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Exploring team working and shared leadership in multi-disciplinary cancer care

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Exploring team working and shared leadership in multi-disciplinary cancer care

This article explores team working and shared leadership in the context of multi-disciplinary cancer care in the UK NHS, in particular, its relevance to the concept of the multi-disciplinary team, (MDT). The latter has been evolving since the Calman-Hine report in 1995 and subsequent policy documents, and national guidance, and they are currently the preferred way of organising cancer care in the UK, and in other countries, (Fleissig, et al, 2006, Lamb, et al, 2011 b, Taylor et al, 2010). Implementation of the idea of multi-disciplinary teams has been spurred by national guidelines on clinical outcomes, and in the case of cancer, by national service frameworks for cancer care, (Taylor, et al, 2010, Carter et al, 2003, p126). Indeed, use of MDTs for specific tumour groups is now mandatory in the UK, (Lamb, et al, 2011b).

Cancer services are undergoing wider strategic change as part of new policy initiatives in the UK NHS. In order to respond to such change, and the ongoing development of multi-disciplinary working, shared leadership, as opposed to traditional conceptualisations of leadership, may be worthy of further exploration. This is particularly so, given that such services have already developed collaborative organisational arrangements, for example, MDTs, cancer alliances, networks and new models of care.

The aim of this article is to explore shared leadership from the cancer service perspective. Firstly, it will look at MDTs and the policy background to shared leadership in cancer services; secondly, it will define shared leadership and assess the behaviours and attributes that might underpin it; and thirdly, it will discuss the implications and make recommendations about how to develop shared leadership in the context of multi-disciplinary cancer services and the continued use of MDTs.

Policy background to cancer service in the NHS

Development of multi-disciplinary teams, (MDTs).

As noted, multi-disciplinary team working is now the accepted way of organising and delivering cancer care as recommended by the Calman-Hine report which advocated a shift in cancer services from individual working to an 'overtly multi-disciplinary model', (Haward, 2006, p338). The rationale for introducing multi-disciplinary team working is the increasing complexity of care and the consequent need for all relevant professionals to be involved in clinical decision making, (Taylor, et al, 2010). Complexity and specialisation are said to be important drivers of the development of multi-disciplinary teams in cancer service delivery, (Blazeby, et al, 2005, p1). In a European policy statement on cancer care it has been stated that 'optimal decision making in the diagnosis, treatment and support of cancer patients is being increasingly associated with multi-disciplinary teams, (MDTs)', (European Partnership Action Against Cancer consensus group, 2014, p476).

While this has been the case for some years, evidence specifically of MDT effectiveness is limited, (Fleissig, et al, 2006, p935, Taylor, et al, 2010). However, the effectiveness of teams generally has been the subject of considerable research. Borrill, et al, point out that:

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3 'there is substantial empirical evidence that the introduction of teamwork and group goals
4 in diverse settings and involving diverse task types, can lead to increased effectiveness..',
5 (Borrill, et al, (a) 2000, p364).
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8 There is also considerable evidence that effective healthcare teams are associated with
9 reduced clinical error, increased safety, and team member well-being, (West and
10 Lyubovnikova, 2013, p134). Similarly, it is noted that effective team working may contribute
11 to reduced hospitalisation, patient satisfaction, team motivation and so forth, (Borrill, et al,
12 2000, (b) p 4).
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15 Theoretical approaches have been dominated by a systems- based, input-process-output,
16 (IPO), framework- in which teams benefit, or otherwise, from various inputs, or antecedent
17 factors, such as the characteristics of team members and the organisational context; team
18 processes such as leadership, decision making, and communication; and the extent to which
19 these inputs and processes lead to the desired outputs, or, in healthcare, outcomes, (Borrill,
20 et al, 2000, (a),p365; Haward, et al, 2003, p16; Lemieux-Charles, et al, 2006, p266, Mathieu,
21 et al, 2008, p412, West and Lyubovnikova, 2013, p136). There are numerous characteristics
22 of effective team working identified in the literature that may be embedded in this
23 framework, for example, participation, emphasis on quality, support for innovation, or
24 shared team objectives, (Poulton and West, 1999, p 10).
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28 Studies of MDTs and their effectiveness have identified leadership as an important
29 characteristic in the IPO framework, and one of the key factors that might be associated
30 with enhanced performance of such teams, (Fleissig, et al, 2006, Haward et el, 2003, Lamb,
31 et al, 2011 a). For example, in a systematic review of decision making in MDTs, it was found
32 that quality, patient safety and team morale are likely to depend on effective leadership ,
33 (Lamb, et al, 2011,a p2122). Conversely, in a study of the effectiveness of multi-disciplinary
34 teams in breast cancer care, it is suggested that where there is a 'lack of clarity or conflict
35 about leadership [this is] strongly and negatively related to effectiveness', (Haward et el,
36 2003, p21). Similarly, it is argued that lack of leadership or unstable leadership are among
37 the causes of problems with team working in healthcare, (Ndoro, 2014, p727). Whether
38 positive or negative, leadership is an important factor when considering the effectiveness of
39 MDTs, and will be the focus of this paper.
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44 **Policy development in cancer care**

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46 Leadership is important given the wider policy background to cancer services in the UK
47 which is rapidly evolving, the result of recent wide ranging policy reviews such as 'Achieving
48 World Class Cancer Outcomes: A Strategy for England', (Independent Cancer Taskforce
49 2015), which outlines the way forward for cancer services over the next five years and is the
50 cancer specific strategy as part of the Five Year Forward View (NHS England, 2014). The
51 former strategy says that a shared approach is important determinant in making the
52 strategy work: 'success in delivering the aspirations of this strategy will depend on devolved
53 decision making, agility and new models of care', (Independent Cancer Taskforce, 2015,).
54 Leadership will be required to deliver the strategy and its six strategic priorities ie upgrade
55 in prevention and public health; earlier diagnosis; priority to patient experience;
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3 transformation of support for people with cancer; investing in a modern high quality service;
4 and overhauling the processes for commissioning accountability and provision,
5 (Independent Cancer Taskforce, 2015,).

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7 Of particular interest in the context of a shared approach is the priority to establish Cancer
8 Alliances bringing together commissioners, providers and patients and providing 'cancer
9 specific leadership', (NHS England 2016, a p 4). Similarly, new models of care are premised
10 on the importance of a shared approach such as the national Cancer Vanguard led by
11 Christie and Royal Marsden hospitals, piloting a clinical network model, (NHS England 2016,
12 a p18). The task forces strategy has been endorsed by the government and will guide
13 implementation of the changes over the next five years. Operational planning and
14 contracting guidance for 2017-2019 is to work with alliances and cancer vanguard to
15 implement the task force report for cancer, (NHS England, b 2016) . The Government has
16 established a new national structure to implement the changes, including a National Cancer
17 Transformation Board and Advisory Group and work stream groups overseeing the six
18 strategic priorities.

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20 Along with patient involvement it is envisaged that clinical leadership will play a key role in
21 promoting these changes, particularly where this involves a 'bottom up as opposed to top
22 down' approach to clinical leadership, (Walsh and Lynas, 2016, p8). There will be a need to
23 ensure that the workforce in cancer services 'have the right skills, knowledge, and
24 competence to provide high quality cancer care', (NHS England 2016 a p 15). One may argue
25 that this includes skills, knowledge and competence in collaborative working and shared
26 leadership.

27 28 29 30 31 32 33 **Shared leadership in cancer services**

34 35 **Definitions**

36 Leadership remains a popular solution to the problem of 'improving the quality of
37 healthcare and the improvement of organisational processes', (Hartley and Benington,
38 2010, p3). However, leadership is a disputed subject area and difficult to define.
39 Notwithstanding this difficulty, it is possible to suggest there are at least three ways of
40 conceptualising or defining leadership in terms of broad focus: that is, by person, position or
41 process, (Hartley and Allison 2000, cited in Malby, et al, 2011, p341). Traditional
42 conceptualisations of leadership, such as traits, style or charismatic leadership, and other
43 approaches, like authentic leadership, leadership competency, and so forth, rely on the
44 *person* or *position* ie an individual perspective, with emphasis on top leaders who are
45 expected to display 'heroic' characteristics and behaviours and lead the organisation
46 forward almost single-handedly. However, it is noted that this may be problematic in
47 circumstances where such leaders display inappropriate or unethical behaviours, (Alimo-
48 Metcalfe and Alban- Metcalfe, 2011, p7). There is the possibility that this will result in
49 'divisive and dysfunctional leadership', (Lamb, et al, 2011, c p1201). In the current and
50 future climate and given policy changes emerging, and the complexity of cancer services,
51 individual notions of leadership may no longer be appropriate.
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3 More recent conceptualisations see leadership as a process 'shared by multiple individuals
4 who may or may not be positioned at the top of the hierarchy', (McKee, et al, 2013, p12). It
5 is premised on the fact that shared leadership involves at least two or more leaders, and
6 that individual leaders are unlikely to possess all qualities required for effective leadership,
7 (Bergman, et al, 2012, p18). Such conceptualisations focus on group dynamics and the
8 process of interaction between different members of a team, each of whom may assume a
9 leadership role according to the circumstances, although this does not necessarily preclude
10 the co- existence of positional leadership within a team. This allows for the fact that leaders
11 may emerge in organisations when 'they are needed, when their relevant skills, knowledge
12 and expertise are required by the team', (Bergman, et al, 2012, p18). When they are not
13 being a leader they are followers, and 'followership' rather than a leader-centric approach,
14 is said to be important in healthcare, (Mannion, et al, 2015,).
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19 While defining shared leadership has proved difficult there is some agreement in the
20 literature that it is:

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22 'a relational, collaborative leadership process or phenomenon involving teams or groups
23 that mutually influence one another and collectively share duties and responsibilities
24 otherwise relegated to a single leader', (Kocolowski, 2010, p24).
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27 This definition supports the emphasis on the process, but also suggests the importance of
28 horizontal, as opposed to vertical relationships between leader and follower and this has
29 become increasingly relevant in the NHS as more emphasis is attached to concepts such as
30 partnership working, collaboration, and inter-professional team working. This is the case
31 with regard to the organisation and delivery of cancer care but it applies generally to
32 healthcare delivery. It is said that health care organisations are receptive to shared
33 leadership as the quality of care may be affected by the presence or otherwise of effective
34 collaborative working between different professionals working towards a common goal,
35 (Kocolowski, 2010, p26). Emphasis on collaborative working may be particularly relevant in
36 cancer care. Fennell, et al, point out that:
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40 'quality cancer care is complex and depends upon careful coordination between multiple
41 treatments and providers and upon technical information exchange and regular
42 communication flow between all those involved in treatment', (Fennell, et al, 2010, p72).
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45 Complexity makes it difficult for a single leader to be effective, hence the shift to shared
46 leadership whereby tasks may be distributed according to expertise or skill, (Kunzle et al,
47 2010, p 1). Shared leadership is said to be important 'when dealing with complex tasks in
48 which the active engagement of multiple team members may be critical in solving a
49 problem', (Bligh, et al, 2006, p309). Similarly, shared leadership may be effective where
50 work tasks are highly interdependent, complex and depend on creativity, (Hartley and
51 Benington, 2010, p33). These criteria may resonate with the work of MDTs, indeed,
52 involvement in complex problem-solving and decision making is the *raison d'être* of such
53 teams.
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56 Thus shared, as opposed to individual conceptualisations, of leadership, may be seen as an
57 appropriate way forward in the context of cancer care, particularly given the continuing
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3 emphasis on multi-disciplinary teams. This is supported by Haward, et al, 2003, in a study of
4 breast cancer teams, who found that 'teams with shared leadership of their clinical decision
5 making were most effective', (Haward et al, 2003, p 15). While adopting shared leadership
6 may be the way forward, it may also be problematic as it involves a transition from
7 traditional, individualised clinical care and professional autonomy to new emphasis on
8 shared care and expertise provided by clinical teams, (Willard, and Luker 2007, p719). On
9 the other hand, where this transition is successful, it has been reported that teams with
10 shared leadership have 'less conflict, greater consensus, and higher intragroup trust and
11 cohesion', (Bergman, et al, 2012, p34).

15 Leadership behaviours and attributes for shared leadership

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17 Definitions of shared leadership emphasise that it is a process whereby leadership is shared
18 within the group but it is also important to identify just what is shared ie what constitutes
19 the activity, skills, expertise or behaviour that is shared by group members. It has been said
20 that this aspect – 'the leadership qualities of whole teams'- has been neglected in the
21 literature, (Hartley and Benington, 2010, p84). This question has multiple answers
22 depending on the perspective taken and is by no means agreed.

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25 One possibility, taken up by Bergman, et al, although not in a health care context, is that of
26 generic leadership behaviours based on the work of Yukl, and Sundstrom, De Meuse, and
27 Futrell, (Bergman, et al, 2012). These **behaviours and underpinning skills** will be explored
28 further in the context of cancer care **and the MDT**, although it is noted that they are by no
29 means a definitive list of behaviours, (Bergman, et al, 2012). Hence, within a team it is
30 suggested that there are at least four generic categories of leadership behaviour that may
31 be shared: initiating structure behaviours (task- oriented); consideration behaviours
32 (relations-oriented); envisioning behaviours (change oriented); and spanning behaviours
33 (oriented towards dealing with the boundary between team and wider organisation),
34 (Bergman, et al, 2012, p19). Leaders need to be adaptive in their choice of such behaviours,
35 **and underpinning skills**, depending on the needs of their followers and the organisation,
36 (Mannion, et al, 2015, p270).

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41 **It can be argued that** the first two - task and relations- oriented - behaviours - are
42 complimentary, in that they are concerned with achieving the core tasks of the MDT - such
43 as diagnosis, **and** treatment/ rehabilitation goals - and at the same time, ensuring that
44 relationships and interactions within the team are conducive and supportive of these goals.
45 While **individual leaders may have a** preference for a particular **behaviour**, the advantage of
46 adopting shared leadership is that a range of **behaviours** may be available to the MDT,
47 depending on team members and the context or task. A task- oriented style may, in fact, be
48 provided by a positional or hierarchical leader within the team. McKee, et al suggest there
49 may be a need for 'old style' leadership providing direction and focusing on tasks, to
50 counter balance other approaches, (McKee et al, 2013, p17).

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55 Adopting task -oriented leadership behaviour means that leaders of MDTs are **likely to**
56 engage in activities like planning, organising, monitoring, coordinating, forecasting and goal
57 setting. **These** underpin the more traditional leadership functions and, as such, may overlap
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3 with classical definitions of management. The leaders' effectiveness in adopting these
4 behaviours may depend on underpinning cognitive, analytical, technical and organisational
5 skills and knowledge and understanding of the context. However, it has been stated that
6 there is now a shift away from this approach to leadership, although both approaches may
7 still be required:
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10 '[..]after many years acknowledging the importance of task and more cognitive- oriented
11 conceptions of health leadership, the balance appears now to be switching towards an
12 understanding of the importance of the emotional and relationship dimension', (Skinner and
13 Spurgeon, 2005, p11).
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16 The latter dimension is important in cancer care, not least because problems relating to
17 relationships within the MDT may have an adverse effect on patient care. One reported
18 problem is that some team members felt excluded or marginalised, particularly nurses,
19 (Lamb, et al, 2011 b p1975). Similarly, a study noted the problem of hospital cancer nurse
20 specialists not being accepted by medical colleagues, and other members of the team,
21 (Willard and Luker, 2007, p712). In another study of MDT coordinators in multi-disciplinary
22 cancer teams it was reported that coordinators felt that they 'neither contribute to the MDT
23 discussion nor their opinions carry weight', (Jalil, et al, 2012). These problems may be
24 compounded by other issues, such as the levels of stress and burnout in staff working in
25 cancer care, (Black and Westwood, 2004, p578).
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30 In such circumstances, leaders of MDTs may adopt relations- oriented leadership
31 behaviour, for example, showing consideration, nurturing and supporting team members
32 from differing professional backgrounds, taking account of individual and group needs, and
33 ensuring a contribution from all team members. The leaders' effectiveness in this aspect of
34 their role may be underpinned by their communication skills, (Lamb, et al, 2011, c p1201).
35 Similarly, one may suggest that emotional intelligence (EQ) is important and enables the
36 leader to demonstrate 'awareness of the feelings, moods and emotions of oneself and
37 others, and the ability to act in ways that contribute to goal formulation and goal
38 achievement', (Hartley and Benington, 2010, p p81). This is said to be particularly important
39 in an era where various inquiries into scandals in the NHS, for example, the Francis Inquiry,
40 have highlighted that there is a pressing need to take more account of the emotional
41 dimension in healthcare, (O' Sullivan, and McKimm, 2014, p283).
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46 The third set of generic behaviours- change- oriented, or envisioning, behaviours- are also
47 important for leaders seeking group support for the development of vision, ideas, and goals,
48 (Bergman, et al, 2012, p19). These may provide the MDT with the capacity to respond to
49 change or be innovative in the delivery of care and also facilitate change in clinical practice.
50 Receptiveness to change is imperative in cancer care where the translation of research into
51 practice is vital. Such change may be triggered internally, or as a result of external policy
52 changes like those described earlier. In a study of upper gastro-intestinal cancer MDTs the
53 authors argue that 'team working represents a potentially powerful lever for change',
54 (Blazeby, et al, 2005, p3). The ability to lead such teams by adopting appropriate, change-
55 oriented behaviours is particularly apposite in the context of an NHS currently in the process
56 of implementing major policy change, not least in cancer care.
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3 While such behaviours may be provided by a formally appointed leader of the team such as
4 the Chairperson or MDT coordinator, they may also be provided by a team member who has
5 a special interest and expertise in the proposed change. Indeed, it is suggested that the
6 leadership or influencing role during periods of change 'passes, informally or at different
7 phases, between different individuals and groups, with differing bases of expertise and
8 legitimacy at different times, (Hartley and Benington, 2010, p33). The leaders' effectiveness
9 in the influence process may be **underpinned by** transformational leadership ie idealised
10 influence; inspirational motivation; intellectual stimulation; and individualised
11 consideration, (Northouse, 2004). There is some overlap here with the generic leadership
12 behaviours so far described, for example, 'individual consideration' is similar to relation-
13 oriented behaviours. Of interest in the context of change is the emphasis on motivating and
14 stimulating different members of the team, and encouraging 'innovative and creative
15 behaviour', (Willcocks, 2016, p227).

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20 Finally, given that MDTs are likely to function as part of a wider network of similar teams
21 both within and outside the immediate organisation leaders may need to adopt spanning
22 behaviours to facilitate collaboration and cooperation with other teams and other
23 organisations. Patkar, et al, report that the latter is a potential challenge for the MDT, for
24 example, in establishing 'reliable interfaces with primary care to ensure continuity of care',
25 (Patkar, et al, 2011, p4). This is increasingly important with the onset of various collaborative
26 initiatives in healthcare generally, and cancer services in particular, such as the
27 development of cancer alliances and networks spanning across provider organisations
28 delivering care. Fitzgerald, et al, suggest that the 'boundary spanner' role may be exercised
29 by 'clinical hybrids', that is those staff occupying both clinical and managerial roles,
30 (Fitzgerald, et al, 2013, p236).

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35 Regardless of who occupies the role of 'boundary spanner' within the MDT, one may argue
36 that the leaders' effectiveness **in this** may be **underpinned by** skills associated with
37 'connective leadership'. This involves the leader in creating:

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39 'inter- connections between and across practice settings, the purpose of which is to better
40 coordinate and integrate patient care services in a caring, non- competitive, collegial
41 manner', (Gopee and Galloway, 2009, p56).

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44 It has been suggested, in a study of breast cancer, that breast cancer nurses may act as a
45 lynch pin for the MDT, providing information that connects the work of the team with other
46 'treatment modalities' outside of the MDT, (Amir, et al, 2004, p313). In this role they may be
47 acting as 'boundary spanner' for the MDT. It can be noted, however, that there is some
48 debate about which specialties tend to be predominately involved in the leadership of
49 MDTs, and, as stated earlier, whether some may be excluded, (Lamb, et al, 2011 c, p1206).

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52 In general, it has been concluded that 'the likelihood of a team experiencing a full range of
53 leadership behaviour [such as the above] increases to the extent that multiple team
54 members share leadership', (Bergman, et al, 2012, p34). The suggestion is that each of these
55 various behaviours and **underpinning** skills and attributes may be demonstrated by different
56 members of the MDT, some may be formally appointed, such as the Chairperson or
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3 Coordinator, but others may emerge as the most suitable leader depending on the activity,
4 the circumstances, and the expertise/ skills of the individual team member. In a study of the
5 role of breast cancer nurses it suggested that this professional group may emerge as 'the
6 informal leaders of the team', (Amir, et al, 2004, p310). Lamb, et al, believe it is not so much
7 the clinical specialty of the team member as the possession or otherwise of 'interpersonal,
8 non- technical skills', suggesting that leadership could be exercised by any member of the
9 team, (Lamb, et al, 2011, p1201).

12 **Implications / recommendations**

14 While shared leadership may lead to a cohesive multi-disciplinary team, with collegial
15 working relationships and strong sense of purpose, as stated, it is not easy to achieve as it
16 may involve a transition from traditional ways of working and divergence from traditional
17 norms and professional values. As noted by Fennell, et al:

20 'different medical specialties and affiliated professionals are all subject to the specific
21 norms and expectations of their own professional groups and these do not always align, '
22 (Fennel, et al, 2010, p76).

24 Developing shared leadership in the context of MDTs requires a shift away from traditional
25 ways of leadership where leadership is assumed by one person, who may be the appointed
26 leader ie positional leadership. While there may still be a role for the latter within the MDT,
27 there is a need to make more use of the leadership **behaviours**, and **underpinning** abilities
28 and expertise of **different team** members. This is particularly apposite in the context of an
29 MDT involved in cancer care which typically comprise various highly trained clinicians from
30 different professional backgrounds and training such as consultants and supporting junior
31 staff in radiotherapy, oncology and surgery, radiographers, other allied health professionals
32 and specialist nurses.

34 Such staff are a key resource for the team and provide a source of shared learning,
35 education and development, (Taylor, et al, 2010). Shared learning is particularly important
36 given criticism of healthcare organisations that they have failed to learn from the past and
37 need more reflective leadership, (Hartley and Benington, 2010, p71). The latter may be
38 more likely with shared leadership given its emphasis on participation and interaction within
39 the team. As a resource it can contribute to an improved clinical decision making process
40 informed by the full range of expert knowledge within the team. This is supported by
41 Whelan, et al, in a study of breast cancer MDTs, who report that clinical decision making 'is
42 most effective in MDTs with a shared leadership style', (Whelan, et al, 2006, p121).
43 Similarly, Haward, et al report that 'teams with shared leadership of their clinical decision
44 making were most effective', (Haward, et al, 2003, p15).

46 Given that shared leadership relies on participation it is also likely to have the effect of
47 empowering and motivating staff, which in turn is likely to stimulate greater creativity and
48 innovative solutions to problems. The latter is an espoused aim of the reforms currently
49 underway in the NHS and is relevant particularly to MDTs involved in cancer care. Shared
50 leadership is also said to provide a 'mutually supportive environment' for team members,
51 (Fleissig, et al, 2006, p937). This suggests that shared leadership may contribute to the

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3 mental health well-being of the team. However, it is important to ensure clarity in the
4 leadership process as without this there is a risk of inertia in decision making or confusion
5 about who is responsible for particular initiatives. In other words, it is important to avoid a
6 situation where there may be a leadership vacuum where no one assumes a leadership role
7 within the MDT.
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10 Shared leadership may also be enhanced by organisational factors that contribute to
11 collaborative working of MDTs, such as information flow, IT, coordination and
12 communication mechanisms, and the availability of time and admin support. Equally, where
13 these are not provided, or they are inadequate, there may be an adverse effect on the
14 process of shared leadership. With regard to communication, this may be aided by shared
15 leadership although 'conflict over leadership and lack of clarity about leadership were both
16 negative predictors of effective internal communications', (Fleissig, et al, 2006, p939).
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19 It has been stated that possible solutions to some of these problems include greater
20 attention to job planning, development/ training opportunities in leadership and team
21 working skills, and ensuring team members, particularly nurses, are not excluded from the
22 decision making process, (Lamb, et al, 2011,a p2123). . Shared leadership is likely to work
23 where there is 'planning as well as cultural change and strong commitment', (Konu and
24 Viitanen, 2008, p36). With regard to development and training, this partly depends on the
25 extent to which team members, individually and collectively, possess certain behaviours,
26 and underpinning skills, knowledge and so forth, to lead the team, for example, personal
27 qualities and human relations skills that are important in team leadership. It can be argued
28 that as leadership roles may be shared there is less need for all the above attributes to be
29 developed across the team. But development may be required, both in terms of acquisition
30 of individual behaviours, skills, etc, and also team development, ensuring the team works
31 collegially in achieving team goals. A focus on the latter, more than the individual, is said to
32 be important as a means of addressing 'wicked' (difficult) problems in healthcare,
33 (Edmonstone, 2014, p463).
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37 Just as important as these initiatives will be measures to ensure that the culture of the
38 organisation is supportive and encouraging of new ways of working which rely less on
39 traditional conceptualisations of leadership and more on the philosophy of shared
40 leadership. It is important to ensure that all team members are nurtured and supported in
41 their leadership role. This involves adhering to different views about the way in which
42 decisions are made in MDTs and the way in which power is devolved to the level of the
43 team. It has been suggested that there is a developmental challenge in overcoming
44 traditional 'rigid hierarchy of power and influence' in healthcare organisations, (Black and
45 Westwood, 2004, p577).
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49 **Organisations need to pay particular attention to the latter and the more general issue of**
50 **facilitating cultural change. They may do this by various means such as providing training**
51 **that is based on shared learning and a multi-disciplinary ethos. More generally,**
52 **organisations may need to pay attention to their style of leadership and governance and the**
53 **way in which clinical staff are integrated, or otherwise, into the running of the organisation.**
54 **A large scale study of leadership in the NHS identified key themes that need to be**
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3 considered: supporting and respecting others, developing team working, removing barriers
4 to communication, encouraging a questioning approach, and 'promoting behaviour that
5 encourages the creation of a culture supporting people's personal development', (Alimo-
6 Metcalfe and Bradley, (2009). One may argue the latter is particularly important in the
7 context of developing effective multi-disciplinary team working and leadership in cancer
8 care.
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11 At a national level, there may be a need to pay more attention to the way in which clinicians
12 are trained in their undergraduate schools, with more emphasis on shared learning and
13 exposure to multi-disciplinary team working and leadership early on in their training.
14

15 Research Implications

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17 Case study- based research may be needed to test the ideas in this paper. Such research
18 may explore leadership and team working in specific multi-disciplinary teams in cancer care,
19 that is specific tumour groups. It has been noted that while there is research on team
20 effectiveness generally, 'research evidence on the benefits [specifically] of MDT working is
21 sparse', (Fleissig, et al, 2006, p937). However, research may be problematic as it is
22 suggested that not all teams are 'real teams' in terms of having team characteristics such as
23 shared objectives and interdependent working, and may be described as 'pseudo teams',
24 (West and Lyubovnikova, 2013, p136).
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28 One issue may in fact be addressing the problem of whether an MDT is a 'pseudo team' or a
29 real team, and if the former, exploring ways of how to make the transition to a real team.
30 West and Lyubovnikova suggest that research needs to 'better describe' teams in terms of
31 real team characteristics, (West and Lyubovnikova, 2013,p139). Another issue has already
32 been suggested, that is, the contribution of different team members may be problematic,
33 (Lamb, et al, 2011, p1975, Willard and Luker, 2007, p712). Research may be needed to
34 explore the reasons for this perceived problem.
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38 Other issues that may be researched include the leadership behaviours and underpinning
39 skills and knowledge required by team members, the barriers to team working, and the role
40 power and authority play in enhancing or inhibiting team work and leadership. The latter is
41 of particular interest. Research may be needed to explore the extent to which the culture of
42 the MDT, and the culture of the professions generally, acts as a facilitator or barrier to
43 effective team working and leadership. Such research will need to include qualitative
44 research to facilitate understanding of the perceptions, emotions, and subjective meanings
45 held by those actually involved in team work settings in multi -disciplinary cancer care.
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49 Conclusion

50 This article has explored shared leadership in the context of multi-disciplinary cancer
51 services in the UK. It has suggested that this may be an appropriate way forward in
52 developing leadership of such services, particularly as they have already adopted
53 collaborative models of care.
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56 While the policy and organisational context lends itself to the adoption of shared leadership,
57 the latter is not without problems as it involves a transition to new ways of working and
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3 decision making. These may be surmounted by attending to structural and cultural aspects
4 of cancer care delivery and facilitating acceptance of a shared approach. In particular, the
5 leadership behaviours, and **underpinning** expertise and attributes of individual team
6 members in cancer care need to be nurtured and developed and made available for the
7 benefit of the MDT as a whole.
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10 Shared leadership is not the only way forward for improving services in cancer care but it is
11 worthy of exploration and further research in the context of the MDT and other
12 collaborative initiatives. Given the complexity of such services described earlier shared
13 leadership is an important aspect requiring attention when considering the organisation and
14 delivery of cancer care services.
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