



Cover Page

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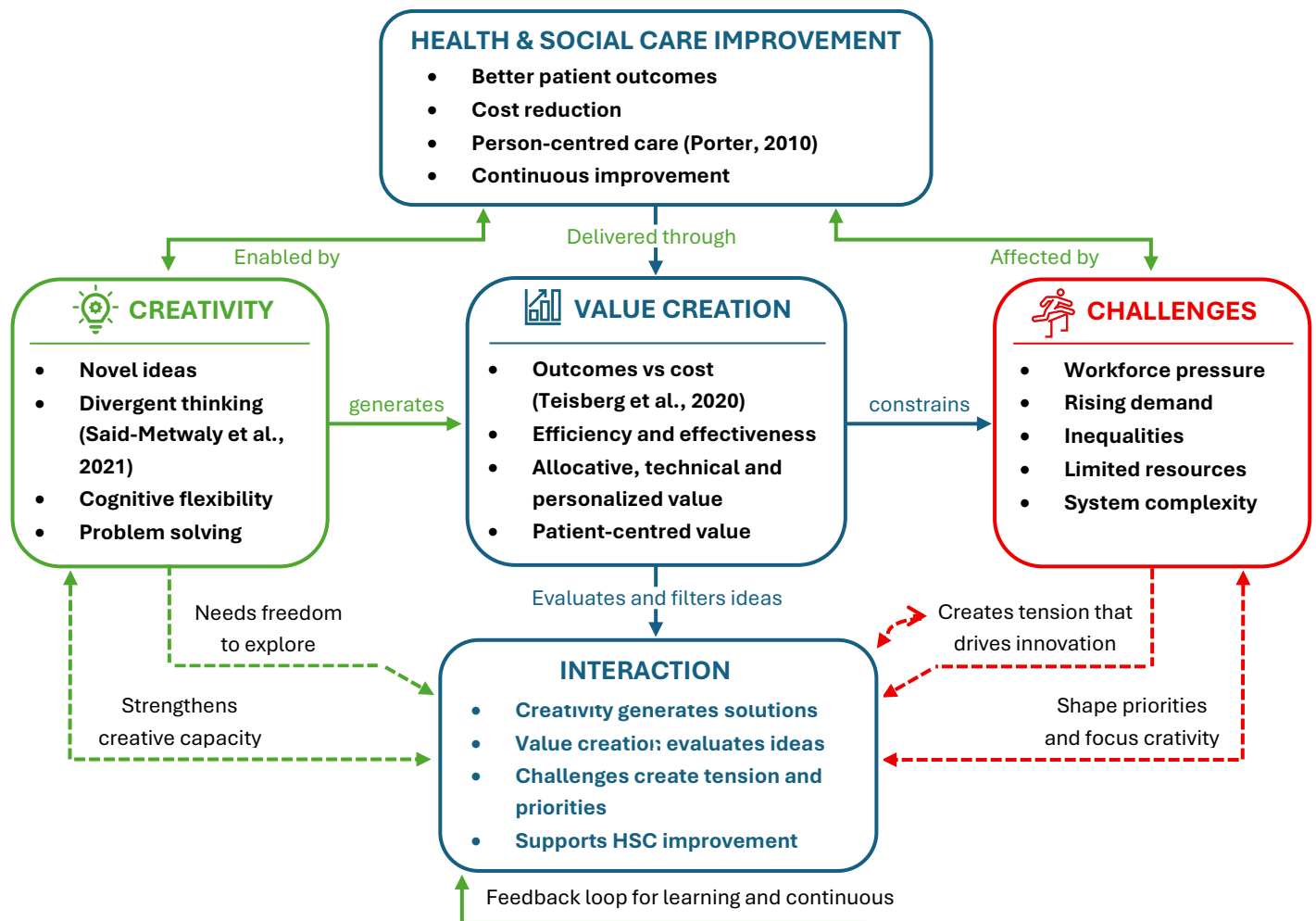
Assignment Title: Component 1: Online Portfolio of Set Exercises

Task 1 – Concept Map

Create a concept map that outlines the relationship between creativity, value creation, and health and social care improvement. Within the concept map explain how these concepts interact in a health and social care context (250 words).

Please refer to week 1 content

Concept Map: The Interaction of Creativity, Value Creation, and HSC Improvement



Explanation: Creativity, value creation and health and social care (HSC) improvement are closely linked rather than separate steps. Creativity involves generating new and useful ideas (Runco & Jaeger, 2012), and Boden (1994, cited in Carlile and Jordan, 2012) similarly describes this as producing novel and valuable ideas. In HSC, these ideas are shaped by "press" factors from Rhodes (1961) 4Ps model, such as staff shortages and rising demand. However, creativity alone does not improve services. Porter's (2010) value framework suggests ideas must be judged by outcomes and efficient use of resources, while Nilsson et al. (2024) highlight relational aspects such as trust and empathy, which are harder to measure but central to care quality. Overall, the relationship is iterative rather than linear.

Verhoest et al. (2024) show that separating divergent idea generation from convergent evaluation improves innovation quality as mixing both reduces effectiveness. This is reflected in Saha et al. (2024), where NHS pressures supported idea generation but reduced impact during implementation. In contrast, Bowness et al. (2025) show that creative problem-solving can still create value at an individual level, improving wellbeing without financial cost. This highlights how context influences whether creativity leads to meaningful impact. For example, a falls prevention team could generate home safety ideas from patients, then apply cost and feasibility criteria to select interventions. Overall, HSC improvement depends on balancing creativity with structured evaluation so ideas are both generated and implemented effectively in practice, although evidence remains limited in social care, so further research is needed outside NHS settings.

Task 2 - Self-Reflection of Group Activity

Complete a self-Reflection on the Convergent/Divergent paperclip thinking class activity using a reflective model (250 words, 1 source)

Please refer to Week 2 content.

Self-Reflection on the Paperclip Divergent/Convergent Thinking Activity

Using Gibbs' (1988) reflective cycle, I evaluate the paperclip activity. I completed this in a group of four during class.

Description: We generated alternative uses for a paperclip (divergent thinking), then evaluated feasibility (convergent thinking).

Feelings: Initially I felt constrained, assuming a paperclip had limited practical value. As my group suggested unusual ideas, I became more confident. During convergence, I felt frustrated when creative ideas were dismissed without clear justification.

Evaluation: Our group generated 27 ideas in ten minutes, more than I could have produced alone. However, we lacked decision making criteria and spent too long debating one idea, which reduced efficiency.

Analysis: Verhoest et al. (2024) argue that separating divergent and convergent stages improves innovation, which our experience supports. However, their model assumes structured facilitation which frontline teams often do not have. Rhodes (1961) explains how “press” factors such as time pressure can limit creativity. In real care contexts, ethical factors like dignity matter in ways this task ignored (Bowness et al., 2025). We also had no facilitator to keep stages separate. This changed my thinking, I used to see creativity as just generating ideas but now I understand that without structured evaluation, ideas can create risks in care settings, such as wasting time or affecting safety.

Conclusion: I conclude that structured creativity needs both protected time and ethical grounding to transfer to care settings.

Action plan: In future practice, I will use timed brainstorming followed by a simple matrix to rank ideas based on impact on patient dignity and cost and then check for safety.

Task 3 - Case Study of a UK innovation

Write a concise case study analysis of an innovative project or initiative within the NHS or UK social care. Focus on how creativity was used to drive change and the value it created for patients or service user's (400 words, 2 sources).

Please refer to Week 3 content

Case Study Analysis: AI in Radiology for Early Cancer Diagnosis

Introduction

This case study critically evaluates how Artificial Intelligence (AI) is being integrated into NHS radiology services for early cancer detection. The innovation uses deep learning algorithms as a 'second reviewer' for mammograms, CT and MRI scans. With a 29% consultant radiologist vacancy rate (Royal College of Radiologists, 2024), the NHS is facing continued workforce pressure alongside rising demand for diagnoses. This analysis applies Porter's (2010) value-based healthcare framework to explore whether AI-driven diagnosis creates meaningful clinical value or whether it mainly replaces human skill while introducing new risks to care quality and fairness.

Creativity as Strategic Reconfiguration

The creative element is not the AI technology itself but how clinical workflows are reorganised between humans and machines. The Topol Review (NHS Health Education England, 2019) emphasises that AI should support clinicians rather than replace them, helping with decisions while keeping professional judgement with healthcare professionals. However, there are concerns that over-reliance on AI could lead to deskilling, especially for junior radiologists who may get less exposure to complex or unclear cases (Davenport & Kalakota, 2019). McKendrick et al. (2023) found that AI-assisted radiologists detected 8.4% more breast cancers, but confidence dropped when AI results conflicted with their own judgement. This creates a tension, AI improves diagnostic performance in the short term but may weaken clinical skills over time.

Value Creation: Beyond Technical Efficiency

Porter's (2010) framework suggests that technical efficiency alone does not guarantee real healthcare value. McKinney et al. (2020) found a 9.4% reduction in false negatives, although there is still limited evidence of large-scale UK implementation. From a personalised value perspective, Stanley et al. (2024) reported that AI systems produced 12% higher false positive rates for Black and South Asian women, raising concerns about algorithmic bias and health inequalities. From an allocative perspective, implementation costs are significant and need to be weighed against other priorities, such as hiring more radiographers. NHS England (2024) also highlights ongoing interoperability challenges, meaning AI tools do not always integrate smoothly with existing NHS radiology systems, limiting wider use.

Conclusion

Reflecting on my group's divergent thinking activity, AI has potential, but I am not convinced the NHS should prioritise it over hiring radiographers. The evidence on bias (Stanley et al., 2024) and deskilling (McKendrick et al., 2023) is concerning and opportunity costs are real. Until equity audits are mandatory, AI risks widening health inequalities rather than improving outcomes.

Task 4 - Research Task

Identify a current issue in health and social care (e.g. e.g., mental health stigma, access to care for vulnerable populations). Find two pieces of academic research (journal articles) that explain the reason for this problem. Paraphrase the findings of each article (300 words, 2 sources).

Please refer to week 4 content.

Current Issue: Mental Health Stigma in UK Minority Ethnic Communities

Identifying the Problem

Mental health stigma in UK minority ethnic communities creates allocative inefficiency within value-based healthcare (Porter, 2010), as NHS resources fund services that patients avoid. Rice and Atkin (2009) define campaigns as attempts to influence behaviour,

but Geense et al. (2013) argue health promotion fails if barriers are not identified. Stigma is therefore a systemic barrier that needs empirical understanding before campaign design.

Critical Analysis of Finding 1

Stepanova et al. (2025) found that mental health stigma in UK minority ethnic communities is maintained through a “concealment cycle,” where shame and fear of NHS insensitivity prevent disclosure of distress. They interviewed 32 participants in North England, identifying three barriers: cultural stigma, NHS insensitivity and language difficulties. Shame creates a self-perpetuating cycle of concealment, challenging individual explanations of non-engagement by highlighting structural avoidance. However, excluding people with no service contact may underestimate stigma, leaving the true extent of concealment unclear.

Critical Analysis of Finding 2

Uppal et al. (2025) surveyed 1,001 Sikh UK adults and found shame scores were significantly higher than the general population, acting as a moderate negative predictor of intention to seek professional help ($\beta = -0.34$). However, shame explains only 11% of the variation in help seeking, suggesting other factors also contribute. The cross-sectional design means causality cannot be established, as shame may justify rather than directly cause non-engagement. This is important because attitudes may change through awareness campaigns, while behavioural barriers may require different interventions (Geense et al., 2013).

Synthesis and Implications

Both studies show stigma operates at individual, family and institutional levels. However, neither study alone fully supports a campaign strategy. Co-produced, culturally tailored approaches targeting institutional barriers before individual shame may be effective, although further causal testing using mixed-methods approaches is still needed.

Task 5 - Podcast

Record a two-minute Podcast introducing your idea for component 2 using <https://www.rev.com/onlinevoicerecorder> The MP3 audio must be downloaded and embedded as a file (see guidance video on how to do this here: <https://www.youtube.com/watch?v=D21isld0agw>) or an accessible OneDrive link if using a chromebook (make accessibility – anybody) before inserting into your portfolio. Check the accessibility of the link before submitting.

Please refer to week 4 & 6 content.

[Please click here to access podcast folder \(Audio + Transcript\)](#)

Task 6 - NHS Leadership Framework Analysis

Write a short summary (200 words) explaining the key components of the NHS Leadership Framework. Then, choose one component and describe (150 words) how a leader might use it to encourage creativity and improve care in the NHS (2 sources).

Please refer to week 7 content.

The NHS Leadership Framework (NHS Leadership Academy, 2011) creates a degree of separation between seven leadership domains: Demonstrating Personal Qualities, Working with Others, Managing Services, Improving Services, Setting Direction, Creating the Vision and Delivering the Strategy. A ward manager cannot manage services without simultaneously setting direction and improving services. The framework's strength is supporting distributed leadership, meaning improvement responsibility sits at all staff levels (Fullan, 2016). Unlike hierarchical command and control models, this theoretically empowers frontline staff.

Yet Tourish (2014) raises a valid critique, competency frameworks are reductionist because leadership is relational and context-dependent. A fixed domain cannot capture how a ward manager responds differently to a staffing crisis versus a patient safety

incident. The King's Fund (2024) confirms this limitation, noting the framework is being replaced because prescriptive models struggle with adaptive challenges like workforce shortages. This raises questions about the continued usefulness of competency frameworks in complex NHS environments. One counterargument is that any framework provides a shared language for multidisciplinary teams (King's Fund, 2024). The answer is developmental for novice managers, the domains provide useful scaffolding. But for experienced leaders, rigid application risks "leadership by checklist" (Tourish, 2014). Therefore, leaders should use the framework diagnostically to identify gaps, not prescriptively as a rulebook.

Application: Improving Services

The "Improving Services" domain (NHS Leadership Academy, 2011) aligns with transformational leadership (Bass, Avolio and Atwater, 1996), where staff question routines. However, applying this faces a paradox, intellectual stimulation requires psychological safety (Edmondson, 2018), yet hierarchical NHS ward structures discourage juniors from challenging senior colleagues (Tourish, 2014). A ward manager implementing weekly ten minute "innovation huddles" must establish ethical leadership (Franczukowska et al., 2021) to create psychological safety.

Verhoest et al. (2024) show that separating divergent thinking from convergent thinking prevents premature dismissal of creative solutions. Saha et al. (2024) found this reduced medicine waste by 22%, creating allocative value (Porter, 2010). However, this evidence comes from a single acute trust with dedicated time, absent in most community settings (King's Fund, 2024). Therefore, the 'Improving Services' domain is limited without two conditions: protected time for divergent thinking and demonstrable action on staff suggestions. Without both, huddles risk reducing psychological safety (Edmondson, 2018).

Task 7 - Self-Reflection Journal Entry

Write a short journal entry about what you learned in this module. Focus on how your understanding of creativity and value creation within H&SC has changed and how it has informed your professional practice (200 words).

Please refer to week 9 content.

Before this module, I thought creativity in HSC was just art or music therapy, not essential. Week 9 changed that. Learning about homeostasis (Ross & Wilson, 2018), how the body maintains balance through negative feedback, made me see creativity differently.

Both homeostasis and creativity respond to disruption. The body's feedback loops happen automatically. In care settings? Nothing is automatic. Mannion & Exworthy (2022) note we expect staff to innovate but give no systematic way to learn from failure.

As a support worker short on communication boards for a non-verbal resident, I grabbed household items as alternatives. Divergent thinking (Verhoest et al., 2024) helped generate options. But I hit reality, compliance policies. Would management see this as resourceful or safeguarding risk? Dixon-Woods et al. (2023) call this "normative conformity", suppressing creative ideas to avoid breaking unwritten rules.

Porter (2010) would call this allocative inefficiency. Saha et al. (2024) found the same in NHS pharmacy, good ideas blocked by culture, not cost.

I have not solved this tension. I have just learned to name it. My practice is better because I now ask: "What creative solution serves this person safely, within real constraints?" No perfect answer, but asking is progress. Next week, I will bring one creative idea to my team and ask for feedback using a simple safety and dignity checklist.

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