ANZICS

2013 Annual Report

Advocate for intensive care throughout Australia and New Zealand

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ANZICS

Advocate for intensive care throughout Australia and New Zealand

President's Report

The future of the Society: Strategic Planning

A Strategic Planning Workshop was held prior to the Board meeting in February this year. The Workshop was attended by the majority of the Board Directors. The Board reviewed the progress made against the goals and objectives agreed in the 2010 Strategic Planning process and attempted to establish the focus and objectives for the next three years. Our Society's stated goal is to be respected as a leading authority and advocate for intensive care in Australia and New Zealand. There was much discussion and many suggestions around how we maintain and consolidate that position including improving our visibility and profile, improving access to information and reports, showcasing ANZICS' achievements and regular review of ANZICS' relevance.

ANZICS Conferences and Scientific Meetings

The ANZICS/ACCCN ASM has been the premier educational event in Intensive Care in Australia and New Zealand for over 35 years. There is now increasing competition in that space. We must continually examine and re-invent this meeting in order to retain our key position. The Education Committee has been working hard exploring new and innovative options for the ASM and indeed all of our educational meetings to increase the output and exposure to ANZICS members. One of the ideas is to capture content at conferences, predominantly the ASM, and develop an online journal club for smaller, regional units or units with limited access to such resources or the ASM

The integration of CTG, CORE, Death and Organ Donation and other appropriate Standing Committees in to the main ASM programme is a welcome addition to the Hobart meeting. The inclusion of these sessions will provide an opportunity both to promote the work of the Committees to the wider membership and to engage with members.

The 2nd Singapore-ANZICS Intensive Care Forum took place in Singapore in July. It was a resounding success. Jonathan Tan, Jason Phua, Michael O'Leary and Charles Gomersall put together an impressive programme, "Intensive Care in Asia: Opportunities and Challenges". The Singapore-ANZICS Intensive Care Forum is well positioned to develop into a major educational resource for the region. The organisers are keen that the meeting become a regular feature on the ANZICS calendar. I would like to thank all who were involved.

ANZICS Global Rising Star Programme

The Global Rising Star Programme aims to identify promising and innovative young clinician/scientists and with assistance provided by Baxter Healthcare and ANZICS, to support their travel to the ANZICS ASM. At the ASM there will be a dedicated session so that delegates can listen to the latest research from the 'best and brightest' young minds in intensive care medicine from across the globe. This has been the brainchild of Adam Deane from the outset. He has put a tremendous amount of work into the programme for which we are very grateful.

The organisers have been very impressed with the quality of the applicants, with submissions from international clinician/scientists who have first or last author publications in Nature, New England Journal of Medicine, JAMA, Critical Care Medicine and American Journal of Respiratory and Critical Care Medicine. I hope that as many delegates as possible can attend what is likely to be a very innovative and exciting session at this year's ASM.

CORE

The proposed move of CORE to Monash is off the table for the foreseeable future. The initial benefits of Monash hosting the CORE Enterprise Reporting System (CERS) to provide the required security has now been negated with the recent upgrade of the ANZICS IT network which includes the facility to host identified data meeting the ACSQHC technical specification for Quality Clinical Registries. The Board and the Executive were completely supportive of the move to Monash as long as it could be achieved without risk to ANZICS CORE and the Society. I am confident that the correct decision has been made at this time.

On behalf of the Board I would like to thank David Pilcher and all the members of the CORE Management and Advisory Committees for the considerable amount of work which has been committed to this endeavour over the past three years. David has put a significant amount of personal effort into this for which we are very grateful.

There is a considerable amount of extremely important work being undertaken by CORE at the moment, including the CERS project and the redesign of AORTIC. I would encourage you to read Dave's report where he goes into this in more detail. As a result of this work ANZICS CORE aims to demonstrate to potential funders that CORE is setting a foundation for improved registry services into the future to meet the needs of the clinical community and the jurisdictions.

President's Report

Work continues on the funding arrangements for private hospitals in Queensland.

The 2010-11 CORE Annual Report was published in early February and can be viewed at http://www.anzics.com.au/core/reports. I would encourage you to read this comprehensive and extremely informative report.

Safety and Quality

The Australian Commission on Safety and Quality in Health Care has published 10 standards for safety and quality. These standards have the potential for significant impact on the practice of intensive care. By the time you read this the SQAO conference will have taken place in Sydney. These standards were among some of the very important topics discussed at the meeting. The meeting was a tremendous success with over 80 registrants.

Independent Hospital Pricing Authority

ANZICS continues its advocacy role on behalf of the members in our engagement with the IHPA. A consultation paper has been released by the IHPA on the Pricing Framework for Australian Public Hospital Services 2014-15. As you will remember the plan for 2013-14 had been to use the CICM Level 3 classification as a basis for payment of the ICU adjustment. ANZICS felt that there was significant risk of disadvantage to smaller units should that classification be used. In response to the concerns raised for the first two funding periods 2012/2013 and 2013/2014 the IHPA invited the jurisdictions to include any additional hospitals where they saw fit.

The plan for 2014-15 is to use hours of invasive mechanical ventilation as the basis of the intensive care adjustment. Whilst mechanical ventilation is a marker of severe illness, of itself it may not accurately reflect the patient-mix or the complexity of modern intensive care practice. ICU admission may be required to support other organ system failures in the absence of a need for invasive mechanical ventilation. Neither does it reflect the significant role now required of ICUs under the ACSQHC Safety and Quality Standards to provide support for deteriorating patients outside of intensive care. We have represented that view to Dr Tony Sherbon CEO of the IHPA and we will continue to engage on our members behalf on this very important issue. The IHPA are keen to engage with the Society understanding that ANZICS through its annual CCR survey is the single biggest repository of data related to intensive care practice in Australia.

PricE

Workforce planning issues remain a concern amongst members, many of whom have communicated their concerns to the Society and also to the College. There are reports of unemployed and underemployed Fellows particularly in the Eastern states. There are other reports of positions being advertised with no applicants. There would appear to be a trend towards employing new consultants on very short-term contracts. The College has recently surveyed all Fellows up to three years post qualification addressing some of these issues.

ANZICS has surveyed all members and Unit Directors on the workforce issue. There is a wealth of information regarding the work status of members captured currently in the CCR survey. Hopefully we will gain some useful information and with the College can continue to engage with HWA on this very important issue.

In line with the advocacy role of ANZICS, Ian Jenkins on behalf of PricE has made a submission to the discussion paper on Reform to Deductions for Education Expenses. PricE has also been involved more recently in discussions with DoHA around item numbers for out of ICU activities.

Death and Organ Donation Committee

The Death and Organ Donation Committee has recently published the revised ANZICS Statement on Death and Organ Donation. The current version *3.2* is published in electronic format.

The End Of Life Care Working Group continues to work on the next version of the statement on End of Life Care (formerly Withholding and Withdrawing). This is an enormous task which will have far reaching consequences for practice in this key area of intensive care. I would like to thank all who are involved.

The survey on attitudes to organ donation has recently been circulated. I cannot emphasise strongly enough the potential of the results of this survey in terms of informing AOTA policy and intensive care practice in this other key area. It is gratifying to realize that AOTA sees this area as fundamentally within the scope of practice of intensive care physicians.

President's Report

CTG

The CTG goes from strength to strength. The track record of the CTG in attracting funding is a testament to its success as a research group. Significant grants were awarded to a number of projects including SPICE and RELIEF. The RELIEF study, a collaborative study with the ANZCA Trials Group of peri-operative fluid management, was also funded and particularly notable as the highest scoring proposal in that NHMRC round.

There were a number of significant publications during the past year including two in the New England Journal of Medicine (CHEST and the NICE-SUGAR hypoglycaemia analysis). CHEST was published to great acclaim in November 2012 and significant changes to clinical practice have ensued. Congratulations also to all involved in the Early PN study which was published in JAMA in May of this year.

There have been a number of excellent CTG run meetings during the year which have challenged our traditional ways of thinking. The Novel Trial Design Workshop was just such an event. All of these factors contribute to that continual re-invention which makes the ANZICS CTG such a success.

None of this would be possible without the tremendous hard work and dedication of the intensive care community in both countries. We are incredibly fortunate to have such a committed group of research coordinators who work tirelessly to further the cause. Their engagement and support is central to the success of the CTG. The hard work of the doctors and nurses at the bedside also cannot go unrecognized.

Steve Webb stood down from his position as Chair in December 2012 following three and a half years of excellent leadership for which we are very grateful. I am confident that the stewardship of Colin McArthur will maintain the tremendous track record. He and the truly dedicated CTG Executive must also be congratulated for all of their efforts.

World Federation of Societies of Intensive and Critical Care Medicine

The 11th Congress of the WFSICCM was held in Durban in August this year. ANZICS has a proud tradition of involvement with the World Federation having been there at the foundation. Malcolm Fisher and Geoff Dobb have demonstrated tremendous commitment and involvement in the past. Unfortunately we have had no Australian and New Zealand representation for the past few years. I am delighted to be able to congratulate John Myburgh on his election as the ANZICS representative to the Council. I am sure that John will be a worthy advocate for the Society.

Steven Warrillow also attended to bid on behalf of ANZICS to host the World Congress in Melbourne in 2019. I am delighted to say that the bid was successful. Steven has put a prodigious amount of work into this endeavour over a number of years. We are very grateful to both him and John.

ANZICS India Knowledge Exchange Initiative

This has now taken place for the second time. Geoff Shaw, Michael O'Leary and Ed Litton represented ANZICS and presented in Mumbai and Delhi. I would like to thank them for giving so generously of their time to support this initiative.

Governance Review

Discussions about Governance can cause anxiety among some doctors and I would include myself in that group. Having now spent two years in this position I recognise the vital importance of good governance to the success of our Society. Governance is simply about maximising quality and reducing risk. I am sure we would all agree that these should be the guiding principles for delivery of good outcomes for our members, for the wider intensive care community and for our patients. There has been a considerable amount of work done over the past 18 months on the Governance Review project, with a number of key policy documents having been reviewed by the Board and the production of a robust Endorsement policy.

President's Report

ANZICS Central

Many of you will be aware of Erin O'Sullivan's resignation. Erin has worked in the General Manager position at ANZICS for over four and a half years. During that time she has proved herself to be an incredibly hard working and valuable member of our team. Her commitment to the Society, its values and the members has been extraordinary. She has always been a tremendous advocate for the staff at ANZICS House. On a personal note, she has been a great support to me in my role as President, always available, helpful and willing to engage in whatever task was presented. We wish her well in her new venture.

I would like to welcome Justin Williams to the GM position. Justin comes to us having worked as a Director with Deloitte in the not-for-profit section. His experience in this area will I am sure be of great value to the Society. I am looking forward to working with him as ANZICS continues to grow and develop.

There was an interim of a month between Erin's leaving and Justin's start. Gloria Sleaby who has previously worked with the Intensive Care Foundation stepped into the breach as acting GM. I would like to take this opportunity to thank all of the staff at the House for working so hard during that time and indeed all of the time. We have an incredibly committed and hard-working team at the House who work tirelessly to ensure that the Committee and Society outputs are maintained at the highest standard. Alex Reade and Brent Kingston, Joy Najm and Don Stewart (Central), Chris Nash (Education, ASM and DOD), Sue Huckson (CORE), Jenny Holmes (S and Q) and Donna Goldsmith and Simone Rickerby (CTG), thank you all very much.

I have come to the end of my two year term as President. I wish to thank the members of the Exec; Andrew Turner, Marc Ziegenfuss and Simon Erickson for all of their support during that time. I would also like to thank the Board members and chairs of the Standing Committees for their hard work and dedication. We have had two College of Intensive Care Medicine Presidents sit on the Board during my time, John Myburgh and Ross Freebairn and we are very grateful to both of them. During my term as President I have also been lucky enough to be invited to attend and speak at a number of ANZICS and CICM meetings. I have met many extremely hard-working intensive care doctors and members of our Society, who are excellent clinicians often working in difficult environments. So many of these people give so much extra to the intensive care community and our patients in terms of their contributions to education, research and administration. I salute them and thank all of the ANZICS members who have been so incredibly supportive to me during my time as President.

Mary White
President

Treasurer's Report

Dear ANZICS Members,

The financial position of your Society remains sound. The last financial year was well weathered with the Society recording its fourth consecutive annual budget surplus. This was due to the conservative approach of the Board in drafting last year's budget, reduced expenditure and unexpected income generated during the financial year. However, compared to turnover, the Society generated a very modest profit, resulting in a 2.3% increase in net total equity for the Society to $ 4.068 Million.

The Adelaide ASM generated a favourable result instead of the anticipated breakeven result. The Safety and Quality meeting and India Scientific Exchange Initiative also yielded favourable financial outcomes for the Society. The Society is grateful for the organising committee's and volunteer's efforts for these events.

ANZICS CORE, the ANZICS CTG and other Committees reported budget surpluses gained by increased incomes and reduced expenditures through efficiencies. Their respective management groups are to be congratulated for their continued efforts.

From a whole of Society, financial management and risk perspective, the Finance, Risk and Audit Committee has reconvened, its Terms of Reference have been finalised and a management plan for this group is currently being drafted. This Committee is central to our Society continuing to perform well while minimising financial risk.

I would also like to thank KPMG for their continued support of the Intensive Care Foundation.

Looking ahead, ANZICS continues to enjoy a stellar international reputation as a respected pillar of intensive care practice especially in Australia and New Zealand, and also worldwide. The Board will seek to provide financial support for initiatives that further the interests of the membership pertaining to all issues related to our profession. ANZICS Central will seek further opportunities and efficiencies to support the Committees and Working Groups. We will follow political trends closely and manoeuvre ANZICS to position itself to ensure strong membership representation and a proactive approach to uphold the values for which ANZICS is renowned and respected.

Marc Ziegenfuss
Honorary Treasurer

ANZICS Board of Directors

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Mary White

Vice President
Andrew Turner

Honorary Treasurer
Marc Ziegenfuss

Honorary Secretary
Simon Erickson

Paediatrics
Johnny Millar

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David Pilcher

Clinical Trials Group (CTG)
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Tasmania Regional Chair
David Rigg

Victoria Regional Chair
Stephen Warrillow

New South Wales Regional Chair
Satyadeepak Bhonagiri

Queensland Regional Chair
Anthony Holley

Western Australia Regional Chair
Ian Jenkins

South Australia Regional Chair
Stewart Moodie

General Manager's Report

The past year has been one of change and of setting direction. ANZICS has seen the departure of long serving General Manager, Erin O'Sullivan, the decision for ANZICS CORE to remain at ANZICS House and the renewed initiative for CTG to run sessions at the ASM in lieu of the Spring Research Forum.

In taking on the role of General Manager, I would like to take this opportunity to thank Erin for having amassed the fantastic team that is behind the continued growth and success of ANZICS. Additionally, due to the timing of Erin's departure and my commencement I would like to thank the staff of ANZICS for continuing their great work and commend Gloria Sleaby for stepping in as Acting General Manager.

Back to the year in review, the planned relocation of ANZICS CORE to Monash University was found to be not financially viable. This finding enabled the redirection of resources toward the CERS (CORE Enterprise Reporting System) project and the redevelopment of AORTIC (Australasian Outcomes Research Tool for Intensive Care).

Increasing member engagement continues to be critical to ANZICS long-term success. In order to enhance your organisation, ANZICS is assessing how we can best meet your needs. One of the first initiatives being assessed is redeveloping the ANZICS website. The focus of this is to provide members with an interactive touchpoint and valuable information resource, rather than being a static website.

The Committees and Regions remain a hive of activity. Their achievements and success are a direct correlation to the continual involvement and dedication by active members. The CCR and Workforce surveys were also completed this year as part of the ANZICS commitment to improving service to you, the members.

The preparation required in running a high quality ASM continues to grow and, in recognition of this, the ASM 2014 Committee have commenced planning (more than 14 months out from the event).

The activities of the past year have also included a widening of focus for the Society and involvement in international events beyond our bi-national boundaries such as; the ANZICS India Scientific Initiative, and the 2nd Singapore ANZICS Intensive Care Forum 2013. Activities such as these provide international exposure and context for ANZICS.

As always, the considerable growth and accomplishments that provide a solid platform for further relevance and expansion would not be possible without the hard work and commitment of the staff at ANZICS and the members.

Justin Williams
General Manager

ANZICS Activities 2012/2013

6th International Conference on Safety, Quality, Audit & Outcomes Research in Intensive Care (SQAO 2012), July 2012

24th ANZICS Intensive Care Medicine Course Focusing On ICU Management Of The Critically Ill', August 2012

'ANZICS/ACCCN ASM, Adelaide, October 2012'

'ANZICS Clinical Trials Group Spring Research Forum 2012', October, 2012

29th Australian Short Course On Intensive Care Medicine', February 2013

'ICU Research Coordinator Workshop 2013', March 2013

ANZICS Clinical Trials Group 15th Annual Meeting on Clinical Trials in Intensive Care – Noosa 2013

'ANZICS NZ Conference 2013', March 2013

'ANZICS Clinical Trials Group Novel Trial Design Workshop', Wellington, May 2013

Membership Report

ANZICS continues to thrive with an ever growing membership. A growing membership is essential to both maintain and expand the role of ANZICS in advocating for Intensive Care Practitioners in Australia and New Zealand. While ANZICS is dependent on its members, it is important that ANZICS fulfils its important role in supporting its members and acts always in the interest of its members in the intensive care community, which faces more and more challenges every year.

The membership of ANZICS continues to grow (up by 4%) thanks to the enthusiastic role played by the ANZICS link-persons and regional chairs. It is particularly encouraging to see a big increase in trainee memberships.

ANZICS continues to offer its membership educational opportunities, research activities, quality assurance, industrial activity and professional development. However it is incumbent on ANZICS to continually reassess its role and the value it provides to its members.

The future of ANZICS depends on up-and-coming trainees and consultants getting involved in ANZICS activities and continually driving the society forward.

Simon Erickson
Honorary Secretary

Membership Totals:

Total: 740

Country:

AU ANZICS Members: 636

NZ ANZICS Members: 97

Broken down by type:

Full: 485

Trainee: 129

1st Year Free Trainee: 33

Associate: 42

Affiliate: 44

Honorary: 7

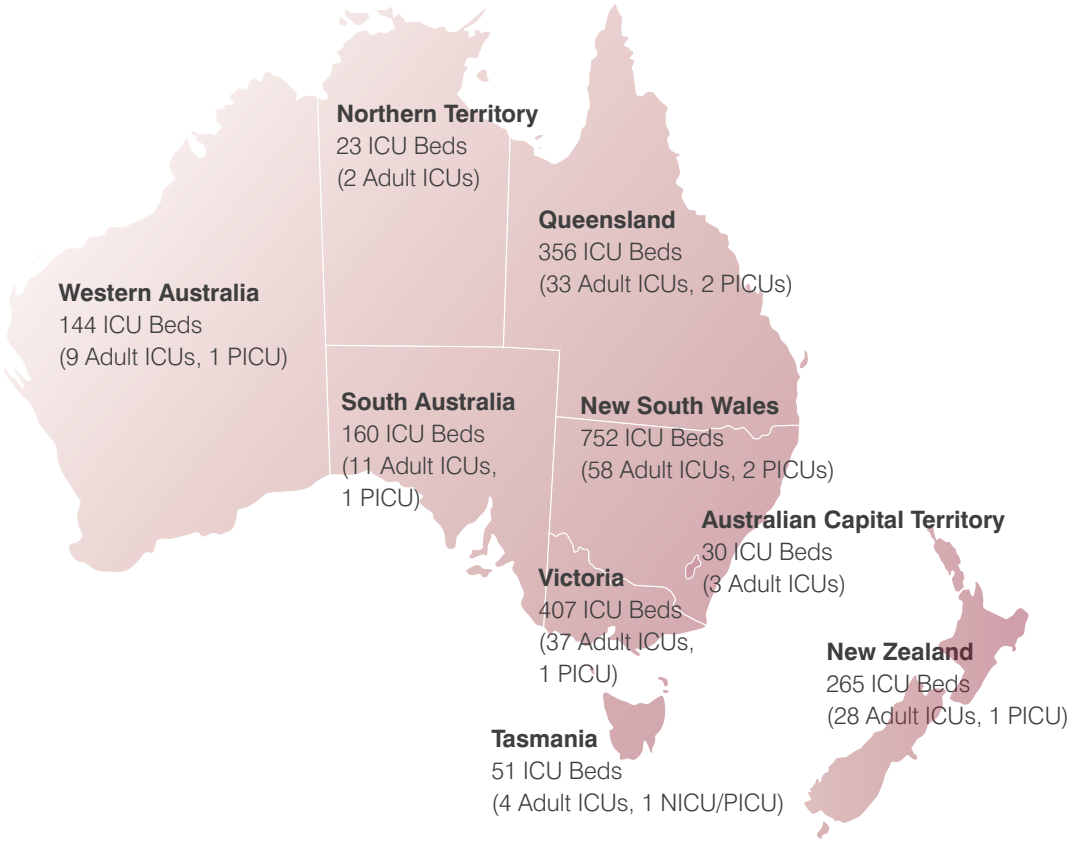
Committee Reports

ANZICS Centre for Outcome and Resource Evaluation

The past year has seen a number of developments at ANZICS CORE. Under the direction of manager Sue Huckson, the group has built on its reputation as one of Australia and New Zealand's most well recognised clinical registries to become more even productive. We have welcomed new member hospitals and seen staff members returning from maternity leave to bring CORE to its full complement of staff for the first time in a number of years.

Present ANZICS CORE Registry Activities

Submissions to the Adult Patient Database have grown to over 120,000 per year and there are presently over 10,000 submissions to The ANZ Paediatric Intensive Care Registry. With the progressive decline in hospital mortality for adult admissions to ICU from 15% in the late 1990's to less than 10% now in the early 2010's, there has been increased focus on new markers of quality of care in the ICU. CORE has introduced additional reports which detail the ICU's readmission rates, after-hours discharge rates and provision of prophylaxis for venous thrombo-embolism which are available through the ANZICS CORE web portal http://www.anzics.com.au/core. The new Central Line Associated Blood Stream Infection Surveillance Reporting system https://anzics-clabsi.registry.org.au has been collecting data for one year and presently provides comparative reports to 45 hospitals with the anticipation of another 20 more in the near future. Through activities such as the Critical Care Resources Registry, ANZICS CORE is unique in being able to describe the provision of ICU services throughout Australia and New Zealand. On-line reports comparing ICU resources, beds and staffing levels are now also available to all contributing units http://www.anzics.com.au/apd/apd-reports-a-sas-portal.



Committee Reports

External Collaborations & Research

Numerous projects and collaborations have developed this year with other organisations: the Australian Commission for Safety and Quality in Health Care, The Australian Organ and Tissue Donation and Transplantation Authority, The Australian and New Zealand Society of Cardiac and Thoracic Surgeons and The Health Departments of Tasmania and Victoria to name but a few. The research output has increased significantly through collaboration with hospital based research groups through the country and the ANZIC-Research Centre at Monash University and has resulted in numerous publications this year. Anyone interested in being involved in research with ANZICS CORE should contact us at anzics.core@anzics.com.au.

Development of the ANZ Risk of Death Model

Over the past ten years, reports from ANZICS CORE to contributing ICUs have used the APACHE severity of illness scoring system to risk adjust adult mortality outcomes. In modern Australian and New Zealand ICU outcomes are consistently better than predicted by APACHE III-j. Over the past 2 years ANZICS CORE, in conjunction with Monash University has developed a mortality prediction model specifically tailored for use in modern adult Australasian Intensive Care practice. This is undergoing final phases of testing prior to introduction into routine clinical practice and a paper describing its development is due for publication in the Journal of Critical Care later this year.

ANZICS CORE engaging with the ICU clinical community

Clinician seminars: A new CORE initiative in 2011/12 was introduced offering seminars for clinicians with the aim to encourage local site base engagement in the use of CORE data and how it can be used to support quality activities and research. The seminars also provide opportunities for clinicians to become familiar with the features of the AORTIC software, which is freely available from CORE, to interrogate their local data sets. These have been very successful with multiple requests to provide additional forums.

Paediatric Clinical Advisory Group (PaedCLAG): This year saw the establishment of the ANZPICR Paediatric Clinical Advisory Group (PaedCLAG). A resolution from the Paediatric Study Group was to establish a group with representation from all PICU's to oversee unit-identified data review and strategic planning for the ANZPIC Registry.

Outlier Working Group: In 2012 a new 'Outlier Working Group' was established including members of the CORE management committee and additional ICU clinicians with strong statistical backgrounds. The group ensures that the analyses provided to units are as complete and appropriate as possible, as well as providing a regional perspective where possible. The group has assisted with feedback to aid in the refining of the outlier management process, and we look forward to working with the group in the future to further improve the analysis we provide to units. All outlier analyses remain confidential and are provided to the unit itself and the local jurisdictional body where appropriate.

Despite the achievements described above there have been hurdles and disappointments this year:

Queensland and Funding from Private Hospitals

ANZICS CORE is funded through agreements with jurisdictional health departments. The decision by Queensland Health to reduce their funding for ANZICS CORE activities has led to contracts being sought directly with private hospitals in Queensland. Presently half the private hospitals in the state have committed to joining the ANZICS CORE quality assurance and reporting program. However there remain a number of hospitals who are yet to decide. This presently represents a funding shortfall for ANZICS CORE and compromises our ability to report and benchmark outcomes of private hospital ICUs.

The "Monash Move" is off

Since 2010 ANZICS CORE had been in discussion with Monash University to relocate to the Department of Epidemiology and Preventive Medicine at Monash University. In April 2013, a decision was made that CORE would remain situated at ANZICS House in Carlton. The costing models for the transition were not viable for ANZICS CORE. CORE continues to have a strong with Monash through ANZICS RC and the Registries Special Interest Group.

A final word and thanks

We look forward to the next year with anticipation as we embark on new projects which have the capacity to alter not only the way CORE works, but also change the way Intensive Care practice is monitored throughout Australia and New Zealand. These include the redevelopment of AORTIC, redesign of the ANZICS CORE reporting system and introduction of the new ANZ Risk of Death model for adult Intensive Care. A final big thank you to all the staff at CORE for their hard work and dedication (without you we are nothing!), to everyone who collects the data (without you, we have nothing!) and to all the clinicians who support CORE's activities.

David Pilcher
Chair, ANZICS CORE

Committee Reports

Quality of Care Research

Blyth, Christopher C, Steve A R Webb, Jen Kok, Dominic E Dwyer, Sebastiaan J van Hal, Hong Foo, Andrew N Ginn, et al. "The Impact of Bacterial and Viral Co-infection in Severe Influenza." Influenza and Other Respiratory Viruses 7, no. 2 (March 2013): 168–176.

Coventry, Charles, Arthas Flabouris, Krish Sundararajan, and Tracey Cramey. "Rapid Response Team Calls to Patients with a Pre-existing Not for Resuscitation Order." Resuscitation 84 no.8 (January 29, 2013): 1035-1039.

Flabouris, Arthas, Jellsingh Jeyadoss, John Field, and Tom Soulsby. "Association Between Emergency Department Length of Stay and Outcome of Patients Admitted Either to a Ward, Intensive Care or High Dependency Unit." Emergency Medicine Australasia: EMA 25, no. 1 (February 2013): 46–54.

Flabouris, Artha Jeyadoss, Jellsingh, Field, John, Soulsby, Tom . "Direct and Delayed Admission to an Intensive Care or High Dependency Unit Following Discharge from the Emergency Department: Associated Patient Characteristics and Hospital Outcomes." Critical Care and Resuscitation: Journal of the Australasian Academy of Critical Care Medicine 14, no. 3 (September 2012): 191–197.

Karalapillai, D, D Story, G K Hart, M Bailey, D Pilcher, A Schneider, M Kaufman, D J Cooper, and R Bellomo. "Postoperative Hypothermia and Patient Outcomes after Major Elective Non-cardiac Surgery." Anaesthesia 68, no. 6 (June 2013): 605–611.

Kok, Jen, Christopher C Blyth, Hong Foo, Michael J Bailey, David V Pilcher, Steven A Webb, Ian M Seppelt, Dominic E Dwyer, and Jonathan R Iredell. "Viral Pneumonitis Is Increased in Obese Patients During the First Wave of Pandemic A(H1N1) 2009 Virus." PloS One 8, no. 2 (February 2013): e55631.

Tiruvoipati, R, J A Botha, D Pilcher, and M Bailey. "Carbon Dioxide Clearance in Critical Care." Anaesthesia and Intensive Care 41, no. 2 (March 2013): 157–162.

Visser, Philip, Linton R Harriss, Graeme K Hart, Megan Bohensky, Lalitha Sundaresan, and Marcus Kennedy. "Factors Involved in Intensive Care Unit Mortality Following Medical Retrieval: Identifying Differences Between Intensive Care Unit Survivors and Non-survivors." Emergency Medicine Australasia: EMA 25, no. 3 (June 2013): 260-267.

Health Services Research

Bohensky, Megan A, Damien Jolley, David V Pilcher, Vijaya Sundararajan, Sue Evans, and Caroline A Brand. "Prognostic Models Based on Administrative Data Alone Inadequately Predict the Survival Outcomes for Critically Ill Patients at 180 Days Post-hospital Discharge." Journal of Critical Care 27, no. 4 (August 2012): 422 e11-21.

Flabouris, Arthas, Graeme K Hart, and Angela Nicholls. "Accessibility of the Australian Population to an ICU, and of ICUs to Each Other." Critical Care and Resuscitation: Journal of the Australasian Academy of Critical Care Medicine 14, no. 3 (September 2012): 177–184.

Flabouris, Arthas, Hart, Graeme K, Nicholls, Angela "Patients Admitted to Australian Intensive Care Units: Impact of Remoteness and Distance Travelled on Patient Outcome." Critical Care and Resuscitation: Journal of the Australasian Academy of Critical Care Medicine 14, no. 4 (December 2012): 256–267.

Godfrey, George, David Pilcher, Andrew Hilton, Michael Bailey, Carol L Hodgson, and Rinaldo Bellomo. "Treatment Limitations at Admission to Intensive Care Units in Australia and New Zealand: Prevalence, Outcomes, and Resource Use*." Critical Care Medicine 40, no. 7 (July 2012): 2082–2089.

Ho, Kwok M, and Shaila Chavan. "Prevalence of Thrombocytosis in Critically Ill Patients and Its Association with Symptomatic Acute Pulmonary Embolism. A Multicentre Registry Study." Thrombosis and Haemostasis 109, no. 2 (February 2013): 272–279.

Kasza, J, J L Moran, P J Solomon, for the ANZICS Centre for Outcome and Resource Evaluation (CORE) of the Australian, and New Zealand Intensive Care Society (ANZICS). "Evaluating the Performance of Australian and New Zealand Intensive Care Units in 2009 and 2010." Statistics in Medicine (March 25, 2013).

Litton, Edward, Kwok M Ho, and Steven A R Webb. "Comparison of Physician Prediction with 2 Prognostic Scoring Systems in Predicting 2-year Mortality after Intensive Care Admission: a Linked-data Cohort Study." Journal of Critical Care 27, no. 4 (August 2012): 423.e9–15.

Moran, John L, and Patricia J Solomon. "Statistical Process Control of Mortality Series in the Australian and New Zealand Intensive Care Society (ANZICS) Adult Patient Database: Implications of the Data Generating Process." BMC Medical Research Methodology 13, no. 1 (May 24, 2013). 66.

Committee Reports

Clinical Trials Group

Over the past year, the CTG has continued to further its mission to promote collaborative multi-centre clinical research in intensive care and focus on improving patient-centered outcomes. Major achievements include further funding from the National Health and Medical Research Council (NHMRC) and the Health Research Council (HRC) of New Zealand, adding to a CTG cumulative total of over $50M, and publication of 2 manuscripts in the New England Journal of Medicine – the CHEST study and the NICE-SUGAR study hypoglycaemia analysis.

There has been significant success in NHMRC project funding in the past year with the SPICE (Sedation Practice in Intensive Care Evaluation) researchers being awarded $2.75M to conduct a phase III study of early goal-directed sedation vs standard care, and the RELIEF study (a phase III trial of liberal versus conservative fluid therapy for patients undergoing major elective surgery), a collaboration of the Australia and New Zealand College of Anaesthetists Trials Group and the ANZICS CTG receiving $2.38M. There were also awards from the HRC of New Zealand with a $214,000 to support the BLING phase II study of beta-lactam antibiotics administered by infusion vs intermittent dosing and $149,000 for 'HOT or NOT' (a feasibility study of hyperoxic vs normoxic post cardiac arrest care).

Furthermore, a successful multi-million euro international collaborative application to European funders focused on respiratory infection is likely to lead to CTG involvement in the future. This is illustrative of the growing spectrum of international research links for the CTG, both from local trials expanding to include international sites, and collaborative programmes to develop global research strategies in particular through the International Severe Acute Respiratory and Emerging Infection Consortium (ISARIC) and the International Forum of Acute Care Trialists (InFACT). As there were several major studies funded in late 2011, there were no CTG applications to the NHMRC this year. However, support funding from New Zealand's HRC for RELIEF and SPICE is being sought, along with feasibility project funding for SPLIT (a pilot cluster-crossover trial of 0.9% saline vs balanced salt solution for ICU resuscitation).

The culmination of many years' work from several CTG studies has occurred in the past year with publications in major journals. These include the phase II STATINS (RCT of atorvastatin in sepsis) and the SPICE observational studies in the "Blue Journal" (AJRCCM), ENTERIC (RCT of early nasojejunal vs nasogastric tube feeding) in Critical Care Medicine, the Early PN study (RCT of early parenteral nutrition in patients not initially expected to be enterally fed) in the Journal of the American Medical Association and the analysis of hypoglycaemia and risk of death from the NICE-SUGAR study in the New England Journal of Medicine. Also published in the New England Journal was the 7000-patient CHEST study, the largest RCT ever conducted in intensive care, which compared resuscitation with hydroxyethyl starch in saline vs 0.9% saline alone. This in conjunction with other research groups' results lead to regulators in the UK, Europe and the USA limiting or withdrawing use of hydroxyethyl starch products in the critically ill.

The past year has seen recruitment commence in TRANSFUSE (fresh vs standard issue red call transfusion), ADRENAL (low dose hydrocortisone vs placebo in septic shock), HEAT (paracetamol vs placebo in fever associated with sepsis) and PHARLAP (staircase recruitment in ARDS). A growing number of studies including ARISE (early goal-directed resuscitation in sepsis), ADRENAL, two studies in traumatic brain injury (POLAR and EPO-TBI), and TRANSFUSE now have active recruitment from sites outside Australia and New Zealand including in Ireland, United Kingdom, Finland, Denmark, France, Saudi Arabia, Hong Kong and Singapore, with more countries under consideration.

There are also international collaborative programmes such as SuDDICU (selective digestive tract decontamination) and ISARIC which will be seeking local study sites. Wider inter-disciplinary collaboration with local researchers is also extending in anaesthesia (RELIEF), emergency medicine (ARISE), infectious diseases (BLING, ARISE), physiotherapy (TEAM, PHARLAP) and dieticians with ICU nutrition studies.

Crucial to the development of high quality research programmes are the regular meetings held by the CTG for study presentation and debate. Over the past year we have held the Winter Research Forum (Melbourne), the Spring meeting prior to the ANZICS ASM in Adelaide and our major annual meeting in Noosa in March. Prof Jean-Daniel Chiche, President of the European Society of Intensive Care Medicine was the main guest speaker at Noosa with 190 delegates attending, including 90 research coordinators meeting for a day prior to the main gathering. A very successful 'Novel Trial Design' meeting was also held in Wellington in May, prior to the College ASM, to explore adaptive and cluster-crossover trial designs, with Prof Roger Lewis and Prof Derek Angus the international speakers. We look forward to these approaches to trial design featuring in CTG studies in the next few years.

Committee Reports

On behalf of the CTG Executive, I would like to thank Donna Goldsmith, our Executive Officer, and Simone Rickerby, Executive Assistant, who have tirelessly done a superb job in organising and coordinating the CTG's activities over the past year. Thanks also to our sponsors, CSL Biotherapies, who have assisted with this report as well as our meetings, and also Hospira, Covidien, Baxter, Spiral Web Solutions who have been meeting sponsors.

Finally, I would like to acknowledge and thank Steve Webb who stepped down as CTG Chair in December after three and a half years in the role, and who has been a major contributor to the growth of the CTG over this time. Thanks also to Jamie Cooper, the previous immediate past Chair who retired from the Executive after 11 years; his knowledge and wisdom will be missed.

Colin McArthur
Chair, ANZICS CTG

Death and Organ Donation Committee

DODC Activity

During this year the DODC has further revised the ANZICS Statement on Death and Organ Donation (latest version on line) and will be meeting by teleconference to review further responses to the changes.

ANZICS Survey Regarding Organ Donation 2013

In June of 2013 the Death and Organ Donation Committee ran a survey regarding organ donation. This survey was last performed in 2006 and with the inception of The Australian Organ and Tissue Authority (AOTA), there have been some significant changes in this area. In addition to general questions regarding attitudes and practice in organ donation, there were also questions regarding the new AOTA family conversation workshops (FDC). These workshops have been suggested as part of the new curriculum. Oversight of the data analysis will be by the DODC.

AOTA Activity

The Australian Organ & Tissue Authority (AOTA) continue to roll out the family donation conversation (FDC) workshops. Thus far there have been 22 FDC core workshops held around Australia with a total attendance of nearly 590 clinicians (intensivists, ICU nurses, organ donor coordinators, emergency department doctors). The feedback has continued to be positive. There have also been 22 practical FDC workshops with nearly 300 participants with positive feedback on the benefit of the end of life conversation training. The trial of the 'collaborative' and 'designated requester' models of organ donation requesting is now underway in a number of states. I wish to remind you again that the evaluation of both models is being supervised by an AOTA sponsored steering group (J Gillis, C Corke, H Opdam, R Herkes, W Silvester).

End-of-Life Care Working Group (EOLCWG)

The working group established under the Death and Organ Donation Committee is continuing its work on the review and redevelopment of the ANZICS Statement on Withholding and Withdrawing Treatment, which the group has now agreed should be re-titled 'The ANZICS Statement on End-of-Life Care'. While being based on the original statement, this document is planned to be far more comprehensive, providing practical advice and linking to external resources. As the document is planned to be published in an electronic format, this will provide the opportunity for specialists to easily access the information contained within the document.

William Silvester
Chair, DODC and EOLCWG

Committee Reports

Education Committee

The work of the Society has a reputation around the world, however can sometimes seem inaccessible to not only our members, but to others with an active interest in Intensive Care. While there are several meetings a year such as the ASM, SQAO, and CTG forums, our reach can be somewhat limited to those that actually have the ability and flexibility in their schedules to attend these events. Much of the work of The Education Committee this financial year, as well as the plans for next year, has been centred around bringing the work of the Society to the forefront of what we do.

Following immediately on from the ASM in 2012, the Education Committee ran a review process of the Conference, separate to that of the review conducted by the Professional Conference Organiser. The first phase of this review was conducted amongst medical delegates who attended the event. The results of this survey then served as a starting point for a survey of ANZICS members who did not attend the ASM. Together, these two surveys provided the opportunity for all ANZICS members to provide input into the future direction of this flagship event of the Society. After each survey, sets of recommendations have been tabled to the Board, which will affect several aspects of the ASM. One recommendation that was embraced by the Society was that the activities of the Society be presented at the ASM in a format outside of the Annual General Meeting. As a result, this year has the ANZICS Clinical Trials Group presenting some of their latest research in a concurrent stream on Friday the 18th of October at the Hobart ASM. The ANZICS Centre for Outcomes and Research Evaluation (CORE) will also be presenting a session on Friday afternoon. Further to these integrated presentations at the ASM, the Education Committee is currently developing a trial transition course to be run at the 2013 ASM. It is anticipated that this will be an introduction for Senior Registrars and new Fellows on how best to utilise the tools that the Society offers, making them more competent and skilled in their work within the ICU.

Another major initiative of the Education Committee is the development of an online Education system, to be rolled out in the 2014 calendar year. Content will be taken from a variety of areas such as the ASM, SQAO, and the various committees of the Society. The delivery of these recorded sessions and presentations will be in the form of a webinar which will require pre-registration. Following each of these video presentations, there will be a hosted chat forum where those who have watched the video can interact with an expert in the area, ask questions, and have discussions about some of the issues surrounding the presentation. This is a considerable shift for the Society, but is one that must be taken if we are to remain relevant in Intensive Care in a digital age. Every effort will be made to ensure that this attracts CPD points from the College of Intensive Care Medicine, to provide legitimate value to our members and other stakeholders in this program.

Finally, the ASM Database that has been designed by the Education Committee is under further development. This was created as a database to house information regarding all presentations including, title, topic, when it was presented and who presented it. As this was initially created by members of the Committee, planning is underway to make the database a more robust tool for the Society. During our next full day meeting at ANZICS house, those of the Committee who were instrumental in its design will meet with the ANZICS in house Computer Programmer to iron out minor bugs in the database, but also develop it to be able to list presentations from SQAO and other conferences. In this way, the Society will have a central repository for all conferences, and what their contents were.

I would like to recognise the hard work of not only our Committee, but also the work of the ANZICS membership. The feedback they provide through surveys helps us to shape and develop the activities that are produced by our Committee. As always, the Committee is dedicated to the membership and is open to any suggestions or comments you may have. Please direct any queries to anzics@anzics.com.au in the first instance, and we will be in touch.

Gerry O'Callaghan
Chair, Education Committee

Committee Reports

Paediatric Committee

The last year has been a busy one for the paediatric section. In particular there have been important changes and activity in the ANZPIC Registry and the Paediatric Studies Group.

ANZPIC Registry

Preliminary data from the Registry's 2012 Annual Report has been sent out to contributing units and the Report is now being finalised for printing. The number of admissions contained in the Report continues to increase annually, with more than 10,000 paediatric admissions to intensive care in 2012. The Report also contains more detailed data pertaining to both respiratory therapy and extracorporeal life support, reflecting evolving changes in practice.

ANZPICR Clinical Advisory Committee

The ANZPICR Clinical Advisory Committee was established 1 year ago. The Committee contributes to strategic planning for the Registry and also addresses specific questions and problems regarding data collection and interpretation. Preliminary outcome data from each year are reviewed by the Committee prior to publication of the Annual Report. Unit-identified data are reviewed and discussed by representatives from each unit, with plans to develop a mechanism to address data outliers. The Committee also reviews data requests and research proposals. There are ongoing discussions about data linkages between the Registry (as part of CORE) and other national databases to improve access to long-term outcome data.

Paediatric Index of Mortality (PIM)[3]

The most recent iteration of the paediatric index of mortality, PIM3, has been completed using data from the Registry and from the UK PICANet. A manuscript detailing the refined score will be published later this year.

Paediatric Study Group

The Paediatric Study Group made a significant contribution to the Noosa GTG meeting in March this year, with results of ongoing studies and new proposals being presented to the meeting. The Group is gathering significant momentum; it has not only begun a more collaborative relationship with the CTG, but is also forging important links with overseas PICU research networks. New terms of reference for the Group were presented to and accepted by the Board in June. The Group is now a working party of the CTG and continues to report to the Board via the Chair of the Paediatric Committee.

The following studies have been completed and are in various stages of analysis and manuscript preparation: Hypothermia in Traumatic Brain Injury in Children (HITBIC), the Cool Kids trial and the CLOTS Study (Prophylactic Heparin to reduce CVC thrombosis and infection). Point prevalence data collection continues apace, most notably with the ongoing SAFE-EPIC project looking at fluid resuscitation in PICU. This international study is gathering data from more than 120 units around the world and is being led by Rino Festa (Westmead Children's Hospital, Sydney).

A three month observational study of sedation practices in PICU (Baby SPICE) has been completed and data entry is closed. Approximately 250 patients were enrolled and the results will be presented at the ANZICS ASM in October. A group led by Simon Erickson (Princess Margaret, Perth) is working on a grant proposal for an interventional trial along the lines of the SPICE trial being run by the Clinical Trials Group.

Further studies being planned include an international observational study of transfusion practices in children with congenital heart disease, and epidemiology and outcomes of paediatric chronic critical illness.

Hobart ASM

This year's ASM in Hobart is keenly anticipated and excellent international speakers have been secured for the paediatric programme. Peter Laussen, Chief of Critical Care in Toronto and Tex Kissoon, president of the World Federation of Paediatric Critical Care Societies will both contribute to what promises to be a great couple of days in a unique setting.

Johnny Millar
Chair, Paediatric Committee

Committee Reports

Practice and Economics Committee

The PricE Committee has continued to be active over the past twelve months with a number of activities around providing a forum for members to debate and discuss workforce issues, continuing negotiations with the Department of Human Services and with Medicare and groups commissioned by them about new and existing item numbers in the Medicare schedule, and with dealing with various professional matters ranging from individuals' issues with respect to billing or rostering, through to agency requests for information or assistance on a wide range of professional and industrial matters.

1. Workforce

We are all aware that there are a large number of registered CICM trainees and that there has been a significant increase over the past ten years in the number of new fellows graduating each year. It is also self-evident that Intensive Care Medicine, more than almost any other specialty, is quite 'inelastic'- that is, consultant positions are dependent upon ICU beds, either public or private, and that it is very difficult for an Intensivist to 'self-generate' workload outside of either public hospital departments or existing private practice groups. What has become apparent in the discussions over the last twelve months is that there is disagreement, predominantly between the PricE Committee of ANZICS and CICM, as to whose responsibility it is to try to manage the matching of likely positions to the number of trainees that are being produced.

However, there are changes to the training structure by CICM, both definite (commencing 1 January 2014) and yet to be confirmed, that will go some way toward ensuring that those who train in Intensive Care Medicine are both suitable and prepared for the arduous path that training requires, and that the number of trainees commencing that path is more reasonably matched to likely jobs at the other end.

The PricE Committee recently surveyed members online about workforce and work-style issues and there has been a very pleasing high response rate to this survey. Results will be circulated to members in the near future.

2. Medicare

Last year I reported that our previous Medicare submissions had been essentially rejected, save for the probability that an item number relating to ward consultations would be introduced. Whilst there was some stuttering progress on this, progress had ground to a halt until mid-2013, when the Department of Health and Ageing appointed an external consultancy, Aspex Consulting, to prepare a submission around four new item numbers or groups of numbers, including for consultations performed outside of the Intensive Care Unit by a specialist working in Intensive Care Medicine. This would include consultations done as part of MET calls to private patients and also other times we are asked to attend patients with complex illness outside of the ICU. This work is currently in progress, but we are confident that we can achieve a good outcome for members.

3. ICU Funding under Activity Based Funding (ABF)

As members may be aware, the Commonwealth now funds State entities based on activity, with an 'efficient price' for various diagnosis-related-groups (DRGs) being determined by the Independent Pricing Authority. Where a DRG (such as with cardiothoracic surgery) implies a very likely admission to ICU, the ICU cost component is included in the moiety paid for the overall DRG. Where that is not the case, a *per diem* payment for ICU has been in place. Initially it was intended that this be restricted to only Level III ICUs, based on the CICM classification. This would have severely impacted on the funding for smaller and, in particular rural and regional hospitals and their ICUs, so this restriction was lifted temporarily where states specified they wanted a payment for other ICUs. This is about to change again, and the proposal is to limit funding, on a *per diem* basis, to ventilated patients only. Again this would relatively disadvantage ICUs in smaller or regional centres where many admissions may not be ventilated, but are not well enough to be safely cared for on the ward.

ANZICS PricE Committee will be working closely with the National Pricing Authority to establish a model that is equitable in relation to other specialties, robust, fair and reliable- and most importantly does not limit the ability of regional and metropolitan ICUs to deliver high quality care.

4. Future Directions for PricE Committee

The year ahead sees plenty of work for PricE to carry out, around the above three areas. The fiscal position of the States and the Commonwealth is far from rosy, Intensive Care Medicine can be expensive, and we must be vigilant, on behalf of our patients that ICU is not unduly targeted in any cost-reduction strategies. If you have any comments, concerns or queries please contact your regional representative, listed below.

Ian Jenkins
Chair, PricE Committee

Committee Reports

Safety and Quality Committee

In 2012/2013 the Safety and Quality Committee has continued to strive towards promoting safe high quality care in Australian and New Zealand intensive care units. In order to do this the Committee has held four Committee meetings throughout the year and undertook its first strategic planning workshop in July 2012. The process of forming the Committee's first Strategic Plan was an opportunity for the Committee to think carefully about where they saw the Committee heading into the future. After rewriting its Terms of Reference and reforming the Committee in 2011, the Strategic Planning process was the next important step for the Committee to take. Writing the Strategic Plan is a collaborative piece of work between both the Committee and the ANZICS Board, it is currently in draft form and when finalised will guide the Committee through to 2015.

One of the Committee's goals is to promote safe patient centred care. One objective in order to achieve this goal has been the ongoing development of 'Prevention of Ventilator Associated Pneumonia in the Mechanically Ventilated Patient Consensus Statement'. The basis of this document was a 2009 survey of ANZICS members and the release of the Australian Commission of Safety Quality in Health Care ACSQHAC) *'Australian Guidelines for the Prevention and Control of Infection in Healthcare*' (2010), where a number of strategies for minimising Ventilator Associated Pneumonia were recommended. The Safety and Quality Committee agreed it was important to respond to these recommendations. In the past 12 months the Committee has taken a considerable amount of time in preparing a consultation version of the document. ANZICS members were invited to provide feedback on the consultation version and were invited to participate in a survey to determine the level of agreement with the recommendations made in the document. Approximately 25% of ANZICS members completed the online survey and the Committee is grateful for both your participation and feedback. The feedback and the analysis of the survey results are awaiting review and discussion by the Committee and their next meeting. It is anticipated that a smaller working group will be formed to further develop the statement.

The Committee aims to promote safe, high quality care practice in Australian and New Zealand intensive care units. The Committee's first project in achieving this goal is to develop a Central Line Insertion Training Framework for Intensive Care Units to use when training clinicians new to inserting central lines in intensive care. A draft version has been written and the Committee has identified key areas where there is a lack of evidence in the literature. The Committee will seek consensus from ANZICS members to guide further development of the framework.

The CLABSI Prevention Project which was a collaborative project between the ACSQHC and ANZICS came to an end at the end of June 2012. Since this time a project report has been received and is available on the ANZICS website. The Safety and Quality Committee has continued to respond to enquiries regarding CLABSI and maintain the dedicated website; www.CLABSI.com.au. The website is a source of information and resources including the ANZICS Central Line Insertion and Maintenance Guideline (2012), insertion checklist and compliance calculator.

The 6th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (SQAO) was held at The Grand Hyatt, Melbourne in July 2012. An important aim for SQAO organisers is to develop a programme that promotes and encourages active discussion of issues relating to safety and quality in intensive care. This is primarily achieved through the half day workshop and allocation of discussion time at the end of each session. This year the Safety and Quality Committee hosted the 'Large ICU management' workshop. The workshop forum provides registrants with an opportunity to discuss their own work place practices with others and take the workshop's recommendations back to their institutions to promote safer, higher quality care. This year's workshop generated lively discussion during the three sessions.

The sessions addressed: unit structure, development and review of clinical policies and procedures and communication within large ICUs – specifically shift handover.

As a result of this workshop and the roll out of the ACSQHC 10 National Standards it was determined that the SQAO 2013 workshop would further explore the issue of clinical handover. The remaining SQAO programme included sessions to explore: Quality: What does it mean?; Open Disclosure: A communication tool; Shift work and sleeping better; Senior medical rosters: Tiredness versus patient safety; Clinical Information systems: How they can help; Medical Management: Electronic help; and 2 sessions for presentation of free papers. The Safety, Quality, Audit and Outcomes conference again collocated with the CTG Winter meeting to produce a stimulating week of academic and practical presentations.

The Committee has actively engaged with external stakeholders including S&Q Committee members attending as ANZICS delegates to the ACSQHC Labelling Recommendations Reference Group. This group has developed the *'National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines*'.

Committee Reports

The Committee was also invited to endorse the Society of Critical Care Medicines '*Clinical Practice Guidelines for the Management of Pain, Agitation and Delirium in Adult Patients in the Intensive Care Unit*'. The Committee acknowledged the extensive amount of work undertaken by the Authors; however, the Committee agreed they were unable to endorse the Guideline.

I would like to thank all members of the Safety and Quality Committee for their contribution to the Committee's projects: Tony Burrell, Jeffrey Presneill, Sumesh Arora, Manoj Singh, Cameron Knott, Michael Buist, Benoj Varghese, Krishnaswamy Sundararajan, John Lewis, Tony Williams, Alex Kazemi, Bernadette Grealy, Mary Pinder, and Brigit Roberts. If you are interested in safety and quality and would like be involved, we would invite to be in touch by contacting: safetyandquality@anzics.com.au.

Finally, the Safety and Quality Committee is grateful for the generous support of Baxter in providing funding to maintain the Executive Officer position to support all the Committee's activities.

Deepak Bhonagiri
Chair, S&Q Committee

Regional Reports

Victoria Committee

The year just past has been full of change and challenges in Victoria. All intensive care specialists will have experienced increasing workload demands and the implementation of complex administrative processes such as NEAT targets, new accreditation standards, a changed college training program and an ever-increasing requirement for substantiating documentation.

A large number of Victorian trainees have been subject to retrospective changes brought in by the RACP during the final stages of their advanced training in intensive care. The process for appealing the decision of the RACP has taken quite some time, but it is now apparent that a satisfactory resolution is imminent for affected trainees. During this difficult time, it has been reassuring to see the high levels of support available to these future colleagues as they work their way through the RACP defined pathway.

A range of education initiatives have progressed during the year past. The Victorian Intensive Care Network continues to establish itself as a well-regarded forum for discussing clinical and professional issues. The ANZICS educational meetings have focussed on collaboration with other professional societies, including the TSANZ. Additionally, the opportunities for trainees to present original research have been expanded by the initiation of a night dedicated to young researchers. Ramesh Nagappan convened another well-attended Intensive Care Medicine Course, with registrants from emergency medicine, anaesthesia, internal medicine and intensive care. The course seeks to provide a broadly comprehensive update on relevant topics, which invites attendees to reflect on evidence and clinical practice. The monthly citywide trainee education days continue to be successful with the involvement of eight metropolitan centres and occasional attendance by rural trainees. The varied program and utilisation of centre-specific expertise remains a strong factor contributing to the program's effective engagement with trainees.

Melbourne's bid to host the WFSICCM 2015 or 2017 Congress was not successful, but given the highly positive feedback provided by the World Federation board, another bid is underway in an attempt to win the 2019 event. The considerable support from government, specialist colleges, industry and ANZICS members is sound justification for taking on this considerable task and promoting Australia as a worthy host for this prestigious event. At the World Congress in Durban this year, the General Assembly will meet to elect a new council for the WFSICCM. ANZICS have nominated Professor John Myburgh as our candidate for the council and has commenced a process to promote his election. This will be an important step in ensuring optimal representation of our region and interests at this global forum.

Other developments include the departure of Erin O'Sullivan from her role as general manager of ANZICS. While full accounts of her contributions will no doubt be provided elsewhere, I would like to personally thank Erin for her diligent and comprehensive efforts to promote the interests of intensive care at all levels. Her support of Victorian intensivists has been wonderful. Similarly, I would like to thank Rob Citroni who recently stepped down from his role as vice-chair here in Victoria. Rob has been a great champion of critical care practice for ANZICS members and will no doubt continue to do so through various means in the future.

Finally, much work is underway to prepare for the ANZICS/ACCCN annual scientific meeting, which will be held in Melbourne next year. A large and enthusiastic organising committee has been formed and has already made remarkable progress on the formulation of the program. In addition to a strong scientific meeting, attendees will experience enhanced interactivity through innovative IT based engagement systems. Much work is also going in to ensuring that the social program also meets the high expectations associated with events hosted within Melbourne's premier entertainment and cultural precinct.

Stephen Warrillow
Chair, VIC Regional Committee

Regional Reports

South Australia Committee

Following on from the successful 2012 ASM, many South Australian ANZICS members continue to give their time and energy to support the growth of the Society. Thanks must go to Gerry O'Callaghan for his work and ideas as the Educational Committee Chair, Sandy Peake in her the role of Secretary of the CTG and all the regional representatives who contribute to the various committees and working groups. Equally thank you to the many members who have supported local ANZICS events over the year and contributed their views into how our speciality evolves.

Behind the scenes, ANZICS SA has had some success in representing intensive care interests to other clinical services. Although with other clinical groups, such as cardiothoracic surgery, some problems remain to be resolved. Unfortunately it is not just clinical matters where disagreement occurs, and the how the role out of the SA health plan affects all Intensivists in the state remains to be seen. New 24hr intensive care coverage at a hospital in the north means Adelaide will have 5 public intensive care units within the metropolitan area. Issues such as acuity of the patients, access to specialty services, accreditation of ICU networks, our roles outside of the ICU and 24hr in house Consultant cover may all benefit from discussion at a state level.

Over the next year I look forward to hearing any ideas from ANZICS members on events that they would like us to be involved with and help organise. Many thanks to those in the central office for the support given to current projects and committees.

Stewart Moodie
Chair, SA Regional Committee

Tasmania Committee

ANZICS activity in Tasmania over the past year has been dominated by planning for the 2013 ANZICS ASM being held in Hobart this October. The scientific and social programmes both look great and it promises to be a successful event.

Most of our Intensivists, supporting Anaesthetists in the Launceston and Burnie and trainees are now ANZICS members. ANZICS Committee representation remains strong considering the small number of specialists located here in Tasmania.

The well-needed Royal Hobart Hospital ICU redevelopment is ongoing, with 11 new bed spaces opened earlier in the year. Work continues and the new unit should be fully opened some time in early 2014.

Organ Donation services continue to evolve in Tasmania, with locally based coordination services now fully up and running after many years of relying heavily on support from Victoria. The Tasmanian based service has proven very successful with increasing numbers over the past few years. We are also engaged in a trial of the collaborative consent model under the guidance of Andrew Turner and the Donate Life team.

Interest in intensive care training in Tasmanian hospitals remains strong and our trainees are also joining as ANZICS members. The first ever Tasmanian BASIC courses were recently run in Hobart and Launceston and have proven both popular and successful, with local faculty leading the way.

Sadly for Tasmania and the North West Regional Hospital, Dr Alan Rouse is leaving after more than twelve years service in Burnie, to return to his native Queensland. Alan has been a dedicated and valued colleague and will be missed by staff and friends all over the state. We wish him well for the future.

David Rigg
Chair, TAS Regional Committee

Regional Reports

New Zealand Committee

The past year has seen our membership continue to grow. The vocationally and nonvocationally registered demographic of our members mean that ANZICS continues to reflect the true New Zealand Intensive Care workforce.

The key focus of the year was the March regional ANZICS Conference. Mike Hunter and team hosted an outstanding meeting which was attended by almost a third of our regions full members. The program was extremely well considered and truly had something for everyone (unless you had an aversion to sheep's stomachs).

We remain committed to education within the region and were delighted to help support the Wellington Intensive Care Medicine Course. The quality of Chris Poynter's program attracted many candidates from Australia and the flattering feedback should result in a secure future. We also received AGM endorsement for a travelling lectureship fund to allow exceptional local presentations to gain a wider audience around the country. The finer detail of this $1500 travel fund is in its final stages and should be announced very soon. I hope this will allow the ANZICS brand to reach a wider non-ICU audience.

The year has also seen some major regional investment in critical care. The month of May saw the long suffering ICU staff of Waikato hospital finally join their HDU colleagues in the collocated $12 million redevelopment facility in the Meade Clinical centre. Further south, Canterbury welcomed the announcement that its earthquake-hit health sector would be receiving a $600 million redevelopment over the next 5 years. The actual critical care investment is yet to be finalised, but we hope we will be allowed to offer an expanded service that will allow Cantabrians a service that is at least equitable with the rest of the country.

PHARMAC continue to wrestle with the mammoth task of how they will coordinate medical device access and procurement in the future. Whether this will have any major impact at the bedside is still unclear and we will continue to provide expertise and guidance as required. We are also in the final stages of drafting a joint position statement with the college in reference to the ongoing availability of hyydroxyethyl starch on the preferred medicine list (PML). I am still fascinated by the divergence of opinion this subject endears and the document aims to provide a considered view.

Finally, I would like to advertise next year's ANZICS meeting in Christchurch (March 12th-14th 2014). This will be the first excuse that many of you will have had to visit our "munted" city since the seismic events of 2011. The venue is right in the heart of the city and will give a taste of the magnitude of the rebuild process. We have secured excellent speakers from North America, Europe and the UK (though they tell me this is also in Europe). I look forward to seeing you there.

David Knight
Chair, NZ Regional Committee

Regional Reports

Queensland Committee

The last financial year has seen significant changes to Queensland's health system under the conservative Newman government. In May 2012 legislation was introduced to formalise the conversion of the health districts created in the 2005 Queensland restructure to independent local Hospital and Health Services (HHSs). Under these new arrangements the HHSs each have their own board that manages and oversees the operations of the HHS and is accountable to the Minister for Health. These new management structures have sought to curtail health spending and hence we have witnessed disturbing job losses in the health sector. Trends in the size, age and health status of the Queensland population mean that intensive care services will face significant demands over the next decade—and services will need to address these demands within an environment of finite health resources.

The demand for public adult intensive care services from residents of Queensland in 2011–12 financial year was 14,838 episodes and 49,972 bed days. The demand increased by 2079 episodes (16 per cent) and 6858 bed days (16 per cent) between the financial years 2007–08 and 2011–12. This forms the background to the Queensland adult intensive care services state-wide health service strategy document, published in 2013. This document seeks to determine the magnitude of the problem and after consultation with significant stakeholders, inform strategy to deliver intensive care services into the next decade. It is likely we will see the development of state-wide admission guidelines, enhanced use of telemedicine and an increase in the number of intensive care beds. This, however in the setting of needing to save money, will almost certainly see a change in the conditions of service for the Queensland intensivist population. We will as a group need to be vigilant and astute to ensure the expert care we deliver continues to be valued.

ANZICS members will recall 2012 saw the withdrawal of state funding for private Queensland intensive care units to submit data to ANZICS. The new model relied on private hospitals funding their own ICU data submissions to ANZICS CORE. The efforts of the ANZICS executive and CORE committee have resulted in a pleasing number of private hospitals recognising the utility of this service and continuing to contribute to the data collection.

The Queensland training Pathway has survived the harsh financial environment and continued to very effectively coordinate the state-wide intensive care training scheme. The advantages of this system are very obvious, where individual trainees are guided through their training, thereby maximising training experience. Opportunities for trainees have been created in a range of facilities and this centrally directed process has ensured Queensland remains a popular state for registrars to undertake their training.

Queensland is fortunate to have a very productive intensive care research group, who continue to generate world class research and attract major grant funding. The CTG meeting in Noosa this year was again well attended and a great success. Thank you to all of those involved in its organisation. On the meeting front, 2014 promises to be an exciting year in Brisbane with both the CICM ASM and the Social Media and Critical Care (SMACC) conferences taking place in our capital city.

The co-badged CICM/ANZICS Registrar Research Forum will again be held in Brisbane in November, with the intention of encouraging an interest in research among Queensland registrars and specialists. This will be the third year ANZICS has provided financial support to this meeting which aims to provide an opportunity for established researchers to mentor and encourage new researchers.

Queensland ANZICS has a strong and stable membership that represents the members' interests in a range of activities, including safety, quality, research and private practice. In the current climate, membership is more relevant than ever. In the coming months ANZICS Queensland will be seeking expressions of interest from members wishing to be considered for positions on the regional committee. This is a great opportunity to make a contribution to our specialty within our state.

Anthony Holley
Chair, QLD Regional Committee

Regional Reports

Western Australia Committee

During 2012-2013, Western Australians continue to fill many busy roles within ANZICS and also represent the interests of Intensivists at various levels- Prof Geoff Dobb, a past ANZICS President was re-elected to the position of Vice President of the Australian Medical Association for a third term, the first Intensivist to hold such a high office in the AMA. He also, within Western Australia, continues as Chair of the Southern Country Health Service Governing Council. Prof Steve Webb stepped down as CTG Chair and, as Past Chair remains on CTG Executive. Our current CTG executive member remains Ed Litton, whilst KM Ho is the CORE member and John Lewis has replaced Brad Power as the Safety and Quality committee member. As the Regional Chair for the College of Intensive Care Medicine, John is a useful link between the sister bodies. Greg McGrath remains as Western Australia's PricE Committee representative whilst I occupy the Chair of that committee.

Locally we have had excellent research meetings throughout the year at which our research coordinators, research directors from the tertiary centres, the CTG Chair and Executive representative and other parties interested in research all meet- these evening meetings, which are kindly supported by industry, are superbly organised and scheduled by Brigit Roberts from Sir Charles Gairdner Hospital.

We have also held several evening educational meetings, with presentations from speakers from all the hospitals- these have been well attended by full members, non-members and trainees alike. The only mild disappointment has been the ongoing low rate of trainee membership uptake, which has been encouraged for those attending these sessions.

The management of some of the general hospitals on the periphery of Perth and one regional centre, Bunbury, continue to develop ICUs, essentially in isolation from the tertiary centres in Perth. This is unfortunate, expensive and probably not sustainable in the new world of activity-based funding, especially if this is changed by the Commonwealth to only provide an 'ICU co-payment' for ventilated patients- see the PricE Committee report.

Western Australia ANZICS continues to perform without a standing committee, even although, as a state, we are over-represented at bi-national level. As I wrote last year, this does make it difficult to represent our interests at a state level if and when opinions are sought by various bodies including government. Instead, as in many states, individuals are approached to represent our craft group at different times and levels.

In conclusion, ANZICS, as advocate for intensive care, both for the patient and practitioner, remains strong in Western Australia. We continue to assist members in areas of their professional lives and to promote excellence in intensive care medicine.

Ian Jenkins
Chair, WA Regional Committee

Regional Reports

News South Wales Committee

The NSW Regional Committee held an AGM in March of this year. ANZICS NSW has not been particularly busy this year, and there have been no major issues I have had to address. I have not heard of any ICU bed closures in NSW as reported in other states. The NSW statewide CIS implementation is awaited and correspondence regarding this should be available soon. ANZICS NSW members are very active in the CTG, Safety and Quality, PricE and other ANZICS activities. There is broad support in NSW for ANZICS to maintain an ongoing role in the professional development and welfare of intensivists. The ANZICS LinkPersons initiative has been developed to address this issue and we now have LinkPersons in a number of NSW ICUs. We hope to conduct regional meetings in the coming year and, as always, we are keen for enthusiastic members to volunteer to become involved with ANZICS Committees at a state or bi-national level. If you are interested in joining a Committee or you have some suggestions, please don't hesitate to contact me.

Deepak Bhonagiri
Chair, NSW Regional Committee

ANZICS Awards

Matt Spence Medal

The Matt Spence Award is highly sought after prize by trainees 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 Vankatesh	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	NSW
2007	Dr A Nichol	VIC
2008	Dr B Tang	NSW
2009	Dr M Brain	TAS
2010	Dr R Fischer	SA
2011	Dr J Raj	SA
2012	Dr Susan Kelly	SA

Past 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)

ANZICS Awards

ASM Oration

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

Perth 2002	Malcolm Fisher	New South Wales
Cairns 2003	Lindsay Worthley	South Australia
Melbourne 2004	Jack Cade	Victoria
Adelaide 2005	Bob Wright	New South Wales
Hobart 2006	Stephen Streat	New Zealand
Rotorua 2007	Geoffrey Parkin	Victoria
Sydney 2008	Frank Shann	Victoria
Perth 2009	David Tuxen	Victoria
Melbourne 2010	Anthony Bell	Tasmania
Brisbane 2011	Brad Power	Western Australia
Adelaide 2012	Neil Matthews	South Australia

ANZICS Honour Roll

The ANZICS Honour Roll provides an opportunity for colleagues to recognise a member's outstanding contribution to the specialty of Intensive Care Medicine, well above and beyond being a dedicated clinician.

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

Financial Report

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 2013 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 Mary G White *President*

Dr Andrew J Turner *Vice President*

Dr Simon Erickson Hon. Secretary *(appointed 26/10/2012)*

Dr Marc Ziegenfuss *Hon.Treasurer*

Dr Satyadeepak Bhonagiri

Dr Anthony Holley

Dr Ian Jenkins

Dr David Knight

Dr Colin McArthur *(appointed 3/12/2012)*

Dr Kenneth John Millar

Dr Stewart Moodie

Dr David Pilcher

Dr David Rigg

Dr Stephen Warrillow

Dr Michael O'Leary *(resigned 26/10/2012)*

Dr Steven Webb *(resigned 3/12/2012)*

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 entity during the year was to provide services including advocacy, research and education to its members and stakeholders.

Directors' Report

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 M G White
Qualifications: MBBS/BSc/ChB/FFARCSJ
Experience: Director since 2002
Special Responsibilities: President

Dr A J Turner
Qualifications: MBBS/BMed Sci/FRACP/FCICM
Experience: Director since 1999
Special Responsibilities: Vice-President

Dr Simon Erickson
Qualifications: MBBS, FRACP, FCICM
Experience: Director since Oct 2012
Special Responsibilities: Hon. Secretary

Dr M Ziegenfuss
Qualifications: FCICM/FRCS
Experience: Director since 2008
Special Responsibilities: Hon. Treasurer

Dr D Bhonagiri
Qualifications: MBBS/MD/FCICM
Experience: Director since March 2010
Special Responsibilities: Chair – N.S.W. Region

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

Dr I Jenkins
Qualifications: BHB/MBChB/FCICM
Experience: Director since March 2010
Special Responsibilities: W.A. Region/PricE Chair

Dr D Pilcher
Qualifications: MBBS/MRACP/FRACP/FCICM
Experience: Director since Jul 2010
Special Responsibilities: Chair – CORE Management

Dr D Rigg
Qualifications: MBBS/MSc/FACEM/FCICM
Experience: Director since Nov 2009
Special Responsibilities: Chair – Tasmania

Dr S Warrillow
Qualifications: MBBS/FCICM/FRACP
Experience: Director since March 2010
Special Responsibilities: Chair – Victoria Region

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

Dr S Moodie
Qualifications: MBChB/FRCA/FCICM
Experience: Director Feb since 2012
Special Responsibilities: Chair – SA

Dr D Knight
Qualifications: MBChB/MBCP/FRCA/FCICM
Experience: Director since Feb 2012
Special Responsibilities: Chair New Zealand Region

Dr Colin McArthur
Qualifications: BHB, MBChB, FCICMQ
Experience: Director since Dec 2012
Special Responsibilities: Chair – Clinical Trials Group

Directors' Report

Directors' meetings

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

Directors	Number eligible to to attend	Number attended
Dr S Bhonagiri	3	2
Dr S Erickson *(appointed 26 Oct 2012)*	2	2
Dr A Holley	3	2
Dr I Jenkins	3	3
Dr D Knight	3	3
Dr C McArthur *(appointed 3 Dec 2012)*	3	3
Dr KJ Millar	3	2
Dr S Moodie	3	3
Dr M O'Leary *(resigned 26 Oct 2012)*	1	1
Dr D Pilcher	3	2
Dr D Rigg	3	2
Dr A J Turner	3	3
Dr S Warrillow	3	2
Dr S Webb *(resigned 3 Dec 2012)*	1	0
Dr M G White	3	3
Dr M Ziegenfuss	3	2

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

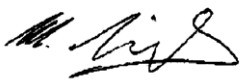
The Society is incorporated under the *Corporations Act 2001* and is a company limited by guarantee. Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member, 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 $14,640 (2012: $14,060) being 740 (2012: 703) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2013 has been received and can be found on page 33 and forms part of the directors' report.

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

Dr Mary White
President



Dr Marc Ziegenfuss
Hon.Treasurer

Dated this 2nd day of September 2013.

Lead Auditor's Independence Declaration under Section 307C of the Corporations Act 2001

To: the directors of Australian and New Zealand Intensive Care Society

I declare that, to the best of my knowledge and belief, in relation to the audit for the financial year ended 30 June 2013 there have been:

(i) no contraventions of the auditor independence requirements as set out in the Corporations Act 2001 in relation to the audit; and

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

KPMG

KPMG

Darren Scammell
Partner

Melbourne

2 September 2013

Statement of Profit or Loss and other Comprehensive Income

for the year ended 30 June 2013

	Note	2013 $	2012 $
Revenue from ordinary activities	2	2,329,029	2,321,610
Employee expenses		(1,321,966)	(1,122,687)
Administration expenses		(363,002)	(466,701)
Conference and meeting expense		(279,418)	(313,100)
Travel and committee expenses		(117,495)	(116,736)
Depreciation expense		(43,644)	(46,449)
Other expenses from ordinary activities		(75,821)	(41,262)
Profit for the year		127,683	214,675
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss:			
Gains on revaluation of land and buildings	8	-	288,005
Other comprehensive income for the year, net of income tax		-	288,005
Total comprehensive income for the year		127,683	502,680

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2013

	Note	2013 $	2012 $
Current Assets			
Cash and cash equivalents	4	2,282,410	2,107,514
Trade and other receivables	5	63,592	183,044
Financial assets	6	83,001	81,026
Other current assets	7	96,995	90,297
Total current assets		2,525,998	2,461,881
Non-Current Assets			
Financial assets	6	18,364	16,521
Property, plant and equipment	8	2,497,322	2,519,439
Total non-current assets		2,515,686	2,535,960
Total Assets		5,041,684	4,997,841
Current Liabilities			
Trade and other payables	9	663,643	784,367
Employee benefits	10	164,319	119,163
Income fund liability	6(i)	83,001	-
Total current liabilities		910,963	903,530
Non-Current Liabilities			
Employee benefits	10	26,762	37,009
Income fund liability	6(i)	-	81,026
Total non-current liabilities		26,762	118,035
Total Liabilities		937,725	1,021,565
NET ASSETS		4,103,959	3,976,276
Equity			
Reserves	11	716,097	716,097
Retained profits		3,387,862	3,260,179
TOTAL EQUITY		4,103,959	3,976,276

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2013

	Note	2013 $	2012 $
Cash flows from operating activities			
Receipt of grants		1,134,048	1,318,281
Cash receipts from members and customers		1,233,059	1,094,864
Interest received		88,266	126,907
Payments to suppliers and employees		(2,255,481)	(2,124,395)
Net cash provided by operating activities	12	199,892	415,657
Cash flows from (to) investing activities			
Purchases of property, plant and equipment		(23,153)	(10,038)
Purchases of other financial assets		(1,843)	-
Net cash used in investing activities		(24,996)	(10,038)
Net increase in cash and cash equivalents		174,896	405,619
Cash and cash equivalents at beginning of financial year		2,107,514	1,701,895
Cash and cash equivalents at end of financial year	4	2,282,410	2,107,514

The accompanying notes form part of these financial statements.

Statement of Changes of Equity

for the year ended 30 June 2013

	Note	Retained profits $	Asset revaluation reserve $	Total $
Balance at 30 June 2011		3,045,504	428,092	3,473,596
Profit attributable to the Society		214,675	-	214,675
Total other comprehensive income for the year	8	-	288,005	288,005
Balance at 30 June 2012		3,260,179	716,097	3,976,276
Profit attributable to the Society		127,683	-	127,683
Total other comprehensive income for the year		-	-	-
Balance at 30 June 2013		3,387,862	716,097	4,103,959

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

for the year ended 30 June 2013

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 a company limited by guarantee. The registered office and principal place of business of the Society is 10 levers Terrace Carlton, Victoria, 3053.

1. Summary of significant accounting policies

Basis of Preparation

Australian and New Zealand Intensive Care Society has elected to early adopt the Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010-2: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements. Accordingly, the entity has also early adopted AASB 2011-2: Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements and AASB 2012-7: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements in respect of AASB 2010-6: Amendments to Australian Accounting Standards – Disclosures on Transfers of Financial Assets and AASB 2011-9: Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive Income.

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 *Corporations Act 2001*. 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 a financial report containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of this financial report 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 accruals 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 2nd September 2013 by the directors of the company.

Accounting policies

(a) Revenue

Revenue from the rendering of a service is recognised upon the delivery of the service to the customer. Subscriptions, sponsorships, fees from conferences and meetings, grants and donations relating to the reporting period are recognised as income. Subscriptions, sponsorships, fees from conferences and meetings, and grants received for periods not within reporting period are recorded as income in advance.

Non-reciprocal grant revenue is recognised in the profit or loss when the entity obtains control of the grant and it is probable that the economic benefits gained from the grant will flow to the entity and the amount of the grant can be measured reliably.

If conditions are attached to the grant which must be satisfied before it is eligible to receive the contribution, the recognition of the grant as revenue will be deferred until those conditions are satisfied.

When grant revenue is received whereby the entity incurs an obligation to deliver economic value directly back to the contributor, this is considered a reciprocal transaction and the grant revenue is recognised in the statement of financial position as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

Interest rate revenue is recognised using the effective interest rate method, which for floating rate financial assets is the rate inherent in the instrument.

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 endorsed as an income tax exempt charity 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.

Property

Freehold land and buildings are shown at their fair value based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings.

In periods when the freehold land and buildings are not subject to an independent valuation, the directors conduct directors' valuations to ensure the carrying amount for the land and buildings is not materially different to the fair value.

Notes to the Financial Statements

for the year ended 30 June 2013

Increases in the carrying amount arising on revaluation of land and buildings are recognised in other comprehensive income and accumulated in the revaluation reserve in equity. Revaluation decreases that offset previous increases of the same class of assets shall be recognised in other comprehensive income. All other decreases are recognised in profit or loss.

Any accumulated depreciation at the date of revaluation is eliminated against the gross carrying amount of the asset and the net amount is restated to the revalued amount of the asset.

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 including buildings, but excluding freehold land, is depreciated on either a straight line or diminishing value basis over the asset's useful life to the entity 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
• Buildings	40 years
• Plant and equipment	4 – 25 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 entity 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 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 as expenses in profit or loss.

Classification and subsequent measurement

Financial instruments are subsequently measured at either fair value, amortised cost using the effective interest rate method or cost. Where available, quoted prices in an active market are used to determine fair value. In other circumstances, valuation techniques are adopted.

Amortised cost is calculated as the amount at which the financial asset or financial liability is measured at initial recognition less principal repayments and any reduction for impairment, and adjusted for any cumulative amortisation of the difference between that initial amount and the maturity amount calculated using the effective interest rate method.

The effective interest rate method is used to allocate interest income or interest expense over the relevant period and is equivalent to the rate that exactly discounts estimated future cash payments or receipts (including fees, transaction costs and other premiums or discounts) through the expected life (or when this cannot be reliably predicted, the contractual term) of the financial instrument to the net carrying amount of the financial asset or financial liability. Revisions to expected future net cash flows will necessitate an adjustment to the carrying amount with a consequential recognition of an income or expense item in profit or loss.

Fair value is determined based on current bid prices for all quoted investments. Valuation techniques are applied to determine the fair value for all unlisted securities, including recent arm's length transactions, reference to similar instruments and option pricing models.

(i) Financial assets at fair value through profit or loss

Financial assets are classified at 'fair value through profit or loss' when they are held for trading for the purpose of short-term profit taking, derivatives not held for hedging purposes, or when they are designated as such to avoid an accounting mismatch or to enable performance evaluation where a group of financial assets is managed by key management personnel on a fair value basis in accordance with a documented risk management or investment strategy. Such assets are subsequently measured at fair value with changes in carrying value being included in profit or loss.

(ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at

Notes to the Financial Statements

for the year ended 30 June 2013

amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iii) Held-to-maturity investments

Held-to-maturity investments are non-derivative financial assets that have fixed maturities and fixed or determinable payments, and it is the Society's intention to hold these investments to maturity. They are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

(iv) Available-for-sale investments

Available-for-sale investments are non-derivative financial assets that are either not capable of being classified into other categories of financial assets due to their nature, or they are designated as such by management. They comprise investments in the equity of other entities where there is neither a fixed maturity nor fixed or determinable payments.

(v) Financial liabilities

Non-derivative financial liabilities (excluding financial guarantees) are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial liability is derecognised.

Impairment

At the end of each reporting period, the Society assesses whether there is objective evidence that a financial asset has been impaired. A financial asset (or a group of financial assets) is deemed to be impaired if, and only if, there is objective evidence of impairment as a result of one or more events (a "loss event") having occurred, which has an impact on the estimated future cash flows of the financial asset(s).

In the case of available-for-sale financial assets, a significant or prolonged decline in the market value of the instrument is considered to constitute a loss event. Impairment losses are recognised in profit or loss immediately. Also any cumulative decline in fair value previously recognised in other comprehensive income is reclassified to profit or loss at this point.

In the case of financial assets carried at amortised cost, loss events may include: indications that the debtors or group of debtors are experiencing significant financial difficulty, default or delinquency in interest or principal payments: indications that they will enter bankruptcy or other financial reorganisation; and changes in arrears or economic conditions that correlate with defaults.

For financial assets carried at amortised cost (including loans and receivables), a separate allowance account is used to reduce the carrying amount of financial assets impaired by credit losses. After having taken all possible measures of recovery, if management establishes that the carrying amount cannot be recovered by any means, at that point the written-off amounts are charged to the allowance account or the carrying amount of impaired financial assets is reduced directly if no impairment amount was previously recognised in the allowance accounts.

When the terms of financial assets that would otherwise have been past due or impaired have been renegotiated, the company recognises the impairment for such financial assets by taking into account the original terms as if the terms have not been renegotiated so that the loss events that have occurred are duly considered.

Derecognition

Financial assets are derecognised where the contractual rights to receipt of cash flows expires or the asset is transferred to another party whereby the Society no longer has any significant continuing involvement in the risks and benefits associated with the asset. Financial liabilities are derecognised where the related obligations are discharged or cancelled, or have expired. The difference between the carrying value of the financial liability, which is extinguished or transferred to another party, and the fair value of consideration paid, including the transfer of non-cash assets or liabilities assumed, is recognised in profit or loss.

(e) Impairment of assets

At the end of each reporting period, the Society assesses whether there is any indication than an asset may be impaired. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying value. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss, unless the asset is carried at a revalued amount in accordance with another Standard (e.g. in accordance with the revaluation model in AASB 116). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard.

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 the asset belongs.

(f) Employee benefits

Provision is made for the Society's liability for employee benefits arising from services rendered by employees to the end of the reporting date. Employee benefits that are expected to be settled within one year have been measured at the amounts expected to be paid when the liability is settled. Employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits. In determining the

Notes to the Financial Statements

for the year ended 30 June 2013

liability, consideration is given to employee wage increases and the probability that the employee may not satisfy vesting requirements. Those cash outflows are discounted using market yields on government bonds with terms to maturity that match the expected timing of cash flows.

(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 payables

Trade and other payables represent the liabilities for goods and services received by the company during the reporting period that remain unpaid at the end of the reporting period. The balance is recognised as a current liability with the amounts normally paid within 30 days of recognition of the liability.

(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) Comparative figures

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

(k) Critical accounting estimates and judgments

The directors evaluate estimates and judgments incorporated into the financial statements 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

Impairment

The freehold land and buildings were independently valued at 23 August 2011 by Opteon. The valuation was based on the fair value less costs to sell. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $288,005 being recognised for the year ended 30 June 2012.

At 30 June 2013, the directors have reviewed the key assumptions adopted by the valuers in 2012 and do not believe there has been a significant change in the assumptions at 30 June 2013. The directors therefore believe the carrying amount of the land and buildings correctly reflects the fair value less costs to sell at 30 June 2013.

(l) Change in accounting policies

Presentation of items of other comprehensive income (OCI)

As a result of early adopting AASB 2012-7, which includes amendments to disclosure requirements arising from Tier 1 (full-disclosure) Standard AASB 2011-9: Amendments to Australian Accounting Standards – Presentation of Items of Other Comprehensive income that became mandatorily applicable from 1 July 2012, the following changes to the presentation of the Society's financial statements were made during the year:

– items of OCI were grouped into:
– items that will not be reclassified subsequently to profit or loss; and
– those that will be reclassified subsequently to profit or loss when specific circumstances occur; and

– the title "income statement' was changed to "statement of profit or loss and other income". Although other titles are also permitted, the Society has decided to use the title "statement of profit or loss and other income".

Notes to the Financial Statements

for the year ended 30 June 2013

	2013 $	2012 $
2. Revenue and other income		
Revenue:		
Grants	1,117,451	1,124,499
Subscriptions	477,541	448,748
Surplus from ASM	143,379	137,236
Conferences and meetings	316,110	324,909
Sponsorship	126,564	142,182
	2,181,045	2,177,574
Other income:		
Interest received – cash and cash equivalents	94,624	101,977
Interest received – held to maturity investments	1,219	1,141
Sundry income	52,141	26,147
Rent received	-	14,771
	147,984	144,036
Total revenue and other income	2,329,029	2,321,610

3. Auditor's remuneration

The auditors of the Society for the year ended 30 June 2013 are KPMG. The total fee is $10,000 of which $5,000 is paid directly to the Australian and New Zealand Intensive Care Foundation as a donation on KPMG's behalf. In the year ended 30 June 2012, the total fee was $10,000 of which 100% was paid directly to the Australian and New Zealand Intensive Care Foundation as a donation on behalf of KPMG.

	2013 $	2012 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	242,362	386,554
Cash on short term deposit	2,039,748	1,720,660
	2,282,410	2,107,514
5. Trade and other receivables		
Trade receivables	53,868	178,492
Other receivables	9,724	4,552
	63,592	183,044

Notes to the Financial Statements

for the year ended 30 June 2013

	2013 $	2012 $

6. Financial assets

Current:

Held to maturity financial assets		
- Australians Donate Education Fund (i)	83,001	81,026

(i) ANZICS manages a grant provided by Australians Donate Inc. for the establishment of an Australians Donate Education Fund to be used for educational purposes with the aim of improving the quality of Human Organ and Tissue Donation. The funds are held in trust by ANZICS, and are expended at the discretion of an "allocation group" established to approve submissions for the allocation of funds. ANZICS cannot use the funds for administrative costs or travel or meeting expenses, and any interest accrued on the funds must be used for the specific purposes described above. Funds on hand have been invested in a 3 month term deposit with ANZ at 4.25% p.a.

	2013 $	2012 $

Non-current:

Held to maturity financial assets		
- NZ Debentures (Balanced Fund)	18,364	16,521

7. Other current assets

Prepayments – general	88,983	86,797
Prepayments and deposits – ASM	8,012	3,500
	96,995	90,297

8. Property, plant and equipment

Land and buildings

Freehold land – at valuation	1,540,000	1,540,000
Buildings – at valuation	970,000	970,000
Less accumulated depreciation	(44,458)	(20,208)
	925,542	949,792
Total land and buildings	2,465,542	2,489,792

Plant and equipment

Plant and equipment – at cost	170,578	208,915
Less accumulated depreciation	(138,798)	(179,268)
Total plant and equipment	31,780	29,647
Total property, plant and equipment	2,497,322	2,519,439

Notes to the Financial Statements

for the year ended 30 June 2013

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
2013			
Balance at 1 July 2012	2,489,792	29,647	2,519,439
Additions	-	23,153	23,153
Disposals	-	(1,626)	(1,626)
Depreciation for the year	(24,250)	(19,394)	(43,644)
Balance at 30 June 2013	2,465,542	31,780	2,497,322
2012			
Balance at 1 July 2011	2,226,575	41,271	2,267,846
Additions	-	10,037	10,037
Revaluation increment	288,005	-	288,005
Depreciation for the year	(24,788)	(21,661)	(46,449)
Balance at 30 June 2012	2,489,792	29,647	2,519,439

Asset revaluations

The freehold land and buildings were independently valued at 23 August 2011 by Opteon. The valuation was based on the fair value less costs to sell. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $288,005 being recognised for the year ended 30 June 2012.

At 30 June 2013, the directors have reviewed the key assumptions adopted by the valuers in 2012 and do not believe there has been a significant change in the assumptions at 30 June 2013. The directors therefore believe the carrying amount of the land and buildings correctly reflects the fair value less costs to sell at 30 June 2013.

Notes to the Financial Statements

for the year ended 30 June 2013

	2013 $	2012 $
9. Trade and other payables		
Trade creditors	7,712	34,301
Sundry creditors and accruals	28,750	37,453
Grants received in advance	377,009	367,460
Subscriptions received in advance	196,199	285,070
Sponsorship & registrations received in advance	53,973	60,083
	663,643	784,367
10. Employee benefits		
Current		
Provision for annual leave	88,391	89,649
Provision for long service leave	30,528	-
Other employee benefits	45,400	29,514
	164,319	119,163
Non-current		
Provision for long service leave	26,762	37,009

Provision for employee benefits

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).

Notes to the Financial Statements

for the year ended 30 June 2013

	2013 $	2012 $
11. Reserves		
Asset revaluation reserve	716,097	716,097
Balance at the beginning of the year	716,097	428,092
Revaluation increment (Note 8)	-	288,005
Balance at the end of the year	716,097	716,097

The asset revaluation reserve records the revaluations of non-current assets.

12. Notes to the Statement of Cash Flows		
Reconciliation of cash flow from operations with profit after income tax		
Profit from ordinary activities	127,683	214,675
Add/(less) non-cash items:		
Depreciation	43,644	46,449
Loss on disposal of non-current assets	1,626	-
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	119,452	32,965
(Increase)/decrease in other current assets	(6,698)	12,023
Increase/(decrease) in trade and other payables	(120,724)	101,533
Increase/(decrease) in provisions	34,909	8,012
Net cash provided by operating activities	199,892	415,657

13. Related Parties

Directors

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

Dr Mary G White, Dr Andrew J Turner, Dr Marc Ziegenfuss, Dr Simon Erickson, Dr Satyadeepak Bhonagiri, Dr Anthony Holley, Dr Ian Jenkins, Dr David Knight, Dr Colin McArthur, Dr Kenneth John Millar, Dr Stewart Moodie, Dr Michael O'Leary, Dr David Pilcher, Dr David Rigg, Dr Stephen Warrillow, Dr Steven Webb

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

14. 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:

	2013 $	2012 $
Key management personnel compensation	382,894	306,348

Notes to the Financial Statements

for the year ended 30 June 2013

15. Financial risk management

(a) Overview

The Society has exposure to the following risks from its use of financial instruments:

- credit risk
- liquidity risk
- market risk (interest rate risk).

This note presents information about the Society's exposure to each of the above risks, its objectives, policies and processes for measuring and managing risk, and the management of capital. Further quantitative disclosures are included throughout this financial report.

The Board has overall responsibility for the establishment and oversight of the risk management framework and for developing and monitoring risk management policies. Risk management policies are established to identify and analyse the risks faced by the Society, to set appropriate risk limits and controls, and to monitor risks and adherence to limits.

Risk management policies and systems are reviewed regularly to reflect changes in market conditions and the Society's activities. The Society, through its training and management standards and procedures, aims to develop a disciplined and constructive control environment in which all employees understand their roles and obligations.

The Board oversees how management monitors compliance with the Society's risk management policies and procedures and reviews the adequacy of the risk management framework in relation to the risks faced by the Society.

(b) Credit Risk

Credit risk is the risk of financial loss to the Society if a customer or counterparty to a financial instrument fails to meet its contractual obligations.

Trade and Other Receivables

The Society's exposure to credit risk is influenced mainly by the individual characteristics of each member/customer. The Society has established the following policies to ensure the credit risk is minimised when dealing with its member/customers:

Sponsorship: Written applications are signed by all sponsors stating the amount that is owed to the Society and the relevant payment terms. Membership Fees: Written renewal invoices are provided to members each year, and membership renewal is not brought to account unless the member has paid. Registration Fees: Registration fees are collected in advance before the commencement of the course and are brought to account when payment is received.

The carrying amount of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date is disclosed in Note 16.

The Society has established an allowance for impairment that represents its estimate of incurred losses in respect of trade and other receivables and investments. The main components of this allowance are a specific loss component that relates to individually significant exposures.

(c) Liquidity risk

Liquidity risk is the risk that the Society will not be able to meet its financial obligations as they fall due. The Society's approach to managing liquidity is to ensure, as far as possible, that it will always have sufficient liquidity to meet its liabilities when due and by maintaining sufficient cash and cash equivalents to meet normal operating requirements.

(d) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows will fluctuate due to changes in market interest rates. The Society's interest-bearing financial assets and financial liabilities expose it to risks associated with the effect of fluctuations in the prevailing levels of market interest rates on its financial position and cash flows.

(e) Capital management

The Society's policy is to maintain a strong capital base to ensure it can fund research in the future whilst continuing as a not-for-profit. There were no changes in the Society's approach to capital management during the year. The Society is not subject to externally imposed capital requirements.

Notes to the Financial Statements

for the year ended 30 June 2013

16. Financial instruments

(a) Financial Assets:

Financial Instruments	Accounting Policy	Terms & conditions
Cash and cash equivalents	Cash and cash equivalents are carried at nominal value.	N/A
Receivables – trade	Trade Receivables are carried at nominal amounts due less any provision for doubtful debts. A provision for impairment loss is recognised when collection of the full amount is no longer achievable.	Credit sales are on 30 day terms
Receivables – other	Other amounts receivable are carried at nominal amounts due.	N/A
Payables	Liabilities are recognised for amounts to be paid in the future for goods and services that have been performed to date.	Trade liabilities are normally settled on 30 day terms.

(b) Fair value versus carrying amount

	2013 Carrying amount $	2013 Fair value $	2012 Carrying amount $	2012 Fair value $
Cash and cash equivalents	2,282,410	2,282,410	2,107,514	2,107,514
Trade and other receivables	63,592	63,592	183,044	183,044
Other current assets	96,995	96,995	90,297	90,297
Trade and other payables	663,643	663,643	784,367	784,367

The basis for determining fair values is disclosed in note 1(d).

(c) Interest Rate Risk

	Carrying amount 2013 $	Carrying amount 2012 $
Floating rate instruments		
Cash and cash equivalents	2,282,410	2,107,514

Fair value sensitivity analysis

A change of 100 basis points in interest rates would not have a significant effect on the Society's equity.

Cash flow sensitivity analysis

A change of 100 basis points in interest rates at the reporting date would not have a significant effect on equity and profit or loss.

Notes to the Financial Statements

for the year ended 30 June 2013

(d) Credit Risk

The Australian and New Zealand Intensive Care Society's exposure to credit risk at balance date in relation to each financial asset is the carrying amount of those assets as indicated on the Statement of Financial Position.

Exposure to credit risk

The carrying amount of the entity's financial assets represents the maximum credit exposure.

The entity's maximum exposure to credit risk at the reporting date was:

	Carrying amount	
	2013 $	2012 $
Loans and receivables	63,592	183,044

The Society has no material credit risk exposures to amounts receivable at balance date.

The following table details the Society's trade and other receivables exposed to credit risk (prior to collateral and other credit enhancements) with ageing analysis and impairment provided for thereon. Amounts are considered as 'past due' when the debt has not been settled within the terms and conditions agreed between the Society and the customer or counter party to the transaction. Receivables that are past due are assessed for impairment by ascertaining solvency of the debtors and are provided for where there are specific circumstances indicating that the debt may not be fully repaid to the Society.

The balances of receivables that remain within initial trade terms (as detailed in the table) are considered to be of high credit quality.

	Gross amount $	Past due and impaired $	Past due but not impaired (days overdue)				Within initial trade terms $
			<30 $	31-60 $	61-90 $	>90 $	
2013							
Trade receivables	53,868	-	50,973	2,895	-	-	50,973
Other receivables	9,724	-	-	-	-	9,724	9,724
Total	63,592	-	50,973	2,895	-	9,724	60,697
2012							
Trade receivables	178,492	-	151,305	7,700	12,375	7,112	151,305
Other receivables	4,552	-	1,187	3,077	-	288	4,552
Total	183,044	-	152,492	10,777	12,375	7,400	155,857

Provision for impairment of receivables

Current trade receivables are generally on 30 day terms. These receivables are assessed for recoverability and a provision for impairment is recognised when there is objective evidence that an individual trade receivable is impaired.

No provision for impairment was raised in respect of the year ended 30 June 2013 or the previous financial year.

Notes to the Financial Statements

for the year ended 30 June 2013

(e) Liquidity Risk

The following are the contractual maturities of financial liabilities of the Society:

	Carrying amount $	Contractual cash flows $	6 mths or less $	6–12 mths $	1–2 years $	2–5 years $	More than 5 years $
30 June 2013							
Payables	663,643	663,643	419,785	243,858	–	–	–
30 June 2012							
Payables	784,367	784,367	641,833	142,534	–	–	–

17. Events subsequent to reporting date

Since the end of the financial year, there are no events or transactions which could render any particulars included in the financial statements to be misleading or inaccurate.

Directors Declaration

1. In the opinion of The Directors of Australian and New Zealand Intensive Care Society (the "Society"):

(a) the financial statements and notes in the Directors' report, set out on pages 34 to 50, are in accordance with the Corporations Act 2001 including;

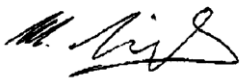
  (i) giving a true and fair view of the Society's financial position as at 30 June 2013 and of the Society's performance, for the financial year ended on that date; and

  (ii) complying with Australian Accounting Standards (including the Australian Accounting Interpretations) and the Corporations Regulations 2001;

(b) there are reasonable grounds to believe that the Society will be able to pay its debts as and when they become due and payable.

Signed in accordance with a resolution of the Directors.

Dr Mary White
President



Dr Marc Ziegenfuss
Hon. Treasurer

Dated this 2nd day of September 2013.

KPMG

Independent auditors' report to the members of Australian and New Zealand Intensive Care Society

Report on the financial report

We have audited the accompanying financial report of Australian and New Zealand Intensive Care Society (the Company) which comprises the statement of financial position as at 30 June 2013, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes 1 to 17 comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

Directors' responsibility for the financial report

The directors of the Company 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 *Corporations Act 2001* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. Those standards require that we comply with relevant ethical requirements relating to audit engagements and plan and perform the audit to obtain reasonable assurance whether the financial report is free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgement, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation of the financial report that gives a true and fair view 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 entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

We performed the procedures to assess whether in all material respects the financial report presents fairly, in accordance with the *Corporations Act 2001* and Australian Accounting Standards – Reduced Disclosure Requirements, a true and fair view which is consistent with our understanding of the Company's financial position, and of its performance.

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

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

Auditor's opinion

In our opinion, the financial report of Australian and New Zealand Intensive Care Society is in accordance with:

a) the *Corporations Act 2001*, including:

(i) giving a true and fair view of the Company's financial position as at 30 June 2013 and of its performance for the year ended on that date; and

(ii) complying with Australian Accounting Standards – Reduced Disclosure Requirements and the *Corporations Regulations 2001*

KPMG

Darren Scammell
Partner

Melbourne

2 September 2013

Appendix One

Annual General Meeting

5.30pm Friday 26th October 2012
Hall D, Adelaide Convention and Exhibition Centre, Adelaide, South Australia

Draft Minutes

1. Welcome, Present & Apologies

Mary White (MW) welcomed members to the meeting and noted the attendance and apologies.

Present

A/Prof Mary White (President)
A/Prof Michael O'Leary (Immediate Past President)
Dr Andrew Turner (Secretary)
Dr Marc Ziegenfuss (Treasurer)
Dr Michael Anderson
Dr Troy Browne
Dr Anthony Burrell
Dr John Cade
Dr Peter Cameron
Dr David Cooper
Dr Andrew Davies
Dr Adam Deane
Dr Kush Deshpande
Dr Graeme Duke
Dr Arthas Flaouris
Dr Elizabeth Fugaccia
Dr John Green
Dr Louise Hitchings
Dr Anthony Holley
Dr Ian Jenkins
Dr Daryl Jones
Dr David Knight
Dr Cameron Knott
Dr Shashi Bhaskara Krishnamurthy
Dr Kenneth Lee
Dr Paul McGinn
Dr Johnny Millar
Dr Stewart Moodie
Dr Gerry O'Callaghan
Dr Michael O'Fathartaigh
Dr Helen Opdam
Dr Rakshit Panwar
Dr Ranald Pascoe
Dr Mathew Piercy
Dr David Pilcher
Dr Michael Reade
Dr Brett Sampson
Dr John Santamaria
Dr Phil Sargent
Dr Geoff Shaw
Dr Wayne Sorour
Dr Andrew Spiers
Dr Antony Tobin
Dr Richard Totaro
Dr Barbara Trytko
Dr Andrew Udy
Dr Stephen Warrillow
Dr Gerald Wong
Dr Robert Young

Apologies

Dr Colin McArthur
Dr Steve Webb
Dr Deepak Bhonagiri
Dr Yahya Shehabi
Dr Ron Trubuhovich
Dr Ronald Lo
Dr Geoff Cutfield
Dr Colin George Merridew
Dr Mainak Majumdar
Dr Maurice Le Guen

In Attendance

Dr Matthew Spotswood (Trainee)
Erin O'Sullivan (General Manager)
Sue Huckson (CORE Manager)
Chris Nash (Minutes)

Appendix One

2. Minutes of Previous Meeting

Motion:	The minutes are accepted as a true and accurate record of the meeting.
Proposed:	Mary White
Seconded:	Michael O'Leary

Motion Carried

3. President's Report

Mary White (MW) presented the President's report. MW reported that this year was an active one as demonstrated by committee output. MW noted that the PricE Committee has established a workforce interest group to address future workforce numbers and working conditions. The Education Committee is also conducting to work to inform and guide direction of future ASMs.

It was reported that the Safety, Quality, Audit and Outcomes (SQAO), and CTG meetings in July were very successful, as was the October ASM. It was noted that the Large Unit Workshop preceding SQAO will hopefully become a recurring event. The India Knowledge Exchange Initiative which took place in April was also very successful.

MW asked members to review the treasurer's report, and noted that the Society has been experiencing a four year period of financial stability. It was also noted that while surpluses have been returned, the Society will face a number of challenges in the coming years. Regarding the ASM, it was noted that there is increasing competition from other meetings and falling sponsorship money. The Society has also faced a reduction of 40% of funds received to CORE by Queensland Health.

MW acknowledged the support of Erin O'Sullivan in her first year as President, along with ANZICS House. Thanks were also extended to the Executive Committee of ANZICS, Michael O'Leary, Andrew Turner, and Marc Ziegenfuss, the Chairs off the ANZICS Committees and the Regional Chairs on the Board, and also to the members of the Society.

4. Treasurer's Report

Marc Ziegenfuss (MZ) presented the Treasurer's report.

MZ reported that the Society currently enjoys a strong financial position, continuing on from the growth of the previous year. Ordinary revenues have continued to increase this year by 5%, in addition to the reduction of a variety of expenses, all contributing to a healthy total comprehensive income for the financial year. Due to increased income, Society equity has increased by 12%.

MZ thanked Erin O'Sullivan, Don Stewart, for their continuing efforts in managing the Society budget and providing value for money for our members.

MZ reported that a conservative budget has been approved by the Board for the year ending 2013, with a projected loss of $307,000. This was noted as not including ASM profit, and reflects an investment of expected revenues back into the committees and their initiatives. MZ noted that first quarter results are ahead of budget with $2.4 million in cash assets covering $835,000 in liabilities. The resulting current ratio is a robust 2.87.

Motion:	That KPMG be appointed as auditors for the financial year ended 30 June 2013.
Proposed:	Marc Ziegenfuss
Seconded:	Mary White

Motion Carried

Motion:	That membership subscriptions remain the same for the financial year ended 30 June 2013.
Proposed:	Marc Ziegenfuss
Seconded:	Anthony Holley

Motion Carried

5. College Of Intensive Care Medicine Report

Mike Anderson (MA) presented the College of Intensive Care Medicine report on behalf of Ross Freebairn.

MA reported that the college has engaged fellows through such courses as the "Bush Track to Boulevard" rural update course in Byron Bay. There were further opportunities to co-badge other meetings similar to this, however funding restrictions have limited this possibility. Further to this MA noted that an educational meeting will be taking place on the Gold Coast in 2013.

The College's 2012 ASM in Canberra was their largest to date.

MA reported that following review, there was a new certification program implemented for Fellows. MA noted that there were 58 new Fellows, with 813 active fellows during the year.

MA reported that John Myburgh has been replaced by Ross Freebairn as President of the Board, and that Di Stephens has been elected as Northern Territory representative.

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6. Membership Report

Motion:	That the membership report be taken as read.
Proposed:	Andrew Turner
Seconded:	Mary White

Motion Carried

7. ANZICS Honour Roll

The following Honour Roll recipients were presented to the meeting:

Dr Graeme Duke

Dr George Downward

8. Professional Practice

8.1 ANZICS Clinical Trials Group

Andrew Davies (AD) presented the Clinical Trials Group report on behalf of Steve Webb.

AD reported that there are currently 73 member ICUs, 23 endorsed studies currently active and 2 supported studies, being the result of international collaboratives. It was noted that this reflects the growing success of the Committee.

AD reported that members will now receive a tri-annual newsletter. The 2011-2012 activity report has been completed, and will be available electronically from the week of the 29th of October 2012, with printed versions being sent to member units and stakeholders.

The following changes of office were noted:

- Jamie Cooper retiring
- Steve Webb (Immediate Past Chair) *
- Colin McArthur (Chair) *
- Andrew Davies (Vice Chair) *
- Vacancy for Victorian Representative *

** Changes effective as of December 2012*

AD noted that he has requested the ANZICS Victorian representative, Stephen Warrillow to assist in finding a replacement Victorian representative for the Committee.

It was reported that in October 2012 the NHMRC had granted $5.1m for the SPICE and RELIEF studies.

AD Reported that in 2011/2012 combined funding from the NHMRC and HRCNZ totalled $6.83m for the TRANSFUSE, PHARLAP, BLING II, ARISE, and ADRENAL studies.

The following CTG meetings were held in 2013:

- Noosa: to be held at The Outrigger. Jean-Daniel Chiche, President ESICM, as keynote speaker
- Novel Trial Design Workshop: Wellington 30th May, prior to CICM ASM
- Research Foundations Workshop: Singapore-ANZICS Intensive Care Forum 12th – 14th July
- Winter Forum: Melbourne, August 22nd – 23rd
- Annual meeting at the ANZICS/ACCCN ASM in Hobart

8.2 ANZICS Centre for Outcome and Resource Evaluation

David Pilcher (DP) presented the ANZICS CORE report.

DP provided a summary of CORE registries and activities.

DP reported that ANZICS CORE is currently engaged in negotiations with Queensland Health who have indicated that they will be withdrawing 40% of their funding to CORE, which totals $80,000. This will result in CORE operating on a deficit, pending the outcome of negotiations.

It was reported that a cost analysis has been run on the proposed moved of ANZICS CORE to Monash, which has shown that that this would increase the costs of running the registries. The Committee is currently performing a cost/benefit analysis of such a move.

DP noted that redevelopment of the reporting systems are currently planned, building on current capabilities. DP urged Queensland units to continue contributing to CORE despite QLD Health proposing to remove some of their funding.

8.3 Practice and Economics Committee

Ian Jenkins (IJ) presented the ANZICS Practice and Economics Committee report.

IJ provided a summary of the works of the committee and continuing to engage Medicare Australia. It was reported that that central line insertions are now claimable, following the Australian Society of Anaesthetists approaching Medicare.

IJ noted that Medicare wanted to redefine their definition of ICU, but there has been no further discussion from Medicare on this. Work on the out of ICU Consultation item has not progressed, however this issue will remain on the agenda to ensure proper remuneration for Intensivists.

IJ presented a chart of projected Intensivist growth rates for Australia over the next 20 years, using data provided by CICM, expressing concerns regarding an over training of Intensivists.

The workforce interest group mailing list has been re-established.

Appendix One

8.4 Safety and Quality Committee

MW made special mention of the ongoing success of the Committee with record attendances at the 2012 Safety, Quality, Audit and Outcomes (SQAO) conference.

Tony Burrell (TB) presented the ANZICS Safety and Quality Committee report on behalf of Deepak Bhonagiri.

TB noted that following the securing of sufficient funding, Jennifer Holmes had been appointed as Executive Officer, who has assisted the Committee in setting a new Terms of Reference, and setting a plan for the future.

It was reported that the VAP consensus statement is still in preparation with a view to publishing soon. TB noted that the process of membership review of statements as a successful process.

TB noted that the Committee has identified that there are few competency processes for insertion of central lines and intercostals tubes. TB noted that the Committee is currently drafting a central line insertion statement, and has begun preliminary work for an airway management statement.

There were over 100 registrants to SQAO in 2012, with the 2013 conference planned for Sydney.

8.5 Death and Organ Donation Committee

Stewart Moodie (SM) presented the ANZICS Death and Organ Donation Committee report for Bill Silvester.

SM noted that it had been a quite year for Committee.

It was noted that Geoff Dobb had attended the WHO forum on development of guidelines for determination of death.

SM noted concerns have been raised by the ANZICS Board regarding the quality of the Family Donation Conversation Workshops, based on the Gift of Life Institute (GoLI) framework, and formally requested the Committee conduct a survey of members who have attended this to gauge their experiences.

SM also noted that the content of Medical ADAPT is set to be reviewed by CICM, ANZICS and AOTA, with ANZICS acting as lead on this project, and will focus on diagnosis of braindeath and communication.

The next Death and Organ Donation Committee meeting is scheduled for November.

8.6 Education Committee

Gerry O'Callaghan (GOC) presented the ANZICS Education Committee report.

It was noted that administrative support, Chris Nash, has been appointed.

GOC reported that a review of the 2012 ASM is currently open for collection of responses. It was noted that following the results of this review, an additional survey will be developed for ANZICS members who did not attend the ASM, providing all ANZICS members the opportunity to provide feedback on improving ASMs.

It was reported that the Committee has also created an ASM database, housing all talks from ASMs for the last six years. GOC noted that all previous ASM programs since 2005 are also available on the ANZICS website. Anyone seeking information about speakers or their presentations, to please contact the Committee who will have a report prepared and sent.

GOC reported that a Continuing Medical Education (CME) activity stock-take project is planned for the next calendar year.

9. Intensive Care Foundation

Michael O'Leary (MOL) presented the Intensive Care Foundation (ICF) report on behalf of Yahya Shehabi.

MOL noted the appointment of Robin Strathdee as Executive Officer and Harshan Seneviratne as Finance and Administration.

44 applications had been received to the ICF for research funding, illustrating the urgent need for this type of funding in the Intensive Care community, and that ICF is the only organisation providing such funding.

MOL reported a threat to going concern of the Foundation, and appealed for all intensivists to support the foundation. It was reported that if there are no changes in conditions, the foundation will no longer be a going concern within the next financial year.

10. Future Meetings

38th ANZICS / ACCCN Intensive Care Annual Scientific Meeting (ASM)

Hobart 17th – 19th October 2013

MW thanked the Adelaide ASM Organising committee on the tremendous quality of scientific content, and noted that the ASM should be the premier event in the Intensive Care community.

MOL noted that the Singapore-ANZICS Intensive Care Forum will be run again from the 12th to the 14th of July 2013. MOL further noted that the Society is very interested in expanding this opportunity for partnership with SICM, and noted that this meeting is not in conflict with the ASM.

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11. Election of Office Bearers

MW noted that MOL has finished his term as immediate past president, concluding his term on the Board. MW offered sincere thanks and congratulations to MOL for his 9 years of service, commitment and support with ANZICS, noting that he has been a huge support to MW over the past year. His presence will be missed on the Board.

MW made special mention to thank the staff in at ANZICS house. Sue Huckson was thanked, as was ANZICS Central staff Jennifer Holmes, Chris Nash, Brent Kingston, Alexandra Reade, Joy Najm and most importantly Erin O'Sullivan who has been a great support. She has been committed and available at all times, demonstrating unwavering dedication to the Society.

MW made special mention to thank the staff at ANZICS house. Sue Huckson from CORE, Donna Goldsmith and Simone Rickerby of CTG were thanked. As was ANZICS Central staff Jennifer Holmes (S&Q), Chris Nash, Brent Kingston, Alexandra Reade, Joy Najm and most importantly Erin O'Sullivan who has been a great support. She has been committed and available at all times, demonstrating unwavering dedication to the Society.

12. Other Business

Dr Michael O'Fathartaigh (MOF) provided a brief summary of Past ASMs, and noted that without the ASM, the Society would not have the position it currently has financially. MOF noted that the ASM was the foundation of ANZICS, and requires the support of members. MOF thanked the Convenors of the 2012 ASM.

MW made special mention of thanks to the ANZICS Abstract Review Committee and the work they do on an annual basis.

13. Date of Next Meeting

Friday 18th October 2013, Hobart, Tasmania

Advocate for intensive care throughout Australia and New Zealand