaumont, 2018). Brown et al. (2010) noted that massification had exerted significant pressure on typical job opportunities for graduates and markedly contributed to the decrease in the value of university degrees. Even so, new types of

graduate employment have arisen, especially in an ever-evolving (healthcare) workplace context (Elias and Purcell, 2004), where graduate job demand remains high in specific sectors, such as healthcare practice. Arguably, following COVID-19, acute health and care professional shortages have shielded the sector against increased job demand. To illustrate, the number of vacant positions in the NHS and social care professions has grown significantly since September 2020. These shortages have and will continue to impact patients and care delivery (Waitzman, 2022).

Despite this, self-improvement and continuing professional development are essential elements that students and graduates felt were crucial in grounding their awareness of the potential overcrowding in the graduate labour market (Diamond et al., 2012). While there is little agreement on the essential competencies and skills needed for health managers to manifest in their day-to-day practice (e.g., those expressed by Slipicevic and Masic (2012)), there is no disputing the importance of further learning and professional growth for the proficient execution of management duties in a highly intricate and ever-changing atmosphere such as that of healthcare management (Manley et al., 2018; Williams and Ewell, 1996). A vital component of the programme's self-improvement and continuing professional development is its intentional focus on developing modules relevant to the sector with transferable knowledge and skills to assist learners in progressing their knowledge across each level of study (e.g., levels 4, 5, and 6) in a way that fosters application for the local UK healthcare market and the international healthcare context. Participants specifically said that this point was necessary. This supports Evans' (1999) notion of practice-based learning.

6.1.2.2 Sub-theme 2b: Leadership, Management and Other Transferable Skills

Multiple studies suggest that, along with the degree requirement, other selection parameters, such as dispositions and aptitudes for work, "soft" or "transferable skills" or markers of job readiness, and work experience, are essential in graduate recruitment (Baldauf and Luchinskaya, 2019, p. 6). This sub-theme explored the healthcare management knowledge, qualification and sector-relevant skills

programme expectations of students and graduates. According to Stefl (2008), academic and professional programmes continue to emphasise the development of crucial graduate workplace competencies. The essence is to support prospective managers in developing efficiency to lead service delivery using evidence-based. Stefl (2008) noted that the emphasis on evidence-based leadership has resulted in several efforts to determine the competencies most suited for healthcare management practice. In this vein, the knowledge and skills expressed by participants, such as leadership, communication, management knowledge, critical thinking, interpersonal skills, and the ability to decipher CQC and sector requirements and manage care homes, were all vital healthcare management dimensions. Introspecting on these, they mostly came across as skills and knowledge contextualised in a way that allows them to be moulded into transferable skills to support managers. Assisting students in developing healthcare management knowledge and graduate skills using evidence-based is crucial. For instance, Mansour and Mupinga (2007) suggested that because of the combination of face-to-face lectures and web-facilitated learning settings, blended programmes present an ideal instructional format for a wide range of student learning preferences (and graduate skill development). Therefore, programmes using a blended learning approach are associated with high learning efficacy (Van Doorn and Van Doorn, 2014).

Without exception, all the students and graduates in the study were non-traditional students who, as adult learners (i.e., aged anything between 22 and 55+), also worked full-time while balancing parental duties (in some cases), which means they are more amenable to signing up for flexible (higher education) courses (Munro, 2011). It is not uncommon for these groups of students to be more focused on acquiring proficiency in skills, hence having less time to commit to rigid and poorly organised programmes (Hoyert and O'Dell, 2009) that would not serve this purpose.

From the feedback, it was apparent that participants had conceived what they would have expected the programme to contribute to supporting them – i.e., in terms of theoretical knowledge, qualifications and transferrable skills. This might be because students are savvy and increasingly notice that a university degree is sometimes insufficient to find a job. Because of this, they are keen on acquiring skills that would

increase their employment opportunities (Messum et al., 2015; Tomlinson, 2008).

Mezirow and Taylor (2011) referred to the role of the individual experience the students bring to the blended learning space as the core means for the type of transformative learning that supports the contextualisation of information, including what each learner brings with them (i.e., previous experiences) and what they encounter within the synchronous and asynchronous classroom. This serves as a springboard for dialogue leading to a critical analysis of the normative assumptions that drive the learner's value judgement or expected behaviour in the blended learning classroom (Mezirow and Associates, 2000). In this case, the instructor stimulates and generates experience through classroom activities, which both the students and the instructor reflect on as they discover fresh perspectives about themselves and the world of practice around them. The knowledge and graduate attributes explored are socially constructed, allowing them to be dissected and acted upon through discourse and self-reflection. This situation arises because the students can use their knowledge and skills as a foundation to support efficient work performance and even move between jobs or roles while leveraging their skills, knowledge, and traits to continue supporting their development (Mezirow and Taylor, 2011).

6.2 Theme 2: Strengths

Participants provided rich data on the programme's strengths and those specifically demonstrated by students and graduates. This theme was a conduit between theme 1, knowledge, characteristics, skills and employability expectation and theme 4, knowledge, skills and transfer to practice. The sub-themes are discussed below.

6.2.1 Sub-theme 1: Academic, Student and Graduate Articulated Strengths

When participants situated as insiders relative to the HEI provided feedback about what they thought the programme's strengths were, there was a difference in how students and graduates articulated this compared to academic staff. Although both groups were insiders in the organisation, it was not surprising that their understanding of the programme's strengths conceptually differed. For instance, academics typically

have at least two years of programme teaching experience, giving them familiarity and a deeper understanding of the pedagogical intention and resources driving programme delivery. At the same time, while students and graduates may have diverse levels of understanding of the programme curriculum compared to academics, their experience as users added depth and richness, complementing the academic perspective. The headings below, starting with 6.2.1.1, are further sub-themes designed to deepen our understanding of sub-theme 1 of theme 2 (Strengths).

6.2.1.1 Sub-theme 1a: Diversity and Flexibility

Diversity is the degree to which cultures, identities, and various other economic and social factors differ in each society (Dune et al., 2021). Participants expressed it to imply that a diverse student community has different identities, is from diverse socio-cultural backgrounds, and has different work orientations and experiences. Unlike this being seen as a challenge, especially in managing learning in such environments, it was viewed as an opportunity, for example, by Randolf. This is because the blended learning healthcare classroom has a high sense of collective belonging. The diversity seen in higher education in the UK today could be attributable to massification, which has led to more universities and a more diverse student population (Evans et al., 2021). Students tend to feel a sense of belonging at institutions with a pleasant educational climate and can see faculty and staff who look like them. This sense of being part of a community is essential for excellent mental health and student retention. Students who do not have this sense of identity are more likely to drop out and, in some instances, underachieve (Stones and Glazzard, 2019).

Those who referred to the diversity of students on the programme cited it as a strength, particularly alluding to its contribution to developing a learning community. The vital role blended learning plays as a mode of instruction in making this a strength was particularly noteworthy. Soeiro et al. (2012) stressed that diverse learners can engage and learn while using learning management systems in blended learning settings; diversity, in which case, can be an asset, primarily when the learning management systems function as mediators fostering meaningful collaboration amongst learners. While diversity presents a massive opportunity for educators and students in blended

learning classrooms, Cannon and Newble (2000) argued that the diversity of learners is a challenge HEIs must confront by introducing flexible learning and instruction and assuring equity. Ensuring equity for all sometimes equates to equitable attainment and graduate outcomes for all learners (*ibid.*).

Looking at diversity through the lens of the HEI's resolve to enhance the participation of underrepresented groups in higher education is also an interesting perspective. This would, at heart, appear to showcase the massification of HE at play—that is, a phenomenon that widely assumes and presents the view that admission to higher education is an entitlement for individuals who meet specific criteria (Evans et al., 2021; Noui, 2020). While the notion of massification has led to further democratisation of access to higher education, its volumetric expansion makes the desire for quality sometimes impossible to meet by creating the antithesis of what it claims to do (Noui, 2020). 'Quality' is difficult to describe and define in higher education (Schindler et al., 2015). For example, it could offer learners high employability, analytical and hands-on skills applicable in various job-related contexts, or learning that will make them autonomous and critical thinkers. It is also context-specific and could be comprehended differently in higher education institutions with varying foci and techniques (Giannakis and Bullivant, 2016). Even so, the broad notion of enhancing participation in underrepresented groups in the UK, for example, would appear to be supported by key government policies such as the Dearing Report of 1997 (see Dearing, 1998) and the Higher Education and Research Bill of 2017 (Higher Education and Research Bill, 2017) — all of which put particular emphasis on widening participation to promote access to higher education and improve social mobility. This is a point Randolph raised when he referred to the power of higher education in promoting social mobility.

Even before COVID-19 was declared a pandemic in 2020, leading to the disruption in learning and HEIs' switch to delivering degree programmes online and consequently blended learning (Abi Jumaa et al., 2023), our HEI delivered its BA (Hons) Healthcare Management Programme using blended learning. Indeed, with its global shift to remote learning, the COVID-19 pandemic intensified the need for HEIs to provide flexible learning choices for students (Bashir et al., 2021). The ability of this mode of

delivery to exercise immense flexibility to respond to the time, work pressure, and other commitments experienced by non-traditional learners (as an example) is crucial. Müller et al. (2023) proposed that flexible learning satisfies students' desire for greater freedom and independence in structuring their learning experience, and it is frequently implemented through technology in a blended learning architecture. This flexibility comes from the content and resources built around less rigid knowledge, skills, and graduate attributes that require less ritual-like face-to-face classroom attendance in a physical learning environment.

From a pedagogical standpoint, various features could be used to explain flexible learning (Müller et al., 2023). To illustrate, Li and Wong (2018) suggested that the characteristics underpinning flexibility could be expressed in line with the time, material (or content), teaching approach, set entry requirements, resources, and available support offered, to name a few. The participant feedback would appear to indicate that the strengths of the healthcare programme are that it demonstrates flexibility not only through its programme entry criteria but also through its content, resources and the teaching approach used by lecturers who often have professional (healthcare) experience. Umaru, for example, referred to this professional experience as a strength that aids the process of knowledge contextualisation to practice for transfer.

6.2.1.2 Sub-theme 1b: Knowledge, Skills and Employment Requirements

The healthcare management programme has precise learning outcomes and graduate attributes woven through it to advance learners' knowledge and graduate employment skills. These outcomes are developed following standard QAA subject benchmarks for the following subject areas: Health Studies, Business and Management and Social Work. Using these three ensures the knowledge, skills and attributes it covers are diverse and holistic. Learning outcomes are the knowledge, skills, abilities, attitudes, and appreciation a student will obtain due to the learning experience (Leite et al., 2020). The importance of clear and cogent learning outcomes, under the tutelage of an instructor, in setting the parameters for developing relevant practice knowledge is paramount. In this vein, participants articulated the situatedness of the programme in supporting them to learn knowledge that develops their practice confidence.

Participants especially felt confident in the knowledge and skills domains of the programme; for example, multidisciplinary teamwork, management knowledge, and interpersonal skills were pivotal. This bodes well for the students and graduates, as the Conference Board of Canada evidence shows that 8 out of 10 employers believed that graduates ought to possess excellent interpersonal skills, proficiency in writing, capacity for presentation, listening skills, and collaborative (teamworking) abilities (KnowledgeHouse, 2000).

To illustrate, one participant described how she was equipped to take control and function as an advocate when she suddenly found that a vulnerable service user in her care (with no immediate family members) had an unmet care need. The proactive approach used to avert a case of neglect is corroborated by (Lewis et al., 2018), who, in their study to evaluate student learning outcomes in oral health knowledge and skills, found that inadequate dental knowledge and skills among caregivers contributed significantly to the neglect of efficient healthcare service delivery for elderly service users.

Also, feedback from work peers and managers validating the knowledge and managerial graduate skills students and graduates exhibit was a key feature of student and graduate responses. While the programme outcomes were the catalyst for the knowledge, skills and graduate attribute development participants alluded to, references were made to specific leadership and operational management modules like the 'Finance,' 'Essential Skills' and 'Inter-agency' modules and their role in supporting theoretical and practical knowledge and skills. Two other main types of knowledge explored in the literature are explicit and tacit (Polanyi, 1958). Nevertheless, participants' differentiation of the knowledge into theoretical and practical broadly aligns with Jacobs et al. (2016), who further delineated knowledge into instrumental, conceptual, and symbolic use. Unsurprisingly, several strengths mentioned by students, graduates and academic staff alluded to knowledge, skills and specific graduate employment skills the programme imbues.

Although there is controversy concerning the definitions of knowledge and skills and what differentiates the two, knowledge, in this case, would indicate information and facts gained from the programme through sensory processing. To illustrate, being

exposed to or studying new theory information in a module. On the other hand, skills refer to the capacity to apply the knowledge learnt in certain circumstances, which could be perfected through practice and experimentation (Boulet, 2015). The implication is that for a student or graduate of the programme to be professionally competent, they should be able to demonstrate essential employability skills relevant to the sector (see CEDEFOP, 2008). Knight and Yorke (2003) argued that unless students can transform accomplishments garnered from their well-perceived programmes of study into a medium of communication that employers understand, their intellectual, cultural and social capital will go unrealised in the employment market.

The debate about precise definitions of terms such as knowledge, skills, and even the 'competency' required to apply them (Flynn, 2014) in employment is ongoing. Nevertheless, the OECD (1999) maintained that skills and knowledge are inextricably intertwined, with skills constituting knowledge gained via practice. Harris et al. (2013) observed that the accumulation of knowledge, advanced skills, and capabilities is increasingly being recognised as a critical component in the strategic thinking of employers and governments. Harris and colleagues (2013) noted how this has led to increased pressure on educational institutions (higher education in particular) to develop a knowledgeable and competent labour force able to compete and respond to the present and future needs of the UK economy (ibid). Some participants expressed how the programme went beyond the UK healthcare management environment and prepared them to appreciate global healthcare management better. This would confirm the programme's relevance in developing local sector-relevant knowledge in the UK and global citizenship, a crucial graduate attribute in modules like global health and sustainability. Specifically, knowledge transfer (to healthcare management practice) relies on a non-linear transmission of knowledge and skills from higher education institutions; it depends on access to personnel, data and relevant infrastructure (Graham et al., 2006).

Still, participants' expression of knowledge appeared to draw on the theoretical and practical knowledge covered in the programme. This would affirm Brockmann et al. (2011) and Mohajan (2016), who, while agreeing that the most common classification

of knowledge is explicit and tacit, argued that other more common forms of knowledge include practical and theoretical knowledge. Theoretical and practical knowledge examples voiced by participants in the study included knowledge of management, problem-solving, care and assessment planning, communication and multidisciplinary teamwork. This aligns with Boyatzis (1982), who cited the following traits of management effectiveness as necessary to leadership: motivation, competence, knowledge, self-worth, and specific behaviours like understanding the immediate and distant work environment (i.e., the sector). What was interesting to note is that the knowledge and skills participants referred to could be broadly framed under technical competence, conceptual skills, and interpersonal skills, all of which are vital leadership competencies. Technical competence would indicate knowledge of healthcare services, treatments, and technology and knowledge about the environment in which health and care organisations operate; conceptual skills entail having the capacity to analyse, plan and make judgements which are critical to organisational functioning; interpersonal skills indicate an awareness of the wants and sentiments of peers in the workplace, which includes being mindful of how emotions relate to others (West et al., 2015).

6.2.2 Sub-theme 2: Employer Observed Strengths of Students and Graduates

Despite labour constraints (i.e., shortages) in the UK's health and social care sector, currently exacerbated by the advent of COVID-19 (Powell et al., 2022), the HSc employment space is highly competitive. Hence, graduates having the right skills is essential to employers. This is because students and graduates in the post-industrial age have a greater need to comprehend endurance techniques, which are dependent on improved knowledge and developed skills. If not, there is potential for growing cultural and educational disparities ensuing, which will stifle long-term, sustainable progress (UNESCO, 2021). Wooldridge (2012) argued that such increased knowledge disparity impairs the expansion of global and technological advancement and, consequently, work efficiency and service quality.

However, Bridgstock (2009) noted that workers must be promptly and effectively employable in a constantly evolving information – and knowledge-intensive economy

like the UK health and care sector. To do so, students and graduates of the programme need not just acquire and maintain knowledge and skills unique to healthcare practice but also possess 'generic' management skills, attitudes, and qualities that are transferrable to a wide range of health and care settings and locations (ibid). Done and Mulvey (2016, p. 6) contended that (as educators) we must understand that *“for an employer, taking on a new person...”* (especially a graduate) *“... is a big deal. It is going to increase their payroll”* and *“when they do find someone, they are going to have to allocate time (which is valuable resource) to integrate...”* them *“...into the workplace quickly, so that they can function well and be a valued addition to the organisation.”* Therefore, universities have a leading role in championing the development of the right graduate skills to meet present and future employer demands. This must be done with an understanding that there are distinctions between how the higher education classroom and the workplace operate. To further our understanding of the difference, Raelin (2008) noted that the work environment can often be chaotic and unpredictable, whereas the classroom is typically more controlled. This poses a challenge for students enrolled on higher education programmes that do not offer practicums that provide structure to the workplace experience.

Even so, in the study, employers expressed strengths aligning with the knowledge and skills they observed students and graduates demonstrate in the work setting. While employers mainly conveyed strengths from the construct of student and graduate work performance, some were able to express strengths they observed to be associated with the programme. This was despite one of the employers conveying how they felt their knowledge of strengths (of the programme) needed to be more robust, owing to their outsider positionality relative to the HEI. For them, this meant a need for a complete understanding of how the programme teaching and learning is implemented to support knowledge and skills transfer.

Employer-observed strengths included all facets of the programme and those demonstrated by students and graduates in their workplace performance. This was important in helping engender a better understanding of the study's aim. Employer feedback indicated that despite the lack of practicums, students and graduates demonstrate high confidence in their practice. This would corroborate feedback from

students and graduates about the increased confidence noted in their practice, especially concerning implementing care plans and managing service delivery. However, this is at odds with a study conducted by Günay and Kılınc (2018), which demonstrated that trainee nurses' clinical knowledge and abilities were poor, and they frequently struggled to apply what they had learned to clinical practices.

Although confidence is commonly associated with and referenced as a predictor of behaviours and their associated outcomes, its meaning and interpretation are changeable and inconsistent (Oney and Oksuzoglu-gven, 2015). For example, it is also closely linked to words such as self-efficacy, self-esteem, expectancy and trust; however, these are not to be viewed as being synonymous with confidence (Gist and Mitchell, 1992). Demonstrating an increased level of confidence makes others view (a healthcare manager) as being more competent (Owens and Keller, 2018). Nevertheless, individual worker confidence, while objectively it cannot be conflated with competence in the workplace, has an essential effect on team confidence and overall organisational confidence (Owens and Keller, 2018), which is highly linked to service user (or patient) experience. It is important to reiterate that one of the most pressing concerns for healthcare leaders is the service user experience (Wolf, 2017).

Furthermore, research on leadership reveals that the most influential leaders are confident and empowered. Correspondingly, empowered leaders use techniques to encourage, inspire confidence, and create organisational loyalty amongst their employees, resulting in the attainment of targeted performance goals (Havei et al., 2014). An emphasis on confidence, as put by one of the employers, was observed “*afterwards*.” This would indicate that during the employment journey of students and graduates with the employer, there was a time before enrolling on the programme that their performance was different from what it currently was. Unlike the employers, however, confidence was not necessarily related to “*an afterwards*”—*when* the student or graduate had enrolled on the programme. While not always in healthcare, it may be down to the fact that all the students in the study had worked before enrolling on the programme. Even so, a reasonable inference will be that the reference to ‘afterwards’ could mean that confidence in practice was noticeable after they had enrolled and formally started studying on the programme. This may be

because blended learning programmes like ours, with features like interactive online quizzes, classroom discussion, debates, and imaginative presentations, are associated with knowledge development, transfer and confidence (Van Doorn and Van Doorn, 2014). Although this was not apparent in the findings, Van Doorn and Van Doorn (2014) suggested that perceived confidence manifests differently in traditional and non-traditional students, with traditional students tending to have more confidence before joining the programme. Conversely, the experience of non-traditional students who might have been out of a formal learning setting for many years is such that they will need to establish their confidence later on while self-motivating to stay on the programme and in the educational community (ibid.).

Employers also provided examples of how the confidence had manifested in the practice of students and graduates – for example, Layla referred to Gemma's forthrightness and her passion for discussing and sharing knowledge learnt on the programme with her peers and managers during team meetings. Similarly, Tamika expressed this confidence because of discussions she had with Garry, who had pointed out how the knowledge learnt in modules (e.g., the Finance and Budgeting module) mirrors resource and budget management implementation in the workplace. This led to the employer confirming that the congruence between the programme learning content and what happens in practice is an essential strength of the programme. To deepen our understanding of this, Knight and Yorke (2003, p. 19) stated the following: "*What we recommend as employability-enhancing practices*" should also appeal to universities committed to increasing "*the quality of learning, teaching, and assessment: the principles of good learning and those for enhancing employability tend to be congruent.*" Again, governments, employers, and other stakeholders today expect universities to significantly contribute to developing a wide range of sophisticated skills required for success in the workplace (Knight and Yorke, 2003).

Another aspect employers expressed their opinion about 'practice confidence' is commitment and determination. Commitment is an essential personal characteristic for working in healthcare management. Commitment is fundamental, as in such settings, managers coordinate and implement care services for service users, who

are often vulnerable and rely on others for support to meet their 'daily living activities' (i.e., activities of daily living). Working as a manager in such a stressful environment requires high confidence and resolve to meet service targets despite resource limits. Employers thought of commitment to service delivery and the organisation primarily as necessary in showing a worker's determination to support organisational objectives. This commitment adds to the knowledge and lifelong learning yearning of students and graduates based on participant feedback. Lifelong learning is strongly associated with professionalism and professional commitment as it allows professionals to stay current on industry advances and participate in ongoing education (Cao et al., 2023).

One of the employers also stressed that improvements in his employees' writing and ability to analyse information were crucial strengths. What is important to highlight here is that such knowledge and skills are essential in the student's role as compliance lead. Bridgstock (2009) maintained that literacy, written and spoken communication, technology use, teamwork, and aptitude for mathematics are vital generic skills (e.g., for healthcare graduates to develop) to transfer to practice. Both writing and analytical skills are required to display a coherent presentation and a thorough explication of measures taken by the care provider to promote compliance and collaborate with regulators such as the CQC to achieve their standards.

6.3 Theme 3: Length of Stay with Employer and Reason

As my analysis in Chapter 5 noted, the employer question pilot with students and graduates partly informed this theme. The feedback indicated a need to add an open-ended question to the employer question about why students and graduates stayed with an employer.

Following feedback from the pilot and my reflection on the quantitative and qualitative elements associated with the feedback to the question, I needed to analyse it. Doing this engenders a profound understanding of the extent to which the employer knows the employee well enough to comment comprehensively on their employment before enrolling in the programme while studying and even after graduating. Another

conclusion to implicitly draw from it is whether decisions made by students, graduates of the programme and higher education graduates in general about staying with an employer or seeking opportunities elsewhere are because of the potential newfound knowledge, skills, and graduate attributes or an entirely different reason.

6.3.1 Sub-theme 1: How Long Student or Graduate Worked for Employer

According to the findings, students typically worked for employers for at least one year and up to ten years. This would suggest an average retention rate of more than two years. This is at odds with current sector trends of high staff turnover. To illustrate, Kelly et al. (2022) argued that employers in the NHS and social care in the UK face tremendous hiring and retention issues, with vacancies much higher than pre-pandemic levels. It is important to note that both industry sectors rely on many workers who, while frequently highly talented, lack official degrees and earn lower-than-average UK earnings (ibid.).

An average staff retention of over two years would be a reasonable amount of time for employers to get acquainted with employees well enough to comment on their work output and the knowledge and skills they observe in their daily work habits. Nevertheless, the data collection phase of the study fell during the COVID-19 pandemic period. This was a time when there was much uncertainty experienced by students and graduates about their education and graduate prospects. The epidemic had a tremendous impact on students' lives, compelling many to spend time in isolation, disrupt their everyday activities, cause loss of employment, and face tremendous financial stress (Son et al., 2020). The Office for Students (2020) observed that students were apprehensive about their economic prospects following the COVID-19 pandemic. Nonetheless, other studies have been slightly more upbeat. For example, in a Higher Education Policy Institute (HEPI) poll conducted in late March (of the same year), 79% of students were confident in their capability to obtain a graduate-level job (HEPI, 2020).

6.3.2 Sub-theme 2: General Determinants for Staying with Employer

Reasons students and graduates tend to stay with their organisation, according to employers, include reputation, a supportive environment, and career support provided by the employer. For healthcare organisations, a good image is an asset. It is essential, along with credible market positioning, to attract patients and qualified employees devoted to their work (HealthManagement, 2016).

Moses associated reputation with the quality of care his organisation provided, staff pay, and not accepting 15-minute flying visits or homecare-allocated care visits. Although this tends to be for prompting medication and preparing a light breakfast, from experience working in social care management, employers feel more is needed to provide adequate care for vulnerable service users with multiple and complex needs. Campbell (2015) highlighted that eight local authorities in England commissioned 593,000 care calls totalling at most five minutes in 2010 and 2011, while three-quarters of local authorities commissioned care professionals to make visits for under 15 minutes. These short care visits have come under intense scrutiny and criticism from NICE for not giving care providers enough time to do their work without feeling rushed or jeopardising their service users' dignity and overall well-being.

According to the most recent data, slightly more than two-fifths of university graduates (43%) chose their jobs because they fit into their future career plans or were precisely the type of work they wanted. Such individuals (91.5%) had professional positions (ibid.). In deepening our understanding of employee retention, Tamika provided a fascinating set of reasons why she approaches retention differently. What fascinated me about her response was that with current recruitment pressures and shortages of healthcare workers (see Powell et al., 2022; Kelly et al., 2022), a reasonable conclusion to make is that employers would be fighting extremely hard to retain highly qualified staff like healthcare management graduates. This differs from Tamika's workplace, which actively supports graduates in their next career step. Even so, a counternarrative to this is that this may have a hugely positive impact on encouraging loyalty from students who witness such goodwill from the employer.

Graduates are among the most prevalent talent pools, and many high-performing

healthcare organisations regard them as a critical supply of individuals with significant potential (Garavan and Morley, 1997). Hiring, developing, and keeping graduates is thus viewed as a reasonable talent management strategy that promotes organisational development and expansion (McDermott et al., 2006). Employers in healthcare management generally want to keep graduates. Knowing full well the value added, they could contribute to supporting service delivery management.

The findings revealed that employers agreed that graduates almost usually left for better career prospects. Employers acknowledged this when one of them claimed that the reason graduates decided to leave was for job progression. There was almost a sense of defeatism in their admission that the graduates would have to move on to better things. While not limited to a single industry, health and social care organisations have not always spent judiciously in reasonable talent management programmes to develop and retain graduates. McCracken et al. (2016) affirmed this by stating that university graduates have received little consideration from some key sector employers as part of their talent management strategy. This is especially evident in the social care sector, which prefers registered managers with NVQ level 5 qualifications and the less evident routes for graduates to use their degree qualifications to secure a CQC registered manager qualification. It also looks like graduates are less eager to enrol in vocational training since it feels like a step down to a lower level. This is seen in a suggestion (in theme 6) that Moses, a graduate himself, made about the need for more robustness, especially with the verifiability of the academic integrity of the NVQ level 5 assessments (i.e., which currently leads to the CQC registered manager award).

Another associated factor is pay. While pay is better in parts of the healthcare industry (i.e., particularly the NHS) compared to social care, the Department of Health and Social Care admitted that pay for healthcare providers is currently at unsustainably low levels. Therefore, it is no surprise that the Health and Social Care Committee concluded that what was required was a long-term, viable strategy, including the possibility of pay improvement, ongoing professional training, and clear paths to career advancement (Bottery, 2022).

6.4 Theme 4: Knowledge, Skills and Transfer to Practice

This was a significant theme in the study. It had the most mentions and contributed directly to answering the study's research questions. The theme is discussed under two sub-themes: 'Positive transfer' and 'Neutral and transfer difficult to determine'.

6.4.1 Sub-theme 1: Positive Transfer

'Positive transfer' is further divided into the following sub-themes: "Curriculum design, resources and support," "Community of practice, knowledge and graduate skills," and "Integration, sector knowledge and skills transfer." The sub-theme explores the integration, scaffolding and resourcing within the blended learning healthcare management programme and how this encourages and provides a mechanism for knowledge and skill transfer to practice. The following sections go over other sub-themes.

6.4.1.1 Sub-theme 1a: Curriculum Design, Resources and Support

The healthcare management programme uses a thematic curriculum model that puts modules and topics into themes relevant to management practice (see the HEI's learning model and explanation in Chapter 2). Findings also asserted that the programme uses a spiral model, which supports examining topics and ideas more than once at various levels of study while applying a further layer of depth and complexity to them. This process cannot overemphasise the importance of flipped learning for supporting knowledge and skills application. Noe (2022) suggested that flipped learning is used in blended curriculums to encourage learners to read ahead of lessons and complete assigned tasks before face-to-face seminars. Completing these ensures that the face-to-face classroom time focuses on reinforcing and applying knowledge and skills relevant to practice.

Results from the study emphasised the importance of the curriculum implementation approach, content and resources in building the foundational knowledge and support through which students and graduates can recognise how theory knowledge and skills connect with healthcare management practice. The blended learning programme

mixes online learning, face-to-face instruction, and other modalities of delivering rich instructional content, resources and tuition, giving learners greater autonomy while at the same time promoting 'independent study' and challenging them to assume greater ownership of their learning (Wang et al., 2023). Some participants' feedback about the intra-programme coGENCY, integration, and links between modules looked at odds. For instance, although one commented on the coherence, scaffolding, and linkage within the programme content, another (the second) noted that each module had its specific focus. As I introspected on this, I became increasingly convinced that the second participant's views expounded on the different modules and their emphasis on supporting specific knowledge, skills, and graduate attributes. My conviction is rooted in the affirmation of the thematic curriculum model in use in the programme.

Regardless of how exceptional the blended learning settings are, learner achievement (i.e., brought on by efficient content and resources) could be influenced by motivations, beliefs, and self-theories. In short, what will occur with student success in these settings can only be probable (Knight and Yorke, 2003). This implies that curriculum designs must provide an enabling framework (and not a strict prescription) for student learning on the programme (Ganesan et al., 2002). Recognising this offers the option of adding rich learning content and resources suited to the requirements of learners and their development while keeping consistent with the (inter)disciplinary norms (see Knight and Yorke, 2003) associated with healthcare management. In this vein, the HEI uses 'iLearn' (a virtual learning platform) to support active learning. Active learning requires lecturers to build tutor-supported online discussions where students can actively interact with the material they are studying (Ngoasong, 2022). iLearn works as a multi-purpose hub that, besides employability resources, academic study skills support, and a virtual student wellbeing centre, hosts the module content, assessment, discussion forum links, and lesson activities to deepen students' understanding as they walk through lessons. Students primarily use the latter as a self-assessment tool. Ersoy-Babula and Babula (2018) indicated that, unlike using it as a place to store learning resources, a Moodle-based virtual learning environment supported by smart mobile educational devices (e.g., as seen in blended learning) offers an effective way of redirecting learners' focus to encourage engagement in online conversations, learning forums, and podcasts.

This virtual learning content is brought to life in 8 hours of weekly face-to-face learning seminars for blended learning students. Participants noted the interactivity and suitability of these resources. The tools use synchronous and asynchronous instructions, including case studies, which are highly contextualised to increase students' understanding of healthcare management practice. Results indicate that the resources also challenge and broaden the teaching faculty's knowledge of new theoretical content relevant to the subject area. Bidarra and Rusman (2017) contended that the resources within blended learning might further accentuate the capabilities needed to thrive in an online and interconnected society, such as inventiveness, problem-solving, thinking critically and efficiency.

Support for students exists in different forms - for example, support from lecturers with accessing academic resources and assimilating knowledge explored in the classroom. The support is also available and accessible through the 'Student Support' service function. This includes advice on accessing student wellness resources, careers, inclusion, and mental health. However, findings focused on the support provided by the lecturers. This stressed the crucial role of lecturers in introducing students to critical skills to enhance their understanding of undertaking research and accessing the resources on the virtual learning hub. In their study, Johnson et al. (2018) found that lecturer support is so essential that students specifically complimented their blended learning instructors on their expertise and capacity to impart knowledge and offer them further support. Kintu et al. (2017, p. 2) suggested similar findings by asserting that support offered in face-to-face blended learning sessions, student characteristics, "background", and how the learning is designed are essential pillars for learning. Hughes (2007) demonstrated in their study that proactive tutor support in blended learning is essential in ensuring that learners remain motivated and submit coursework while having access to peer and tutor assistance on the programme. Entwistle (2007) observed that a teaching and learning ecosystem includes all elements students encounter to help them learn more efficiently, such as educational resources, lecturer assistance, and work products.

The word '*showing*' was used to describe how lecturers support the development of a culture of research in the blended learning classroom. '*Showing*' would indicate a

'demonstration of how to carry out something,' an essential way for learners to engage and learn through instructional information. Nonetheless, sharing information in the classroom and with peers and managers (in the workplace) is a vital learning feature. The use of e-learning methods in addition to the traditional face-to-face offers an opportunity to improve the inter-professional exchange of knowledge and skills (Pfenninger et al., 2010). Investigating the use of Yammer, a social media site, to foster dialogue beyond typical educational hours that rely on within-the-classroom work, Warner (2016) noted that it is possible to create a learning community in which learners feel that they belong in an identically defined learning environment reminiscent of an in-person face-to-face class where they have the opportunity to participate more profoundly with discussions of theory and socially.

Findings indicate that all students struggle to moderate between their studies and work and life pressures. Some participants highlighted the difficulty associated with students balancing personal commitments and how this has often led to an exacerbation of sub-optimal student engagement in the programme. Johnson et al. (2018) discovered in their study that some higher education students have a less-rounded awareness of their academic ability to organise themselves when commenting on how long they were required to complete coursework, i.e., it was frequently more protracted than anticipated, implying that they appear to misjudge both the amount and quality of work, as well as the amount of time required to devote to their study (ibid). In addition to HEI support, it is important to establish expectations and provide practical assistance with time management.

6.4.1.2 Sub-theme 1b: Community of Practice, Knowledge and Graduate Skills

Participants emphasised the importance of communities of practice in advancing the professional practice of students and graduates. Nevertheless, a part of me grappled with whether participants would have framed this differently—for example, through the lens of a community of learning instead of a community of practice—if they had not had experience working in health and care management. While 'communities of learning' are similar to 'communities of practice,' there are differences. Conversely, communities of practice are formed by individuals participating in collective learning

and development to improve their practice. For instance, a team of healthcare managers is dedicated to solving identical issues about quality care provision (Wenger-Trayner and Wenger-Trayner, 2015). Lave and Wenger (1991) established the notion of a community of practice, defining it as a small circle of individuals that embrace shared practices. Other literature, however, described it as a social network that evolves to foster more profound knowledge among members, offer an opportunity to share their specialisation and thrills regarding similar problems, obstacles, or issues and continually interact and increase their skills and knowledge (Azan et al., 2017; Pyrko et al., 2017; Wenger et al., 2002).

Findings showed that the blended learning environment is a fertile ground for developing knowledge and graduate skills relevant to healthcare management. According to the participants, learning within the modules taught in the programme was central to imbuing knowledge and graduate attributes relevant to sector skills for managers. Participants noted that learning within taught modules on blended learning is central to imbuing knowledge and graduate attributes relevant to sector skills for managers. The immersive learning experience, which has rich and highly relevant content, both in the virtual learning environment and the practical knowledge and experience explored in the community of practice, catalyses things, developing a level of practice familiarity for application. According to the results, this was noted across the diverse student and graduate population, enhancing their self-image and professional persona while reassuring them to 'transport' relevant transferable skills from their learning to practice. This affirms findings from (Rovai and Jordan, 2004), who discovered that blended programmes foster a more powerful feeling of community amongst students than more normative or fully online programmes. The students and faculty initially form a learning community that morphs into a community of practice. Affirming this was Scott, in a small-scale qualitative study he conducted, which found that respondents with mobile access to a community of learning, an instructor, and an interactive programme structured similarly to our blended learning programme (e.g., which explicitly fosters employment-engendered self-management skills and attitudes) showed positive outcomes (Scott, 2016; Scott, 2018). This also reinforces the social-cultural nature of communities of practice, which is crucial in providing a forum for the legitimate peripheral participation of students and graduates

(see Pyrko et al., 2017; Wenger et al., 2002).

Thriving Communities of practice often have three levels of participation (Wenger, 2001), with the core group consisting of people who go beyond to contribute, participate, and drive the community. The second tier comprises the active group, which consists primarily of community members who partake publicly in discussions and gatherings but are not considered part of the core group. The peripheral group is the third layer. This group rarely interacts with and contributes successfully to the community. Even though they are merely observers, they tend to hold discrete conversations alongside other participants while expanding their comprehension (Mavri et al., 2021). This participation will be especially evident as students and graduates navigate from being novice outsiders to demonstrating 'expert' healthcare management knowledge and skill mastery, which brings them into the fold of core group members (Lave and Wenger, 1991). While participant feedback was not explicit about this, Fox (2000) noted that if the dynamics in the community and disparate power relationships at this point are less successfully dealt with, they can harm people with less strong voices (at the periphery). Unfortunately, these would have less of a say in the negotiation of meaning and what constitutes knowledge and the suite of graduate skills for its application.

Unsurprisingly, participants referred to the COVID-19 lockdown period in the UK (i.e., March 2020 and March 2021) as significant in its contributory effect on working in communities. To illustrate, the need for them to work in online communities while losing the face-to-face element that blended learning offered heightened the importance of working together collaboratively. Blended instructional resources were a favourable influence in supporting the online learning transition and establishing a community of practice.

Findings also confirmed that the 8-hour face-to-face (weekly) seminar component of blended learning allowed learners to come together and apply their learning while encouraging reflections on their diverse and complementary practice experiences. This is interesting to note as organisations are hardly uniform, and even within the same (employment) duties (e.g., in healthcare), there is bound to be a wide range of circumstances, knowledge, and points of view (Eraut and Hirsch, 2007). The coming

together also supports them in actively contextualising the application of theoretical knowledge. Within this space, participants hinted at the importance of contextualisation sometimes happening in a simulated environment (through problem-based learning) to mimic the workplace. Findings indicate that this is most effective where students have healthcare work experience. This is a critical area to reflect on, as it would have ramifications for the learning of students and graduates enrolled in non-clinical healthcare management degrees that do not provide students with formal work placements.

Participants expounded on the links between learning communities, knowledge, and graduate skill development opportunities by noting that some students and graduates worked as health and social care managers. This, combined with other students' and academics' operational healthcare practice knowledge and experience, adds an element of tacit and overt learning exchange (Nonaka, 1994) that occurs in the community, often through practical knowledge sharing and discussions. Communities of practice facilitate knowledge gain, enhancement of skills, application in real life, and socialisation (see Gibbons et al., 1994; Nonaka, 1994). Findings indicated that beyond the blended learning classroom, the tacit knowledge that forms parts of student and graduate workplace autobiographies is only sometimes apparent once they are faced with similar situations in practice. The level of expressed, ingrained, and enculturated knowledge is where tacit knowledge typically resides. The knowledge which has then been entrenched and encoded is typically explicit, which implies that it has been documented, recorded and codified (Crawford et al., 2016).

Using certain mobile aids such as WhatsApp groups and the discussion forum for the community to express themselves and share knowledge and experience across the learning space and practice appears to support 'deep dives' that strengthen student and graduate confidence in applying graduate attributes and skills from modules. Developing such confidence is crucial, as noted by Rainey and Gifford (2016), who described how diverse students on blended learning courses, such as the BA (Hons) Healthcare Management Programme, often lack confidence in their unique talents as well as their appreciation of the vital role they play in the delivery of holistic healthcare services. Nevertheless, these students learn and can develop analytical and critical

thinking abilities and discover how to use solutions based on evidence to defend and support the care they give. According to Nevo and Slonim-Nevo (2011), the implementation of evidence in one's practice (e.g., students and graduates), in this case, should be informed by evidence (emanating from the programme content) in the blended learning classroom rather than be dependent on evidence in of itself. This approach demonstrates an asset-based strategy for learning, which recognises capabilities and helps students believe that they can add value to both practice and their respective educational advancements (Rainey and Gifford, 2016).

6.4.1.3 Sub-theme 1c: Integration, Sector Knowledge and Skills Transfer

This is a fundamental sub-theme relative to answering my study's research question. As I reflected on the sub-theme during analysis, I noticed its focus on unpacking the mechanisms within the blended learning programme that make it unique in its ability to develop and reinforce knowledge and skills transfer to healthcare management practice. The sub-theme is an extension of "Curriculum design, resources and support" and "Community of practice, knowledge and graduate skills".

In a study by Tayebinik and Puteh (2013), the authors observed that because internet-based (online) instructional settings and teaching conducted in a physical classroom have their respective strengths, integrating the two, as blended learning programmes do exert tremendous power in supporting flexible learning and interpersonal interactions through which learning and learner skill and competence development flourish. The latter – interpersonal interactions in communities of practice, was explored in further depth in the sub-theme "Community of practice, knowledge and graduate skills" (see 6.4.1.2). In line with this, findings from the study underscored the level of knowledge integration within and across modules of the programme and how this, together with the programme's learning and teaching, is linked to knowledge development, confidence and self-awareness heralding and supporting healthcare management skill transfer to practice.

Findings indicate that the programme maintained a broad focus on healthcare management, which is necessary given the diversity of student experiences and practices. This alludes to the breadth of the curriculum in imbuing the necessary

sector skills for diverse management practices. A study by Ashraf et al. (2021) found that blended learning instructors value the incorporation of instructional approaches to promote the diversity of student participation and inclusive practice. Instructors operating in this space “*often adopt blended learning to improve student’s learning experiences*” (ibid., p. 2). Participants illustrated how they had developed knowledge, skills, and confidence from the programme, which had upskilled them to explicitly appreciate the self-application they now demonstrate in their practice, such that they have noticed changes in their approach to healthcare delivery. This raises a crucial point about how knowledge (e.g., in a blended learning classroom) could be an ever-evolving amalgam of experience which supports professional insight and wisdom, reflexivity situated application and self-worth (Crawford et al., 2016).

Findings suggested that knowledge in modules is integrated across the programme. To illustrate, knowledge from one module builds on and scaffolds another within and across the different programme levels (levels 4, 5 or 6). The scaffolding referred to here was mentioned as a strength by students, graduates and academic participants. Presenting findings from their systematic review, Van Laer and Elen (2017) identified scaffolding as a vital characteristic linked to enhanced cognitive processing and student motivation in a blended learning setting. Blended learning, in this case, would refer to the delivery mode used by the HEI to integrate both traditional (i.e., face-to-face) and virtual instructional learning methods (Boelens et al., 2015). This uses ICT (and active learning strategies) to improve learning results by making education and learning more satisfying and relevant to students' needs, interests and employment pursuits (Ashraf et al., 2021).

Integration of knowledge denotes a process through which learners acquire and work to combine previously unconnected information from various sources and contexts into a unified information structure. Although from concepts, experiences and theories explored in the learning environment (e.g., while simultaneously embedding situated workplace experiences), the knowledge obtained often includes reflections, personal experience, and observations (Schneider, 2012). The level of integration referred to by participants appears to confirm the interdisciplinary mix of modules on the programme, which draw on three QAA subject benchmarks – that is, Business

Management, Social Work and Health Studies. The programme draws on these subject areas to form an interdisciplinary mix of Business Management, Social Work and Healthcare modules. According to Ivanitskaya et al. (2002), interdisciplinary learning promotes knowledge integration to extend learners' comprehension and assist them in creating links between theory knowledge, situations, and perspectives from multiple fields, which has a significant impact on setting the groundwork for developing occupational competencies valued by employers (Ari, 2020). Nonetheless, Brown et al. (2008, p.16) argued that employers often express noticeable concerns about higher education graduates' ability to showcase "*soft skills*" and behavioural competencies like creativity, initiative, collaborative working, and time management. As a result, they uniquely value healthcare management programmes facilitating or intensifying efforts to facilitate knowledge and skills transfer opportunities to practice (Harris et al., 2013).

Findings implied the uniqueness of individual modules of the programme in developing specific managerial skills. For instance, participants highlighted modules such as Communication and Collaboration, Project Management, and Inter-Agency Working, which focus on graduate healthcare management skills and support learners' managerial expertise and efficacy in leading reflexively and managing services. The Leitch Review of Abilities (2006) associated communication, relational, managerial, and the capacity for leadership as essential competencies for management practice. Programmes using modules with such a high level of integration, as is apparent in the blended learning programme, look to promote the development of graduate skills and capabilities that align with employer needs and expectations (see Rios et al., 2020).

Findings further indicated that integrating and developing relevant graduate attributes are intricately linked with transferring knowledge and skills to healthcare management practice and employability enhancement. This would suggest a push to stimulate the formation of resources and endorsed skills, knowledge, and traits for graduates that make them employable for the greater good of society (Hage, 2020). Transfer of learning affirms the use of skills and knowledge gained via training in the workplace (MacRae and Skinner, 2011). Haskell (2001) identified this as the foundation for

thinking, acquiring knowledge, and valuable problem-solving skills, frequently seen as an essential objective of (higher) education. It is, nevertheless, critical that higher education learners, regardless of the academic discipline, are equipped to transfer their learning beyond academic and non-educational environments. Galoyan and Betts (2021) and Kubsch et al. (2020) went so far as to argue that one of the fundamental aims of education is the ability to transfer or communicate one's knowledge outside the immediate milieu in which it was acquired.

Participants expressed that the structures through which knowledge integration happens are the online learning content and in-class face-to-face blended learning activities. The in-class lessons promote the use of active learning strategies (e.g., self-reflection, paired work, group work, class presentations, synchronous discussion forum activities) through which learners learn theory and concepts linked to healthcare and discuss and simulate these through case studies about their application (also see Mode 2 (Gibbons et al., 1994)). Techniques of learning that encourage 'Social constructivism' also emphasise active collective knowledge building instead of the passive knowledge exchange and transfer (see Rovai and Jordan, 2004).

The professional work experience of the lecturer was named an essential resource in helping transform theoretical knowledge into something meaningful for application in healthcare management practice. For HEIs offering blended learning programmes, meaningful learning aimed at progressing integration and supporting transfer transcends merely adapting resources or blending educational materials online. It entails fundamental modifications to accomplish academic, emotional, and complementary goals that HEI's leadership and educators agree upon to underlie a credible blended instructional strategy (Kessler, 2017). In this vein, Ngoasong (2022) observed in their study that the crucial ingredients to successfully blending the (e.g., online and face-to-face) learning environments include workforce development, the transformation of the course content, construction of interactive resources and the integration of technological resources inside the selected instructional management system, such as a VLE.

Scenarios (including case studies) extend to students being encouraged to reflexively engage in flipped learning and other synchronous in-class activities such as role-play

and exploring resources that simulate the healthcare management workplace and associated challenges and ethical dilemmas managers confront. The intention is to get them to experience practice in the classroom while drawing on their work experience to make more sense of it. This resembles Nicolini's (2012) view of practice learning (Evans, 1999), which is described as dealing with learning through contextualisation and application in both professional and academic contexts and not just exclusive to placements (ibid.). For graduates to be better able to generalise their learning to other scenarios, the graduate model emphasises the value of creating learning scenarios analogous to the workplace setting (Burke and Hutchins, 2007). To achieve this, instructors should use practical tasks and creative teaching to make the curriculum more relevant while still ensuring that students comprehend the fundamental ideas behind the abilities (skills) they acquire (Jackson, 2016).

Participants believed that knowledge and skills transfer to practice are evident and supported by the programme. Perkins and Salomon (1999) considered that education programmes that are well designed have the potential to achieve knowledge and skills transfer. This is especially the case for *"reflexive or low road transfer,"* which *"involves the triggering of well-practised routines"* (in healthcare management practice) *"by stimulus conditions similar to those in the"* blended *"learning context"* (Perkins and Salomon, 1999, p. 2). Perkins and Salomon (1999) assumed a positionality that would support the concept of Mode 2 learning, which promotes creating contextual information for use in the workplace (Gibbons et al., 1994). To illustrate, Nowotny et al. (2003) noted that their fundamental concept of the 'New Production of Knowledge' (i.e., Mode 1 and Mode 2) sparked an intriguing conversation in the research and academic scholarly world as well as outside of it. Still, both Mode 1 and Mode 2 argue in favour of a kind of knowledge production that acknowledges individual expertise and contextual reflexivity, as well as for Mode 2 (i.e., specifically) a consideration of the larger social context (see Gibbons et al., 1994; Nowotny et al., 2001; Nowotny et al., 2003). Mode 2 is situational, contextual, experiential, collaborative, and favourable knowledge created in its application context. Allen et al. (2011) concluded that learning occurs in environments (e.g., where Mode 2 is implemented) in which theoretical knowledge, case studies, and practical experiences are combined to produce fresh understandings for learners. According to Budwig and Alexander

(2020) and Nicolini (2012), this novel practice-based learning approach could also be transdisciplinary.

While some of the findings would indicate a linear mechanism for the transfer of knowledge and skills between the blended learning classroom and the healthcare management workplace, others noted the bidirectional or even cyclical nature of knowledge and skills transfer in a way that at best may be described as an amalgamation of a forward and backward reaching transfer (Perkins and Salomon, 1999) between the classroom and the workplace. I mean that learners either developed theoretical knowledge, graduate attributes, and skills in the programme to aid application in practice or used the experience from the healthcare management workplace to support their 'immerse' discussions in the classroom to aid the unpacking of theory information. Prihodova et al. (2019) also insisted that knowledge transfer and utilisation are more complex than unidirectional and should be best thought of as a complicated, non-linear mechanism for learners to navigate (ibid.). See my definition of 'knowledge transfer and utilisation' (a term coined in Chapter 2 to encompass various explanations of knowledge conceptualisation, transfer, and literature such as (Barnett and Ceci, 2002; Gibbons et al., 1994; Jacobs et al., 2016), which describe how knowledge is applied and knowledge and skills are positioned and contextualised for possible transfer (e.g., between contexts).

Still, findings are aligned with Barnett and Ceci (2002), who affirmed the possibility of transfer when comparable or similar performance outcomes (such as healthcare management knowledge and practice) are evident. Galoyan and Betts (2021) also corroborated this while further attempting to draw our attention to the fact that there is a parallel between knowledge and skills transfer and deep learning. Furthermore, Argote and Ingram (2000) also hinted at the possibility of the 'transfer' of learning transcending learning and happening within the same organisation. Other views that do not outright reject the possibility of transfer but ask for caution when determining its existence include Eraut (2008), Dougherty (2013), and Hempenstall (2019).

By referring to participants' improved understanding of the sector and their demonstrating knowledge and relevant healthcare management skills, employers also appear to recognise the knowledge and skills transfer orientation demonstrated

in the programme. Despite this, other factors impacting successful transfers raised by employers include the workplace context, role expectations, and organisational culture. Again, this alludes to the broader literature (e.g., Eraut, 2008; Eraut and Hirsch, 2007; Hajian, 2019; Jackson, 2016; Perkins and Salomon, 1999). Findings also raised concerns about the challenges faced in studying the programme. While they had not cited these as a negative factor in their ability to integrate the knowledge and skills from the programme for application and transfer, it was worth noting. In this vein, the challenges (and dilemmas) participants raised include the over-reliance of other learners in their learning community on them for support and maintaining the right balance between workload and academic studies. Granting the workload concern was viewed as a challenge; other participants felt that juxtaposing work with studies presented an opportunity for students to progress further in their career options at a later stage. Since the study group was primarily adult learners working in busy healthcare management jobs, it appears that given the quick rate at which learning technology shifts, blended learning research and its current varied possibilities might still not feature solutions that benefit this current student population (McKenna et al., 2020) to the fullest compared to younger learners.

6.5.3 Sub-theme 2: Neutral and Transfer Difficult to Determine

“Neutral and transfer difficult to determine” is a sub-theme made up of 16 participant quotes. The findings hint that “Positive transfer” and “Neutral and transfer difficult to determine” sit at opposite ends of a spectrum, where factors informing both interact to determine the transfer outcome (Figure 22, Chapter 5). This finding is slightly at odds with Barnett and Ceci (2002), who differentiated knowledge transfer outcomes into ‘context’ and ‘content’ and other ‘learning’ transfer literature, indicating that transfer could either have ‘positive’, ‘negative’, or zero outcomes (see Schunk, 2004).

Ensuring students can use what they have learnt in various situations in multiple capacities constitutes one of higher education's primary objectives (OECD, 2018). Nevertheless, it is not in all cases that the anticipated knowledge and skills' transfer' envisaged with higher education programmes is observable or even evidenced. The challenge is that learners need help using newfound knowledge and skills in different

settings (e.g., work) (Hajian, 2019). According to Konkola et al. (2007), theorised ideas of transfer are based on factors such as what needs to be transferred—including from where, the categorisation of transfer, and the intended outcome. To further highlight the classification, Konkola and colleagues (2007) suggested cognitive and contextual perspectives as two significant categories to consider. The first, the 'cognitive' approach, focuses on abstracted mental models and linkages, as well as how they fit into the context of learning and unique circumstances that learners encounter. The second, the 'situated' learning paradigm, emphasises the mediator elements impacting the stimulation and integration of previous knowledge for transfer (Galoyan and Betts, 2021). The findings showed that most of the participant feedback around the "Neutral and transfer difficult to determine" was associated with the latter perspective (i.e., situated). This is not to say that the two (i.e., the cognitive and situated perspectives) are entirely mutually exclusive of each other, as learning transfer (from a programme of study) often includes more than one perspective (Vermunt and Donche, 2017).

The view that "Neutral and transfer difficult to determine" sit directly opposite "Positive transfer" as dual constructs and outcomes of knowledge and skills transfer partly contradicts other literature (e.g., Kober, 2015; Barnett and Ceci, 2002; Perkins and Salomon, 1999). Even so, the "Neutral and transfer difficult to determine" brings together two elements: "neutral," which is almost akin to far transfer (i.e., arguably because of the absence of formal placements—see Perkins and Salomon (1999)), and "Difficult to determine," which participants somewhat likened to a missed opportunity to directly observe and evidence the knowledge transfer and competency demonstration by students and graduates, principally because of the lack of a formal practicum. The sub-theme comprehensively attempts to elucidate how knowledge and skills transfer from the programme is either not apparent or that the participants perceived the programme to have had little to no impact on knowledge and skills transfer to healthcare management practice.

Participant feedback suggested they acknowledge the academic team's effort during programme conceptualisation to ensure it is stimulating and relevant. Furthermore, using resources within the course that promote active learning in the blended learning

classroom was identified as significantly impacting the potential for transfer. The resources referred to seem vital in embedding and reinforcing essential healthcare management knowledge and skills (including attributes), all explicitly mentioned in modules. Jackson (2016) suggested that developing students' skills in an environment of collaboration through active learning, small group instruction, and peer feedback is vital in helping instructors focus their energy on supporting students to appreciate how they learn (including metacognition) rather than just on the content. Rovai and Jordan (2004) also argued that blended learning approaches provide a unique opportunity to reconceptualise the way to higher education learning. However, the extent to which stakeholders who experienced it often felt that it had reshaped their focus was not very clear—that is, from the information/instruction being merely presented to students and graduates to them acquiring the requisite declarative knowledge while leveraging technology and collaboration with others in their community (*ibid.*).

Findings further described how measuring knowledge and skills transfer should go together with a more structured (objective) and neutral performance measurement approach beyond the classroom, undertaken in a setting like a workplace by employers and practice mentors. However, the literature (e.g., Eraut and Hirsch, 2007; Nonaka, 1994; Perkins and Salomon, 1999; Robertson et al., 2019; Sadeghi, 2020; Taskin and Flore Bridoux, 2010) extensively documents the difficulty of demonstrating or efficiently measuring knowledge and skills transfer from one context to another (i.e., often from a learning environment to practice or within organisations). Eraut and Hirsch (2007) elaborated on this challenge, claiming that knowledge transfer is related to an individual's learning to use existing skill sets, knowledge, and competence in a completely novel context. This process is reasonably straightforward if the situation is remarkably identical to one formerly experienced or lengthy and complex if it turns out to be complicated or unknown. Hajian (2019) clarified this viewpoint by arguing that the anticipated transfer to practice is only occasionally granted. Hence, the knowledge gained is only sometimes used adaptably in multiple circumstances by learners and graduates. The role of practice in supporting transfer is quite essential. Jackson (2016) found that an encouraging work atmosphere is crucial to learning transfer beyond the learning environment (e.g., the blended

learning classroom). This is partly because a supportive manager, superior, or mentor is integral to learners receiving crucial feedback about their workplace output, learning gains demonstrated, and performance against set competencies (ibid.).

Findings on whether students and graduates displayed enough to suggest that the transfer of knowledge and skills to practice is obvious and expressly recognised in the programme revealed that some participants believed the links were not fully manifest. This appears to be informed or drawn from two possible conclusions: one, the belief that learning on the programme is only tacitly recognised and thus, in its current theoretical form, is unlikely that it will enhance or hamper learners' and graduates' ability to demonstrate it in their practice (see Demicheli, 2020); or two, that the knowledge and skills are explicit and obvious but are not, in their orientation, transferable or considered to be transferable to practice by students and graduates. The latter aligns with Nonaka's literature on tacit and explicit knowledge in organisations (Nonaka, 1994). Indeed, the greatest obstacle to the transfer of personal knowledge across contexts arises when the individual receiving it does not have sufficient experience (prior experiential knowledge) of it before the transfer (Winkelbach and Walter, 2015); that is, in a way, its conversion from tacit to explicit is near impossible to achieve (Cairó Battistutti and Bork, 2017).

Still, some participants observed that it was not that the relationship was not obvious but merely that it was not always apparent at the start as students completed their first set of modules. The turning point for these is when the students and graduates are exposed to the healthcare management workplace, where they can observe the application of the theory knowledge (and skills) to practice. The latter appears plausible in this case, as participants also expressed a belief that the lack of work placements to assess learners and graduates against workplace competencies has resulted in a situation in which the transfer of knowledge and skills from the programme is largely tacit, nuanced, or, at best, difficult to determine. This has ramifications for the programme, as it raises a question about whether the responses framed by students and graduates to the question would have been different if they had not worked in healthcare or at least had recent healthcare management experience.

Nonaka, in his seminal work 'Nonaka's Four Modes of Knowledge Conversion' observed that "*a failure to build a dialogue between tacit and explicit knowledge can cause...*" difficulty (Nonaka, 1994, p. 20) with the transfer of knowledge and skills to practice (Perkins and Salomon, 1999). Based on his work, Nonaka postulates four different modes of knowledge conversion, including (1) "*from tacit knowledge to tacit knowledge*," (2) "*from explicit knowledge to explicit knowledge*," (3) "*from tacit knowledge to explicit knowledge*" and (4) "*from explicit knowledge to tacit knowledge*", under the premise that knowledge and wisdom emerge through "*conversion between tacit and explicit knowledge*" (Nonaka, 1994, p. 18). Nonaka (1994) argued that an organisation's effective communication procedures (e.g., my HEI) must be combined with the individual experiences (e.g., of learners, graduates and academic teams), social connections (with stakeholders in the HEI and outside - e.g., employers) and efficient communication processes (captured in the programme learning outcomes and delivery plan) to successfully transition implicit knowledge to explicit knowledge (ibid.).

Also, findings showed how pervasive the view about a work placement experience's effect on the programme's ability to support knowledge and skills application to practice while evidencing transfer was among participants. Even so, there was no complete consensus on this matter. For instance, one of the participants noted that there was a level of transfer apparent in some modules of the programme. The participant opined that there is a 'level of transfer' in some modules that students and graduates would find immensely useful in helping them apply theoretical knowledge to management practice. Nevertheless, in their view, the extent to which knowledge and skills transfer would occur is uncertain or even immeasurable in determining their level of proficiency. Perkins and Salomon (1999) also acknowledged that transfers go beyond simply interacting and using appropriate material; they underline how skills and knowledge are transportable between practice management and other settings, such as the workplace. Indeed, the exposure of learners to work-placement experiences (in healthcare management) dramatically influences their ability to transfer work-related skills and knowledge from training, according to Jackson (2016).

Prospectively, participant feedback showed that the programme would benefit hugely

from further work to help understand how knowledge and skills transfer occurs from the classroom to the healthcare management workplace. Specifically, placements were viewed as a critical missing component. Cleak and Wilson (2018) suggested that objectives associated with placements, in this case, are that they give learners a chance to put into practice concepts and theories learnt in a way that helps evidence their application and competency demonstration. What makes placements unique is their use of curriculums to develop and enhance learner awareness and expertise in specific contexts whilst simultaneously enabling them to look for and access resources and assistance during times of ambiguity and lack of knowledge. Curriculums also establish guidelines and the requirements for ongoing support and direction during the work placement (Zuchowski et al., 2023).

In rationalising why placements were required, one of the participants asserted that finding out how the transfer of graduate skills, knowledge, and capabilities obtained on the programme occurs would necessitate following the students and graduates up for up to a few years after graduation to document their use of the knowledge and skills from the programme. Although this would help the HEI understand its graduate outcome data or graduate destination survey results better, the difficulty is that unless students and graduates take ownership of self-reporting on the practice skills and competencies they experience (which might not be overtly objective). This is also bound to be resource-intensive and difficult to manage for the HEI.

Despite the diverse student groups working together in communities, the programme's emphasis on theory with no placement opportunities for students to put the learning into practice appeared to be highlighted as a negative factor that influences obvious and apparent linkages between theory and practice. Hesse et al. (2015) proposed that the strength of linkage (e.g., between a programme of study and its intended area of practice) provides significant knowledge on the potential for transferring knowledge and skills between the two. Still, this was also linked to the confidence to apply the knowledge comfortably in one's place of work. The mention of a community of learners confirms Nonaka's notion of socialisation in organisations and the power this exerts in progressing knowledge and skill transfer for practice. Fundamentally, people are the ones who produce knowledge in organisations. This

would include HEIs, which, as knowledge acquisition bastions, also have all the hallmarks of organisations. Therefore, the organisation's role is to encourage imaginative individuals (e.g., in constructing and contextualising theory knowledge) or offer conditions for individuals to produce knowledge (Nonaka, 1994). Participants went as far as expressing that placements should be a necessary component of the programme to objectively ascertain linkages between knowledge, skills and healthcare management practice. The emphasis on placements appears to be that the placement is an area designed to support the student and graduate to develop uniquely designed skills, which offer the opportunity for programme teams to be informed with some certainty that the students and graduates are applying themselves and their skills while improving themselves in the process (Jackson, 2018).

The nature of the placement was an area of debate, with participants noting the shape it could take. For instance, some participants felt it could be managed centrally by the school or through a voluntary or paid manager job shadowing in healthcare management. The latter involves collaborating with a manager and learning from them about what they do on a typical day of their life leading a service. Findings suggest that if all this is not possible, there should be a consideration of how work experience could form a strict programme entry prerequisite. Edwards (2014) noted that work placements are associated with better job chances owing to their positive effect on students' sense of self-worth, particularly concerning their confidence in handing in applications, attending interviews, and communicating their abilities and assets as well as expanding their networks and establishing more possibilities for employment (Jackson and Bridgstock, 2020). In a study by Divan et al. (2022), the authors contended that undergraduate learners who engage in and complete work placements have better career outcomes after graduation. The most exciting part of their finding was that students who completed a placement year have more than a 10% opportunity of graduating with a first (distinction) classification compared to students who did not complete one. This has enormous implications for improving attainment in the school and the HEI.

My reflections on this sub-theme and the supporting literature explored are that while

a positive transfer of knowledge and skills from the blended learning programme could not be discounted, essential factors should be reviewed simultaneously as a determination is made about whether 'transfer' has occurred. Fuchs et al. (2002) support this, predicting several factors determining transfer success. Eraut and Hirsh (2007) emphasised the difficulty with the 'concept of transfer', stating that when the transfer is from introductory higher education courses, the cognitive challenge is exacerbated by the disparity between HEI's forward transfer rhetoric and the retrospective transfer strategy required in the workplace. Although participants had not raised this as something they had noticed on the curriculum or believed it to hurt transfer in their experience, it should not be assumed that transfer is a smooth process that students and graduates seamlessly demonstrate.

6.5 Theme 5: Suggested Improvements

Suggested improvements in the study were akin to recommendations made by participants about the programme. These suggestions highlighted areas where the programme could improve to gain additional opportunities for knowledge and skills transfer. Employability, resources and skill support featured quite heavily in the findings. The sub-themes draw on and are linked to other essential themes, such as theme 4, knowledge, skills and transfer to practice; theme 2, Strengths; and theme 1, Knowledge, characteristics, skills and employability expectation.

6.5.1 Sub-theme 1: Enhancing and Internationalising Programme and Skills Support

The Oxford Learner Dictionary defines an '*enhancement*' as increasing or further developing someone or something's positive qualities, value, or position (Oxford Learner Dictionary, 2023). Findings showed that participants alluded to the need for further enhancements to the programme induction and academic resourcing and support. In line with this, participants suggest that the range of opportunities student inductions offer must be fully utilised.

Programme-specific inductions are already in place on the programme. This follows

from the HEI's student induction conducted by the Student Support team. The programme induction takes approximately three hours. It is conducted face-to-face in the student's chosen study centre (or through a hybrid of face-to-face and online if required). The participant feedback is that despite this induction, there is still a noticeable gap in students' understanding of expectations and responsibilities as independent learners. To illustrate, the available study skills resources, research and final project module expectancies, and responsibilities associated with being independent learners in higher education. According to Simons et al. (1976), new learners experience various disorientation for which they must make personal, administrative, social, and intellectual adjustments as they are inducted into higher education. Simons and colleagues (1976) discovered that the factors that lead to disorientation include a variety of factors, such as unrealistic or unreasonable expectations and learners being ill-prepared for or unsuitable for their programme of study. This is important, as is the relationship between learner expectation and long-term commitment to staying on a programme of study (Smith, 2017). Lobo and Gurney (2014) suggested that learners' unfulfilled expectations, particularly those that form well before they begin their educational journey, might adversely impact retention, general contentment, and satisfaction with their programme and HEI.

For the 'Research Method and Final Project Module,' participant feedback indicates students experience some difficulty with the module. The 'Research Method and Final Project module leaders in the study confirm that the difficulty expressed is brought on by the module being delivered on a six-week block (i.e., three-hour-a-week) workshop schedule, which is not mandatory to attend. Findings confirm that the flexible structure with the delivery means students do not always engage well with the module. Attendance is flexible, and students may elect not to attend and rely on online resources, thus missing the full opportunity to take advantage of learning the basics of research methodology. The findings suggest that these students profoundly struggle. Hockey (1994) hinted that the supervision process offers students the opportunity to receive guidance and critical, constructive, and supportive feedback that develops their understanding, self-esteem and confidence. Programme material (and delivery style), workloads, contacts with instructors and other students, studying time, and feedback procedures are critical expectations students have, which need

fulfilling to support their study (Lobo and Gurney, 2014).

Findings also showed concerns about supervision experience – for instance, the lack of adequate guidance and support and, in some cases, the conflicting message received when they sought information from the university’s central dissertation team. The advent of COVID appears to be a negative factor that participants associate with their dissertation experience. The COVID-19 pandemic has significantly impacted blended learning students and their perception of what support they could receive from HEIs (Abi Jumaa et al., 2023). Participants appreciated the supervisors’ efforts and even defended the supervision process while expressing concern about the improvements needed to restructure the dissertation coordination process and the support students received.

Also, findings suggested the need for supervisees to be aware of their role in driving the supervision process (i.e., taking responsibility). Participants also expressed the need for students undertaking their final project (dissertation) to be resilient and initiative-taking. This was also feedback highlighted when criticisms arose about the supervision support one of the students received. Effectively managed supervision is highly beneficial and fruitful, but it is crucially important that students work hard to manage the relationship well. Part of the most important things to be aware of is knowing precisely what to anticipate during the supervisory process. Horn (2012, p. 68) argued that this is crucial because supervisors are very busy and “*have a number of academic tasks to carry out...*” including “*teaching, course administration, research, consultancy work, seeking external funding*” and “*book-writing*”. From my experience of supervising and managing the supervision process as a programme lead in a former role, students are notified once the dissertation module is released and are advised about the process. They are then allocated to supervisors once they engage with the process, produce a working title and send it to the dissertation team. This then triggers the respective school to allocate a supervisor.

However, many students who miss the workshops develop a misconception about who drives the process. From the findings, there is an expectation issue that the HEI needs to address. This would enable students to communicate the support they expect from the process and their preferred way of meeting or submitting work for

review (McMillan and Weyers, 2012). In addition, Thompson et al. (2005) advised that although resourcing supervision pools in higher education with the right expertise could sometimes be challenging, HEIs must consider the impact of the comparatively underappreciated activity of efficient supervision on breeding a culture of scholarship and the research and academic experience of learners, perhaps even long after they complete their course.

Academic study skills support (including bringing students into the academic community) was primarily a concern for the teaching faculty. Historically, the HEI has had to play catch up with resourcing its academic skills support services. Adequate resourcing of this service is essential because Noyens et al. (2020) observed that transitioning into higher education, with its many complex systems, processes, and expectations, is challenging for students. Whether they know it or not, transitioning students face difficulties such as a different learning atmosphere, intense workloads, and exceedingly tasking academic study skills requirements (ibid).

Findings showed that the HEI has made huge strides with what is available for students now. However, gaps still exist with (some) students and graduates efficiently and correspondingly demonstrating core graduate skills like communication and digital skills (IT skills competence) for studies and practice. From all indications, the academic skills support department is well embedded in the HEI, but to further close the skills gap, students need to have access to and be encouraged to utilise the academic study support services to meet their varied and unique demands so as to retain them (i.e., support retention) in higher education (Schumacher and Ifenthaler, 2018). Academic study support services have also been attributed to better retention outcomes (Noyens et al., 2020).

Using more one-to-one tutorial support targeted at students who are less engaged in the classroom or appear to have challenges with specific skills appeared to have been hampered by online learning during the COVID-19 lockdown period. Unlike pre-COVID-19, when academics could call these students aside and discuss support and signpost them to specific departments in the HEI, learning exclusively online made this challenging and student uptake of support was low. Cahill et al. (2014) emphasised the importance of group and online tutorials in supporting learning

efficiency in students (e.g., in the blended learning classroom). While the findings appear to hint that the hybrid approach to delivery during COVID-19 made it easier for some students to hide and not accept tutorial offers, there was an opportunity for learners who do well academically to fill this gap and serve as peer instructors to formally assist others in their group develop efficient study routines and inspire enthusiasm for studying (Cheng, 2020). This will support the whole ethos of a learning community working as a community of practice (Lave and Wenger, 1991).

Findings further highlighted the need to expand the programme's resources to cater to the diverse students working across different practices and countries worldwide. One of the participants especially highlighted the concern that some of the programme content is narrow in its focus on the UK. They also alluded to the opportunity for the programme curriculum to be broadened so that blended learning students studying in Berlin and other parts of the world would find the contextualisation more straightforward. Internationalising the curriculum entails giving learners insights about their area of study from a global perspective while expanding their knowledge base to feed career advancement (Higher Education Academy [HEA], 2014). Green and Whitsed (2015, p. xii) provided a comprehensive explanation of internationalisation by noting that: "*Internationalisation of the curriculum is the process of incorporating international, intercultural and global dimensions into the content of the curriculum as well as the learning outcomes, assessment tasks, teaching methods and support services of a program of study.*" This definition inadvertently hinted at the challenges with internationalising the HEI's curriculum. To elaborate, the global and cultural dimensions make it tricky to navigate between truly catering for a broad and holistic student base and not marginalising local students (Green and Whitsed, 2015). Of course, there is also the problem of how the hidden curriculum is accounted for during the internationalisation of the curriculum (ibid.).

6.5.2 Sub-theme 2: Learning Resourcing and Assessments

The findings revealed a preference for a long and thin module in which students can spend more time on a module (compared to the present six-weekly block cycle). Staying longer on modules, participants suggested, will place less strain on lecturers

with marking turnover deadlines and allow students to assimilate better and process the codified and practice knowledge explored in the classroom. To put this finding into perspective, however, some existing literature supports the six-week block approach, where students focus on one module at a time. For instance, Ghapanchi (2022) and Mckie (2022) maintained that the block approach to teaching, especially in undergraduate programmes, is potentially the way for higher education to go in future. Both authors reason that this approach allows students to focus on one module at a time for a three to six-week study period (ibid.).

Mckie (2022) especially went on to list several universities in the UK and beyond that have introduced different variants of block teaching for different purposes and how this had informed her position that the traditional semester model of up to 12 weeks studying different modules might be setting students up to fail. Despite this, Ghapanchi (2022) affirmed some of the concerns raised by participants about the intensity it poses, and the challenge this brings on for learners who might feel that module content coverage is being rushed is not to be ignored. Ghapanchi (2022) also contended that a student who misses a lesson due to ill health or has an excused absence in the block teaching approach might need help to catch up or are at risk of failing the module (ibid.).

Results from the study also indicated that the module content and focus would require revisiting to ensure it is not too heavily tilted towards non-healthcare-related modules (e.g., business and finance) or outdated and out of touch with recent developments in the sector. The former called for a subject-specific healthcare degree that focused more fervently on the (healthcare) profession. The difficulty with this is that the programme was intentionally written to train managers who could draw on business, health studies and social work graduate attributes to improve their employability opportunities—making interdisciplinarity the core strength and unique selling point of the degree. Using data from a sizeable qualitative investigation that included interviews with key players and organisations, Pollard et al. (2015) presented results regarding the value of a degree qualification to a graduate. For example, compared to other European nations, greater employment possibilities are available to recent graduates who hold any degree, regardless of the disciplinary specialisation. Also,

three-quarters of those employers questioned said they searched for specific knowledge in the field. This puts our students in good stead as they are equipped with knowledge of healthcare practice, social work, business management, and leadership (ibid.).

Another correlated finding was a concern over module order. The findings indicate this was problematic since the notionally pinned and paired module order, which follows a predefined order, was not adequately conceptualised with the learner programme entry points in mind. The consequence appears that some level 4 students who join the programme after September would usually miss the essential skills module (an introductory module), which puts them at a disadvantage. This has since been addressed within the revamped programme, where the essential skills module is fully pinned and running each teaching cycle. According to Ghapanchi (2022), there is a worry about preserving quality and curriculum design when switching from standard semester mode to block teaching methods. The HEI was fully aware of the risks and had worked around this by resourcing the academic study skills support function to intensify the support students enrolled on the programme after the Skills module has either run or is yet to be released.

Discrepancies existing with how lecturers bring the blended learning lessons to life in the face-to-face seminars came up in the findings. The concern is how some lecturers use didactic teaching styles bereft of further contextualisation in an outward-facing way that acknowledges the workplace skills and graduate attributes required by students and graduates. The HEI has invested significant time and resources over the years to develop schemes of work and tutor packs to reinforce active learning and encourage coherence in the students' learning experience. The investment made by the HEI aligns with the higher education sector. Indeed, the higher education sector has recently experienced a significant increase in the use of active learning environments to help address what is dubbed the *"iron triangle of cost, access, and quality."* Active learning spaces do not only support a collaborative learning environment but help *"at-risk student populations"* – who ordinarily would struggle to achieve on a programme of study, and others in the learning space to interact with peer feedback and the support faculty provide to improve the cognitive processing of

information (Alexander et al., 2019, p. 34; Jackson, 2016).

Assessments are essential in contextualising, measuring, developing, reinforcing and bridging 'theory knowledge' to 'practice application.' Findings emphasised this importance. Assessment and feedback can help students and educators review performance while continually enhancing their learning (Galoyan and Betts, 2021). Specifically, formative and summative assessments are beneficial in extracting meaningful information from retained memory and further strengthening recall (ibid.). Brown (2004) established that using specific assessment techniques has a profound effect on helping learners engage in the type of deep learning that equips them with the necessary skills to integrate into the employment market after graduation.

Interestingly, findings show that students sometimes experience a disconnect between some of the module's content and assessments. From experience, this hints that there is a need to reflect on whether the pressures brought on by a 6-weekly teaching cycle are not inadvertently encouraging teaching-to-assessment, which might reduce learners' opportunities to engage with the modules' broader knowledge and skills goals. Misaligned teaching due to flawed assessment practices and methods presents a significant issue for a student's learning experience in higher education. Ramsden (1992) rightly noted this when they suggested that no effort should be spared to ensure that, as instructors, we mirror assessments to the intended learning outcomes of our programmes (Biggs, 2003). According to Biggs (2003), our assessments, in the eyes of our learners, are the curriculum. This means that instead of learning and focusing on the curriculum attributes or the knowledge and skills deliberated in the classroom, they will put more effort into understanding what they believe they will be assessed on (ibid).

The findings revealed that more assessment diversity, reduced focus on 3000-word assignments, and a varied assessment diet that is supportive of graduate skills while also protecting against plagiarism were important improvements. This is particularly important in broadening the employability skills of learners. Martin et al. (2011) contended that there are a variety of assessment formats, including blogs and portfolios, which are effective in fostering metacognition while encouraging students and graduates to dedicate themselves to lifelong educational endeavours. Jackson

(2016) hinted at how varied assessment types (like portfolios of tasks) are ideal for supporting knowledge and skills transfer.

Findings also suggested that with more investment, there is vast potential in using the university's digital presence and resources to support assessment variety and graduate skill development. This would make the HEI more agile, outward-facing and in line with what competitors are doing to stay on top of the ever-changing dynamics of higher education. Blended learning approaches and entirely online choices have become popular as a preferred course delivery strategy. This is especially true post-COVID-19 when HEIs increasingly use media-rich digital educational mediums, personalised or adaptable programme resources, and virtual interaction systems that link learners for concurrent distant exercises (Alexander et al., 2019; JISC, 2023). Despite the proliferation, there is still room for further growth to make HEIs more resilient (JISC, 2023).

6.5.3 Sub-theme 3: Personal Development, Digital Skills and Work Placements

Findings suggest that personal development opportunities should be emphasised in the programme to ensure that students and graduates benefit. This was identified as beneficial to developing student confidence and graduate readiness for work. Personal development is an instructional and lifelong pursuit of knowledge in which individuals assess their skill sets and attributes and what they want to achieve to maximise their potential over time (Tremblay et al., 2012).

Results from the study also highlighted that closer ties between the programme curriculum and the healthcare management workplace are significant in fostering graduate skills development and making it easier for students to self-assess themselves relative to their skills and future career interests. In short, the linkages allow students to engage in self-inventory-like tasks to map current knowledge, interests, and skills and use knowledge from the programme to map career employability goals. Findings illustrated that activities such as CV writing, interview preparation techniques and signposting to relevant job sites are essential for some students and graduates. This indicates a salient link between personal development

on the programme and the development of confidence to recognise the effect and outcome this would contribute to the professional practice. Nastasa and Cazan (2012) contended that professional development training comprises a dual set of goals: self (personal) improvement and professional self-determination, which dictate the acquisition, coaching, and improvement of specific skills in the workplace. The HEI has a careers department that offers separate employability skills resources, support and student workshops. This is an additional layer to the professional skills embedded within the programme curriculum. While this approach is not novel, this link between personal and professional development in higher education and employability in the workplace is supported by broader literature (e.g., Allbon and Dua, 2016; Konkola et al., 2007; Mullins, 2020; Sadeghi, 2020).

Findings indicate that many students required support with digital skills such as IT knowledge and awareness (i.e., proficiency). This was more acute in students enrolling on the 3-year undergraduate blended learning healthcare management programme than in the 4-year foundation programme. This was a fascinating finding as the HEI ensures students enrolled in the 4-year foundation and 3-year undergraduate programme have equity of experience regarding access and use of digital resources. It would appear, though, that part of the difference in proficiency could be explained by academic participants' feedback about the students in the foundation year, as the name would imply, having more support than other students.

All students on programmes have access to online libraries, blended learning content, induction content, skills support, and career employability, to name a few. Findings also indicate that the programme would need to focus on digital (IT) skills support development because this is increasingly becoming an essential graduate employability skill that students and graduates would need to be successful in their role as managers. Alexander et al. (2019, p.14) suggested that: *"merely maintaining the basic literacies by which students and instructors access and evaluate information is no longer sufficient to support the complex needs of a digitally mediated society"*. The importance of getting and improving digital skills for personal use and professional practice was heightened during the COVID-19 pandemic. Since then, employers have been especially mindful of such skills in a productive workforce

(Stofkova et al., 2022). *“Digital skills are necessary life skills and are critical for life in today’s digital and knowledge society”* (Minocha et al., 2015, p. 7) – for healthcare.

The programme’s emphasis on theory and learning and contextualisation of practice in the classroom without a placement for students to put their knowledge and skills to the test was highlighted as a concern by participants. Findings indicate that participants will value the programme’s adoption of a formal work placement opportunity for students, as this is crucial in efficiently facilitating knowledge and skills transfer to healthcare management practice. Participants thought the theory knowledge alone was insufficient to get them into management practice, and placement in their second or third year or during the summer would then suffice in helping them directly apply their learning. What distinguishes placements is how they use the curriculum to develop and deepen learner awareness and expertise (Zuchowski et al., 2023). Edwards (2014) supports embedding work placements in programmes because of their incredibly positive impact on fostering confidence and job readiness. Divan et al. (2022) went as far as demonstrating the impact placements have on improving students’ ability to achieve a first in their degree classification. If the programme decides to embed placements, there should be opportunities to do this, given the difficulties with filling current job vacancies in healthcare management in the UK. This was alluded to by employers who expressed the difficulty they experience in recruiting care workers to work for them and retaining them, further compounding the challenges they face. In my view, embedding placements formally into the programme requires much work, which would require a significant rethink of how the programme will be delivered.

6.6 Theme 6: The Higher Education Landscape

The intention behind the question informing this theme was to explore thoughts and perceptions about the context of higher education in the UK, its strengths and areas for further consideration. It provides essential information about the *‘horizon’* of the BA (Hons) Blended Learning Healthcare Management Programme that vital stakeholders should be mindful of. The sub-themes are explored below.

6.6.1 Sub-theme 1: Access, Motivation, Integrity and Academic Study

Despite evidence of societal disparities, the accessibility of higher education in the United Kingdom has received nearly twenty years of perpetuated research, policy, and across-party-lines political focus, starting with the Dearing inquiry report (Waller et al., 2017). Access to higher education is instrumental in promoting inclusion, diversity, and social mobility in higher education. Participants expressed it from two broad perspectives. The first was access to higher education as a means of assisting in widening participation and, in the process, increasing diversity and promoting social mobility in society. Findings in line with this indicated that the current full-time higher education mode of delivery in the UK is restrictive in the level of flexibility it demonstrates. The suggestion is that it favours students coming 'fresh' from compulsory education and are younger and yet to have significant personal and professional commitments – i.e., work and family responsibility. The consequence has been that – students in work and the older, more mature students find higher education somewhat inflexible to cater to their complex needs. While the participants had not been explicit about how this impacts the career progression for this group specifically, it is not unreasonable to assert that they would ordinarily struggle to commit to further study to improve their career prospects. It would appear from the findings that even my HEIs blended learning programme, which purports to offer more flexibility for learners, is not immune to the same restrictions that might deter participation for people in unrepresented groups in higher education. Even so, Baldauf and Luchinskaya (2019) suggest that one out of two young people under 30 would have participated in higher education by age 30, transforming higher education institutions in the UK into mass education systems. Many graduates from these institutions still work in positions deemed as graduate jobs. This aligns with the intentions behind widening participation - widely attributed to the Dearing Report 1997.

The second lens to access, from the participant feedback, was whether, despite widening access to everyone, HEIs have adequate safeguards to make sure entry criteria are not too flexible and unrestrictive to allow for abuse of the system by students who neither have the capacity, attitude, or right motivation to study in higher education. Feedback suggests level 3 (diploma) qualifications and work experience

should be considered minimum for entry into higher education programmes in general. In contrast, other findings from the study also indicate a distrust of the robustness of vocational level 3 qualifications, especially calling into question their usefulness in forming credible entry criteria for an academic programme of study. My HEI expects students enrolling through non-APEL routes to have a recognised (and accredited) 90-credit level 3 qualification. Flexibility exists where candidates opt to use a combination of work experience and academic qualifications. In this case, the academic assessor could make concessions if they feel they have significant healthcare practice or management experience to offset, for instance, a 60-credit level 3 diploma in health and social care qualification, among others.

As noted by Bekrahdnia (2013), the primary goal of subsequent governments in encouraging improving access and expanding involvement in higher education has always been to guarantee that the UK economy is supplied with the (e.g., vocational) skills and knowledge required to increase its ability to compete 'internationally' while retaining its standing as a high creativity and thriving country. More work is required to ensure certain groups, for example, older mature learners and people with family responsibilities, including childcare, are more catered for. The latter, it would appear, forms part of the UK Government's policy thinking in expanding the 30 hours of free childcare provision to parents doing more than 16 hours of work per week from 2025 (Gov.UK, 2023). This could be more imaginative and inclusive if it embraced education and training fully.

Another finding linked to access is the exorbitant cost of studying in higher, which leaves the average graduate saddled with much debt and negatively impacts social mobility. This is an important finding given the concern for value for money alluded to in the Higher Education Bill of 2017 (see Higher Education and Research Bill, 2017) and the proliferation of degree apprenticeships that offer a different funding model to access higher education.

Participants indicated that the COVID-19 study period and the flexible hybrid delivery method provided by HEIs was commendable in furthering student access to study despite a critical incidence which had significantly impacted the lives of students and

graduates in the UK and elsewhere. Despite the most immediate consequences of the COVID-19 pandemic, which include the forced closure of educational institutions and universities (Watermeyer et al., 2020), resulting in the cessation of learning, teaching, and assessment as well as the implementation of online contingency plans to continue education via a digital interface (Rapanta et al., 2020), the HEI and many other institutions adaptable and made a readily available flexible virtual delivery plan to fulfil the needs of learners. This was hugely positive, and participants appreciated the university's effort to support them during a critical period (see Abi Jumaa et al., 2023).

Participants' feedback outlines the pervasiveness of contract cheating in higher education and how universities could discourage students prone to using these services from doing so. A dissenting view was expressed by one of the employers, the only employer educated to a master's degree. The employer noted that despite the challenges faced with contract cheating, universities are well placed with their procedures and systems to deal with concerns about academic integrity – much more than vocationally oriented institutions are. Harper et al. (2019) stated that academic institutions and faculty are becoming increasingly dissatisfied with the scourge of contract cheating in higher education. A poll by eight universities in Australia showed that over 68% of academics presumed learners were turning in coursework and declaring acknowledgement for work they had not personally completed. For these academics, the most significant indicator of their concern with work product from students is the observed disparity relating to learners' academic abilities and language proficiency and the quality of work they produce (Bretag et al., 2018; Harper et al., 2019). Contract cheating is not always blatant. Although software used by HEIs, like Turnitin, helps with general cases of academic malpractice and, more recently, highlights the use of artificial intelligence (AI) software, higher education will continue to grapple with this for many years. This is especially the case as we continue to see the proliferation of AI software tools (like Chat GPT), which can write assignments for students. I sit in Voce Viva interviews for students suspected of plagiarising their assignments, and AI makes up many of these panels now. A cautionary statement to add, however, is that Turnitin's AI detection software also wrongly flags the use of popular proofreading tools like Grammarly. This is because Grammarly, like many

similar tools, has AI built into it (Shrivastava, 2023).

6.6.2 Sub-theme 2: Careers, Professionalism, Technology and Sustainability

Participants described higher education as a suitable medium for career progression for students and graduates. Hence, findings highlighted higher education as a stage with enormous potential to open new career paths for learners and graduates. Literature on the role of higher education in society would suggest universities have a third mission. This means universities should contribute to society by using their knowledge, expertise, capability, and resources to advance society's socio-economic needs (see Evers et al., 2020; Laredo, 2007). As highlighted in sub-theme 6.6.2, HEIs could collaborate more closely with employers to support graduate competency development and employability skills (Jackson, 2016). Jackson (2016) posits that this collaboration provides students access to professional communities that develop career readiness for thriving novices in their respective fields of study.

Findings indicated that imbuing professional values that make higher education students stand out in demonstrating professionalism linked to their anticipated area of expertise should start with prioritising faculty employment with the right professional profile and industry experience. Having these in place partly supports practice learning (see Nicolini, 2012) aimed at embedding practical workplace experience scenarios in the classroom (see Gibbons et al., 1994). Participants suggested this to partly mitigate challenges students and graduates might demonstrate in healthcare management programmes with no practicums. Jarvis (2021) noted how the cooperation involving learners, educators (with practitioner experience), and industry leverages excellent benefits for students and graduates. Using instructors with practitioner experience is nothing new in healthcare, with professions like nursing and social work using academics with practitioner experience to instruct students and manage programmes. The government has also recognised this benefit, with the Department for Education launching a five-million-pound plan in September 2020 to recruit specialists with different technical skills and competencies to pursue careers in institutions of higher learning (Gov.UK, 2018). Another way of embedding practitioner experience in higher education teaching is using industry professionals

as guest lecturers on programmes. However, Gentelli (2015) in their study associated its overuse in undergraduate programmes with negative learning experiences for students.

Findings are contradictory about the role massification plays in higher education on the graduate job market. For instance, participants contend that 'massifying' higher education could create a crowded and competitive job market for graduates. Given the crucially significant role healthcare managers play in the sector and with healthcare vacancies in the NHS and social care at an all-time high (see Bottery, 2022), this is undoubtedly a good thing. Nevertheless, this contests some of the findings in this study, which indicate that employers are struggling to recruit healthcare workers. A potential logical explanation is that the demand-supply ratio for healthcare is much different from that of other sectors, such as business. Another is that the competition may be more apparent in senior healthcare management roles than at practitioner levels.

The opportunities for more student enrolments (Gedye and Beaumont, 2018) because of massification, the competition it creates in the job market, and, in some cases, the devaluing of university degrees (Brown et al., 2008) have been well-documented in the available literature. Despite this, the NHS and social care sectors continue to experience acute staff shortages, which are widening (Bottery, 2022), especially post-COVID-19, and the shortages are beginning to affect patient care and service safety (Waitzman, 2022).

The sustainability of higher education was a concern expressed in the study. Findings indicate that higher education and its role in society would need reassessment. This is important given funding challenges, reductions in revenue post-COVID-19, and pressures (e.g., from the OfS) to deliver value for money for stakeholders while remaining competitive and innovative in an era of technological advancement. The financial challenge is mainly because of the weakening economy (in most countries – e.g., slow growth, reduction in student recruitment, the cost-of-living crisis brought on by the conflict in Ukraine and the general effects of lockdown following the COVID-19 pandemic). These have significantly impacted many higher education institutions in the UK, forcing them to reduce their budgets by cutting costs across different

departments (Velazquez et al., 2005; Watermeyer et al., 2021). The viability of the broader higher education sector's finances is raising concerns. With an anticipated £2500 shortage for home undergraduate students this academic year, university vice-chancellors and analysts are expressing unease that a significant rethinking of long-term finance for English institutions is required. This is necessary to avert a dire situation like the mid-1990s, which preceded the enactment of tuition charges (Foster et al., 2023). Although sustainability initially appeared to have been coined from a financial prudence tangent in the findings, it is an essential yet broad and complex concept. Rossi (2023), for instance, discussed it under the term ecological sustainability. Ecological sustainability implies that a significant responsibility associated with higher education is to advance education, which has a beneficial effect on individuals and the preservation of their natural environment around the globe (ibid.).

Rossi (2023, p.39) contends that: *“each...”* of the Sustainable Development Goals of the United Nations *“...is further broken down into more detailed targets...”* and *“...from the list it is clear that these are not goals simply linked to protecting nature”* alone. *“Apart from being one of the goals in its own right, education (no. 4) plays a key role if the other SDGs are to be achieved. Target 4.7 is of particular relevance for inclusive higher education.”* This posits that by 2030, students across the globe should *“...acquire the knowledge and skills needed to promote sustainable development, including, among others, through education for sustainable development and sustainable lifestyles, human rights, gender equality, promotion of a culture of peace and non-violence, global citizenship and appreciation of cultural diversity and culture's contribution to sustainable development.”* Therefore, understanding sustainability beyond technology and the locale of higher education institutions provides a more transparent framework for how global strategy would continue to shape HEIs in their stride for sustainability. Universities should evolve into entities that actively care about the entire planet and not just see themselves as knowledge-acquisition centres (Rossi, 2023, p.39).

In their study, Neuwirth et al. (2020) found that the COVID-19 pandemic has catapulted learners and educators into an entirely novel phase of technology

utilisation to support remote and interactive learning via virtual platforms. Evidence of this was observed in the swift transition many HEIs had undergone during the COVID-19 lockdown period (Di Gennaro et al., 2020). With participants reminiscing on this, the role of technology in shaping higher education was highlighted as particularly important to the future of higher education. This must be understood in the context that universities and educational institutions worldwide are under significant strain to evolve to become more competitive and efficient. In addition, they are responsive and connected to various external markets and are concerned with the requirements of learners and learning results (Whitchurch and Gordon, 2009). This implies that in planning for the university of the future, HEIs must heavily invest in technology that allows them to offer innovative ways to support learning – both in and outside the classroom. This could not be more pertinent to blended learning. Affirming this even before the advent of the pandemic, Atkins (2005) suggested that there were discussions and debates about what lies ahead for higher education, specifically considering the digital revolution that technology has brought and the growth of globally competitive, knowledge-intensive economies. The COVID-19 pandemic and the lockdown of HEIs globally have further accelerated and amplified this (Camilleri, 2021), with students feeling the most significant physical and emotional brunt of HEIs lack of preparedness (Abi Jumaa et al., 2023) and agility to embrace technology.

6.6.3 Sub-theme 3: Emphasis on Skills, Practice Experience and Confidence

The findings in the study highlighted the significance of relevant practice knowledge consideration in the higher education classroom to support graduate skill development. This was framed in a way that recognises the propensity of higher education to focus on knowledge acquisition and the need for it to move away from this. Knowledge acquisition is a procedure for obtaining, organising, and integrating knowledge gathered from multiple sources, primarily trained professionals, so that it might be used in a personal, educational or practical context (Wagner, 2003). There is an element of knowledge sharing that occurs between two parties: an expert and the seeker of the knowledge (Ravikumar et al., 2022). Historically, learning (in higher education) has had to grapple with the fact that knowledge acquisition does not always ensure the effective utilisation of the acquired knowledge (Everwijn et al.,

1993). Indeed, Whithead (1968) agreed with this view when they suggested that the most important goal of learning ought to be to train learners in how to use knowledge. While knowledge acquisition is undoubtedly crucial in learning, for healthcare management students and graduates, applying this in practice is especially important.

A systematic review by Shahmoradi et al. (2017) insinuated that it is essential for practitioners to apply (acquired) knowledge management and associated strategies within the health and care sector to efficiently deliver pertinent information (and interventions) at the appropriate moment to aid decision-making at the point of care delivery. Shahmoradi et al. (2017) argued that doing this has quality and service safety connotations for improving the service experience for care users in communities and hospitals.

Communication, assertiveness, general awareness of one's surroundings, and the use of common sense in decision-making are among the specific skill sets identified by the study's participants as necessary for learners and graduates to embody. Even so, Everwijn et al. (1993, p. 425) argued that discipline-specific knowledge and skills are insufficient to respond to "*discipline-transcending, new and unknown problems adequately*". Next to discipline-specific knowledge and skills, more general knowledge and skills are needed around communication, problem-solving, use of information, analysis, and decision-making. General knowledge and skills, however, offer no guarantee that somebody also has sufficient discipline-specific expertise.

Results from the study also showed that understanding healthcare policies and procedures was essential to supporting practice. Nevertheless, there was a cautionary note against their overuse as a de facto position for managers who project their lack of confidence and creativity to adaptably make decisions or solve problems for which they need to take responsibility and lead. The overreliance by higher education students and graduates on policy in a way that supplants the practice of wisdom, thinking on one's feet, or improvisation was what the findings expressed as problematic. The problem was not that higher education students and graduates could not use policy and procedures to guide their practice, but that sometimes they were unable to convert the theory knowledge from the classroom across to the workplace (see Gibbons et al., 1994; Nonaka, 1994; Nowotny et al., 2003). Again, as Gibbons

et al. (1994, p. 16) suggested, these managers must view the higher education space as temporary "*new sites of knowledge production,*" for which the goal is to apply the knowledge in the context of practice. Nowotny et al. (2003) rightfully noted the challenges with the 'transportation' of this knowledge by insinuating that the mass proliferation of HEI and organisations referred to as expert institutions, which ideally should serve a crucial role in advancing knowledge used to support the growth of skilled careers and technical expertise, have a pivotal role to play.

To address this concern, argued Everwijn et al. (1993, p. 427), the emphasis should be on promoting the progression of broad and "*discipline-independent*" abilities like problem-solving, evaluation, information utilisation, "*decision-making, valuing, and communication.*" The premise follows that general skills and knowledge have "*a high transfer value*" and could be applied to a wide range of non-specialised management circumstances. This notion broadly aligns with findings from Jackson (2016), which demonstrated that because there is usually very little difference across graduates (e.g., from higher education), an overarching and generic framework regarding skill transfer and associated remediation strategies for instructors and employers could be adopted as best practice. However, the drawback of generic "*knowledge and skills*" is that they tend to be ineffective when confronting "*function-specific*" concerns and challenges, such as managing complex care service delivery (Everwijn et al., 1993, p. 427).

Findings also indicated that employers in the healthcare sector have a lot to offer higher education students and graduates in terms of professional growth. For instance, they supported the coordination of student and graduate placements and observed performance practice competencies. There was an emphasis on a credible employer-university relationship that would catalyse the promotion of graduate-ready students. There is little research on the impact of collaboration between universities and industry on undergraduate education experiences (Gentelli, 2015), especially in non-clinical healthcare management programmes without practicums. However, feedback from participants suggested that this is important in supporting a positive graduate outcome for work in middle and strategic healthcare management roles. Employers have a stake in making sure recent university graduates have the

capability of operating efficiently in modern workplace contexts (Jackson, 2018). Etzkowitz and Leydesdorff (1997) and Scholz (2020) raised similar concerns when they pointed out the close association that should exist between higher education, society's needs, and governments. In line with this, findings would align with Santiago et al. (2008), who noted that the European Union's post-compulsory education sectors were under intense scrutiny to contribute to a knowledge economy that incorporates value to economic advancement and improves the competitiveness of the member nations in the global arena (including the UK before Brexit in 2016).

6.7 Implication of Study Findings

Implications of study findings are described as an undertaking that sheds light on the significance of research results and conclusions on key stakeholders such as practitioners, the academic community, policymakers, the general public and the world (Elsevier, nd).

6.7.1 Practice and Policy Implications

As I reflected on the findings of the study, it was interesting to observe that the employers,' graduates,' and students' knowledge, characteristics, skills, and employability expectations were complementary. To illustrate, employers have broad expectations, such as demonstrating professionalism, and a more comprehensive outlook on sector-specific ideals, such as showing dedication, knowledge, and an understanding of the policies and procedures underpinning healthcare management practice. On the other hand, students and graduates tended to focus more on specific knowledge and skills they expected to develop from the programme. To give an example, consider leadership, management, interpersonal skills, and the ability to apply their learning and themselves in the workplace. The soft and hard skills alluded to by employers, students, and graduates in the study would appear to align with (Baldauf and Luchinskaya, 2019; Pearson, 2022).

The findings appear to affirm that there is evidence of a positive transfer of knowledge and skills from the BA (Hons) Blended Learning Healthcare Management Programme

to the workplace, corroborating previous literature (e.g., Perkins and Salomon, 1999; Barnett and Ceci, 2002; Eraut and Hirsch, 2007). Even so, challenges with fully evidencing knowledge and skills transfer (i.e., due to the absence of practicums) from the programme to the workplace (in real life) were highlighted as a concern. This would broadly align with other literature (e.g., Taskin and Flore Bridoux, 2010; Robertson et al., 2019; Sadeghi, 2020). While the study was concerned with knowledge and skills transfer to practice and not necessarily transfer of learning in and of itself, my findings did not observe negative transfer or even zero transfer, which some studies have highlighted as an outcome of transfer (e.g., Healy and Wohldmann, 2012).

There was confusion in the literature about the semantics of knowledge and skills transfer and the varying and sometimes contradictory explanations of how to reconcile these—for example, knowledge transfer, knowledge translation, transfer of learning, implementation science, and knowledge-to-action (Graham et al., 2006; Khalil, 2016; MacRae and Skinner, 2011; Straus et al., 2009; Straus et al., 2013). The blurriness and lack of clarity in the literature may arguably contribute to the notion that positive knowledge and skills transfer (as demonstrated in my findings) is single-directional and linear in shape (e.g., from the blended classroom to the workplace). In line with Bullock et al. (2013), findings from my study also suggested a multi-directional and back-and-forth nature to the transfer between the (blended) learning classroom and the healthcare management workplace. Specific implications are discussed below.

6.7.1.1 Undergraduate Programme Alignment

While the programme of study, according to the findings, appears to be broadly aligned with the skills, knowledge, and graduate attributes required for healthcare management practice, healthcare management as a sector is highly dynamic. Also, because the skills and knowledge expectations are sometimes articulated differently across diverse healthcare management-related provisions (see Slipicevic and Masic, 2012; Stefl, 2008), there is a need for undergraduate programmes delivering similar programmes to proactively and regularly engage in reviews of programme content to ensure that there is no misalignment with the knowledge and skills employers expect

students and graduates to demonstrate in their line of work. This is likely to be transformative in ensuring that their study-to-work transition is seamless. Furthermore, closer collaboration with employers and professional bodies and having them provide constructive input into undergraduate programmes are crucial for healthcare management programmes, regardless of whether they offer practicums.

From a broad perspective, given the impetus on student and graduate employability and the significance of recruiting higher education lecturers with (healthcare) practitioner experience to teach learners, there is a need for organisations like Advance HE (formerly The Higher Education Academy) to review the flexibility of its UKPSF dimensions (i.e., Areas of activity [A1-A5], Professional values [V1-V4], and Core knowledge [K1-K6]) in supporting higher education practitioners with more sustained strengths in professional practice than academic experience. The dimensions, particularly the A1-A5, are heavily focused on demonstrating learning and teaching or scholarship (e.g., doctoral supervision), which may pose challenges for early-career academics with extensive practitioner backgrounds. Adapting the dimensions could better accommodate sustained strengths in professional practice and encourage more practitioner involvement in higher education.

6.7.1.2 Instructional Design Strategies

This sub-heading is an extension of 6.7.1.1, that is, '*Undergraduate programme alignment.*' Pedagogic approaches such as case studies, active learning, and problem-based learning, combined with simulations of the healthcare management setting, including challenges related to management, were identified as essential for encouraging practice (or experiential) learning. Therefore, encouraging practice learning (i.e., learning by doing) in undergraduate programmes of a similar nature would have a profound effect on providing a platform by which students and graduates could learn (experientially) through contextualising and integration across professional and academic contexts (Evans, 1999; Nicolini, 2012). Indeed, the undergraduate classroom settings where these pedagogic strategies are implemented could be imagined or conceptualised as places of Mode 2 knowledge

production for application (Gibbons et al., 1994) where communities of learners work together to perfect their healthcare management skills—that is, from beginners to expert practitioners (Benner, 1982).

6.7.1.3 Formal Employer-Higher Education Partnerships

Knowledge transfer through university-industry cooperation has received considerable interest in the last few years among researchers and managers of businesses (Robertson et al., 2019). Employer-higher education collaboration is an area that the study findings showed to be important in facilitating knowledge and skills transfer from the blended learning classroom to the healthcare management workplace. Undergraduate programmes would benefit from leveraging these relationships in ways that allow them to solicit employer feedback during programme conceptualisation, validation, and periodic subject reviews. Indeed, the relationship could be leveraged further to benefit UK society and the economy (see Etzkowitz and Leydesdorff, 1997; Scholz, 2020). Compagnucci and Spigarelli (2020) used the term ‘third mission’ to refer to the relationship between university and society, which is vital in supporting knowledge production and utilisation (Bortagaray, 2009).

This is particularly important as current vacancies in the UK’s health and social care sector are at an all-time high (Bottery, 2022). While the collaboration could take the form of more recognised approaches, such as professionals from the industry working with programmes as visiting lecturers, guest lecture work (Gentelli, 2015), and joint scholarly work, a more radical approach will be for undergraduate programmes and higher education career departments to articulate new relationships with employers that allow employers to recruit from higher education institutions directly. This will have buy-in, as it will reduce the cost of advertising for employers and provide a direct, steady stream of graduates from which to pick. Universities would also benefit from achieving better graduate outcomes.

Another area of collaboration that HEIs should examine is the deeper integration of practicum into academic faculty roles. This provides a view of academics and the academic role that legitimises lecturers’ responsibility for directly mobilising and

overseeing practicums. What this does is provide a continuum of knowledge and skill development monitoring and evidence that extends beyond the classroom and into the workplace setting. It also eliminates the over-reliance on placement officers, whose roles are more administrative and frequently disconnected from the work that academics do to facilitate knowledge and skill development. There must be an incentive for this, as well as time set aside in academic contracts to facilitate the shift.

6.7.1.4 Flexible and Robust Programme Entry Frameworks

The study underscored massification's significant impact on higher education since the Dearing Report of 1997 (see Dearing, 1998). The impact has been felt on undergraduate programmes like the BA (Hons) Blended Learning Healthcare Management Programme, with more than 85% of its students working in some capacity in health and social care during enrolment. This presents a transformative opportunity to support the existence of a dynamic community of practice in the classroom. Nonetheless, this has also presented challenges, primarily in terms of having students with the right motivations to study, and higher education providers sometimes need help finding the right balance in providing the precise academic and wrap-around support required to develop their confidence.

Given the challenges in recruiting students with the right motive and attitude, there is a need for higher education institutions to review current entry criteria to ensure they are flexible, robust, and immune to abuse. This is not to downplay that entry criteria exist within a complex play of factors juxtaposed with widening access to higher education. Wilkins and Burke (2013, p. 2) argued that an essential and complex consideration about the variation "*in cultural dispositions...*" behaviours, "*and motivations informing students' perceptions and valuations of higher education*" can be seen in a significant number of educational studies. For example, studies exploring "access, retention, institutional barriers, admissions, enrolment, pedagogy, and learning." However, I am not suggesting that entry criteria that consider personal and professional experience, like APEL, not be used, as this will go against the spirit of inclusive higher education, social mobility, and the knowledge economy (also see Bekrahdnia, 2013). I suggest that undergraduate programmes look at such

applications (APELs) in conjunction with other vocational and professional qualifications. According to Nikolou-Walker and Garnett (2004), the use of APELs was inspired by the belief that it is critical to widen higher education access to older and more mature learners, who were disproportionately underrepresented relative to younger learners. Costley et al. (2021) added their voice to higher education access by noting that 'Recognition of Prior Learning [RPL]', credit consideration, and transfer are of the utmost importance in supporting equality, diversity, and inclusion (EDI) in higher education.

6.8 Reflections and Chapter Summary

6.8.1 Personal Reflections on the Chapter

This chapter is by far the most challenging of all the other chapters. The difficulty experienced was with the amount of work required to make sense of the findings and to reconcile them with the broader literature. Once I overcame this and immersed myself in the discussion, it became even more noticeable what the study findings had been saying to me all along. The chapter has spurred me more than a few times to return to the NVivo analysis and the themes generated to unpack what they meant and if they had efficiently and comprehensively encompassed all participant feedback. Following this, some of the sub-themes were further condensed and renamed to fit more clearly with the main themes in the study. Significant reflexivity was required during this stage to guarantee that my insider knowledge enriched the findings.

What struck me when I started to expound on the findings from participant feedback was that, in fact, all the themes suddenly were coherent and 'comprehensively' logical. Until now, I had not seen the complete (and more extensive) picture or macro level of how the themes built on each other and communicated to me. To illustrate, theme one, 'Knowledge, characteristics, skills and employability expectations,' divided into employer and student, and graduate expectations, provided context to theme two, 'Strengths,' which participants associated with the programme and students and graduates. Again, the sub-themes informing the 'Strength,' put together with the knowledge, characteristics, skills and employability expectations, appear to uniquely place the programme to articulate if, indeed, knowledge and skills transfer

to healthcare management practice is possible and what mechanisms are present in the programme, if any, to support the process of transfer.

The two sub-themes making up theme four – ‘neutral and transfer difficulty to determine’ and ‘positive transfer’- are grounded in feedback that draws on themes one and two. The theme appears to bring to the fore and make explicit what it is within the programme that allows it to transfer knowledge and skills to practice (i.e., which is explicit). In addition, while being mindful of the wealth of experience my situatedness as an insider had contributed to the study, I sometimes had to take a step back to ensure I was interpreting the findings objectively. This is not to say that my case study design suddenly adopted a positivist approach – merely that I realised at a personal level that I needed to be fully reflexive to ensure my findings were leading discussions and not entirely the literature.

Findings were unequivocal about the transfer of knowledge and skills from the programme to the healthcare practice being possible and observable (also see Kober, 2015). For a healthcare management programme that does not offer practicums, the positive transfer of knowledge and skills observed occurs through a combination of the following mechanisms, which are neither in a continuum nor their performance formally recorded in a placement context:

- Mindful transfer, which occurs as students and graduates intentionally and carefully choose to engage with abstract theoretical healthcare management knowledge, context, and skills in the blended learning classroom – i.e., in their search for meaningful ties to their current professional practice and past experiences.
- Forward-reaching transfer in which the students and graduates engage in learning abstract healthcare management information and soft and hard skills in a way that helps prepare them to apply it somewhere else in their current or future practice.
- Backward-reaching transfer, in which the students and graduates exposed to a particular healthcare management situation or problem conceptualise it first before reflecting backwards and finding answers/solutions from similar

situations that had ensued in discussions in the classroom and care practice experience.

(Perkins and Salomon, 1999)

6.8.2 Chapter Summary

This chapter presents a detailed interpretation of the study findings. The six main themes and sub-themes were explored in depth and discussed in view of published literature and evidence. This chapter offered a holistic view of the context within which the findings are situated and how they intersect or differ from crucial evidence linked to knowledge and skills transfer. The implications of the study findings were finally explored, highlighting the potential contribution of the study to the body of evidence on knowledge and skills transfer. The next chapter, Conclusion, summarises the study's findings, allowing for broad and specific conclusions and recommendations.

Chapter 7: Conclusion

7.0 Introduction

Chapter 7 is the last, ending the doctoral thesis write-up. As a chapter, it brings all the different strands of the study together to draw broad and specific conclusions emerging from the findings and proffer recommendations for key stakeholders. The chapter also draws the reader's attention to the limitations encountered and how this could have impacted how the study was conducted.

7.1 Broad Conclusions and Contribution to Practice

The study demonstrated that students and graduates have expectations they conceive before enrolling on the programme. These expectations centred around developing knowledge and transferable skills like interpersonal, leadership and management capacities. Students and graduates associate the knowledge, attributes, and skills with helping them improve their practice, support knowledge and skills application and enhance their employability. The characteristics, knowledge, skills, and attributes employers have while complimentary to students and graduates were broadly specific to espoused practice knowledge and sector-anticipated skills and attributes such as policy understanding, dedication to service, academic writing, professionalism and passion.

The expectations students have partly derived from the perceived strengths of the programme. As noted above, this could not be said of employers whose views were linked more closely to what they thought were fundamental requirements for healthcare managers to succeed in the sector. The strengths of the programme, as articulated by students and graduates, are aligned with the knowledge, skills and graduate attributes written in the programme.

Findings showed that retaining graduates in healthcare management presents a challenge for the health and social care sector. Most students in the study worked in social care management, where to gain registered manager status, a level 5 NVQ qualification was required – something that could be considered a step-down and

unnecessary for a graduate who already has a level 6 management qualification. This raises a concern about the destination of these graduates and why this has not been redressed by the key stakeholders (e.g., Skills for Care, CQC) by offering a route to registered managership for graduates.

The study has crucially contributed to the debate and literature about knowledge and skills transfer from blended learning (undergraduate) healthcare programmes to practice. This is important as higher education programmes increasingly invest more in blended and online technologies to insulate them from disruptions – similar to those experienced during the COVID-19 pandemic.

Findings indicate knowledge and skills transfer was observed from the BA (Hons) Blended Learning Healthcare Management Programme. However, not all participants felt this was transparent and fully observable from the programme. All five out of the 28 participants who felt this way attributed it to the absence of practicums to affirm this fully. Further longitudinal research in similar settings (e.g., across multiple HEIs) is required to determine whether the outcome would have been different if all of the students and graduates recruited in the study were not in health and social care roles or if the programme included formal practicums.

7.2 Specific Conclusions

Specific conclusions describe how the study's findings attempted to answer primary research questions. In keeping with this, my initial goal was to address the following research questions:

- a) *How supportive is the BA (Hons) Blended Learning Healthcare Management Programme of knowledge and skills transfer to the healthcare management workplace?*
- b) *Is there clear evidence of knowledge and skill transfer to the healthcare management workplace and is the process transparent in the programme?*

7.2 a. How supportive is the BA (Hons) Blended Learning Healthcare Management Programme of knowledge and skill transfer to the healthcare management workplace?

All participants (mainly insiders) alluded to the programme's support in facilitating and transferring healthcare management theory and practice knowledge and skills. Findings showed that the breadth and scope of materials and skills and the diversity and flexibility of programme resources were essential supportive structures that form the groundwork for contextualising discussions that usher impactful learning and graduate skill development to the fore. These discussions adhere to a practice learning strategy that embeds experiential learning from students and graduates - who mainly worked in healthcare (including management) and instructors with noteworthy professional expertise. The blended learning classroom, through these interactions, becomes fertile ground for leveraging active learning techniques such as group work, presentations, critical reflection, debates, case studies and simulations of the healthcare management workplace to develop healthcare management knowledge, skills and attributes.

7.2 b. Is there clear evidence of knowledge and skill transfer to the healthcare management workplace and is the process transparent in the programme?

Participants generally agreed that there was affirmative evidence of an 'actual' transfer of knowledge and skills from the programme to healthcare management practice (i.e., 23 out of 28 agreed). The mechanism through which knowledge and skills transfer is supported is through the coverage of curriculum content and resources that usher in highly relevant knowledge, attributes, and skills to aid healthcare service planning and delivery. According to the findings, the curriculum makes it possible for students and graduates to learn in a blended learning classroom, which, although highly theoretical, is fully concurrent with what occurs in the workplace. Participant feedback indicated that within the programme, there was a close integration within and across modules—almost akin to a spiral curriculum with a scaffolded coverage across the different levels of study. By design, the learning setting enabled students with moderate to extensive work experience to collaborate

in a community of practice, assisting them in developing the necessary healthcare practice reflexivity and confidence to apply the theoretical information explored in the classroom.

Findings also implied that the lack of practicums somewhat obscures the transparency and evidence of the healthcare management programme's ability to demonstrate knowledge and skills transfer to the healthcare workplace fully. Five out of the 28 participants expressed this view. Also, all of the five participants who felt the evidence of clear transfer was not fully apparent or observable indicated that it was not a question of the knowledge, skills and capabilities being missing from the modules but that it was more apparent and noticeable in some than others and having these explicit in the modules cannot always equate to evidence of transfer. When I delved into this more, the unease raised was primarily concerned with the lack of placements and a credible strategy to monitor in the workplace if the students and graduates fully demonstrate evidence of transfer and to what level of competency they do.

Placement opportunities, unsurprisingly, were a prevalent issue for improvement. Other areas highlighted include:

- Supporting digital skills and professional development opportunities.
- Diversifying assessments (i.e., consider the programme assessment diet).
- Expanding programme resources and focus for both local and international students/graduates.

Barely two years after the COVID-19 pandemic, the higher education sector is still reeling from its impact. Findings provided a critical analysis of areas of consideration for the sector to prioritise in a drive to remain an essential stakeholder in supporting graduate outcomes, social mobility, and the knowledge economy. Despite concerns about academic integrity and contract cheating brought on by the proliferation of essay mills and gaps in academic study skills demonstrated by students enrolling on programmes with all the wrong motivations, findings indicated that higher education should remain genuinely inclusive while shoring up entry criteria from potential abuse. Professionalising higher education while remaining mindful of sustainability pressures

and opportunities provided by technological innovation is also required to shift the emphasis from a narrow skill set for healthcare managers to developing and consolidating practice experience and confidence.

7.3 Recommendations

Engaging in this study has given me perspectives of the programme (and HEI) and the higher education landscape that I had yet to anticipate as possible at the beginning of the project intention. As I conclude the study and make recommendations, the conclusion emerging from the findings and the suggestions in the form of recommendations will add to the body of literature that help inform current and future programme improvements in the school of health and care.

Recommendations are discussed below under two main subheadings – recommendations for the HEI and recommendations for the HE sector. The recommendations for the programme are equally relevant to the higher education landscape as the recommendations to the higher education sector are for the HEI.

7.3.1 Recommendations for the HEI

7.3.1.1 Experience-Based Learning Through Work Placements

The school and HEI should promote the incorporation of hands-on activities into the undergraduate blended learning healthcare programme. This should include the essential dimensions of job shadowing managers and formal practicums. Although this requires working out logistically, articulated contracts will be required with NHS trusts and social care organisations. The HEI could follow a similar approach to vocational and BTEC National Diplomas, in which students manage the 200 hours of placement outside of formal learning and teaching. The manager's job shadowing and practicums could result in a portfolio of evidence and reflective statements related to module formal assessment or a care certificate matched to sector-specific employability skills. The findings suggest that the students and graduates will immensely benefit from using the practicum settings to apply theory knowledge and experiment to solve practical situations and dilemmas associated with practice. This

will not only close the distance between abstract learning and practice but also ensure that it is possible to measure the effectiveness of the transfer between the classroom and practice.

Strong sector-linked partnerships will be crucial to this process. The HEI is well placed to use its career department to pursue such relationships with organisations like the NHS and social care employers to serve this purpose. In time, the relationship could expand and complement the school's industry or guest lecture initiative and open, collaborative research and project ventures that benefit employers, students, graduates and the UK economy.

7.3.1.2 Embedded Appraisal and Feedback Mechanism

In connection with establishing healthcare sector relationships, the curriculum should consider developing systems beyond the graduate outcome survey to assess the efficacy of knowledge and skill transfer to healthcare management careers. This could be done by periodically obtaining the views of organisations that graduates and learners work for (e.g., once a year) and those of learners and graduates themselves. Making this a mainstay of the programme will ensure the programme can more proactively embed emerging knowledge and skills employers deem necessary for the healthcare management job market and consolidate the possibilities and processes for the further augmentation of the programme structure and curriculum to support employability.

7.3.1.3 Professional Development Skills

Looking at the work the careers department of the HEI is doing to support employability and improve graduate outcomes, there is an opportunity and scope for the school to collaborate with them and other departments to develop bespoke professionally oriented training that could be serialised, differentiated and conducted for students across all levels of study. For this to be effective, it should focus on essential knowledge and skills in digital awareness, communication, teamwork, managing change, mental health, and prioritisation. This could be delivered under a

mantra of professional development to build work readiness and confidence for a sustained engagement with continuing professional development resources such as refreshers and professionally accredited and non-accredited skills training. To illustrate, resources offered by professional bodies, such as the Chartered Management Institute, could be used to support this initiative.

7.3.2 Recommendation for HE Sector

7.3.2.1 More Interdisciplinarity

The programme draws on the knowledge and skills from three subject benchmarks and disciplines - i.e., social work, business management and health studies, which form the framework for its embedment of interdisciplinary learning. Given this potential and the capacity of learners to weave together skills and knowledge spanning different fields, I recommend that undergraduate healthcare management programmes of a similar nature consider adopting an interdisciplinary or even transdisciplinary approach to their curriculums to support a more diverse and rich experience for HE learners. This is especially important as healthcare management often emphasises the use of multidisciplinary, which offers students and graduates a less-rounded understanding of the complexities of managing healthcare service delivery. Higher education institutions must still ensure that the interdisciplinary curriculums are dynamic, continually reviewed, and brought in line with core knowledge and graduate skills most appropriate to management roles in healthcare.

7.3.2.2 Career Mentors

The healthcare management environment is competitive and, in some cases, far removed from the theory knowledge (by itself alone) learnt in the classroom because of constraints and acute staffing challenges. Students and graduates, therefore, need a level of preparation to help them bridge the gap between the perfect "world of theory" and reality and prepare them for a career in management. There is also the element that studying in higher education does not directly guarantee that a student will quickly get into management. As a result, HEIs should work with the healthcare industry to create mentorship programmes linking undergraduates studying

healthcare management with seasoned experts in the area. These mentors could function as coaches to offer support, wisdom, and essential knowledge about the sector, assisting learners gradually in building the confidence and social capital to leap from university studies into healthcare leadership positions. Organisations like the Chartered Management Institute offer similar initiatives for their members.

7.3.2.3 Inquiry-Practice and Wider Stakeholder Partnerships

The findings indicate that technological innovation and sustainability are crucial for the higher education sector. These are critical in allowing the sector to become more robust in its development of future leaders. However, the COVID-19 pandemic exposed vulnerabilities with a lack of investment in technology to support agile methods such as blended learning and the universities' overreliance on international students to make them sustainable. As a result, the sector should collaborate closely with key stakeholders like employers, students, technology companies, and the government to develop channels for knowledge transfer collaborations through transdisciplinary research projects.

These collaborations usher in new ways of investigating the impact of various instructional strategies, approaches to learning, or adjustments needed for practical skill development in blended learning healthcare management programmes. Through these partnerships, it is possible to address wicked problems like long-term sustainability concerns - i.e., amid challenges with massification and providing high-value undergraduate degrees that support social mobility. The collaboration also offers opportunities for the curation of novel assessment approaches (in HE) linked to practice (e.g., simulations), insulated against academic malpractice and contract cheating technologies.

7.4 Study Limitations

Limitations are flaws in the design of my study, which influenced the findings and conclusions drawn out from my research. As a scholar, I owe it to my peers in the scientific community to convey the complete and genuine limits of my (insider)

research study (Ross and Bibler Zaidi, 2019).

The study limitations are that:

- a. The case study is limited to a single HEI with blended learning facilities in the UK and Berlin. Because of this, the scope of generalisability of my findings to all undergraduate blended learning healthcare management programmes or even higher education in the UK is limited.
- b. As a Deputy Head of School, I directly manage undergraduate programmes, creating a power dynamic between me and the students, graduates and academics in the study. This could affect the behaviour of the people being examined, leading to inaccurate portrayals of genuine perceptions and data integrity. Recognising the importance of power dynamics, I recruited two proxy data collectors from other schools in the HEI to conduct student and graduate focus group discussions and academic staff interviews. It took me longer to transcribe and make sense of the interview and focus group recording. There was also a missed opportunity to delve into specific subjects that came up during proxy focus groups and interviews.
- c. The study participant recruitment coincided with COVID-19 restrictions, which hampered my ability to recruit more healthcare employers for the study. Initially, I intended to recruit up to five employers. However, after months of following up on leads from students and graduates, only three employers agreed to be interviewed. Reflecting on my data collection phase now, recruiting more managers and participants from the university's career department (which was scaling up at the time) would have given the study a complete picture.
- d. Finally, beyond knowledge and skills transfer studies on transfer in clinical settings and undergraduate programmes that offer integrated work placements, the paucity of literature on knowledge and skills transfer from undergraduate blended learning healthcare management programmes suggested that there was a missed opportunity for a more holistic exploration of seminal literature linked to specific aspects of my findings.

7.5 Chapter Summary

This is the thesis's concluding chapter, and it draws it to a close. As a chapter, it pulls together broad and specific conclusions related to the findings of the programme's knowledge and skills transfer orientation and how apparent this is. Key areas from the study were evaluated and placed inside the study's frame of reference to help illuminate how the set research questions were answered. The findings were contextualised in light of the literature and recommendations for higher education institutions and the higher education sector. The study limitations and contribution to practice were also interrogated.

7.6 My Doctoral Journey – Reflections and Stock Taking

The project formally started with an iterative programme approval plan (PAP) presentation to a panel. Reflecting on the PAP, the advice provided around clarifying the scope within which my project was situated was immensely useful in shaping my understanding of doctoral research and why robust terms of reference were required.

Starting the programme in 2019, no one would have imagined that a COVID-19 pandemic would have come along and caused a global lockdown and havoc that affected all my plans. The effects of it have been far-reaching. Even as I applied for ethics, in hindsight, I had not fully appreciated the impact this would have had on my study and data collection protocol. Nevertheless, it became a blessing in disguise in some ways, as changing my interview protocol from face-to-face to exclusively Zoom made it possible to recruit more academic staff, students, graduates, and employers across the different regions of England. This diversity of participants has added to my study's depth.

Having implemented the study protocol and collected the data, I had never imagined how immersive and fulfilling the data analysis process would have been. This process illuminated my understanding of my research questions and the liminality within which my project intention operated. Until a few years ago, I had only read about NVivo. Using NVivo presented its challenges. First, I needed to learn to import different data sets and then code them consistently to derive a coherent thematic framework. With

trial and error and further research, I could code the data and add relevant data characteristics using case classifications. What I learned about myself at this stage was the need to be patient and resilient in the face of adversity. Later, I came to appreciate this critical leadership quality when I realised some codes were duplicated during my Chapter 5 write-up. Tidying up the duplicates using coding stripes meant that the number of themes changed several times as I analysed the data.

The study demonstrated that the two research questions were addressed through its findings. Using a breadth of participants associated with the programme (i.e., 28 participants) meant that the findings provided fascinating insights from the different stakeholders, which the HEI should be able to derive plausible learning. Framing one of the questions around suggestions about the higher education sector would indicate that similar undergraduate programmes should be able to derive benefit from the findings.

The journey has been challenging, and there were times when it felt like there was no light at the end of the tunnel. There were also moments when I enjoyed the writing and almost felt a sense of accomplishment, even with the ambivalence, the self-questioning, and the anxiety that I would not complete the write-up in time for my submission deadline. However, what was never doubted was how undertaking the Doctorate in Professional Studies (Health) had enriched the lens through which I view leadership, change, and enhancements in healthcare and higher education. This essential scholarly lens will benefit my practice as I lead undergraduate programmes and increasingly pivot towards facilitating senior (NHS) leader apprenticeship (SLA) programmes.

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Appendices

Appendix 1: Middlesex University REC Approval



Health and Social Care REC

The Burroughs
Hendon
London NW4 4BT

Main Switchboard: 0208 411 5000

06/09/2021

APPLICATION NUMBER: 17825

Dear Saikou Sanyang and all collaborators/co-investigators

Re your application title: Knowledge/skills transfer and application to healthcare

Supervisor: Catherine Kerr, Gordon Weller

Co-investigators/collaborators:

Thank you for submitting your application. I can confirm that your application has been given APPROVAL from the date of this letter by the Health and Social Care REC.

The following documents have been reviewed and approved as part of this research ethics application:

| Document Type | File Name | Date | Version |
|---|--|------------|---------|
| In-Person Face to Face Research Template | In Person Face-to-Face Research Template_Saikou Sanyangfinal | 05/04/2021 | |
| Informed Consent Form | Participant Information Sheet employer v2 30.04.21 | 30/04/2021 | 2 |
| Informed Consent Form | Participant Information Sheet student & staff v2 30.04.21 | 30/04/2021 | 2 |
| Aims, objectives and hypotheses | Project Outline Template_Saikou Sanyang.edited | 03/05/2021 | 1 |
| Methods and data | Research Procedure Template_Saikou_v2 03.05 | 03/05/2021 | 1 |
| Data Protection Declaration | Data Protection Checklist and Declaration Form v1 03.05.21 | 03/05/2021 | 1 |
| Further details | Project budget plan | 04/05/2021 | 1 |
| Further details | Conflict of Interest Form .edited | 04/05/2021 | 1 |
| Agreement for data collection by proxy | Research-collaboration-agreement with proxy .edited | 16/05/2021 | 2 |
| Training information for data collection by proxy | Fieldwork Code of Conduct for PI and Proxy | 16/05/2021 | 2 |
| Permission/Agreement Letter | Combined_Research_Proposal_and_Ethics_Form_v4_final version.edited | 16/05/2021 | v2 |
| Permission/Agreement Letter | Consent Form_Saikou v1 16.05.21 | 16/05/2021 | 1 |
| Debriefing Sheet | Participant_debrief_sheet_Saikou v1 16.05.21 | 16/05/2021 | 1 |
| Participant Recruitment Information | Participant invitation letter v2 16.05.21 | 16/05/2021 | 2 |
| Materials | Focus Group Discussion.v2 16.05.21 | 16/05/2021 | 2 |
| Materials | Semi-structured interview for employers_v2 16.05.21 | 16/05/2021 | 2 |
| Materials | Semi-structured interview for academics_v2 16.05.21 | 16/05/2021 | 2 |
| Resubmission Response to Feedback Summary | Resubmission Feedback Summary_final | 10/07/2021 | 1 |

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|---|--|------------|---|
| Revised documents as part of resubmission | Project Outline Template_Saikou Sanyang.edited | 13/07/2021 | 2 |
| Revised documents as part of resubmission | Participant invitation letter v2 16.05.21 | 13/07/2021 | 2 |
| Revised documents as part of resubmission | In Person Face-to-Face Research Template_Saikou Sanyangfinal | 13/07/2021 | 2 |
| Revised documents as part of resubmission | Focus Group Discussion.v2 16.05.21 | 13/07/2021 | 2 |
| Revised documents as part of resubmission | Research Procedure Template_Saikou_v2 03.05 | 14/07/2021 | 2 |
| Revised documents as part of resubmission | Gatekeeper Letter Saikou Sanyang_SS3743 | 14/07/2021 | 1 |
| Revised documents as part of resubmission | Semi-structured interview for academics_v2 16.05.21 | 14/07/2021 | 2 |
| Revised documents as part of resubmission | Participant Information Sheet employer v3 15.07.21.edited | 15/07/2021 | 3 |
| Revised documents as part of resubmission | Participant Information Sheet student & staff v3 15.07.21.edited | 15/07/2021 | 3 |

Although your application has been approved, the reviewers of your application may have made some useful comments on your application. Please look at your online application again to check whether the reviewers have added any comments for you to look at.

Also, please note the following:

1. Please ensure that you contact your supervisor/research ethics committee (REC) if any changes are made to the research project which could affect your ethics approval. There is an Amendment sub-form on MORE that can be completed and submitted to your REC for further review.
2. You must notify your supervisor/REC if there is a breach in data protection management or any issues that arise that may lead to a health and safety concern or conflict of interests.
3. If you require more time to complete your research, i.e., beyond the date specified in your application, please complete the Extension sub-form on MORE and submit it your REC for review.
4. Please quote the application number in any correspondence.
5. It is important that you retain this document as evidence of research ethics approval, as it may be required for submission to external bodies (e.g., NHS, grant awarding bodies) or as part of your research report, dissemination (e.g., journal articles) and data management plan.
6. Also, please forward any other information that would be helpful in enhancing our application form and procedures - please contact MOREsupport@mdx.ac.uk to provide feedback.

Good luck with your research.

Yours sincerely

Assistant Chair: Ruth Miller

Health and Social Care REC

Appendix 2: HEI Gate Keeper Letter (also Confirming REC Approval)

School of Healthcare Management

[Redacted]

[Redacted]

[Redacted]

14th July 2021


To whom it may concern

I am writing to confirm that Saikou Sanyang (SS3743) has permission from [Redacted] to conduct data collection for the purposes of his PhD study '*A practice learning experience from a UK Higher Education Institution's (HEIs) BA (Hons) Healthcare Management Programme: how supportive is the programme of knowledge and skills application transferable to the healthcare (management) workplace?*'.

He may collect data from current students, alumni and academic staff, in line with the ethics approval granted by the Research and Ethics Committee, [Redacted].


If any further information is required, please do not hesitate to contact me.

Yours faithfully






[Redacted]
Head of School of Healthcare Management
Faculty of Business
[Redacted]


Appendix 3: Participant Invitation Letter

| | |
|---|---|
|  <p style="text-align: center;">Invitation to participate in a study about your experience of the BA (Hons) Healthcare Management Programme and how supportive it is of knowledge and skills application transferable to the healthcare management <u>workplace</u></p> <p>Version 2, 16.05.21</p> <p>Dear (insert participant group),</p> <p>I am an academic and Deputy Head of School/Principal Lecturer School of Healthcare Management at [redacted]. The School, which sits in the [redacted], has a BA (Hons) Blended Learning Healthcare Management Programme. I am particularly interested in how supportive this part of the programme is in knowledge and skills application transference to healthcare management practice – that is, for both students enrolled on the programme and graduates/alumni.</p> <p>My study aims to investigate the learning experiences of students enrolled on the programme and this will be achieved through focus group discussions with alumni (who completed their studies with us between 2017 and 2021) and current students, semi-structured interviews with healthcare academics and employers as well as existing secondary literature. As well as this, the study also explores how well placed the programme is in supporting knowledge and skills application transferrable to healthcare management practice in the UK.</p> <p>I hope to use the information from the study to make suggestions about potential improvements required for the programme - especially with student achievement, graduate outcomes, learning and teaching strategy and the overall student experience. I am inviting you to join the study as you belong to one of the following participant groups: current students/alumni, healthcare academics in the School of Healthcare Management and employers working with current students and graduates.</p> <p>As a student/alumni or healthcare academic, if you agree to take part in the study, you will receive a full Participant Informed Consent Sheet explaining the study intention, potential benefits and risks, your rights, how we will collate data, process and analyse it in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. Data collection in the study for students and alumni and academics will be through Zoom focus group meetings and Zoom and face-to-face semi-structured interviews; respectively with a proxy data collector. Each focus group will comprise 6-8 students and alumni and will take approximately 1 hour or 1 hour 30 minutes at most. The proxy data collector will be moderating this alongside conducting the individual one-to-one academic semi-structured interviews on behalf of the principal investigator (Saikou Sanayang). Again, the academic interviews will take approximately 1 hour to complete. Part of the reason for using a proxy data collector is to ensure the relative power dynamics between the principal investigator and students and academics does not impact the data integrity of the study.</p> <p>As an employer, if you agree to take part in the study, you will also receive a full Participant Informed Consent Sheet explaining the study intention, potential benefits and risks, your rights, how we will</p> | <p>collate data, process and analyse it in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. The researcher will schedule a Zoom interview to explore with you some themes relevant to the research aim. The interview will usually last anything between 30 minutes to an hour.</p> <p>After the data collection is complete, we will like to keep in touch with you and if needed follow up with you to clarify some of the information shared during focus group discussions and semi-structured interviews; respectively. In the meantime, if you have any questions, please do not hesitate to get in touch with me at: SS3743@live.mdx.ac.uk</p> <p>Many thanks for your support.</p> <p>Yours sincerely</p> <p>Saikou Sanayang DProf Student Health Studies/Principal Investigator Middlesex University The Burroughs Hendon, London Email: SS3743@live.mdx.ac.uk</p> <p>Advisors/Supervisors:</p> <p>Dr Gordon Weller Middlesex University, The Burroughs, Hendon, London. NW4 4BT Tel: 02084114509 Email: G.Weller@mdx.ac.uk</p> <p>Dr Catherine Kerr Middlesex University, The Burroughs, Hendon, London. NW4 4BT Tel: 0208 411 4595 Email: C.kerr@mdx.ac.uk</p> |
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Appendix 4: Proxy Data Collaboration Contract/Agreement

| <div style="text-align: right; margin-bottom: 10px;">  </div> <p style="text-align: center;">Research Collaboration Agreement with Proxy</p> <p>Project Name: 'A practice learning experience from a UK Higher Education Institution's (HEIs) BA (Hons) Healthcare Management Programme. How supportive is the programme of knowledge and skills application transferable to the healthcare workplace?'</p> <p>Start date of contract: 30th June 2021</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>This project collaboration detailed, herewith in this document, is based on the action research looking at the learning experiences of students enrolled on a UK Higher Education Institution's (HEIs) BA (Hons) Blended Learning Healthcare Management Programme.</p> </div> <p>Conducted by Mr Saikou Sanyang (Principal Investigator), a doctoral student at Middlesex University, the document articulates an agreement between the principal investigator and Dr Dominic Appiah, an academic and module leader in the School of Leadership and Management at Arden University. The agreement is that Dr Appiah will act as a proxy data collector supporting data collection during focus group discussions with students/alumni and semi-structured interviews with healthcare academics teaching on the BA (Hons) Healthcare Management Programme. The role is purely voluntary but there is an acknowledgement that compensation in kind will be considered at the successful completion of the collaboration.</p> <p style="text-align: center;">Particulars of the agreement</p> <p>This is to confirm that both collaborators (referred to above) agree that the following provisions are incorporated into the contract document. The agreement is only valid once signed and dated by both parties. The collaborators also agree that the terms of this agreement prevail over the terms of any other document relating to and a part of the contract in which this attachment is incorporated.</p> <p>Rights and responsibilities of Principal Investigator</p> <ol style="list-style-type: none"> a) Necessary equipment to facilitate data collection (e.g. recording device, Dictaphone or an appropriate recording device) is made available to the proxy. b) Appropriate training and support is provided to the proxy before data collection. c) Appropriate risk assessment is carried out and the information shared with the proxy and other stakeholders where face-to-face contact is required to collect data. <p style="font-size: small; margin-top: 20px;">Research Collaboration Agreement for a proxy data collector Version: 03 May 2021 Page 1 of 3</p> | <div style="text-align: right; margin-bottom: 10px;">  </div> <ol style="list-style-type: none"> d) Monitor the data collection protocol and provide further guidance for the proxy where further clarification/information is needed from participants. e) Responsible for (and with Middlesex University), owns all intellectual property to do with the data collected in the study. f) There is a process in place to acknowledge and reimburse any agreed cost incurred by the proxy during the data collection. <p>Rights and Responsibilities of the Proxy Data Collector</p> <ol style="list-style-type: none"> a) Collect data in line with study protocols provided by the principal investigator and his advisors – Dr. Gordon Weller and Dr. Catherine Kerr b) Where they have direct access to personally identifiable data/information, ensure this is used/processed in line with GDPR (2016) and DPA 2016. c) Look after any equipment used as part of the research and return this or appropriately dispose of in line with project protocols. d) Be entitled to reasonable reimbursements where direct project-related cost has been incurred. e) Be fully acknowledged in the study as a facilitator for parts of the data analysed for publication. f) Conduct further follow-up, if needed, to clarify information provided by participants. <p>Terms and conditions</p> <ol style="list-style-type: none"> 1.1 This 'Agreement' commences on the date specified on the first page of this 'Agreement'. 1.2 Either Party may terminate the 'Agreement' by giving 28 days prior written notice to the other. 1.3 Each Party is liable for its acts and omissions in relation to the conduct of the Project. <p>Details and signatures of the Parties</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 50%;">Principal Investigator</th> <th style="width: 50%;">Proxy</th> </tr> </thead> <tbody> <tr> <td style="font-size: x-small;">Name: Saikou Sanyang Role: D/Prof Student Health Studies Middlesex University The Burroughs Hendon, London Email: SS3743@live.mdx.ac.uk</td> <td style="font-size: x-small;">Name: Dr [REDACTED] Role: Business Lecturer/ Proxy data collector [REDACTED] [REDACTED] London [REDACTED] Email: [REDACTED]</td> </tr> <tr> <td style="font-size: x-small;">Signature: _____ Date: _____</td> <td style="font-size: x-small;">Signature: _____ Date: _____</td> </tr> </tbody> </table> <p style="font-size: x-small; margin-top: 10px;">Research Collaboration Agreement for a proxy data collector Version: 03 May 2021 Page 2 of 3</p> | Principal Investigator | Proxy | Name: Saikou Sanyang Role: D/Prof Student Health Studies Middlesex University The Burroughs Hendon, London Email: SS3743@live.mdx.ac.uk | Name: Dr [REDACTED] Role: Business Lecturer/ Proxy data collector [REDACTED] [REDACTED] London [REDACTED] Email: [REDACTED] | Signature: _____ Date: _____ | Signature: _____ Date: _____ | <div style="text-align: right; margin-bottom: 10px;">  </div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Advisors/Supervisors: Dr Gordon Weller Middlesex University, The Burroughs, Hendon, London. NW4 4BT Tel: 02084114509 Email: G.Weller@mdx.ac.uk</p> </div> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Dr Catherine Kerr Middlesex University, The Burroughs, Hendon, London. NW4 4BT Tel: 0208 411 4506 Email: C.kerr@mdx.ac.uk</p> </div> <p style="font-size: x-small; margin-top: 20px;">Research Collaboration Agreement for a proxy data collector Version: 03 May 2021 Page 3 of 3</p> |
|--|---|------------------------|-------|--|---|------------------------------|------------------------------|---|
| Principal Investigator | Proxy | | | | | | | |
| Name: Saikou Sanyang Role: D/Prof Student Health Studies Middlesex University The Burroughs Hendon, London Email: SS3743@live.mdx.ac.uk | Name: Dr [REDACTED] Role: Business Lecturer/ Proxy data collector [REDACTED] [REDACTED] London [REDACTED] Email: [REDACTED] | | | | | | | |
| Signature: _____ Date: _____ | Signature: _____ Date: _____ | | | | | | | |


Appendix 5: Focus Group Questions – Students and Graduates

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| <p style="text-align: right;">  </p> <p>Version 2, 16.05.21</p> <h3 style="text-align: center;">Student Focus Group</h3> <p>Introductory statement:</p> <p>Thank you for participating in this focus group discussion. I have invited you to the focus group to provide feedback about your experience of the BA (Hons) Healthcare Management Programme- specifically how well placed it is in supporting the type of practice learning which helps encourage knowledge and skills application transferable to the healthcare (management) workplace. Please feel free to express your honest opinion. This is a safe space for you to provide us with valuable feedback to help inform the conclusions the research arrives at and for potential recommendations about further enhancements to the programme. During the discussion, you are also welcome to build on each other's thoughts and ideas.</p> <p>My role in this interaction is that of a researcher interested in finding out what your experience of the programme is and how situated it is in its learning, teaching and assessment to support knowledge and skills application transferable to the healthcare management workplace. In this vein, any information shared will be kept anonymous and your confidentiality will be maintained at all times.</p> <p>To make sure all concerns to do with a potential conflict of interest and power dynamics between the principal investigator and students/alumni, a proxy data collector (who will be an academic working in a different school) will be recruited to conduct focus group discussions with students.</p> <p>Information provided in the focus group discussions will be recorded for transcription later. This will potentially inform the analysis and the conclusions arrived at with regards to potential improvements for the programme. If you have any concerns about this, please let me know before participating in the focus group discussion. Please sign the consent form.</p> <p style="text-align: right;">1</p> | <h3 style="text-align: center;">Section 1: Demographic questions</h3> <p>What is your gender?</p> <p>a) Male <input type="checkbox"/></p> <p>b) Female <input type="checkbox"/></p> <p>c) Prefer not to say <input type="checkbox"/></p> <p>What is your age in years?</p> <p>a) 18-25 <input type="checkbox"/></p> <p>b) 26-33 <input type="checkbox"/></p> <p>c) 34-41 <input type="checkbox"/></p> <p>d) 42-49 <input type="checkbox"/></p> <p>e) 50 and above <input type="checkbox"/></p> <p>Before enrolling on the BA (Hons) Healthcare Programme, what was the highest qualification you have?</p> <p>a) No formal qualification <input type="checkbox"/></p> <p>b) GCSE or NARIC equivalent <input type="checkbox"/></p> <p>c) NVQ 2/3 <input type="checkbox"/></p> <p>d) NVQ 4/5 <input type="checkbox"/></p> <p>e) BTEC Level 3 Extended Diploma <input type="checkbox"/></p> <p>f) Level 3 Access to Nursing/Healthcare <input type="checkbox"/></p> <p>g) BTEC Level 4 Higher National Certificate <input type="checkbox"/></p> <p>h) BTEC Level 5 Higher National Diploma <input type="checkbox"/></p> <p>i) Other, please specify: _____</p> <p>Which of the following categories best describe your ethnicity?</p> <p>a) Black African <input type="checkbox"/></p> <p>b) Black Caribbean <input type="checkbox"/></p> <p>c) White <input type="checkbox"/></p> <p>d) Mixed race <input type="checkbox"/></p> <p>e) Asian <input type="checkbox"/></p> <p>f) Black British <input type="checkbox"/></p> <p>Other, please specify: _____</p> <p>Before enrolling on the programme, how long have you studied in Higher Education?</p> <p>a) Less than 1 year <input type="checkbox"/></p> <p>b) 1-3 years <input type="checkbox"/></p> <p>c) 4-6 years <input type="checkbox"/></p> <p>d) 7-9 years <input type="checkbox"/></p> <p>e) More than 10 years <input type="checkbox"/></p> <p>How long have you been working in health and/or social care (including management)?</p> <p>a) Less than 1 year <input type="checkbox"/></p> <p>b) 1-3 years <input type="checkbox"/></p> <p>c) 4-6 years <input type="checkbox"/></p> <p>d) 7-9 years <input type="checkbox"/></p> <p>e) More than 10 years <input type="checkbox"/></p> <p style="text-align: right;">2</p> | <h3 style="text-align: center;">Section 2: focus group questions</h3> <p>When you chose the BA (Hons) Healthcare Programme, describe what knowledge and skills you were expecting to gain from the programme.</p> <p>How did you hope the programme would prepare you for future employment in healthcare management?</p> <p>How did you feel the programme integrates knowledge from one module to the other to help you understand healthcare management practice better?</p> <p>How did you feel the modules of the programme and the programme as a whole make apparent the link between the knowledge and skills covered and the employability skills you need as a healthcare manager?</p> <p>What additional skills or knowledge do you need to develop that are not being targeted in the programme?</p> <p>Drawing on your experience of the programme so far, describe how the learning in the blended learning classroom supports knowledge transfer to the healthcare workplace.</p> <p>Drawing on your experience of the programme so far, describe how the learning in the blended learning classroom supports skills and competency application in the healthcare workplace.</p> <p>Is there anything else you would like to tell the BA (Hons) Healthcare Programme management team about how they could further enhance the programme to support knowledge and skills transfer to the healthcare management workplace?</p> <p>Is there anything else that you wanted to comment on regarding Higher Education study?</p> <h3 style="text-align: center;">Additional questions for Alumni (Graduates)</h3> <p>What aspects of the BA (Hons) Healthcare Management learning experience benefit you in your work the most?</p> <p>What knowledge and skills have you learned in the first year in your position that you could have learned on the programme but did not?</p> <p>Have you received any feedback from line managers about how your contribution before studying the programme compares to after completion of the programme?</p> <p>You have reached the end of the focus group discussion. Thank you for taking part in the study. Please refer to the Participant Informed Consent letter for further information about contacting the researcher, requesting more information or timelines around withdrawing your consent.</p> <p style="text-align: right;">3</p> |
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Appendix 6: Semi-structured Interview Pilot Instrument Questions– Academics

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| <div style="text-align: right;">  </div> <p>Versus 2, 14.05.21</p> <h3 style="text-align: center;">Semi-structure interview questions (academics)</h3> <div style="border: 1px solid black; padding: 5px;"> <p>Introductory statement:</p> <p>Thank you for participating in this semi-structured interview. The interview will aim to explore with you your experience of the BA (Hons) Healthcare Management, specifically how well placed it is in supporting the type of practice learning which helps encourage knowledge and skills application transferable to the healthcare management workplace. Please feel free to express your honest opinion. This is a safe space for you to provide valuable feedback to help inform the conclusions the research arrives at and for potential recommendations about further enhancements that could be made to support knowledge and skills transfer from the programme to the healthcare management workplace.</p> <p>My role in this interaction is that of a researcher interested in finding out what your experience of the programme is and how situated it is in its learning, teaching and assessment to support knowledge and skills application transferable to the healthcare management workplace. In this vein, any information shared will be kept anonymous and your confidentiality will be maintained at all times. This will be through the use of codes for participants and the removal of all personally identifiable information from the transcribed data before analysis.</p> <p>To make sure all concerns to do with a potential conflict of interest and power dynamics between the principal investigator and academics in the study, a proxy data collector (who will be an academic working in a different school) will be recruited to conduct the semi-structured interviews with academics.</p> <p>Information provided in this interview will be recorded for transcription later. This will potentially inform the analysis and the conclusions arrived at, with regards to potential improvements for the programme. If you have any concerns about this, please let us know before we start. Also, participation in the study is purely voluntary. Please sign the consent form.</p> <p>Is there any question you wish to ask or point to make before the interview commences?</p> </div> <p style="text-align: right;">1</p> | <h3 style="text-align: center;">Section 1: Demographic questions</h3> <ul style="list-style-type: none"> • What is your gender? <ul style="list-style-type: none"> a) Male <input type="checkbox"/> b) Female <input type="checkbox"/> c) Prefer not to say <input type="checkbox"/> • What is your age in years? <ul style="list-style-type: none"> a) 20-26 <input type="checkbox"/> b) 27-33 <input type="checkbox"/> c) 34-40 <input type="checkbox"/> d) 41-47 <input type="checkbox"/> e) 48-54 <input type="checkbox"/> f) 55 and above <input type="checkbox"/> • How long have you been a university lecturer? <input style="width: 100px;" type="text"/> • How long have you been a lecturer/academic on the BA (Hons) Healthcare Management? <input style="width: 100px;" type="text"/> • Do you currently lead any of the BA (Hons) Healthcare Management modules? <input style="width: 100px;" type="text"/> • If your answer to the previous question is yes, how many modules do you currently lead? <input style="width: 100px;" type="text"/> • Which of the following statements best describes your experience as an academic? For example, are you... <ul style="list-style-type: none"> a) A practitioner-academic actively working in a recognised professional role <input type="checkbox"/> b) A practitioner-academic who has not worked in a recognised professional capacity for over 2 years <input type="checkbox"/> c) A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice <input type="checkbox"/> d) An academic neither actively participating in academic scholarly activity nor working in a recognised professional capacity <input type="checkbox"/> <p style="text-align: right;">2</p> | <h3 style="text-align: center;">Section 2: Semi-structured interview questions (for academics)</h3> <ul style="list-style-type: none"> • Could you explain how long you have been teaching on the BA (Hons) Blended Learning Healthcare Management Programme? • Could you describe what you feel the key strengths of the BA (Hons) Healthcare Management Programme are? • How do you think the programme strengths fit with the career opportunities we are preparing students for in healthcare management practice? • How do you feel the modules of the programme and the programme as a whole make apparent the link between the knowledge and skills covered and the competency requirement of a healthcare manager? • Do you think there are skills or knowledge that students need to develop that are not being targeted in the BA (Hons) Healthcare Programme? • Drawing on your experience of the programme, describe how the learning in the blended learning classroom supports knowledge transfer to the healthcare workplace. • Drawing on your experience of the programme, describe how the learning in the blended learning classroom supports skills and competency application transferable to the healthcare (management) workplace. • What do you feel the key improvements are to the BA (Hons) Healthcare Management Programme and why? • Is there anything else you would like to tell the BA (Hons) Healthcare Programme manager/s about how the programme could be developed further to support knowledge and skills application transferable to the healthcare management workplace? • Any other comments about Higher Education in general? <p>This is the end of the interview. Thank you for taking part in the study. Please refer to the Participant Informed Consent letter for further information about contacting the researcher, requesting more information or timelines around withdrawing your consent.</p> <p style="text-align: right;">3</p> |
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Appendix 7: Semi-structured Interview Questions - Academics (final version)

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| <p style="text-align: right;">  </p> <p>Venues 3, 01.12.21</p> <p style="text-align: center;">Semi-structured interview (academics)</p> <div style="border: 1px solid black; padding: 5px;"> <p>Introductory statement:</p> <p>Thank you for participating in this semi-structured interview. The interview will aim to explore with you your experience of the BA (Hons) Healthcare Management, specifically how well placed it is in supporting the type of practice learning which helps encourage knowledge and skills application transferable to the healthcare management workplace. Please feel free to express your honest opinion. This is a safe space for you to provide valuable feedback to help inform the conclusions the research arrives at and for potential recommendations about further enhancements that could be made to support knowledge and skills transfer from the programme to the healthcare management workplace.</p> <p>My role in this interaction is that of a researcher interested in finding out what your experience of the programme is and how situated it is in its learning, teaching and assessment to support knowledge and skills application transferable to the healthcare management workplace. In this vein, any information shared will be kept anonymous and your confidentiality will be maintained at all times. This will be through the use of codes for participants and the removal of all personally identifiable information from the transcribed data before analysis.</p> <p>Information provided in this interview will be recorded for transcription later. This will potentially inform the analysis and the conclusions arrived at, with regards to potential improvements for the programme. If you have any concerns about this, please let me know before we start. Also, participation in the study is purely voluntary. Please sign the consent form.</p> <p>Is there any question you wish to ask or point to make before the interview commences?</p> </div> <p style="text-align: center;"> </p> <p style="text-align: right;">1</p> | <p style="text-align: center;">Section 1: Demographic questions</p> <ol style="list-style-type: none"> How long have you been a university lecturer? <ol style="list-style-type: none"> Under 1 year 1-2 years 3-4 years 5-6 years Over 7 years What is your age in years? <ol style="list-style-type: none"> 20-26 [] 27-33 [] 34-40 [] 41-47 [] 48-54 [] 55 and above [] What is your gender? <ol style="list-style-type: none"> Male [] Female [] Prefer not to say [] How long have you been a lecturer on Arden's BA (Hons) Healthcare Programme? <input style="width: 100%;" type="text"/> Are you a BA (Hons) Healthcare Management module leader? <input style="width: 100%;" type="text"/> If your answer to question 5 is yes, how many modules do you currently lead, please list them. If no, go to question 7 <input style="width: 100%;" type="text"/> Besides healthcare management, do you teach on other programmes at the University? <input style="width: 100%;" type="text"/> Which of the following statements best describe your experience as an academic? For example, are you...? <ol style="list-style-type: none"> A practitioner-academic actively working in a recognised professional role [] A practitioner-academic who has not worked in a recognised professional capacity for over two years [] A practitioner-academic actively engaged in recent scholarly activities linked to healthcare practice [] <p style="text-align: right;">2</p> | <p>d) An academic neither actively participating in academic scholarly activity nor working in a recognised professional capacity []</p> <p style="text-align: center;">Section 2: Semi-structured interview questions</p> <ol style="list-style-type: none"> Could you describe what you feel the key strengths of the Healthcare Management Programme are? How do you think the programme strengths provide the foundation to support employability skills needed for healthcare management? How do you feel the modules and the programme as a whole make apparent the link between the knowledge and skills covered and the competency requirement of a healthcare manager? Do you think there are skills or knowledge that students need to develop that are not being covered in the BA (Hons) Healthcare Programme? Based on your experience of the programme, how do you think the blended learning approach utilised supports knowledge transfer to healthcare management practice? Drawing on your experience of the programme, how do you think the blended learning approach utilised supports skills and competency application to managing healthcare service delivery? What do you feel the key improvements are to the BA (Hons) Healthcare Management Programme and why? Is there anything you would want to comment on, suggest or change on the programme and why? Any other comments about Higher Education in general? <p>This is the end of the interview. Thank you for taking part in the study. Please refer to the Participant Informed Consent letter for further information about contacting the researcher, requesting more information and timelines around withdrawing your consent.</p> <p style="text-align: right;">3</p> |
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Appendix 8: EFGD Study Data Collection Instrument Pilot

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| <div style="text-align: right;">  </div> <p>Version 2, 16.05.21</p> <h3 style="text-align: center;">Semi-structure interview (employers)</h3> <p>Introductory statement:</p> <p>Thank you for agreeing to participate in this semi-structured interview. The interview will aim to explore your experience of working with Higher Education students, specifically your experience of managing students/trainees of the BA (Hons) Healthcare Management. The study is specifically looking into how well placed it is in supporting the type of practice learning which helps encourage knowledge and skills application transferable to the healthcare (management) workplace. Please feel free to express your honest opinion. This is a safe space for you to provide valuable feedback to help inform the conclusions the research arrives at and for potential recommendations about further enhancements that could be made to the programme.</p> <p>Any information shared will be kept anonymous and your confidentiality will be maintained at all times. This will be through the use of codes for participants in the study and the removal of all personally identifiable information from the transcribed data before analysis.</p> <p>Information provided during the interview will be recorded for transcription later. This will inform the analysis and the conclusions arrived at, with regards to improvements needed for the programme. If you have any concerns about this, please let me know before we start. Also, participation in the study is purely voluntary.</p> <p>NB: the researcher wishes to add that the interview instrument is by no means a performance review tool or suggestive of a review of individual performance of an employee or employee. The interview only aims to gather employer feedback about the potential knowledge and skills application transferable to the healthcare management workplace from the BA (Hons) Healthcare Management Programme of an HEI in the UK.</p> <p>Is there any question you wish to ask before the interview commences?</p> <p style="text-align: right;">1</p> | <h3 style="text-align: center;">Section 1: Demographic questions</h3> <p>What is your gender?</p> <p>a) Male <input type="checkbox"/></p> <p>b) Female <input type="checkbox"/></p> <p>c) Prefer not to say <input type="checkbox"/></p> <p>What is your age in years?</p> <p>a) 20-26 <input type="checkbox"/></p> <p>b) 27-33 <input type="checkbox"/></p> <p>c) 34-40 <input type="checkbox"/></p> <p>d) 41-47 <input type="checkbox"/></p> <p>e) 48-54 <input type="checkbox"/></p> <p>f) 55 and above <input type="checkbox"/></p> <p>What is your job title?</p> <input type="text"/> <p>How long have you been working in healthcare management?</p> <input type="text"/> <p>How many Higher Education students and graduates do you have working for you?</p> <input type="text"/> <p>How has your organisation usually advertised and recruit for jobs in healthcare/healthcare management?</p> <input type="text"/> <p>Are you a Care Quality Commission (CQC) registered health and social care manager and/or have other healthcare management qualifications?</p> <p>If yes, please specify the management qualifications below, if not, please proceed to section 2</p> <input type="text"/> <p style="text-align: right;">2</p> | <h3 style="text-align: center;">Section 2: semi-structured interview questions</h3> <ul style="list-style-type: none"> How long has a BA (Hons) Healthcare Management student/graduate worked for your organisation? Could you explain how many students from the BA (Hons) Healthcare Management Programme/graduates you have employed/worked with over the years? How long do Higher Education graduates such as those from the BA (Hons) Programme generally stayed with your organisation? Describe the key characteristics, knowledge and skills you look for when hiring workers with healthcare management knowledge and/or qualifications? What have you observed to be the main strengths students/graduates from HE (including those of the BA (Hons) Healthcare Programme) possess? What have you observed to be the weakness that students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme) show in the execution of their duties and responsibilities? Reflecting on your experience working with students/ graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), do you feel they demonstrate enough to suggest learning on their programmes supports knowledge transfer and skills application transferable to the healthcare management workplace? What have you observed to be the difference in the contribution of students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), before and after enrolling on their respective healthcare programmes? Based on your supervision experience and interaction with students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), are there any specific management skills and healthcare knowledge you feel need addressing? Is there anything else you would like to tell the BA (Hons) Healthcare Management Programme managers about further enhancements needed to explicitly support knowledge and skills application transferable to the healthcare management workplace? Any other comments about Higher Education in general? <p>You have reached the end of the interview. Thank you for taking part in the study. Please refer to the Participant Informed Consent letter for further information about contacting the researcher, requesting more information or timelines around withdrawing your consent.</p> <p style="text-align: right;">3</p> |
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Appendix 9: Semi-structured Interview Questions - Employers (final version)

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| <div style="text-align: right;">  </div> <p>Version 1, 05/06/22</p> <h3 style="text-align: center;">Semi-structured interview (employers)</h3> <p>Introductory statement:</p> <p>Thank you for agreeing to participate in this semi-structured interview. The interview will explore your experience working with Higher Education students, specifically your experience managing students alumni of the BA (Hons) Healthcare Management Programme. The study is specifically looking into how well placed it is in supporting the type of practice learning that helps encourage knowledge and skills application transferable to the healthcare (management) workplace. Please feel free to express your honest opinion. This is a safe space for you to provide valuable feedback to help inform the conclusions the research will arrive at and for potential recommendations about further enhancements to the programme and sector at large.</p> <p>Any information shared will be kept anonymous. Your confidentiality and anonymity of your organisation will be maintained throughout the study. This will be done with the use of codes for participants in the study and the removal of all personally identifiable information from the transcribed data before analysis.</p> <p>The information you will provide during the interview will be recorded for transcription later. This will inform the analysis and the conclusions the study will arrive at. If you have any concerns about this, please let me know before we start. Also, participation in the study is purely voluntary.</p> <p>NB: the researcher wishes to add that the interview instrument is by no means a performance review tool or suggestive of a review of individual performances of an employee or employees. The interview only aims to gather employer feedback about the potential knowledge and skills application transferable to the healthcare management workplace from the BA (Hons) Healthcare Management Programme of an HEI in the UK.</p> <p>Is there any question you wish to ask before the interview commences?</p> <p style="text-align: center;">Section 1: demographic questions</p> <p>1. What is your gender? a) Male <input type="checkbox"/> b) Female <input type="checkbox"/> c) Prefer not to say <input type="checkbox"/></p> <p style="text-align: right;">1</p> | <p>2. What is your age in years? a) 20-26 <input type="checkbox"/> b) 27-33 <input type="checkbox"/> c) 34-40 <input type="checkbox"/> d) 41-47 <input type="checkbox"/> e) 48-54 <input type="checkbox"/> f) 55 and above <input type="checkbox"/></p> <p>3. What is your job title? <input type="text"/></p> <p>4. What part of the UK is your organisation? i) Please specify, for example, if your organisation is in England, Scotland, Wales, or Northern Ireland. <input type="text"/> ii) Also, specify the county or borough your organisation is in <input type="text"/></p> <p>5. How long have you worked in management (including healthcare)? <input type="text"/></p> <p>6. Are you a Care Quality Commission (CQC) registered health and social care manager or with other healthcare management qualifications? a) Yes <input type="checkbox"/> b) No <input type="checkbox"/> c) Other, please explain <input type="text"/></p> <p>7. If your answer to question 6 is 'yes' please specify the management qualification below; if your answer is 'no', please indicate any qualification/s you have that is/are relevant to health or social care management in the UK. <input type="text"/></p> <p>8. How many Higher Education (HE) students and graduates do you currently have working for you? <input type="text"/></p> <p>9. How many students and graduates from the BA (Hons) Healthcare Management Programme have you employed and worked with over the past six years? <input type="text"/></p> <p style="text-align: right;">2</p> | <div style="text-align: right;"> <input type="text"/> <input type="text"/> </div> <p>10. How has your organisation usually advertised and recruited for jobs in healthcare, including healthcare management? <input type="text"/></p> <p style="text-align: center;">Section 2: Semi-structured interview questions</p> <ol style="list-style-type: none"> How long has a BA (Hons) Healthcare Management student/graduate worked for your organisation? How long do Higher Education graduates, such as those from the BA (Hons) Programme, generally stay with your organisation? Do you know why? Describe the key characteristics, knowledge, and skills you look for when hiring workers with healthcare management knowledge and qualifications. What have you observed to be the main strengths students/graduates from HE (including those of the BA (Hons) Healthcare Programme) have? What have you observed to be the weakness that students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme) show in carrying out their duties and responsibilities? Having worked with students/ graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), do you feel they demonstrate enough to suggest learning on their programmes support knowledge transfer and skills application transferable to the healthcare management workplace? What have you observed to be the difference in the contribution of students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), especially before and after enrolment or completion of their programme? Based on your supervision experience and interaction with students/graduates from Higher Education (including those of the BA (Hons) Healthcare Management Programme), are there any specific management skills and healthcare knowledge you feel need addressing? Is there anything you want to comment on, suggest or change on the BA (Hons) Healthcare Management Programme? Any other comments about Higher Education in general? <p>You have reached the end of the interview. Thank you for taking part in the study. Please refer to the Participant Informed Consent letter for further information about contacting the researcher, requesting more information or timelines around withdrawing your consent.</p> <p style="text-align: right;">3</p> |
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Appendix 10: NVivo Codebook

Thematic codes: Academic, Employer Semi-structured interviews and Focus Group

| Theme and sub-theme name/information | Files | References |
|---|-----------|------------|
| Theme 1 Knowledge, characteristics, skills and employability expectation | 5 | 35 |
| <i>Sub-theme 1: Employer expectations</i> | 3 | 11 |
| Dedication and understanding policies and sector needs | 3 | 5 |
| Professionalism, passion and knowledge | 3 | 6 |
| <i>Sub-theme 2: Student and graduate expectations</i> | 2 | 24 |
| Employment, self-improvement and applying learning to practice | 2 | 8 |
| Leadership, management, and other transferable skills | 2 | 16 |
| Theme 2 Strengths | 17 | 50 |
| <i>Sub-theme 1: Academic, student and graduate articulated strengths</i> | 14 | 44 |
| Diversity and flexibility of resources | 10 | 17 |
| Knowledge, skills and employment requirements | 11 | 27 |
| <i>Sub-theme 2: Employer observed strengths of students and graduates</i> | 3 | 6 |
| Theme 3 Length of stay with employer and reason | 3 | 10 |
| <i>Sub-theme 1: How long student or graduate worked for employer</i> | 3 | 7 |
| <i>Sub-theme 2: General determinants for staying with employer</i> | 3 | 3 |
| Theme 4 Knowledge, skills and transfer to practice | 17 | 87 |
| <i>Sub-theme 1: Positive transfer</i> | 16 | 71 |
| Curriculum design, resources and support | 4 | 8 |
| Community of practice, knowledge, and graduate skills | 9 | 18 |
| Integration, sector knowledge and skills transfer | 15 | 45 |
| <i>Sub-theme 2: Neutral and transfer difficult to determine</i> | 6 | 16 |
| Theme 5 Suggested improvements | 16 | 57 |
| <i>Sub-theme 1: Enhancing and Internationalising programme and skills support</i> | 8 | 19 |
| <i>Sub-theme 2: Learning resourcing and assessments</i> | 8 | 15 |
| <i>Sub-theme 3: Personal development, digital skills and work placement</i> | 12 | 23 |
| Theme 6 The current higher education landscape | 15 | 32 |
| <i>Sub-theme 1: Access, motivation, integrity and academic study</i> | 7 | 15 |
| <i>Sub-theme 2: Careers, professionalism, technology and sustainability</i> | 7 | 9 |
| <i>Sub-theme 3: Emphasis on skills, practice experience and confidence</i> | 5 | 8 |

Appendix 11: HEI REC and Ethics Approval Confirmation Email Trail Between REC Secretary, Members and Me

From: [REDACTED]
Sent: 12 May 2021 10:35
To: 'Research and Ethics Committee' [REDACTED]
Cc: Saikou Sanyang [REDACTED]
Subject: FW: REC ethics approval application for my insider research

Dear all,

Please see the attached Ethics Proposal and accompanying documentation, submitted to the Research and Ethics Committee for Ethics Approval. This has been approved by the Chair, please could all other members respond with any queries, recommendations or conditions you may have prior to the final approval date of Friday 14th May 2021 (by end of day).

The Proposal is submitted by Saikou Sanyang, who is copied in to respond to any queries.

Attached are the following documents:
Participant Information Sheet [REDACTED]
Participant Informed Consent form
Proposal document and ethics form
Debrief sheet
Data collection instruments - for instance, focus group questions, semi-structured interview questions for academics and employers; respectively Invitation letter.

In addition, also attached are forms to be submitted to Middlesex University to help the committee have a more holistic view of the proposed approach.
The documents here include:
Conflict of Interest form
Proposed project budget and resourcing
Data protection checklist

Kind regards,
[REDACTED]

Correspondence Shared by Secretary to REC to Confirm Ethical Approval


From: [REDACTED]
Sent: 14 May 2021 3:40 PM
To: Saikou Sanyang [REDACTED]
Subject: RE: REC ethics approval application for my insider research

Hi Saikou,

The deadline for REC Members to feedback has now passed and no issues have been raised, as such final approval is now confirmed. Thank you for submitting to the Committee and complying with the process.

Kind regards,
[REDACTED]

Appendix 12: Participant Information Sheet for Students/Graduates and Academics



MIDDLESEX UNIVERSITY

Version Number and date: 3; 15/07/2021

**Participant Information Sheet (PIS)
More Than Minimal Risk or High Risk Projects**

Participant ID Code:

SECTION 1

1. Project/Study title
A practice learning experience from a UK Higher Education Institution's (HEIs) BA (Hons) Healthcare Management Programme: how supportive is the programme of knowledge and skills application transferable to the healthcare workplace?

2. Invitation paragraph
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

The study is being conducted by Saikou Sanyang, a student undertaking a Doctorate in Professional Studies Health at Middlesex University.

Thank you for reading this.

3. What is the purpose of the study?
The purpose of the study is to investigate the learning experiences of students enrolled on the BA (Hons) Healthcare Management Programme of an HEI in the UK. The study will explore how well placed the programme is in supporting management knowledge and skills application

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

transferable to the healthcare workplace in the UK. This will be looked at from the perspective of current healthcare management students working in healthcare practice, alumni, employers, academics and existing secondary literature. The part of the study you are being recruited to is in two folds – the first of these is the focus group discussion with students and alumni of the BA (Hons) Healthcare Management Programme. This will be conducted on behalf of the researcher by a proxy data collector.

The second is a semi-structured interview with academics teaching on the healthcare programme. This will be with academics who have taught on the programme for at least 2 years.

4. Why have I been chosen?
It is important that we access as many participants as possible, and you have indicated that you are interested in taking part in this study. You have been chosen to participate in the study as you belong to one of the following groups of participants (i.e. students, alumni and/or academics in the researcher's HEI) who broadly make up the inclusion criteria for participants the researcher intends to recruit for focus group discussions and semi-structured interviews; respectively. As a participant, your experience of the programme and/or knowledge and graduate skills demonstrated by its students will help illuminate how situated the programme is in fostering management knowledge and skills application transferable to the healthcare management workplace.

In all, over 25 participants will be potentially recruited in the study. This will include 3 focus groups of 6-8 students – that is, from years 1 and 2 and 3 and alumni. So that the programme is covered by student comments, focus groups will be conducted after October 2021. This will ensure, as a minimum, students selected would have completed a module at each level. While this will help, the researcher generally does not have a concern about this as students on the blended learning healthcare programme are enrolled at 4 staggered recruitment cycles. That is, September, February, April and June. This in effect means there is a good spread across each level.

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

In addition, 10 academics in the healthcare management programme team who have had experience teaching on the programme for 2 years and above will be recruited in the study. This would allow for all academics to have insight into the whole programme. Up to 80% of academics currently teaching on the programme would have been teaching on the programme for at least 2 years. This will be complemented by the recruitment of up to 5 employers working with current students on the programme and/or alumni.

The reference to more than 25 here is on the basis that recruiting a minimum of 6 students/alumni for the three focus groups takes the student/alumni focus group numbers to 18. In addition to this, I intend to recruit 10 academics from the healthcare school as well as up to 5 employers. Adding the three together takes my numbers up to 33 participants altogether. The study sample is likely to go up to 39 if the researcher can recruit all of the 8 students/alumni per focus group.

5. Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. If you do decide to withdraw from the study then please inform the researcher as soon as possible, and they will facilitate your withdrawal. If, for any reason, you wish to withdraw your data please contact the researcher within a month of your participation. After this date, it may not be possible to withdraw your data as the results may have already been anonymised or published. However, as all data are anonymised, your individual data will not be identifiable in any way.

A decision to withdraw at any time, or a decision not to take part, will not affect your e.g. status as a student or place on team and employment (i.e. for academics).

6. What will I have to do?
As noted above, this part of the data collection is in two phases. The first of these will involve zoom focus groups with students across all levels of the undergraduate healthcare degree and alumni. The second will involve semi-structured interviews with academics teaching on the programme. Partaking in the respective parts of the data collection will potentially help

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

the researcher better understand your perception and experience of the BA (Hons) Healthcare Management Programme in supporting knowledge and skill transfer applicable to the healthcare management workplace.

While virtual data collection (for the focus groups will involve the use of zoom, academic face-to-face interviews will be conducted in any of the 5 blended UK study centres – that is, Ealing, Holborn, Towerhill, Birmingham or Manchester. See the information below clarifying both phases of data collection and what your involvement in either means.

Phase I: Students/Alumni Focus Groups
As a current healthcare management student/alumni, you will be invited to partake in at least one focus group discussion about your experience of the BA (Hons) Healthcare Management Programme. If you consent to this, during focus group discussions with other students and alumni, a moderator (i.e. the proxy researcher) will guide you on pertinent areas your input is required. Responses provided will be recorded, transcribed and analysed later for discussion. Any identifying information included in these recordings will be removed to ensure your anonymity and privacy is protected at all times (please see section 2 for further information).

Phase II: Academic Semi-structured Interviews
As an academic, if you consent to partake in the study, feedback will be solicited from you through one-to-one semi-structured interviews carried out either through face-to-face interviews (which is the researcher's preferred choice) and/or zoom online (if the Covid-19 pandemic and lockdown rules/guidance necessitate this). Face-to-face interviews will be recorded through the use of Dictaphones. This will be stored on the researchers Middlesex University OneDrive account for transcription, coding and analysis (please see the privacy notice in section 2 for further information).

As a contingency, where face-to-face interviews are not feasible because of challenges associated with access to the blended study centres due to Covid-19 restrictions, the researcher will conduct zoom interviews; however, preceding this will be a pilot study involving some of the healthcare academics. While the pilot will not be used as part of the final data, it will provide an opportunity for the researcher and proxy data collector to fine-tune any areas of zoom use for such purposes.

The researcher's zoom account is also linked to his HEI's zoom license which is set up to automatically record and store data on the HEI's secure server. This process will ensure data collected virtually is stored safely. To

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

further assure anonymity, the researcher will download all zoom interviews separately and rename the links using codes before saving them on his HEI/Middlesex University's OneDrive accounts. Zoom interviews in this case will be conducted separately for each participant and conducted at a convenient time and place for both participants and the researcher (or proxy data collector).

The overall data collection and analysis phase will last for between 6 months and a year. While the data collection to do with the semi-structured interviews and focus groups is scheduled to last for up to 3 months, the researcher acknowledges that due to covid-19 and its potential impact on access to participants, this may last for up to 6 months – that is, to start by August/September 2021 and run-up to February/March 2022.

Please note that to ensure quality assurance and equity this project may be selected for audit by a designated member of the committee. This means that the designated member can request to see signed consent forms. However, if this is the case your signed consent form will only be accessed by the designated auditor or member of the audit team.

7. What are the possible disadvantages and risks of taking part?
There are no known risks in participating in this project. We hope that participating in the study will help you. However, this cannot be guaranteed. A disadvantage could be your time to take part.

Appropriate risk assessments for all procedures have been conducted and will be followed throughout the study.

8. What are the possible benefits of taking part?
We hope that participating in the study will help you. However, this cannot be guaranteed. Information from this study will help to better understand the student experience of the BA (Hons) Healthcare Management Programme and how well-placed it is in supporting knowledge and skills application transferable to the healthcare management workplace. This provides the foundation upon which further suggestions for enhancements could be made to potentially improve the programme outcomes, student experience and graduate competencies covered by the programme as well as improve overall graduate outcomes (e.g. for current and future students).

As a student/alumni and/or an academic, you are unlikely to potentially gain any direct benefit from participating in this study.

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

9. Will my taking part in this study be kept confidential?
The research team has put several procedures in place to protect the confidentiality of participants. You will be allocated a participant code that will always be used to identify any data you provide. Your name or other personal details will not be associated with your data. For example, the consent form that you sign will be kept separate from your data. All paper records will be stored in a locked filing cabinet, accessible only to the research team, and all electronic data will be stored on a password-protected Middlesex University's OneDrive folder. All information you provide will be treated in accordance with the UK Data Protection Act.

Personal data (e.g. your name, email address, or any data that can identify you) will NOT be collected by this study and your confidentiality will be protected. For example, data collected from zoom focus groups and/or semi-structured interviews will be stored on a secure server and recording titles changed and renamed to help assure anonymity.

It is important to add that your data will be used in accordance with the General Data Protection Regulation 2016 (GDPR) and the Data Protection Act 2018. All data will be treated confidentially until it is anonymised. If consent has been given to transcribe and use a recording of your participation, all transcription and recordings will be destroyed in line with GDPR. Your data will only be accessible to the researcher, proxy data collector (i.e. for both academic interviews and student focus groups) and Academic advisors/Supervisors: Dr Gordon Weller and Dr Catherine Kerr. All data will be destroyed on or before 1st October 2024.

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form (not applicable for an anonymous survey questionnaire). If you decide to take part you are still free to withdraw at any time and without giving a reason.

A decision to withdraw at any time, or a decision to take part or not, will not affect the standard of education / your course assessment (e.g. students) and employment/association with the School of Healthcare Management (e.g. academics, alumni) in any way.

You should think about the opportunity to withdraw; normally interview data will be anonymised and amalgamated into the analysis and so difficult to delete if requested.

Participant Information Sheet – (PIS) for 1-3 Stars (not Minimal Risk, Middlesex University Ethics P/04/2020)

'Withdrawal will be possible up to (period of time, of one month) after the interview, after which time, the data will be anonymised and amalgamated into the analysis'

10. What will happen to the results of the research study?

The results of the research will be used to write up a thesis as part of the researcher's assessment for Doctorate in Professional Studies Health at Middlesex University. The findings may also be disseminated through journal articles/academic papers and conferences.

Findings of the study will also be used to inform suggestions for the researcher's HEI. Specifically around enhancements to the 'BA (Hons) Healthcare Management Programme' to support the student learning journey and overall programme experience. In addition, explore potential opportunities to further develop the programme graduate competencies (in healthcare management) and inclusive graduate outcomes.

11. Who has reviewed the study?

The study has received full ethical clearance from the Research Ethics Committee (REC) who reviewed the study. The committee is the Middlesex University Health and Social Care Ethics Sub-committee and the researcher's HEI RECs respectively.

12. Contact for further information

If you require further information, have any questions or would like to withdraw your data then please contact:

Principal Investigator:

Saikou Sanyang
Email: SS3743@live.mdx.ac.uk

Advisors/Supervisors:

Dr Gordon Weller
Middlesex University,
The Burroughs,
Hendon, London,
NW4 4BT
Tel: 02084114509
Email: G.Weller@mdx.ac.uk

Dr Catherine Kerr
Middlesex University,

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The Burroughs,
Hendon, London,
NW4 4BT
Tel: 0208 411 4595
Email: C.kerr@mdx.ac.uk

Thank you for agreeing to take part in this study. You (the participant) should keep this "Participant Information with Consent" sheet since it contains important information and the research teams contact details.

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