

Applied Leadership and Management in the Workplace

Module Assignment Submission

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Introduction

Creativity and innovation are essential for organisations to adapt and improve. This assignment critically evaluates key innovation models and explores how leadership, collaboration and organisational culture can harness creativity and turn ideas into meaningful improvements within health and social care.

Using at least two recognised models of innovation critically examine the ability of the organisation to innovate effectively.

Pearson's (1988) Stage Specific Processes of Innovation model challenges the assumption that innovation follows a single, predictable pathway. The model does this by arguing that innovation develops according to how clearly an organisation understands its objectives and the methods needed to achieve them. This represents a significant contribution to innovation theory because it acknowledges that leaders must respond differently as uncertainty changes. I agree with Pearson's central argument, as many challenges within health and social care are complex and cannot be resolved through immediate solutions. However, I would argue that the model focuses primarily on the process of innovation and gives less consideration to the organisational culture that determines whether innovation is accepted, sustained or ultimately abandoned. Consequently, while Pearson provides a valuable framework for understanding according to Garvin (1993) innovation and successful implementation depends upon leadership behaviours that encourage learning, rather than innovation alone.

Pearson's exploratory stage is particularly valuable because it encourages organisations to investigate problems before attempting to solve them Pearson (1988). Too often, organisations react to performance concerns by introducing new policies or procedures without first understanding the underlying causes of the problem. I believe this reactive approach often creates compliance rather than meaningful improvement because staff are expected to implement change without contributing to its development. According to Greenhalgh et al. (2004) successful innovation within health services depends upon organisational context, communication and staff engagement, suggesting that understanding people is just as important as understanding processes. For this reason, I believe leaders should use the exploratory stage to encourage reflective practice, open discussion and knowledge sharing rather than simply collecting data. In my opinion, organisations that invest time in understanding problems before introducing solutions are more likely to achieve sustainable change than those relying solely on management direction.

As uncertainty reduces, Pearson (1988) argues that organisations become clearer about their goals while continuing to explore the most appropriate methods for achieving them. This demonstrates that innovation requires adaptability rather than rigid planning, which I consider one of the model's greatest strengths. Nevertheless, Pearson assumes that organisations can move logically through each stage, whereas leadership in health and social care is often influenced by competing priorities, limited resources and workforce pressures. According to Dawson et al (2017) organisational change is rarely

straightforward, leaders must constantly adapt to changing internal and external environments. I believe leaders must remain flexible enough to revisit earlier stages whenever new evidence or challenges emerge. This flexibility becomes increasingly important when attempting to influence organisational culture, as changing attitudes and behaviours often requires repeated reflection rather than one off interventions.

A further strength of Pearson's model is its recognition that innovation frequently creates opportunities beyond its original purpose Pearson (1988). I support this perspective because innovation should not end once a single objective has been achieved. Instead, leaders should encourage continuous learning by asking what additional improvements can be developed from successful initiatives. However, I would argue that Pearson underestimates the importance of emotional engagement throughout this process. Staff are more likely to support innovation when they feel respected, listened to and involved in decision making rather than simply instructed to adopt new practices. According to Goleman et al (2013) emotionally intelligent leaders build trust, collaboration and commitment by recognising the emotional impact of organisational change. Consequently, I believe innovation is influenced as much by relationships and leadership behaviours as it is by structured processes. Without emotional intelligence, even well designed innovations may struggle to become part of everyday practice.

From my perspective, Pearson's greatest contribution is encouraging leaders to view innovation as an ongoing process rather than a single organisational initiative. This closely reflects my own leadership philosophy. As I progress towards a management role, my ambition is not simply to introduce new systems or procedures but to help create a learning culture where continuous growth becomes everyone's responsibility. I also believe organisations achieve sustainable success when staff feel psychologically safe to share knowledge, reflect on practice and learn from both successes and mistakes. Garvin (1993) argues that learning organisations continually create, acquire and transfer knowledge to improve performance, while Senge (1990) suggests that sustainable improvement depends upon collective learning rather than individual expertise. These perspectives strengthen Pearson's theory by demonstrating that innovation becomes far more effective when learning is embedded within organisational culture instead of existing as isolated improvement projects.

Despite its strengths, Pearson's model can be criticised for paying limited attention to the wider organisational and political factors that influence innovation. Health and social care organisations operate within environments shaped by legislation, professional regulation, financial constraints and increasing service demands, all of which influence leaders ability to implement change successfully. Osborne et al (2010) argue that innovation within public services is significantly more complex than in many private organisations because leaders must balance competing stakeholder expectations while maintaining quality, accountability and public trust. This suggests that Pearson's framework should not be viewed as a complete explanation of innovation but rather as one component of a broader leadership strategy. In my opinion, innovation is most effective when structured processes are combined with emotionally intelligent leadership, organisational learning and a culture that values reflection, collaboration and shared responsibility for improvement.

Overall, I believe Pearson's Stage Specific Processes of Innovation remains highly relevant because it recognises that innovation develops through increasing clarity rather than immediate certainty. However, I do not believe innovation alone transforms organisations. Sustainable improvement occurs when

leaders create environments where learning is continuous, staff are empowered to contribute ideas and organisational culture supports rather than resists change. This reflects the type of leader I aspire to become. My long-term goal is to help develop organisations where learning, collaboration and innovation are embedded within everyday practice instead of becoming isolated management initiatives. Therefore, while Pearson provides an excellent framework for understanding how innovation develops, I believe its greatest value lies in supporting leaders who recognise that lasting organisational change begins with people before it begins with processes.

Innovation is fundamental to improving quality, safety and sustainability within organisations especially health and social care. Cooper's (2011) Stage-Gate Model is one of the most influential innovation frameworks because it introduces a structured process for evaluating and implementing new ideas through a series of decision points. By assessing innovation at each stage, organisations can minimise risk, allocate resources effectively and avoid investing in projects unlikely to deliver value. Although these strengths make the model attractive within health and social care, I argue that its emphasis on structure and control limits its ability to explain how innovation is sustained within complex care environments.

One of the model's greatest strengths is its ability to introduce accountability into innovation. Cooper (2011) argues that projects should only progress when evidence demonstrates they are achievable, financially viable and aligned with organisational priorities. Within health and social care this is particularly valuable because innovation should improve outcomes without compromising patient safety or wasting limited resources. Structured decision making also encourages leaders to justify investment through evidence rather than intuition. However, I question whether the model assumes that unsuccessful innovation is primarily the result of poor planning. In reality, many healthcare innovations fail because organisations underestimate the importance of staff engagement rather than because governance is weak. Employees who feel excluded from decision making are less likely to support change, regardless of how carefully projects have been planned. Edmondson (2019) argues that psychological safety encourages staff to speak openly, challenge existing practice and contribute new ideas without fear of blame. This suggests that innovation depends as much on organisational culture as it does on structured management processes.

The Stage-Gate Model also provides a logical method for screening ideas before substantial investment occurs Cooper (2011). This enables organisations to reject unsuitable projects early, reducing financial and operational risk. While this reflects responsible management, I believe it also presents one of the model's greatest weaknesses. Decisions regarding which ideas deserve investment are frequently influenced by senior management priorities, potentially overlooking valuable suggestions from frontline professionals. Within health and social care, those delivering care often possess the greatest understanding of service challenges and opportunities for improvement. According to Pfeffer (1998) organisations achieve sustainable performance by recognising employees as their greatest strategic asset rather than simply those responsible for implementing managerial decisions. Innovation should be evaluated collaboratively rather than through hierarchical decision making alone. A structured process is valuable, but it should never replace professional judgement or discourage staff from contributing creative solutions.

A further strength of Cooper's framework is its emphasis on feasibility. Evaluating financial, operational and technical requirements before implementation reduces organisational uncertainty and encourages evidence based leadership Cooper (2011). Nevertheless, this stage can unintentionally encourage risk aversion. Like most organisations Healthcare operates within financial pressures and workforce shortages, making innovative ideas appear unrealistic during the early stages of development. If leaders focus primarily on affordability, genuinely transformational opportunities may be rejected before their long term value is recognised. Dawson et al (2017) argue that innovation requires leaders to tolerate uncertainty because creativity rarely develops through predictable or linear processes. I therefore believe feasibility should consider strategic value alongside immediate cost. Effective leaders must balance financial responsibility with a willingness to invest in innovations capable of producing long term improvements in service quality and organisational performance.

Another limitation is the model's assumption that innovation progresses sequentially. Although the Stage-Gate process provides clarity, health and social care organisations rarely experience such predictable conditions. Changing legislation, workforce pressures, technological developments and increasing patient expectations frequently require leaders to revisit previous decisions rather than move progressively through predefined stages. Osborne and Brown (2010) argue that innovation within public services is shaped by political, organisational and professional influences that cannot be managed through linear models alone. Consequently, I view the Stage-Gate Model as a flexible guide rather than a prescriptive framework. Leaders who rigidly follow each gate risk prioritising process over adaptability, potentially limiting innovation rather than encouraging it.

Cooper's greatest limitation is that the model focuses on managing projects instead of developing the organisational culture needed to sustain innovation. While governance, planning and evaluation are essential, they cannot by themselves create organisations that continuously improve. Innovation is ultimately driven by people who feel trusted, supported and empowered to question existing practice. According to Tidd et al (2018) innovation emerges through organisational learning, collaboration and knowledge sharing rather than project management alone. As a future health and social care manager, I would use the Stage-Gate Model to strengthen governance while ensuring each decision point became an opportunity for reflection, staff engagement and multidisciplinary learning. Rather than viewing gates solely as approval mechanisms, I would use them to encourage discussion, identify barriers and capture learning that could improve future innovation.

I also believe that leadership plays a more significant role than Cooper acknowledges. Structured processes cannot motivate people to embrace change, particularly within health and social care where innovation often challenges established professional behaviours. West et al. (2017) argue that compassionate leadership creates cultures characterised by trust, inclusion and collaboration, enabling innovation to become embedded within everyday practice. I strongly agree with this perspective because sustainable improvement depends upon developing people rather than simply implementing systems. Leaders who encourage learning and shared responsibility are more likely to create organisations capable of adapting to future challenges than those relying exclusively on formal innovation frameworks.

Overall, Cooper's Stage-Gate Model remains a valuable innovation management framework because it introduces structure, accountability and evidence based decision making into organisational change.

However, its emphasis on governance means it explains how innovation should be managed more effectively than how innovation actually develops within health and social care. Its sequential design underestimates the complexity of organisational culture, professional relationships and leadership behaviours that influence whether change succeeds or fails. Therefore, while I would adopt the Stage-Gate Model to strengthen governance and reduce unnecessary risk, I would adapt it by prioritising collaboration, psychological safety and continuous organisational learning. In my judgement, sustainable innovation is not created by successfully passing through gates but by creating a culture where staff are empowered to question practice, share knowledge and continuously improve the quality of care.

Evaluating the Organisation's Ability to Harness Creativity and foster a creative culture in the workplace

Creativity is increasingly important within health and social care because organisations must respond to changing resident needs, workforce pressures and expectations for personalised, high quality services. However, creativity should not be understood simply as an individual's ability to produce new ideas. According to Amabile (1996) creativity is influenced by both individual capability and the organisational environment. Factors such as organisational encouragement, supervisory support, work group support, autonomy and resources are important influences on workplace creativity. Research developed and validated the KEYS instrument for assessing organisational climates for creativity and demonstrated differences between environments associated with high- and low-creativity projects. This provides a strong basis for arguing that organisations cannot simply expect employees to be creative leaders have responsibility for creating conditions in which creativity can develop.

This is particularly relevant within residential dementia care. Frontline staff develop substantial knowledge through their everyday relationships with residents and may recognise opportunities to improve communication, activities, routines, environments or quality of life. However, possessing this knowledge does not automatically mean it becomes organisational innovation. Greenhalgh et al. (2004) in their systematic review of innovation within service organisations, demonstrate that the spread and sustainability of innovation are affected by organisational and contextual factors. This challenges the assumption that a worthwhile idea will naturally become established practice. Instead, leadership is required to recognise useful ideas, connect people with different forms of knowledge and create opportunities for suggestions to be discussed and developed.

The distinction between creativity and innovation is therefore significant. Creativity involves generating ideas that are both novel and useful, whereas innovation requires those ideas to be successfully implemented within practice Amabile (1996). From this perspective, an organisation could employ highly creative individuals yet remain relatively uninnovative if their ideas are never heard, developed or implemented. The leader's role should therefore not be viewed as having all the creative ideas personally. More effective leadership involves **harnessing collective creativity** by recognising the strengths, experience and knowledge already present within the workforce.

Amabile et al. (1996) provide further support for this argument because their research demonstrates the importance of the work environment rather than treating creativity purely as an individual characteristic. Within residential care this creates an important challenge. Employees may have considerable experience and motivation but still have limited opportunity to reflect or contribute ideas when immediate care requirements dominate the working day. Staffing pressures, increasing resident dependency and time critical responsibilities can understandably produce task focused working. Therefore, a lack of visible innovation should not automatically be interpreted as a lack of creativity or commitment among employees. The organisational question is whether leadership can create realistic opportunities for staff knowledge to be heard despite these pressures.

However, autonomy and creativity must be treated carefully within health and social care. Encouraging employees to question routines and suggest alternative approaches can support person-centred practice, but residential dementia care also operates within safeguarding, regulation, professional accountability and duty-of-care requirements. Creativity cannot mean unrestricted experimentation with vulnerable people's care. Greenhalgh et al. (2004) show that innovation within health services is complex and dependent upon interactions between the innovation, adopters and organisational context. Consequently, effective leadership must balance creative freedom with governance. Staff should be encouraged to ask whether something could be done differently while leaders ensure that proposed improvements remain safe, ethical, evidence based and centred upon residents.

Collaboration is central to achieving this balance. Tidd and Bessant (2018) position innovation as an organisational process requiring knowledge, interaction and implementation rather than simply individual inspiration. Within residential dementia care, potentially valuable knowledge exists across different occupational and professional groups. Nurses may contribute clinical knowledge, care workers detailed observations from everyday interactions, activity staff knowledge of engagement and personal interests, while domestic and catering staff may notice environmental or dietary issues that are less visible to others. Families and external healthcare professionals can add further perspectives. A forward-thinking leader can therefore increase the organisation's creative capacity by bringing these different forms of knowledge together.

However, simply placing people together does not guarantee effective collaboration. Employees must also feel sufficiently secure to ask questions, disagree constructively and suggest alternatives. Edmondson's (1999) research into work teams established psychological safety as an important factor associated with team learning behaviour. Psychological safety concerns whether people perceive that interpersonal risks, such as admitting uncertainty or offering an alternative view, can be taken without fear of humiliation or rejection. This has clear relevance for creativity because an employee who expects criticism for questioning established practice may choose silence instead.

This does not mean that psychological safety removes accountability. In residential care, challenging ideas can be as important as generating them. A psychologically safe team should be able to say both "Could we try this differently?" and "What evidence do we have that this is safe?" Effective leadership therefore requires openness combined with professional challenge. This is particularly important when innovation affects vulnerable residents because participation should broaden decision making without weakening responsibility.

The organisation's "Care from the Heart" value can provide a shared purpose around which this collaborative approach develops. However, organisational values only become meaningful when they are reflected in everyday behaviours. Schein (2017) argues that organisational culture develops through shared assumptions that become embedded through organisational experience. Therefore, displaying a value is different from living it. If leadership translates *Care from the Heart* into listening, knowledge sharing, mutual respect, reflective practice and genuine involvement in improvement, the value can influence both how residents are cared for and how employees work with one another.

Garvin's (1993) concept of the learning organisation strengthens this argument by emphasising systematic problem solving, experimentation, learning from experience and transferring knowledge. Senge (2006) similarly identifies shared vision, team learning and questioning existing mental models as important to organisational learning. These perspectives suggest that creativity does not need to sit outside normal care practice. Handovers, supervision, multidisciplinary discussions and reflective conversations can become opportunities not only to identify what must be completed but also to consider what has been learned and what could be improved.

Overall my organisation's ability to harness creativity depends significantly upon leadership's ability to create the conditions in which employees can contribute. Amabile demonstrates the importance of organisational support for creativity, Edmondson explains the interpersonal conditions necessary for learning and speaking up, while Greenhalgh et al. (2004) demonstrate the contextual complexity surrounding innovation within health services. Consequently, effective leadership should not be judged by whether the leader personally produces the most ideas. It should be judged by whether leadership can bring out the knowledge and creativity of the workforce, critically evaluate ideas and turn appropriate suggestions into improvements.

Harnessing individual ideas is only the first stage. The greater organisational challenge is creating a culture in which creativity, collaboration and learning become sustained rather than occurring occasionally. Schein (2017) argues that culture is embedded through shared assumptions and organisational learning. This means that leaders influence creative culture through what they consistently model, encourage and reinforce. If questioning, learning and collaboration are welcomed, employees gradually understand that improvement is part of their role. If established routines are rarely questioned, creativity may remain dependent upon isolated individuals rather than becoming an organisational capability.

West (1990) identified vision, participative safety, task orientation and support for innovation as central dimensions of a climate supportive of innovation. Anderson et al (1998) also developed and validated the Team Climate Inventory to measure climate for innovation within work groups. Importantly, their validation research was not confined to commercial organisations, it included hospital management, primary healthcare, social services and psychiatric teams. This gives the framework particular relevance when considering collaborative working within health and social care.

Vision provides creativity with direction. Within the organisation, *Care from the Heart* has the potential to act as more than a slogan by providing a shared purpose for improvement. Creativity should not be pursued simply because organisations are expected to innovate. Instead, the central question should be whether an idea improves residents' wellbeing, experience, dignity or quality of care. Leadership can

therefore use organisational values to prevent innovation becoming disconnected from the purpose of the service.

West's (1990) concept of participative safety is equally significant because a creative culture depends upon people believing that their contribution is valued. This aligns with Edmondson's (1999) psychological safety research. Together, these theories suggest that leaders should create opportunities for employees at different organisational levels to contribute rather than allowing improvement discussions to be dominated by management or the most confident members of a team. Within dementia care this matters because valuable knowledge can come from people who may not hold formal authority but have extensive direct contact with residents.

However, participation alone is insufficient. West's (1990) task orientation introduces an important critical element because teams also require commitment to quality, appraisal and improvement. Creative culture should therefore not mean accepting every idea. Leaders need to encourage staff to question existing approaches while also encouraging them to question new suggestions. This creates a more mature form of creativity, where ideas are welcomed, but they are tested against evidence, resident outcomes, safeguarding requirements and available resources before implementation.

A practical technique to support this collaborative approach is De Bono's Six Thinking Hats (1985). The method separates different modes of thinking: the white hat focuses upon information, red upon feelings and intuition, black upon risks, yellow upon benefits, green upon alternatives and creativity, and blue upon managing the thinking process. Within residential care, a leader could use this structure when a multidisciplinary team is considering an improvement such as increasing resident engagement, improving mealtimes or addressing a recurring communication problem. Rather than different employees immediately defending their own positions, the group is encouraged to examine the same problem from several perspectives.

There is evidence suggesting potential value in structured creative-thinking techniques, although it should not be exaggerated. Vernon and Hocking (2014) compared structured problem construction techniques and found that Six Thinking Hats produced benefits in originality relative to controls. Gocmen et al (2019) subsequently examined different thinking hats during brainstorming and found differences in creative idea generation, with the green-hat condition particularly associated with unique ideas under aspects of their experimental conditions. These findings provide some evidence beyond De Bono's original claims.

This is an important distinction because organisations can sometimes introduce creativity tools without changing the conditions that originally restricted creativity. Amabile et al. (1996), Anderson and West (1998) and Edmondson (1999) suggest that organisational support, participative conditions and interpersonal safety are more fundamental than any individual technique. Six Thinking Hats may help structure collaboration, particularly by encouraging a group to consider perspectives beyond its usual way of thinking, but leadership must still ensure that staff have a genuine voice and that worthwhile ideas receive a response.

A further requirement is moving from ideas to action. If employees repeatedly contribute suggestions but never learn what happened to them, participation may eventually decline. Greenhalgh et al (2004)

demonstrate that implementation and sustainability are important dimensions of innovation within service organisations. Leaders therefore need a visible feedback process. Appropriate ideas might be developed, tested and evaluated within suitable governance arrangements, while suggestions that cannot proceed should still receive an explanation. This closes the gap between *asking people to be creative* and genuinely harnessing their creativity.

A learning culture can also make innovation more achievable under the pressures of residential care. Garvin (1993) and Senge (2006) both challenge organisations to learn systematically rather than repeatedly relying upon established routines. However, this does not necessarily require lengthy innovation meetings or major programmes. In a busy residential setting, small reflective discussions, improved handovers, short multidisciplinary problem-solving sessions, staff mentoring and opportunities to share successful approaches may be more realistic. This recognises operational pressure while refusing to accept that pressure must completely eliminate reflection and improvement.

In conclusion leadership acts as the connecting mechanism between organisational culture, collaboration, creativity and innovation. Ultimately, fostering a creative culture within residential dementia care requires more than encouraging employees to “think outside the box”. It requires leadership that gives people a voice, values different forms of knowledge, creates psychological safety, provides constructive challenge and follows ideas through to action. Operational pressures and governance requirements inevitably limit how much freedom exists, but these constraints make effective leadership more important rather than less important. Care from the Heart can provide the shared vision underpinning this approach if it is reflected not only in relationships with residents but also in how staff communicate, learn and improve together. The organisation’s creative potential therefore lies largely within its people. Effective leadership determines how effectively that potential is brought together, developed and converted into meaningful innovation for residents.

Conclusion

Overall, creativity provides the ideas from which innovation can develop, but ideas alone do not guarantee successful change. The innovation theories and models explored demonstrate that innovation requires a process through which creative ideas are evaluated, developed and implemented. Hisrich and Kearney (2014) emphasise innovation through individuals, teams and organisational processes, while Rogers (2003) and Mahajan (2010) focus more on how innovation is communicated, adopted and diffused through social systems. Although offering different perspectives, the theories collectively demonstrate that creativity and innovation cannot operate in isolation. Ultimately, strong leadership must bring people at all levels of an organisation together, allowing creativity, knowledge and experience to be shared and transformed into meaningful and lasting innovation.

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