ANZICS

2014 Annual Report

Advocate for intensive care throughout Australia and New Zealand

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President's Report

My first year as President has seen a year of consolidation. The proposal for two important joint working parties to be formed with the College will ensure that intensivists remain in control of our workforce and work practices. Financially we have tracked well against budget, however a small loss would have been reported if not for an increase in the value of Ievers Terrace. The loss highlights the need for ongoing budgetary vigilance and sourcing of revenues. The Board will continue to investigate ways to grow our business and continue to fund the good works that the Society performs for intensive care in our two countries.

The Society is still dependent on volunteers to perform much of the required work. The unexpected death of Ramesh Nagappan highlighted this given his tireless work over a number of years as Convenor of the Intensive Care Medicine and Clinical Challenges in Critical Care courses. His passing not only leaves personal sadness, but also leaves a void that must be filled. To the Board, Committee Chairs, Committee Members and others who perform voluntary work for the Society, I would like to extend my sincere thanks.

The attempt to unilaterally introduce individual contracts for staff specialists in Queensland which attempted to remove many of the employment rights that we take for granted was seen as a major issue by the Society. The Society supported our members by directly appealing to the Health Minister, running a half page advertisement in the Saturday Courier Mail, and then uniting with the ASA and ASEM in further correspondence to the Government. Fortunately, the combined efforts of many groups including the Senior Medical Officer Task Force led to new contracts being created which contained a number of concessions, and which were accepted by most of the Staff Specialists in Queensland. The Society is proud of our involvement and support of our Queensland colleagues. The Society has also been involved in other local hospital issues outside Queensland, and if anyone of our members need support please contact your regional Board Representative.

The change in formulation of Noradrenaline has been discussed with Hospira and referred to the Safety and Quality Committee who will investigate the need for uniform prescribing and supply of an appropriate formulation of Noradrenaline. It is hoped that through this response patient safety can be improved across Australia and importantly achieve this at little cost.

Rapid Response Teams have become very much part of the standard work of intensive care. The SQAO committee this year ran a meeting themed on Medical Emergency Teams and was oversubscribed. A similarly themed meeting will be held in a larger venue next year. Given that these teams have significant impacts on ICU resources, and affect registrar training, a joint working group has been proposed between the Society and the College.

This group will be tasked with defining minimum standards for MET teams and the appropriate minimum resource requirements. This is an important space for the Society and College given the mandated ACSQHC standard 9 requirements.

The Death and Organ Donation Committee has been working with the Australian Organ and Tissue Authority, and the College to develop education and training tools for intensivists within Australia. The committee has ensured that New Zealand has been represented, and that the final resource will be applicable for both Countries.

The End of Life Care Working Group has completed the draft of the Care and Decision-Making at the End of Life Statement. This document has been circulated for comment, and will become an important resource document for intensivists working within our two countries. It is hoped that the document will be launched at the ASM.

In 2013 the Department of Human Services (DHS) Medicare Division commissioned an external consultancy, Aspex Consulting to prepare an application to the Medical Services Advisory Committee (MSAC) with respect to ward consultations by Intensivists. The ANZICS PricE Committee and Executive worked extensively with Aspex to develop an application that accurately reflected the current situation of ward based consultations and the inequity between those with and without joint FRACP.

President's Report

Unfortunately, despite initial encouraging feedback, MSAC declined to recommend to the Minister that the proposed new item numbers be adopted. It would appear that for applications to be accepted there must be evidence of improvement in patient outcomes, or a reduction in healthcare costs.

There have been a number of concerns raised about the future of the intensivist workforce. A joint College/ Society summit will be conducted later this year in order to determine the magnitude of the problem and to develop strategies to mitigate the effect. The Society understands the importance of these issues and will keep members informed of any outcomes.

The ANZICS website will be updated this year, which will be more contemporary and will allow for greater functionality. Committee information will be better represented and educational resources should be better managed.

I recommend all members read the detailed Committee Reports that follow, with a special mention for the Clinical Trials Group which reached its 20th Anniversary this year.

There have been a number of changes to the Board, and Committees this year. David Knight has been replaced by Ben Barry as Chair of New Zealand region, Tony Slater who has been Chair of ANZPIC since its inception has stepped down and has been replaced by Johnny Millar, Deepak Bhonagiri has stepped down as Chair of Safety and Quality and has been replaced by Angus Carter, and Ian Jenkins has stepped down as Chair of PricE and has been replaced by Mark Nicholls. To all the outgoing Chairs I would like to express a note of thanks and appreciation on behalf of all ANZICS members, and I would like to welcome and congratulate all incoming Chairs.

The Executive has remained unchanged this year and Marc Ziegenfuss, Simon Erickson and Mary White need to be thanked for their continued efforts and support, which often goes unrecognised.

Mary will retire from the Executive in October, and I would especially like to thank her for her hard work, guidance and assistance this year. I would also like to thank the Board and all Committee Members for their continued efforts and dedication. Thanks must also go to the Staff at ANZICS House – Justin Williams, Brent Kingston, Joy Najm, Don Stewart, Sue Huckson, Donna Goldsmith, Simone Rickerby and Jenny Holmes. Jessyca Menzel has been appointed this year and must be welcomed, and special thanks must go to Alexandra Reade who has worked tirelessly and will be leaving us for a new career.

Andrew Turner
President

Treasurer's Report

Dear ANZICS Member, the financial status of your Society remains sound. As the financial report reflects, the last financial year was an expensive one for ANZICS. Administrative and committee expenses were high and will be a focus for rationalisation in the coming financial year. Revenue was up by 9.75 %, generated mainly by grants. ANZICS house was re-evaluated and in keeping with the upswing in the property market value resulted in a favourable contribution to the net assets of the Society, which currently exceed four million dollars.

The Finance, Risk and Audit Committee had presented to the Board its recommendation to redistribute monies held by the Society and also pursue a share portfolio managed by Perpetual Fund Managers in the new financial year. The asset distributions are reflected in the current report.

The Hobart Intensive Care ASM returned a higher than expected profit and our thanks go out to the Organising Committee for their efforts. Thank you for your ongoing support of the ASM as the premier annual Intensive Care conference in Australia and New Zealand – we look forward to seeing you in Melbourne in 2014 and Auckland in 2015.

ANZICS CORE and the CTG continue to be productive and perform well. The risks in reliable ongoing jurisdictional CORE funding are well recognized and present a substantial hurdle for the Society's financial health in the future.

ANZICS continues to be regarded as an authority in matters pertaining to Death and Organ Donation. The End of Life Working Party has been heavily supported by ANZICS to facilitate face to face meetings and generating the Society's perspective on end of life care.

The financial report also reflects the re-evaluation of liabilities such as untaken annual and long service leave by staff. Depreciation expense has also been minimised.

Toward the future ANZICS will be introducing further efficiencies in committee activities and expenses. Investments expanding the Society's strengths will be considered by the Executive and Board.

The greatest wealth of the Society lies in you, its membership, and the Staff. At no cost to the Society Directors give their time and effort to further the interests of the internationally renowned entity that is ANZICS. I thank the committees, our General Manager and his support staff for their efforts.

To the membership I appeal to help recruit more colleagues into the Society and advertise the Brand for what it stands: "a proud advocate for Intensive Care in Australia and New Zealand".

Marc Ziegenfuss
Honorary Treasurer

ANZICS Board of Directors

President
Andrew Turner

Immediate Past President
Mary White

Honorary Treasurer
Marc Ziegenfuss

Honorary Secretary
Simon Erickson

Paediatrics
Johnny Millar

Centre for Outcome and Resource Evaluation (CORE)
David Pilcher

Clinical Trials Group (CTG)
Colin McArthur

Practice and Economics
Ian Jenkins

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Ben Barry

Tasmania Regional Chair
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Victoria Regional Chair
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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 of setting direction. Safety and Quality, CTG and CORE have continued to position the Society, and strongly represent the interests of our members nationally and internationally.

From a year in review perspective, it has seen the continuing development of internal capability to better service members and your interests. A significant activity for the COREs has been the ongoing development and soon to be launched CORE Enterprise Reporting System, this process will improve reporting back to you on how your unit is performing. CTG continues to lead the world in the generation of evidence to guide treatment and improve outcomes for those admitted to intensive care. Safety and Quality and PricE continue to liaise across the industry and with agencies to ensure Intensivists and their role in improving patient outcome are not forgotten.

Increasing member engagement continues to be critical to ANZICS long-term success. In order to enhance your organisation, ANZICS is continually assessing how we can best meet your needs. Prior to the 2014 ASM there will be a new ANZICS website, providing you with an interactive touchpoint and valuable information resource, rather than a static website.

The Committees and Regions continue remain a hive of activity. Their achievements and success are a direct correlation to the continual involvement and dedication by active members. There has been a significant level of work undertaken by the Death and Organ Donation Committee as well as the End of Life Care Committee, 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 2015 Committee commenced planning (more than 18 months out from the event). The environment in which the ASM operates continues to provide challenges and those closely involved will understand when I say that without the determination of the organising committee the ASM would not be possible.

I was fortunate to have attended the New Zealand Regional ASM this year and highly commend the Organising Committee for having the vision to bring the event to Christchurch and run a fantastic event complemented by a moving tour of Christchurch.

The activities of the past year have also included a widening of focus for the Society and have included the development of agreements with other societies internationally. Within Australia and New Zealand the Society took a stand on behalf of all Intensivists during the Queensland Medical Contracts debate. Activities such as these provide national and 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,
ANZICS General Manager

Membership Report

ANZICS membership continues to prosper with annual numbers steadily growing. Continued growth of the Society is essential to maintain, grow and support Intensive Care Practitioners in Australia and New Zealand. As ANZICS is dependent on its members, it is important that the Society continues to act in their interest and support the challenges faced in the greater Intensive Care community.

The Society has seen a rise of 4% in its membership numbers, largely thanks to the hard work of the ANZICS LinkPersons and Regional Chairs. It is also encouraging to see the rise in 1st Year Free Trainees and the continued growth of Full Members to the Society. ANZICS continues to offer its membership educational opportunities, research activities, quality assurance, industrial activity and professional development. However, ANZICS has a duty to continually reassess its role and ensure the value it provides to the membership.

The future of the Society relies heavily on the newly emerging Trainees and Consultants involvement all of the ANZICS activities to continually drive the Society forward into the future.

Simon Erickson
Honorary Secretary

Membership Totals

Total:	**769**
Country	
Australia:	**653**
New Zealand:	**97**
Type	
Full:	**496**
Trainee:	**127**
1st Year Free Trainee:	**42**
Associate:	**42**
Affiliate:	**53**
Honorary:	**9**

Centre for Outcome and Research

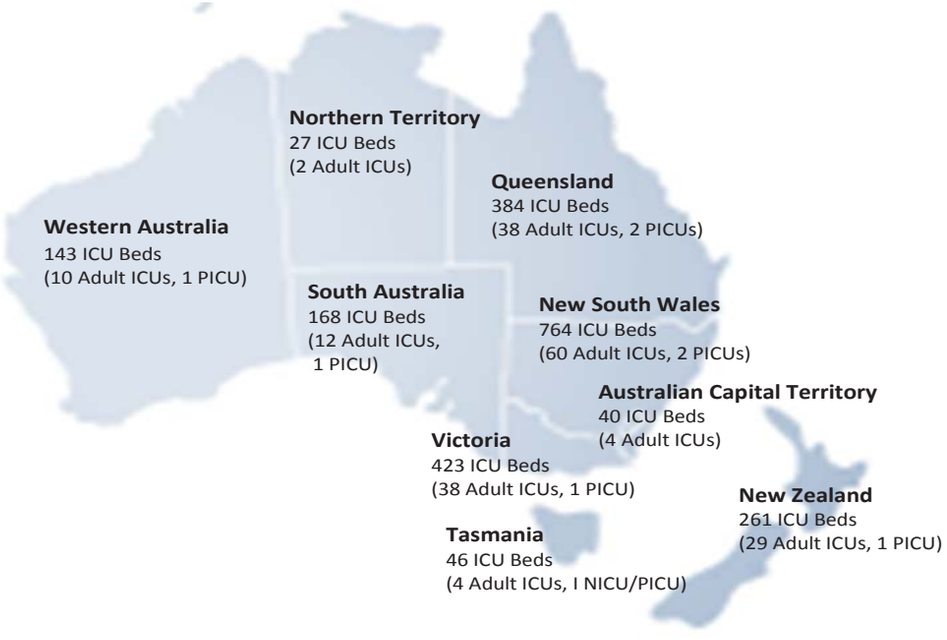
The work of the CORE staff is often not immediately obvious to medical staff sitting in their ICUs but a small but very dedicated and diligent team of 10 based in Melbourne and Brisbane, working under the supervision of Sue Huckson, co-ordinate the submission, processing and reporting of over 140,000 ICU admissions per year, the provision of reports to over 160 ICUs every three months, a National CLABSI surveillance system, an annual survey of ICU resources and perform detailed investigations of any ICU appearing to have worse mortality outcomes than their peer group and these are just the routine activities!

Detailed below are just some of the additional activities from CORE over the past year. If you want to know more (and there is lots more!) download the CORE annual report at **http://www.anzics.com.au/core/reports.**

The CORE Enterprise Reporting System – the 'biggest thing' happening at CORE in a long time

For the past 18 months, CORE staff have been engaged in a huge project to redevelop the central database, consolidate all four CORE registries' data in 'one place' and produce a modern reporting system. Later this year, tertiary ICUs and jurisdictional health departments will see the initial versions of this new ANZICS CORE Reporting system. It will allow users to see comparative demographic and outcome tables, funnel plots, EWMA charts, data quality reports, CLABSI, staffing and resources information all in one place. ANZROD will replace APACHE III-j as our main risk adjustment tool for adult ICUs (although the APACHE III-j SMR funnel plots will still be available).

Figure 1: A profile of all ICUs across Australia and New Zealand.



Source: CCR 2012/13 and follow-up of sites by phone to obtain remaining bed numbers not reported through CCR. Population was 23,130,900 for Australia and 4,470,800 for New Zealand
Sources: http://www.abs.gov.au/ausstats/abs@.nsf/mf/3101.0/ and http://www.stats.govt.nz/browse_for_stats/population/estimates_and_projections/NationalPopulationEstimates_HOTPAt30Jun13.aspx

Centre for Outcome and Research

In addition, it will be possible to filter reports to specific time periods and broad diagnostic groups. The same system will also allow automated uploading and processing of submitted data. This represents a major step forward in the capacity of CORE to report on ICU outcomes as well as engage with the clinical community. For more information please contact **sue.huckson@anzics.com.au.**

Funding –still as precarious as ever!! A shout out to New Zealand and Queensland

ANZICS CORE is primarily funded by the jurisdictional departments of health of Australia and New Zealand. Funding runs on a three yearly cycle. Negotiations have been ongoing with funders as we enter the first year of the next triennial cycle in 2014/15. Despite CORE's record of achievement and important role in benchmarking Intensive Care practices throughout our two countries, there is a constant struggle to maintain adequate funds for routine activities, let alone development of vital new infrastructure such as upgrading AORTIC. Presently Queensland contribute only 60% of their allocated funding (covering public hospital ICUs only) and this year, the New Zealand department of health threatened complete withdrawal of funding unless there was an increase in NZ ICUs contributing data (presently only 43%). I encourage all NZ ICUs and all private ICUs in Queensland to join ANZICS CORE and start to submit data. This is the only way to obtain comparative ICU outcome reports but also provides access to all other services offered by CORE.

Publications and Research – ongoing success

The year has been a productive one for research. Research is undertaken essentially unfunded and through co-operation between CORE, the Intensive Care community and research centres such as the ANZIC-Research Centre at Monash University and The George Institute in Sydney. March 2014 saw CORE's highest profile publication so far with Maija Kaukonen's paper in JAMA **(http://www.ncbi.nlm.nih.gov/pubmed/24638143)** which elegantly described the excellent and continually improving outcomes of patients with sepsis admitted to ICUs in Australia and New Zealand. This paper received considerable publicity and showcased Australasian Intensive Care practices to the world. This paper was just one of 18 – all listed below. Anyone interested in research with ANZICS CORE can contact us by filling in a data request form available at **http://www.anzics.com.au/core/information-requests.**

The CORE Workshop in Noosa

In early March 2014, CORE ran a half day workshop ("CORE, Clinical Information Systems and Big Data") at the Noosa Clinical Trials Group Meeting. This sold-out event brought together local experts on ICU clinical information systems, researchers and policy makers. Two themes were highlighted as priorities for the future development of ANZICS CORE: the collection of information on the critically ill outside of ICU (possibly through a MET Call Registry) and the importance of looking at outcomes other than just mortality (such as the functional capacity and long-term survival of all ICU patients).

A new head for the ANZ Paediatric Intensive Care Registry

This year, Tony Slater steps down as director of the ANZ Paediatric Intensive Care Registry after 15 years. Tony has overseen the development of the registry to the point where there are presently over 10,000 critically ill paediatric admissions reported from adult and paediatric ICUs throughout Australia and New Zealand. We wish Tony all the best with his new role as Director of ICU at The Lady Cilento Children's Hospital in Brisbane and look forward to working with his successor, Dr Johnny Millar from the Royal Children's Hospital in Melbourne.

And finally……

Thank you to all collecting data and an equally big thank you to the staff at ANZICS CORE. Without all your efforts, none of this would be possible. Keep in touch with ANZICS CORE at **www.anzics.com.au/core** or follow us on twitter @ANZICSCORE

David Pilcher
Chair, CORE

Centre for Outcome and Research

List of publications:

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Clinical Trials Group

In our 20th anniversary year, the CTG has continued to further its mission to promote collaborative multicentre clinical research in intensive care, focussed on improving patient-centred outcomes. Major achievements include further funding from the Health Research Council (HRC) of New Zealand and the Australian NHMRC adding to a CTG research total of over $63M and passing the milestone of more than 100 publications.

There has been a high level of activity in CTG-Member ICUs this year with many trials recruiting. ARISE (early-goal directed resuscitation in sepsis vs standard care) completed recruitment of 1600 patients in April and results will be published in October. The 400-patient BLING II (infusion of beta lactam antibiotics) has also recently finished, and HEAT (paracetamol versus placebo for fever in sepsis) has just completed its 700 patient recruitment. Current actively recruiting major studies include ADRENAL (low dose hydrocortisone for septic shock), TRANFUSE (fresh vs standard aged red cells), EPO-TBI (erythropoietin in traumatic brain injury), POLAR (prophylactic hypothermia for traumatic brain injury), PHARLAP (open lung strategy for ARDS), SPICE (targeted light sedation, using dexmedetomidine vs standard care sedation), RELIEF (restrictive vs. liberal fluid use peri-operatively, jointly with the ANZCA Clinical Trials Group), and PATCH (prophylactic tranexamic acid in trauma, jointly with ambulance services and emergency medicine).

In the development area of novel trial design, the first CTG cluster-crossover trial, SPLIT (a 4-ICU pilot study of 0.9% saline vs balanced salt solution for ICU resuscitation) which, as a sign of what such study designs can achieve, is nearing completion with over 2000 patients recruited in 6 months. The Point Prevalence Programme has been re-invigorated this year, and will undertake its 8th day in September as a collaborative between the George Institute for Global Health and the CTG. Many of these larger studies have international sites, and we currently have collaborators recruiting in many countries including Ireland, the United Kingdom, Finland, Denmark, France, Germany, Saudi Arabia, Hong Kong, Malaysia and Singapore. We have seen significant success with project funding, particularly from New Zealand, in the 2013/14 year. Paul Young was awarded $200,000 for SPLIT last July and the study will complete recruitment in a little more than 1 year after funding. PATCH (prophylactic tranexamic acid in trauma) received $60,000 from the NZ Lottery Grant Board to help start this NHMRC-funded study in NZ. More recently the HRC NZ awarded SPICE (Sedation Practice in Intensive Care Evaluation) researchers $1.18M to support the multi-national phase III study of early goal-directed sedation vs standard care, and this study has also been successful in Malaysia with a $200,000 project grant. RELIEF, a NHMRC-funded phase III trial of liberal versus conservative fluid therapy for patients undergoing major elective surgery undertaken in collaboration with the College of Anaesthetists Trials Group was also supported by the NZ funder receiving $771,000, and the international SuDICCU (selective GI tract decontamination) collaborative was successful with a $1.2M award.

Significantly, the Medical Research Institute of New Zealand based in Wellington, which has facilitated some of the previous NZ ICU research, was also awarded additional infrastructure funding from the HRC this year to further extend our NZ research capability. Although there were no CTG-endorsed studies with NHMRC project grant applications in 2013, support for Australian research in collaboration with European-funded programmes was provided to Jamie Cooper ($358,000 for effectiveness research in traumatic brain injury) and Steve Webb ($376,000 for preparedness against emerging epidemics); both of these awards will facilitate future CTG involvement in these international collaborative programmes. This year NHMRC project grant applications have been submitted for TARGET (augmented vs. reduced goals for energy delivery, Marianne Chapman), REVITALISE (Vitamin D supplementation in critical illness, Priya Nair), the ARISE/ProCESS/PROMISE individual patient data meta-analysis (EGDT vs standard care in sepsis, Michael Reade), TEAM (trial of early activity and mobility, Carol Hodgson) and SuDICCU (Ian Seppelt). We are also grateful for the Intensive Care Foundation which has continued to support early-stage CTG research: Priya Nair ($29,000; Vitamin D dosing), Ed Litton ($34,000; prophylactic intra-aortic balloon counterpulsation), Glen Eastwood (therapeutic hypercapnœa after cardiac arrest) and Heidi Buhr ($5,000; ADRENAL consent study).

Clinical Trials Group

A successful CTG Winter Research Forum was held in Melbourne in August, and CTG researchers contributed to the ANZICS Annual Scientific Meeting held in Hobart with sessions on research in fluids and nutrition. The major meeting of the year was again held in Noosa in March and our international speaker was Prof Anders Perner from the Scandinavian Critical Care Trials Group. A total of 218 delegates attended the main meeting and the two associated meetings of the Intensive Care Research Co-ordinators Interest Group and the Centre for Outcome and Resource Evaluation (CORE).

As part of our 20th anniversary celebrations, special tribute was paid to the five previous CTG chairs - Rinaldo Bellomo, Simon Finfer, John Myburgh, Jamie Cooper and Steve Webb - who were all present in Noosa this year - and we took the opportunity to acknowledge their contributions to the CTG's development since 1994. We were also delighted to congratulate John Myburgh who became an Officer of the Order of Australia in the 2014 Queens' Birthday honours. John has made a major contribution to the development of intensive care research in Australia and New Zealand, and continues to lead the Division of Critical Care and Trauma at the George Institute for International Health, which has been a key collaborator in major projects throughout our 20-year history

This year seen some changes to the regional representatives on the CTG Executive Committee and we are pleased to have Manoj Saxena (NSW), Michael Reade (QLD), Adam Deane (SA) and David Cooper (TAS) as new members. On behalf of the Committee, 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. Finally, I would like to acknowledge and thank the research co-ordinators and clinical staff of the ICUs throughout Australia, New Zealand, and internationally, who have continued to contribute so enthusiastically to the CTG study programme.

Colin McArthur
Chair, Clinical Trials Group

Death and Organ Donation

DODC Activity

During this year the DODC has worked closely with the College of Intensive Care Medicine (CICM) and The Australian Organ & Tissue Authority (AOTA) on a number of projects. The first project was the review of the new Family Donation Conversation (FDC) workshop content. As mentioned in last year's report, the revised workshop was developed by OTA. Many of the DODC members and two CICM committee members attended the FDC pilot workshop in March 2014 and subsequently provided advice and feedback on more than a hundred workshop powerpoint slides. Mary White and I are both ANZICS representatives on the OTA Family Conversation Steering Group (OTA FCSG). The DODC also continues to work with CICM to develop relevant on-line teaching materials for trainees and fellows. To manage this work, the DODC has been meeting monthly by teleconference.

A reminder that the ANZICS Statement on Death and Organ Donation was published online as Edition 3.2. last year. This is a reminder to all members that this is available from **http://www.anzics.com.au/death-and-organ-donation,** or under the DODC downloads section under **http://www.anzics.com.au/downloads/cat_view/12-death-and-organ-donation-committee.**

AOTA Activity

AOTA continue to roll out the family donation conversation (FDC) workshops with continuing positive feedback. The national pilot evaluation of the 'collaborative' (QLD, VIC, ACT, NT, TAS and WA) and 'designated requester' (NSW) models of organ donation requesting has continued since 2013. South Australia is not participating in this study. An interim analysis was presented at the OTA FCSG. So far more than 900 ICU and ED doctors and nurses have been surveyed and more than 100 donation conversations have been recruited for analysis.

End-of-Life Care Working Group (EOLCWG)

The EOLCWG, established as a subcommittee of the Death and Organ Donation Committee (with additional non-DODC membership) has continued its work on the ANZICS Statement on Care and Decision-Making at the End-of-Life for the Critically Ill. Although originally commenced as an expansion of the 2 page original ANZICS statement on Withholding and Withdrawing Treatment this document is now more than 100 pages, far more comprehensive and referenced and provides practical advice and linking to external resources. A 'for-consultation-draft' has been finalised and circulated to the ANZICS membership as well as to relevant external stakeholders for review and feedback. The EOLCWG looks forward to reviewing the statement in light of received feedback and aims to have a completed version published in October 2014 in time for the Annual Scientific meeting (ASM). The document is due to be published in an electronic format which will a) facilitate keeping the document up to date and b) provide the opportunity for readers to easily access the document.

William Silvester
Chair, DODC and EOLCWG

Education Committee

The work of ANZICS has a reputation around the world, yet 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.

The ANZICS Education Committee was established in part to investigate and implement ways for the Society to become more engaged with new consultants and senior trainees in Intensive Care Medicine. Through the course of discussion, the ANZICS Education Committee has identified the opportunity for complementary training for new Fellows, which shows them how to use the tools at their disposal from within the Society and the broader Intensive Care community, for the benefit of their ICUs and their careers.

The inaugural New Consultant Course: ANZICS – 'Keeping it Real' was held at the Hobart ASM in 2013. The program for the 2013 course consisted of various sessions presented by leaders within the Society including Immediate Past President Prof Mary White, and President Andrew Turner and facilitated by the education committee. It was an introduction for Senior Registrars and new Consultants on how best to utilise the tools that the Society offers. Results from the course evaluation show that course participants achieved a better understanding of the learning objectives and the Society as a whole. The Education Committee is dedicated to continuing to deliver this course with the new name 'ANZICS Foundation Course', and are pleased to advise that it will be integrated into the ASM program for 2014 as well as in future years. It has been designed to complement the content of transition to consultant courses which are now mandatory for Fellows of the College of Intensive Care Medicine.

Another initiative of the Education Committee is the development of an online Education system, to be rolled out in the 2014 -2015 calendar year.

Content has been taken from a variety of areas such as the ASM, SQAO, and the various committees of the Society and will be made available online. The delivery of recorded sessions and presentations will also be rolled out in the form of webinars 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. Due to the prevailing reality of a "full" clinical training calendar and the many courses available to trainees, it was agreed that the 2014 ICM course would be postponed until February 2015.

As many of you will be aware, for the last 7 years this course was impeccably convened by the late A/Professor Ramesh Nagappan, I would like to take this opportunity to recognise Ramesh's dedication to ANZICS and providing continuing education to Intensive Care specialists.

Finally, 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. 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

Paediatrics

The Paediatric Committee membership and meeting frequency has declined in recent years, partly because of increased activity of associated groups such as the Paediatric Studies Group and the Registry Clinical Advisory Committee. However, there are plans to rejuvenate the Committee in the coming months and re-establish regular meetings. Paediatric involvement and representation is important for a healthy and dynamic Society that can reflect the full range of Intensive Care practice in our region.

ANZPIC Registry

Dr Tony Slater is stepping down as Director of the ANZPIC Registry to concentrate on his new appointment as Director of ICU at the Lady Cilento Children's Hospital in Brisbane. Tony has steered the Registry since its inception in 1997 and overseen its growth from a far-sighted idea to a robust and comprehensive binational database. We would like to take this opportunity to thank Tony for his sustained and Herculean efforts for the last 15 years and wish him all the best in his new post. Dr Johnny Millar will be taking over as the Director of the Registry.

Data for the 2013 Annual Report have been finalised and distributed to contributing units, with the complete report to be published shortly. The Report continues to grow; 11,000 paediatric admissions to ICUs were documented in 2013. 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 has met regularly over the last year and is a valuable forum in which to discuss strategic planning for the Registry, address specific questions and problems regarding data collection and interpretation and develop mechanisms to investigate data outliers. Preliminary unit-identified outcome data from each year are reviewed and discussed by the representatives from each specialist PICU prior to publication of the Annual Report. The Committee also reviews data requests and research proposals.

There are ongoing discussions about data linkage 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 and was published in late 2013. The utility of this locally-developed scoring system has been gaining increasing international recognition and is becoming more widespread. Local (Australia and New Zealand) calibrations are used for the calculation of standardised mortality ratios published by ANZPICR.

Paediatric Studies Group

The Paediatric Study Group has had a busy period, having completed a number of studies and embarking on several new projects. The committee has been stable now for a number of years and has managed to oversee a period of excellent collaboration among the 8 paediatric ICU's in Australia and New Zealand.

The Hypothermia in Traumatic Brain Injury in Children (HITBIC) study has now been completed and the manuscript is under revision for publication. This was a great collaborative project for our group and emphasized some of the difficulties in doing research in paediatric intensive care. It coincided with other trials in Canada (HypHIT) and the US (Coolkids). The HITBIC results have been presented at a number of forums (CTG Noosa, PALISI meeting in Chicago and ANZICS ASM)

Major activity in the PSG revolves around the SPICE (Sedation Practices in ICU) programme in children:

An observational study looking at sedation practices in PICU (Baby SPICE) was completed in mid-May 2013 and was presented at the PICU World Congress in Istanbul. The study was supported by an unrestricted grant from Hospira® and a seeding grant from the Princess Margaret Hospital Foundation.

Paediatrics

An RCT of Early Goal Directed Sedation is being planned with an NHMRC grant application in preparation, also funded by Hospira® and the PMH Foundation. A Management Committee has been established to work on the grant application with assistance from the ANZIC-RC. A pilot study is about to start in 5 PICUs, results of which will aid the NHMRC grant application and hopefully lead to a phase III RCT. The SAFE-EPIC Study was an international point prevalence study looking at fluid resuscitation in PICU that has now been completed. The PI is Marino Festa who has managed to include over 120 PICU's internationally for 2 point prevalence days. This study was funded by a seeding grant from ANZICS. The results were presented at the PICU World Congress in Istanbul this year.

Other PSG studies in development or being completed include:

Inception study on transfusion practice in peri-operative congenital heart disease (CHD): A multi-centre observational inception study with the aim to describe red blood cell transfusion practice and "quality" of red blood cells transfused by clinicians, in Australasia and North America, in children with congenital heart defects (CHD). Dr. Elena Cavazzoni (Westmead Children's) is the PI.

Epidemiology of Paediatric Chronic Critical Illness in Australia and New Zealand. An epidemiological study looking at the outcome of long-stay PICU patients. The PI for the study is Siva Namachivayam from Royal Children's Hospital, Victoria. This study has been completed and a manuscript is about to be submitted for publication

Melbourne ASM

This year's ASM is keenly anticipated and excellent international speakers have been secured for the paediatric programme. Professor Pat Kochanek, Editor of Pediatric Critical Care Medicine and Kevin Morris, President of the UK Paediatric Intensive Care Society will both contribute to what promises to be a great couple of days in Melbourne.

Johnny Millar
Chair, Paediatric Committee

Practice and Economics

Medicare

The Practice and Economics (PricE) Committee's main focus over the 2013-2014 year was the progression of our longstanding submission to the Department of Human Services (DHS) with respect to the development and introduction of new item numbers for out-of-ICU consultations by Intensivists, such as occurs during Medical Emergency Team (MET) calls. The previous submission produced by ANZICS was re-worked by a consulting firm- Aspex Consulting, commissioned by the department. This was in concert with submissions from other craft groups that also have among their number some practitioners who have access to Consultant Physician item numbers for referred consultations and some who do not. These specialties include occupational medicine, sexual health and addiction medicine.

Despite initial positive response, the Medical Services Advisory Committee (MSAC) of the DHS chose to advise the Health Minister that there was insufficient evidence that providing out-of-ICU consultation item numbers will improve health outcomes for patients- essentially the only criterion on which they base their decisions. We conveyed our disappointment, reiterated that this submission was about equity- same rebate for same specialist service, about universality- not being restricted to Intensivists, and about encouraging keeping patients out of ICU.

Admission of a deteriorating patient to Intensive Care is nearly always clinically appropriate, although it may not be the most cost-efficient way of providing care. Our members should not be required to subsidise a healthcare system, which has declined to address the inequity in the current CMBS structure.

Over the coming year PricE will continue to work toward negotiating a fair Medicare rebate system that provides for an equal patient rebate for the same service provided by Intensivists with differing specialist qualifications.

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 ANZICS and the CICM, as to whose responsibility it is to try to manage the matching of likely positions to the number of trainees that are working toward Fellowship.

The changes in CICM training regulations has had an apparent large effect on the rate of registration for training- although, when comparing the first three months of 2014 with the first three months of 2013, the big reduction is somewhat skewed by the large number of doctors who registered toward the end of 2013 to avoid being beholden to the new training programme.

PricE Committee's concerns are two-fold with respect to the flood of graduates- firstly and most importantly we are interested in their welfare and employment prospects. Secondarily, we are worried about the effect a large overhand of un- or under-employed young fellows will have on the terms and conditions of current Intensivists and the roles and work patterns (e.g. night shift work) that may be imposed by hospital administrations.

ICU Funding under Activity Based Funding

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 Hospital Pricing Authority.

Practice and Economics

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 since the initiation of this ABF funding model. 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. Whilst there have been suggestions that ICU funding may be based on some acuity-based model, utilising CORE Adult Patient database (APD) data, there has been minimal or no progress over the last six months of 2013-2014. PricE Committee awaits further news from the IHPA.

Future Directions for PricE Committee

The period 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.

At the end of 2013-1014 PricE Committee undertook an election for Chair. I did not stand for re-election and I am pleased to announce that Dr Mark Nicholls from NSW was elected as the new Chair. I wish Mark all the very best in his role over the coming years.

Ian Jenkins
Chair, PricE Committee

Safety and Quality

In 2013/2014 the Safety and Quality Committee has continued to strive towards promoting safe high quality care in Australian and New Zealand Intensive Care Units. The Committee meets regularly throughout the year, reporting back to ANZICS members via the Intensivist Newsletter. The Committee and the ANZICS Board finalised the Committees Strategic Plan in the past year and whilst some of the projects have changed the over arching values by which the Committee works remains the same.

The Committee enacted its Terms of Reference in October 2013 leading to a change in some members of the Committee. As a result the Committee this year now has every region represented. I would like to make a special mention of the Immediate Past Chair Deepak Bhonagiri for his contribution to the Committee in the role of Chair for the past 2 years. Deepak's corporate knowledge and support of the Committee continues in his position of Immediate Past Chair. I would also like to acknowledge and thank the outgoing Committee members including: Jeffrey Presneill (QLD), Sumesh Arora (NSW), Manoj Singh(NSW), Cameron Knott (Vic), Michael Buist(Tas), John Lewis (WA), Tony Williams (NZ), and Brigit Roberts (WA).

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 sought feedback from ICU Directors and ANZICS members in the key areas in February 2014. The surveys indicated that there is strong support from members for continued development of an education package in this area. The Safety and Quality Committee has also 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.

During the past year the Committee has undertaken a review of the 2010 ANZICS Percutaneous Dilatational Tracheostomy Statement led by Krish Sundararajan. Following minor amendments to the document the ANZICS Board has approved the 'ANZICS, Percutaneous Dilatational Tracheostomy Consensus Statement', 2014.

In order to meet the Committee aim to promote the use of appropriate clinical indicators when measuring and comparing practice the Committee is working more closely with CORE in regards to 'safety and quality' data. Using the ACSQHC National Standards as a guide Jonathan Barrett took a lead role in representing the Committee and working with ANZICS CORE in reviewing and amending the questions in the annual Critical Care Resources Survey. Jonathan has also taken a lead role in representing the Committee in preliminary discussions regarding the feasibility of developing a national Rapid Response Team database.

The Committee is committed to developing closer relationships with external stakeholders including the Australian Commission on Safety and Quality in Health Care in documenting and promoting safe, high quality care. Krishna Ponasanapalli represented the Committee in developing a joint ANZICS / CICM response to the Australian Commission on Safety and Quality in Health Care's consultation on training and competencies for recognising and responding to clinical deterioration in acute care (included in Standard 9: Recognising and Responding to Clinical Deterioration in Acute Health Care).

The7th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (SQAO) was held at The Hilton Sydney in July 2013. There were 90 registrations to the conference which covered a broad range of topics including sessions on: The Australian Commission on Safety and Quality in Health Care's Ten standards for safety and quality and how these standards relate to ICU; recognition and management of sepsis; communication with families and free paper presentations. The program also included a facilitated workshop to explore the issue of clinical handover in the ICU.

Safety and Quality

An Executive Summary of the Workshop was presented in the May 2014 Edition of the ANZICS 'Intensivist' Newsletter. Major themes to emerge from the workshop included:

Governance and Leadership

- Establish written guidelines for clinical handover in ICUs
- Directors and senior staff lead by example by modelling good handover technique
- Regularly review handover practices

Clinical handover processes

- Distinguish clinical handover from other processes such as ward rounds
- Ensure scheduled, dedicated, uninterrupted time for handover
- Include senior clinical supervision
- Develop a structured handover process including minimal mandatory components

Patient and carer involvement in clinical handover

- Inform patients and carers on the purpose of handover
- Balance involvement to achieve valuable contribution and handover efficiency
- Identify appropriate information to share with patients a and carers and effectively manage patient privacy and confidentiality issues

I would like to thank all the current members of the Safety and Quality Committee for their hard work: Jonathan Barrett (Vic), Krishna Ponasanapalli (WA), Krishnaswamy Sundararajan (SA), Ian Seppelt (NSW), Benoj Varghese (Tas), Alex Kazemi (NZ), David Schell (Paediatrics), Deepak Bhonagiri (IM Past Chair), Bernadette Grealy (ACCCN), and Mary Pinder (CICM).

I would also like to recognise the contribution of all ANZICS members in providing feedback to the Safety and Quality committee via the surveys we distribute.

Results of the surveys help us define and develop the activities the Committee undertakes. The Committee is open to any comments or suggestions you may have and we invite you to be in touch by contacting: safetyandquality@anzics.com.au.

Angus Carter
Chair, Safety and Quality Committee

Victoria

Victorian Intensivists have continued to enhance and expand the reach of collaborative educational and training support networks. This is well exemplified by the Victorian Intensive Care Education Network which now incorporates most teaching hospital intensive care units, including a major trauma center, a paediatric referral center, a major private hospital as well a range of other major metropolitan units. Trainees from participating hospitals and rural sites are supported by monthly whole day educational events hosted by each hospital in a manner that fits with their patient casemix and specialty services. While not following a formal rigid curriculum, over the annual cycle of events a very broad range of critical care topics are covered and much opportunity is provided to participate in hands-on simulation and professional development topics. By obtaining feedback from participating trainees, each site receives useful data to guide future educational activities. Further expansion is planned and is largely driven by the enthusiasm of trainees and their supervisors for inter-hospital collaboration.

The Alfred Department of Intensive Care are once again coordinating the organization of another trainee research presentation night. This event will occur in the latter part of the year at a venue and date to be decided and will provide a great opportunity to showcase the very best of trainee led research to a supportive audience of peers and senior clinicians. Specific details will be announced as soon as plans are confirmed.

The ASM will be the major focus of Melbourne activity during the second half of 2014 and the dynamic organizing committee has been working hard with our ACCCN colleagues to ensure that the meeting achieves the high standards established over so many years. Local and overseas experts will share updates on the cutting edge of practice across all ICU domains. Specific highlights will include the presentation of the ARISE study results, a session providing the opportunity to engage with editors from several journals, a session led by critical care experts affiliate with the Australian Defence Forces, professional development for trainees and several skill-based workshops. The number and quality of free paper submissions is also notable this year.

It hardly needs to be stated that the social events will be extraordinary- the MCG will clearly be a great venue for the Friday night party. Delegates are strongly advised to book accommodation early as this is a popular time of year to visit Melbourne.

During the course of this year our society has lost a valued colleague and friend. Ramesh Nagappan was known to all in ANZICS as a tireless champion of intensive care practice, clinical training, assessment and trainee support. As a caring clinician he was loved by patients and their families. As an organizer and promoter of education, he was greatly appreciated by trainees. As a mentor, colleague and friend, he will be missed by his peers. Vale Ramesh- especially in Victoria we will miss your witticisms, kind accolades, devotion to patient centered care and above all, your friendship.

Stephen Warrillow
Chair, VIC Regional Committee

South Australia

2013-14 has continued to see many South Australian intensivists contribute to the ongoing success of the Society. Many of these individuals have been contributing for a number of years and continue to advance our specialty at a national and international level. We have welcomed a number of new members to the society who we hope will gain benefit and find ways to get involved with some of the important work that ANZICS does.

From an educational and research perspective, South Australia continues to punch above its weight. Dr Yasmine Abdelhamid won the 2013 Matt Spence medal in Hobart. This makes a South Australian trainee the recipient of this award for an unprecedented 4th year in a row. This success, as always, is built upon the strong leadership and mentorship from all the clinical educators and researchers within SA. Special mention must go to A/Prof Adam Deane, A/Prof Sandy Peake and Dr Mary White who through ANZICS continue to raise the bar and support our trainees. Many other individuals contribute to this success by giving time to chair and speak at sessions during the ANZICS ASM.

Despite this success, intensive care locally continues to experience pressure from external factors. There are massive changes occurring within the whole of SA Health, the new Royal Adelaide Hospital is due to open in 2016 although current commentary makes a delay seem likely. With this huge investment in infrastructure, at a time of severe constraints in the health budget, how to effectively deliver intensive care services across the State is in the spotlight. Intensive care has a unique position in the health system, allowing other teams to have immediate backup to high level support for their patients. Clearly many public hospitals can operate effectively without this access, although greater attention and thought needs to go into what procedures are performed and on whom. Limiting access to intensive care is the most effective way to change behavior and can be done without affecting patient care.

Being a small State, with a worsening financial position, how to equitably distribute the health care dollar needs careful thought and clinical engagement.

Given staff costs are such a large part of the health budget, it is in all clinicians interests to provide a cost effective service of good quality. Over the next two years, constructive engagement will be required to ensure that our patients, our specialty and ourselves are not disadvantaged. Thank you to all those at ANZICS central for their administrative support, we look forward to a productive year ahead.

Stewart Moodie
Chair, SA Regional Committee

Tasmania

Over the past couple of years ANZICS activity in Tasmania has largely revolved around the planning of the 2013 ANZICS ASM. Once again, it was a well attended and successful meeting, both academically and socially. Thanks again to all those who gave their time. Society Membership remains strong and stable here in Tasmania, with small changes largely reflecting trainee migration. For some time now the number of specialists has remained small but stable - presently there are 11 adult Intensivists employed across three campuses. Support from anaesthetic colleagues, including some with CICM Fellowship, remains a key factor in maintaining critical care services in the north of the state, at both Launceston General and Northwest Regional Hospitals.

Tasmania has had a difficult few years in the health sector, and critical care has seen many challenges. Significant budget cuts imposed by the former state government look set to continue under the new state government, elected in March this year. There will however, be wholesale changes to the state's health system. The Health Minister recently announced that the three Tasmanian Health Organisations (THOs) set up under the Rudd funding reforms will be merged into one statewide THO by July next year. This change is widely supported and consistent with what most clinicians thought should have been done originally. It makes better sense for a state with a widely dispersed population of only 500,000, and only three major public hospitals, to have a single well coordinated overarching management structure. As usual, the devil will be in the detail, and we will continue to engage with policymakers and see what develops. It is likely that many clinical services will be restructured into proper statewide services and we will have to wait and see how this ultimately impacts on critical care. During this period of budget cuts we have also seen significant increase in demand for ICU beds in our two major public hospital units, LGH and Royal Hobart Hospital. For example, ICU admissions at RHH, the state tertiary referral centre, increased by around 8% per year from the 2011-14 period compared to 2007-10. LGH has had similar increases in the past few years and both continue to have upward trends in admissions.

A significant part of the workload in these two centres comes from the North West Regional Hospital, which has had difficulty maintaining staffing and services over the past few years. Both RHH and LGH regularly operate over their funded bed numbers, with nursing availability being a major limiting factor. Additionally, we are all experiencing rapidly rising MET workloads, without any additional support or funding. Clearly, considerable challenges remain, and we are working on a number of fronts to improve statewide collaboration, streamline inter-hospital critical care referral processes whilst maintaining high levels of both clinical care and training. Data provided via ANZICS CORE continues to help us support arguments for change. On the more positive front, we have recently had major upgrades to the ICU facilities and equipment at both LGH and RHH. These were very much overdue, and whilst extra bed spaces aren't funded, there are more physical beds now than ever before. All staff at both units are enjoying working in their new environments.

Coming up to five years since the national reforms around organ donation, it is a good time to reflect on the substantial gains made here in Tasmania. Prior to 2009, all organ donation in Tasmania was managed by coordinators coming from Victoria, with local Intensivists. A statewide Donate Life team was set up from scratch, with staff now based at all three major hospitals. Whilst year-on-year data can be misleading due to the very small population here, average annual donation rates, on a per population basis, over the past five years have more than doubled compared to the previous decade and are now around the national average. NWRH at Burnie had their first organ donor in 2010 and there is a DCD system working well at RHH. This is an outstanding achievement in a short time and congratulations must go to all concerned.

Training in Intensive Care in Tasmania continues to be popular, as we are able to provide a wide range of clinical cases, good access to non-ICU training rotations, rural and regional critical care experience and excellent Senior Registrar posts with on-call. The new curriculum will pose new challenges and we will continue to look at statewide rotations for trainees and to assist those wanting to do all their training here in Tasmania. Finally, I would like to thank all the Tasmanian Intensivists who have given time to work with ANZICS Committees. We are few and spare time is increasingly hard to find. This work is important and I hope you can continue to give your time.

David Rigg
Chair, TAS Regional Committee

New Zealand

This year's NZ ASM held in March in Christchurch was a great event and well attended, with 123 delegates in all. Congratulations to all the team involved, led by Dave Knight and Nikki Ford. The excellent speakers included Hannah Wunsch, Brian Kavanagh and Kathleen Vollman visiting from North America, Brian Robson from Scotland and local speakers from New Zealand and Australia. It was a great opportunity both to catch up with colleagues from around the country and to see the regeneration of Christchurch after the devastating earthquakes of February 2011. Dinner in the transitional "cardboard" Cathedral was a memorable highlight.

The AGM held at that meeting was also well attended. Our support for the New Zealand Nurses Organisation Critical Care Nurses Section continues by way of donating a share of the conference profits to provide scholarships for members to attend future conferences. Other suitable uses of the funds raised by the annual NZ Meeting were discussed. This will include sponsorship of a NZ branch of the 'Intensive Care Network' website and events. We continue to support the successful Wellington Intensive Care Medicine Course organised by Chris Poynter and hope to be able to support a New Zealand Primary Exam Course also in the near future .

There will be no NZ ASM next year as Middlemore Hospital will be hosting the ANZICS/ACCCN ASM at Sky City in Auckland under the banner of ICU Under Pressure on 29 – 31 October. Save the date for what promises to be an excellent meeting!

NZ researchers continue to make a significant contribution to the ANZICS CTG, chaired by Colin McArthur and with Rachael Parke and Shay McGuinness on the Executive Committee. Thank you to all who have enrolled patients to the HEAT study (paracetamol vs. placebo), which is now completed. Enrolment for the SPLIT study (Saline vs. Plasmalyte) is now more than three-quarters complete. Future NZ led studies include Rachael Parke's post-cardiac surgery fluid management study, Paul Young's gastric protection study (PEPTIC: PPI vs. H2 blocker), and Alex Psirides' observational study of Medical Emergency Team Calls.

There will be a second Intensive Care Research Symposium held in Wellington 12 – 13 November organised by Rachael Parke and Shay McGuinness from Auckland CVICU. This will be a great opportunity for anyone involved in ICU research to meet up and exchange ideas.

This year, Professor Barry (Arthur Barrington) Baker was awarded a Member of the General Division of the Order of Australia in the Queen's Birthday Honours for his significant service to medicine. He was foundation Professor of Anaesthesia at the University of Otago at Dunedin from 1975 to 1992 and also of Intensive Care from 1981. He was Inaugural Chair of the Section of Intensive Care of the Faculty of Anaesthetists, Royal Australasian College of Surgeons, and was an organiser of the first Australasian Intensive Care Conference of the Faculty in Adelaide 1976.

NZ membership currently stands at a total of 97, including 13 trainee members. We are so close to passing the magic 100 mark! Please continue to encourage your colleagues, including our trainees, to join us.

Ben Barry
Chair, NZ Regional Chair

Western Australia

During 2013-2014, 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 elected to the Board of Australian Medical Association (AMA) at a federal level after three years as Vice President of the Australian Medical Association, Ed Litton continues as our CTG Executive member, whilst Krishna Ponasanapalli replaced John Lewis as the Safety and Quality Committee member. Greg McGrath remains as our PricE representative and I remain as PricE Committee Immediate Past-Chair. Given that the management and governance structure of CORE is once again being revisited, Western Australia's regional committee has withheld nominating a CORE regional representative.

During the year, one of ANZICS (WA)'s most esteemed, and certainly respected and liked, members, Brad Power retired from clinical practice. Brad has been Medical Convenor for the ANZICS/ACCCN ASM not once but twice - 2001, just weeks after the Bali bombing and 2009, in the face of serious and protracted illness and has been Regional Chair and regional representative on Safety and Quality Committee. His razor-sharp wit matched only by the sharpness of his clinical acumen and ability to teach, enlighten and amuse concurrently will be terribly missed. The Regional committee suspects we will see Brad back doing non-clinical activities to further our profession before very long.

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

We have also held several evening educational meetings, including presentations from international speakers- from Intensive Care epidem-iologist experts like Kathy Rowan from ICNARC (Intensive Care National Audit and Research Centre) and Jerry Nolan from London, who is an expert on post-resuscitation pathophysiology, management and prognostication. 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 have been previously over-represented at a 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

Queensland

The last financial year has been incredibly challenging for the intensive care medical workforce in Queensland, with the last 8 months largely overshadowed by complex and at times hostile contract negotiations with the Queensland Government. By May 2014, the stalled contract negotiations appeared certain to destroy the health system, with significant numbers of Senior Doctors pledging to resign on mass. The principle concern of the Senior Doctors was not the introduction of individual contracts, but rather the draconian conditions revolving around conflict resolution and unfair dismissal clauses. Furthermore, the draft contract was basically meaningless, as it was feasible for the Director General at anytime to issue a directive overriding any conditions of the contract.

ANZICS demonstrated significant support for the Senior Doctors, including several firm letters imploring the government to reconsider its stance and ultimately, the unprecedented step, of taking a half page advertisement in the Saturday Courier Mail. The determined efforts of those in the Senior Medical Officer Task Force saw a final intense week of standoff and discussion. Ultimately an in-principle agreement over senior medical contracts was achieved after Health Minister Lawrence Springborg made a series of significant concessions. The new contracts are not perfect, and time will tell if they are detrimental to the development of our work force. However, what we do know is that the concessions were sufficient to allow the vast majority of specialists to sign the contracts and continue as they had always wanted, to deliver world class care to the people of Queensland. It is also worth noting that many intensivists were very involved in the negotiations and in this regard particular credit goes to Dr Siva Senthuran and Professor John Fraser.

Significant changes to the health structure have simultaneously occurred. Legislation was introduced in May 2012 by the Health Minister, Lawrence Springborg, formalising the conversion of the health districts created in the 2005 restructure to independent local Hospital and Health Services (HHSs). This model provides for each HHS to have their own board to manage the operations of the HHS. Effectively we now work for individual Hospital and Health Services, as opposed to being Queensland Health Employees. It is in this environment that the concept of clinical streaming is being introduced which in turn may present new challenges to the intensive care medical workforce. ANZICS will monitor developments very closely and will always be prepared to intervene in the interests of the critically ill and the Society's membership.

The 2012 state government withdrawal of funding supporting the submission of data to ANZICS CORE by private Queensland intensive care units has unfortunately seen a number of hospitals over 2013 withdraw from this vital activity and the Executive and CORE Committee continues to strongly encourage units not to be left out of an important quality assurance activity.

The Queensland Training Pathway has yet again survived the harsh financial environment and continued to very effectively coordinate the state-wide intensive care training scheme. This system not only guides registrars through their training, but maximises their training experience with this centrally controlled process ensuring Queensland remains a popular state for intensive care medicine training. Queensland is blessed with a very energetic intensive care research group, who attract major grant funding and deliver world class research outcomes. The CTG meeting in Noosa this year was again a great success. Thank you to all of those involved in its organisation. The co-badged CICM/ANZICS Registrar Research Forum was once again hosted in Brisbane in November 2013 receiving very positive feedback. The intention is to again support this years Registrar Research forum.

Queensland ANZICS continues to have 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 month ANZICS Queensland will be seeking expressions of interest from members wishing to be considered for the Regional Chair of Queensland. We look forward to a toughly contested vote. This is a great opportunity to make a contribution to our specialty within our state and to serve in this capacity is both a wonderful challenge and privilege.

Anthony Holley
Chair, QLD Regional Committee

New South Wales

ANZICS NSW has not been particularly busy this year, and there have been no major issues I have had to address. We conducted 4 Educational meetings since the last report and these have been well attended. I do however hope that participation in these meetings improves and am focusing on making these meetings more interesting and accessible to all ANZICS members. We cobadge these meeting with CICM and more recently with The Intensive Care Network in an effort to reach out to more Intensive Care specialists and trainees.

I have not heard of any ICU bed closures in NSW as reported in other states. We in NSW kept a close eye on the issues faced by specialists in Queensland and will continue to monitor any proposals by the NSW Ministry of Health to review specialist awards in NSW.

The NSW statewide CIS implementation is progressing rapidly and the first sites are expected to 'go live' later this year. Correspondence regarding this is being regularly disseminated. 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 a 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
1983	Dr S Gatt	Sydney
1983	Dr R Raper	Sydney
1984	Dr N Gibbs	Perth
1985	Dr W Griggs	Adelaide
1986	Dr A Bersten	Adelaide
1987	Dr M Oliver	Auckland
1988	Dr P McQuillan	Perth
1989	Dr T Buckley	Hong Kong
1990	Dr C McAllister	Sydney
1991	Dr R Bellomo	Melbourne
1992	Dr S Parkes	Adelaide
1993	Dr R Totaro	Sydney
1994	*No award presented*	
1995	Dr A Davies	Melbourne
1996	Dr B Venkatesh	Brisbane
1997	Dr D Blythe	Perth
1998	Dr N Edwards	Adelaide
1999	Dr V Pelligrino	Melbourne
2000	Dr I Seppelt	Canberra
2001	Dr R Frengley	Waikato
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 S Kelly	SA
2013	Dr Y Abdelhamid	SA

Past Presidents

1975 - 77	M Spence (NZ)
1977 - 79	GM Clarke (WA)
1979 - 80	RC Wright (NSW)
1980 - 81	R 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	NSW
Cairns 2003	Lindsay Worthley	South Australia
Melbourne 2004	Jack Cade	Victoria
Adelaide 2005	Bob Wright	NSW
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
Hobart 2013	Felicity Hawker	Victoria

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

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 2014 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 Andrew J Turner *President*
Dr Simon Erickson *Hon. Secretary*
Dr Ben Barry *(appointed 21/11/2013)*
Dr Anthony Holley
Dr David Knight *(resigned 21/11/2013)*
Dr Kenneth John Millar
Dr David Pilcher
Dr Stephen Warrillow
Dr Mary G White *Immediate Past President*
Dr Marc Ziegenfuss *Hon.Treasurer*
Dr Satyadeepak Bhonagiri
Dr Ian Jenkins
Dr Colin McArthur
Dr Stewart Moodie
Dr David Rigg

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

Dr M G White
Qualifications: MBBS/BSc/ChB/FFARCSJ
Experience: Director since 2002
Special Responsibilities: Immediate Past 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 B Barry
Qualifications: MBBS/FRCA/FCICM
Experience: Director since Nov 2013
Special Responsibilities: Chair – NZ Region

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 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 attend	Number attended
Dr B Barry *(appointed 21/11/2013)*	2	2
Dr S Bhonagiri	3	0
Dr S Erickson	3	2
Dr A Holley	3	3
Dr I Jenkins	3	3
Dr D Knight *(resigned 21/11/2013)*	1	1
Dr C McArthur	3	3
Dr KJ Millar	3	3
Dr S Moodie	3	3
Dr D Pilcher	3	3
Dr D Rigg	3	3
Dr A J Turner	3	3
Dr S Warrillow	3	3
Dr M G White	3	3
Dr M Ziegenfuss	3	3

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

The Society is incorporated under the *Corporations Act 2001* and is a company limited by guarantee. Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member, for payment of the debts and liabilities of the Society (contracted before he/she ceases to be a member) and of the charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $15,020 (2013: $14,640) being 751 (2013: 740) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2014 has been received and can be found on page 4 and forms part of the directors' report.

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

Dr Andrew Turner - President
Dated this 28th day of August 2014

Dr Marc Ziegenfuss – Hon.Treasurer

Auditor's Independence Declaration under subdivision 60-C section 60-40 of Australian Charities and Not-for-profits Commission Act 2012

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

I declare that, to the best of my knowledge and belief, in relation to the audit for the financial year ended 30 June 2014 there have been:

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

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

KPMG

Darren Scammell
Partner

Melbourne

28 August 2014

Statement of Profit or Loss and other Comprehensive Income

for the year ended 30 June 2014

	Note	2014 $	2013 Restated $
Revenue from ordinary activities	2	2,496,976	2,275,132
Employee expenses		(1,443,638)	(1,321,966)
Administration expenses		(550,802)	(361,658)
Conference and meeting expense		(266,240)	(275,089)
Travel and committee expenses		(181,796)	(117,495)
Depreciation expense		(38,706)	(43,644)
Other expenses from ordinary activities		(68,557)	(63,199)
Profit (Loss) for the year		(52,763)	92,081
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss:			
Gains on revaluation of land and building	8	100,626	-
Other comprehensive income for the year, net of income tax		100,626	-
Total comprehensive income for the year		**47,863**	**92,081**

The accompanying notes form part of these financial statements.

Statement of Financial Position

As at 30 June 2014

	Note	2014 $	2013 Restated $
Current Assets			
Cash and cash equivalents	4	2,001,647	2,156,098
Trade and other receivables	5	179,652	63,401
Financial assets	6	-	83,001
Other current assets	7	53,487	96,995
Total current assets		2,234,786	2,399,495
Non-Current Assets			
Property, plant and equipment	8	2,609,198	2,497,322
Total non-current assets		2,609,198	2,497,322
Total Assets		4,843,984	4,896,817
Current Liabilities			
Trade and other payables	9	611,479	661,554
Employee benefits	10	192,003	164,319
Income fund liability	6	-	83,001
Total current liabilities		803,482	908,874
Non-Current Liabilities			
Employee benefits	10	31,458	26,762
Total non-current liabilities		31,458	26,762
Total Liabilities		834,940	935,636
NET ASSETS		4,009,044	3,961,181
Equity			
Reserves	11	816,723	716,097
Retained profits		3,192,321	3,245,084
TOTAL EQUITY		4,009,044	3,961,181

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2014

	Note	2014 $	2013 Restated $
Cash flows from operating activities			
Receipt of grants		1,364,007	1,134,047
Cash receipts from members and customers		984,586	1,255,140
Interest received		77,321	88,266
Payments to suppliers and employees		(2,613,410)	(2,308,828)
Net cash provided by (used in) operating activities	12	(187,496)	168,625
Cash flows from (to) investing activities			
Purchases of property, plant and equipment		(49,956)	(23,153)
Proceeds from other financial assets		83,001	-
Net cash used in investing activities		33,045	(23,153)
Net increase (decrease) in cash and cash equivalents		(154,451)	145,472
Cash and cash equivalents at beginning of financial year		2,156,098	2,010,626
Cash and cash equivalents at end of financial year	4	2,001,647	2,156,098

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2014

	Note	Retained profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2012		3,153,003	716,097	3,869,100
Profit attributable to the Society		92,081	-	92,081
Total other comprehensive income for the year	8	-	-	-
Balance at 30 June 2013		3,245,084	716,097	3,961,181
Profit (Loss) attributable to the Society		(52,763)	-	(52,763)
Total other comprehensive income for the year	8	-	100,626	100,626
Balance at 30 June 2014		3,192,321	816,723	4,009,044

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

for the year ended 30 June 2014

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 not-for-profit company limited by guarantee. The registered office and principal place of business of the Society is 10 Ievers Terrace Carlton, Victoria, 3053.

1. Summary of significant accounting policies

Basis of accounting

In the opinion of the directors, the Society is not deemed to be publicly accountable for the purposes of determining it's financial reporting requirements. The financial statements are Tier 2 general purpose financial statements which have been prepared in accordance with Australian Accounting Standards - Reduced Disclosure Requirements adopted be the Australian Accounting Standards Board and the Australian Charities and Not-for-profits Commission Act 2012. These financial statements comply with Australian Accounting Standards - Reduced Disclosure Requirements.

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 are in Australian dollars and have been rounded to the nearest dollar.

The financial statements were authorised for issue on 28th August 2014 by the Board of directors.

The Company has consistently applied the following accounting policies to all periods presented in these financial statements:

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).

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

(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.

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.

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

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

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

(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.

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

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 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.

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

(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 24 February 2014 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 $100,626 being recognised for the year ended 30 June 2014. At 30 June 2013, the directors reviewed the key assumptions adopted by the valuers in the 2012 valuation and concluded there were no significant changes in the assumptions at 30 June 2013. The directors therefore concluded the carrying amount of the land and buildings correctly reflects the fair value less costs to sell at 30 June 2013.

(l) Changes in accounting policies

The Company has adopted the following new standards and amendments to standards, including any consequential amendments to other standards, with a date of initial application of 1 July 2013.

a. AASB 13 *Fair Value Measurement*

b. AASB 119 *Employee Benefits* (2011)

The nature and effects of these changes has not materially impacted upon the financial statements.

The Company has determined that the assets, liabilities and results of the New Zealand Region of ANZICS are separately controlled and managed, and therefore will no longer be incorporated into the financial reports of ANZICS. The policy has been applied retrospectively in accordance with Australian Accounting Standards. Consequently, the comparative figures have been restated. The quantitative impact of the change is set out below:

Statement of Financial Position as at 30 June 2013

	As previously reported $	Restated $
Cash and cash equivalents	2,282,410	2,156,098
Trade and other receivables	63,592	63,401
Financial assets	18,364	-
Total Assets	5,041,684	4,896,817
Trade and other payables	663,643	661,554
Total Liabilities	937,725	935,636
Retained profits	3,387,862	3,245,084
Total equity	4,103,959	3,961,181

Notes to the Financial Statements

for the year ended 30 June 2014

1. Statement of significant accounting policies (continued)

Statement of profit or loss and other comprehensive income
for the year ended 30 June 2013

	As previously reported $	Restated $
Revenue from ordinary activities	2,329,029	2,275,132
Administration expenses	363,002	361,658
Conference and meeting expenses	279,418	275,089
Other expenses from ordinary activities	75,821	63,199
Profit for the year	127,683	92,081
Total comprehensive income	127,683	92,081

Except for the changes below, the Company has consistently applied the accounting policies set out above to periods presented in these financial statements.

	2014 $	2013 Restated $
2. Revenue and other income		
Revenue:		
Grants	1,472,370	1,117,451
Subscriptions	463,230	477,541
Surplus from ASM	105,662	143,379
Conferences and meetings	224,053	272,544
Sponsorship	107,220	126,564
	2,372,535	2,137,479
Other income:		
Interest received – cash and cash equivalents	67,597	94,624
Sundry income	56,844	43,029
	124,441	137,653
Total revenue and other income	2,496,976	2,275,132

3. Auditor's remuneration

The auditors of the Society for the year ended 30 June 2014 are KPMG. The total fee is $10,000 of which $5,000 paid directly to the Intensive Care Foundation as a donation on KPMG's behalf.

4. Cash and cash equivalents

Cash on hand	300	300
Cash at bank	2,001,347	116,050
Cash on short term deposit	-	2,039,748
	2,001,647	2,156,098

5. Trade and other receivables

Trade receivables	179,607	53,677
Other receivables	45	9,724
	179,652	63,401

Notes to the Financial Statements

for the year ended 30 June 2014

	2014 $	2013 Restated $
6. Financial assets		
Current:		
Held to maturity financial assets		
- Australians Donate Education Fund	-	83,001
7. Other current assets		
Prepayments – general	35,022	88,983
Prepayments and deposits - ASM	18,465	8,012
	53,487	96,995
8. Property, plant and equipment		
Land and buildings		
Freehold land – at valuation	1,600,000	1,540,000
Buildings – at valuation	950,000	970,000
Less accumulated depreciation	(7,916)	(44,458)
	942,084	925,542
Total land and buildings	2,542,084	2,465,542
Plant and equipment		
Plant and equipment - at cost	220,534	170,578
Less accumulated depreciation	(153,420)	(138,798)
Total plant and equipment	67,114	31,780
Total property, plant and equipment	2,609,198	2,497,322

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
2014			
Balance at 1 July 2013	2,465,542	31,780	2,497,322
Additions	-	49,956	49,956
Revaluation	100,626	-	100,626
Depreciation for the year	(24,084)	(14,622)	(38,706)
Balance at 30 June 2014	2,542,084	67,114	2,609,198
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

Notes to the Financial Statements

for the year ended 30 June 2014

8. Property, plant and equipment (continued)

Asset revaluations

The freehold land and buildings were independently valued at 24 February 2014 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 $100,626 being recognised for the year ended 30 June 2014.

	2014 $	2013 Restated $
9. Trade and other payables		
Trade creditors	8,022	7,779
Sundry creditors and accruals	19,847	26,594
Grants received in advance	268,646	377,009
Subscriptions received in advance	258,464	196,199
Sponsorship & registrations received in advance	56,500	53,973
	611,479	661,554
10. Employee benefits		
Current		
Provision for annual leave	90,205	88,391
Provision for long service leave	68,243	30,528
Other employee benefits	33,555	45,400
	192,003	164,319
Non-current		
Provision for long service leave	31,458	26,762

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 2014

	2014 $	2013 Restated $
11. Reserves		
Asset revaluation reserve	816,723	716,097
Balance at the beginning of the year	716,097	716,097
Revaluation increment (Note 8)	100,626	-
Balance at the end of the year	816,723	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 (loss) after income tax		
Profit (loss) from ordinary activities	(52,763)	92,081
Add/(less) non-cash items:		
Depreciation	38,706	43,644
Loss on disposal of non-current assets	-	1,626
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	(116,251)	119,388
(Increase)/decrease in other current assets	43,508	(6,698)
Increase/(decrease) in trade and other payables	(50,074)	(116,326)
Increase/(decrease) in provisions	32,379	34,910
Increase/(decrease) in other liabilities	(83,001)	-
Net cash provided by (used in) operating activities	(187,496)	168,625

13. Related Parties

Directors

The following persons held the position of Director of the Society during the financial year:
Dr Andrew J Turner, Dr Mary G White, Dr Marc Ziegenfuss, Dr Simon Erickson, Dr Ben Barry, Dr Satyadeepak Bhonagiri, Dr Anthony Holley, Dr Ian Jenkins, Dr David Knight, Dr Colin McArthur, Dr Kenneth John Millar, Dr Stewart Moodie, Dr David Pilcher, Dr David Rigg, Dr Stephen Warrillow

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:

	2014 $	2013 $
Key management personnel compensation	384,731	382,894

Notes to the Financial Statements

for the year ended 30 June 2014

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.

Notes to the Financial Statements

for the year ended 30 June 2014

15. Financial risk management (continued)

(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.

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

	2014 Carrying amount $	2014 Fair value $	2013 Carrying amount $	2013 Fair value $
Cash and cash equivalents	2,001,647	2,001,647	2,156,098	2,156,098
Trade and other receivables	179,652	179,652	63,401	63,401
Other current assets	53,487	53,487	96,995	96,995
Trade and other payables	611,479	611,479	661,554	661,554

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

(c) Interest Rate Risk

	Carrying amount 2014 $	Carrying amount 2013 $
Floating rate instruments		
Cash and cash equivalents	2,001,647	2,156,098

Fair value sensitivity analysis

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

Notes to the Financial Statements

for the year ended 30 June 2014

16. Financial instruments (continued)

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.

(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	
	2014 $	2013 $
Loans and receivables	179,652	63,401

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) <30 $	31-60 $	61-90 $	>90 $	Within initial trade terms $
2014							
Trade receivables	179,607	-	178,527	-	-	1,080	178,527
Other receivables	45	-	45	-	-	-	45
Total	179,652	-	178,572	-	-	1,080	178,572
2013							
Trade receivables	53,677	-	50,782	2,895	-	-	50,782
Other receivables	9,724	-	-	-	-	9,724	9,724
Total	63,401	-	50,782	2,895	-	9,724	60,506

Notes to the Financial Statements

for the year ended 30 June 2014

16. Financial instruments (continued)

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 2014 or the previous financial year.

(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 2014							
Payables	611,479	611,479	347,924	263,555	–	–	–
30 June 2013							
Payables	661,554	661,554	417,696	243,858	–	–	–

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

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

(a) the Society is not publicly accountable;

(b) the financial statements and notes that are set out on pages 36 to 53, are in accordance with the Australian Charities and Not-for-profits Commission Act 2012 including;

(i) giving a true and fair view of the Society's financial position as at 30 June 2014 and of its performance, for the financial year ended on that date; and

(ii) complying with Australian Accounting Standards – Reduced Disclosure Regime and the Australian Charities and Not-for-profits Commission Regulation 2013; and

(c) 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 Andrew Turner
President

Dr Marc Ziegenfuss
Hon. Treasurer

Dated this 28th day of August 2014

KPMG

Independent auditor's 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 Society), which comprises the statements of financial position as at 30 June 2014, and statements of profit or loss and other comprehensive income, statements of changes in equity and statements of cash flows for the year ended on that date, notes 1 to 17 comprising a summary of significant accounting policies and other explanatory information and the directors' declaration of the Society.

This audit report has also been prepared for the members of the Society in pursuant to *Australian Charities and Not-for-profits Commission Act 2012* (ACNC).

Directors' responsibility for the financial report

The Directors of the Society 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 ACNC. The Directors' responsibility also includes such internal control as the Directors determine necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement whether due to fraud or error.

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. These Auditing 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 Society'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 Society'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 gives a true and fair view, in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the ACNC, a true and fair view which is consistent with our understanding of the Society'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 *Australian Charities and Not-for-profits Commission Act 2012*.

Auditor's opinion

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

(a) giving a true and fair view of the Society's financial position as at 30 June 2014 and of its performance for the year ended on that date; and

(b) complying with Australian Accounting Standards – Reduced Disclosure Requirements and the *Australian Charities and Not-for-profits Commission Regulation 2013*.

KPMG

Darren Scammell
Partner

Melbourne

28 August 2014

Appendix One

ANNUAL GENERAL MEETING

5.30pm Friday 18th October 2013
Concert Hall, Hotel Grand Chancellor, Hobart, Tasmania

DRAFT MINUTES

1. WELCOME, PRESENT & APOLOGIES *President*

Present

A/Prof Mary White (President)
A/Prof Andrew Turner (Vice President)
Dr Simon Erickson (Hon Secretary)
Dr Marc Ziegenfuss (Hon Treasurer)
Dr Michael Anderson
Dr Troy Brown
Dr Anthony Burrell
Prof John Cade
Dr Peter Cameron
Dr Jonathan Casement
Dr David Cooper
A/Prof Andrew Davies
Dr Adam Deane
Dr Kush Deshpande
Dr Graeme Duke
Dr Arthas Flabouris
Dr Elizabeth Fugaccia
Dr John Green
Dr Louise Hitchings
Dr Anthony Holley
Dr Ian Jenkins
Dr Daryl Jones
Dr David Knight
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 Michael O'Leary
Dr Helen Opdam
Dr Rakshit Panwar
Dr Ranald Pascoe
Dr Mathew Piercy
Dr David Pilcher
Prof Michael Reade
Dr Brett Sampson
Dr John Santamaria
Dr Phil Sargent
Dr Geoff Shaw
Dr Wayne Sorour
Dr Andrew Spiers
Dr Matthew Spotswood
Dr Antony Tobin
Dr Richard Totaro
Dr Barbara Trytko
Dr Andrew Udy
Dr Stephen Warrillow
Dr Gerald Wong
Dr Robert Young
Dr Marc Ziegenfuss

Apologies

Dr Ron Trubuhovich

In Attendance

Alexandra Reade *(Minutes)*
Brent Kingston (ANZICS)
Chris Nash (ANZICS)
Justin Williams (ANZICS General Manager

Presenters

Felicity Hawker (CICM)
Gill Hood (ICF)

2. MINUTES OF PREVIOUS MEETING *President*

Mary White (MW) proposed the Minutes of the previous AGM, held Friday 26th October 2012 be accepted.

Motion: The minutes are accepted as a true and accurate record of the meeting.
Proposed: Andrew Turner
Seconded: Mary White

Motion Carried

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3. TREASURER'S REPORT *Hon Treasurer*

Marc Ziegenfuss (MZ) presented the Treasurers Report.
MZ thanked the previous General Manager, Erin O'Sullivan (EOS) for her years of service and support to the Society and extended ANZICS Community.
MZ welcomed Justin Williams (JW) as General Manager.
MZ thanked Don Stewart (DS) and Joy Najm (JN) for their support to the running and report of the finances of the Society.
MZ referred to the various standing and regional Committees of the Society and thanked them for a year of hard work, especially the management groups of each Committee.
MZ confirmed the Finance, Risk and Audit Committee (FRAC) had been reconvened to govern the financial areas of the Society.
MZ also confirmed the Terms of Reference for the Committee had been put together, as well as a management plan.
MZ noted the Committee was tracking well and meeting four times per year.

MZ proposed the following motions for acceptance by the Society:

Motion: That the Honorary Treasurer's report be accepted.
Proposed: Marc Ziegenfuss
Seconded: Andrew Turner

Motion Carried

Motion: That Under section 327 of the Corporations Law, KPMG continues to hold office until removal or resignation and will be auditor for the financial year ended 30 June 2014
Proposed: Marc Ziegenfuss
Seconded: Mary White

Motion Carried

Motion: That membership subscriptions remain unchanged.
Proposed: Marc Ziegenfuss
Seconded: Andrew Turner

Motion Carried

The report was taken as read.

4. MEMBERSHIP REPORT *Hon Secretary*

Simon Erickson (SE) presented the Membership Report.
It was noted there was growth in membership of the Society.
SE advised encouraging the participation of trainees in the Society and promotion of the worth of the Society and benefits of membership.
SE confirmed the Society was showing good growth in membership, with numbers increasing from 765 to 770 members in total.

SE proposed the following motion for acceptance by the Society:

Motion: That the membership report be taken as read. **Proposed:** Simon Erickson **Seconded:** Mary White

Motion Carried

The report was taken as read.

5. PRESIDENT'S REPORT *President*

Mary White (MW) presented the Presidents Report.
It was noted the term for MW as President had come to an end and the election for a new President would occur as the next item on the agenda.
It was also noted MW could continue as Immediate Past President and sit on the Executive and FRAC Committees in that role for the next year.
MW thanked the staff at ANZICS House, members of the Executive Committee, EOS and JW for support in the role of General Manager, members of the Board and also members of the Society for support for the past two years.

The report was taken as read.

6. ELECTION OF OFFICE BEARERS *President*

MW advised that Marc Ziegenfuss was unopposed in continuing as Honorary Treasurer, Simon Erickson was unopposed in continuing for a second term as Honorary Secretary, and Andrew Turner appointed unopposed as President. It was noted that MW will continue as Immediate Past President.
MW proposed the following motion for acceptance by the Society:

Motion: That the office bearers be accepted. **Proposed:** Mary White **Seconded:** Andrew Turner

Motion Carried

7. ANZICS HONOUR ROLL *President*

In recognition of their outstanding contribution to the specialty of intensive care medicine, the following Honour Roll recipients were presented to the meeting:

- **Dr Peter Hicks**
- **Professor John Myburgh**

8. PROFESSIONAL PRACTICE

8.1 Practice and Economics Committee *PricE Chair*

Ian Jenkins (IJ) presented the Price Committee Report.

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IJ discussed a change in terms to the Medicare approach to external consults and out of ICU item numbers for attendance to private patients.
IJ presented workforce data put together by works done by the PricE Committee. IJ presented the results of the Workforce Survey which was circulated to the membership in June 2013. IJ confirmed 238 responses to the Survey were received.

IJ summarised the results of the Workforce Survey were as follows:

- 5 beds (mean) 'closed' per ICU surveyed
  - 2 FTE new consultants per ICU (132)
- significant new beds planned
- planned hiring less than AIHC benchmark
- continued 'surplus' of new Fellows to continue
- wide range of work patterns and hours
- little apparent time out of ICU
- hours worked seems to match 'wanted' hours'

IJ confirmed the PricE Committee were approached by Aspex Consulting, an external consultant group contracted by the Department of Health and Ageing, to put together a proposal using ANZICS data on out of ICU Medicare items. IJ confirmed the submission was in progress and would be submitted to the department in 2014.

The report was taken as read.

9.2 ANZICS Centre for Outcome and Resource Evaluation *CORE Chair*

The report was noted and taken as read.

9.3 ANZICS Clinical Trials Group *CTG Chair*

The report was noted and taken as read.

9.4 Safety and Quality Committee *S&Q Chair*

The report was noted and taken as read.

9.5 Death and Organ Donation Committee *DODC Chair*

The report was noted and taken as read.

9.6 Education Committee *Education Chair*

The report was noted and taken as read.

9. INTENSIVE CARE FOUNDATION *ICF*

Gill Hood (GH) presented the Intensive Care Foundation Report.
GH confirmed the previous Chair and CEO of the Foundation had resigned and the Foundation had undergone a staffing restructure in an attempt to place emphasis on generating revenue to maximise grant funding rather than costs on operational expenditure.

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GH confirmed the following were on the Board of the Foundation:

- Gill Hood
- David Tuxen
- Peter Kruger
- Neil Orford

GH also confirmed grants from the College of Intensive Care Medicine continued to be received.
GH noted high expectations were placed on the Board of Directors to ramp up output and generate funds to the Foundation.
GH confirmed Justin Williams would operate as interim CEO to the Intensive Care Foundation during this period of change and transition, and thank ANZICS for ongoing support.

The report was taken as read.

10. COLLEGE OF INTENSIVE CARE MEDICINE REPORT *CICM*

Felicity Hawker (FH) presented the CICM Report.
FH presented an update to the membership on CICM activities.
FH confirmed training regulations were finalised and a supporting document would be approved at the upcoming November Board Meeting.
FH discussed AMC accreditation and noted the next accredited visitation was scheduled, however would hopefully be deferred until the trainee selection was finalised and approved at the June Board Meeting, with the curriculum to go into effect from June 2014 onwards.
FH advised changes would only apply to those who would commence training, not people currently in training, with regular performance processes to continue.
FH noted an increase of numbers sitting the Fellowship Exam since 2007.
FH advised the CICM Board will vote in November whether other primary qualifications can assist in CICM primary as an exemption.
FH confirmed of the 58 candidates sitting the examination, 23 passed and would present the oral component of the examination in November.

The report was taken as read.

11. FUTURE MEETINGS

- *39th ANZICS / ACCCN Intensive Care Annual Scientific Meeting (ASM) Melbourne Exhibition and Convention Centre, Melbourne, Victoria 9th – 11th October 2014*

12. OTHER BUSINESS *President*

No further business noted.

13. DATE OF NEXT MEETING

- *Friday 10th October 2014, Melbourne, Victoria*

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