



Prifysgol Cymru
Y Drindod Dewi Sant
University of Wales
Trinity Saint David

Changemakers: Creativity and Value Creation Professions (BMHP5014)

Component 1: Online portfolio of set exercises

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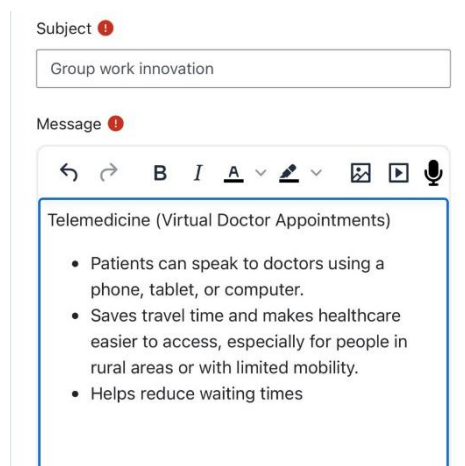
Introduction

This portfolio demonstrates my engagement with the core concepts of creativity, innovation, value creation, leadership and digital technology within health and social care. Through a series of structured tasks I explore theoretical frameworks, apply them to real-world challenges, and reflect on my own learning and professional development. The work draws on academic literature, NHS guidance and practical examples to show how creative and enterprising approaches can generate progressive solutions to current service pressures. Each task builds on module content delivered through lectures and activities, evidencing both critical understanding and the ability to transfer learning into practice.

Task 1 – Defining Key Concepts in Practice

Innovation

Innovation is the successful introduction and adoption of new ideas, processes, products or services that create measurable improvement (West and Farr, 1990). Rogers' Diffusion of Innovation Theory explains how new ideas and technologies spread through organisations and are gradually adopted by staff (Rogers, 2003). In health and social care, innovation is essential because services face rising demand, workforce shortages and complex patient needs. A practical example is the expansion of virtual wards, which allow patients who would otherwise occupy hospital beds to receive acute-level care at home. This reduces pressure on inpatient capacity while maintaining clinical quality.



Creativity

Creativity is the generation of novel and useful ideas (Amabile, 1996). Amabile's Componential Theory of Creativity states that creativity occurs when individuals combine domain-relevant knowledge, creative-thinking skills and intrinsic motivation to produce useful new ideas (Amabile, 1996). Creativity matters in health and social care because it enables staff to design person-centred solutions when standard pathways do not fit individual circumstances. An example is a multidisciplinary team developing a simplified discharge checklist and visual care plan for patients with limited health literacy, improving understanding and reducing readmissions.

Value Creation

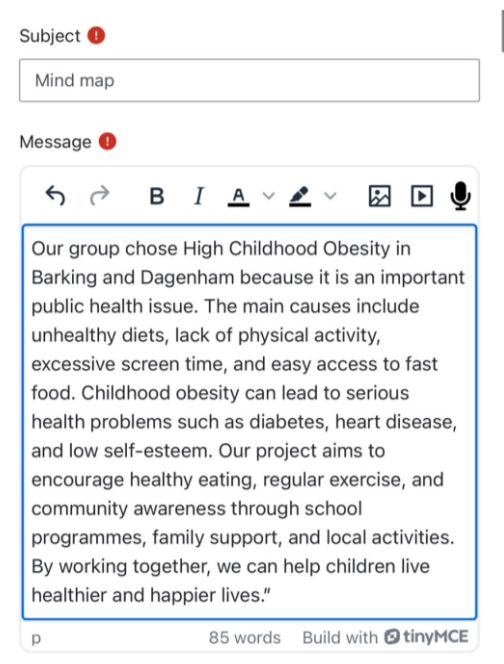
Value creation in healthcare occurs when services improve patient outcomes relative to the cost of delivering care (Porter, 2010). Porter's value-based healthcare framework emphasises outcomes that matter to patients over activity volume. This concept is vital because limited resources must deliver the greatest possible benefit. An example is the introduction of remote blood-pressure monitoring for patients with hypertension, which improves control, reduces clinic visits and frees clinical time for more complex cases, thereby increasing value for both patients and the system.

Change

Change is the process of moving from a current state to a desired future state. Lewin's Change Management Model suggests change occurs through unfreezing current practice, implementing new behaviours, and stabilising (refreezing) the improvement (Burnes, 2017). Effective change is critical in health and social care because services must continually adapt to new evidence, technology and population needs. An example is the phased introduction of electronic prescribing: staff are prepared through training (unfreeze), the system is piloted and refined (change), and new protocols become routine practice (refreeze), reducing medication errors.

Task 2 – Mind Map: Staff Burnout in Health and Social Care

Staff burnout is a critical problem across the NHS and social care. A systems thinking approach recognises that health and social care problems arise from interconnected factors within the wider care system rather than a single cause (Meadows, 2008). High workloads, chronic understaffing and emotional labour interact to produce exhaustion, cynicism and reduced professional efficacy. If left unaddressed, burnout drives higher sickness absence, staff turnover and poorer patient outcomes, disproportionately affecting front-line nurses, care workers and those in high-pressure specialties. The mind map illustrates these interconnections and highlights practical levers for improvement, including workforce planning, accessible psychological support and leadership behaviours that prioritise staff wellbeing. Addressing burnout is therefore both an ethical imperative and a system-level necessity for sustainable, high-quality care.



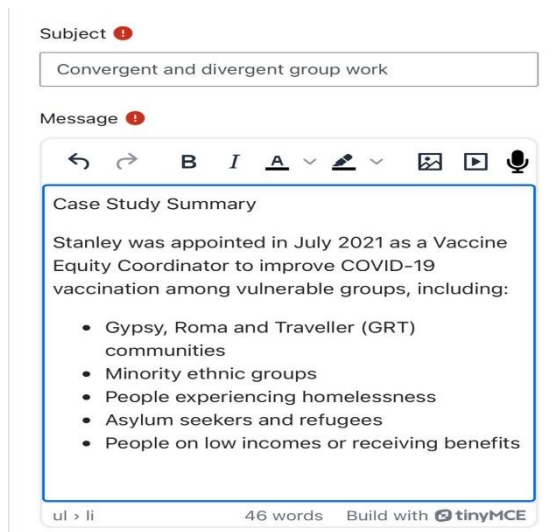
Task 3 – Self-Reflection of Group Activity (Convergent and Divergent Thinking)

Using Gibbs' reflective cycle (Gibbs, 1988), I reflected on a group activity that required us to generate ideas for reducing delayed hospital discharges. Divergent thinking involves generating many varied possibilities, while convergent thinking involves evaluating and selecting the most workable solution (Guilford, 1967).

Description and feelings: In the divergent phase the group rapidly produced ideas ranging from digital discharge summaries to community "discharge champions". I felt energised by the free-flowing discussion. When we moved to convergent thinking I noticed tension as we narrowed options.

Evaluation and analysis: I contributed several creative ideas early on, yet I initially resisted discarding some of them. I realised that while divergent thinking felt natural to me, I needed to strengthen my ability to evaluate ideas against practical constraints such as cost and staffing. When disagreement arose I suggested a simple pros-and-cons matrix, which helped the group move forward constructively.

Conclusion and action plan: I learned that effective teamwork requires deliberate switching between the two thinking styles and that facilitating structured decision-making is a valuable skill. Next time I will explicitly signal the transition from idea generation to evaluation and invite quieter members to contribute earlier, ensuring both creativity and practicality are balanced.



Task 4 – Case Study Analysis of a UK Innovation: Virtual Wards

Virtual wards (also known as Hospital at Home) address the dual pressures of rising acute demand and limited hospital bed capacity. Patients who would traditionally require inpatient admission receive consultant-led care, remote monitoring and multi-disciplinary support in their own homes (NHS England, 2024). Creativity was central to the model: clinicians reimaged the traditional ward environment, combining digital remote monitoring technology with community nursing and medical oversight to replicate hospital-level care outside institutional walls.

Value has been created for patients (higher satisfaction and recovery in familiar surroundings), staff (new ways of working) and the system (reduced non-elective admissions and bed days). Evaluations report outcomes comparable to or better than inpatient care for mortality and readmissions, with significant bed-day savings and high patient satisfaction (NHS England, 2024; Norman et al., 2023). Rogers' Diffusion of Innovation Theory helps explain adoption: the innovation is perceived as

advantageous, compatible with existing goals of care closer to home, and increasingly easy to trial (Rogers, 2003). The model is transferable to other acute pathways and integrated care systems.

Task 5 – Research Task: Causes of Staff Burnout

Staff burnout remains a major challenge in health and social care. Two peer-reviewed sources illuminate its causes.

Gemine et al. (2021) examined work-related burnout among NHS staff and identified heavy workloads, high physical and emotional demands, and insufficient recovery time as primary drivers. Their findings align with the Job Demands-Resources model, showing that when demands consistently exceed available resources, exhaustion and disengagement follow. In real settings this appears as staff working beyond contracted hours, skipping breaks and experiencing moral distress when unable to deliver the standard of care they value.

Nagle et al. (2024) conducted a scoping review of factors affecting healthcare worker burnout. They categorised causes into socio-demographic, individual and work-environment domains, with the strongest evidence pointing to organisational factors such as high patient numbers, long working hours, limited autonomy and inadequate managerial support. Both sources agree that organisational and workload factors outweigh purely individual characteristics. The second paper adds nuance by highlighting how understaffing and lack of flexibility amplify risk, reinforcing the need for system-level rather than solely individual interventions.

Task 6 – Exploring Digital Innovation in Health and Social Care

Benefit of Wearable Health Technologies

Wearable devices such as smartwatches and continuous glucose monitors enable real-time tracking of vital signs and activity levels, supporting self-management of chronic conditions. One clear benefit is earlier detection of deterioration and improved patient engagement. For example, remote monitoring of heart rate, oxygen saturation and activity in patients with heart failure or COPD allows clinicians to intervene before a crisis develops, reducing unplanned admissions (NHS England, 2023). The Technology Acceptance Model explains that patients are more likely to use these tools when they perceive them as useful and easy to operate (Davis, 1989). When integrated into care pathways, wearables shift the focus from reactive treatment to proactive management, empowering service users and freeing clinical capacity.

Electronic Health Records and Collaboration

Electronic health records (EHRs) improve communication by providing a single, up-to-date source of clinical information accessible to authorised professionals across settings. When a patient moves

from primary care to hospital or community services, clinicians can view medications, allergies, test results and care plans without relying on incomplete paper notes or verbal handovers. This reduces duplication, medication errors and delays in decision-making (NHS Digital, 2022). Shared records also support multidisciplinary team working, enabling GPs, specialists, nurses and social care staff to coordinate care more effectively around the individual's needs.

Digital Technology for Preventative Care and Health Promotion

Digital tools can extend preventative care beyond traditional clinic walls. A practical example is the use of NHS App-linked or third-party apps that deliver personalised health coaching, medication reminders and lifestyle advice for people at risk of type 2 diabetes or cardiovascular disease. Combined with remote blood-pressure or weight monitoring, these interventions support behaviour change and early risk reduction (Public Health England, 2021). By reaching individuals in their own homes and at a time convenient to them, digital health promotion can increase uptake among groups who face barriers to attending face-to-face services, contributing to more equitable preventative outcomes.

Task 7 – Understanding the NHS Leadership Framework

Summary of the Healthcare Leadership Model

The NHS Healthcare Leadership Model (NHS Leadership Academy, 2013) sets out nine dimensions of leadership behaviour that apply to staff at every level: Inspiring shared purpose, Leading with care, Evaluating information, Connecting our service, Sharing the vision, Engaging the team, Holding to account, Developing capability, and Influencing for results. The model is important because effective leadership is strongly associated with staff engagement, patient experience and organisational performance. It moves beyond hierarchical authority and emphasises everyday behaviours that create a culture of compassion, continuous improvement and psychological safety. By providing a common language and developmental framework, it supports leaders to create the conditions in which creativity and innovation can flourish within health and social care teams.

Leadership Behaviour: Inspiring Shared Purpose

A leader who focuses on inspiring shared purpose can encourage creativity by articulating a compelling vision of better patient outcomes and inviting the team to contribute ideas that advance that vision. For example, a ward manager might frame the challenge of reducing falls as a shared goal of keeping patients safe and independent, then create protected time for staff to test small changes. Transformational leadership theory suggests that leaders who inspire through vision and intellectual stimulation help teams adopt new ideas and improve practice (Bass and Avolio, 1994). By linking everyday innovation to a meaningful purpose, the leader builds ownership, reduces resistance to change and ultimately improves the quality and experience of care.

Task 8 – Self-Reflection Journal Entry

Reflecting through the lens of Kolb's experiential learning cycle (Kolb, 1984), my understanding of creativity and value creation has shifted significantly. At the start of the module I tended to view innovation as something reserved for senior leaders or technology specialists. Completing the mind-map task and the virtual-wards case study showed me that creativity is a practical, everyday capability that front-line staff can exercise when they are given permission and psychological safety. The convergent-divergent thinking activity particularly highlighted how structured idea generation followed by disciplined evaluation produces workable solutions.

I now see value creation less as cost-cutting and more as improving outcomes that matter to service users relative to the resources used. In future practice I intend to apply this mindset by questioning routine processes, involving patients and colleagues in co-design, and using small tests of change. The key concept I will carry forward is that sustainable improvement depends on both creative thinking and thoughtful leadership that creates the conditions for that thinking to be heard and acted upon.

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