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Relating structures and processes with team culture and communication in multidisciplinary cancer meetings in an academic hospital in Austria: is there room for improvement?

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P633

External

Evaluation

INTRODUCTION

In Austria, multidisciplinary cancer meetings (MDTs or tumor boards) are **considered the gold standard** in cancer treatment.

The problem:

- MDTs need high **financial, personnel and time resources**.
- **Evidence of its quality in cancer care is still missing**.

This is the **first study in Austria** that allowed conclusions to be drawn about the **effectiveness and efficiency of tumor boards.**

Results of a **self-assessment tool developed for tumor boards**, focusing on structures and processes linked with team culture, are **reported**.

OBJECTIVES

The study analysed the work of **tumor boards and their relationship with team culture** to enhance the quality of multidisciplinary cancer meetings.

Assessing tumor board members´ perception of…

… **structures,**

… **processes and**

… **outcomes**

in their daily work.

Analysis effective teamwork processes

(i.e. communication, decision-making and patient-centred care).

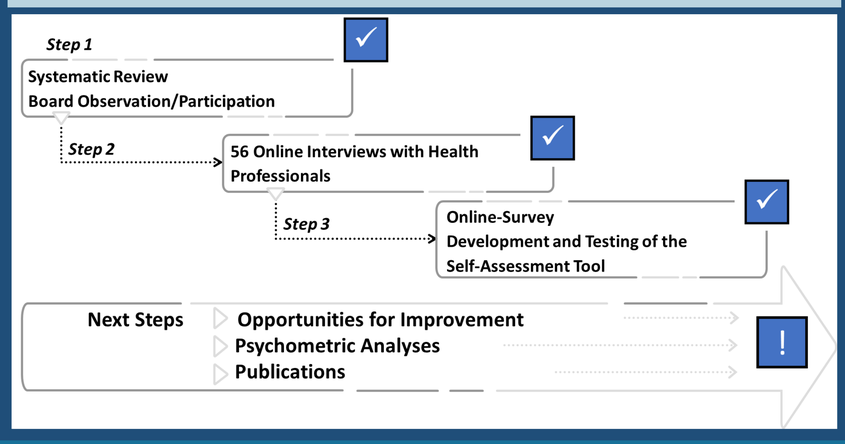
Identification of opportunities for **quality improvement.**

MIXED-METHODS STUDY DESIGN

Retrospective observational study with tumor boards in an Austrian hospital (since February 2020).

Mixed-methods-design (qualitative and quantitative data collection).

The project consists of:



METHODS

The **Austrian Tumor Board Survey (ATS)** was developed from October 2020 to date (based on the systematic review and the interviews).

The online survey was pre-tested in nine MDTs in an academic hospital with 117 participants (March-May 2022; response rate of 58%).
Ten items were changed and added.

Second online survey and sample:

- 52 items on nine scales
- Response options on a 5-point Likert scale
- Open questions after each item
- Nine different MDTs with 81 participants (January-August 2023; response rate of 55.5%).

RESULTS

Table 1 presents **positive and significant Spearman correlation** results, with moderate and strong correlations (Cohen, 1988).

The strongest correlation is between **'organisation'** and **'quality of presented information'** (r = .79, p < .01).

The weakest correlation is between the **'decision-making process'** and **'organisation'** (r = .37, p < .01).

It can be assumed that the **better the structure and organisation of the MDT**, the more likely the tumor board **will work together as an effective multidisciplinary team with a positive work culture.**

Location, measure of dispersion and Spearman correlations with Fieller confidence intervals

Variable	*M (SD)*	*Md (IQR)*	Quality of presented information	Team culture and communication	Structures and guidelines	Organisation	Decision-making process
Quality of presented information	3.96 (.53)	4.00 (.75)					
Team culture and communication	4.19 (.46)	4.13 (.62)	.72** [.60, .82]				
Structures and guidelines	4.01 (.54)	4.14 (.72)	.70** [.57, .80]	.66** [.51, .77]			
Organisation	3.89 (.55)	4.00 (.79)	.79** [.69, .86]	.69** [.56, .79]	.64** [.48, .75]		
Decision-making	4.04 (.39)	4.00 (.50)	.41** [.20, .58]	.45** [.26, .62]	.50** [.31, .65]	.37** [.16, .55]	
Attendance	3.48 (.60)	3.50 (1.00)	.52** [.33, .67]	.42** [.21, .59]	.62** [.46, .74]	.49** [.30, .65]	.56** [.39, .70]

Table 1. Explanation of the abbreviations for the statistical key figures: *M* = mean score, *SD* = standard deviation, *Md* = median and *IQR* = interquartile range. The confidence intervals are given in square brackets. The asterisks (**) indicate that the correlations are significant (p < .01).

Figure 2 illustrates the nine scales of the questionnaire in relation to nine tumor boards (n = 81).

In the **'poor' and 'sufficient' categories**, the scales **'attendance'** (60.5%) and **'documentation'** (37.0%) achieved the **highest levels of agreement**.

The **'team culture and communication' scale was rated as sufficient, average and good** by 75.3% of respondents.

The scales **with the highest average responses were 'decision-making'** (44.4%) and **'quality of presented information'** (38.3%).

The category **'excellent'** was the most **frequently selected for the scale 'role in the MDT'** (44.4%).

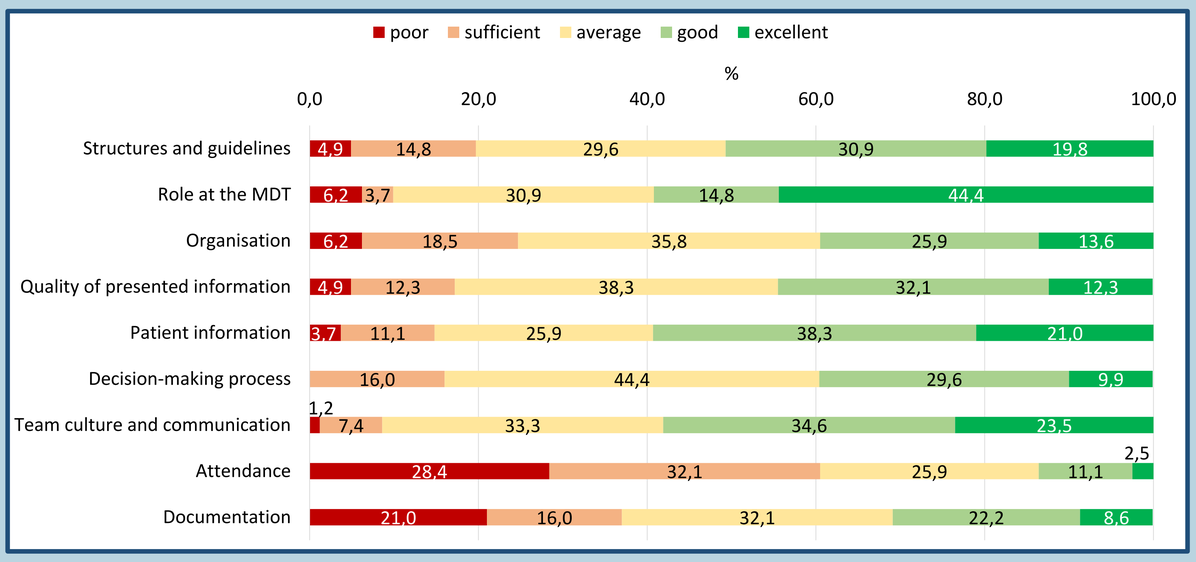


Figure 2. To describe the responses at the scale level, the respective response options on the five-point Likert scale were divided into the categories 'poor' (all mean scores up to 3.00 - dark red), 'sufficient' (all mean scores between 3.01 and 3.50 - orange), 'average' (all mean scores between 3.51 and 4.00 - yellow), 'good' (all mean scores between 4.01 and 4.50 - light green) and 'excellent' (all mean scores between 4.51 and 5.00 - dark green).

Areas identified as poor, sufficient, and average indicate potential for quality improvements, particularly in the comparison of different MDTs and the scales associated with 'team culture and communication' ('organisation', 'attendance', 'documentation', or 'decision-making process'). For example, based on our 'documentation' scale results, the hospital implemented new software to improve documentation.

CONCLUSION

Results indicate that targeted team training programmes and **organisational change** could **improve the performance of MDTs:**

- Active team development
- Board observations
- Debriefings
- Feedback
- Providing time for preparation
- Ensuring the quality of patient results
- Enabling regular attendance

Another possibility is to utilise learnings from COVID-19, whereby a **hybrid form of meetings** could maintain the social contact of the team but would mean **more flexibility for the participants**.

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