

Applied Leadership and Management in the Workplace

Module Assignment Submission

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Introduction

This assignment critically examines the ability of an anonymised care organisation to innovate effectively and foster creativity in the workplace. It applies Cooper's Stage Gate model and Chesbrough's Open Innovation model to assess how the organisation introduces and sustains change. The discussion also evaluates how leadership, staff expertise, motivation, autonomy, resources and organisational culture influence creativity. Particular attention is given to digital care records, electronic medication systems, staff training, handovers and person centred support. The analysis argues that the organisation can generate and adopt new ideas, but its main weakness lies in embedding improvements consistently over time.

Using at Least Two Recognised Models of Innovation, Critically Examine the Ability of the Organisation to Innovate Effectively

Innovation is often associated with developing new products, but this definition is too narrow for a care organisation. Innovation in care is more likely to involve changes to services, technology, working practices and the way support is delivered. Singh and Aggarwal (2022) define innovation as the implementation of adaptive solutions that create commercial or social value. This is relevant to care because value may be demonstrated through improved safety, dignity, communication and wellbeing rather than profit. However, introducing something new does not mean innovation has been successful. A digital recording system may appear modern, but if it increases administrative work without improving care, its value is questionable. Innovation should therefore be judged by whether improvements are useful and sustained rather than by the number of new systems introduced.

The organisation examined is an anonymised care provider in South Wales. It has introduced digital care records, electronic medication administration records, revised handovers, staff training, person centred support practices and new activities. This shows a willingness to change, but willingness should not be confused with innovation capability. The organisation has sometimes struggled to maintain improvements once the initial attention around implementation has reduced. It therefore appears more successful at introducing change than embedding it into everyday practice.

This distinction matters because visible modernisation can give the impression of progress even when working practices remain similar. Digital records may improve access to information and create clearer audit trails, but they can also increase screen time and duplicate recording. Training may communicate new expectations, but it does not demonstrate organisational learning if staff lack the time or support to apply it. Similarly, person centred care may feature strongly in policies while staffing pressures and fixed routines continue to restrict choice. Innovation should therefore be assessed through outcomes and sustained practice rather than the existence of new policies or technology.

Cooper's Stage Gate model provides one way of examining this issue. It divides innovation into stages such as idea generation, feasibility, development, testing and implementation, with decision points between each stage (Cooper, 1990, 2011). These gates allow an organisation to decide whether an idea should progress, be adapted or stopped. This appears useful in care because some changes involve significant risk. Electronic medication systems, for example, should not be introduced without considering staff capability, technical reliability, data security and medication safety.

However, Stage Gate assumes that innovation can be organised into relatively clear stages. This is questionable in care because services are shaped by human relationships and changing individual needs. A handover process may work well when staffing is stable but become difficult during sickness or emergencies. An activity may work well for one service user but be unsuitable for another. Innovation in care is therefore less predictable than the linear appearance of Stage Gate suggests. Cooper (2019) later recognised that modern versions require flexibility, overlapping stages and repeated learning. This makes the model more realistic, but also suggests that the traditional version is too rigid if followed literally.

Digital care records illustrate both the strengths and weaknesses of Stage Gate. Management may first identify problems with paper recording before assessing costs, internet reliability, staff confidence and compatibility with current systems. Testing should include busy shifts rather than ideal conditions, while implementation should involve training, technical support and review. However, a more important question is who is actually involved in these stages. Were frontline workers consulted before the system was selected, or were they expected to adapt afterwards? Were problems identified during testing genuinely addressed? A process may appear organised while still excluding the people who understand daily care most closely.

Frontline workers often have detailed knowledge of how systems operate across different shifts. If managers control every gate, this knowledge may be treated as informal opinion rather than useful evidence. Stage Gate may then reinforce hierarchy rather than improve decision making. Staff may comply with a new process because they are required to, but compliance is different from ownership. Limited involvement could therefore help explain why some improvements weaken once management attention reduces.

There is a reasonable counterargument. Care organisations have safeguarding, medication and regulatory responsibilities, meaning managers cannot allow unrestricted experimentation. However, regulation does not require frontline staff to be excluded. Systems designed without practical input may actually create additional risks. The issue may therefore be less about regulation and more about how managers interpret risk. If every challenge to current practice is treated as unsafe, Stage Gate becomes a way of protecting existing routines rather than evaluating better alternatives.

Tidd and Bessant (2021) argue that innovation involves searching for opportunities, selecting suitable options, implementing them and capturing value. Stage Gate supports this by providing review points and clarifying responsibility. This is valuable for high risk or expensive changes such as electronic medication systems. However, applying the same level of control to every improvement would be unnecessary. Requiring formal approval for minor changes to activities or individual routines could reduce responsiveness and discourage staff initiative.

This is particularly important because care is already heavily documented. Additional forms, meetings and approval stages may create the appearance of stronger governance while increasing workload. If these processes remove time from direct care or reflection, they may create the conditions that make innovation harder to sustain. Stage Gate is therefore useful only when applied proportionately. Structure should help staff test and maintain improvements rather than become another layer of bureaucracy.

The model may be most useful after implementation. The organisation's main weakness is not a lack of ideas but that improvements can lose momentum. A post implementation gate could examine whether digital records remain accurate, electronic medication systems reduce errors and revised handovers improve communication. Klein and Sorra (1996) argue that implementation effectiveness depends on innovations being used consistently and appropriately. This supports the view that a successful launch is not enough.

Even then, measuring compliance alone would be too limited. Staff may complete digital records correctly while feeling that the system creates unnecessary work, while service users may see little improvement in their care. Management should therefore ask whether an innovation produces better outcomes rather than simply whether employees follow the procedure. A system can become embedded administratively without actually becoming beneficial.

Chesbrough's Open Innovation model provides a different perspective. It challenges the idea that useful knowledge must come from inside the organisation. Instead, innovation can involve ideas moving across organisational boundaries through partnerships, collaboration and external networks (Chesbrough, 2003). This fits care because providers work alongside local authorities, healthcare professionals, pharmacies, technology suppliers, training organisations, relatives and service users.

Open Innovation could increase access to useful expertise. Pharmacists and nurses may contribute to safer medication practices, technology suppliers provide specialist knowledge and relatives or service users may identify issues staff overlook. Other care providers may also have experience of systems that have succeeded or failed. However, Chesbrough's model was developed mainly around commercial organisations, research and development and intellectual property. Its direct application to care is therefore limited. Care organisations also need to prioritise dignity, safeguarding, confidentiality and continuity of relationships. Open Innovation remains useful, but only when adapted to recognise social and ethical value.

Open Innovation can also be linked to service user involvement. Bovaird (2007) argues that co-production treats people who use services as contributors rather than passive recipients. Involving service users in activities, routines and support planning could therefore produce ideas that better reflect their needs. However, consultation should not automatically be described as co-production. If service users are asked for preferences but management continues to make every important decision, their influence remains limited. Genuine openness requires evidence that their views actually change practice.

The same criticism applies to employees. Staff may be invited to contribute ideas during meetings, but this does not mean those ideas have influence. Managers still control budgets, priorities and final decisions. Open Innovation assumes that organisations are willing to absorb knowledge, but says less

about what happens when that knowledge challenges authority. If suggestions are repeatedly ignored, staff may eventually stop contributing. The organisation could therefore appear open while remaining closed in practice.

External partners also have their own interests. Technology suppliers may promote systems as efficient because they improve reporting for managers or regulators while increasing frontline workload. The organisation therefore needs to ask whose problem an innovation is actually solving. External knowledge is useful, but it is not automatically neutral.

Roy's (1993) study of Dyson and Sanders demonstrates that ideas can emerge when knowledge is transferred between different contexts. A care organisation could similarly learn from structured hospital handovers or incident review systems used in other high risk settings. However, copying methods from another sector without understanding why they work could create problems. Care relies heavily on trust, relationships and individual judgement. Standardisation may improve consistency but could also reduce personalisation. External learning is therefore most useful when ideas are adapted rather than copied.

March (1991) provides another challenge to the assumption that organisations should constantly pursue innovation. He describes organisational learning as a tension between the "exploration of new possibilities and the exploitation of old certainties" (p. 71). This fits the care organisation well. New approaches are necessary when existing practice is not working, but reliable routines are also essential for safety. Too much exploration could lead to constant initiatives and instability, while too much reliance on existing routines could protect ineffective practice.

The organisation's weakness may be that it introduces new approaches but does not always turn successful changes into dependable routines. March therefore suggests that more innovation is not automatically better. The organisation may gain more from carefully selecting useful changes and sustaining them than continually introducing something new. However, relying too heavily on familiar routines may also encourage complacency. Effective innovation therefore requires balance.

Greenhalgh et al. (2004) consider how organisations can "spread and sustain innovations in health service delivery and organization" (p. 582). Their work places greater emphasis on organisational readiness, leadership, communication, professional relationships and whether an innovation fits existing practice. This challenges the idea that choosing a good innovation is enough. Even a strong idea can fail if the organisation lacks the capacity to support it.

March and Greenhalgh et al. offer slightly different explanations. March focuses on balancing new possibilities with established routines, while Greenhalgh et al. focus on whether the wider organisation is ready to support change. Both are useful, although Greenhalgh et al. may be more directly relevant because the organisation's main problem is sustaining innovation rather than generating ideas.

Staffing and leadership are important here. Employees may agree with a change but abandon parts of it during demanding shifts because immediate care needs take priority. It would be too simplistic to label this resistance. Management needs to ask whether new practices are realistic with the staffing, training and supervision available. If they are not, inconsistent implementation may reflect organisational planning rather than poor employee attitudes. However, staffing pressure should not explain every

failure. Employees may also resist change because familiar routines feel easier. Management therefore needs to distinguish genuine resource barriers from habit or weak accountability.

Overall, neither Stage Gate nor Open Innovation fully explains innovation within the organisation. Stage Gate provides structure and accountability but may increase bureaucracy and reinforce hierarchy. Open Innovation broadens access to knowledge but may introduce ideas that do not fit the care environment and provides less guidance on sustaining them. March warns against treating constant innovation as automatically desirable, while Greenhalgh et al. show that sustainability depends on organisational readiness.

A combined approach could still be useful. Open Innovation could gather ideas from staff, service users and external professionals, while Stage Gate could provide proportionate checks around feasibility, safety and outcomes. March could help managers balance experimentation with stable routines, while Greenhalgh et al. highlight the importance of readiness and long term support. However, if managers continue to control every decision without meaningful staff involvement, even this combined approach would remain largely top down.

The evidence therefore suggests that the organisation has limited rather than strong innovation capability. It is willing to introduce technology and new ways of working, but willingness is not the same as effectiveness. Its difficulty sustaining improvements points to weaknesses in staff involvement, leadership consistency, evaluation and resource planning. Stage Gate provides the strongest structural foundation because the organisation needs more consistent testing, support and review. Open Innovation can improve the quality of ideas through wider knowledge, but it should not encourage constant new initiatives before existing changes are established. The organisation's main challenge is not generating more ideas but turning the right ideas into practical improvements that continue under pressure and genuinely improve care.

Evaluate the Organisation's Ability to Harness Creativity and Foster a Creative Culture in the Workplace

Creativity involves producing ideas that are original and useful, while innovation involves putting those ideas into practice. Csikszentmihalyi (1997) argues that creativity is not simply an individual ability because ideas also need to be recognised and accepted within a wider social setting. This is particularly relevant in a care organisation. Staff may identify better ways to communicate, organise activities or support service users, but those ideas have limited value if managers do not listen, evaluate them or support implementation. The organisation's ability to harness creativity should therefore be judged by whether employee ideas influence practice rather than simply by whether staff are invited to make suggestions.

The organisation does provide opportunities for staff to contribute through handovers, team meetings and informal discussions. Employees may suggest new activities, changes to support plans or different

ways of responding to individual needs. This suggests that creative thinking exists within the workforce. However, having ideas is not the same as using them effectively. Suggestions may be discussed and then forgotten, with little explanation about whether they were accepted or rejected. If this happens regularly, staff may reasonably question the value of contributing. The organisation therefore appears better at allowing ideas to be voiced than at turning them into sustained improvement.

Amabile's componential theory provides a useful way of understanding this problem. Amabile (1988, 1996) argues that creativity depends on expertise, creative thinking skills and task motivation. Frontline care workers often have detailed knowledge of service users, routines and everyday difficulties. This may allow them to recognise issues that senior managers do not see directly. For example, a care worker may notice that a service user becomes anxious during a certain routine or that a recording process creates unnecessary duplication.

However, expertise does not automatically lead to creativity. Experience can provide valuable knowledge, but it may also make familiar routines feel safer and harder to challenge. Roy (1993) similarly shows that innovation requires specialist knowledge alongside the willingness to question established practice. The organisation should therefore value experience without assuming that longer service always leads to better ideas. Expertise supports creativity only when employees are willing to reconsider how things are currently done.

Amabile's framework is also limited because it can make expertise, motivation and creative thinking appear more separate than they are in practice. Anderson et al. (2014) argue that creativity and innovation are influenced by interacting individual, team and organisational factors. This means that a motivated and knowledgeable care worker may still struggle to contribute if workload, hierarchy or management behaviour restricts their influence. Amabile is therefore useful for identifying conditions that support creativity, but it does not fully explain who has the power to decide which ideas are taken seriously.

Creative thinking also depends on whether staff feel able to explore alternatives. Care work is highly regulated through policies, care plans, safeguarding procedures and risk assessments. These controls are necessary, but they may encourage employees to focus on compliance rather than asking whether current practice could be improved. However, regulation should not be treated as the main reason creativity is restricted. Staff can still improve communication, activities and person centred support while remaining within safe boundaries. The more important issue is how management interprets regulation.

A manager who treats policy as a safe boundary for improvement may encourage staff to explore different approaches while maintaining standards. A risk averse manager may use the same policy as a reason to reject change. If most suggestions are met with concerns about risk before their potential value is considered, employees may learn that creativity is not genuinely encouraged. The barrier may therefore be less about regulation itself and more about a culture that treats existing practice as automatically safer.

Motivation is another important part of Amabile's theory. Care workers may be motivated by a desire to improve dignity, safety and quality of life. Deci and Ryan (2000) argue that motivation is strengthened

through autonomy, competence and relatedness. Staff may therefore be more willing to contribute ideas when they feel trusted, capable and connected to the people they support.

However, intrinsic motivation should not be treated as unlimited. Meaningful work does not remove the effects of exhaustion, poor staffing or weak management. A care organisation may rely too heavily on the commitment of staff and assume that because employees care about service users they will continue to go beyond what is expected. This is not sustainable. Personal commitment may support creativity for a time, but it cannot replace adequate resources, recognition or leadership support. Motivation is therefore shaped by organisational conditions as much as by personal values.

Amabile also identifies management practices that influence creativity, including challenge, freedom, resources, work group features, supervisory encouragement and organisational support. Challenges can encourage creative thinking when work is meaningful and demanding. However, care work can quickly move from productive challenges into excessive pressure. Staff dealing with medication, personal care, documentation and unexpected incidents may have little time to reflect on better ways of working. The organisation may technically allow employees to suggest ideas, but this freedom becomes largely symbolic if staff have no time to develop them.

Autonomy creates a similar tension. Too little autonomy may suppress initiative, but complete freedom would be inappropriate in areas such as medication administration or safeguarding. The organisation therefore needs bounded autonomy. Staff could have more influence over activities, communication and smaller improvements while remaining accountable to essential standards. However, responsibility should not be confused with autonomy. If employees are expected to solve problems while management controls all resources and final decisions, responsibility has been passed down without any real increase in authority.

Resources also influence creativity. New activities may require funding, transport or extra staff, while digital changes may depend on suitable equipment and training. It is sometimes argued that constraints encourage creative problem solving, and this may be true in limited situations. However, chronic under resourcing is different. Persistent shortages are more likely to push attention towards immediate tasks than experimentation. The idea that employees should simply be more creative with fewer resources risks allowing management to avoid structural problems.

Team climate is equally important. Edmondson (1999) argues that psychological safety allows employees to raise concerns, admit mistakes and challenge established practice without fear of humiliation or punishment. This is particularly relevant in care because improvement often begins with somebody being willing to say that an existing practice is not working. If employees expect blame or criticism, silence may feel safer than suggesting change.

Psychological safety is also affected by hierarchy. Nemphard and Edmondson (2006) found that leader inclusiveness supported psychological safety and engagement in improvement within healthcare teams. This suggests that managers need to do more than tell staff that they can speak openly. They need to actively invite views, respond to them and show that frontline knowledge is valued. Even then, inclusion should be judged by influence rather than friendliness. Staff may feel comfortable speaking to a manager while still having little effect on final decisions.

Simply asking for ideas during meetings is therefore not enough. If suggestions repeatedly disappear without explanation, staff may stop contributing. Supervisory encouragement requires more than praise. Managers need to respond, explain decisions and follow up. The organisation's difficulty sustaining improvements may partly reflect inconsistent leadership attention. New initiatives may receive significant focus during training or launch but lose importance when managers move on to another priority. Staff may then reasonably assume that the change is temporary.

Organisational culture is also important. Schein (2010) argues that culture operates beneath visible policies and stated values through shared assumptions about how people are expected to behave. A care organisation may claim to support creativity while rewarding employees mainly for completing tasks quickly, maintaining documentation and avoiding problems. These activities matter, but if they dominate performance expectations, staff may focus on visible compliance rather than less measurable improvements in wellbeing.

Schein's view is useful, but the idea of one organisational culture may be too simple. Mannion and Davies (2018) argue that healthcare organisations contain different professional and occupational subcultures. Managers may experience the care home as supportive and innovative while frontline employees experience high workload, hierarchy and limited influence. Service users may experience it differently again. The organisation should therefore be cautious about describing itself as having a creative culture based only on policies or managerial perceptions.

Braithwaite et al. (2017) found associations between positive organisational cultures and outcomes such as patient satisfaction, fewer falls and lower infection rates. This supports the argument that culture matters for quality. However, this should not be interpreted as proof that changing culture alone will improve outcomes. Staffing, skills, leadership and resources may be equally important. The organisation should therefore avoid treating culture as a convenient explanation for problems that are actually structural.

Tolerance of failure is another complicated issue. Creativity requires some degree of experimentation, but care organisations cannot accept failures that place service users at risk. This does not mean that every unsuccessful idea should be treated as poor performance. A new activity or communication method may fail without causing harm and can still provide useful learning. The organisation needs to distinguish safe experimentation from negligence. If every failed idea is punished, staff may avoid risk. If failure is accepted without review, the organisation may repeat the same mistakes.

Service user involvement could also strengthen creativity because residents and relatives may identify priorities that staff overlook. However, Masterson et al. (2022) found considerable variation in how co production and co design are understood in health and social care. Asking service users for preferences does not automatically amount to genuine co production. If people are asked what they want but management retains control over every important decision, their involvement remains limited.

The organisation therefore needs to consider whether service user involvement actually changes practice. Some suggestions may not be possible because of safeguarding, staffing or cost, but those limitations should be explained. Genuine involvement does not mean accepting every suggestion. It

means ensuring that service users have meaningful influence rather than simply providing information that management may choose to ignore.

The creativity process of incubation, illumination and translation also offers some insight. Incubation involves processing information, illumination is the emergence of an idea and translation turns that idea into something useful. However, this model places considerable emphasis on individual thinking. Creativity within care is often collective, with ideas developing through conversations between staff, service users and relatives rather than through one individual having a sudden moment of insight.

Translation is the most useful part of the process for understanding this organisation because idea generation does not appear to be the main problem. Staff already have practical knowledge and opportunities to suggest improvements. The greater weakness lies in turning those ideas into changes that last. Creativity only becomes valuable when the organisation has the leadership, resources and follow up needed to move from suggestion to practice.

Leadership is therefore central. West et al, (2014) argue that healthcare innovation is influenced by leadership, team climate and organisational support. Participative leadership may encourage staff involvement, but it would be unrealistic to argue that this style is always appropriate. During emergencies or safeguarding incidents, a more directive approach may be necessary. The important issue is whether managers can recognise when control is required and when participation would produce better decisions.

Managers who remain directive in every situation may achieve compliance but restrict creativity. Equally, managers who encourage participation without making clear decisions may create frustration. A creative culture therefore depends less on one leadership style and more on leaders using the right approach while showing that staff knowledge is genuinely valued.

Overall, the organisation demonstrates some ability to harness creativity because staff possess valuable practical knowledge and have opportunities to contribute ideas. However, the culture appears only partially supportive. Workload, limited resources, hierarchy and inconsistent follow up reduce the likelihood that ideas will move from discussion into lasting practice. Amabile's framework is useful because it identifies conditions that support creativity, while Anderson et al, (2014) show that creativity is shaped across several interacting levels. Mannion and Davies (2018) also demonstrate why managers and frontline workers may experience the same organisation very differently.

The organisation should therefore be judged as uneven rather than strongly creative. It does not primarily need more ideas. It needs better ways of listening to existing knowledge, giving staff meaningful influence, responding clearly to suggestions and supporting useful ideas after their initial introduction. A stronger creative culture would include protected time for discussion, psychological safety, genuine service user involvement and proportionate opportunities for safe experimentation. Most importantly, creativity needs to be supported consistently rather than encouraged only when a new initiative is being introduced.

Conclusion

Overall, the organisation is capable of introducing new ideas and systems, but it is less successful at sustaining them once the initial focus has passed. Stage Gate can provide useful structure for testing and reviewing change, although it risks adding bureaucracy and strengthening managerial control if frontline staff are not properly involved. Open Innovation can bring in useful knowledge from employees, service users and external partners, but outside ideas will only add value if they are adapted to the realities of care. The organisation also has clear creative potential through staff knowledge and informal idea sharing. However, workload, limited resources, inconsistent leadership and weak psychological safety restrict how far those ideas are developed. Amabile's theory helps explain these conditions, but it does not fully account for regulation, hierarchy and power within care. The organisation therefore does not need more ideas as much as it needs stronger support to turn useful ideas into lasting improvements.

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