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COVID-19

Learnings and Opportunities

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Executive summary

The RACP finds itself in new territory as it navigates the up and downstream impacts of a global pandemic on a profession that lives its life on the frontline. Anxious citizens and governments seeking to lead through a health crisis that has unravelled into an economic, humanitarian and at times geopolitical crisis, have turned to several RACP Faculties and Specialty Societies for expert advice. That expertise, based on rapidly evolving evidence, has been at the heart of decision-making taken by government at all levels, and delivered a significant, positive impact on the suppression of COVID-19 in the ANZ region. Since the very start of the pandemic, the Australasian Faculty of Public Health Medicine and RACP Infectious Disease experts have been at the centre of Australia and Aotearoa New Zealand's successful fight against COVID-19. The success of Australia and Aotearoa New Zealand in quelling COVID-19 has become the envy of the world, achieved because their governments adopted the advice of Public Health and Infectious Disease Fellows and other experts amongst the RACP Divisions, Faculties and Chapters, and Specialty Societies. The leadership of the RACP and its members in the future of health policy, prevention and health services has arguably never looked brighter or been more valued.

The RACP finds itself with an unique opportunity to lead, but also in a place of great challenge. Its members, staff and communities need it to protect their health, that of the organisation and the wider community. The RACP must also protect the standards of its Fellowships and support its members to develop and maintain their professional competence in circumstances that expose a fragility to physician education, learning, development, and assessment most often delivered in clinical settings.

Navigating the terrain with purpose, clarity and fortitude requires courage, agility, and adaptability. Organisations everywhere must balance risk and resilience whilst focusing on new horizons that sustain themselves far beyond the pandemic. This will involve an understanding of the opportunities and challenges for their workforce, members, partners or customers, their activities, and their governance. This report shares insights of emerging global trends gleaned from desk-based research and lived experience captured via senior leadership interviews. These insights span new working arrangements, new education, learning, assessment and development arrangements, work health and safety matters, mental health, health, prevention and policy, professional practice and governance and leadership. At the end of the report, recommendations for action by the RACP in 2021 are proposed to allow for focused and aligned Board and management consideration.

The greatest opportunities for organisations lie in more dynamic and flexible ways of operating, removal of barriers to decision-making, the deployment of enabling technology and the promotion of creativity and innovation. For the RACP, this includes Member products and services being fully digitally enabled, and the RACP playing a strong and enduring leadership role in the future of medical education, health policy and prevention, the 'physician of the future', professional practice, and in safety, efficacy and equity in healthcare. These imperatives have been intensified and accelerated by the pandemic response and the sights of others on the medical workforce supply chain.

The RACP has an opportunity to determine where best to invest its focus and resources to ensure the challenges are overcome and the opportunities that align with its purpose are leveraged. Doing so provides the path to stability and sustainability in a future of uncertainty and new models of specialist care.

1. Introduction

1.1 Widespread impact of COVID-19

The year 2020 will go down in history as a global reset; the year in which a health crisis became a global pandemic, closing borders, shuttering economies, interrupting education, exposing the fragility of supply chains, bankrupting businesses, segregating families, redefining community, raising unemployment and fundamentally changing the world of work. The health, economic and humanitarian crisis triggered by COVID-19 has cost lives and livelihoods, plunged countries into decades of debt and challenged the efficacy and funding of existing social protection systems. It has tested governments and business leaders in unprecedented ways. Governments, hospitals, universities, schools, and businesses have had to rapidly adapt, reinvent, and embrace a 'new normal'. Resilience has depended on flexibility, adaptability, agility, resourcefulness, creativity and forward-thinking. It has demanded that leaders remain level-headed, provide clarity and motivation, and act decisively and swiftly amid uncertainty and risk.[1]

Governments have become more involved than ever before with their citizens and companies with their employees. **The way people work, where and the role of government in economies and globalisation has all been upended. Long-term societal impacts such as the exacerbation of inequity and the impact on health will take years to unwind**.

Companies have had to rethink everything from their cash flow, operating model and supply chains to their customer experience, communication, and resilience. The RACP is no exception. The work of the Board of Directors, Council, Committees, and staff has all had to move online. Advocacy for health equity, Member safety, telehealth, CPD compliance and protected clinical training has grown by necessity. The mobility of trainees to new rotations could easily have been disrupted by hospital COVID-safe plans, and their exposure to a range of clinical experiences curtailed by infection control, the cessation of elective surgeries and the discharge of many elderly patients back into aged care. Through proactive management and advocacy, these risks have been largely mitigated by the RACP's negotiation with health departments. Supervisors and those helping prepare trainees for the clinical exam have been juggling their usual roles and commitments with the potential redeployment of the medical workforce and the postponement of outpatient clinics. The timing and delivery of the high stakes Divisional Clinical Examinations has had to innovate and adapt to constant flux as policy, rules and laws change from virus hotspot and jurisdictional levels to national contexts.

No RACP Member or employee has been immune from the threat of the virus itself nor to disruption to their work: from the physician clinical researcher whose research has been placed on hold, to the contraction of specialist referrals during lockdowns, stay at home orders, social distancing and a time of exceptional public anxiety. GPs report seeing more adolescents and mature-age people presenting with depression and anxiety disorders and specialists are concerned with rising avoidant care, or late presentations resulting in poorer health outcomes. Much has changed. Senior RACP members report that they have been retrained in the intubation of critical respiratory patients. Others have been brought out of retirement to bolster the resilience of the healthcare workforce or are embarking on telehealth for the first time. Some, particularly the Australasian Faculty of Public Health Medicine and Infectious Disease experts find their expert advice at the heart of decision-making by governments at all levels.

1.2 Opportunities for growth and transformation

Whilst numerous industries and businesses have collapsed as a result of this global pandemic, others are growing at extraordinary rates. Sectors like health, logistics, ecommerce[2], digital communication, cloud-based storage, data science, automation, artificial intelligence (Appendix 1), learning management, streaming services, delivery services and other enabling technologies have all experienced rapid expansion.[3] The dominant opportunities are represented in Figure 1.

Figure 1: Growth opportunities in the "post Corona world". ***Source: World Economic Forum***

Massive challenges like COVID-19 offer multiple opportunities for meaningful change and crises typically allow for much more rapid transformation and innovation than would occur in more stable and prosperous times.[4]

"Calamities, even tragic once-in-a-century global pandemics, require business leaders to find opportunities in the chaos…the competitive order will change far more now than it ever will in prosperous times. The big winners are the bold…that break from the mainstream, acting courageously and fast."

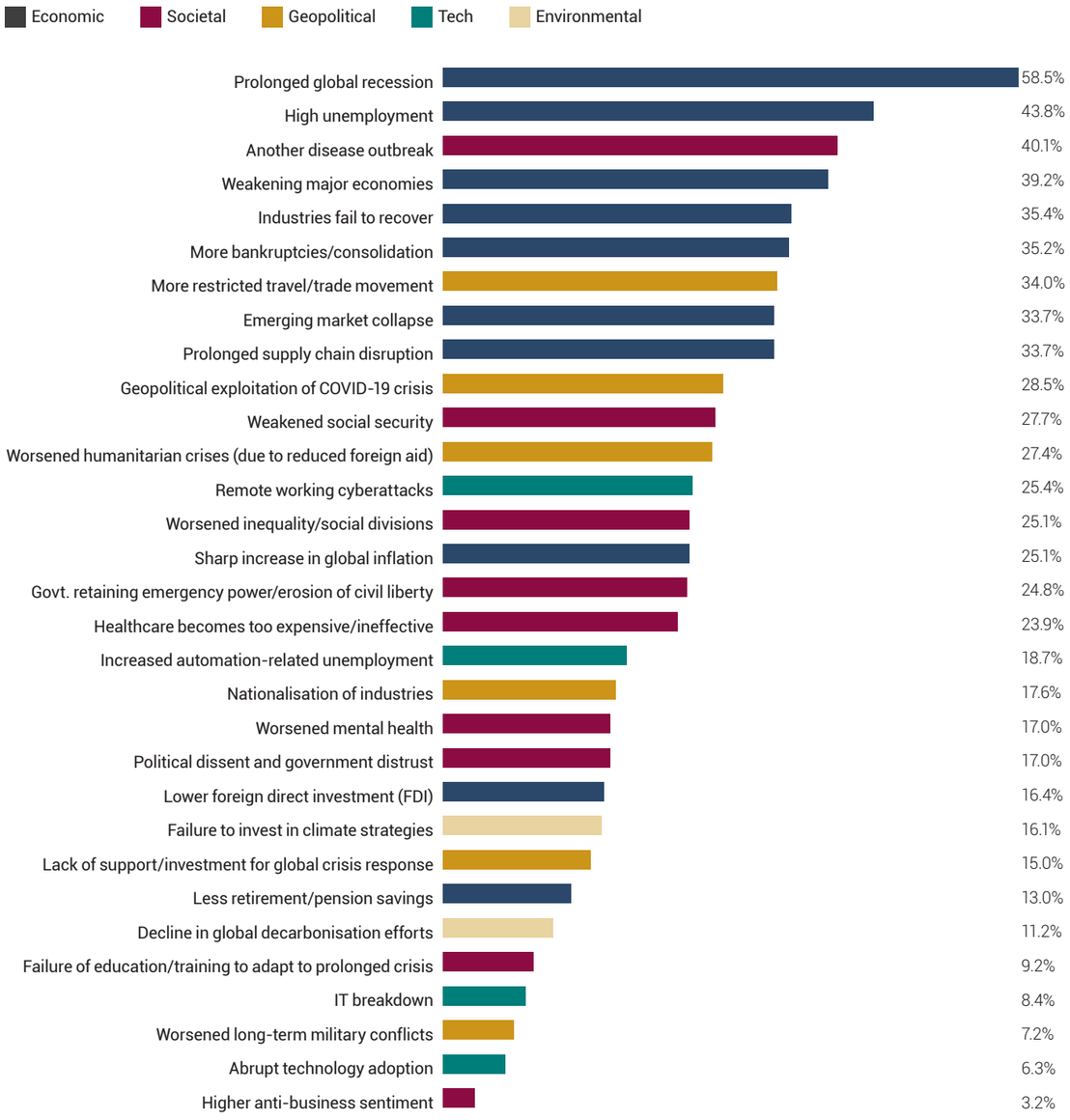
(**Colvin, G**, Fortune Magazine, 25 June 2020)

While technology has proven a significant enabler in an unparalleled time of large-scale remote work, and digital tools have enabled remote communication and collaboration among teams and between clinicians and their patients, their accelerated adoption come with inherent risk. These include but are not limited to technology overload, inequity of access, cyber-attack, data privacy breaches, structural unemployment from increasing automation and rising Work Health and Safety (WHS) risks. Advances in gender equity and climate change also risk diminution as attention to these priorities and targets takes a back seat to economic survival and recovery.[5]

Growth in jobs is typically in the gig economy[6] – a sector where the casualisation of the workforce, few protections and part time hours at minimum wage replace previously permanent employment. It is also a time of significant under-employment as pilots, senior executives and others find themselves adapting to layoffs by becoming drivers, distribution centre staff or call centre operators.[7] Governments and employees fear that employers may use the current economic recession as an opportunity to outsource, offshore and/or casualise functions, increasing job insecurity, unemployment, underemployment and economic instability, each of which have profound impacts upon health and vulnerable populations. The New South Wales Council of Social Services (NCOSS) pre-budget submission (October 2020) details "*long-term scarring on individuals and communities*" resulting from the increased disadvantage created by the pandemic. They forecast significant rises in disadvantage for the State's vulnerable people across the areas of homelessness, domestic violence, health and suicide.[8] This is a phenomena that will not be unique to New South Wales, but repeated the world over.

The following Figure documents the top 31 risks ranked in a World Economic Forum survey of 347 global risk analysts in April of this year. These cover economic, societal, geopolitical, technological, and environmental risks and reflect the impact of COVID-19 on the futures being seen and feared.

Figure 2: Greatest concerns for the World



Source: World Economic Forum COVID-19 Risks Outlook

Figure three below extracts the top societal risks ranked by the same 347 global risk analysts. The majority listed implicate health.

Figure 3: Societal risk

Rank	Societal Risk	%
#10	Another global outbreak of COVID-19 or different infectious disease	30.8%
#13	Governmental retention of emergency powers and/or erosion of civil liberties	23.3%
#14	Exacerbation of mental health issues	21.9%
#15	Fresh surge in inequality and social divisions	21.3%
#18	Anger with political leaders and distrust of government	18.4%
#23	Weakened capacity or collapse of national social security systems	16.4%
#24	Healthcare becomes prohibitively expensive or ineffective	14.7%
#26	Failure of education and training systems to adapt to a protected crisis	12.1%
#30	Spike in anti-business sentiment	3.2%

1.3 Impact on medical education

Closer to home, the disruption caused by the COVID-19 pandemic has prompted the catalytic transformation of medical education that has been on the horizon for more than a decade.[9] Curricula change in Medical Schools and Colleges is occurring at a faster pace. The RACP has already embarked on this renewal journey but must maintain strong forward momentum to remain relevant and of value to prospective and existing members. In the whole of Medicine, the trend towards Entrustable Professional Activities to determine competency and replace high-stakes, one-time assessments will now occur more rapidly. A bi-national taskforce of the Medical Deans of Australia and Aotearoa New Zealand has recently formed to examine this opportunity, together with multi-source feedback and portfolios.[10]

1.4 The road ahead

Despite the unknowns and disruption caused by the pandemic, businesses can outmanoeuvre the uncertainty by leaders turning their attention from the 'Now' they have helped to stabilise, to the 'Next' – a period of unpredictable and muted economic recovery and personal mobility, with new operational and competitive threats and opportunities. **Leaders like the Board of Directors of the RACP now face a decade of the 'Never Normal', defined by fast changing shifts in cultural norms, societal values and behaviours, and a demand for responsible business practices and a purpose that adds to the value of society itself.[11] Success lies in organisations embracing the new normal, building new competencies, thinking strategically about the longer term to harness the opportunities ahead, and balancing members and employees' natural sense of fear and optimism.**

The best RACP future balances emerging needs and long-term, albeit somewhat uncertain futures. One in which the RACP plays a leadership role in future disease prevention, health policy, and models of care, physician practice and workforce, and in medical education, professional standards, medical ethics, and medical research. Nevertheless, COVID-19 presents new risks and challenges for the organisation. Success therefore lies in properly addressing emergent risks, and balancing crisis management with a focus on what is next for the organisation in different scenarios while maintaining focus on other governance issues.[12]

The RACP can anticipate rapid and wide-ranging innovation by universities and medical schools within their existing graduate and new postgraduate markets. They will develop new curricula, chase new training markets, develop more experiential and simulated remote learning and seek new ways to develop medical competency to offset global restrictions to the movement of medical graduate and postgraduate students. Clinical research and clinical trials are also likely to be conducted in new ways that account for health orders. The RACP should continue to learn about, anticipate, and lead these pivots, as well as stay close to prospective partners and emerging competitors. It will also help to stay close to members and employees' values, interests, strengths, and anxieties, since this will allow the organisation to strengthen its adaptability and resilience. **Uncertain futures provide an opportunity for the RACP and others to experiment in different ways of learning, educating, credentialing, advocating and working which may prove far better for members and staff than traditional arrangements long after the crisis is over.**[13]

This report explores those opportunities in the leadership, focus and operations of the RACP – from trust to business continuity; from agile ways of working and rapid decision-making to new delivery mechanisms for education, learning and assessment; from online Member events and digital services to policy leadership and advocacy; from committee work and organisational governance to the monetisation of streaming educational content; and from leadership and communication to workplace culture, teamwork and talent management.

Key takeouts

1. The way people work and where, including clinicians, has been upended.
2. Inequity has been exacerbated, posing implications for health.
3. Calamities offer opportunities for transformation.

2. Remote working

The world over, public health orders and the importance of work health and safety (WHS) have seen the workforce shift to a much more distributed model.[14] Knowledge workers have proven they can work from home, education institutions have demonstrated they can deliver remote learning, and businesses have shown they can pivot in new directions or move services online. Consumers, seeking to keep themselves and others safe, have changed both their path to purchase and the way they interact with businesses. From home improvement centres offering 'click and collect' to General Practitioners (GPs) and medical specialists offering telehealth, organisations have changed their operating models to cater to their communities.

Remote working has generated many positive benefits with less traffic, less time spent commuting, a reduction of emissions, more free time, and greater levels of engagement and productivity as employees are able to engage in somewhat more flexible work arrangements and feel a greater locus of control over their environment and safety.[15]

2.1 The transition of RACP operations to remote working

The RACP like other knowledge businesses and education institutions, has proven its Board, Committees, Councils, and staff can maintain business continuity and work effectively remotely. **Unlike many other businesses, the RACP was well poised to enable this, having already implemented part of its 5-year vision as a digitally enabled organisation for its members and staff.** These implementations had occurred to deliver against Goal 6 of the RACP Strategic Plan, 2019–21, "*We will be an effective and modern College*".

With all staff already enjoying mobile working on laptops with applications and cloud solutions that allow remote file sharing and collaboration, the RACP was able to leverage existing features such as Microsoft Teams to further enhance remote productivity. The recent upgrades to the RACP network, and implementation of a Virtual Private Network (VPN) and other security features supported, protected, and secured remote access to the College's digital systems and applications. This enabled the maintenance of business continuity from meeting schedules to payroll; from Zoom-based Board and Committee meetings to Fellow-led adaptation of the Divisional Clinical Exams.

The pandemic required the RACP's 2020 Annual General Meeting (AGM) to be moved to a hybrid format (online and physical presence at both Sydney and Auckland). In executing this, consideration needed to be provided to technical and risk matters as well as procedural fairness, due process, and privacy protections for the provision of secure Member voting. Whilst the Constitution required a quorum of 20 members to attend in person, the digital elements were contracted to a third-party supplier with the platform, expertise, and experience to deliver a seamless solution. While some locations did experience connection issues (Aotearoa New Zealand experienced a video connection fault of 15 minutes), the format made Member participation easier and supported otherwise digitally resistant members to migrate online. As the future of effective vaccines, government policy and commercial flights remain uncertain, the RACP has an opportunity to use the learnings from its first mostly digital AGM to explore maintaining this form of annual meeting and to improve the online experience; something that can be done at significantly lower cost than a face-to-face meeting. Such a progression offers an opportunity to engage the membership more widely in its activities and performance. It also provides an opportunity to directly demonstrate the RACP's commitment to fighting the health impacts of climate change. The RACP Board may wish to retain the

opportunity to meet members in person, yet a digital AGM can be carbon-neutral with no Directors, management or members flying to attend. Whilst there is some consideration being given to allowing listed companies to run full virtual AGMs at present, it is not clear if new laws will override Constitutional requirements. It is therefore safe to assume constitutional amendments would be necessary to activate this opportunity at the RACP. Nonetheless, the AGM is fertile ground for digital modernisation. To do so advances achievement of Goal 6 of the RACP's Strategic Plan 2019–21 – *to be a modern and effective College.*

2.2 Board experiences of remote working

COVID-19 has necessitated many new ways of working expected to outlast the pandemic and restrictions to movement.[16] In an era of conservatism regarding a return to 'normal', virtual Board meetings, digital communications and working from home are anticipated to remain in many sectors, at least in part. The Australian Institute of Company Directors reports that remote working has increased free time for Directors and reduced the volume of work for Boards since Directors would normally invest additional time in travel, Board dinners, ancillary meetings and connecting with management. They also report that digital meetings have led to a shortening of Board meetings, with a sharper focus on mindset (to protect Directors, the company and others); strategy (to plan for different scenarios including a growth trajectory); delegations and more rapid decision-making (to empower management to make necessary operational adjustments); and disclosure (continuing to meet obligations as rules change).[17] The RACP Board has adapted to remote meetings, but this necessity has limited opportunities for Directors to develop interpersonal relationships, especially with new Directors joining the Board in May who have had no opportunity to meet fellow Directors in person. The importance of connecting and developing collegiality as a Board of Directors is extremely valuable, and a recommendation of the report prepared by Effective Governance to enhance Board effectiveness. The opportunity to build connection with the senior management team is also valuable. For this reason, Directors may wish to consider a return to face-to-face Board meetings as restrictions ease.

Interviews with Senior Leaders for this report indicate that the organisation has not seen a transition to fewer or shorter College body or internal business meetings during the pandemic, in part because additional meetings were necessary to support the transition from office to remote working. Sixty four percent of respondents to a recent staff WHS survey report Zoom fatigue and almost 51 per cent find it difficult to switch off after work. The opportunity to transition towards shorter, focused meetings with appropriately delegated decision-making will therefore help to sustain the productivity and responsiveness of the company, and the health and wellbeing of its people.

2.3 Changing behaviours

The shift to remote work has acted as a catalyst for several changes in behaviour. Team Leaders who felt their teams would be less productive once dispersed have had their fears allayed, and the staff WHS survey reports that over 92 per cent of staff feel trusted to get their job done.

RACP communications intentionally adopted a more personal and humanistic tone with the onset of the pandemic. This was in alignment with the RACP Service Principles, and something that has been well received. The clear, detailed and regularly updated COVID-19 information available to staff has increased a sense of transparency which has helped to grow the confidence of staff in the organisation and its focus on their safety and that of its members.

The transition out of the office saw mail, print and production costs collapse overnight. Such costs are currently being born by staff themselves or reduced as remote working encourages more paperless work. Should remote working continue, a staff technology, maintenance and consumables allowance for home offices would need to be considered, with the condition these spaces meet legislated WHS requirements. Here may lie a future opportunity to empower staff to procure their own equipment on a three year renewal cycle to a funded minimum specification, reducing the need for the company to own a fleet of devices or for centralised IT staff to undertake their set up and installation. A 'Bring Your Own Device' model provides flexibility to the user but also increases complexity for IT network integration and technical support. For this reason, it is an opportunity that requires detailed examination to test that the company can discharge its WHS obligations, protect its assets and maintain the security and privacy of its data in such a devolved model without raising IT support costs.

2.4 Hybrid working arrangements

A preference for a hybrid model of safe home and office-based working is a trend observed by many reporting on the impact of COVID-19 on businesses.[18] In the recent staff WHS survey, 95 per cent report themselves to be enjoying remote working and just over 92 per cent would like to continue remote working in some capacity. Seventy-five percent of respondents would like to work from home for between two and four days' each week. Nonetheless, 64 per cent of staff report missing face-to-face interactions. However, over 88 per cent feel staff wellbeing is adequately supported while working remotely.

Many companies are embracing a hybrid working strategy since it allows them to engage new talent rather than be limited to candidates in proximity to their premises.[19] In a climate of uncertainty, and with much more movement of people between jobs, there are unmatched opportunities to hire exceptional candidates from multiple markets. Remote working broadens the talent pool companies get to choose from.

Hyrbid working arrangements also offer an opportunity to reduce office footprints and cut the cost of commercial rents[20], equipment and other office amenities. This opportunity is available to the RACP, particularly in its Sydney CBD head office and Aotearoa New Zealand Wellington locations. With the leasing arrangements at 70 Philip Street due for renewal in 2022, the search for premises and assessment of options commences in 2021. Work is already underway to find better earthquake-rated premises in Wellington. This makes it an appropriate time for the RACP to consider the scale and fit-out of its offices. If the organisation continues to adopt a remote working or hybrid model, the Sydney footprint could potentially reduce, and other RACP locations potentially expand. With commercial city rents tumbling as organisations move out, more favourable leasing agreements and lowered costs are realistic possibilities. Writing in Fortune Magazine in June of this year however, Geoff Colvin cautions Boards against a laser focus on cutting costs since it risks approaching every decision with a siege mentality which creates pessimism that can impact productivity. In the case of the RACP an exclusively cost focus threatens delivery of experiences that members value as part of their subscription, whilst constraining important innovation in areas such as Education Renewal, IT Renewal, Professional Practice upgrades and new Member Services that meet the Member needs identified in RACP Member Journey Mapping research and the 2019 Member Engagement Survey. Nonetheless, space is an expensive commodity and a significant component of annual RACP expenditure. To explore the opportunities, the CEO has formed a cross-College (staff) working group which will develop models of operation that accommodate the flexibility of hyrbid working arrangements, different level restrictions imposed by the national, Federal and State governments, and interpersonal collaboration and connection.

2.5 Member event opportunities

Like many other Colleges and businesses, RACP Member events have been forced online, and admission to Fellowship ceremonies suspended. Opportunities to create dynamic online events abound and many companies have been highly successful in hosting multi-dimensional summits, conferences, masterclasses, learning quests and workshops. Technology enables concurrent streams and protocols allow for live Q&A. Whilst the technology costs associated with dynamic online events may be higher than face-to-face events, the lack of large venue costs more than offsets this and allows value to be translated into the delegate experience. New opportunities to secure the best

international speakers without travel requirements help to lift programs and participant numbers, whilst the scope to monetise the content and stream it to non-members could diversify revenue and reduce pressure on Member fees.

The RACP had to cancel its 2020 plans for a face-to-face annual Congress and later piloted livestream, on demand and podcast content delivery. In 2021, RACP Congress is planned for delivery in six Aotearoa New Zealand sites over a two-week period. Delegates can purchase a ticket to attend virtually or a face-to-face day ticket and view all other days' content on-demand. This allows equity of access to the face-to-face dimension of the event but also a switch to full online delivery should health orders require. Opportunities for delegates to network via digital breakout rooms and online communities are also being explored, since this is a key reason that delegates attend Congress each year.

Staff are increasingly experiencing members curating digital events in the regions and Aotearoa New Zealand wishing to open-up access to the whole membership. The ability to record events either in Zoom or by activating the *OnAir* recording functionality of the RACP's new events management system makes it possible for members to view these on-demand.

The shift to online events is unlikely to snap back post pandemic. This is therefore the time for the RACP to formalise a whole of College online event strategy. Questions become "should we ever return to large scale face-to-face events or convert fully to a digital future?". Such a direction would not preclude the RACP from retaining the flexibility to turn on smaller, safe, face-to-face Member events in satellite locations as health orders and mobility permit. There is also the third option of a hybrid event model that supports members to attend smaller satellite venues to network with one another and participate in a live webinar with a high-profile expert screened from anywhere in the world.

While online experiences give members access to quality clinical content and thought-provoking discussion about the big issues, it does not fully satisfy the need of members to connect and network in more interpersonal ways. A return to smaller face-to-face events – once possible to host safely in compliance with health orders — could be dispersed into satellite locations near hospitals that may better enable Member participation. This does not require the RACP to own or rent office space but would require well-managed, COVID-safe venues with the appropriate digital services to create a positive and valued Member experience. Head office events or local live events in Australia and Aotearoa New Zealand could be shared more widely digitally, empowering members in any location or time zone with access to meaningful RACP experiences, connections, and content. This has the potential to create significant value for membership. To progress this, a dispersed event operating model would need developing. This should assess the operating model, cost, targeted Member experience, technology requirements, venue safety, need for staff support (catering to various scenarios of restrictions to movement of members, speakers, and staff) and health order compliance.

2.6 Returning to RACP offices

Subject to robust safety protocols such as temperature checks, sanitising stations, workspaces that support physical distancing, an efficient cleaning regime, a booking and contact tracing system and COVID-safety trained officers, a model offering some office access to employees brings several benefits. For example, people who may be struggling working from home, those who require closer management or who experience busy, cramped, or unsafe working environments at home can be brought back into the office.

2.7 Opportunities in new work arrangements

A hybrid model of remote and home office working creates new job share opportunities that offer more flexible work arrangements to entice more parents to return to work. A hot-desk arrangement subject to strict sanitising protocols becomes not only more desirable[21] for booked office days, but also allows for office time to be focused on team and collaborative activities that can promote social connection, engagement and productivity[22]. Adopting a hybrid arrangement negates the need to expand the RACP head office footprint by another floor, representing $750k of avoided costs. A move to more flexible work arrangements can further reduce the organisation's floorspace requirements and create scope to consolidate Sydney staff on to one site. This allows the Board to consider the use of 145 and 147 Macquarie Street as a source of income.

The floorplans of all RACP offices could be designed to offer more collaborative, creative and configurable spaces that support various types of staff and Member work and innovation. New workspace configurations can also support the embodiment of organisational values (expected to be signed off in 2021) and healthy working (rethinking air quality and flow, temperature, noise, and lighting).[23]

2.8 Flexible support for staff

If and when the RACP decides to fully transition staff back to the office, management will need to demonstrate flexibility and understanding to help staff who may be experiencing excessive worry or fear regarding their ability to control the safety of the office environment. The same will apply to members when they return to in-person Member events or meetings. Managers will need to speak to individuals to find out what they need, especially if there are signs of struggle or distress. Thought will need to be put into commute times, hours away from home, necessary limits on the numbers attending at any one time, and staggered office/meeting hours, days, or weeks. The RACP People and Culture team has already deployed a range of employee supports including stress management activities, coaching of managers, remote working resilience training and mandatory COVID-19 safety training. An ongoing focus on staff morale and coaching those experiencing heavy workloads will be important. The culture being developed should support regular team and individual reflection on what has been learned and what improvements could be made.

2.9 Flexible support for members

The RACP has continued delivery of its Physician Health and Wellbeing Strategy throughout the pandemic, and strengthened advocacy for all aspects of Member safety, Personal Protective Equipment in the workplace and protected training time. The RACP has also provided additional Member resources as rates of burnout and mental health difficulties rise in frontline healthcare workers. In line with Goal 1 (*Improving the member experience*) and Goal 2 (*Education and professional development*) of the RACP Strategic Plan, 2019–21, the RACP has produced resources to specifically support members in Telehealth and Selfcare. The RACP can continue to add online learning modules with educational videos and articles that encourage selfcare, promote EAP services, acknowledge efforts, demonstrate how the RACP workplace is being made and kept safe, and show how the RACP is advocating for the safety of its members and the progression of trainees through their training.

2.10 Social connection

Where teams continue to work remotely, activities that help promote connection and cohesion should continue. Leaders need to look for opportunities for groups to share their work or be reminded of what innovation in medical education looks like. They could unite to focus on business challenges together, look for innovation opportunities and celebrate recent achievements. Whilst this does not replace often-valuable corridor conversations, it can help support collaboration, human connection, collective problem solving, innovation and personal and professional wellbeing.

2.11 Member experience of remote College work

Feedback from the Executive indicates that members have found remote working on College business much less disruptive to their clinical roles than face-to-face meetings. members speak of needing to commit far less time without the need to travel. The College, staff and Committee members have gained significant experience in Zoom and other video-based meeting software, such that technical or user issues are now relatively uncommon. The days of dialling in remotely and struggling to hear comments from around a large Council table with roving microphones and a polycom phone are not missed. Staff observe members leaving the meeting to take work calls while online less likely than in person meetings, perhaps knowing they can respond during breaks when they would normally be networking with their peers.

2.12 The future of digital Member meetings

Digital meetings require somewhat different protocols to face-to-face meetings to compensate for participants being unable to read body language and having to raise a digital hand to contribute. RACP leaders advise that digital meetings also require staff to be more dexterous in supporting Chairs by monitoring questions posed over the meeting's digital message function. With the opportunity to share messages with all participants or privately between individuals, the Chair can find it difficult to read the room and be unaware of multiple side conversations within the meeting. Clear guidance in online meeting etiquette, active secretariat monitoring of screens and messages for members' contributions, and disabling the message function until comments are invited by a Chair are ways to address these challenges.

RACP Leaders consistently reported Committee and Council members indicating preference for three digital meetings and one face-to-face meeting in a future where travel is possible. While a travel bubble has commenced between Aotearoa New Zealand and Australia, the lifting of the need for any quarantine is yet to transpire. As such, it is realistic to plan for a full suite of digital meetings in 2021 or until such a time as an effective vaccine is widely available to members and staff. While there is a rise in hosting/carrier costs for increasing the balance of digital meetings, this is entirely insignificant when compared to the cost of mobilising and accommodating members or moving staff to attend face-to-face meetings. In the extreme case of fully digital meetings, the RACP would achieve an estimated saving in meeting costs of $4–5m p.a. A hybrid arrangement of three digital and one face-to-face meeting for most Committees and Councils per year, would save a proportionate amount of between $3–4m p.a. Making such a move during COVID-19 has given the College opportunity to test out a digital committee model, whilst also contributing to infection control and being fiscally and environmentally responsible. The decision to go fully or partially digital generates new challenges and opportunities. For example, if members are no longer rewarded for their College work with travel, airmiles and hotel stays, would the RACP see the pro-bono workforce decline? What support is needed to assist Chairs in managing digital meetings? How would by-laws need to change, and what is the position if Chairs seek to meet remotely more frequently than current by-laws specify? Would any staff delegations need to change, and what training would optimise the effectiveness of committees meeting digitally? How does going digital increase opportunities for more focused and agile working groups that allow for more Member voices to more quickly heard and considered?

2.13 Monitoring new working arrangements

The RACP has deployed several practices to monitor and enhance employee sentiment and wellbeing during remote working. These include the use of news bulletins, webpages, initial twice-weekly staff meetings, and anonymous digital Q&A tools with rapid and transparent responses to issues raised. These strategies helped to surface and target employee concerns early, such as challenges cutting off from work at home and feeling compelled to work longer hours. The RACP experience, like many companies, is that their staff have been working harder and longer since working from home. The recent Staff WHS Survey showed that satisfaction with homeworking sits at 95 per cent. Whilst no benchmark data was available for comparative purposes, the majority of respondents felt their wellbeing had been maintained or improved compared to its quality 12 months prior. Nevertheless, the survey identified that 8 per cent of staff feel it has declined over that same period. Those expressing this concern were asked if they would welcome contact from the People and Culture Team to explore this further. Whilst this decline may not be entirely attributable to the vulnerabilities of remote working during a pandemic, management is conscious of this decline and working to better understand and actively address this.

Digital systems have the capacity to monitor employee devices, presenting a limited opportunity to assess whether safe working hours are being adhered to. However, such surveillance does not account for time spent working off a company device such as phone calls or reading articles on another device. The value of monitoring is somewhat limited, particularly since benchmark data from prior to the pandemic are not available. Monitoring of any kind raises compliance issues (with both privacy and surveillance laws) and is likely to be experienced as intrusive by staff, damaging trust. It is not recommended that the RACP activate such surveillance, but were it to decide to, it must be clear of the reasons for monitoring its employees and disclose these to discharge its legal obligations. Staff need to be aware of information being collected on them and why and how it will be used and shared and whether anyone can modify it. Privacy and surveillance are not just a matter of legislation, but a health and safety issue too.[24]

2.14 New ways of working, new skills

Effective remote working and hybrid working arrangements require the laying out of clear expectations for teams and their leaders. It necessitates transparency with teams and regular check-ins and updates to keep activities and people on track. It also requires additional support, especially for those who may be struggling. The recent staff WHS survey indicates that 95 per cent of team leaders know what is expected of them. RACP Senior leaders recognised the need for transparency and clear expectations early and held many team and one-on-one meetings in the early weeks of remote working. Staff that leaders anticipated might struggle with remote work have in fact flourished. Whilst new staff hired during COVID-19 missed out on in-person introductions and connection created by proximity to colleagues, leaders have made efforts to create social moments online. Furthermore, those team leaders that needed or wanted it, have been coached by the Head of People and Culture to help them adapt to the new needs of their remote teams.

Remote and hybrid working arrangements require trust in staff that they will perform and openness for honest, frank and supportive discussions if they do not.[25] It is also critical that a drop in performance is not automatically written off as a genuine performance issue. It may in fact be an anxiety or declining mental health (and thus WHS) issue triggered by isolation and remote working. Senior Leadership interviews provided encouraging evidence that not only is increased productivity being observed, but staff engagement has also improved as they enjoy higher levels of trust to work effectively, and more flexibility in the way they work.

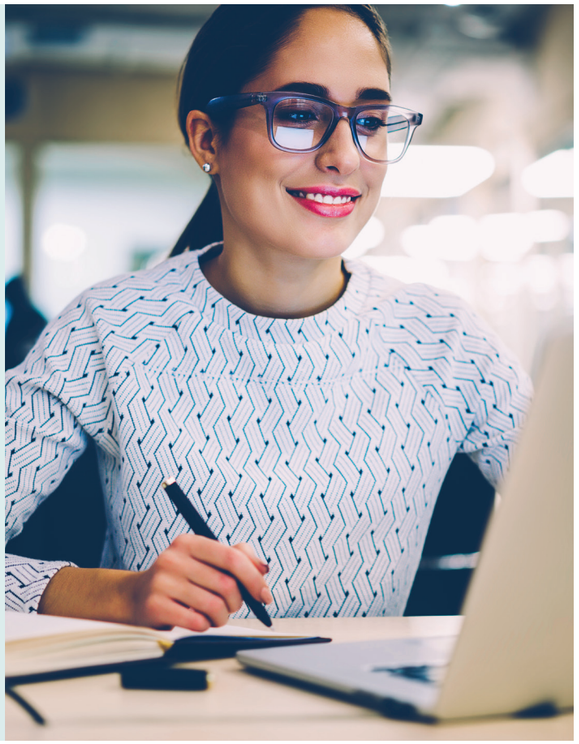
2.15 Trainee wellbeing

The RACP has acted to support trainee wellbeing during the pandemic, with a particular focus on the cohort due to sit the clinical exams. Pulse surveys have explored the impact of the pandemic on training rotations, working conditions and exam preparation. The impact on health and wellbeing forms part of the Physician Trainee Survey that went live on 22 October. These impacts are also explored by the Medical Board of Australia's Annual Trainees Survey and good data is expected by the year end.

It is evident from the research for this report that the RACP has much to be proud of regarding how quickly and effectively it mobilised its workforce, stayed connected to members, supported staff and Member wellbeing and explored and responded to the impacts of the pandemic on its trainees. This has allowed the RACP to maintain operations for its members, despite the disruption of the pandemic and the need for flexibility in the arrangements for the clinical examinations and for remote working.

Key takeouts

1. Hybrid working arrangements are anticipated to continue post-pandemic. These provide flexibility that aid talent attraction, increase staff engagement, and allow for healthier, more flexible, and configurable workspaces.
2. Hybrid working arrangements create opportunities to reduce an organisation's space requirements, helping to manage costs.
3. Organisations need to understand and manage the WHS implications of new work arrangements, proactively responding to staff experiencing difficulty with the arrangements.
4. Organisations need to balance the fear and optimism of their people whilst building resilience and trust.



3. Work health and safety

Safe, diverse, and engaged teams are much more productive, but it is rare for organisations to be safe throughout, particularly with rapid changes to operating models such as an overnight move to remote work. Existing WHS and HR support, monitoring and prevention practices may not be sufficient for a workforce fully or partially distributed. Changing operating models require companies rebalance for risk and resiliency and employees engage in more dynamic self-management and continual adaptation, drawing upon or fostering skills in resilience, agility, and growth. **While remote work can protect and empower workers, a heightened focus on employee safety and virtual care is required by employers.**

3.1 Discharging WHS responsibilities in the 'New Normal'

With thousands of Boards and employees working remotely across Australia and Aotearoa New Zealand and little to no opportunity for site visits or corridor conversations, Boards face new challenges to stay connected to their organisations, monitor culture and ensure their WHS obligations are discharged.[26] Speaking to the individual and collective legal liability of Directors for ensuring the workplace is a safe operating environment, Gartner's recent 22nd HR Leaders Survey of 800 global leaders raised the need for an army of assessors to routinely evaluate the safety of the operating environment which for many is now their home. Looking at the impact of remote, home working arrangements on Workers Compensation exposure, Lexology recommend employers work proactively to mitigate work injury risk while working from home. They suggest defining work hours, communicating standards for a home office, (re)training employees on safety measures and ergonomics to prevent injuries and identify hazards, communicating safety policies and reminding employees of the claim reporting process.[27]

Whilst assessing someone's home may raise concerns about trust, privacy and cultural safety, current Australia/ Aotearoa New Zealand case law suggests that the employers WHS obligations reach into the home, and that employers may well be queried about assessments of the home work environment. Thought needs to be given in relation to how to discharge these duties in a sensitive way. So too the need to address staff safety in smaller regional offices such as Perth, Adelaide and Brisbane, where working from home by some staff may leave others opening the office alone. Mitigating the risks of lone working would need to be addressed to ensure no staff member was placed at undue risk, nor denied the opportunity to work from home like colleagues in larger RACP offices.

Gartner's 22nd HR Leaders Survey findings also advises Boards of the need to monitor organisational and individual wellbeing and resilience, and to work to ensure staff anxiety is mitigated and management fatigue avoided. With such considerations in mind, many companies are working to make their workplaces safer both during and post pandemic, looking at areas such as air quality, contactless hygiene processes, breaches of personal space etiquette, enhanced mental health supports and stricter WHS policies.

3.2 Emerging WHS risks

In distributed and hybrid workforce arrangements, employees may be at an increased risk of family violence or declining mental health. Bullying and harassment may move online and rise with the increased opportunity to perpetrate without witnesses. The deployment of collaboration tools that allow real time instant messaging 24 hours a day gives employees access to all colleagues anytime. This has the potential to blur boundaries between professional and personal hours, and an increased risk of breaches to etiquette, conduct, boundaries, and policies that can result in complaints and WHS claims.

Other safety issues that the RACP will need to consider include those of vulnerable employees who may have been subject to online bullying or harassment by colleagues at home. The RACP must also consider what happens to that individual's safety if they are then called in to socially distanced near empty offices to work with those individuals; a circumstance the organisation may have no visibility of.

A safe workplace impacts the bottom line in relation to staff retention, quality of work contributed and feeling safe. When considering the future operating model and location of their workforce, the RACP will need to balance the natural fears of its staff and members with acceptance of the uncertainties. This can be facilitated by a risk management framework that helps manage the trade-offs. This framework should include the risk that mental health disorders become a significant issue.[28]

Both Marsh Research and Briefings[29], and Deloitte[30] predict an increased likelihood of workers suffering from mental health injuries, at an increased severity and with longer recovery times in an environment of lockdowns and home working. While they anticipate an increase, they also expect those claims to remain open for longer as access to claim resources such as independent medical examination, field investigation and workers compensation hearings may be disrupted or delayed by the pandemic. Trend data are not yet available to benchmark this assertion. The RACP can continue to use its risk management framework to monitor its own and industry data to foreshadow any increasing frequency, severity, duration and costs of claims, and any material change to insurance premiums.

3.3 WHS findings

In the recent employee WHS survey, staff indicated a strong preference for a hybrid working arrangement when RACP offices reopen. However, questions have been raised about who will fund ergonomic office set up in the home, and how this sits with the employer's obligation towards staff safe working. The RACP needs to seek clarity from its insurers and regulators to ensure its duties are fully discharged in a dispersed or hybrid workforce model.

More than 96 per cent of respondents report feeling psychosocially safe when working at home. This number drops to 90.5 per cent at the office. Staff also report a strong sense of cultural safety working from home with 69.1 per cent agreeing or strongly agreeing with this statement. This number drops to 48.4 per cent when considering cultural safety at the office.

These data and preferences provide an opportunity for the RACP to rethink the WHS of its employees, and the sort of supportive culture that needs to be fostered to create a workplace that is safe for all. It also provides an opportunity for Directors to clarify any adjustments to the organisation's WHS policy, practices and monitoring they feel help them to satisfy their obligations to keep the organisation safe under new working arrangements.

Key takeouts

1. Safe, diverse and engaged teams are more productive.
2. New operating models including remote and hybrid work arrangements create new WHS concerns, requiring Directors balance for risk and resiliency and place an increased focus on employee safety and virtual care.
3. New working arrangements create an opportunity for Directors to clarify any adjustments to the organisation's WHS policy, practices and monitoring to satisfy their obligations to keep the organisation safe.

4. Mental health in COVID-19

4.1 Increasing mental health risks

Emerging evidence signals social isolation, uncertainty and direct experience of COVID-19 can elevate rates of anxiety and increase the risk of long-term mental health difficulties, with certain populations at most risk. These include healthcare workers, people with pre-existing anxiety disorders and mental health problems, those placed into quarantine, and business owners, the unemployed and casualised workforce whose financial stress make them more predisposed to higher levels of distress, poor health and worsened mental health outcomes than the wider population. So too the risk of PTSD, anxiety disorders, anger, loss and loneliness.[31] The RACP as an employer and an advocate for the physician workforce, needs to anticipate these outcomes, mobilise interventions and supports that provide their members and staff with the best possible health outcomes.

"There will be a significant minority who will be affected by long-term anxiety as a result. Health care workers, people placed in quarantine, and individuals with life-threatening cases of COVID-19 are at increased risk of long-term mental health problems."

(**Black Dog Institute**, *Mental Health Ramifications of COVID-19: An Australian Context*. 2020)

4.2 Mental health supports

With fear and anxiety expected to diminish for many as the pandemic eases, professional intervention may not always be necessary. Practical support, particularly measures that ease the stress brought about by unemployment and financial insecurity are essential support measures that the Australian and Aotearoa New Zealand governments have put in place for their citizens – from job keeper payments to a moratorium on evictions for defaults on mortgage and rental payments. Nevertheless, as these supports are wound back, a spike in stress is anticipated.

Job insecurity and the perception of job insecurity[32] have been shown to increase effects of poor mental health, and a three-fold increase in rates of anxiety and depression.[33] Health organisations like the RACP are being called to live up to their purpose of educating, advocating and innovating for the improved health of their profession, their patients and their communities. Practical support for trainees, Fellows and staff such as flexible payment terms, paid coronavirus leave, flexibility for training time when in self-isolation, and increased EAP services are examples of practical supports the organisation has and can continue to offer. Any structural changes to jobs, employment or the organisation should not only protect the long-term health of the RACP but also its people.

RACP members treating the community and RACP staff can be susceptible to fear and panic fuelled by myths, misinformation and 'fake news' spread by social media, sensationalised, alarmist media coverage, or confusing information and advice from experts and governments. Black Dog Institute report that studies of prior pandemics show that media portrayals of respiratory illnesses are often threat-based and sensational, rather than accurate, factual, or informative about the symptoms of the virus, and how it can be prevented. **The RACP, its members and advocacy committees can continue to play a crucial role in counteracting the spread of fear-based information and contain rising rates of anxiety by sharing free, trustworthy, high quality, evidence-based, accurate information about COVID-19.** This helps to reduce confusion and anxiety and provides the community with a greater sense of control. The regularly updated COVID-19 and physician health and

wellbeing pages on the RACP website and staff intranet address this need and should be prioritised for regular updating. The opportunity to strengthen RACP health and wellbeing products and services for members aligns well with the implementation of the RACP Physician Health and Wellbeing Strategy and Goal 1 (*Improve the member experience*) of the RACP Strategic Plan, 2019–21. The ability to customise and target health and wellbeing products, services, supports, and messages to members is an opportunity, though one currently constrained by the limitations of the Aptify software which houses the mwember database.

Other measures such as booking systems to attend RACP offices with clear social distancing and infection control measures in place, coupled with the flexibility to contribute or work remotely on an ongoing basis help to improve the locus of control staff and members experience. The scope to achieve the same outcomes for members in clinical settings relies on advocacy and health services' own protocols. However, the RACP does have the ability to foster opportunities for the social inclusion and engagement that is critical to connectedness and wellbeing. Zoom based staff meetings, online committee meetings, online communities, special interest groups and virtual Congresses, scientific meetings, summits, and events all provide opportunity to connect and could continue beyond the pandemic. As previously detailed, appropriately managed, and COVID-safe satellite meetings in local settings may also form part of this future.

4.3 Post-traumatic growth

Whilst concerns for a "social recession" and the diminution of mental health and wellbeing as a result of the pandemic are warranted, people respond to trauma and uncertainty in various ways. Many show resilience and do not develop long-standing mental health problems. Indeed, many psychologists witness resilience in patients who have faced unimaginable trauma. Post-traumatic growth, a term coined by psychologists Tedeschi and Calhoun in the mid-1990s, is similar to resilience but articulates a positive change that occurs in the aftermath of struggling with a major life crisis or traumatic event. It is a process rather than an outcome and involves developing positive responses in the areas of appreciation of life, enhanced relationships with others, new possibilities in life, newly identified personal strength and existential change.[34] While the extent of post-traumatic growth may not be apparent until the COVID-19 pandemic and its associated disruption is over, there is already evidence that the "loneliness epidemic" that plagued 2/3 of Americans in 2019 has improved during COVID-19.

Whilst improvement is not uniform across age cohorts and populations, several recent studies published in the American Psychologist, demonstrate that loneliness has improved[35] as people adapt and find ways to maintain social connection and a sense of belonging despite the circumstances. While the RACP must be mindful of the fears felt by its members and staff, the pandemic may catalyse a cultural shift in which members and staff come together to build healthy connections. The design of RACP workplaces, operations, products, services, and events could be reimagined to enhance social wellbeing and strengthen professional bonds.[36]

Key takeouts

1. COVID-19 can trigger increasing rates of mental health disorders in the community, with healthcare workers most at risk.
2. Health organisations like the RACP are expected to protect the health of their organisations and their people. RACP members play a vital role in providing accurate information to advise governments and citizens of appropriate health measures.
3. While a social recession is likely, some may experience post-traumatic growth as a result of the pandemic's effects.

5. Policy, advocacy and professional leadership

5.1 Leadership by design

The pandemic has created an unparalleled opportunity for the RACP to propel itself into a strong and ongoing health prevention, health policy and clinical leadership role. Governments the world over are now regularly taking advice from public health experts, infectious diseases specialists, virologists, immunologists together with epidemiologists, translational scientists, frontline clinicians and health system leaders. Similarly, citizens seek plain English expert population health and clinical advice to understand the risks of infection and how to protect themselves. **Never in modern times has the professionalism of physicians been more highly valued by so many.**

With governments and citizens looking to their preventative health and clinical communities for advice, guidance, and leadership, the RACP has a unique opportunity to set the health agenda in many aspects of clinical research, public health, disease management and health policy. From this place of influence, opportunities for the RACP to drive improvement in preventative health, equity of access to healthcare, and to address care gaps, affordability, and clinician and patient safety, including cultural safety, become greatly enhanced.

COVID-19 provided the RACP with the opportunity to powerfully advocate to government for the accelerated roll out and upgrade of quality telehealth solutions. It is one of four specialist medical Colleges working with the Australian Department of Health to improve and extend telehealth with a view to it continuing beyond the pandemic. In a May survey to Australian members, the RACP identified that 87 per cent of respondents support the retention of MBS telehealth items introduced in response to COVID-19, beyond the pandemic. The same survey identified that telehealth now forms a significant part of members' practice, with 27 per cent of respondents indicating the new MBS telehealth items account for more than 80 per cent of their practice, and 55 per cent reporting they account for more than 50 per cent of their practice. Seventy-five percent of respondents perceive the availability of these new MBS Telehealth items to have improved the accessibility of healthcare; and seventy percent report that their patients are more likely to keep their telehealth appointments than in-person appointments.

With COVID-19 significantly impacting already stretched health budgets and the continuous pressure on health departments to do more with less, digital health solutions and remote medicine offer some hope. Whilst it does not allow for all forms of baseline measures, diagnostics, clinical management and therapeutics, technology enabled distance care, including telehealth, wearable and at home medical devices, help to provide care to patients too vulnerable or fearful to attend clinics in person. It also provides better access to those in regional, rural and remote locations where the specialist medical workforce is in short supply. RACP advocacy for high quality protocols and technology to support distance care goes some way towards addressing the care gap.

The RACP should continue its advocacy efforts in resourcing best practice telehealth, particularly given the spike in adoption during COVID-19 by both healthcare providers and patients. The extended lockdowns in Victoria have seen many services and physician consultations transition to telemedicine. A rise in adoption of home-based and wearable devices that allow for remote monitoring of patients with chronic disease and other conditions has also occurred. Having crossed the IT hurdle to engage in care this way, patients and clinicians are unlikely to fully snap back to face-to-face care.

There are many benefits of mindfully implemented remote care including patients feeling more at ease in their own home and not having to experience the burden of travel to specialists' clinics and rooms. However, there are also risks and liabilities. **The RACP should stay in touch with members' experiences of telehealth as they represent the opportunities and importance of quality and safety, the digital divide and equitable access to policymakers**. It could also undertake analysis of the risks and benefits of specialist telehealth.

US telehealth adoption data reported on 30 June 2020 indicated 20 per cent of doctors surveyed expect to be using telehealth tools "significantly" more post-pandemic than before (Figure 4).

Figure 4: COVID-19 impact on the future of telehealth in the US

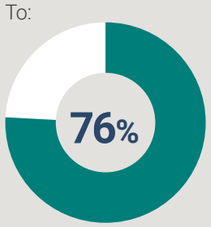
How has COVID-19 changed the outlook for telehealth?

1 Consumer

Shift from:

use of telehealth in 2019

To:



now interested in using telehealth going forward

While the surge in telehealth has been driven by the immediate goal to avoid exposure to COVID-19, with more than 70 percent of in-person visits cancelled,[a] 76 percent of survey respondents indicated they were highly or moderately likely to use telehealth going forward,[b] and 74 percent of telehealth users reported high satisfaction.[c]

2 Provider

Health systems, independent practices, behavioural health providers, and others rapidly scaled telehealth offerings to fill the gap between need and cancelled in-person care, and are reporting

50–175x
the number of telehealth visits pre-COVID.[d]

In addition,

57% of providers
view telehealth more favorably than they did before COVID-19 and

64%
are more comfortable using it.[e]

3 Regulatory

Types of services available for telehealth have greatly expanded, with the Centers for Medicare and Medicaid Services (CMS) temporarily approving more than

80 new services

and lifting restrictions on originating site, allowing Medicare Advantage plans to conduct risk assessments via telehealth, and adding other regulatory flexibilities to increase access to virtual care.[f]

a. McKinsey COVID-19 Consumer Survey, April 27, 2020.
b. McKinsey COVID-19 Consumer Survey, May 20, 2020.
c. McKinsey COVID-19 Consumer Survey, April 13, 2020.
d. Ibid
e. McKinsey COVID-19 Physician Survey, May 2020.
f. Medicare telemedicine health care provider fact sheet, March 17, 2020, cms.gov.

May data from the MBS in Australia shows around one third of all MBS services were delivered using telehealth solutions that month (Figure 5). The adoption of telehealth is much higher in primary care. Nonetheless, 29 per cent of MBS Specialist consultations are reported to have been delivered via telehealth over the same reporting period.

Figure 5: MBS Australia telehealth summary

Medicare Benefits Schedule (MBS), Australia Telehealth Summary

Total number of MBS consultations reported in May 2020 **16.6M**

May 2020 Activity

Total number of telehealth consultations this month **5.4M**

(overall % of MBS services delivered by telehealth this month) **32.7%**

4.9M (90.9%) by telephone

493K (9.1%) by videoconference

General Practitioner Consultations	Specialist Consultations	Mental Health Consultations	Nurse Practitioner Consultations	Allied Health Consultations
Total: 12.5M Telehealth: 4.3M (34%)	Total: 2.1M Telehealth: 607K (29%)	Total: 1.0M Telehealth: 469K (47%)	Total: 71K Telehealth: 12K (17%)	Total: 975K Telehealth: 71K (7.3%)

Total number of telehealth consultations since COVID-19 (March – May 2020)
12.5M

Total number of MBS consultations (March – May 2020)
49.4

Source: MBS Online; http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.isp: Accessed July 2020.
Suggested Citation: Snoswell, C.L., Caffery, L.J., Hobson, G., Taylor, M.L., Haydon, H.M., Thomas, E., Smith, A.C. Centre for Online Health, The University of Queensland, Australia. Telehealth and coronavirus: Medicare Benefits Schedule (MBS) activity in Australia. July 2020, available at: www.coh.centre.uq.edu.au

Taking advantage of the leap taken in telemedicine during COVID-19, the RACP has significant opportunity to advocate for its further development and to increase health literacy and patient-centred care in rural, regional and remote areas to help address health equity. It also has opportunity to advocate for equity of access by Indigenous populations, prison populations and homeless populations, wherever they are. **Unmet and under-met need is exacerbated in a distance care model when patients lack good access to smart phone, video technology or reliable networks or phonelines and needs to be overcome.**

For remote care services to meet the needs of the population, they need to be culturally safe in both Australia and Aotearoa New Zealand. Where Māori and Aboriginal Torres Strait Islander people have access to the right tools to participate in healthcare remotely, full attendance rates are often reported. Face-to-face appointments, particularly those that require hours of travel across remote areas typically experience low attendance rates. In the case of remote, regional, or rural Indigenous populations, distance care is most effective when patients are supported by local Māori or Aboriginal Health Workers, and by other Allied Health professionals. These can help patients by acting as plain English interpreters of specialist advice, as advocates to ask questions on their behalf, or undertake physical tests and examinations at the request of the consulting specialist.

5.2 Skilling the physician workforce

Using recently produced and new resources, the RACP has an opportunity to support members to strengthen their skills in telehealth and to support clinician research on the impact of telehealth upon detection rates, treatment, and health outcomes for various diseases. This could be catalysed at the recommendation of the RACP Research Committee with funds made available through the RACP Foundation. There is also opportunity to support clinical research on the longer-term health effects of COVID-19 for co-morbidities and complex care, or to examine any disproportional impacts of COVID-19 on disadvantaged communities such as prisoners. These issues can be advocated by the College as a whole and across Divisions, Faculties, Chapters and Societies. For example, the Australasian Faculty of Rehabilitation Medicine can address the longer term health effects, co-morbidities, and complex care, while the Faculty of Public Health Medicine looks to the needs of the general population and specific communities.

5.3 Strengthening mental health supports for healthcare workers

The RACP has an important role of working with government to strengthen mental health support systems for healthcare workers, and ensure due consideration is given to frontline health workers at risk of infection or in regular and direct contact with COVID-19 patients. Their anxiety and that of their colleagues and loved ones is likely to be significant, especially given well established evidence from Beyond Blue that healthcare workers are at greater risk of anxiety, depression and suicide ideation than the general population. Consideration should be given to the provision of ongoing mental health monitoring for impacted healthcare workers.

The RACP can continue to advocate for its members feeling

"*informed, prepared and properly trained, having access to the appropriate protective equipment and access to psychological support…to alleviate fears and…minimise the impact of psychological distress… [A]dditional and ongoing psychological support is likely to be needed for frontline healthcare workers.*"

(**Black Dog Institute**, 2020).

There is a clear opportunity for the RACP to push for a firmer and ongoing leadership position in the setting of government policy and support of the physician workforce across all dimensions of this health crisis. It is worth the RACP considering what further investments may strengthen this strategic endeavour – Goal 5 of the RACP Strategic Plan, 2019–21.

Key takeouts

1. The pandemic creates a unique opportunity for the RACP to propel itself into a strong and enduring leadership role, especially in the design of health prevention and health policy.
2. The opportunity to address issues of equity in healthcare, Indigenous health, affordability, safety, and gaps in care is greatly enabled.
3. Distance care and all forms of digital medicine are here to stay, and particularly valuable in chronic disease management, with the potential to collapse barriers to specialist care. They also create challenges that must be understood and overcome.

6. Education, learning, assessment and professional development

The area of RACP business perhaps most impacted by the pandemic is that of Education, Learning and Assessment (ELA), and by association, RACP trainees, supervisors, examiners, the College Education Committee (CEC) and associated committees.

Whilst healthcare workers are regarded as "Essential Workers" in every jurisdiction, the RACP was quick to assess the risk and scenario plan for disruption to the education, learning and assessment activities of physician trainees, and to the professional development of its Fellows. Specific focus was placed on disruptions to trainees' hospital rosters, rotations, the flow of trainees into rural, regional, and remote areas, as well as to examination preparation and the Divisional Clinical Exams (DCE). Any disruption to the latter has widespread implications for hospital recruitment and progression through training.

6.1 Impact of COVID-19 on RACP Education, Learning and Assessment policy and delivery

Any interruption to training and exam preparation has the potential to impact the number of trainees applying to sit the clinical exams in both 2020 and 2021, whilst the availability of DCE places impacts the opportunity to progress through training. The timing of the Divisional Clinical Exams impacts the capacity to be recruited into an Advanced Training position or a qualified clinical position. For this reason, the RACP has worked closely with health departments and hospitals during the pandemic to advocate for RACP trainees across issues of safety at work, working hours, protected training time, clinical exam preparation, and health and wellbeing.

Education policy determines that significant, high-impact changes to the education, learning or assessment of trainees require more than 12 months' notice to prepare any affected cohorts. In the case of COVID-19, where impacts have proven significant, far reaching, essential and immediate, education policy has needed to adapt and rapidly so. Education leaders, their committees, the College Education Committee (CEC) and RACP Board have been challenged to operate very differently. They have been called to act with agility, confidence, and speed, whilst maintaining quality standards of the RACP training program, and ensuring no trainee is disadvantaged.

Rigid policies, hierarchical structures, and a reliance on a pro-bono contribution alongside full clinical and/or academic roles can inhibit agility and speed. To address this, the CEC have met out of session and agreed changes to policy and delegations (endorsed by the Board) that enable the RACP to reinvent its education, learning and assessment frameworks to respond swiftly and defensibly to the emerging 'new normal'. There is opportunity for the Board to further reduce the red tape involved in passing through multiple RACP Committees for decisions on education matters. This would allow for the more rapid and responsive decision-making required in a crisis. It may also be worth the Board and CEC considering the experience of making a major change to the Education, Learning and Assessment of trainees with less than 12 months' notice. If this is tolerated during the pandemic, it may allow for more rapid deployment of elements of the Education Renewal program. This would help to keep the RACP in line with, and better still, ahead of advances other medical colleges and medical schools are now making, propelled by the restrictions created by the pandemic.

6.2 Adapting delivery of Education, Learning and Assessment for trainee physicians

Crises of any kind show where inherent and existing vulnerabilities lie that need to be addressed. COVID-19 has illuminated the frailty of a clinically based Fellowship training program reliant upon the mobility of trainees, and in-person access to supervisors, patients, cases and clinics for the development and assessment of clinical competencies.

The RACP has prepared for a worst-case scenario of no Divisional Clinical Exams (DCE) in 2020. This could become reality should a third COVID-19 infection wave start spreading among the Australian and/or Aotearoa New Zealand community. At this stage, the DCE is intended to go ahead with long cases commencing on 14 November. The RACP should retain and continue to refine its response should it become necessary to cancel the DCE later this year or in 2021.

COVID-19 presents a novel opportunity to deliver innovation that enhances the medical education, learning and assessment experience. For example, simulation can be used for clinical practice and skills development where access to patients is restricted, although these can be costly to create in the first instance. COVID-19 also presents opportunities for trainee physicians to develop their competency in critical and adaptive thinking, innovation, collaboration, problem-solving, reflective practice, and technology literacy. All of these are important competencies for physicians.

Writing in the Journal of the American Medical Association, Lucey and Johnston contend that the COVID-19 pandemic has had transformational effects on medical education. Innovation such as the renewal of curricula, long overdue, is speeding up under COVID-19. However, it is noted that clinical skills can be the most problematic to transition online.[37] Technology can also act as a barrier if quality is poor, and inhibit the development of trust, rapport and empathy with patients and other clinicians when compared with live settings.

6.3 The new Divisional Clinical Exams

Nevertheless, the delivery of the DCE has had to radically change to allow for public health orders, hospital demand, infection control, social distancing and patient and clinician safety. The timing of the Adult and Paediatric DCEs has been delayed by almost 4 months. The long and short case components of the 2020 DCE have been split for the first time, and much of its delivery has gone digital. The long case will now be delivered online, requiring fast and reliable broadband connections, new tools and cloud systems, as well as means of securing patient confidential data and authenticating the identity of examiners, trainees and patient participants. A move online also requires new ways of preparing trainees, patients, and examiners not only for how things should proceed, but what to do if technology issues arise. Instant access to support technicians will be critical and an expense unique to this format. The deployment of a new examination format enabled by new technology is therefore not without expense or risk. The cost associated with delivering the DCE in 2020 has shifted from mobilising examiners, patients, and trainees, to solutions that require design expertise, software solutions and third-party technical support. The need to invest in new, digital solutions has coincided with universal pressure on incomes and a desire to reduce Member fees.

Such wholesale change as taking the DCE online requires clarity regarding the message as well as resilience, adaptability, and flexibility on the part of the hospital system, trainees, examiners, supervisors and associated RACP committees and staff. Resistance to change needs significant effort to overcome and execution requires vast contributions of Fellow-led co-design and staff-led planning. Most of all, it requires confidence and courage. COVID-19 has been the catalyst to take the DCE online. Understanding the validity, efficacy and viability of a digital clinical exam as a future format can only be developed by trialling it and evaluating the collective experience, challenges, costs and outcomes after the end-to-end process has completed. It is likely that the RACP will need to make a preliminary decision regarding the format of the 2021 DCE before it is able to fully evaluate its 2020 experience.

Committees and staff should be commended for working to achieve education, learning and assessment solutions intended to support the best outcomes for the profession in a rapidly changing environment. Gaining speed by design is essential in the intensely variable conditions created by COVID-19 and the RACP should continue to look for ways to gain it. Speed is enabled by structures that support good decisions made quickly, strong communication and collaboration, as well as good use of technology and the tolerance for risk. Nowhere is this needed more than in relation to the DCE.

6.4 Trainees in distress

COVID-19 has the capacity to result in more trainees under stress and a greater uptake of the services available from the Training Support Unit (TSU) including applications to interrupt training and movement onto the Trainee in Difficulty pathway. Education, Learning and Assessment (ELA) monitors these services continuously and has observed an uncharacteristic surge from a median of 16 referrals to the TSU per half year, to 36 at the mid-term mark in August of 2020.

6.5 Professional practice and the OTP bulge

In the area of Professional Practice, the pandemic has exacerbated an existing bottle neck in the assessment of Overseas Trained Physicians (OTPs). Assessors of those on the OTP pathway have always been in short supply in Aotearoa New Zealand. This has been compounded by the exponential rise in OTPs wishing to practice in Aotearoa New Zealand since a pandemic was declared.

Aotearoa New Zealand's intake of overseas trained medical workforce is amongst the highest in the world. This has risen sharply as Aotearoa New Zealand prioritises virus elimination and home countries see surging infection rates. This is placing increasing pressure on the RACP who must process OTP applications in-line with the targets specified by the Medical Council of Aotearoa New Zealand (MCNZ). The problem is not just one of increased application levels and short supply of assessors, but also travel restrictions preventing assessors from visiting OTPs in their supervised practice. Assessing the clinical competence of an OTP is much more difficult to do online. There is little the RACP can do to address this COVID-inflated challenge beyond continuing to work closely with the MCNZ to adopt more realistic processing time targets, and with RACP members to progress outstanding OTP applications as soon as restrictions permit.

6.6 CPD Compliance

The RACP has negotiated with the Australian Medical Council (AMC) and the Medical Council of Aotearoa New Zealand (MCNZ) for flexibility in the submission of evidence of Continuing Professional Development by its physicians, considering the disruption caused by COVID-19 to many professional development opportunities. The opportunity to present at conferences for example has changed dramatically with many planned events cancelled. Likewise, hospitals have had to make calls to pause clinical research trials to ensure capacity for COVID-19 patients. While some of this work is now resuming, it will take some time for RACP members to access the same scope of professional development opportunities they enjoyed pre-pandemic.

Key takeouts

1. The pandemic has had a profound impact on physician training delivery, requiring flexible policy and innovation, rapid, confident, and defensible decision-making, and resilience of trainees, examiners, supervisors and supporting staff.
2. Crises show the vulnerability of a clinically based Fellowship training program reliant upon face-to-face clinical interactions to develop and assess competency.
3. The pandemic has triggered long overdue innovation in medical education. The RACP had already commenced this innovation journey but must maintain pace to not be overtaken.

7. Recommendations

The experiences, trends and insights captured in this report create opportunities worthy of further exploration and action by the RACP. This section recommends actions the organisation may wish to explore during the remainder of 2020 and into 2021.

Opportunity	Action	Due date	Pros/Cons
Hybrid working arrangements	Determine the optimal quantum, size, and arrangement of RACP offices, and recommend lease and fit-out options with projected cost/savings	Lease for 70 Philip Street, Sydney due for renewal or notice by mid-2021	• Opportunity to consolidate space requirements and achieve preferable leasing arrangements. • Opportunity to promote collaboration and more collective ways of working. • Opportunity to design the new Wellington premises to better suit working arrangements expected post-pandemic. • Opportunity to offer more flexible ways of working, improving attraction and retention of talent. • Opportunity to create highly configurable workspaces and healthier work environments that enhance the health and productivity of staff and attending members.
WHS	• Clarify how to practically meet all WHS obligations where the workplace is an employee's home. • Develop options to discharge these duties and monitor WHS in remote and hybrid working models. • Develop mitigations to address the risk of increased domestic violence for employees working from home.	First quarter 2021	• Increase in injuries, lost days due to injury, and workers compensation claims. • Need for increased protections and remote care. • Proactive discharge of WHS obligations. • Protection of worker safety. • Improved worker health and wellbeing.

Opportunity	Action	Due date	Pros/Cons
Digital AGM	• Identify options, requirements, and prospective solutions to repeat 2020 AGM format in 2021. • Identify Constitution change requirements, technical and business requirements, and prospective RFP to allow the AGM to be run as a partially or fully digital format after a Member vote on Constitutional Reform in 2022.	First quarter 2021	• Relatively short timeframe to source a third-party solution unless continuing with the 2020 provider, which did not deliver a seamless solution. • Access is democratised amongst the membership, but the digital divide may disadvantage senior members. • Can repeat 2020 format in 2021. Can propose amendments to the Constitution to remove the requirement for a physical quorum to hold an AGM when Constitutional reforms are considered by the membership in 2022. This need not preclude the organisation from continuing to offer a physical meeting alongside digital access.
Digital committee meetings	Develop a proposal for digital and hybrid College body meetings in 2021 and beyond, including any training or changed resources that may be required to support this format.	First quarter 2021	• Would need to be sensitively communicated by the Board to Chairs and committee members. • May require change to many College body by-laws. • Meetings policy needs to support the new format. The FRMC has already been considering this matter to reduce the College's carbon footprint. • Ensures work of Committees continues regardless of health orders, vaccines, or commercial flights. • Protects the health of RACP members and staff. • Reduces annual costs by c. $3–4m. • May discourage members from expressing interest for Committees if travel opportunities are limited. • More difficult for committee members to network and develop inter-personal connections if worse case of fully digital meeting arrangement is necessary.
Digital Member events	• Develop a draft whole of College digital event strategy. • Develop a dispersed event operating model for smaller, local, face-to-face events that comply with variable jurisdictional health orders. • Develop a hybrid face-to-face and virtual event operating model. • Develop a proposal for monetising streamed event content to non-members to offset Member fees	End of quarter 3, 2021 to take up learnings from a hybrid 2021 Congress model in May 2021.	• Allows connection and streaming of valuable content across the membership and beyond, regardless of time zone, location, or restrictions. • Allows small groups to meet safely face-to-face (where health orders permit). • Provides opportunity for communities of practice to form and evolve. • Potential to diversify or increase revenue from the sale of streamed content to non members.
Telehealth	• Continue active role in telehealth policy design via the Department of Health (Australia) Specialist Advisory Group. • Seek parallel opportunities in Aotearoa New Zealand. • Advocate to protect quality and safety of telemedicine, and to ensure digital literacy and equity of access. • Stay close to members' experiences of telehealth to inform policy design. • Examine opportunities to fund research on the pros, cons, efficacy, and impact of telehealth. • Continue to develop resources to support members' adoption and competency in telemedicine.	Ongoing	• Opportunity for leadership role. • Risk of poor-quality care if inadequately executed. • Risk that the digital divide will increase inequities in health. • Concerns regarding Member liability and protections.

Opportunity	Action	Due date	Pros/Cons
Health and Wellbeing	• Continue to advocate for PPE for specialists. • Continue to advocate for protected training and exam preparation time. • Continue to advocate for improved mental health supports for healthcare workers. • Continue to implement the Physician Health and Wellbeing Strategic Plan. • Continue to monitor the health and wellbeing of the physician workforce. • Continue to enhance RACP health and wellbeing products and services.	Ongoing	• Trainee and physician burn out. • Poorer health outcomes. • Disruption to the physician workforce.

Opportunity	Action	Due date	Pros/Cons
Innovation	• Monitor the new format of the DCE and make recommendations for changes or improvements for 2021.	Early Q1 2021	• Several scenarios for the DCE in 2021 will need to be planned for. • More streamlined decision-making still requires governance oversight and may require changes to by-laws. • Resistance to change and fast decision-making is a hurdle that will take collective effort and reassurance to overcome. • Other Colleges and Medical Schools following RACP lead on curricula renewal to include Entrustable Professional Activities as evidence of clinical competency. The new Basic Training curricula hold up well in a pandemic environment.
	• Identify opportunities to speed up defensible decision-making on educational policy and operations.		
	• Explore the scope for a more flexible Education Policy that allows for more rapid innovation and deployment of change.	End Q1 2021	
	• Develop a plan for alternatives to face-to-face training – where these do not compromise the quality of physician training and competence to practice.	Mid 2021	
	• Continue to work with the regulators to address the impact of the pandemic on members' capacity to complete their annual CPD.	Ongoing	
	• Develop options for CPD that maintain demonstration of physician competency whilst complying with health orders.	Q1 2021	

Opportunity	Action	Due date	Pros/Cons
Research	Explore opportunities to fund Member research on COVID-19.	End of Q1 2021	Work with donors, the RACP Foundation and the RACP Research Committee.
Overseas Trained Physicians (OTP)	• Monitor growth in OTP applications in Australia and Aotearoa New Zealand.	Ongoing	Work with Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) to address issues of supply and demand.
	• Develop proposals to progress these applications while travel restrictions may limit assessment opportunities.	Q1 2021	
	• Renegotiate targets for OTP processing with MC Aotearoa New Zealand in light of the pandemic.	Ongoing	

8. Summary

The COVID-19 pandemic has highlighted frailty in the physician training supply chain, and challenged members, leaders, and staff in exceptional ways. The organisation has had to adapt to rapidly changing and highly variable contexts, whilst generating resiliency for its purpose, members, and staff. It has needed to design and implement significant operational change to its support systems and to its training and professional practice programs, whilst being careful not to compromise worker and Member health and safety, or the quality of its Fellowships in particular.

The Board finds itself leading, directing, protecting, and sustaining the RACP as it enters years of uncertainty right across its operations. It has actively engaged management and its peak Committees throughout this crisis to support a future that sustains and meets the organisation's strategic goals.

The RACP can emerge from this pandemic as a leader – in medical education and professional development, research, physician careers and workforce, policy and advocacy, effective sustainable operations and Member experience – in ways that are even more valued than previous arrangements. This is an exceptional time to enhance the RACP's leadership position and assure a valuable and influential future beyond the current pandemic.

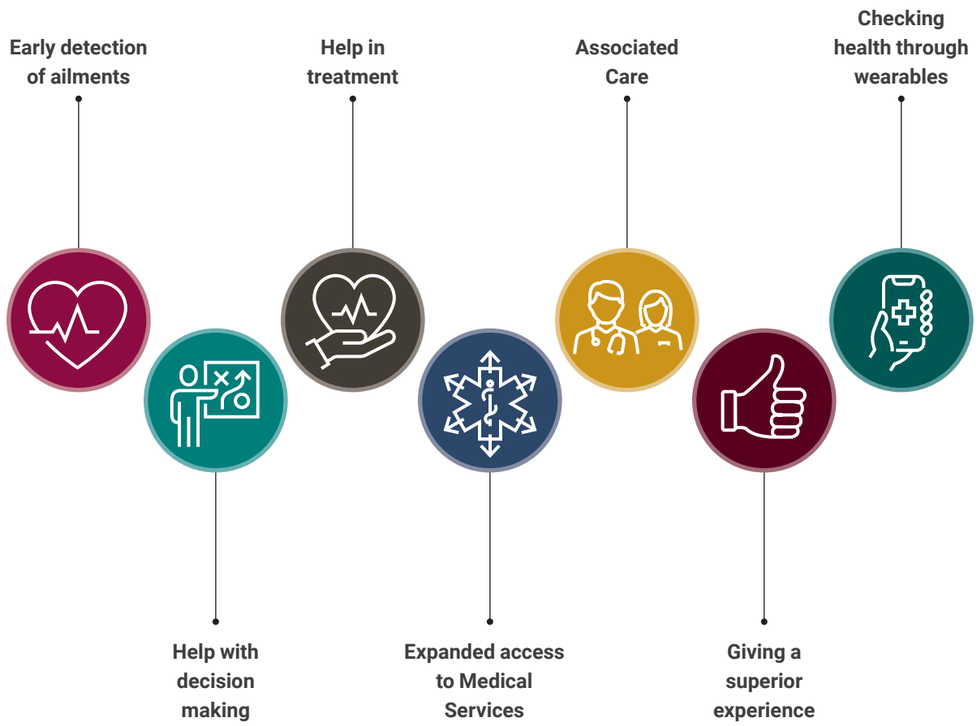
The prominence and value of the FRACP and Fellowship of its Faculties and Chapters within the community, the medical profession and government has risen during the pandemic. The time for the RACP to ride this wave and fully step into a leadership role in its jurisdictions and sector is now. Crises present many opportunities and there are many available to the RACP (and to potential future competitors). The key now is to interrogate these opportunities and mobilise resources around those that deliver the most value for the organisation, its members, and its communities.

Key takeouts

1. Governing in and beyond a pandemic requires organisations shift focus from the 'new now' to the 'never normal next'.
2. Scenario planning, critical questioning and rapid decision-making help organisations steer through emerging challenges and harness opportunities for organisational resilience, sustainability, and growth.
3. The RACP can emerge from the pandemic as a world leader in medical education, physician practice, workforce, member service, preventative health, and public policy in ways that are more valuable than pre-pandemic.

9. Appendices

9.1 Appendix 1: Role of AI in Healthcare

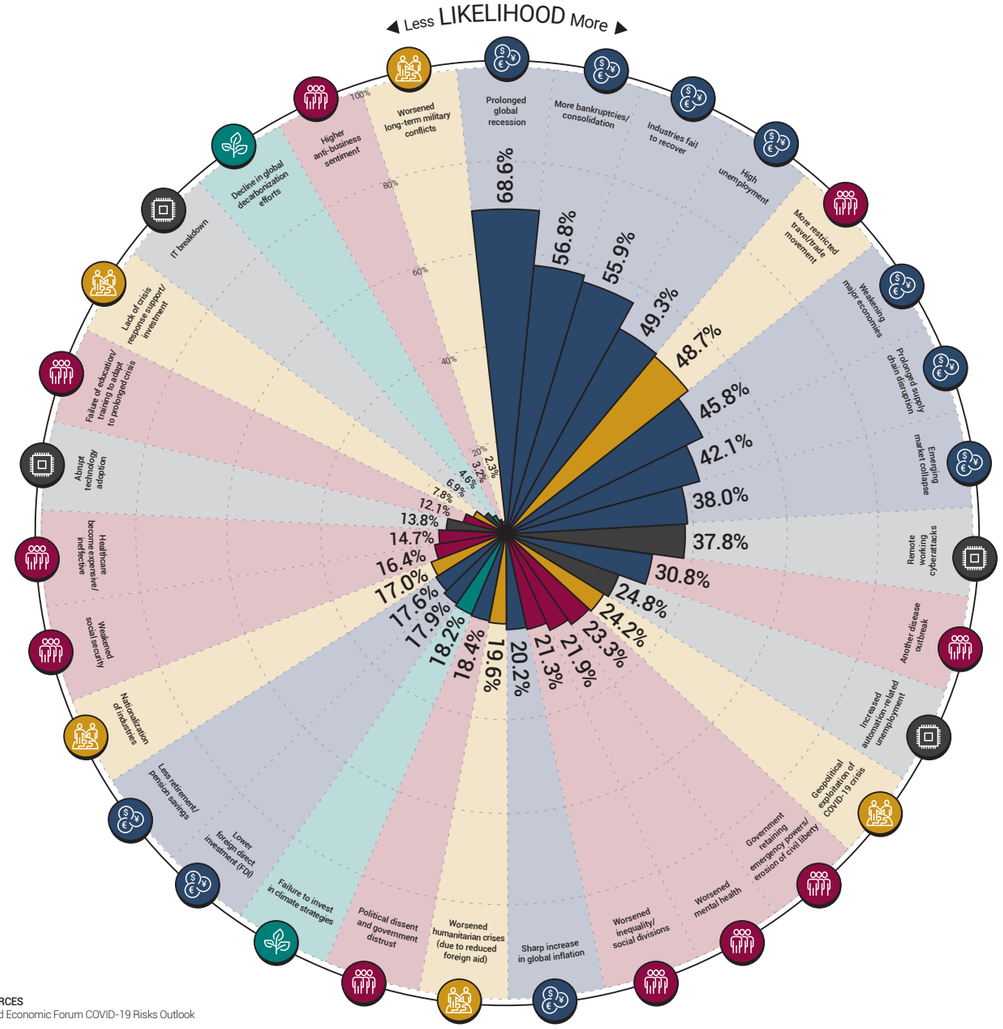


Source:
Importance of AI in Healthcare Sector – www.data-flair.training

9.2 Appendix 2: 18 months risk profile with COVID-19 – source: *World Economic Forum*

COVID-19 will leave lasting impacts on life as we know it. Many of these dramatic changes are already in effect.

The World Economic Forum surveyed 347 senior risk analyst on the impending threats most likely to contribute to a global fallout—and no area from the economy to the environment is untouched.



SOURCES
World Economic Forum COVID-19 Risks Outlook

Limitations of the report

The COVID-19 RACP Learnings Report was compiled in September after undertaking desktop research and short interview sessions with the RACP's executive team and some subject matter leaders in Aotearoa New Zealand, IT and People and Culture.

The desktop review included publicly available existing research and data. The insights compiled are therefore limited by the recency of peer reviewed and published literature, and the scope of publicly available information.

The interviews also provided the lived experience of RACP's Directors, senior executives and leaders who have proactively led the RACP's pandemic response.

Feedback on this report is welcomed and may be provided to communications@racp.edu.au.

Interviews were conducted in short, 60-minute sessions. Only key issues were raised, and so additional or more nuanced concerns may not have been voiced. However, participants had the opportunity to share additional ideas, and review a draft of this report, and many did so.

The draft report was considered by the RACP Board in November 2020. The Board asked for it to be reviewed by the RACP COVID-19 Expert Reference Group prior to publishing, which was undertaken.

The COVID-19 RACP Learnings Report provides an integrated view of internal and external trends, data, insights, and experiences. It is designed to act as a reflection piece and as an input to strategic planning processes. Many of the opportunities captured in this report would require further analysis outside of the scope of this report. Additional time and consideration of these factors is recommended to advance strategic planning.

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