CONNECTING THE INTENSIVE CARE COMMUNITY

ANZICS

2020 Annual Report

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President's Report

It is with a great deal of pride that I have the privilege of delivering the ANZICS President's Report to the membership. Our Society has been incredibly busy for the last twelve months and has acquitted itself remarkably well in challenging times. The single most gratifying aspect of our work has been the genuine collaboration and tremendous teamwork demonstrated by our members, fellow societies and colleges. Every one of our committees has contributed to the critical care effort.

It is very rewarding to see ANZICS reaffirm its position on the world stage over the last twelve months. Most notably the overwhelmingly successful World Congress of Intensive Care Medicine was held in Melbourne in October 2019. The meeting was very well attended, with over 2400 delegates from over 80 countries. The diversity of the speakers, exceeding over 300 in the scientific program and the resounding success of the associated social functions that our ASM does so well to connect colleagues. A significant thank you to Dr Stephen Warrillow, A/Prof Adam Deane, Dr Johnny Millar and Dr David Ku for their tremendous efforts in organising and executing this world class event over the last several years.

The CORE committee has continued to provide valuable and reliable data to inform the critical care community and other important stakeholders. Most would be aware of the ANZICS vital surge capacity planning survey and analysis that was published in April 2020 in the MJA and how it has guided much of the critical care pandemic planning. This ability to collate meaningful data was further developed in conjunction with the Commonwealth Government, Ambulance Victoria and Telstra Purple to develop the CHRIS (Critical Hospital Resource Information System) platform. This unique tool has been effectively implemented across Australia and New Zealand, providing a contemporaneous situational awareness of the critical care space. The project has received substantial Commonwealth funding and we have confirmed funding until 2022. We will continue to canvass support, so long as the system provides substantial value. The effort from our CORE team to achieve this has been nothing short of stupendous. We, as a Society, are extremely proud of the force multiplier that this capability provides.

ANZICS responded to our membership's concerns regarding the potential for an overwhelming number of critical care presentations and produced a thoughtful and insightful document providing guidance and a framework for complex decision making. This important body of work has effectively stimulated debate and raised a challenging conversation in a productive forum.

These guidelines complemented the ANZICS COVID-19 Guidelines. Over the period of five weeks, two versions were generated and were extremely well received by the critical care community both locally and internationally. These Guidelines have again been revised with the release of version 3 in October. Every aspect of the critical care response to COVID-19 has been afforded attention by the society and our involvement with, and representation on the pharmaceutical supply group generated a useful publication.

The centrepiece of the ANZICS response has been collaboration. The COVID-19 Critical Care Collaborative chaired by the President of CICM has resulted in a practical liaison between ANZICS, CICM, ANZCA, ACEM, ACCCN and the ASA. This has provided a valuable forum for consensus across difficult issues including PPE use. We have also enjoyed a wonderful relationship with ACCCN and our combined working group targeting the understanding critical care staffing has been very useful. The positive relationships developed will be enduring and provide the basis for future collaboration.

ANZICS has played an important role in advising government on concerning issues such as the provision of care to the more remote areas of Australia and the protection of vulnerable populations. The regional chairs have been proactive in providing educational opportunities in various forums that have been very well received.

Our Clinical Trials Group have been highly focussed on establishing studies, data collection tools and seeking grant funding. We are all exceedingly proud of the Victorian critical care community and their tremendous response the Victorian outbreak. The data from this significant experience have already been utilised to contribute to the international literature.

Whilst our conferences were extremely successful and well attended over the last twelve months, including the Congress, Safety & Quality Conference, CTG Noosa, CORE Datathons and a number of other state events. The cancellation of the 2020 ASM was

a difficult decision made by the Joint ANZICS and ACCCN Executive based on the current advice from the Australian Government and the escalation of the COVID-19 risk, this decision was deemed necessary to protect the health and safety of delegates, staff, suppliers, speakers and the general public. Intensive Care as a specialty has faced a challenging year, networking and connecting with colleagues in our community at our events is something that we are hopeful will return in 2021/2022.

The Society has not been immune to the financial impact of the pandemic over this period with many of our revenue generating meetings, not being unable to procced. The Finance, Risk and Audit Committee, together with the ANZICS operational staff have worked exceedingly hard to mitigate against the financial impact on the society. We will look to new revenue generating opportunities in the latter part of this year.

We remain on-track to co-locate with the College at 101 High Street, Prahran and this exciting development will bring a multitude of opportunities and potential economies of scale. We are fully committed to this move and are finalising the most effective way to secure the purchase of our floor.

We have established the terms of reference for our Past President Panel and look forward to convening this group when travel is again feasible. I would envisage the first 'in person meeting' of this collection of great minds by mid-2021 and we are confident this will be a real value add to our society.

We remain busy at ANZICS, with several membership and committee-based projects/events planned in the coming months:

1. Ensure that our new governance structures are compliant with relevant legislation, meet contemporary governance standards, and most importantly, serve the needs of our membership (current and future).
2. Commitment to increase the number of member-based events and engagement opportunities.
3. Review processes to engage and potentially increase the involvement and opportunity for non-medical members of the ANZICS community.
4. Develop an ANZICS/CICM Joint Special Interests Group focused on Global Health Initiatives.
5. The workforce guidelines project led by ANZICS and including 18 societies and colleges will provide

It would be remiss of me not to report the very powerful and positive media exposure critical care has received through our engagement with various press outlets. We have fielded over 100 media enquiries, including 10 radio interviews, provided information to 40 written pieces and had 10 TV appearances. These interactions have provided the opportunity to deliver a balanced, calming and informative understanding of intensive care.

Our Society will continue to face challenges both COVID and non- COVID related. We will need to develop our core business and the important work surrounding our structure and governance will continue to be reviewed.

Our Immediate Past President, Dr Stephen Warrillow's tenure on the ANZICS Board of Directors will soon come to end. Stephen has been on the ANZICS Board since 2010, in the positions of; Regional Chair, Vice President, President and finally Immediate Past President. Stephen's has been an exceptional mentor, colleague and during his time as President, has contributed massively to critical care.

I would also like to express my gratitude to the ANZICS Office team who have worked extremely hard over the last twelve months, supporting the Society, Committees and membership. Our Victorian-based staff have had to work in challenging circumstances throughout the pandemic and have delivered exceptional outcomes, particularly in ensuring ANZICS strong response to COVID-19. Our CEO, Gian Sberna has done an tremendous job in leading the office through these conditions.

Finally, I would like to thank one and all for the outstanding dedication, commitment and enthusiasm shown as we continue to advocate for critical care patients and their health care providers.

Dr Anthony Holley
ANZICS President

Treasurer's Report

This is my second report to the ANZICS membership in the role as Honorary Treasurer and it continues to be my great privilege to serve the Society and to provide the members with this update on our financial position.

The 2020 financial year (particularly the last 6 months) was marked by considerable challenge, with a new global pandemic causing stress and uncertainty, instability in macroeconomic conditions, and major logistical changes in the day-to-day workings of the Society. Given this, I am pleased to report that with considerable hard work and diligence on the part of the ANZICS staff, and careful oversight by the Finance, Risk and Audit committee (FRAC), the Society has maintained a steady footing in order to ensure ongoing viability and to continue to serve our members and the intensive care community.

Despite the challenges, in the 2020 financial year ANZICS generated an overall surplus of $249,825. Subscription income remained steady at $511,511 (including $320,261 in individual membership subscriptions and $191,250 in CTG subscriptions). ANZICS received grant funding totaling $1,799,444. This included $1,374,844 in funding for CORE activities, $21,600 related to the ANZICS Death and Organ Donation Statement, and $403,000 in Commonwealth funding for the Australia and New Zealand Critical Health Resources Information System (CHRIS). The CHRIS funding has subsequently been paid out as planned to our partners in the project; additionally, ANZICS contributed substantial in-kind resources to this important undertaking. Due to a decrease in revenue coinciding with the Covid-19 pandemic, ANZICS qualified for government support in the form of the JobKeeper allowance of $167,000 as well receiving the $50,000 government cash boost.

Distribution and administrative fees from the successful World Congress in Melbourne in October 2019 resulted in a surplus to ANZICS of $235,950. Surpluses from the CTG Noosa conference, CTG Winter conference and Safety and Quality conference collectively returned $101,730. The necessary cancellation of the planned 2021 ANZICS/ACCCN ASM resulted in a loss of $31,337. The ANZICS Executive extends its gratitude to all those who have served on organising committees for the conferences and to the ANZICS membership who support these events year on year. The inability to hold our usual meetings due to infection control precautions and travel restrictions has impacted on budget preparations for the subsequent financial year. I urge the ANZICS membership to continue their participation in intensive care education and networking by taking advantage of online and webinar events, until we can enjoy face-to-face meetings again.

In response to volatility in local and international market conditions, in March 2020 the FRAC undertook a meeting with our financial advisors to seek advice on contingency planning and to review the Society's investment strategy. The net return on investments to the end of FY 2020 was a weakly positive result of $25,022 or 0.6% return. Over the last 6 years our average return on investment is 7.4%. The composition and performance of ANZICS' investment portfolio continues to be the subject of close scrutiny, monitoring and consultation in order to safeguard the Society's financial security, and achieve our ongoing strategic objectives including the planned purchase of new office premises.

The employees of ANZICS are one of the society's greatest assets and this year employee expenses totaled $1,593,396, greater than the previous year by $135,559 due to an additional employee and backfill for staff on leave. While due care is taken to constrain these expenses, we are conscious of the need to ensure appropriate remuneration for the staff, whose exemplary contribution to the Society in the face of the Covid-19 pandemic, and generally, is greatly valued. Administrative expenses were $152,231, which is $99,112 less than the previous year, largely due to a change in accounting standards regarding the allocation of rental expense for our current office premises. Depreciation charges were $209,623, this is greater than the previous year by $98,957 but includes $89,771 in the aforementioned right of use assets for the office premises. IT expenses were slightly down at $141,423 and audit, legal and consultancy expenses totaled $111,354.

Regarding our overall financial position, ANZICS holds assets of $7,650,179, including cash and deposits of $2,684,166 and investments of $4,319,235. Our total liabilities at balance date are $1,489,029 resulting in net total equity of $6,161,150.

Dr Danielle Austin
Honorary Treasurer

ANZICS Board of Directors

Dr Anthony Holley	President
Dr Stephen Warrillow	Immediate Past President
Dr Danielle Austin	Honorary Treasurer
Dr Mark Nicholls	Honorary Secretary
Dr Johnny Millar	Paediatrics
Prof David Pilcher	Centre for Outcome and Resource Evaluation (CORE)
Prof Sandra Peake	Clinical Trials Group (CTG)
Dr Mark Nicholls	Professional Activities and Welfare (PAW)
Dr Craig Carr	New Zealand Regional Chair
Dr Michael Ashbolt	Tasmania Regional Chair
Dr Yasmine Ali Abdelhamid	Victoria Regional Chair
Dr Nhi Nguyen	New South Wales Regional Chair
Dr Rajeev Hegde	Queensland Regional Chair
Dr Bradley Wibrow	Western Australia Regional Chair
Dr Michael Farquharson	South Australia Regional Chair
Dr Bronwyn Avard	Australian Capital Territory Regional Chair
Dr Sidharth Agarwal	Northern Territory Regional Chair
Dr David Ku	Director of International Relations

Chief Executive Officer's Report

The scope of the challenges faced by the Australian and New Zealand Intensive Care Society (ANZICS) over the past year have been immense and likely to be never matched in scale or community importance.

Virtually every part of the society has contributed to responding to our mission statement of "Connecting the intensive community". Despite these challenging circumstances, it has been extremely pleasing to witness so many of our members coming together under the ANZICS umbrella to selflessly serve their colleagues and the broader community. The strength of the Society has been exemplified over and over in the past 12 months – and this is largely due to the diligence and tireless work of its members and staff. I thank you one and all for your efforts.

The very purpose of ANZICS is to 'achieve the best possible outcome for patients and their families by advancing intensive care practice' – this is at the very heart of everything that the society does or supports. There has been no greater example of working to this purpose, than the response of the Society and many of its members to the COVID-19 pandemic. Some of the societies more significant achievements during the pandemic, have included:

- Preparation of 2 versions of the ANZICS COVID-19 Guidelines for intensive care practice in Australia and New Zealand
- Preparation of the ANZICS Guiding Principles for Complex Decision-making during the COVID-19 Pandemic
- Collection and analysis of intensive care unit capacity data (four iterations) in response to the COVID-19 pandemic for the Australian Commonwealth Government and Chief Medical Officer (Professor Brendan Murphy) and his Deputy Officers. These detailed assessments outlined the resource capacity of hospitals across Australia and New Zealand to deal with the pandemic.
- Such was the success of the work outlined above, together with Ambulance Victoria and the Commonwealth Government (particularly Deputy Chief Medical Officer, Dr Nick Coatsworth), ANZICS developed the Critical Health Resource Information System (CHRIS) - first ever nation-wide system for near real-time monitoring of the intensive care sector across all jurisdictions in Australia and New Zealand.
- The Society has received over 100 media enquiries during the early phases of the pandemic, leading to 6 television interviews, 5 radio interviews, 4 podcasts, 25+ print media interviews and very significant social media activity. The combined impact of this activity is that ANZICS has become a trusted partner for many media agencies when it comes to providing commentary and/or on matters related to the practice of intensive care.
- ANZICS held numerous webinars for several hundred members and established a discussion forum for our members to share information (leading to >700 active participants and >5,000 posts).
- ANZICS was a founding member of the COVID-19 Critical Care Coordination Collaborative (5C's).
- Under the auspices of the ACCCN, the Society contributed to workforce modelling during the pandemic.
- ANZICS was a founding member of the National COVID-19 Clinical Evidence Taskforce (convened by the Australian Living Evidence Consortium and supported by Cochrane Australia).

Taken together, the response of ANZICS and its members to the challenges posed by the COVID-19 pandemic has been nothing short of outstanding and this work continues unabated after 6 months of the current pandemic.

In October 2019, ANZICS together with its partners at the Australian College of Critical Care Nurses (ACCCN) and the World Federation of Societies of Intensive and Critical Care Medicine (WFSICCM), successfully delivered the 14th Congress of the World Federation of Societies of Intensive and Critical Care Medicine in Melbourne. The event was attended by more than 2200 delegates and was acclaimed as a stunning scientific, educational and social success. The Society has reaped many rewards from this event – which was masterfully orchestrated by the Medical Convenors – Dr Stephen Warrillow, Gabrielle Hanlon, the Scientific Convenors'; A/Prof Adam Deane and with support from the Paediatric Convenor's, Ms Tina Kendrick and Dr Johnny Millar. To all of those who were involved in the successful delivery of this event – our sincere thanks and gratitude.

Governance Review: A continuing major initiative for the society over the past 12 months has been to fully review the governance structures and documentation that underpins the society. This has involved a number of internal and external experts reviewing every aspect of the Society and extensively briefing our board on all governance matters.
The Board of ANZICS and staff have been working assiduously to undertake this review in the best interests of the Society and all its members (current and future). Equally, we have been mindful that any new structures implemented as a result of this review, will need to support those who deliver critical care medicine and those who are recipients of this care in every part of Australia and New Zealand.
On behalf of the ANZICS staff, I would like to take this opportunity to congratulate our Directors for their courage and dedication to undertake this challenging task. Together with all ANZICS staff, I look forward to the outcomes of this review and the new opportunities that will arise as a result.

The fourth edition of the ANZICS Statement on Death and Organ Donation was undertaken by ANZICS Death and Organ Donation Committee over a period of two years and released in late 2019. This was a tremendous and extensive amount of work on an extremely important Statement that assists the intensive care community.
The Committee, ably led by A/Prof Bill Silvester should be congratulated on the delivery of on this significant and renowned ANZICS Statement.

I encourage all current and potential new members, to contact me/us at any time to raise new opportunities for the society to undertake – we are very keen to hear from our members with your feedback.

The next 12 months will see ANZICS host several events – which are most likely to be run as digital events. This is a major undertaking for the society, and we are keen to hear from our members about opportunities of broad appeal to provide to our members. I implore the reader to familiarise themselves with the activities of the Society through this Annual Report.

In the next year, the society will be launching a joint initiative with the College of Intensive Care Medicine on matters related to national and international health – with a focus in resource limited communities. This initiative will be seeking to develop and promote opportunities for clinical support projects, education, research, and collaboration with other critical care groups/related disciplines who have an interest in critical care opportunities in resource limited locations.

As outlined in the Honourable Treasurers report, the Society is in a strong financial position despite the impact of the COVID19 pandemic on our ability to schedule and deliver a number of educational events for our members. We are still on track to purchase a property with the College of Intensive Care Medicine in the forthcoming year. Whilst many challenges are ahead of us with this purchase, we are greatly looking forward to the opportunities that will be afforded to the society through this purchase.

I would like to formally acknowledge my colleagues within the ANZICS team for their outstanding efforts to serve the needs of our members in trying circumstances. The professional and dedicated manner in which they have supported our members and key stakeholders during the past 12 months has been outstanding. I look forward to the continued evolution ANZICS and the opportunities this will provide to our members, the profession of intensive care and our staff.

Finally, the past year has seen the ANZICS President role change hands from Stephen Warrillow to Anthony Holley. Both have assiduously and selflessly served the Society through some of the most significant issues and events in the history of ANZICS. Both have left the society in a better state than what they found it – a testament to their leadership, knowledge, and self-sacrifice to serve their colleagues. Both have done this via their exemplary collegiality – which has been greatly appreciated and admired by all. Congratulations Dr's!

Dr Gian Sberna
Chief Executive Officer

Membership

The Copenhagen polio epidemic in 1952 was most devastating. The mortality rate from respiratory failure and bulbar dysfunction from polio historically up to 90%. During the epidemic, up to 70 patients required ventilation at any point in time. Professor Lassen and Dr Bjorn Ibsen at Blegdam hospital found by inserting a rubber cuffed tracheostomy tube, hand ventilation predominantly by medical students and a dedicated ward had specialised nurses that they were able to reduce the mortality from 80% to 40%. This epidemic was the birth of modern intensive care. In Australia and New Zealand, the first intensive care unit was founded in Auckland in 1958 and came under the direction In of Dr Matthew Spence in 1959. In the following ten years, there was a rapid increase in the number of intensive care units across Australia and New Zealand. The devotees in intensive care decided that to better advocate for this new specialty required a separate society, and in 1975 the Australian and New Zealand intensive care Society was formed. Dr Matthew Spence became the first president and Dr Robert Wright, the first secretary. This year ANZICS celebrates its 45th anniversary. From these early efforts, we have in Australia and New Zealand world-class intensive care services, with a highly trained and professional workforce.

The early reports of a novel coronavirus overwhelming the Wuhan health system were concerning. At the ANZICS January Board meeting there was concerned about the preparedness of the Australian health system to a potential pandemic and the risk to frontline staff notability the intensive care community. The ANZICS Boards view was that we should work in partnership with government to provide current and surge intensive care capacity, and to develop guidelines assist the intensive care community in preparing for the pandemic. These early actions were timely and critical.

Despite the specialty being almost 70 years old, it has struggled for wider community recognition, and it has been difficult to educate the community. Suddenly this all changed as the SARS-CoV-2 pandemic spread across the world. As the pandemic progress, community concern increased, the realisation that intensive care for severe SARS-CoV-2 was lifesaving and that intensive care was fixed resource drew media attention. ANZICS was approached on multiple occasions and provided over 50 media interviews. Our initial media engagement focused initially on the importance of flattening the curve, so the health system was not overwhelmed and ‘what is intensive care’.

All of these activities would not have been possible without ANZICS, the ANZICS staff and ANZICS members. The efforts of former and current ANZICS members over the last 45 years had well-positioned the intensive care community though ANZICS to act. Our registries, the Adult Patient Database (APD), ensuring high-level intensive care across all sites in Australian and New Zealand before the pandemic and the Critical Care Resources Registry provided current and surge capacity. Our ANZICS Clinical Trials Group (CTG), which was formed in 1994, rapidly organised and submitted significant grant applications.

ANZICS strength is its members. We advocate for our patients, their families and the intensive care community. Intensive care has faced challenges with this pandemic and will face other challenges in the future. We are a voluntary organisation, and the more members, the stronger we are to meet those challenges. We also recognise that we need to continue to improve the value proposition of ANZICS. We have the corporate partners program with the Members Benefit Scheme which has been taken up and used by many members. There is discounted registration at ANZICS conferences, and discounted membership to other international societies. We have completed a membership database upgrade which will assist in membership engagement. There is also regional funding availability for state-based membership events.

We continue to have a steady increase in membership, with a total of 1174 members. We are a diverse society with an increasing nurse, allied health and research coordinator membership. We now have 561 full members and 898 medical members.

In five years, ANZICS will be 50 years old, and we thank you for your ongoing support. Please advocate membership to non-members of our society to strengthen our advocacy for intensive care and the intensive care community.

ANZICS Membership	October 2019	February 2020	June 2020	October 2020
Australia	901	937	974	1013
New Zealand	119	121	119	117
Other	54	57	44	44
Total	**1074**	**1115**	**1137**	**1174**

ANZICS Membership by Category	October 2019	February 2020	June 2020	October 2020
Nurse	139	154	169	180
Allied Health	62	68	76	77
RC	11	12	11	13
Associate/Overseas	87	90	76	81
Retired	23	24	16	16
Full	518	525	538	564
New Fellows	40	44	48	56
Honorary	10	10	10	10
Trainee	183	188	194	177
Total	**1074**	**1115**	**1137**	**1174**

ANZICS Membership by State/Territory	October 2019	February 2020	June 2020	October 2020
ACT	15	16	16	16
NSW	200	211	219	229
NT	17	17	18	21
QLD	152	172	178	191
SA	90	93	90	90
TAS	22	28	28	30
VIC	297	337	355	364
WA	61	63	69	72

Dr Mark Nicholls
Honorary Secretary

Centre for Outcome and Resource Evaluation (CORE)

Over 200,000 ICU admissions have been reported to 196 Australian and New Zealand ICUs in the past twelve months. A year ago, most of the world had never heard of a ventilator or the Intensive Care Unit but now everyone knows and wants data!

Thank You

We recognise the massive efforts of all staff working in our ICUs. The outcomes of patients (COVID and non-COVID) admitted to Australian and New Zealand ICUs have been amongst the best in the world. Our special thanks go to all those collecting data, particularly those sites now submitting weekly data. It is through your efforts, that we know how well our patients are doing in this difficult time. We also acknowledge and thank all patients whose data helps inform and improve Australian and New Zealand ICU practice.

ANZICS CORE and Health Departments

This year has seen increasing collaboration between Departments of Health and ANZICS CORE. The ANZPIC Registry was used to inform the Queensland Health Paediatric Critical Care Planning Review. Working parties considered future demand for Paediatric Critical Care services in Queensland, converting projected demand into ICU beds required to deliver services. The ANZPIC Registry provided profiles of patient case mix by region, bed usage, and information on patients' movement throughout Queensland.

ANZICS CORE and COVID-19

In *January*, we saw the impact of COVID-19 in China.

In *February*, ANZICS CORE added the diagnostic subcode of 'suspected or confirmed pandemic infection' to both the Adult Patient Database and ANZ Paediatric Intensive Care Registries.

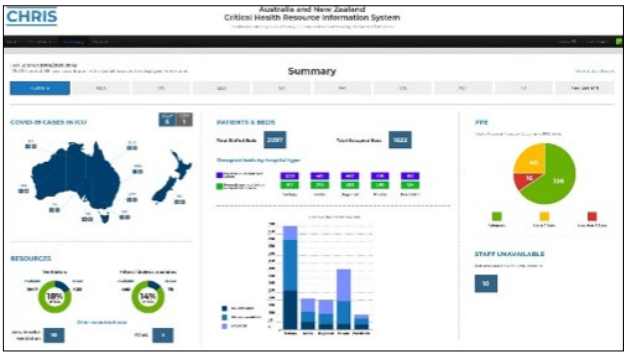
In *March*, ANZICS CORE surveyed every ICU in Australia on behalf of The Commonwealth to measure resources, available ICU beds and equipment capacity to respond to the COVID-19 Pandemic. Results were published in the MJA. (Litton et al. MJA 2020).

In *April*, ANZICS CORE collaborated with The Commonwealth and Ambulance Victoria to launch The Critical Health Information Resources System (CHRIS). This provides a dashboard view of ICU bed capacity, numbers of COVID-19 patients, and utilisation of vital resources such as ventilators and filters throughout Australia and New Zealand. It gives unprecedented and immediate visibility of ICU activity to hospitals, health departments, retrieval agencies and to National Cabinet.

In *May*, we saw the first wave of COVID-19 decline, watched the data and began to breathe a sigh of relief.

In *June*, ANZICS CORE released the first combined COVID-19 Outcomes report in conjunction with the Monash University SPRINT-SARI Investigators. Our world-class outcomes were also subsequently reported in the national press. Almost four out of every five patients with viral pneumonitis who required invasive ventilation, survived to leave hospital alive.

In *July*, COVID-19 was back. At the time of writing this, there have been a total 806 suspected or confirmed COVID-19 admissions to 78 ICUs of whom 281 have had admission diagnoses related to viral pneumonitis or ARDS.



ANZICS CORE supporting research and researchers

This year there were 23 publications using ANZICS CORE data. Highlights have included papers measuring ICU costs (Hicks et al, MJA 2019), investigations into the effect of Intensivist shift patterns on patient outcomes (Gershengorn et al, Crit Care Med. 2020), a study of the relationship between ICU outcomes and pollution (Groves et al, ICM 2020) and a series of papers looking at outcomes of Indigenous patients (Secombe et al, MJA and CCR)

At the 2019 World Congress, the Peter Hicks Fellowship Award was announced. Peter Hicks was a driving force behind ANZICS CORE for over 15 years, bringing his passion for data to improve the care delivered to the critically ill. This award recognises research excellence by junior clinicians working with Intensive Care data. Rachel Bailey, Clinical Nurse Consultant from Caboolture Hospital, Queensland was the recipient of the award for her study on 'Staff perspectives on visiting policies and family involvement in ICUs: Registry Linkage and the Welcome ICU Research Program.'

The ANZICS Global ICU Datathon and Clinical Informatics Workshop was held as a satellite event at the 2019 World Congress. Participants had the opportunity to work with the GOSSIS database that holds critical care data from over 500 ICUs in four continents. This was a truly international virtual event with a team from Argentina participating via video into the early hours.

Professor David Pilcher
Chair, Centre for Outcome and Resource Evaluation

Clinical Trials Group (CTG)

The ANZICS Clinical Trials Group (CTG) has had another very busy year and it is with great pleasure that I highlight some of our most recent successes.

A number of CTG investigators have received NHMRC and MRFF funding for multicentre, randomised trials that aim to answer clinically important questions affecting everyday intensive care practices. The "Australian Resuscitation in Sepsis Evaluation: Fluids" trial (ARISE: Fluids) and the "Bone loss prevention with Zoledronic acid or denusomab in critically ill women" trial (Bone-Zone) both received funding from the MRFF Rare Cancers, Rare Diseases and Unmet Needs programme. ARISE: Fluids, a collaboration with our emergency medicine colleagues, will evaluate restrictive fluids and early vasopressors versus usual resuscitation practices in patients with septic shock presenting to the emergency department (ED) and Bone-zone aims to test anti-fracture therapies in critically ill women at high risk of osteoporosis and fractures. The "Sedation Practice in Intensive Care Evaluation in older ventilated critically ill patients" trial (SPICE IV) received a Clinical Trials and Cohort Studies grant to evaluate the early use of dexmeditomidine as primary sedation in ICU patients aged over 65 year and follows on from the NEJM publication of SPICE III last year. The successful funding of these three trials (over $9 million in total) is a measure of the CTG community's track record for conducting practice-changing, investigator-initiated research published in high-impact journals. We congratulate the trials' chief investigators (Peake, ARISE:Fluids; Orford, Bone-Zone; Shehabi, SPICE IV;) and their co-investigators.

The Paediatric Study Group (PSG) has also been extremely successful in attracting MRFF funding (over $9million in total) for 3 genomic projects: Gene expression to predict long-term outcomes in infants after heart surgery recruited to the NITRIC trial (Chief Investigator Schlapbach); Host gene expression signatures to diagnose sepsis in children (Chief Investigator Schlapbach) and; Whole genome sequencing in critically ill children (Chief Investigator Stark). The PSG continues to grow under the enthusiastic leadership of Luregn Schlapbach, supported by the newly founded Paediatric Intensive care Research Coordinators Interest Group (PIRCIG) with Carmel Delzoppo as the inaugural chair of this group.

Congratulations also go to those researchers involved in the publication of the PEPTIC cluster-cross-over, registry-based trial comparing proton-pump inhibitors versus histamine-2 receptor blockers to prevent stress ulcer prophylaxis in mechanically ventilated patients (JAMA), the ICU-ROX Phase 2b trial comparing liberal versus conservative oxygen therpy in mechanically ventilated patients (NEJM) and the TARGET trial evaluating 6-month functional outcomes after delivery of 100% versus 70% of enteral calorie requirements (AJRCCM). The successful conduct and publication of these randomised trials would not be possible without the dedication and commitment of the wider CTG community and all the participating sites. We look forward to the completion and publication of our many ongoing multicentre, randomised clinical studies including PLUS (Plasma-Lyte 148® versus saline for resuscitation), BLING III (continuous versus intermittent β-lactam infusion in sepsis), EPO-Trauma (erythropoietin alfa versus placebo in ventilated trauma patients) and SUDICCU (cluster cross-over trial of selective decontamination of the digestive tract).

Over the past year the CTG has held two highly productive and well-attended scientific meetings in Noosa (March) and Queenstown (September). These meetings provide important peer-review for new research initiatives in a stimulating and collegiate environment that facilitates the ongoing collaborative research efforts of our community. It is a condition of CTG endorsement that proposed trials are presented at one of these meetings. Special thanks goes to our international speakers (Todd Rice, Mark Peters, Rob Fowler), the many interest groups that held ancillary meetings (Paediatric Study Group, Intensive Care Research Coordinators Interest Group, Novice Investigators, Basic Research) and our sponsors (Pfizer, Baxter, CSL, Spiral) for contributing to the meetings' success. Recent achievements of the CTG were also superbly showcased at the World Congress of Intensive Care in Melbourne last year where ADRENAL (NEJM), TARGET (NEJM), SPICE III (NEJM), RELIEF (NEJM) and POLAR (JAMA) were presented to a packed room of international delegates.

Finally, the CTG community has risen to the challenge of continuing to undertake high-quality research in the face of the COVID-19 pandemic with the rapid development of COVID-19-related domains in the Randomised Embedded Multifactorial Adaptive Platform trial for Community Acquired Pneumonia (REMAP-CAP) and the activation of the Short PeRiod IncideNce STudy of Severe Acute Respiratory Infection (SPRINT-SARI) prospective observational study with contemporary reporting.

The activities of the CTG community would not be possible without the incredible contribution of our Executive Officer, Donna Goldsmith and Executive Assistant, Simone Rickerby. It is impossible to express how much I have appreciated everything they do to support us all, and in particular myself as the new Chair, in our research endeavours. Thank you also to Craig French for his fantastic leadership as CTG Chair for the previous 4 years, the office bearers and other members of the CTG Committee, all the member units and our amazing research community who are responsible for the ensuring we continue to be recognised as one of the world's leading clinical trials group.

Professor Sandra Peake
Chair, Clinical Trials Group

Death and Organ Donation (DODC)

The feedback on the fourth edition of the ANZICS Statement on Death and Organ Donation has been overwhelmingly positive, with some questions being raised by members which the Death and Organ Donation Committee (DODC) are looking at.

DODC is still developing the ANZICS App to be available for smart phones as a bedside aid for ICU and ED doctors and nurses to guide the determination of death (neurological or circulatory) and related legal matters, how to conduct end-of-life and donation conversations and how to provide up-to-date physiological support to a potential donor.

DODC has also provided feedback to the Organ and Tissue Authority on the second edition of the Best Practice Guideline for Offering Organ and Tissue Donation in Australia, with an emphasis on the importance of maintaining the crucial role of the intensivist in all aspects of donor management including end-of-life and donation conversations.

In addition to preparing a discussion paper on organ donation after Voluntary Assisted Dying (VAD), and reviewing the ANZICS Statement on Care and Decision Making at the End-of-Life for the Critically Ill, the DODC and End-of-Life Care Working Group (EOLCWG) has the opportunity to support Australia and New Zealand collaboration in the worldwide prospective validation of an ethical practice score which may assist in identifying end of life practices (doi:10.1001/jama.2019.14608).

Once again I would like to thank all members of the DODC and EOLCWG and the ANZICS staff for the time, effort and expertise in supporting the committee's work.

Dr William Silvester

Chair, Death and Organ Donation

Chair, End of Life Care Working Group

Education

This report marks the end of the current ANZICS Education Committee term of service. During this time, we have focussed on improving intensive care education by fostering an active community of interprofessional clinician educators and by supporting other ANZICS education activities.

Our Committee has been working with members from partner organisations for the past two years to establish the Australia and New Zealand Clinician Educator's Network (ANZCEN) Clinician Educator Incubator programme (https://litfl.com/anzcen-incubator/). After a successful pilot early last year, the Incubator kicked off for real in April 2020. The programme involves over 30 carefully selected interprofessional participants and over 40 faculty, who comprise a diverse range of experts from around the world. This programme uses digital technology to facilitate a virtual community of practice, allowing incubates to learn together, receive mentoring, and work on collaborative interprofessional projects. All proceeds from the programme have been donated to the Australia and New Zealand Intensive Care Foundation and we anticipate the creation of a special fund to help support intensive care education projects in 2021.

Together with ACCCN, the ANZICS Education Committee led a successful session for educators at the 2019 World Congress of Intensive Care. This session featured Prof Liz Molloy on the topic of feedback, Prof Margaret Hay speaking about Assessment, Dr Manisa Ghani discussing the ANZCEN Clinician Educator Incubator programme, and A/Prof Deb Massey sharing insights into the development of an interprofessional education consensus statement for critical care. The session was notable for a large, engaged audience and an inspiring and interactive Q&A session. Also affiliated with the World Congress was the latest iteration of our Clinician Educators Unconference. This one-day event featured streams for working groups developing the projects discussed by Dr Ghani and A/Prof Massey, as well as "Dragon's Den" sessions where participants presented their own education projects and received insights and feedback from their colleagues.

Last year our Committee revamped the nomination and selection process for the prestigious ANZICS Ramesh Nagappan Education Award. From among the excellent nominations, we were proud to recognise the immense contributions to ICU education made by Prof Bala Venkatesh who was a worthy winner. We encourage all ANZICS members to submit nominations again this year.

Intensive care education, like all areas of life, has been profoundly affected by the COVID-19 pandemic. From an ANZICS Education perspective, we were sad that this year's Annual Scientific Meeting needed to be cancelled. However, has been heartening to see grassroots initiatives from ANZICS members as we rise to the challenge of transitioning to digital learning solutions and sharing education resources in a time of rapid change. This included an education channel on the ANZICS COVID-19 Discussion Group Slack workspace (anzicscovid19.slack.com), moderated by Dr Irma Bilgrami. Meanwhile, our Committee's Vice-Chair Dr Swapnil Pawar, has continued to provide a high quality education resource via the "ANZICS Presents the Experts" Podcast series (www.anzics.com.au/podcasts/), which includes a number of COVID-19 related episodes.

Finally, I would like to thank all the ANZICS Education Committee for their hard work and enthusiasm over the past couple of years: Dr Swapnil Pawar, Dr Louise Trent, Dr Yogesh Apte, Dr Anthony Tzannes, and Dr Shivesh Prakash. I look forward to supporting the next ANZICS Education Committee in their endeavours to help shape the future of intensive care education.

Dr Chris Nickson
Chair, Education

Paediatric

This has been a remarkable year for us all, characterised by major change and disruption to our clinical, educational and scientific activities. Despite this, and the continuing time and effort consumed by dealing with the pandemic, Paediatric ANZICS has had a busy and productive year. This small and tight community continues to support and help each other, and this has been more evident in 2020 than ever before.

Paediatric Studies Group (PSG)

The PSG has been very active, and this year's formation of a small Executive Group has helped to maintain momentum and deal with ongoing work in between larger Committee meetings. The PSG Executive has been meeting every two to four weeks, and consists of the Chair, Vice-chair, Past chair, Research Coordinator representative and ANZPICR Director. Thank you to Luregn Schlapbach, Ben Gelbart, Marino Festa and Carmel Delzoppo for their ongoing work in these roles. This year also marked the creation of the Paediatric Intensive care Research Coordinator Group (PIRCIG), with Carmel Delzoppo as the Inaugural Chair. This group has become rapidly active and visible, and is an excellent and important addition to the ANZICS PICU research community.

The PSG research prioritisation study has been completed and submitted for publication. Many thanks to all of the participants, and to Georgia Brown and Sai Raman, who have led the effort. This has been a very useful exercise in identifying areas of future research focus for the group, and the results are already having an impact on the planning of new studies. The PSG has also created the following new working groups to strengthen and ensure sustainability of PICU research: Long-term outcomes (headed by Debbie Long), Early researchers (headed by Ben Gelbart), and Consumer Engagement, (headed by Kate Masterson).

Work continues on several multi-site PSG studies. Notably, the NHMRC-funded Nitric Oxide CPB study is due to complete recruitment this year, which will be a tremendous achievement by Andreas Schibler and the rest of the team. There was a major PSG grant success in 2020, with the team led by Luregn Schlapbach securing more than three million dollars from the Medical Research Future Fund for long-term follow-up projects in children with congenital heart disease.

Luregn Schlapbach, the current PSG chair, is relocating to Switzerland this year. We wish him all the best with this new phase of his career, and are pleased that he will continue to have a leadership role in the PSG.

The Australian and New Zealand Paediatric Intensive Care Registry (ANZPICR)

This year saw the rapid introduction of a pandemic diagnosis code to the ANZPIC Registry, aligning with an identical code in the adult database. However, the biggest changes to the Registry are unrelated to the pandemic, with work currently happening to change how complications and new diagnoses are coded. This large piece of work, driven by Liz Croston, will allow us to better identify and explore events that occur during the ICU admission, and will greatly increase the potential of the dataset. In addition, there are ongoing discussions about how the Registry might collect longer-term, patient-related outcomes.

This year also sees the retirement of Jan Alexander from ANZICS. Jan has been the ANZPIC Registry data manager for 13 years and has been the approachable and helpful face of ANZPICR for us all over that time. We thank her for years of consistently hard work, enterprise and efficiency, and will sorely miss her encyclopaedic knowledge of the Registry and its evolution.

Other Activities

Paediatric members have been active in many of the pandemic-related activities that ANZICS has undertaken, with Liz Crowe, Simon Erickson and Marino Festa on the COVID-19 Working Group, and Melanie Jansen and Paula Lister on the Best Practice Committee.

Our usual educational and scientific opportunities have been severely affected by the current challenges, most notably with the postponement of the WFPICCS World Congress in Mexico, and cancellation of both the SG ANZICS and ANZICS ASM meetings. Many of our members will still participate in the virtual World Congress in December, and we acknowledge the considerable effort that has gone into changing to this format by the local organising committee and the WFPICCS board, currently chaired by Stephen Jacobe. Final presentation of the Melbourne bid to host the World Congress in 2026 has been delayed until December, and we wish Warwick Butt and the local team every success in that endeavour.

Dr Johnny Millar
Chair, Paediatrics

Professional Activities and Welfare (PAW)

ANZICS PAW are committed to a sustainable, adequately remunerated, healthy workforce that continues to deliver high quality intensive care. The Committee has been focusing on the factors that impact on the quality of life of Intensive Care Specialists and the Department of Health MBS Review.

The PAW committee predominate body of work prior to the pandemic is the MBS review. The new ICU MBS item arrangements come into effect from 1 March 2020. A description of the MBS item changes for 1 March 2020 intensive care and emergency medicine and the full revised March MBS Book including the fees associated with each new or changed MBS Item, has been made available at MBS Online. There are a number of new item numbers. Item 13899 is for the provision of goals of care for gravely ill patients outside an intensive care unit. There are also six new items for extracorporeal life support for insertion and daily management. Items 13851 and 13854 have been amended and relate now only to management ventricular assist devices. There is an increased rebate for item 13815 for central vein catheterisation and item 13842 for intra-arterial cannulation. There is the loss of the first day management of IABP item 13847 but an increase in the rebate for the daily management of IABP item 13848. Item 14200 for the gastric lavage procedure has been removed. There will be a rapid MSAC process for the development of rapid response/code blue item numbers. This will be a combined ICU/ED committee. This process has been paused due to COVID-19 and should recommence in the near future.

There is no additional information on the Specialist and Consultant Physicians MBS Review progress. It was released in April 2019. The report recommends a move to a time-based structure. It also recommends a move away from initial and subsequent consultations, to have the same rebates for specialists and consultant physicians and additional payments for complex planning.

If you have any questions or concerns, please contact either myself, your regional PAW representative or our two new representatives, Shona Mair as the Paediatric Representative and Lucy Modra as the WIN Representative.

Dr Mark Nicholls

Chair, Professional Activities and Welfare

Safety & Quality

In 2019/2020 the Safety and Quality Committee has been striving to advance intensive care practice to achieve possible outcomes for patients and their families. The Committee meets regularly throughout the year, reporting back to ANZICS members via the Intensivist Newsletter. Every Australian and New Zealand region was represented this year along with a paediatric representative, a trainee representative, and a nurse from the Australian College of Critical Care Nurses and the New Zealand College of Critical Care Nurses.

Ongoing projects include:

Bed Block Research Proposal
RRT National Registry
CORE CCR Survey and S&Q variables
Environmental Sustainability in ICU
CLABSI Implementation Guides
Mapping CORE data to national standards – matching the CORE registry variables with the ACSQHC & ACHS indicators.

The Committee was re-elected in February of this year and I would like to acknowledge the new members of the Committee: Alex Hussey (NZ); Patrick O'Sullivan (VIC); Deepak Bhonagiri (Chair/NSW); Simon Towler (WA); Benoj Varghese (TAS); John Gowardman (QLD/Immediate Past Chair); Stephen Luke (QLD); Andrea Christoff (Paediatrics); Mary Pinder (CICM); Malcolm Elliott (ACCCN) and Tania Mitchell (NZCCCN).

I would like to acknowledge the work of A/Prof Daryl Jones and the Organising Committee including: Alex Psirides, Arthas Flabouris, Deepak Bhonagiri, Jonathan Barrett, Judy Currey, Ken Hillman, Liz Fugaccia, Judit Orosz, Manoj Singh, Amanda Hill and Brent Kingston who organised the annual Safety and Quality Conference in October 2019. The event took place at Crown Promenade, in Melbourne on the 14th October 2019. There were 220 registered delegates.

The Organising Committee prepared an educational program spread across 3 streams, 1 days exploring aspects of caring for the deteriorating patient for the novice to expert. Specifically, end-of-life care by the medical emergency team, family and patient activation, the deteriorating patient in ED, measuring efficiency of RRS, in-hospital cardiac arrests, the afferent and efferent arms of RRTs. Key note speakers included: Alison Fox-Robichaud, Francesca Rubulotta, Malcolm Green, Amanda Walker and Harvey Lander. The Organising Committee received 15 abstract that were accepted for oral presentations during the conference. Many of the presentations were again recorded and uploaded over time onto the ANZICS You Tube Channel https://www.youtube.com/channel/UCVU_LWubvrXrNklrEHcv7jA. We were grateful for the generous support from Industry through sponsorship and exhibition, in particular Major Sponsors – Midray and Philips Healthcare and Juno and Zoll as exhibitors.

I would like to acknowledge and thank the members of the Committee for all their hard work during their term including: Michael Ashbolt (TAS); Lewis Campbell (NT); Arthas Flabouris (SA); Craig Carr (NZ); Judit Orosz (VIC); Deepak Bhonagiri (NSW); Simon Towler (WA); Tali Gadish (Paediatrics); Mary Pinder (CICM); Gladness Nethathe (Trainee Representative); Malcolm Elliott (ACCCN) and Leah Hackney (NZCCCN).

I would also like to recognise the contribution of all ANZICS members in providing feedback to the Safety and Quality committee. The Committee is open to any comments or suggestions you may have and we invite you to be in touch by contacting: anzics@anzics.com.au.

A/Professor Deepak Bhonagiri
Chair, Safety and Quality

International Relations

After the success of the World Congress in Melbourne, many of our international colleagues reached out and engaged in ongoing activities, particularly in the areas of education, research, data registry and quality. This led to the establishment of the international relations portfolio in January 2020 for ongoing liaison.

Like almost all thing related to international movement, the COVID-19 pandemic caused significant disruption to almost all the engagements during this time. All face to face events came to a halt, with much focus shifted to ensuring the health and safety of our immediate local environment. It was obvious the global critical care community needed to be collaborative, more than ever, and much of the international liaison activities changed focus to connecting experiences of COVID-19 as it swept the world in waves.

As domestic concerns settled, we saw the re-emergence of virtual events and projects once again, especially for SE Asia. ANZICS representation at recent Euroasia **Taiwan** and Asia-Pacific Intensive Care Symposium (APICS) **Singapore** were of particular interest, and ANZICS will kick off the World Day for Critical Lung (WDCL), an event based out of **London** and **Madrid**, as a bilingual, time zone rolling, multi-societal streaming collaboration. Our colleagues at Emirates Critical Care Conference (ECCC) have continued to support our members participation in **Dubai**, and the plans for SG-ANZICS in 2021 is also on track as a virtual and face-to-face event, as Singapore has become a viable travel bubble for the ANZ community. Finally, plenty of hope still holds for the World Congress in **Vancouver** in September 2021, with thanks to our friends in the Canadian Critical Care Society.

The Global Health Special Interest Group was also established, with thanks to CICM and the ANZICS executives, led by John Botha as chair. This group will represent both the Society's and College's interests in matters related to national and international health initiatives – particularly in resource limited areas and in low socioeconomic communities. They will report separately as a group, with many well-known, enthusiastic members already highly engaged.

As Australia and New Zealand emerge from the pandemic, I have no doubt there will be a surge of activity globally in 2021. I look forward to connecting our ANZ colleagues with meaningful international projects in the near future.

Dr David Ku
Director of
International Relations

New South Wales

Who could have predicted the events of the last 6 months and what we have achieved as intensive care community in such a short period of time? We have much to be proud of, the way our clinical community has come together to prepare our units and hospitals for the potential surge in patients during the COVID-19 pandemic..

In the second half of 2019, we enjoyed catching up in Melbourne at the World Congress. The buzz in the convention centre and the particularly memorable conference dinner event set the bar high for what would have been the ASM in Sydney. Unfortunately, as we entered the new year, it became increasingly clear that the world as we knew it was dramatically changing.

In NSW, we managed to gather in February for a long awaited Regional ANZICS dinner. We had over 25 specialists and trainees attend. Fortunately, we had this organised well before the social distancing requirements of COVID-19. It was exciting to see and hear old colleagues reconnect and new connections being made. The dinner allowed for networking and the sharing of stories about ANZICS and its achievements in its formative years as well as allowed us to discuss future challenges and direction for our profession and society. We were fortunate to be able to gain some insight from the Chair of PAWS into the successful outcomes from recent review of MBS items. There was much support for ongoing strengthening of our relationship with the College Regional Committee, explore the variation in awards across the country and strengthening advocacy for NSW Intensive care clinicians.

From a NSW perspective we have been planning the state response to COVID-19 pandemic since the middle of February. With intensive care units being asked to plan to quadruple their current ICU capacity in anticipation of the surge. Through strong public health measures, we have had only 113 COVID positive patients admitted to NSW intensive care units. There has been a total of 16 deaths in ICU. At the time of this report, we have been carefully watching the growing burden on the ICU community in Victoria and brace for the potential of something similar occurring in NSW.

This time of intense planning has seen the adult and Paediatric intensive care community in NSW link in weekly community of practice meetings. These have been wonderful forums to provide updates about preparations, particularly in the early days when there was so much uncertainty about the supply chain for personal protective equipment. We have never been as well connected as we have been in the last few months. There has been a sense of camaraderie and our rural and regional colleagues have welcomed the ability to connect with their tertiary peers.

Through this forum we have highlighted the achievements of ANZICS members leading the way in developing the guidelines for COVID-19. Dr Swapnil Pawar through his Meet the Experts Podcast Series have provided both national and international perspectives of the response to COVID-19. ANZICS has had a high profile during the pandemic from both clinicians and the Ministry of Health pillars.

The embracing of telehealth has opened the doors to the potential to support our regional colleagues to care for patients closer to home. It has made us more comfortable in connecting in the virtual world and minimised the need to travel.

We are certainly in for the marathon and look forward to being able to meet and connect in person in the future.

Dr Nhi Nguyen
Chair, New South Wales

New Zealand

Following the excellent Regional Scientific Meeting hosted in Napier, 2020 has been dominated by the preparations for the potential of significant COVID-19 penetration into the NZ population. Fortunately, to date, public health measures have held this at bay and afforded time for better preparation of the ICU community for the eventuality of an outbreak later in the year.

Capacity has improved but remains limited compared with many other OECD countries and work to make the system more resilient and surge capacity more flexible is on-going. In addition to training non-core ICU staff, purchase of additional ventilators, monitors and NIV machines, upgrades to hospital reticulated oxygen supplies and adaptations to HVAC systems have been necessitated in some areas.

ANZICS members (medical and nursing) together with Fellows of the College of Intensive Care Medicine have participated and collaborated in national preparations including equipment distribution, surge capacity preparation plans, development of triage assistance tools, educational events and regular meetings with the Ministry of Health. Sharing of documents, policies and guidelines between different critical care provider units within the ANZICS community has been appreciated as have the higher-level principle documents produced by ANZICS.

Concerns remain around recommended levels of PPE nationally compared with those of other countries and calls for greater transparency around supplies and stores continue. This is an on-going focus at the present time. By July, 11% of all Covid-19 cases in New Zealand had been in healthcare workers and we seek to improve this and protect our ICU teams.

Several units now contribute to the ANZICS CHRIS Database, but uptake has been patchy following advice that we were to expect an automated MoH NZ specific database in the near future. Work is on-going both to encourage use of the CHRIS Database and also to ascertain if the NZ database, when it is operational, might drop data into CHRIS to offer a complete picture of capacity on both sides of the Tasman.

Provisionally plans are set to hold a late Regional Scientific Meeting in June 2021 and we are currently exploring how this might be facilitated as a mixed modality event if public health measures were to prevent colleagues gathering together. The proposed major theme is “Equity and critical care services” with a second related theme of “Ensuring well-being in the ICU team”. Equity is not only around critical patient issues such as deprivation, ethnicity, access and outcomes but also about staff issues such as improving the voices and educational opportunities of the whole critical care team at the table – the voice of Nurses, Social Workers, Physios, Pharmacists, Allied Health Practitioners and Managers are key to this. An exploration of both equality and equity strategies and how these might best be leveraged to improve the well-being of all promises to be thought-provoking and challenging.

The NZ ANZICS Research Symposium is to be held in Christchurch on November 4th to 5th (pandemic ALERT restrictions allowing) and we hope as many ICU clinicians and researchers as possible will attend. This will provide an excellent opportunity to network and be the first face-to-face ANZICS event in NZ since the RSM. If restrictions prevent meeting, a virtual format may be adopted but we hope that a more convivial, in-person, mixed educational, social and networking event may prove possible.

As was the case in 2019-2020, the year ahead faces us with new challenges and opportunities. As the ICU system creaks and groans at the limits of capacity and suffers regular periods when we struggle to find beds for patients within their local catchment, it is encouraging to see strong governmental signals of a desire to improve things and to work with the profession to achieve advancements for our patients, whanau and staff teams. ANZICS, the College, NZCCCN and the NZ CD and CNM ICU network are all participating; members are encouraged to feed into these groups to influence the future of our national service.

Dr Craig Carr
Chair, New Zealand

Northern Territory

I would like to acknowledge the traditional custodians of the land where we stand and pay my respect to the Elders both past, present and future.

This year, focus has been on Pandemic preparedness that has occurred at many fronts. Strong public health response and mature community has ensured safe territory and health services have been able to provide ongoing care without getting overwhelmed. Limited number of COVID-19 cases had excellent outcomes with no mortality.

Territory hospitals have been busy escalating the response levels and expanding its capacity. The collaboration between health department, public health, health services and various agencies has been unprecedented. Coordination between front line services with innumerable simulation testing has ensured staff safety, continued care of non-COVID patients and fine tuning of patient flow.

Protection of indigenous population is paramount because of high disease burden and difficulties with access to health care. Our past experience with 2009 H1N1 influenza pandemic has shown that indigenous population have disproportionately higher hospital admissions than the rest of population.

Technology has ensured close communication between wider intensive care community, providing much needed closeness and learning opportunities from mutual experiences. Industry participation with use of novel technologies such as 3D printing for the production of face shields has shown new ways and ongoing need for innovation in resource limited setting.

Royal Darwin and Alice Springs intensive care units shared their experiences with pandemic preparedness in first ever webinar. This was cobadged by ANZICS and CICM and was well attended. Planning for future such endeavours is underway. There has been a modest increase in the number of ANZICS members in the territory in last year.

Intensive care specialists from Northern Territory have strong presence in various ANZICS and CICM committees and also at the board level. Their contribution is greatly valued and I acknowledge them for their hard work and ongoing commitment.

This year has bought unique challenges and ANZICS has provided strong leadership in pandemic response. Intensive care community in the Northern Territory is growing and both Alice Springs and Darwin Intensive care units are working closer than ever before.

Dr Sidharth Agarwal
Chair, Northern Territory

Queensland

Queensland had an interesting year so far considering that we had prepared extensively for the COVID -19 Pandemic. The pandemic preparations included the following.

1) Increasing our bed capacity in ICUs across Queensland significantly, if we get increasing number of ICU/Ventilated patients.
2) For example, the physical capacity of Royal Brisbane and Women's Hospital ICU bed capacity was increased over 50 beds.
3) The Queensland ICU network bought number of ventilators which would be distributed equitably to ICUs across Queensland.
4) We also sought help of our anaesthetic colleagues to manage overflow of ICU patients.
5) At RBWH, Anaesthetists attended ICU rounds to familiarise themselves with the routines of the ICU.
6) We developed a short guide (handbook) for management COVID-19 and non Covid-19 patients so that Non- ICU specialists would be able manage ICU patients in the post -op recovery rooms while awaiting ICU specialist consult.

Overall, we only received only handful of patients in the ICUs across Queensland. However, it is likely that there will be a second wave as has happened in Victoria. We, as ICU community in Queensland are very well prepared, if we do get a second wave.

The COVID -19 statistics (16th July 2020) are as follows

Total cases	**1071**
Deaths	**6**
Case fatality rate	**0.56%**

COVID-19 pandemic has also affected the CICM trainees significantly. Here in South East Queensland, some ICUS are not allowing the trainees from other hospitals to visit their ICUS for hot case practice due to concern about spreading COVID-19. This is a major headache for the advanced trainees planning the appear for next seating of the practical final CICM exam.

Dr Rajeev Hegde
Chair, Queensland

South Australia

During the year before March 2020, the SA ICU community had continued to foster collaborative relationships across the four ICU-supported public hospitals in Adelaide. Networking and educational sessions had been held for both fellows and trainees throughout the year.

The highlight was having Michael Reade present an excellent session titled “Lessons That Civilian Hospitals Can Learn From The Military”. This joint CICM/ANZICS event was made possible due to the enthusiasm of Aniket Nadkarni (RAH Advanced Trainee) and generous sponsorship from trade and the South Australian Intensive Care Association. Fully subscribed with a combination of consultant and junior doctors, this entertaining and engaging talk seems quite prescient given the recent Federal Government ADF-lead COVID interventions in Bernie and the aged care networks of Victoria. We thank Michael for being so generous with his time.

ANZICS CORE presented a registry seminar for SA data collectors and ICU clinicians in Adelaide in late November. The CORE team of Sue Huckson and Jennifer Hogan travelled over to run this well received session. The support was very well received, and we hope that SA continues to provide high quality, consistent data to the CORE database.

Once COVID hit, South Australia was very fortunate to have only a small proportion of local transmission in the first wave. With a well-established communicable diseases branch, the contact tracing for any outbreaks was swift and effective. Thankfully SA only had a total of 441 cases with 18 ICU admissions and 4 deaths. Unlike much of the country, SA Health had decided to cohort all COVID cases requiring hospital admission at the Royal Adelaide Hospital. This concentrated all of those ICU cases at the RAH. While this helped hone the skills in doffing and donning, proning and intubation practises, it did have an impact on the tertiary and quaternary services normally offered at the RAH. Other SA hospitals took up the slack for some of the subspeciality surgical work (ENT and neurosurgical) during this period to ensure the SA public were able to have access to required services during the RAH elective surgery ramp down. This model may change should SA suffer a second wave as the state’s ICU teams have a greater say in the strategic plan.

The RAH had one ICU nursing staff member contract COVID. While 33 direct work contacts were placed into quarantine none tested positive which supported the staff social distancing principles imposed during the pandemic response.

Similar to many across ANZ, concerns over supply of PPE, equipment and medication occupied a great deal of the time and energy of many ICU staff in Adelaide. The lull following the first wave has allowed many of these procurement and supply chain issues to be refined and we are more prepared for any potential second wave. The required rapid local protocol development was greatly assisted with the excellent ANZICS COVID-19 Guidelines and the ANZICS slack website. Our thanks to all those that set up and contributed to these amazing resources.

Social distancing has cancelled or delayed many of the planned ANZICS educational/social activities including the annual Tub Worthley Scholarship Dinner. Despite having Adelaide’s social distancing restrictions lifted recently, this has been postponed till later this year. We all keep our fingers crossed that COVID conditions will allow this important event to continue in person.

Dr Michael Farquharson

Chair, South Australia

Tasmania

Tasmania's intensive care units have had a steady 12 months fulfilling their important role in the three regions. As with many services interstate there have been the usual administrative challenges of staffing and exit block. However, quality intensive care has continued with a high case load and the maintenance of excellent outcomes for our local population.

Dr Scott Parkes

2020 marks the retirement from intensive care practice of the widely respected Director of Launceston General Hospital's ICU, Dr Scott Parkes. Scott graduated from the University of Tasmania in 1983 and subsequently completed Fellowships in both Respiratory Medicine (RACP) and Intensive Care (JFICM/CICM). After specialist training at Flinders Hospital in Adelaide (including winning the Matt Spence Medal) he worked at the Royal Children's Hospital, Westmead and The Alfred. In 1996 he returned to Launceston where he has since worked as both an Intensive Care and Respiratory Physician. During his longstanding service as the Director of Intensive Care he has overseen the unit grow substantially, broaden and strengthen its links with other departments, and establish several important external roles. Of note is the ability of the LGH ICU to provide a percutaneous and surgical line insertion service, and high-quality resuscitation and initial intensive care for children and neonates. Scott should be commended for actively maintaining the unit's culture of support for patients and clinicians in other hospitals in the NW region, as well as the unit's reputation for high quality teaching and training in intensive care. Outside of the LGH he has been a CICM examiner for the last 8 years, taught on many airway and mechanical ventilation courses, and has undertaken international humanitarian missions including supporting primary care Vanuatu, the Ebola outbreak in Sierra Leone, and the WHO response in Mosul, Iraq. On behalf of the intensive care community and ANZCIS I would like to thank Scott for his long contribution to intensive care medicine and wish him the best as he continues with his career as a respiratory physician.

Education

In November local ANZICS member Benoj Varghese convened the 3rd Tasmanian Critical Care Meeting at the Hotel Grand Chancellor. The theme focussed on Respiratory Care in the ICU with local and interstate keynote speakers. It was supported by ANZICS, ACCCN and CICM, as was very well received by local clinicians. In conjunction with the RHH ICU, Benoj also arranged sponsorship for three clinicians from Namibia to attend the 2019 World Congress in Intensive Care Medicine in Melbourne. Following the meeting these clinicians then undertook a 2-week observership in the RHH Department of Critical Care Medicine. The generosity of the local intensive care community to supporting this initiative is greatly appreciated by ANZICS.

Membership

Regional society membership has moderately increased over the last 12 months with a pleasing increase in some of the subgroups including trainees and nursing members. Our local clinicans continue to actively recruit to ANZICS-CTG initiated trials, along with ongoing contributions to the CORE dataset. We have broad and active representation across most ANZICS subcommittees where the output of our representatives remains greatly valued, especially considering the small number of Intensivists in the state. I would like to formally recognise everyone's efforts and thank them for their contributions.

COVID19

At both a Regional Committee and National Executive level ANZICS has been in communication with the Tasmanian Premier and State Health Minister regarding our ICU capacity and the risks posed by COVID19. Tasmania was challenged early in the COVID19 pandemic with an outbreak in NW Tasmania. ANZICS is grateful for the aggressive public health response, as well as the immediate support from the ADF and AUSMAT teams in bringing this outbreak under control. Subsequently we have enjoyed our geographical location which, together with strong border controls, has somewhat insulated our health system from the effects of COVID19, at least to this stage. However, we should acknowledge the large amount of preparation and resources that have gone into readying our units for COVID19, the ongoing nature of which is fully supported by local intensive care clinicians and the Regional Committee.

The ANZICS Regional Committee would like to thank members, and the wider intensive care community, for their support over the last 12 months and assistance with the challenges to be faced in the upcoming year.

Dr Michael Ashbolt
Chair, Tasmania

Victoria

The past twelve months have seen significant challenges for the Victorian healthcare system, particularly the ICU community, in the setting of the COVID-19 pandemic. Many Victorian ANZICS members have contributed extensively to the Society's response to the pandemic.

We are grateful for the wonderful efforts of A/Prof Steve McGloughlin and Dr Fraser Magee who led the ANZICS COVID-19 working group and created the ANZICS COVID-19 Guidelines. Dr Stephen Warrillow chaired the ANZICS Best Practice Advisory Committee, which developed the ANZICS 'Guiding principles for complex decision-making during Pandemic COVID-19'. We are also grateful to A/Prof David Pilcher who coordinated the ANZICS assessment of ICU surge capacity, which was provided to the Federal Government. Dr Jason McClure was also instrumental in helping build the Australia and New Zealand Critical Health Resource Information System (CHRIS), which was used extremely effectively to aid ICU planning in Victoria. While Victoria was adversely affected by the 'COVID-19 second wave', we saw exceptional engagement from our membership, most notably the ANZICS Victorian ICU Directors' Forum which has met weekly/fortnightly since March to share knowledge and effectively advocate for members. The increased communication and engagement between senior ANZICS' representatives and the Chief Medical Officer and the Senior Leaders at Safer Care Victoria has been extremely valuable for the Society and our specialty as whole.

While in-person educational events and conferences have been curtailed this year, I would like to acknowledge the outstanding World Congress of Intensive Care Medicine which was successfully held in October last year at the Melbourne Convention and Exhibition Centre. The meeting was an incredible success, with over 2300 delegates in attendance from almost 80 different countries. Over 300 speakers were present, from a diverse number of backgrounds across the specialty. The feedback about the scientific and social programs, as well as the Australian-themed exhibition hall, was outstanding. Thank you to Dr Stephen Warrillow, A/Prof Adam Deane, Dr Johnny Millar and Dr David Ku for all of their hard work in organising this world-class event.

We also saw the Safety & Quality Conference held for 200 delegates on the day prior to the Congress, led by A/Prof Daryl Jones and the Safety & Quality Committee. The event was extremely successful and, once again, resoundingly positive feedback was received. Other events held in our region in the past year were the ANZICS CORE Datathon, the WIN Gender Thinktank and the Education Symposium on Research and Consent in the Emergency Setting. Thank you to all ANZICS members who contributed to the success of these events. I would like to remind our members that videos of most of these events are accessible on the ANZICS YouTube account via this link (https://www.youtube.com/channel/UCVU_LWubvrXrNklrEHcv7jA/videos).

Membership of ANZICS in Victoria continues to grow and we currently have 355 members (increase of 23% in the past year) across a range of disciplines. It is of paramount importance for ANZICS to continue to represent the interests of its members. Over the past 3 years, there have been ongoing discussions at the ANZICS Board and Committee levels about the direction and mission of ANZICS. The Governance Review is ongoing and if you have any suggestions or feedback, please feel free to contact me (yasmine.aliabdelhamid@mh.org.au). It is imperative that the membership is engaged and advocated for during these organisational changes.

I would like to thank the ANZICS staff for all of their ongoing support and assistance, along with Dr Kimberley Haines and Dr Max Moser who serve as office-bearers on the Victorian ANZICS Regional Committee. Given the high level of engagement among the ANZICS community in Victoria, it is possible that I have forgotten to specifically thank some members in my report. Thank you to all of the Victorian ANZICS members who have contributed to the local education, advocacy and research activities and continued to represent Victoria on the various ANZICS Committees.

Finally, I would like to sincerely thank my Victorian ICU colleagues – all of the ICU nurses, doctors, allied health staff and other ICU support staff. Your diligence, compassion, commitment and positive attitude in the face of Victoria's recent significant challenges has been inspiring and it is an honour to be part of such an exceptional team.

Dr Yasmine Ali Abdelhamid

Chair, Victoria

Western Australia

Well as everyone will say, this past year was certainly not just 'more of the same'. After an initial flurry of quite sick cruise ship passengers and crew, in particular, The Artania. WA has been quite lucky in terms of COVID-19 (fingers crossed) - one positive perhaps of being the most isolated city in the world. We now watch and hope that numbers will come down and under control in 'the East'.

The landscape has certainly changed. Lots of preparation and some initial funds for equipment became rapidly available. Some new positions were created and now we are just trying to figure out what we need and what is feasible moving forward.

Research

We finally had some progress with the issue of WA not being able to participate in any research requiring NOK consent. With repeated lobbying from research leads and community advocates and then COVID providing some extra political pressure, legislation was passed in parliament to allow NOK consent for research. There are still some issues with the need for independent medical practitioners to sign off every enrolment making things difficult, but we are in a better place than we were.

Jobs

At the tertiary ICU's we now coordinate jobs at a state level for all trainees (both senior and junior) to ensure all are getting adequate experience in all subspecialty areas and this seems to be working well.

Education

As per previous events in conjunction with the Intensive Care Network, we managed to get one education evening in prior to COVID which went well. Subsequently we did a Zoom meeting to discuss all COVID cases and management which was well attended. We hope to get back to some face to face events in the near future. It's also the ANZICS reps and committee members that have formed the organising committee for the upcoming college ASM in Perth - hopefully we are not still talking about state borders next year!

Congratulations has to go to Mary Pinder who I am fortunate enough to work with and has become our College President. She is a wonderful person as well as a fantastic Doctor and Teacher.

Thank you to all of the ANZICS Committee members and representatives who put in work and time to help our profession and society. You are all valued and appreciated.

It will be interesting times ahead and we hope for the best but continue to plan for everything else.

Dr Bradley Wibrow

Chair, Western Australia

ANZICS Awards

Matt Spence Medal

The Matt Spence Award is a highly sought-after prize by Researchers interested in intensive care. The Matt Spence prize is named after the Society's first President (1975) and co-founder of the organisation, Dr Matthew Spence. The winners of previous awards follow:

1981	**Dr S Streat**	Auckland
1982	**Dr S Gatt**	Sydney
1983	**Dr R Raper**	Sydney
1984	**Dr N Gibbs**	Perth
1985	**Dr W Griggs**	Adelaide
1986	**Dr A Bersten**	Adelaide
1987	**Dr M Oliver**	Auckland
1988	**Dr P McQuillan**	Perth
1989	**Dr T Buckley**	Hong Kong
1990	**Dr C McAllister**	Sydney
1991	**Dr R Bellomo**	Melbourne
1992	**Dr S Parkes**	Adelaide
1993	**Dr R Totaro**	Sydney
1994	**No award presented**	
1995	**Dr A Davies**	Melbourne
1996	**Dr B Venkatesh**	Brisbane
1997	**Dr D Blythe**	Perth
1998	**Dr N Edwards**	Adelaide
1999	**Dr V Pellegrino**	Melbourne
2000	**Dr I Seppelt**	Canberra
2001	**Dr R Fregley**	Waikato
2001	**Dr B Mullan (special)**	Sydney
2002	**Dr D Collins**	Perth
2003	**Dr N Blackwell**	Cairns
2004	**Dr V Campbell**	Adelaide
2005	**Dr P John Victor**	Adelaide
2006	**Dr M Zib**	Newcastle
2007	**Dr A Nichol**	Melbourne
2008	**Dr B Tang**	Penrith
2009	**Dr M Brain**	Launceston
2010	**Dr R Fischer**	Adelaide
2011	**Dr J Raj**	Adelaide
2012	**Dr S Kelly**	Gosford
2013	**Dr Y Abdelhamid**	Adelaide
2014	**Dr M Plummer**	Adelaide
2015	**Dr P Kar**	Adelaide
2016	**Dr T Beckingham**	Adelaide
2017	**Dr N Glassford**	Melbourne
2018	**Dr G Wigmore**	Melbourne
2019	**Dr M Chakraborty**	Wellington

Past ANZICS Presidents

1975-77	**M Spence**	NZ
1977-79	**GM Clarke**	WA
1979-80	**RC Wright**	NSW
1980-81	**RC Wright**	NSW
1981-82	**RV Trubuhovich**	NZ
1982-84	**LIG Worthley**	SA
1984-86	**M Fisher**	NSW
1986-88	**J Cade**	VIC
1988-89	**TE Oh**	WA
1989-91	**JA Judson**	NZ
1991-93	**PL Blyth**	NSW
1993-95	**GA Skowronski**	SA
1995-96	**DV Tuxen**	VIC
1996-98	**GJ Dobb**	WA
1998-00	**A Bell**	TAS
2000-02	**A McLean**	NSW
2002-03	**J Santamaria**	VIC
2003-05	**D Fraenkel**	QLD
2005-07	**I Jenkins**	WA
2007-09	**P Hicks**	NZ
2009-11	**M O'Leary**	NSW
2011-13	**M White**	SA
2013-15	**A Turner**	TAS
2015-17	**M Ziegenfuss**	QLD

ASM Oration

In 2002, the ANZICS Board agreed to award an 'Oration Medal'. The Oration is presented on the final day of the Annual Scientific Meeting. Previous presenters include the following medical specialists.

2002	Perth	**Malcolm Fisher**	NSW
2003	Cairns	**Lindsay Worthley**	SA
2004	Melbourne	**Jack Cade**	VIC
2005	Adelaide	**Bob Wright**	NSW
2006	Hobart	**Stephen Streat**	NZ
2007	Rotorua	**Geoffrey Parkin**	VIC
2008	Sydney	**Frank Shann**	VIC
2009	Perth	**David Tuxen**	VIC
2010	Melbourne	**Anthony Bell**	TAS

2011	Brisbane	**Brad Power**	WA
2012	Adelaide	**Neil Matthews**	SA
2013	Hobart	**Felicity Hawker**	VIC
2014	Melbourne	**Simon Finfer**	NSW
2015	Auckland	**George Skowronski**	NSW
2016	Perth	**Geoff Dobb**	WA
2017	Gold Coast	**John Santamaria**	VIC
2018	Adelaide	**Mary White**	SA
2019	Melbourne	**None due to World Congress**	

Ramesh Nagappan Education Award

2014	Melbourne	**Gerard Fennessy**	VIC
2015	Auckland	**Cameron Knott**	VIC
2016	Perth	**Adam Deane**	VIC

2017	Gold Coast	**Chris Nickson**	VIC
2018	Adelaide	**Mary Pinder**	WA
2019	Melbourne	**Bala Venkatesh**	VIC

ANZICS Honour Roll

Cameron Barrett	**William R Fuller**	**David McWilliam**	**Matthew Spence**
Anthony Bell	**John E Gilligan**	**Valerie M Muir**	**Thomas A Torda**
Rinaldo Bellomo	**Gordon A Harrison**	**John Myburgh**	**Ron V Trubuhovich**
Jack F Cade	**Graeme Hart**	**Ramesh Nagappan**	**David Tuxen**
Bernard G Clarke	**Robert Herkes**	**John O'Donovan**	**Lindsay I Worthley**
Geoffrey M Clarke	**Peter Hicks**	**Paul O Older**	**Robert Wright**
Nick J Coroneos	**Ken Hillman**	**John H Overton**	**Malcolm Wright**
Geoff J Dobb	**Mike Hunter**	**W Geoff Parkin**	**Jack Havill**
George Downward	**James Judson**	**Garry D Phillips**	**Helen Opdam**
Graeme Duke	**Richard Lee**	**Brad Power**	**John Santamaria**
Simon Finfer	**Jeff Lipman**	**Ray Raper**	
Malcolm Fisher	**Michael G Loughhead**	**George Skowronski**	

2020 Financial Report

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Directors' Report

The Directors present their report together with the financial report of the Australian and New Zealand Intensive Care Society (the "Society" or "ANZICS") for the financial year ended 30 June 2020 and the auditor's report thereon.

Directors

The names of each person who has been a director of the Society during the year and to the date of this report are:

Dr Anthony Holley President
Dr Mark Nicholls Hon. Secretary
Dr Yasmine Ali Abdelhamid
Dr Michael Ashbolt
Dr Alastair Carr
Dr Rajeev Hegde
Dr Kenneth John Millar
Dr Sandra Peake
Dr Bradley Wibrow
Dr Stephen Warrillow Immediate Past President
Dr Danielle Austin Hon. Treasurer
Dr Sidharth Agarwal (appointed 16/1/2020)
Dr Bronwyn Avard (appointed 16/1/2020)
Dr Michael Farquharson
Dr David Ku (resigned 22/10/2019, re-appointed 16/1/2020)
Dr Nhi Nguyen
Dr David Pilcher

Directors have been in office since the start of the financial year to the date of this report unless otherwise stated.

The short and long term objectives of the Society

Short term objectives

- Increased provision and facilitation of professional education, leadership in medical settings, clinical research and analysis of critical care resources.
- Increased membership across the Society including both individual clinicians and units.

Long term objectives

- Develop and expand the Society's existing repositories of intensive care clinical and resource data.
- Encourage and support intensive care research through the Clinical Trials Group and patient databases.
- Maintain a high level of membership and increased activity.

Strategy for achieving objectives

To achieve these objectives the Society has adopted the following strategies:

- The Society is focused on increasing its membership through engagement of medical and other professionals.
- The Society has committed to the expansion and improvement of its current functions through the scoping of developmental projects and initiatives.
- The Society recognises the important role and functions of its staff and members and strives to ensure the retention of both important groups through a commitment to development, engagement and communication.

Principal activities

The principal activity of the Society during the year was to provide services including advocacy, research and education to its members and stakeholders.

How the principal activities achieve our objectives

The principal activities have assisted the Society in the development and achievement of the agreed objectives through the facilitation and provision of opportunities for increasing the Society's profile, engagement with members and stakeholders and increased activity through a range of methods. The performance of the Society is measured against: (a) Membership levels: individual and unit (through the Clinical Trials Group); (b) Number of educational meetings and events conducted; (c) Involvement in industry related issues and matters; and (d) Number of publications assisted or published.

Qualifications, experience and special responsibilities of the directors

Dr A Holley
Qualifications: MBBCh/BSc/FACEM/FCICM
Experience: Director since Dec 2010
Special Responsibilities: President

Dr S Warrillow
Qualifications: MBBS/FCICM/FRACP
Experience: Director since Mar 2010
Special Responsibilities: Immediate Past President

Dr M Nicholls
Qualifications: MBBS/FRACP/FCICM
Experience: Director since Oct 2014
Special Responsibilities: Hon. Secretary/Chair – PAW

Dr D Austin
Qualifications: MBBS (Hons)/FRACP/FCICM
Experience: Director since Nov 2017
Special Responsibilities: Hon. Treasurer

Dr Y Ali Abdelhamid
Qualifications: MBBS/FRACP/FCICM
Experience: Director since Dec 2015
Special Responsibilities: Chair – VIC Region

Dr S Agarwal
Qualifications: MBBS/MD/FCICM
Experience: Director since Jan 2020
Special Responsibilities: NT Representative

Dr M Ashbolt
Qualifications: BMed Sci/MBBS/FCICM/FACEM
Experience: Director since Feb 2017
Special Responsibilities: Chair – TAS Region

Dr B Avard
Qualifications: BMed/FCICM/MLMEd PGCertClinUS
Experience: Director since Jan 2020
Special Responsibilities: ACT Representation

Dr A Carr
Qualifications: MB/ChB/MSc/DA/FRCA DICM/FFICM/MBA
Experience: Director since May 2019
Special Responsibilities: Chair – NZ Region

Dr M Farquharson
Qualifications: MBBS/BSc (Hons)/FCICM
Experience: Director since July 2018
Special Responsibilities: Chair – SA Region

Dr R Hegde
Qualifications: MBBS/MD/EDICM/FCICM
Experience: Director since Oct 2014
Special Responsibilities: Chair – QLD Region

Dr D Ku
Qualifications: MBBS/FCICM
Experience: Director since Jan 2020
Special Responsibilities: International Relations

Dr K Millar
Qualifications: MBChB/PhD/FRACP/FCICM
Experience: Director since Feb 2012
Special Responsibilities: Paediatric Representative

Dr N Nguyen
Qualifications: MBBS/FCICM
Experience: Director since Dec 2018
Special Responsibilities: Chair – NSW Region

Dr S Peake
Qualifications: BM/BS/BSc(Hons)/FCICM/PhD
Experience: Director since June 2019
Special Responsibilities: Chair – Clinical Trials Group

Dr D Pilcher
Qualifications: MBBS/MRCP/FRACP/FCICM
Experience: Director since Feb 2019
Special Responsibilities: Chair – CORE Management

Dr B Wibrow
Qualifications: MBBS/FACEM/FCICM
Experience: Director since Dec 2015
Special Responsibilities: Chair – WA Region

Directors' meetings

During the financial year, 3 meetings of directors were held. Attendances by each director were as follows:

Directors	Number eligible to attend	Number attended
Dr Y Ali Abdelhamid	3	3
Dr M Ashbolt	3	3
Dr S Agarwal	2	2
Dr D Austin	3	3
Dr B Avard	2	2
Dr A Carr	3	3
Dr M Farquharson	3	3
Dr R Hegde	3	3
Dr A Holley	3	3
Dr D Ku	3	3
Dr KJ Millar	3	3
Dr N Nguyen	3	3
Dr M Nicholls	3	3
Dr S Peake	3	3
Dr D Pilcher	3	3
Dr S Warrillow	3	3
Dr B Wibrow	3	3

Amount which each class of member is liable to contribute if the Society is wound up

The Society is incorporated under the *Corporations Act 2001* and is a company limited by guarantee. Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member, for payment of the debts and liabilities of the Society (contracted before he/she ceases to be a member) and of the charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $18,380 (2019: $14,540) being 919 (2019: 727) members with a liability limited to $20 each under the Constitution.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2020 has been received and can be found on page 35 and forms part of the directors' report.

This Directors' Report is signed in accordance with a resolution of the Board of Directors.

Dr Anthony Holley
President

Dr Danielle Austin
Hon. Treasurer

Dated this 25th day of September 2020

Auditor's Independence Declaration

UNDER SUBDIVISION 60-C SECTION 60-40 OF AUSTRALIAN CHARITIES AND NOT-FOR-PROFITS COMMISSION ACT 2012
TO THE DIRECTORS OF AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2020, there have been:

(i) no contraventions of the auditor independence requirements as set out in the Australian Charities and Not-for-profits Commission Act 2012 in relation to the audit; and

(ii) no contraventions of any applicable code of professional conduct in relation to the audit.

C.W. Stirling & Co.
Chartered Accountants

John A Phillips
Partner

Dated this 25th day of September 2020
Melbourne

Liability limited by a scheme approved under Professional Standards Legislation

Statement of Profit or Loss and other Comprehensive Income

FOR THE YEAR ENDED 30 JUNE 2020

	Notes	2020 $	2019 $
Revenue	2	3,358,688	2,815,364
Other income	2	6,595	201,288
Employee benefits expenses		(1,593,396)	(1,457,837)
CHRIS Project consultancy expense		(403,850)	-
Audit, legal and consultancy expense – general		(111,354)	(99,769)
Conference and meeting expenses		(256,131)	(385,692)
Depreciation and amortisation expense		(209,623)	(110,666)
Administration expenses		(152,231)	(251,343)
IT expenses		(141,423)	(146,092)
Unrealised loss on revaluation of financial assets		(138,075)	-
Travel and committee expenses		(51,298)	(65,901)
Awards, sponsorships and scholarships		(38,000)	(26,667)
Finance expenses		(6,949)	-
Other expenses from ordinary activities		(13,128)	(18,769)
Current year surplus	3	249,825	453,916
Other comprehensive income			
Items that will not be reclassified subsequently to surplus or loss:			-
Total other comprehensive income for the year, net of income tax		-	-
Total comprehensive income for the year		**249,825**	**453,916**

The accompanying notes form part of these financial statements.

Statement of Financial Position

AS AT 30 JUNE 2020

	Notes	2020 $	2019 $
Current Assets			
Cash and cash equivalents	4	2,684,166	2,698,340
Trade and other receivables	5	323,981	162,676
Other current assets	6	44,018	78,551
Total current assets		3,052,165	2,939,567
Non-Current Assets			
Financial assets	7	4,319,235	3,469,677
Plant and equipment	8	20,021	26,853
Intangible assets	9	176,469	281,063
Right of use assets	10	82,289	-
Total non-current assets		4,598,014	3,777,593
Total Assets		7,650,179	6,717,160
Current Liabilities			
Trade and other payables	11	976,134	429,918
Lease liabilities	12	89,769	-
Provisions	13	419,277	366,706
Total current liabilities		1,485,180	796,624
Non-Current Liabilities			
Employee benefits	13	3,849	1,597
Total non-current liabilities		3,849	1,597
Total Liabilities		1,489,029	798,221
NET ASSETS		**6,161,150**	**5,918,939**
Equity			
Retained earnings		6,161,150	5,918,939
TOTAL EQUITY		**6,161,150**	**5,918,939**

The accompanying notes form part of these financial statements.

Statement of Cash Flows

FOR THE YEAR ENDED 30 JUNE 2020

	Notes	2020 $	2019 $
Cash flows from operating activities			
Receipt of grants		2,182,341	1,505,703
Cash receipts from members and customers		1,230,738	1,135,954
Income from financial assets		139,734	86,855
Interest received		38,415	73,719
Payments to suppliers and employees		(2,526,033)	(2,812,110)
Net cash inflows / (outflows) from operating activities	14	1,065,195	(9,879)
Cash flows from investing activities			
Payment for available-for-sale financial assets		(1,003,610)	(2,739,398)
Proceeds from disposal of available-for-sale financial assets		22,572	661,805
Payment for property, plant and equipment		(3,626)	(13,187)
Payment for intangible assets		(4,800)	(18,901)
Payment for rental property		(89,905)	-
Proceeds from sale of property plant and equipment		-	450
Net cash used in investing activities		(1,079,369)	(2,109,231)
Net increase in cash and cash equivalents		(14,174)	(2,119,110)
Cash and cash equivalents at beginning of financial year		2,698,340	4,817,450
Cash and cash equivalents at end of financial year	4	2,684,166	2,698,340

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

FOR THE YEAR ENDED 30 JUNE 2020

	Retained earnings $
Balance at 1 July 2018	5,465,023
Surplus attributable to the Society	453,916
Balance at 30 June 2019	5,918,939
Balance at 1 July 2019	5,918,939
Adjustment upon adoption of new accounting standard AASB 16	(7,614)
Balance at 1 July 2019 restated	5,911,325
Surplus attributable to the Society	249,825
Balance at 30 June 2020	**6,161,150**

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2020

The financial statements are for Australian and New Zealand Intensive Care Society (the "Society") as an individual entity, incorporated and domiciled in Australia. The Society is incorporated under the *Corporations Act 2001* and is a company limited by guarantee.

Members' Guarantee

If the Society is wound up, the constitution states that each member is required to contribute a maximum of $20 each towards meeting any outstanding obligations of the Society. At 30 June 2020, the number of members was 919 (2019:727).

Registered Office and Principal Place of Business

The registered office and principal place of business of the Society is Suite 1.01, Level 1, 277 Camberwell Road, Camberwell, Victoria, 3124.

1. Summary of significant accounting policies

Basis of accounting

Australian and New Zealand Intensive Care Society applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: *Application of Tiers of Australian Accounting Standards.*

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board (AASB) and the *Australian Charities and Not-for-profits Commission Act 2012*. The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in financial statements containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of these financial statements are presented below and have been consistently applied unless stated otherwise.

The financial statements, except for the cash flow information, have been prepared on an accrual basis and are based on historical costs, modified, where applicable, by the measurement at fair value of selected non-current assets, financial assets and financial liabilities. The amounts presented in the financial statements have been rounded to the nearest dollar.

The financial statements were authorised for issue on 25th September 2020 by the directors of the company.

Accounting policies

(a) Revenue

Revenue recognition

Contributed Assets

The Society receives assets from the government and other parties for nil or nominal consideration in order to further its objectives. These assets are recognised in accordance with the recognition requirements of other applicable accounting standards (for example AASB 9, AASB 16, AASB 116 and AASB 138.) On initial recognition of an asset, the Society recognises related amounts (being contributions by owners, lease liability, financial instruments, provisions, revenue or contract liability arising from a contract with a customer). The Society recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount.

Operating Grants, Donations and Bequests

When the Society received operating grant revenue, donations or bequests, it assesses whether the contract is enforceable and has sufficiently specific performance obligations in accordance with AASB 15.

When both these conditions are satisfied, the Society:

- identifies each performance obligation relating to the grant
- recognises a contract liability for its obligations under the agreement; and
- recognises revenue as it satisfies its performance obligations.

Where the contract is not enforceable or does not have sufficiently specific performance obligations, the Society:

- recognises the asset received in accordance with the recognition requirements of other applicable accounting standards (e.g. AASB 9. AASB 16, AASB 116 and AASB 138);
- recognises related amounts (being contributions by owners, lease liability, financial instruments, provisions, revenue or contract liability arising from a contract with a customer); and
- recognises income immediately in profit or loss as the difference between the initial carrying amount of the asset and the related amount.

If a contract liability is recognised as a related amount above, the Society recognises income in profit or loss when or as it satisfies its obligations under the contract.

Interest Income

Interest rate revenue is recognised using the effective interest rate method.

Dividend Income

The Society recognises dividends in profit or loss only when the Society's right to receive payment of the dividend is established.

All revenue is stated net of the amount of goods and services tax (GST).

(b) Taxation

No provision for income tax has been raised as the Society is exempt from income tax under Division 50 of the *Income Tax Assessment Act 1997*.

(c) Property, plant and equipment

Each class of property, plant and equipment is carried at cost or fair value as indicated, less, where applicable, accumulated depreciation and impairment losses.

Plant and equipment

Plant and equipment are measured on the cost basis and are therefore carried at cost less accumulated depreciation and impairment losses. In the event the carrying amount of plant and equipment is greater than its estimated recoverable amount, the carrying amount is written down immediately to its estimated recoverable amount and impairment losses are recognised either in profit or loss or as a revaluation decrease if the impairment losses relate to a revalued asset. A formal assessment of recoverable amount is made when impairment indicators are present (refer to Note 1(e) for details of impairment).

Depreciation

The depreciable amount of all fixed assets is depreciated on a straight line basis over the asset's useful life to the Society commencing from the time the asset is held ready for use. The estimated useful lives in the current and comparative periods are as follows:

Class of asset	Useful life
Plant and equipment	3 – 10 years

The asset's residual values and useful lives are reviewed, and adjusted if appropriate, at the end of each reporting date.

Gains and losses on disposals are determined by comparing proceeds with the carrying amount. These gains or losses are recognised in profit or loss in the period in which they arise. When revalued assets are sold, amounts included in the revaluation surplus relating to that asset are transferred to retained earnings.

(d) Financial instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the Society becomes a party to the contractual provisions to the instrument. For financial assets, this is the equivalent to the date that the Society commits itself to either purchase or sell the asset (i.e. trade date accounting is adopted). Financial instruments (except for trade receivables) are initially measured at fair value plus transaction costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are recognised immediately. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are used.

Trade receivables are initially measured at the transaction price if the trade receivables do not contain significant financing component or if the practical expedient was applied as specified in AASB 15: Revenue from Contracts with Customers.

Classification and subsequent measurement

Financial Liabilities

Financial liabilities are subsequently measured at:

- amortised cost; or
- fair value through profit or loss.

A financial liability is measured at fair value through profit or loss if the financial liability is:

- held for trading: or
- initially designated as at fair value through profit or loss.

All other financial liabilities are subsequently measured at amortised cost using the effective interest rate method. The effective interest rate method is a method of calculating the amortised cost of a debt instrument and of allocating interest expense over in profit or loss over the relevant period. The effective interest rate is the internal rate of return of the financial asset or liability. That is, it is the rate that exactly discounts the estimated future cash flows through the expected life of the instrument to the net carrying amount at initial recognition.

A financial liability is held for trading if it is incurred for the purpose of repurchasing or repaying in the near term. Any gains or losses arising on changes in fair value are recognised in profit or loss to the extent that they are not part of a designated hedging relationship. The change in fair value of the financial liability attributable to changes in the issuer's credit risk is taken to other comprehensive income and is not subsequently reclassified to profit or loss. Instead, it is transferred to retained earnings upon derecognition of the financial liability. If taking the change in credit risk to other comprehensive income enlarges or creates an accounting mismatch, these gains or losses should be taken to profit or loss rather than other comprehensive income.

1. Summary of significant accounting policies (continued)

A financial liability cannot be reclassified.

Financial Assets

Financial instruments are subsequently measured at:

- amortised cost;
- fair value through other comprehensive income; or
- fair value through profit or loss.

Measurement is on the basis of two primary criteria:

- the contractual cash flow characteristics of the financial asset; and
- the business model for managing the financial assets.

A financial asset that meets the following conditions is subsequently measured at amortised cost:

- the financial asset is managed solely to collect contractual cash flows; and
- the contractual terms within the financial asset give rise to cash flows that are solely payments of principal and interest on the principal amount outstanding on specified dates.

A financial asset that meets the following conditions is subsequently measured at fair value through other comprehensive income:

- the contractual terms within the financial asset give rise to cash flows that are solely payments of principal and interest on the principal and interest on the principal amount outstanding on specified dates; and
- the business model for managing the financial asset comprises both contractual cash flows, collection and selling of the financial asset.

By default, all other financial assets that do not meet the measurement conditions of amortised cost and fair value through other comprehensive income are subsequently measured at fair value through profit or loss.

The Society initially designates a financial instrument as measured at fair value through profit or loss if:

- it eliminates or significantly reduces a measurement or recognition inconsistency (often referred to as an 'accounting mismatch') that would otherwise arise from measuring assets or liabilities or recognising the gains and losses on them on different bases;
- it is in accordance with the documented risk management or investment strategy and information about the groupings is documented appropriately, so the performance of the financial liability that is part of a group of financial liabilities or financial assets can be managed and evaluated consistently on a fair value basis; and
- it is a hybrid contract that contains an embedded derivative that significantly modifies the cash flows otherwise required by the contract.

The initial designation of financial instruments to measure at fair value through profit or loss is a one-time option on initial classification and is irrevocable until the financial asset is derecognised.

Derecognition

Derecognition refers to the removal of a previously recognised financial asset or financial liability from the statement of financial position.

Derecognition of Financial Liabilities

A liability is derecognised when it is extinguished (i.e. when the obligation in the contract is discharged, cancelled or expires). An exchange of an existing financial liability for a new one with substantially modified terms, or a substantial modification to the terms of a financial liability, is treated as an extinguishment of the existing liability and recognition of a new financial liability.

The difference between the carrying amount of the financial liability derecognised and the consideration paid and payable, including any non-cash assets transferred or liabilities assumed, is recognised in profit or loss.

Derecognition of Financial Assets

A financial asset is derecognised when the holder's contractual rights to its cash flows expires, or the asset is transferred in such a way that all the risks and rewards of ownership are substantially transferred.

All the following criteria need to be satisfied for the derecognition of a financial asset;

- the right to receive cash flows from the asset has expired or been transferred;
- all risks and rewards of ownership of the asset have been substantially transferred; and
- the Society no longer controls the asset (ie has no practical ability to make a unilateral decision to sell the asset to a third party).

On derecognition of a financial asset measured at amortised cost, the difference between the asset's carrying amount and the sum of the consideration received and receivable is recognised in profit or loss.

The Society recognises a loss allowance for expected credit losses on financial instruments that are measured at amortised cost or fair value through other comprehensive income. Loss allowance is not recognised for financial assets financial assets measured at fair value through profit or loss.

Expected credit losses are the probability-weighted estimate of credit losses over the expected life of a financial instrument. A credit loss is the difference between all contractual cash flows that are due and all cash flows expected to be received, all discounted at the original effective interest rate of the financial instrument.

The Society uses the following approaches to impairment, as applicable under AASB 9: Financial Instruments:

- the general approach; and
- the simplified approach;

General approach

Under the general approach, at each reporting period, the Society assesses whether the financial instruments are creditimpaired, and:

- if the credit risk of the financial instrument has increased significantly since initial recognition, the Society measures the loss allowance of the financial instruments at an amount equal to the lifetime expected credit losses; and
- if there has been no significant increase in credit risk since initial recognition, the Society measures the loss allowance for that financial instrument at an amount equal to 12-month expected credit losses.

Simplified approach

The simplified approach does not require tracking of changes in credit risk at every reporting period, but instead requires the recognition of lifetime expected credit loss at all times. This approach is applicable to trade receivables. In measuring the expected credit loss, a provision matrix for trade receivables is used, taking into consideration various data to get to an expected credit loss (ie diversity of its customer base, appropriate groupings of its historical loss experience, etc).

Recognition of expected credit losses in financial statements

At each reporting date, the Society recognises the movement in the loss allowance as an impairment gain or loss in the statement of profit or loss and other comprehensive income. The carrying amount of financial assets measured at amortised cost includes the loss allowance relating to that asset.

(e) Impairment of Assets

At the end of each reporting period, the Society reviews the carrying amounts of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs of disposal and value in use, is compared to the asset's carrying amount. Any excess of the asset's carrying amount over its recoverable amount is recognised in profit or loss.

Where the assets are not held primarily for their ability to generate net cash inflows – that is, they are specialised assets held for continuing use of their service capacity – the recoverable amounts are expected to be materially the same as fair value. Where it is not possible to estimate the recoverable amount of an individual asset, the Society estimates the recoverable amount of the cash-generating unit to which it belongs. Where an impairment loss on a revalued individual asset is identified, this is recognised against the revaluation surplus in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation surplus for that class of asset.

(f) Employee provisions

Short-term employee benefits

Provision is made for the Society's obligation for short-term employee benefits. Short-term employee benefits are benefits (other than termination benefits) that are expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service, including wages, salaries and annual leave. Shortterm employee benefits are measured at the (undiscounted) amounts expected to be paid when the obligation is settled.

The Society obligations for short-term employee benefits such as wages and salaries are recognised as part of current trade and other payables in the statement of financial position.

Other long-term employee benefits

The Society classifies employees' long service leave and annual leave entitlements as other long-term employee benefits as they are not expected to be settled wholly within 12 months after the end of the annual reporting period in which the employees render the related service. Provision is made for the Society's obligation for other long-term employee benefits, which are measured at the present value of the expected future payments to be made to employees. Expected future payments incorporate anticipated future wage and salary levels, durations of service and employee departures, and are discounted at rates determined by reference to market yields at the end of the reporting period on high quality corporate bonds that have maturity dates that approximate the terms of the obligations. Any remeasurements for changes in assumptions of obligations for other long-term employee benefits are recognised in profit or loss in the periods in which the changes occur.

The Society's obligations for long-term employee benefits are presented as non-current liabilities in its statement of financial position, except where the Society does not have an unconditional right to defer settlement for at least 12 months after the end of the reporting period, in which case the obligations are presented as current liabilities.

1. Summary of significant accounting policies (continued)

Retirement benefit obligations

Defined contribution superannuation benefits

All employees of the Society receive defined contribution superannuation entitlements. For which the Society pays the fixed superannuation guarantee contribution (currently 9.5% of the employee's average ordinary salary) to the employee's superannuation fund of choice. All contributions in respect of employee's defined contribution entitlements are recognised as an expense when they become due and payable. The Society's obligation with respect to employee's defined contribution entitlements is limited to its obligation for any unpaid superannuation guarantee contributions at the end of the reporting period. All obligations for unpaid superannuation guarantee contributions are measured at the (undiscounted) amounts expected to be paid when the obligation is settled and are presented as current liabilities in the Society's statement of financial position.

(g) Cash and cash equivalents

Cash and cash equivalents include cash on hand, deposits held at-call with banks and other short-term highly liquid investments with original maturities of three months or less.

(h) Trade and other debtors

Accounts receivable and other debtors include amounts due from donors and any outstanding grant receipts. Receivables expected to be collected within 12 months of the end of the reporting period are classified as current assets. All other receivables are classified as non-current assets.

Accounts receivable are initially recognised at fair value and subsequently measured at amortised cost using the effective interest method, less any provision for impairment. Refer to Note 1(d) for further discussion on the determination of impairment losses.

(i) Goods and services tax (GST)

Revenues, expenses, and assets are recognised net of the amount of GST, except where the amount of GST incurred is not recoverable from the Australian Taxation Office (ATO). Receivables and payables are stated inclusive of the amount of GST receivable or payable. The net amount of GST recoverable from, or payable to, the ATO is included with other receivables or payables in the statement of financial position.

Cash flows are presented on a gross basis. The GST components of cash flows arising from investing or financing activities which are recoverable from, or payable to, the ATO are presented as operating cash flows included in receipts from customers or payments to suppliers.

(j) Intangible assets

Software

Software is recorded at cost. Where software is acquired at no cost, or for a nominal cost, the cost is its fair value as at the date of acquisition. It has a finite life and is carried at cost less accumulated amortisation and any impairment losses. Software has an estimated useful life of between one to five years. It is assessed annually for impairment.

Website

Costs that are directly attributable to the development of the website are recognised as an intangible asset and upon commissioning of the new website will be amortised to the Income Statement over a period of five years.

(k) Leases

The Society as a Lessee

At inception of a contract, the Society assesses if the contract contains or is a lease. If there is a lease present, a right-of-use asset and a corresponding lease liability is recognised by the Society where the Society is a lessee. However all contracts that are classified as short-term leases (lease with remaining lease term of 12 months or less) and leases of low value assets are recognised as an operating expense on a straight-line basis over the term of the lease.

Initially the lease liability is measured at the present value of the lease payments still to be paid at commencement date. The lease payments are discounted at the interest rate implicit in the lease. If this rate cannot be readily determined, the Society uses the incremental borrowing rate.

Lease payments included in the measurement of the lease liability are as follows:

- fixed lease payments less any lease incentives;
- variable lease payments that depend on an index or rate, initially measured using the index or rate at the commencement date;
- the amount expected to be payable by the lessee under residual value guarantees;
- the exercise price of purchase options, if the lessee is reasonably certain to exercise the options;
- lease payments under extension options if lessee is reasonably certain to exercise the options; and
- payments of penalties for terminating the lease, if the lease term reflects the exercise of an option to terminate the lease

The right-of-use assets comprise the initial measurement of the corresponding lease liability as mentioned above, any lease payments made at or before the commencement date as well as any initial direct costs. The subsequent measurement of the right-of-use assets is at cost less accumulated depreciation and impairment losses.

Right-of-use assets are depreciated over the lease term or useful life of the underlying asset whichever is the shortest. Where a lease transfers ownership of the underlying asset or the cost of the right-of-use asset reflects that the Society anticipates to exercise a purchase option, the specific asset is depreciated over the useful life of the underlying asset.

(l) Comparative figures

Where required by Accounting Standards comparative figures have been adjusted to conform with changes in presentation for the current financial year.

(m) Critical Accounting Estimates and Judgements

The directors evaluate estimates and judgements incorporated into the financial statements based on historical knowledge and best available current information. Estimates assume a reasonable expectation of future events and are based on current trends and economic data, obtained both externally and within the Society.

Key estimates

Useful lives of property, plant and equipment

As described in Note 1(c), the Society reviews the estimated useful lives of property, plant and equipment at the end of each annual reporting period.

Key judgements

(i) Performance obligations under AASB 15

To identify a performance obligation under AASB 15, the promise must be sufficiently specific to be able to determine when the obligation is satisfied. Management exercises judgement to determine whether the promise is sufficiently specific by taking into account any conditions specified in the arrangement, explicit or implicit, regarding the promised goods or services. In making this assessment, management includes the nature/type, cost/value, quantity and the period of transfer related to the goods or services promised.

(ii) Lease term and Option to Extend under AASB 16

The lease term is defined as the non-cancellable period of a lease together with both periods covered by an option to extend the lease if the lessee is reasonably certain to exercise that option; and also periods covered by an option to terminate the lease if the lessee is reasonably certain not to exercise that option. The options that are reasonably going to be exercised is a key management judgement that the Society will make. The Society determines the likeliness to exercise the options on a lease-by-lease basis looking at various factors such as which assets are strategic and which are key to future strategy of the Society.

(iii) Employee benefits

For the purpose of measurement, AASB 119: Employee Benefits defines obligations for short-term employee benefits as obligations expected to be settled wholly before 12 months after the end of the annual reporting period in which the employees render the related service. As the Society expects that most employees will not use all of their annual leave entitlements in the same year in which they are earned or during the 12-month period that follows (despite an informal internal policy that requires annual leave to be used within 18 months), the directors believe that obligations for annual leave entitlements satisfy the definition of other long-term employee benefits and, therefore, are required to be measured at the present value of the expected future payments to be made to employees.

(n) Fair Value of Asset and Liabilities

The Society measures some of its assets and liabilities at fair value on either a recurring or non-recurring basis, depending on the requirements of the applicable Accounting Standard. "Fair value" is the price the Society would receive to sell an asset or would have to pay to transfer a liability in an orderly (ie unforced) transaction between independent, knowledgeable and willing market participants at the measurement date. As fair value is a market-based measure, the closest equivalent observable market pricing information is used to determine fair value. Adjustments to market values may be made having regard to the characteristics of the specific asset or liability. The fair values of assets and liabilities that are not traded in an active market are determined using one or more valuation techniques. These valuation techniques maximise, to the extent possible, the use of observable market data.

To the extent possible, market information is extracted from the principal market for the asset or liability (ie the market with the greatest volume and level of activity for the asset or liability). In the absence of such a market, market information is extracted from the most advantageous market available to the Society at the end of the reporting period (ie the market that maximises the receipts from the sale of the asset or minimises the payments made to transfer the liability, after taking into account transaction costs and transport costs).

For non-financial assets, the fair value measurement also takes into account a market participant's ability to use the asset in its highest and best use or to sell it to another market participant that would use the asset in its highest and best use.

The fair value of liabilities and the Society's own equity instruments (if any) may be valued, where there is no observable market price in relation to the transfer of such financial instruments, by reference to observable market information where such instruments are held as assets. Where this information is not available, other valuation techniques are adopted and, where significant, are detailed in the respective note to the financial statements.

1. Summary of significant accounting policies (continued)

(o) New and amended Accounting Standards Adopted by the Society

Initial application of AASB 16

The Society has adopted AASB 16 Leases retrospectively with the cumulative effect of initially applying AASB 16 recognised at 1 July 2019. In accordance with AASB 16 the comparatives for the 2019 reporting period have not been restated.

The Society has recognised a lease liability and right-of-use asset for all leases (with the exception of short term and low value leases) recognised as operating leases under AASB 117 Leases where the Society is the lessee. The lease liabilities are measured at the present value of the remaining lease payments. The Society's incremental borrowing rate as at 1 July 2019 was used to discount the lease payments.

The right of use assets for equipment was measured at its carrying amount as if AASB 16: Leases had been applied since the commencement date, but discounted using the Society's incremental borrowing rate per lease term on 1 July 2019.

The right of use assets for the remaining leases were measured and recognised in the statement of financial position as at 1 July 2019 by taking into consideration the lease liability, prepaid and accrued lease payments previously recognised as at 1 July 2019 (that are related to the lease).

The following practical expedients have been used by the Society in applying AASB 16 for the first time:

- for a portfolio of leases that have reasonably similar characteristics, a single discount rate has been applied;
- leases that have remaining lease term of less than 12 months as at 1 July 2019 have been accounted for in the same was as short-term leases;
- the use of hindsight to determine lease terms on contracts that have options to extend or terminate;
- applying AASB 16 to leases previously identified as leases under AASB 117: Leases and Interpretation 4:

Determining whether an arrangement contains a lease without reassessing whether they are, or contain, a lease at the date of initial application; and

- not applying AASB 16 to leases previously not identified as containing a lease under AASB 117 and Interpretation 4.

Initial application of AASB 15 and AASB 1058

The Society has applied AASB 15: Revenue from Contracts with Customers and AASB 1058: Income of Not-for-Profit Entities. There have been no significant changes requiring disclosure from the adoption of these accounting standards.

(p) New Accounting Standards for Application in Future Periods

The AASB has issued a number of new and amended Accounting Standards that have mandatory application dates for future reporting periods, some of which are relevant to the society. The society has decided not to early adopt any of the new and amended pronouncements. The directors anticipate that adoption of the new and amended Accounting Standards may have an impact on the Society's financial statements, however it is impracticable at this stage to provide a reasonable estimate of such impact.

	2020 $	2019 $

2. Revenue and other income

Revenue

Grants - recurrent	1,396,444	1,368,444
Grants – CHRIS Project	403,000	-
Subscriptions	511,511	513,578
Surplus from ASM	235,950	107,618
Conferences and meetings	310,026	424,449
Sponsorship	81,227	124,314
	2,938,158	2,538,403
Other revenue:		
Government support – COVID19	167,000	-
Interest received – cash and cash equivalents	33,231	79,720
Investment dividends and distributions	187,299	142,301
Sundry income	33,000	54,940
	420,530	276,961
Total revenue	3,358,688	2,815,364

Other income

Gain on sale of property plant and equipment	-	520
Gain on disposal of investments held	6,595	1,284
Unrealised gain on investments held	-	199,484
Total other income	6,595	201,288
Total revenue and other income	3,365,283	3,016,652

Transaction price allocated to the remaining performance obligation

The table below shows the grant revenue expected to be recognised in the future related to the performance obligations that are unsatisfied (partially unsatisfied) at the reporting date

	2021 $	Total $
Revenue from government grants and other grants	43,000	43,000

	2020 $	2019 $

3. Surplus for the year

(a) Expenses

Employee benefits expense		
- contribution to defined contribution superannuation funds	131,030	119,220
Depreciation and amortisation expense:		
- plant and equipment	10,458	9,313
- intangible assets	109,394	101,353
- right of use assets	89,771	-
Total depreciation and amortisation expense	209,623	110,666
Financial costs:		
- interest expense on financial liabilities not at fair value through profit or loss	6,949	-
Rental expense on operating leases	-	92,820
Low value lease asset expense	2,928	2,976
Unrealised loss on revaluation of financial assets	138,075	-

	Notes	2020 $	2019 $
4. Cash and cash equivalents			
Cash on hand		175	300
Cash at bank		1,617,644	745,193
Cash on short term deposit		1,066,347	1,952,847
		2,684,166	2,698,340
5. Trade and other receivables			
Trade receivables		185,334	75,163
Other receivables		138,647	87,513
		323,981	162,676
6. Other current assets			
Prepayments		44,018	78,551
7. Financial assets			
Financial assets mandatorily measured at fair value through profit or loss	7(a)	4,319,235	3,469,677
(a) Financial assets mandatorily measured at fair value through profit or loss:			
Investments in listed Australian securities	17	1,715,652	1,631,435
Investments in managed funds	17	2,603,583	1,838,242
		4,319,235	3,469,677

8. Property, plant and equipment

Plant and equipment

	2020 $	2019 $
Plant and equipment - at cost	72,550	68,924
Less accumulated depreciation	(52,529)	(42,071)
Total plant and equipment	20,021	26,853

Movements in carrying amounts

	Plant and equipment $
2020	
Balance at 1 July 2019	26,853
Additions	3,626
Depreciation for the year	(10,458)
Balance at 30 June 2020	20,021
Balance at 1 July 2018	22,909
Additions	13,187
Disposals	(13)
Depreciation for the year	(9,230)
Balance at 30 June 2019	26,853

	2020 $	2019 $

9. Intangible assets

Software - at cost	501,555	496,755
Less accumulated amortisation	(348,213)	(245,419)
Total software	153,342	251,336
Website - at cost	33,000	33,000
Less accumulated amortisation	(9,873)	(3,273)
Total website	23,127	29,727
Total intangible assets	176,469	281,063

Movements in carrying amounts

	Software $	Website $	Total $
2020			
Balance at 1 July 2019	251,336	29,727	281,063
Additions	4,800	-	4,800
Amortisation for the year	(102,794)	(6,600)	(109,394)
Balance at 30 June 2020	153,342	23,127	176,469
2019			
Balance at 1 July 2018	330,516	32,999	363,515
Additions	18,900	1	18,901
Amortisation for the year	(98,080)	(3,273)	(101,353)
Balance at 30 June 2019	251,336	29,727	281,063

10. Right of use assets

The Society's lease relates to a building. The lease has a 3 year lease term. The option to extend or terminate is contained in the property leases of the Society. These clauses provide the Society opportunities to manage leases in order to align with its strategies. The extension or termination option is only exercisable by the Society. The extension options or termination option has not been included in the calculation of the Right of use asset.

	2020 $	2019 $

(i) AASB 16 related amounts recognised in the statement of financial position

Right of use assets	
Leased building	269,312
Less accumulated depreciation	(187,023)
Total right of use assets	82,289

Movements in carrying amounts

Leased buildings:	
Recognised on Initial application of AASB 16 (previously classified as operating leases under AASB 117	172,060
Depreciation for the year	(89,771)
Net carrying amount	82,289

(ii) AASB 16 related amounts recognised in the statement of profit or loss

Depreciation charge related to right of use assets	89,771
Interest expense on lease liabilities	6,949
Low value asset leases expense	2,928

	Notes	2020 $	2019 $
11. Trade and other payables			
Trade creditors		477,588	14,579
Sundry creditors and accruals		179,834	121,316
GST Payable		38,838	34,360
Grants received in advance		43,000	25,498
Subscriptions received in advance		209,574	194,073
Sponsorship & registrations received in advance		27,300	40,092
	11(a)	976,134	429,918
(a) Financial liabilities at amortised cost classified as trade and other payables			
Trade and other payables – current		976,134	429,918
Less deferred income		(279,874)	(259,663)
Financial liabilities as trade and other payables	17	696,260	170,255
12. Lease liabilities			
Lease liability – right of use assets		89,769	-
13. Provisions			
Current			
Provision for employee benefits: annual leave		149,607	122,675
Provision for employee benefits: long service leave		269,670	244,031
		419,277	366,706
Non-current			
Provision for employee benefits: long service leave		3,849	1,597
Analysis of total provisions			
Opening balance at 1 July 2019		368,303	
Additional provisions raised during the year		181,785	
Amounts used		(126,962)	
Balance at 30 June 2020		423,126	

Provision for employee benefits includes amounts accrued for annual leave and long service leave. The current portion for this provision includes the total amount accrued for annual leave entitlements and the amounts accrued for long service leave that have vested due to employees having completed the required period of service. Based upon past experience, the company does not expect the full amount of annual leave or long service leave balances classified as current liabilities to be settled within the next twelve months. However, these amounts must be classified as current liabilities since the Society does not have an unconditional right to defer settlement of these amounts in the event employees wish to use their entitlement. The non-current portion for this provision includes amounts accrued for long service leave entitlements that have not yet vested in relation to those employees who have not yet completed the required period of service. In calculating the present value of future cash flows in respect of long service leave, the probability of long service leave being taken is based upon historical data. The measurement and recognition criteria for employee benefits have been disclosed in Note 1(f).

	2020 $	2019 $

14. Notes to the Statement of Cash Flows

Reconciliation of cash flow from operations with surplus after income tax

Surplus for the year	249,825	453,916
Add/(less) non-cash items:		
Depreciation and amortisation	209,623	110,666
(Gain) loss on write down of plant and equipment	-	(520)
(Gain) loss on disposal of investments	(6,595)	(1,284)
Unrealised (gain) loss on investments held	138,075	(199,484)
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	(152,552)	(113,836)
(Increase)/decrease in other current assets	25,780	95,776
Increase/(decrease) in trade and other payables	546,216	(375,716)
Increase/(decrease) in provisions	54,823	20,603
Net cash provided by / (used in) operating activities	1,065,195	(9,879)

15. Related Parties

Directors

The following persons held the position of Director of the Society during the financial year:

Dr Yasmine Ali Abdelhamid, Dr Sidharth Agarwal, Dr Michael Ashbolt, Dr Danielle Austin, Dr Bronwyn Award, Dr Alastair Carr, Dr Michael Farquharson, Dr Rajeev Hegde, Dr Anthony Holley, Dr David Ku, Dr Kenneth John Millar, Dr Nhi Nguyen, Dr Mark Nicholls, Dr Sandra Peake, Dr David Pilcher, Dr Stephen Warrillow, Dr Bradley Wibrow.

Directors provided their services to the Society at no cost. There were no transactions with Directors during the financial year.

16. Key management personnel compensation

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the Society, directly or indirectly, including any director (whether executive or otherwise) of that company is considered key management personnel. The totals of remuneration paid to key management personnel of the company during the year are as follows:

	2020 $	2019 $
Short-term employee benefits	414,077	413,767
Post-employment benefits	53,043	38,781
Other long-term benefits	-	-
Key management personnel compensation	467,120	452,548

17. Financial risk management

The Society's financial instruments consist mainly of deposits with banks, local money market instruments, short-term and long-term investments, accounts receivable and payable.

The carrying amounts for each category of financial instruments, measured in accordance with AASB 9: *Financial Instruments* as detailed in the accounting policies to these financial statements, re as follows:

	Notes	2020 $	2019 $
Financial assets			
Financial assets at fair value through profit or loss:			
- investments in listed Australian securities	7	1,715,652	1,631,435
- investments in managed funds	7	2,603,583	1,838,242
Financial assets at amortised cost:			
- cash and cash equivalents	4	2,684,166	2,698,340
- trade and other receivables	5	323,981	162,676
Total financial assets		7,327,382	6,330,693
Financial liabilities			
Financial liabilities at amortised cost:			
- trade and other payables	11	696,260	170,255
Total financial liabilities		696,260	170,255

Refer to Note 18 for detailed disclosures regarding the fair value measurement of the Society's financial assets.

18. Financial instruments

The Society measures and recognises the following assets at fair value on a recurring basis after initial recognition:

- financial assets at fair value through profit or loss. The Society does not subsequently measure any liabilities at fair value on a recurring basis, or any assets or liabilities at fair value on a non-recurring basis.

Valuation Techniques

The Society selects a valuation technique that is appropriate in the circumstances and for which sufficient data is available to measure fair value. The availability of sufficient and relevant data primarily depends on the specific characteristics of the asset or liability being measured.

The valuation techniques selected by the Society are consistent with one or more of the following valuation approaches:

- the market approach, which uses prices and other relevant information generated by market transactions for identical or similar assets or liabilities;
- the income approach, which converts estimated future cash flows or income and expenses into a single discounted present value; and
- the cost approach, which reflects the current replacement cost of an asset at its current service capacity.

Each valuation technique requires inputs that reflect the assumptions about risks. When selecting a valuation technique, the Society gives priority to those techniques that maximize the use of observable inputs and minimize the use of unobservable inputs. Inputs that are developed using market data (such as publicity available information on actual transactions) and reflect the assumptions that buyers and sellers would generally use when pricing the asset or liability are considered observable, whereas inputs for which market date is not available and therefore are developed using the best information available about such assumptions are considered unobservable.

	Notes	2020 $	2019 $

18. Financial instruments (continued)

Recurring fair value measurements

Financial assets

Financial assets at fair value through profit or loss:			
- investments in listed Australian securities [(i)]	7	1,715,652	1,631,435
- investments in managed funds [(i)]	7	2,603,583	1,838,242
Total financial assets		4,319,235	3,469,677

(i) For investments in listed shares and managed funds, the fair values have been determined based upon closing quoted bid prices at the end of the financial reporting period.

19. Events subsequent to reporting date

Since the end of the financial year, the Directors note that COVID-19 continues to cause disruption to the economy. The duration and extent of the impact of the COVID-19 outbreak on the Society including the value of its investments, as well as the effectiveness of government and central bank responses, remains unclear at this time.

There are no other events or transactions which could render any particulars included in the financial statements to be misleading or inaccurate.

20. Contingent liabilities

There are no contingent liabilities as at 30 June 2020 (2019: $Nil).

	2020 $	2019 $

21. Capital and leasing commitments

Operating lease commitments

Non-cancellable operating leases contracted for but not recognised in the financial statements.		
Payable – minimum lease payments:		
- not later than one year	87,752	96,855
- later than one year and not later than five years	-	92,028
	87,752	188,883

The property lease commitments are a non-cancellable operating lease contracted for but not capitalised in the financial statements with a three-year lease term with an option to lease for a further three years. Increases in lease commitments are 4.0% per annum.

Directors' Declaration

The Directors of the Australian and New Zealand Intensive Care Society (the "Society") declare that, in the directors' opinion:

1. The financial statements and notes, as set out on pages 32 to 53, are in accordance with the *Australian Charities and Not-for-profits Commission Act 2012* and:
   (a) comply with Australian Accounting Standards – Reduced Disclosure Requirements applicable to the Society; and
   (b) give a true and fair view of the financial position of the Society as at 30 June 2020 and of its performance for the year ended on that date; and
2. There are reasonable grounds to believe that the Society will be able to pay its debts as and when they become due and payable.

This declaration is signed in accordance with subs 60.15(2) of the *Australian Charities and Not-for-profits Commission Regulation 2013.*

Dr Anthony Holley
President

Dr Danielle Austin
Hon. Treasurer

Dated this 25th day of September 2020

Independent Audit Report

TO THE MEMBERS OF AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

Report on the Audit of the Financial Report

Opinion

We have audited the financial report of Australian and New Zealand Intensive Care Society, which comprises the statement of financial position as at 30 June 2020, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

In our opinion, the accompanying financial report of the Australian and New Zealand Intensive Care Society has been prepared in accordance with Div 60 of the *Australian Charities and Not-for-profits Commission Act 2012*, including:

I. giving a true and fair view of the registered entity's financial position as at 30 June 2020 and of its financial performance for the year then ended; and

II. complying with Australian Accounting Standards and Div 60 of the *Australian Charities and Not-for-profits Commission Regulation 2013.*

Basis for Opinion

We conducted our audit in accordance with Australian Auditing Standards. Our responsibilities under those standards are further described in the *Auditor's Responsibilities for the Audit of the Financial Report* section of our report. We are independent of the entity in accordance with the ACNC Act, the ethical requirements of the Accounting Professional and Ethical Standards Board's APES 110: *Code of Ethics for Professional Accountants* (the Code) that are relevant to our audit of the financial report in Australia. We have also fulfilled our other ethical responsibilities in accordance with the Code.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Responsibilities of the Directors for the Financial Report

The directors of the registered entity are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the *Australian Charities and Not-for-profits Commission Act 2012* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement, whether due to fraud or error.

In preparing the financial report, the directors are responsible for assessing the registered entity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the registered entity or to cease operations, or have no realistic alternative but to do so.

Auditor's Responsibilities for the Audit of the Financial Report

Our objectives are to obtain reasonable assurance about whether the financial report as a whole is free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with the Australian Auditing Standards will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of this financial report.

As part of an audit in accordance with the Australian Auditing Standards, we exercise professional judgement and maintain professional scepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial report, whether due to fraud or error, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the registered entity's internal control.
- Evaluate the appropriateness of accounting policies used and the reasonableness of accounting estimates and related disclosures made by the directors.
- Conclude on the appropriateness of the directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the registered entity's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our auditor's report to the related disclosures in the financial report or, if such disclosures are inadequate, to modify our opinion. Our conclusions are based on the audit evidence obtained up to the date of our auditor's report. However, future events or conditions may cause the registered entity to cease to continue as a going concern.
- Evaluate the overall presentation, structure and content of the financial report, including the disclosures, and whether the financial report represents the underlying transactions and events in a manner that achieves fair presentation.
- Obtain sufficient appropriate audit evidence regarding the financial information of the entities or business activities within the entity to express an opinion on the financial report. We are responsible for the direction, supervision and performance of the entity audit. We remain solely responsible for our audit opinion.

We communicate with the directors regarding, among other matters, the planned scope and timing of the audit and significant audit findings, including any significant deficiencies in internal control that we identify during our audit.

C. W. Stirling & Co
Chartered Accountants

John Phillips
Director

Dated this 25th day of September 2020
Melbourne

Annual General Meeting

5.40 pm Tuesday 15 October 2019
Room 219, Melbourne Convention & Exhibition Centre, Melbourne

Attendance

Wisam Al-Bassam
Yasmine Ali Abdelhamid
Michael Ashbolt
Danielle Austin
Roland Bartholdy
Robert Bevan
Neeraj Bhadange
Marianne Chapman
David Cooper
Adam Deane
Michael Farquharson
Elizabeth Fugaccia
David Gattas
Con Giannellis
Peter Harrigan
Rajeev Hegde
Anthony Holley
Patricia Hurune
Ian Jenkins
Daryl Jones
Chris Joyce
Amod Karnik
Cameron Knott
Satyajith Velandy Koottayi
Christopher MacIsaac
Shona Mair
Nhi Nguyen
Mark Nicholls
Yvette O'Brien
Swapnil Pawar
Matthew Piercy
David Pilcher
Sam Radford
Mahesh Ramanan
Raymond Raper
John Santamaria
Manoj Saxena
Peter Seal
William Silvester
Malliux Uzzwal
Bala Venkatesh
Stephen Warrillow
Mary White
Bradley Wibrow
Marc Ziegenfuss
Gian Sberna (Chief Executive Officer)
Brent Kingston (Executive Assistant – Minutes)

1. Welcome, present & apologies

The President welcomed Members to the 2019 ANZICS Annual General Meeting at 5.40 pm and declared a quorum. Members present were as per the sign-in sheet, and apologies were noted.

2. Minutes of previous meeting

The Members ***RESOLVED*** to endorse the minutes of the 2020 ANZICS Annual General Meeting held on 12 October 2018 of meeting as a true and accurate reflection of proceedings. ***Carried by majority vote.***

3. President's report

The President addressed the members and reported on the following over the past 12 months:

- He thanked the CEO for providing support to the Board over the previous 12 months.
- He spoke of the move to the new office space from Ievers Terrace to Camberwell, and the upcoming plans for new office space.
- ANZICS has re-engaged with the World Federation and advised that Mary White was duly elected to represent ANZICS as Honorary Treasurer and he congratulated her on the appointment.
- There has been an increase in membership in the last 12 months, and ANZICS has been actively increasing the value to members.
- A World Congress was held, and a comprehensive and in depth review of the organisational purpose, goals and strategy was undertaken, including work on reviewing the governance structure seeking feedback from the members on a revised constitution.
- The MOU with the College of Intensive Care Medicine.
- The ASM Guidelines with the ACCCN have been reviewed.
- He acknowledged there needs to be improvement in relation to effective binational engagement with all members in both Australian and New Zealand. The Society has a lot of offer and he would like to see more members joining.

He thanked all the members for having an opportunity to serve the Society, colleagues on the Board, the Committee Chairs, Regional Representatives, ANZICS staff for keeping the Board on track, the current executive, and in particular the Immediate Past Presidents.

4. Chief Executive Officers Report

The CEO addressed the members and informed them of the areas of focus for ANZICS for the previous 12 months.

5. Governance Review

The CEO informed members a comprehensive governance review has been completed by the Board, CEO and a Strategic Governance Advisor. The review was undertaken to ensure the Society remains compliant with the Corporations Act that was implemented in 2001, and the ACNC Act, of which the Articles of Association were written well before these Acts and there was a need to modernise the structure. He confirmed the Society is currently compliant, and as part of the review the Board were given the appropriate board training.

The view was to make the Society simple and easy for members and to foster and grow collaboration and opportunities. The Board will be moving from 14 people down to a Board of 9, and the CEO provided a detailed description of the proposed new structure.

The Board will be a Board of Governance and underpinning this Board, it is proposed an ANZICS Council will be formed that is a strategic based Council and will ensure each State is adequately represented to have a voice, along with the Committee Chairs. Supporting the Board of Governance will also be the Executive, and Finance Risk and Audit Committee, which is to remain without change. The Board were in unanimous support of this structure, and lengthy discussions were had, along with many member consultations to achieve the final structure.

Members raised and discussed the structure, including the inclusion of the Board Secretary onto the ANZICS Council, and implementing an upper limit on the tenure a person can serve. A lengthy discussion then ensued on how the role, structure and implementation of the Board and Council would operate.

The CEO advised members were given options to provide feedback through the Committees and Regional Representatives and a significant amount of time went to the consultative process, with the document going through multiple iterations by incorporating all the feedback received. Subject to final feedback, the next steps will be draft and modernise the constitution and Articles of Association. The constitution will include the new structure as outlined, along with a new process for full membership applications and these will be approved through Regional Representatives. Members will have the opportunity to comment on the proposed constitution. The CEO advised they will be making an application to the ATO for Deductible Gift Recipient (DGR) status to assist with diversifying revenue streams and confirmed that by applying for this, it would not be in conflict with the Intensive Care Foundation (ICF) after concerns were expressed by some members.

The Board will have an annual standing agenda item to review the Board Charter once a year. The CEO acknowledged the right balance is required between strategic and governance in order to provide the best service for members and stakeholders to take ANZICS forward into the future.

6. Membership report

A due diligence process has been undertaken on a new property for ANZICS, which will fulfill the commitment to members after the sale of Ievers Terrace. The CEO presented 101 High Street, Prahan which is due to be completed in early 2022. Members were given a detailed overview on the location and proposed floor plans. The College of Intensive Care Medicine will be occupying levels 1 & 2, with ANZICS on level 3 meaning the two organisations will be collocated in the one building. The purchase price will be approximately the same as the sale price of Ievers Terrace ($3.4m) therefore there space will not be funded by debt nor would there be a need to dip into corpus. There is also the opportunity to bring in a tenant with the excess floor space and will generate income for the Society. The purchase of level 3 has unanimous support of the Board and an MOU will be entered into with the College to purchase the floor, which will morph into a legally binding contract of sale.

The CEO updated members on the strategic plan. He advised they were undertaking some in depth market research and will be seeking input from members, and further acknowledged the need to improve communication to current and future members.

ANZICS are wanting to build a sustainable organisation and commercialise its expertise to develop opportunities with partner groups that is advantageous to the society members. They are seeking to raise awareness of the intensive care practice of ANZICS and to raise awareness of intensive care outcomes for disadvantaged and diverse communities. There is active engagement with media and members were asked to provide stories and for members to engage that can be fed back through to the media.

A Global Health Committee with the College is about to be launched.

7. Treasurer's Report

7.1. 2018/2019 Year end Result

The Treasurer presented the finance results ending 2019:

- She advised a summary statement has been tabled for the information of members. A surplus of $452,916 is reported.
- Subscription revenue accounts for 60% individual members and the remaining relates to CTG subscriptions.
- The previous year ASM and other conferences were the major source of revenue.
- The proceeds of the sales of ANZICS house at levers Terrace were reinvested and a return of 13% was recorded.
- ANZICS holds assets of $6.7m, consisting of cash, minus liabilities of $1.9m and ~ $3m in investment resulting in a net position of $5,918,939.
- The budget was approved by the Board and is forecasting a small surplus. Within the budget, funding has been set aside for the region and for specific for projects which has yet to be determined. If members have some ideas for projects, they were invited to contact their Regional Chair or Regional Representatives as there may be funding available.
- YTD we are currently operating within the current budget.

The Members ***RESOLVED*** to approve the financial report as a true and accurate representation of the financial position of ANZICS. ***Carried by majority vote.***

8. Election of Office Barers

8.1. President: Anthony Holley

The Members ***RESOLVED*** to accept and ratify the nomination from Dr. Anthony Holley as President of ANZICS. ***All unanimous in support***.

8.2. Immediate Past President: Stephen Warrillow

The Members ***RESOLVED*** to accept and ratify the nomination from Dr. Stephen Warrillow as President of ANZICS. ***All unanimous in support***.

8.3. Honorary Treasurer: Danielle Austin

The Members ***RESOLVED*** to accept and ratify the nomination from Dr. Danielle Austin as Honorary Treasurer of ANZICS. ***All unanimous in support***.

8.4. Honorary Secretary: Dr Mark Nicholls

The Members ***RESOLVED*** to accept and ratify the nomination from Dr. Mark Nicholls as Honorary Secretary of ANZICS. ***All unanimous in support***.

The Immediate Past President thanked Dr. David Ku for his role as Secretary and for the role he undertook within the Organising Committee for the World Congress. Dr. Anthony Holley thanked Dr. Stephen Warillow for his leadership and inspiration during his term as President and congratulated him on an extremely successful World Congress in his role as Medical Convenor.

9. Membership Report

Dr. David Ku presented the membership report for the year. He noted growth was achieved in every single category of membership, that a new membership database is due to be implemented, and payments for renewal of membership will be streamlined. The Society continues to add value to the membership and will endeavour to connect with the community better with the new governance structure.

10. Professional Practice

10.1. Professional Affairs and Welfare Committee

Dr. Mark Nicholls spoke of the MBS Review Taskforce. He advised the review started in 2016 and a report was completed in 2017 that went through a long consultation process and were fortunate the MBS item numbers are largely unchanged. There are a number of new items that are due to come through, including Family Conference, ECMO and rapid response. Several meetings have been held to work through the time and descriptor notes and early stages discussions about a submission for ECMO and rapid response/code blue and how to work the specialists also be involved.

The physician report has been released and the plan is to move towards a time based structure and remove the difference between specialist and consultant fees. It was felt the recommendation was beneficial to intensive care specialists and therefore the Society did not make a submission and remained silent with the MBS review taskforce.

A burnout study was undertaken, and Shona was thanked for her work on the study. It was reported that 98.1% of intensivists have an average high compassion satisfaction, and 85% work in the job they want to, indicated it is a strong and robust workforce.

10.2. ANZICS Centre for Outcome and Resource Evaluation

A/Prof David Pilcher advised a funding submission was compiled to submit to jurisdictions for the next financial year. There are new reports coming to COMET users, that allows people to receive their reports without having to log on, and new comparative reports will be going onto the portal to make it easier to compare against other units.

He reported there were 14 publications, 4 education days and a variety of data-a-thon projects that continue to be ongoing and encouraged members to attend the next events due to be held in the coming months.

10. Professional Practice (continued)

10.3. ANZICS Clinical Trials Group

Dr Manoj Saxena reported the CTG are almost at 80 member units, noting there is strong support from the staff in the ANZICS office and a good year in terms of funding. A number of high profile publications were reported, and the year has seen people working collaboratively and cohesively across Australia and New Zealand. Elections for the Committee were held and Prof. Sandy Peak was elected to the position of Chair. He informed the Members there is a lack of representation from Tasmania and New Zealand and called upon the Society to help fill the two positions.

The remaining CTG meeting dates were tabled for the information of members.

10.4. Death and Organ Donation Committee

A/Prof Bill Silvester was pleased to report a complete review of the Death and Organ Donation has been undertaken. The whole statement has been rewritten and restructured, and DCD has been incorporated throughout the whole document. The family conversation section has also been rewritten and takes into account organ donation is a normalised part of end of life care. It is leading in terms of standards around organ donation and determination of death in Australian and New Zealand. The ANZICS Executive have approved the new edition (No. 4) and Bill Silvester expressed his appreciation to team, and the ANZICS Board and staff in assisting with the process.

Funding is being explored for the creation of a bedside app, and the team are developing a discussion paper on organ donation on voluntary assisted dying. Legislation is in place with VIC and potentially in WA. This is an area that ANZICS can show leadership from an ethical perspective, and the view as to engage the membership on feedback.

DODC has looked at world consensus statement on brain death. It was thought this could not be endorsed at this stage, as there are fundamental differences between ANZICS position and the Brain Death Statement.

The End of Lifecare Working Group can now start revising and reviewing the ANZICS Statement on Care and Decision Making in End of Life for the Critically Ill, and there continues to be external representation on a number of organ donation and transplant committees around Australia.

10.5. Education Committee

Dr Swapnil Pawar presented the Education Report.

Updates were provided on the ANZIC Clinical Educators Network formed of 8 enthusiastic intensivists. The first 'Unconference' was held the day prior to the 2018 ANZICS/ACCCN ASM online, and again prior to the World Congress.

The Education Committee have also supported the work of ANZCEN with circulating Clinician Incubator Program, with the concept of providing guidance to new educators in intensive care. Resources such as podcasts, and writing a thesis statement around interprofessional education, a number of publications are expected in the coming year.

11. Other Business

Nil to report.

12. Meeting Close & Next Meeting

There being no further business the meeting closed at approximately 7.10 pm.

The next meeting will be held at the 2020 ANZICS/ACCCN Intensive Care ASM on the 15 October 2020 at the International Convention Centre in Sydney, New South Wales.

CONFIRMED AS A TRUE RECORD OF PROCEEDINGS THERE AT BY RESOLUTION

Anthony Holley
President

..... / ..... / 2020

ANZICS

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