ANZICS ANNUAL REPORT 2017

ANZICS

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Australia and New Zealand Intensive Care Society

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"ADVOCATE FOR INTENSIVE CARE THROUGHOUT AUSTRALIA AND NEW ZEALAND"

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PRESIDENT'S REPORT

The past year has again seen a lot of activity at ANZICS. ANZICS welcomes our new General Manager, Dr Gian Sberna who commenced in the position on July 10, 2017. Our thanks goes to Mr Tony Tenaglia for his services to the Society and we wish him well for the future. The staff at ANZICS House remains a formidable team exemplifying collegiality, integrity and efficiency, and I wish to thank them from the outset for their commitment to advocate for all things intensive care. The central office staff have consolidated resources and functions effectively. The entire membership acknowledges the 'behind-the-scenes' efforts of those at ANZICS House.

ANZICS, in the era of FOAMed - Free Open Access Medical Education – continues to produce high quality conferences that attract a renowned expert faculty and diverse delegate attendance. The ACCCN/ANZICS ASM remains well attended and supported and is complemented by the Annual CTG, Safety and Quality and Regional meetings. To this portfolio ANZICS remains a founding member of the SG-ANZICS meeting which is held in Singapore. It is important that we, as an established Society of over 40 years, contribute to critical care practice in the Asia-Pacific region and share our experience and also learn from other Asia-Pacific Intensive Care Societies. ANZICS is pursuing initiatives to be more active in the Digital Media space with the 'Intensive Talk' podcast program – and other forms of 'new age' educational/communication initiatives.

The Women in Intensive Care Network has worked collegiately with ANZICS to ensure more Gender Equity in our workforce and especially with conference faculty. This is being actively accommodated with all our meetings. I will also appeal to all members to champion initiatives that improve our workplace – from a gender equity perspective and to protect our workforce. I am of course referring to efforts to stamp out bullying and harassment in our industry, and also refer to the AMA 'Managing the Risk of Fatigue in the Medical Workforce' Report that places Intensivists as the specialty with the highest risk of fatigue. This is an issue that affects all of us and behoves us all to actively campaign for workplaces that support a healthy and sustainable workforce. The PricE (Practice and Economics Committee) will be further supported by a working group to establish a Position Paper on Intensive Care Workforce issues. PricE has successfully advocated at Medicare Rebate meetings for our Membership regarding remuneration item numbers, and is also actively surveying burnout risk. PricE has also instituted an initiative to support Critical Care Clinicians from neighbouring low socio-economics countries to attend our ASM and with ANZICS supporting the Global Sepsis Alliance and the acceptance of the 'Resolution on Sepsis' by the WHO, ANZICS will actively contribute to the work at hand to improve Sepsis awareness and management across the Globe.

The Death and Organ Donation Committee is currently reviewing its Position paper. During the last year ANZICS, CICM and OTA have signed a MOU to facilitate efficiencies and collaboration. This has been embraced and is already yielding beneficial outcomes for ANZICS.

The Safety and Quality Committee is assisting in the review of Intensive Care clinical indicators and with the publication of the 'Joint Position Statement on Rapid Response Systems in ANZ and the roles of Intensive Care' and the excellent "The Deteriorating Patient' Conference is advocating strongly for the membership. ICU outreach initiatives are widespread and ANZICS is actively supporting these as they do impact on our patient outcomes and workload.

ANZICS CORE (Centre for Outcome and Resource Evaluation) has again lived up to its reputation of excellence. The introduction of the new data capturing tool COMET, the organisation of a well-attended and excellent Datathon, expansion and subscription by non-ANZ units for benchmarking, and numerous publications speak for themselves. Over the last couple of months we have secured further jurisdictional funding and will be looking at more strategic ways to plan and secure the future of ANZICS CORE.

PRESIDENT'S REPORT

The ANZICS Clinical Trials Group continues to be a world leader with its internationally renowned efforts in critical care research. In the era of big data and big Pharma, the CTG is recognised for its integrity and scientific rigour to champion and execute influential research.

I invite you to read the audited financial report and appreciate that the Society is financially sound. We do however need to invest in further income generating initiatives to allow us to expand and grow with the times.

There are real threats to our Society both locally and internationally. We need to actively expand our membership to a multidisciplinary one – for all critical care clinicians – to stand together at social and political forums and advocate for our membership and our patients. We need to highlight our achievements, obtained with local talent and effort, at local meetings as well as internationally.

My tenure as President of ANZICS is drawing to a close. It has been a privilege to lead a Society such as ANZICS in what has been a very busy time. ANZICS has formulated and embraced new challenges and will continue to do so. Our collegiality, efficiency and constant pursuit for excellence continues to be recognised nationally and internationally. A Society is only as strong as its Members and their efforts to further the advocacy for Intensive Care Medicine in Australia and New Zealand and further afield. I urge you get involved in ANZICS activities and carry into the future what has been achieved by so many, for so long. Thank you for your support.

Marc Ziegenfuss
ANZICS President

TREASURER'S REPORT

This is my third Treasurer's report and it continues to be a great privilege for me to hold this position on behalf of the members and to report to the membership on the current financial position of our Society and our performance over the past financial year. ANZICS continues to deliver steady financial results in an environment that has been, and continues to be, challenging.

In summary, ANZICS financial position improved by $862,330 due to the achievement of a profit from operations and investments of $141,576 for the year and an increase in the value of ANZICS House by $720,754.

A high-level review of our profit from operations and investments shows that in what was a fairly tough year for earning revenue, member subscription income of $491,268 remained steady as did grant funding of $1,264,017 (mostly supporting activities undertaken by our CORE group). Our main educational event, the ASM held in Perth in October 2016, was very successfully attended and the event returned a modest surplus of $18,189.

Employee expenses are our largest expense category and represents 64% of all of our total expenses. ANZICS managed to restrict overall employee expenses to less than the previous year partly due to efficiencies in our programs and delays in recruiting employees. Administrative expenses were consistent with the previous year as a result of focussed efforts to streamline functions. Depreciation charges increased by $49,000 to $103,264, mostly due to accounting standard which require us to depreciate our COMET software over a period of 5 years. Whilst this is a non-cash expense it does affect our profit result.

In respect of our financial position, ANZICS maintains cash and deposits of $1,682,065, investments of $569,882 and owns its own building (ANZICS House) which is valued at $3,191,147. Against this, we have commitments and liabilities of $855,362, but overall, the bottom line remains strong. Income from cash on deposit during the year was $43,616. Income from investments was $30,581 along with unrealised gains of $47,628 adding to the overall increase in value of our investments. Reviews of our Investment Strategy are ongoing as part of our relationship with the Investment Manager and to ensure alignment with the Board's commitment to securing the financial future of the Society. The strategies and portfolio are designed to achieve moderate growth over time with an acceptable level of risk. To date, the portfolio continues to perform within expected parameters. As outlined above, our property has been revalued upwards by $720,754 which represents a gain achieved since the last independent valuation 3 years ago. The Society requires a strong financial foundation in order deliver a high quality products to the membership, the critical care professional community, provide additional services to members and to further increase the standing of ANZICS in the medical and wider community.

The Board of Directors, Executive, ANZICS Committees, General Manager and in particular, the staff, have worked very hard to deliver once again a positive and encouraging result and I take this opportunity to thank them all for their contributions.

Anthony Holley
Honorary Treasurer, ANZICS

ANZICS BOARD

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GENERAL MANAGERS REPORT

The past twelve months has seen a number of significant initiatives delivered by the Society. Standing ANZICS Committees (CORE, CTG, S&Q, DODC and Education) have continued to position ANZICS on an international stage and reinforce our organisation as the peak Intensive Care body of Australia and New Zealand.

On behalf of ANZICS staff and members, I would like to acknowledge the contribution of the previous General Manager, Tony Tenaglia, to the ongoing success of ANZICS. Tony has overseen a number of significant initiatives throughout his tenure and I thank him for ensuring that ANZICS has remained financially sound. I would also like to acknowledge and highly commend the ANZICS team for continuing the day-to-day activities of the Society in the period between General Managers.

I am extremely pleased to be in the early stages in my role as the General Manager of ANZICS – in what will be an exciting time ahead for the Society. There are numerous opportunities to further develop what we do to support our members and energise the Society as a whole. We are in the early stages of developing a comprehensive, multi-year strategic plan for the Society, and we will be seeking input from our members and the intensive care community more broadly (medical, nursing, allied health, research, policy makers and leaders) to guide us in these efforts.

CORE has recently deployed the new COMET software to a number of sites – replacing its predecessor, AORTIC. All sites will be transitioned to COMET by early 2018, providing a much more streamlined process for users to capture highly valuable ICU data.

The Safety & Quality Committee continues to deliver on its aim to improve the quality of intensive care practice across both Australia and New Zealand. The 2017 Safety & Quality Conference remains a mainstay of the conference landscape with the event strengthening in popularity each year. The 2017 Conference continues on the theme of 'The Deteriorating Patient' with fundamentals of Safety & Quality returning to the program.

A Joint ANZICS/CICM position statement on Rapid Response Teams has been released, and the efforts of both parties in collaborating on this, should be congratulated.

The Clinical Trials Group (CTG) held its Annual Meeting in Noosa, with a record number of registrations of 271 delegates. CTG-endorsed studies also reached a record high in the past year, totalling $12 million across 6 studies. The upcoming CTG Winter Research Forum to be held in Queenstown in late August 2017, will again be an eagerly anticipated event.

Initial drafting and review of ANZICS Statement on Death and Organ Donation are progressing well. Under the stewardship of the ANZICS Death and Organ Donation Committee (DODC), we are continuing to work with the College of Intensive Care Medicine and Commonwealth's Organ and Tissue Authority to ensure best practice in our region.

Ongoing education for members continues to be a focus of ANZICS. The 2016 ASM held in Perth was undoubtedly a success, with delegates being attracted from across the globe. The 2017 Annual Scientific Meeting on the Gold Coast (11-13 October 2017) looks to be another extremely exciting event on the intensive care calendar. Preparations are advancing well for the rapidly approaching World Congress on Intensive and Critical Care Medicine scheduled in Melbourne in 2019 – with the official launch to be announced at the 2017 WFSICCM in Rio.

I look forward to working and engaging with the intensive care community to progress matters in support of our industry.

Gian Sberna
General Manager, ANZICS

MEMBERSHIP REPORT

The last twelve months have seen significant changes and improvements to the ANZICS Membership. Firstly, I would like to thank Simon Erickson for all of his hard work and contribution over the last 5 years as Secretary. We have seen a continued increase in the changes to the categorised membership types over the past twelve months and are currently evaluating how to further improve the benefit to the Society for all of the Membership. The recent release of access to the Intensive Care Monitor and Intensive Talk, the new podcasting series from the Society are two of the latest efforts undertaken to ensure members have access to critical content.

ANZICS has now appointed Trainee representation on all Standing ANZICS Committees. Engaging Trainee Representation is imperative to ANZICS as a Society, the profession and to better represent the new age Intensivists and the challenges faced from a Trainee and New Fellow perspective. Initiatives like this allow the Society to be more inclusive to the wider intensive care profession and better represent all crafts within the specialty.

The Society continues to offer its Membership educational opportunities, research activities, quality assurance, industrial activity and professional development. ANZICS has an obligation to continually reassess its role and ensure the value it provides to the Membership. The past year has seen the ongoing delivery of educational opportunities, with another successful ASM held in Perth, Safety & Quality hosting the International Rapid Response Conference in 2016, The 8th Annual Tub Worthley Travelling Scholarship, SG-ANZICS, ANZICS/ACCCN Critical Care Collaborative as well as the CTG Noosa and Winter Research Events. ANZICS Membership continues to prosper with annual numbers steadily growing, expansion into new areas of educational interest and also the ever changing environment. 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. While we have seen a steady increase of new Members to the Society over the past financial year; we have also had Members resigning due to: moving overseas, requests to discontinue and outstanding fees.

The future of the Society relies heavily on the newly emerging Trainees and Consultants, along with involvement from the wider craft groups in the intensive care community in all of the ANZICS activities, to continually drive the Society forward into the future and the ever-changing environment.

Adam Deane,
Honorary Secretary

TOTAL MEMBERSHIP: 891

Country

Australia:	**755**
New Zealand:	**110**
Other:	**26**

Type

Full:	**486**
New Fellow:	**61**
Trainee:	**136**
Associate/Overseas:	**54**
Nurse:	**84**
Allied Health:	**30**
Research Coordinator:	**8**
Honorary:	**10**
Retired:	**22**

CENTRE FOR OUTCOME & RESEARCH EVALUATION

More CORE, blazing COMETs and fine wine: David Pilcher stepped down as Chair of CORE this year. David had followed Graeme Hart as Chair and has guided CORE over many years to the position today of being one of Australian and New Zealand's foremost set of registries. David remains as ever active as the Director of the Adult Patient Database. Peter Hicks has taken on the role of Chair and has stepped down as Director of CCR with Ed Litton taking on this role - Peter remains a Co-Director providing a period of transition for Ed.

In response to the ANZICS Board seeking more engagement from CICM Trainees on to CORE Committee we welcomed Chris Mason and Myles Smith to the CORE Committee. Both have provided valuable contribution to engage and support awareness of the Registry activities with the ICU Trainees. We have a new international contributor from the Nemazee hospital in Shiraz, Iran. While the Shiraz region has produced wine since the 9th Century it is not related to the Shiraz wine in Australia which has its origins from Syrah grapes in France.

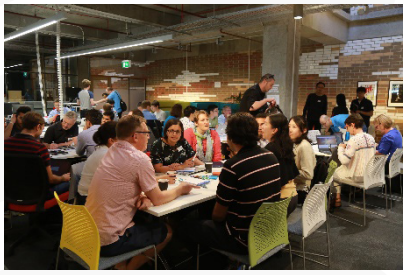
Implementation of COMET

There has been a huge effort from the software developers and the CORE staff to implement COMET (aka CORE Outcome Measurement and Evaluation Tool) the new data collection tool to replace AORTIC. COMET is a web based application hosted 'on premise' with the Australian Institute of Health and Welfare. With the development of COMET has come the opportunity to introduce some new variables and remove other variables that are no longer relevant for benchmarking.

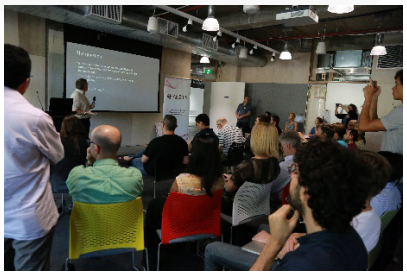
Rollout of COMET began in June 2017 and is expected to be completed in the early part of 2018 when AORTIC will no longer be supported. It removes all the local IT hassle that AORTIC required. COMET is provided free to units while costs have been more than $400,000 so far funded by the jurisdictions and ANZICS.

This is a large transformation for CORE as we become a major IT software provider with a real time program we must support.

ANZICS CORE Datathon 4th & 5th March 2017



Teams working hard.



Presenting results on day 2.

The Datathon ran from March 4th-5th in Melbourne, Australia. Three large datasets were prepared with records from 1.5 million admissions to almost 300 ICUs in both the United States and Australia. The goal of the datathon was to answer clinical questions by retrospectively analysing the data provided. Cloud services were provided to facilitate easy access and use of the data.

The event had 115 delegates with attendees from Australia, New Zealand, UK, US, Canada, Taiwan, Thailand, Italy and Singapore. These participants formed a total of 19 groups each investigating distinct clinical questions. Mentors who had deep expertise of the data and statistical skills were on hand for the participants. At the end of the event,

CENTRE FOR OUTCOME & RESEARCH EVALUATION

all teams gave a brief presentation of their progress over the weekend and any conclusions they could draw from their hack. The formation of teams promoted on-going multi-disciplinary collaboration between Researchers, Clinicians, Statisticians and Data Scientists which has continued long after the event. Two projects have resulted in presentations at the Australasian College of Intensive Care Medicine Annual Scientific Meeting and another five are planned for the ANZICS Annual Scientific Meeting in late 2017. Few forums have the capacity to provide such concentrated research output in such a short time.

Sponsorship and financial support were provided by Phillips, The Alfred Hospital, The Austin Hospital, Melbourne University, Philips, IBM, and MIT. This was essential to the success of this event.

The Global Open Source International Severity Score (GOSISS) Project

ANZICS CORE is partnering with the Massachusetts Institute of Technology (MIT), Philips Healthcare (US) and with critical care registry groups around the world to create an international severity of illness score. At present groups from the following countries have provisionally agreed to be involved: Netherlands, Belgium, Japan, Brazil, and Ireland. Watch this space!

Economic Evaluation of Clinical Quality Registries

The Australian Commission on Safety and Quality in Health Care (ASQHC) engaged Monash University and Health Outcomes Australia to evaluate the economic impact of five Australian clinical quality registries including the ANZICS Adult Patient Database.

This study reviewed the APD outlier management process and reported a 4:1 cost benefit (net benefit $26 million), supporting the value to the health system of systematic auditing and benchmarking of ICU practice.

Economic value was measured through the reduction in intensive care unit (ICU) mortality and average length of stay that was related to the reviewing of outlying units.

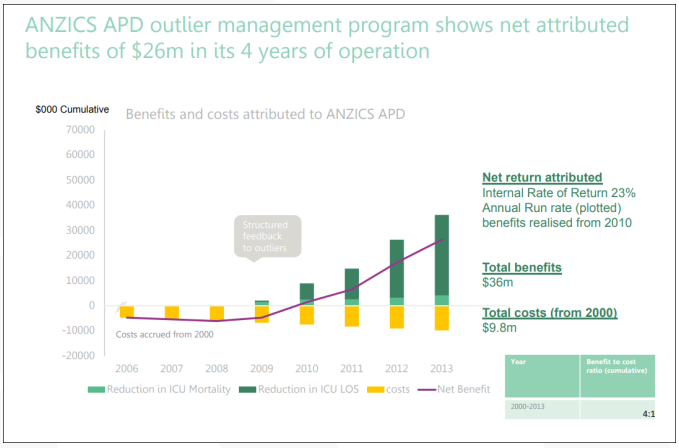
Overall the study showed that Australian clinical quality registries have delivered significant value. Each of the five registries had an influence on clinical practice and improved the value of healthcare delivery at relatively low cost.

The Australian Commission on Safety and Quality in Health Care. Economic evaluation of clinical quality registries: Final report. Sydney: ACSQHC; 2016

ANZICS CORE APD – recognised as a top priority registry

In November 2016 the ACSQHC published a prioritised list of clinical registries to inform a national strategy with regard to development of national Clinical Registries. ANZICS 'Adult Critical Care Registry' was ranked the second highest tier for prioritisation for development, quoting 'Serious consequences of poor quality care, very high strong clinical support and leadership. It is National registry with close to complete coverage.' The costs based on the National Hospital Cost Data Collection (2012/13) for Adult critical is estimated to be $2.40 billion (7.11%) of the National Hospital Costs.

The Australian Commission on Safety and Quality in Health Care. Prioritised list of clinical domains for clinical quality registry development: Final report. Sydney: ACSQHC; 2016. We thank all the units and staff who have contributed to the registries, so that we can provide the quality assurance for you.



CENTRE FOR OUTCOME & RESEARCH EVALUATION: PUBLICATIONS

Publications that have used CORE data in 2016/17. The research output continues to be high and is part of the community benefit from having high quality data sources available. The Paediatric researchers have been very prolific utilising the ANZPIC Registry for research:

Modelling risk-adjusted variation in length of stay among Australian and New Zealand ICUs. Lahn D Straney, Andrew A Udy, Aidan Burrell, Christoph Bergmeir, Sue Huckson, D. James Cooper, David V Pilcher. PLoS One. 2017 May 2;12(5):e0176570.

The burden of invasive infections in critically ill Indigenous children in Australia. Ostrowski JA, MacLaren G, Alexander J, Stewart P, Gune S, Francis JR, Ganu S, Festa M, Erickson SJ, Straney L, Schlapbach LJ. MJA 2017 Jan; doi: 10.5694/mja16.00595

Prognostic Accuracy of the SOFA Score, SIRS Criteria, and qSOFA Score for In-Hospital Mortality Among Adults With Suspected Infection Admitted to the Intensive Care Unit. Raith EP, Udy AA, Bailey M, McGloughlin S, MacIsaac C, Bellomo R, Pilcher DV. JAMA. Jan 2017;317(3):290-300.

ICU mortality is increased with high admission serum osmolarity in all patients other than those admitted with pulmonary diseases and hypoxia. Bihari S, Prakash S, Peake SL, Bailey M, Pilcher D, Bersten A. Respirology. 2017 Apr 17. doi: 10.1111/resp.13055.

Characteristics and outcomes of critically ill patients with drug overdose in Australia and New Zealand. Cioccari L, Luethi N, Bailey M, Pilcher D, Bellomo R. Crit Care Resusc. 2017 Mar;19(1):14-22.

Prediction of pediatric sepsis mortality within 1 hour of intensive care admission. Schlapbach LJ, MacLaren G, Festa M, Alexander J, Erickson S, Beca J, Slater A, Schibler A, Pilcher D, Millar J, Straney L. Intensive Care Med. 2017 Feb 20. doi: 10.1007/s00134-017-4701-8.

Burden of disease and change in practice in critically ill infants with bronchiolitis in Australia and New Zealand 2002 to 2014. Schlapbach L , Straney L , Gelbart B , Alexander J , Franklin D , Beca J , Whitty J , Ganu S , Wilkins B , Croston E , Erickson S , Schibler A. European Journal Of Pediatrics, 2016 Nov, Vol.175(11), pp.1868-1869

Early surgical intervention in severe acute pancreatitis: Central Australian experience. Jacob AO, Stewart P, Jacob O. ANZ J Surg. 2016 Oct;86(10):805–10

Characteristics, incidence and outcome of patients admitted to intensive care because of pulmonary embolism. Winterton D, Bailey M, Pilcher D, Landoni G, Bellomo R. Respirology. 2016 Sep 11.

Trends in PICU Admission and Survival Rates in Children in Australia and New Zealand Following Cardiac Arrest. Straney LD, Schlapbach LJ, Yong G, Bray JE, Millar J, Slater A, et al. Pediatr Crit Care Med. 2015 Sep;16(7):613–20.

Burden and Outcomes of Severe Pertussis Infection in Critically Ill Infants. Straney L, Schibler A, Ganeshalingham A, Alexander J, Festa M, Slater A, MacLaren G, Schlapbach LJ. Pediatr Crit Care Med. 2016 Aug;17(8):735-42.

Characteristics and outcome of patients with the ICU Admission diagnosis of status epilepticus in Australia and New Zealand. Hay A, Bellomo R, Pilcher D, Jackson G, Kaukonen K-M, Bailey M. J Crit Care. 2016 Aug;34:146–53

Acute risk change (ARC) identifies outlier institutions in perioperative cardiac surgical care when the standardized mortality ratio cannot. Coulson TG, Bailey M, Reid CM, Tran L, Mullany DV, Parker J, Hicks P, Pilcher D. Br J Anaesth. 2016 Aug;117(2):164-71.

Timing of onset and burden of persistent critical illness in Australia and New Zealand: a retrospective, population-based, observational study. Iwashyna TJ, Hodgson CL, Pilcher D, Bailey M, van Lint A, Chavan S, Bellomo R. Lancet Respir Med. 2016 Jul;4(7):566-73.

Subarachnoid Hemorrhage Patients Admitted to Intensive Care in Australia and New Zealand: A Multicenter Cohort Analysis of In-Hospital Mortality Over 15 Years. Udy AA, Vladic C, Saxby ER, Cohen J, Delaney A, Flower O, Anstey M, Bellomo R, Cooper DJ, Pilcher DV. 2017 Feb;45(2):e138-e1

Assessing contemporary intensive care unit outcome: development and validation of the Australian and New Zealand Risk of Death admission model. Paul E, Bailey M, Kasza J, Pilcher DV. Anaesth Intensive Care. 2017 May;45(3):326-343.

Characteristics and outcomes of critically ill patients with drug overdose in Australia and New Zealand. Cioccari L, Luethi N, Bailey M, Pilcher D, Bellomo R. Crit Care Resusc. 2017 Mar;19.

CLINICAL TRIALS GROUP

The Clinical Trials Group continues to thrive. 76 member units, 10 manuscripts endorsed in 12 months, 10 new studies endorsed in 12 months - the highest numbers since inception. Thank you to our extraordinary community and to all our supporters.It has been an incredibly active year. TRANSFUSE (fresher vs. standard age red cells) and ADRENAL (hydrocortisone vs. placebo in septic shock) both completed recruitment. The management committees hope to present the results in late 2017. It is expected both will provide clinicians with clear guidance on important clinical issues. While some studies have completed other proceed: SPICE (goal directed sedation) continues to progress well, TARGET (augmented vs. standard dose enteral nutrition) has reached 50% recruitment in a remarkable time frame, SuDICCU (selective decontamination) commenced in the first half of 2017, and PEPTIC (PPI vs. H2 blocker) will conclude in the second half of 2017. If that is not enough activity PLUS (balanced electrolyte vs. Saline) will commence within the next 3 months!

We do face challenges. Our community is stretched and in some centres close to breaking point. The increasing numbers of trials, burdensome governance requirements, and uncertainty around recurrent research funding have led to increased stress. The CTG Committee is aware of these challenges and continues to advocate for the interests of Clinician Researchers. It is particularly pleasing to see that the Australian Clinical Trials Alliance immediate future is secure. Critical Care research is one cog in Australian and New Zealand Clinical Research output. Collaboration and activism with our colleagues from other disciplines is essential to prosecute our agenda with government and bureaucracy.

The CTG Committee is developing our strategic plan for the next three years. The Committee affirmed our mission, vision, and values. We will now critically review our structure and operations to ensure that all we do is consistent with these principles. The CTG has achieved extraordinary success over the last twenty five years. The research landscape is changing and we must ensure that we are adaptable to manage new challenges and take advantage of opportunities: "Change is the law of life. And those who only look to the past or present are certain to miss the future (JFK)."

Our scientific meetings are extraordinarily successful- indeed Noosa is at capacity. I wish to acknowledge our sponsors; Baxter, La Jolla Pharmaceutical, Nikkiso, Mallinckrodt Pharmaceuticals and Pfizer. Their support is critical. Thank you to the CTG office - Donna Goldsmith and Simone Rickerby. It is not possible to clearly convey how much they do for us. Thank you to our community of researchers from 76 Intensive Care Units. You are truly incredible.

Craig French
Chair, Clinical Trials Group

DEATH AND ORGAN DONATION

2017 is proving to be a busy year for the DODC due to engagements with the Organ & Tissue Authority (OTA) and with a major review of the ANZICS Statement on Death & Organ Donation.

In late 2016 and early 2017 the terms of reference for the DODC were reviewed. This led to the following changes in DODC membership:

Standing appointments of the National Medical Directors of OTA and ODNZ and a nominee from CICM to non-voting positions

Standing appointment of a trainee representative Increasing New Zealand representation to two

All other jurisdictions are represented apart from Tasmania and the ACT.

A tripartite Memorandum of Understanding (MOU) has been signed between ANZICS, CICM and OTA to support and facilitate collaboration organ and tissue donation and "the respective support and services provided by intensive care staff to families considering donation". Collaborative outcomes have included:

Review of the core Family Donation Conversation (cFDC) workshop slides and feedback to OTA

Review of the OTA document- "Best practice Guideline for Offering Organ and Tissue Donation in Australia". (http://www.donatelife.gov.au/best-practice-guideline)

A funding agreement between OTA and ANZICS providing $44K to support ANZICS' ongoing work in relation to organ and tissue donation

ANZICS is assisting CICM with the review of the Brain Death Online Learning Module

The DODC Chair continues to represent ANZICS on the OTA Transplant Liaison Reference Group and, along with Mary White, on the OTA FDC Steering Committee. The major review of the 2013 Edition 3.2 of the ANZICS Statement on Death & Organ Donation is well underway.

In addition to an update of the literature the Statement is being completely restructured to take account of the impact of donation after circulatory death (DCD) and the changing family donation conversation landscape. The Statement will also include a review of the guidelines regarding imaging of cranial circulation, particularly CT angiography and MRI scanning. Working groups, teleconferences and face-to-face meetings are working towards the release of a final draft for comment in late 2017/early 2018.

ANZICS has been invited to participate in the "World Brain Death Project", with the aim to establish a global consensus for the determination of brain death. A draft document will be discussed at a meeting prior to the WFSICCM meeting in Rio de Janeiro in November. ANZICS had some input into the New Zealand Ministry of Health review of deceased organ donation and transplantation. This review is now complete (http://www.health.govt.nz/publication/increasing-deceased-organ-donation-and-transplantation-national-strategy).

A bi-national survey (led by Yee Yong Lee, and Frank van Haren and endorsed by ANZICS, and OTA) studied ICU doctors' attitudes, perceptions and self-reported end-of-life care practice regarding DCD. This is in the final preparation for publication.

End-of-Life Care Working Group (EOLCWG)

EOLCWG submitted a commentary on the Victorian Voluntary Assisted Dying (VAD) Bill Discussion Paper. In 2018 it will also be reviewing the ANZICS Statement on Care and Decision Making at the End-of-Life for the Critically Ill which was published in 2014. The EOLCWG will be consulting the ANZICS membership regarding the utility of the Statement. ANZICS receives requests to reference the Statement for the development of related educational resources.

Finally, I wish to thank all committee members and the ANZICS staff for the time, effort and expertise in supporting the committee's work.

William Silvester
Chair, DODC and EOLCWG

EDUCATION COMMITTEE

The last twelve months has seen the ANZICS Education Committee provide advice and support to the ANZICS ASM Organising Committee. The ANZICS New Fellows Workshop was held as a satellite session alongside the Perth ASM. This successful event provided a forum for camaraderie, support and mentoring to emerging Intensivists.

Adam Deane was named as the third recipient of the Ramesh Nagappan Education Prize. This award recognises Adam's substantial contribution and leadership at all levels of education from undergraduates to ICU Trainees as well as fostering the development of Clinician Scientists in our region.

Members of the Education Committee have remained active in their engagement with ICU Clinician Educators, Course Providers, Regional Education Programmes, Online Education Channels and the College of Intensive Care Medicine Education Committee. Such engagement and sharing of ideas is a desirable way for ANZICS to stay abreast of the ever-changing education landscape so it can best deliver value to our membership.

The ANZICS Education Committee is looking for a refreshed approach to membership, goals and activities. As such all positions including the Chair will be vacated and nominations will be sought from amongst the ANZICS Membership. Ideally the new Committee would have representation from: Members from all jurisdictions, Members from Regional and Metropolitan centres, Members with (or working towards) formal qualifications in Education Members with experience in planning and delivering education at Department, Hospital and Regional level. Members with experience in delivering education resources via a variety of techniques and formats including, face to face, online, and simulation, Members with experience in teaching learners from a range of backgrounds including inter-professional education

Please submit a letter of application to the ANZICS Office detailing your achievements against any or all of the criteria above.

I would like to thank all of my colleagues on the Education Committee for their longstanding efforts and support. Lastly, the Staff at ANZICS provide invaluable logistic and moral support and are to be greatly commended for their efforts, thank you all.

Sam Radford
ANZICS Education Chair

PAEDIATRICS COMMITTEE & ANZPICR

This year has seen ongoing involvement of ANZICS paediatric members in international collaborations, ensuring prominent representation on the global stage. Stephen Jacobe's efforts on the Board of the World Federation of Paediatric Intensive and Critical Care Societies have led to important research collaborations and also ongoing representation at WFPICCS meetings. As a consequence there is significant Australian and New Zealand involvement in the World Congress to be held in Singapore next year. Luregn Schlapbach (Lady Cilento Children's Hospital) has been sponsored by ANZICS to be our representative on the Paediatric Surviving Sepsis Campaign guideline development, an acknowledgment of the important work that he has been doing in that area. Many members have continue to take major teaching roles on the burgeoning international paediatric ICU BASIC course programme; in the last 12 months, courses have been run in multiple sites in Australia, New Zealand, Asia, Europe and the Caribbean.

Paediatric Studies Group

The Paediatric Studies Group has had a busy year under the chairmanship of Marino Festa (Children's Hospital Westmead). Rino has reshaped the format of PSG meetings, with a more focused approach to proposed and current studies, and is investigating ways to integrate PSG and CTG discussions.

There are ongoing collaborations with international research groups and several new studies underway, notably a randomised controlled trial of nitric oxide on cardiopulmonary bypass led by Andreas Schibler (Lady Cilento Children's Hospital). This study will start in a small number of centers, with an NHMRC proposal for funding to be resubmitted this year.

ANZPIC Registry

There has been a lot of effort this year to ensure that the new COMET web-based data collection system is valid and functional for ANZPIC Registry data. COMET has been launched in the last few months and there will be a staged roll-out to all sites that have previously used AORTIC for data submission. One advantage of the way in which COMET has been configured is that it will help to bring on new units wishing to contribute to the Registry. In recent months we have had some contact with international sites enquiring about contributing data.

Registry data from 2016 have been finalised. Again, the numbers of admissions recorded has increased, with more than 12,000 episodes of intensive care for children in the calendar year. The Annual Report will be published electronically in coming months.

There is continued enthusiasm for research using Registry data, with a record number of data requests in the last 12 months. The close relationship between the Registry and the PSG means that such research projects involve collaboration between multiple sites and investigators. Publications are listed in the CORE section of this Annual Report.

Johnny Millar
Chair, Paediatrics Committee

PRACTICE & ECONOMICS COMMITTEE

In the last year, the MBS review has been a pressing concern for the PricE Committee. The MBS review taskforce combined Intensive Care and Emergency Medicine into one Clinical Committee. From this Clinical Committee three working groups were formed, emergency medicine, intensive care, and end of life. The meetings for the Clinical Committee and Working Parties all finished at the end of last year. Since then, we have been waiting for the release of a public consultation document.

An AMA MBS review forum was held in Canberra in March this year. At this meeting there were representatives from almost all medical societies and colleges. Professor Bruce Robinson, the MBS Review Taskforce Chair presented on the progress to date. He stated that there have been delays in releasing the public consultation documents due to the replacement of Sussan Ley as Health Minister. In the following Q&A, there was a lot of disappointment in the room. Representatives from Societies and Colleges were disappointed with the Committee member selection process, use of nondisclosure agreements, and the lack of engagement by the task force of the respective Societies and Colleges.

The Intensive Care and Emergency Medicine Consultation Document was scheduled for release in July. When this document is released there is an eight week public consultation period. PricE, in consultation with the ANZICS and CICM Boards will be providing feedback.
This year burnout, clinician mental health issues, and suicide have received considerable media attention. The profile of burnout in intensive care was raised by the excellent article in the MJA earlier this year 'Stress and burnout in intensive care medicine: an Australian perspective' by Nicholas Simpson and Cameron Knott and the associated MJA Insight article 'ICU specialists on road to burnout'. The last Australian intensive care workforce burnout survey was by Yahya Shehabi and others in 2009. Once through ethics, Shona Mair, a Trainee from Queensland, will in conduct a repeat burnout survey for the PricE Committee. Intensive care specialists from AHPRA workforce data work the longest hours of any specialty. The publication by the AMA in July 'Managing the Risk of Fatigue in the Medical Workforce – 2016 AMA Safe Hours audit' and an associated AMA interview highlighted the increased risk of fatigue experienced by our Intensive care specialist workforce. The ANZICS Board and the Practice and Economics Committee have called for a Working Group to establish a Position Paper on this to inform our colleagues at the AMA of the specific issues faced by Intensivists at all levels. All this is needed for pushback against an administrator workforce that do not work clinically and seem to lack an understanding of what we do.

ANZICS and PricE are committed to a sustainable and adequately remunerated, healthy workforce that continues to deliver high quality intensive care.

Mark Nicholls
Chair, Practice and Economics

SAFETY & QUALITY COMMITTEE

In 2016/2017 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. This year the Committee welcomed two new members to provide valuable insight from the perspective of Intensive Care Trainee's and New Zealand College of Critical Care Nurses Representative.

In line with the Committee's aims to maintain and promote safe, high quality care practice in Australian and New Zealand Intensive Care Units a survey into the feasibility of a Rapid Response Team National Registry was designed and distributed to ICU Directors in February 2016. The aim of this survey was to determine membership support of a National Rapid Response System registry and preliminary information on data variables currently collected by institutions and Director's opinions as to what data should be collected as a minimum data set. The Committee identified that the response rate was lower than anticipated (68). There was overall widespread support for a National RRT registry and consistency in responses to what data should be collected as minimum dataset.

The Committee was also responsible for maintaining the suite of resources available to assist ICU Clinicians prevent CLABSI. The Committee has commenced a review of the publication 'Central Line Insertion and Maintenance Guideline (April 2012)'.

The Committee is committed to developing closer relationships with external stakeholders including CICM in documenting and promoting safe, high quality care. ANZICS and CICM worked together to develop a combined position statement on The Role of Intensive Care within Rapid Response Systems (RRS). The overall aim is to produce a high quality document which will provide guidance for intensive care units across Australia and New Zealand in the provision of care to the deteriorating ward patient. The final document was released to the membership early in 2017.

I would like to acknowledge the work of A/Prof Daryl Jones and the Organising Committee including: Alex Psirides, Deepak Bhonagiri, Judy Currey, Ken Hillman, Liz Fugaccia, Manoj Singh and Jenny Holmes (ANZICS), who organise the annual Safety and Quality Conference. The dates for the 2017 Conference were pushed out to August 2017, therefore no event took place during this reporting period.

I would like to acknowledge and thank all members of the Committee for all their hard work including: Arthas Flabouris (SA); Craig Carr (NZ); Jonathan Barrett (VIC); Deepak Bhonagiri (NSW); Simon Towler (WA); Chris James (Paediatrics); Angus Carter (Immediate Past Chair); Mary Pinder (CICM); Gladness Nethathe (Trainee Representative); Malcolm Elliott (ACCCN) and Dayle Pearman and Leah Hackney (NZCCCN).

I would also like to recognise the contribution of all ANZICS members in providing feedback to the Safety and Quality Committee 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.

John Gowardman
Chair, Safety and Quality Committee

VICTORIA

The Victorian intensive care resources were tested during multiple mass casualty events over the last year. At its worst, during the 24 hour period of "Thunderstorm Asthma", over 3400 patients presented to the emergency department across Victoria, with 15% of public ICU beds occupied by the affected. The event certainly highlighted the strengths and weaknesses of the system at multiple levels, and the personnel involved should be congratulated for withstanding such immense pressure. Such pressure on intensive care clinicians has also been the focus of attention, with fatigue, burn-out and the mental health of our profession recognised as some of the worst among the medical profession. With increased conversation and insight, coupled with collaborative efforts with other bodies, improving the ability to look after ourselves and each other should become a priority as much as the care we give to our patients.

In line with the ANZICS non-discrimination statement and ongoing commitment to diversity, Victorian ANZICS has been working with Women in Intensive Care Network (WIN) to ensure our evolving attitude translates into action. With the aim that WIN becomes an integral part of ANZICS to represent the need for balance at all levels of critical care. We look forward to formalising that process in the near future.

ANZICS Victoria works closely with the ANZICS office on multiple fronts, as well as international ventures. The preparation for the 2019 WFSICCM World Congress of Critical Care is well on the way, and Organising Committee members are excited to "receive the baton" at the 2017 Rio Congress. A large number of Victorian intensivists will also be participating in SG-ANZICS 2018, a joint-venture with the Singapore Society of Intensive Care Medicine, choosing to contribute to the Lower Middle Income Country (LMIC) initiative, where for each fully self-funding speaker, the conference will aim to subsidise one LMIC delegate. I thank the generosity of those involved, and look forward to a meaningful and engaging SG-ANZICS 2018.

ANZICS Victoria continues to support multiple events across the state, namely:

The Victorian Intensive Care Education Network (VICEN) has thrived to now 15 participating ICUs and Donatelife. Thank you Manisa Ghani for chairing.

The Critical Care Collaborative (CCC) will be held in August, highlighting topical issues of the state faced by our multi-disciplinary teams.
Thank you Diane Kelly and Kimberley Haines for convening.

The Regional Integrated Critical Care conference will focus on rural critical issues across multiple levels. Thank you Cameron Knott and the Bendigo Health team.

The Critical-STEPS course, evolved from the irreplaceable Ramesh Nagappan's ICM course, also continues to progress into various versions and interstate. Thank you Max Moser and Ashwin Subramaniam for your tireless efforts.

The VPECC Course was also held recently to assist our primary exam Trainees to navigate the tricky waters of basic sciences. Thank you Sarah Yong and Maurice Le Guen for caring for our next generation. And who can forget the ANZICS Datathon in April that was such a resounding success. Thank you ANZICS CORE, Cameron Knott, Sarah Yong, David Pilcher and Rinaldo for your innovation and mentorship.

I am sure I've failed to mention some of the great work done by so many people, so it's no surprise with such an engaging ICU community in Victoria, the ANZICS membership continues to increase. With Stephen Warrillow becoming the ANZICS Vice President, we welcomed a new look Victorian ANZICS Regional Committee in 2017, with Kimberley Haines as one of the first allied health ANZICS member to hold an office-bearer role, as well as Max Moser who contributes significantly towards trainee and team education. It is our hope that this new energy will continue to fuel the vibrancy of the Victorian critical care community, and there is no better time for our members to be involved.

David Ku
Chair, Victorian Regional Chair

SOUTH AUSTRALIA

Restructuring of state-wide health services has had a significant impact on the intensive care community, and indeed the entire healthcare community, in South Australia over the past year. 2017 will see the culmination of a large part of the Transforming Health initiative in South Australia. The new Royal Adelaide Hospital is scheduled to open in September, new facilities will be built at Flinders Medical Centre and a new patient electronic health record has been introduced across multiple SA hospitals. The overall effect of the significant restructuring on patient care and system efficiency remains to be seen.

In educational matters, ANZICS has continued to have a strong presence locally. The 10th Annual ANZICS Tub Worthley Scholarship Dinner was held in May. Congratulations to all of the ICU Registrars who presented the results of their formal College projects and congratulations to Dr Sam Gluck who was awarded the Scholarship. A special thank you is due to Associate Professor Mary White who has tirelessly coordinated the evening in South Australia for the past 10 years and thank you to Professor Jamie Cooper who acted as a visiting judge.

The inaugural SA ANZICS and College of Intensive Care Medicine Committee Fellow Education Dinner took place in June and was a resounding success. The speakers were excellent and several suggestions have been made by attendees for future speakers and topics. The evening provided an excellent opportunity for specialists and trainees from different hospitals to come together. Thank you to Dr Steve Lam and Dr Michael Farquharson who were instrumental in organising the evening. Planning for the next dinner will commence shortly and sponsorship (pharmaceutical & South Australian Intensive Care Association) has been secured.

South Australia has been chosen as the venue for the 43rd ANZICS/ACCCN Annual Scientific Meeting (ASM) to be held 11-13 October 2018 at the Adelaide Convention Centre. Planning for the ASM is progressing well. SA ANZICS and the ACCCN have successfully conducted interviews to select the Professional Conference Organiser and members have visited potential venues for social events associated with the ASM. We are planning an exciting and quality scientific program with a number of high profile international speakers already invited.

The SA ANZICS Committee would like to thank the ANZICS staff for all of their support and practical help behind the scenes over the past year. Finally, a great thank you to all of the SA ANZICS members who have continued to represent South Australia on the various ANZICS Committees and contributed tirelessly to local ANZICS activities. The increasing level of engagement and collaboration between members of different hospitals in SA has been fantastic and the year ahead looks exciting.

Yasmine Ali Abdelhamid
Chair, SA Regional Committee

TASMANIA

Shifting to a state-wide model of care for hospital services has proven to be an ongoing challenge. Recent regional Clinical Lead appointments hope to smooth this process, but the overall impact of this restructure on intensive care services in the state remains to be seen. In Tasmania it is likely that there will always be a need to provide services to three geographically separate areas of the state. Thus, maintaining the case load, training, and staff retention required for excellence in patient care will remain a challenge.

Additionally, there are two major developments that will affect intensive care services in Tasmania in the near future. Firstly, over the next 6 months we will see the rollout of a new clinical information system for intensive care and operating theatres at the Royal Hobart Hospital. The system has been designed to export data for AORTIC/APD, and should result in marked improvements in both data collection and patient care. Secondly in the south, the RHH re-development is well underway with a completion date now likely to be in early 2019. Certainly it is an exciting time to be working in Tasmania, and one likely to bring many challenges!

Funding for intensive care services has remained fairly static despite ongoing annual increases in unit activity, and demands on intensive care staff. On a positive note there has been new additions to specialist staff in the North, and expansion of ICU bed numbers in the South. EBA negations for medical staff have finally completed after protracted arbitration by the Tasmanian Industrial Commission. For intensive care there has been some success with appropriate recognition of the weekend clinical commitment of Intensivists.

Tasmanian intensive care units continue to punch above their weight in research - recruiting too many ANZICS-CTG trials, and making ongoing contributions to ANZICS CORE. Recently the RHH Department of Critical Care Medicine, with support from ANZICS, successfully gained funding from the Tasmanian Health Service (THS) for a permanent research nurse. This additional funding will allow ongoing contributions to clinical trials, and will assist in fostering local research projects and providing higher education in research for staff. All units maintain a strong educational focus and continue to attract trainees from both Australia and overseas. Tasmania can provide all elements of the CICM training program including Senior Registrar posts consistent with the College's expectation of remote "on call" experience. CICM "transitional" positions are also available for appropriate candidates. Currently, all units are accredited for CICM training with Launceston and Hobart both accredited as "general units" suitable for core training, and the NWRH for foundation and rural training.

This September, the Tasmanian ANZICS Regional Committee, together with CICM and ACCCN Regional Committees, will host the Tasmanian Intensive Care Meeting. This is a collaborative educational initiative open to medical, nursing and allied health staff, which we hope to run annually in the future.

Society membership has remained stable over the last 12 months. Despite our small size Tasmania continues to provide valuable contributions to ANZICS, its Board, and subcommittees. As the incoming Chair of the Regional Committee I would like to thank the many Tasmanian Intensivists who have contributed to ANZICS in the past. I am sure Tasmania will continue to be a valuable contributor to ANZICS and its subcommittees for many years to come!

Finally, I would like to thank the departing Regional Chair Dr David Rigg for his valuable contributions to the ANZICS Board over the last 7 years. ANZICS has especially valued his representative role for Tasmania and smaller centres during a time of considerable change. He will continue to be actively involved in ANZICS as the Vice Chair of the Regional Committee, and Tasmanian Representative on the PricE Committee.

Michael Ashbolt,
Chair, TAS Regional Committee

QUEENSLAND

The past 12 months have seen the Queensland ANZICS Members very busy with the organisation of ANZICS/ACCCN Annual Scientific Meeting on the Gold Coast scheduled for the 11th -13th October, 2017.

It is anticipated that the return of the meeting to the popular location on the East Coast, should see the ASM once again surpass 1000 delegates. The theme 'ICU Thinking Outside the Flags' promises a great scientific programme with a focus on the innovative and challenging advances the lie outside the safe zone of current practice, along with the potential dangers that they bring. The Social Program planned for the event will be entertaining and also showcase the iconic location of the conference. The Medical, Allied Health and Nursing Members of the Organising Committee have done an incredible job of organising the ASM. I would particularly like to thank Dr Jeremy Cohen and Dr Phil Sargent for their efforts in leading the Adult and Paediatric Medical elements of the Program as the appointed Medical Convenors.

The APELSO (Asia-Pacific Extracorporeal Life Support Organisation) ASM will also be held concurrently with our ASM. There is an opportunity for the delegates to attend both events at a discounted rate.

Industrially, the initial discussions have started about the next MOCA 5 (Medical Officers Certified Agreement). I have been touch with the members of the negotiating team and intend to have a regular contact with them. It is important to ensure that the next agreement maintains the Status Quo on the "Extended hour's clause". I have also spoken to the Industrial Officer, ASMOFQ about the progress of the negotiations and best time for ANZICS to organise a meeting with ASMOFQ. Renee Lamont, The Industrial Officer has stated that ASMOFQ will have enough information on the progress of the negotiations by October. I am planning to organise a meeting for the negotiating team to meet Queensland ANZICS members in November. I will keep everybody posted on the developments.

Queensland ANZICS continues to be well represented across the Standing ANZICS Committees. Dr John Gowardman deserves a special mention, he is doing a fabulous job as a Chair of the Safety and Quality Committee.

A notable recent major clinical issue has been the PB980 ventilators. The ventilator screen would become inactive with no ability to change parameters, although the ventilator itself would function normally with the parameters already set. The ventilators have now been withdrawn from clinical service in Queensland. These ventilators have been replaced with Servo U ventilators in some hospitals.

After much deliberations, ECMO retrieval service has been established on a trial basis in the South East Queensland. This is an important development, how this will shape up in future knowing the geography of Queensland only time will tell.

Rajeev Hegde,
Chair, QLD Regional Committee

NEW ZEALAND

The New Zealand ANZICS Annual Meeting is always the highlight of the year with the opportunity to get together learning and networking with medical, nursing and allied health colleagues. This year's meeting was hosted In Wellington, which proved very popular with a total of over 180 delegates coming to a meeting held in early April at Te Papa, the Museum of New Zealand. And fortunately, the weather improved on the final day, giving those delegates from outside the Capital a chance to experience just how good "Wellington on a Good Day" can be!

The theme of the meeting was "More and more of less and less", challenging the notion that more intervention is always better and thinking about what we can do that truly makes a difference. With speakers from around New Zealand as well as several coming from Australia, topics ranged widely from the provision of ECMO and the use of 'big data' to the question of a potential role for vitamin C in sepsis. There was also a good amount of discussion how we can most effectively deliver the care that we provide, recognising the importance of both teamwork and self-care. Many thanks especially to Karyn Hathaway and Elinore Harper (Nursing Convenor) as well as Intensivist colleagues in Wellington for their help in putting together this successful meeting.

Next year's New Zealand ANZICS Meeting will be hosted for the very first time by Starship, the Auckland Children's Hospital. This Meeting will likely provide useful insights into Paediatric as well as Adult Intensive Care, both from the perspective of the Tertiary Centre as well as the Units around the Country that call upon their expertise.

The 3rd Biennial New Zealand Intensive Care Research Symposium was held in Wellington in November, again hosted by Shay McGuinness and Rachael Parke from the Cardiovascular ICU, Auckland.

This continues to be a very popular meeting for Intensivists, Nurses and Research Co-ordinators to meet and exchange ideas about current and future research directions, especially within the ANZICS Clinical Trials Group network.

The New Zealand ANZICS funds also continue to support various educational activities including the Wellington Intensive Care Medicine Examination Course and the New Zealand Intensive Care Network. We also provide some financial support for visiting Pacific Island trainees in New Zealand and enabling the collection of data by CORE through the new COMET database. We are able to do these deeds because of the attendance of delegates at the New Zealand Meeting (which is our sole source of income), which in turn is financially made possible by our generous Industry Sponsors including Fisher & Paykel, Aspen and Spiral Software. Please continue to support our work by your continuing membership and encouragement of colleagues (especially trainees) to join us and support us.

Ben Barry
Chair, NZ Regional Committee

NEW SOUTH WALES

In NSW Health there are no major structural reforms at the moment. There are a large number of hospital developments in progress or in the planning stage this includes the new Northern Beaches Hospital, St George Hospital, Prince of Wales Hospital and Nepean Hospital. The state Electronic Record for Intensive Care (eRIC) system is slowly rolling out. Port Macquarie Base Hospital (PMBH) was selected as the first ICU in NSW, followed by St George and Coffs Harbour Hospitals.

Between ANZICS, ICN and CICM there are a large number of ICU educational meetings in NSW. Intensivists are time poor and from an educational perceptive NSW ANZICS have focused on fewer higher quality dinner presentations. The aim is two to three funded dinners per year. The last NSW Regional Dinner meeting was held at the Banjo Paterson Cottage Restaurant, Gladesville. The speakers were Niklas Nielsen from Lund University and Anthony Delaney from Royal North Shore Hospital. The meeting was very well attended.

For noting there is an upcoming Critical Care ECHO course at Leura from the 2-5 September 2017.

Medical membership has only slightly increased. There are a still a number of Trainees who are not members of ANZICS in NSW. There is also an opportunity to expand our non-medical membership. Please draw this to the attention of our nursing and allied health colleagues. I would ask that we all promote membership of ANZICS as an advocate for the intensive care. The more members the stronger ANZICS becomes when representing intensive care to external bodies.

NSW ANZICS members and representatives have been active locally and internationally. NSW ANZICS has been closely involved in the NSW Scope of Practice development and the NSW Agency for Clinical Innovation (ACI) Intensive Care Services Network. NSW Intensivists have been especially active in supporting the Society's engagement with critical care institutions around the world. The Deputy Chair Danielle Austin and CTG Rep Manoj Saxena were heavily involved in the successful Singapore ANZICS meeting held in April.

I would like to thank the NSW Intensivists who give their valuable time to work with the various ANZICS Committees. Despite being very busy with clinical and non-clinical responsibilities. They include Danielle Austin as Deputy Chair, Ian Seppelt for Safety & Quality, Marino Festa for Paediatrics, Sean Kelly for CORE, Michael O'Leary, Liz Fugaccia, Dhaval Ghelani and Charudatt Shirwadkar for Education, Manoj Saxena and David Gattas for CTG and finally Jorge Brieva for DODC.

Thank you to all the ANZICS members who have contributed to the local activities. Please feel free to discuss with me any areas in which you would like ANZICS to be more active and improve engagement. Once again please encourage all your colleagues whether medical, nursing or allied health and especially your trainees to consider joining us.

Mark Nicholls
Chair, NSW Regional Committee

WESTERN AUSTRALIA

The Adult ICU landscape has started to settle over the last 12 months in WA. Three area health systems have been created with Royal Perth heading the East, Sir Charles Gairdner the north and Fiona Stanley the south. It has made the country referral process somewhat simpler and we are still seeing the results in terms of patient numbers and referral patterns.

Expansion however continues with Joondalup Hospital due to grow and SJOG Midland Hospital up and running with essentially a level 2 ICU.

Unfortunately further delays have plagued the opening of the Perth Children's Hospital (which I wrote about last year as being delayed!). This has made it hard on planning, staff and general morale as several building issues between the state and the contractors play out in the media.

The ASM ran well last October with the theme 'Where to from here' and ultimately was a success. There were concerns about getting adequate numbers to make the long journey west but in the end we got there and thanks again to Convenors Anthony Tzannes and Teresa Williams.

We continue to try to develop and maintain inter-departmental links. For the first time this year we have centralised Senior Registrar applications for the state in an attempt to find the best positions for the applicants and ensure exposure to all aspects of ICU medicine. Inter-department research meetings continue with more state-wide investigator lead projects in the pipeline.

The Intensive Care Network continues to do great work in educational meetings and we will continue to work together.

The WA membership continues to grow and we welcome all new Medical, Nursing and Allied Health members.

Brad Wibrow
WA Regional Chair, ANZICS

ANZICS AWARDS

ANZICS AWARDS 2017

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

THE WINNERS OF PREVIOUS AWARDS FOLLOW:

1981	Dr S Streat	Auckland
1982	Dr S Gatt	Sydney
1983	Dr R Raper	Sydney
1984	Dr N Gibbs	Perth
1985	Dr W Griggs	Adelaide
1986	Dr A Bersten	Adelaide
1987	Dr M Oliver	Auckland
1988	Dr P McQuillan	Perth
1989	Dr T Buckley	Hong Kong
1990	Dr C McAllister	Sydney
1991	Dr R Bellomo	Melbourne
1992	Dr S Parkes	Adelaide
1993	Dr R Totaro	Sydney
1994	No award presented	
1995	Dr A Davies	Melbourne
1996	Dr B Venkatesh	Brisbane
1997	Dr D Blythe	Perth
1998	Dr N Edwards	Adelaide
1999	Dr V Pellegrino	Melbourne
2000	Dr I Seppelt	Canberra
2001	Dr R Fregley	Waikato
2001	Dr B Mullan (special)	Sydney
2002	Dr D Collins	Perth
2003	Dr N Blackwell	Cairns
2004	Dr V Campbell	Adelaide
2005	Dr P John Victor	Adelaide
2006	Dr M Zib	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
2014	Mark Plummer	SA
2015	Palash Kar	SA
2016	Tim Beckingham	SA

PAST PRESIDENTS:

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

ANZICS ANNUAL REPORT 2017

FINANCE REPORT

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

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 2017 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 Marc Ziegenfuss *President*
Dr Adam Deane *Hon. Secretary (appointed 21Oct 2016)*
Dr Yasmine Ali Abdelhamid
Dr Ben Barry
Dr Rajeev Hegde
Dr David Ku *(appointed 25 Nov 2016)*
Dr Mark Nicholls

Dr Stephen Warrillow *Vice President*
Dr Anthony Holley *Hon. Treasurer*
Dr Michael Ashbolt *(appointed 3 Feb 2017)*
Dr Craig French
Dr Peter Hicks *(appointed 5 Jun 2017)*
Dr Kenneth John Millar
Dr Bradley Wibrow

Dr Simon Erickson *(resigned 21 Oct 2016)*
Dr David Rigg *(resigned 3 Feb 2017)*

Dr Andrew Turner *(resigned 21 Oct 2016)*
Dr David Pilcher *(resigned 5 Jun 2017)*

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.

How the principal activities achieve our objectives

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

Qualifications, experience and special responsibilities of the directors

Dr M Ziegenfuss
Qualifications: FCICM/FRCS
Experience: Director since Feb 2008
Special Responsibilities: President

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

Dr A Deane
Qualifications: MBBS/PhD/FCICM
Experience: Director since Oct 2016
Special Responsibilities: Hon. Secretary

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

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

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

Dr B Barry
Qualifications: MBBS/FRCA/FCICM
Experience: Director since Nov 2013
Special Responsibilities: Chair – NZ Region

Dr C French
Qualifications: MBBS/FANZCA/FCICM
Experience: Director since June 2015
Special Responsibilities: Chair – Clinical Trials Group

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

Dr P Hicks
Qualifications: MBchB/FCICM
Experience: Director since Jun 2017
Special Responsibilities: Chair – CORE Management

Dr D Ku
Qualifications: MBBS/FCICM
Experience: Director since Nov 2016
Special Responsibilities: Chair – VIC Region

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

Dr M Nicholls
Qualifications: MBBS/FRACP/FCICM
Experience: Director since Oct 2014
Special Responsibilities: Chair – NSW Region/PricE

Dr B Wibrow
Qualifications: MBBS/FACEM/FCICM
Experience: Director since Feb 2016
Special Responsibilities: Chair – WA Region

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

DIRECTORS' REPORT
(continued)

Directors' meetings

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

Directors	Number eligible to attend	Number attended
Dr Y Ali Abdelhamid	3	3
Dr M Ashbolt *(appointed 3 Feb 2017)*	2	2
Dr D Austin *(proxy for Dr M Nicholls)*	1	1
Dr B Barry	3	2
Dr A Deane *(appointed 25 Nov 2016)*	2	2
Dr S Erickson *(resigned 21 Oct 2016)*	1	1
Dr C French	3	1
Dr R Hegde	3	3
Dr P Hicks *(appointed 5 Jun 2017)*	1	1
Dr A Holley	3	3
Dr D Ku *(appointed 25 Nov 2016)*	2	2
Dr KJ Millar	3	2
Dr M Nicholls	3	2
Dr D Pilcher *(resigned 5 Jun 2017)*	3	2
Dr D Rigg *(resigned 6 Feb 2017)*	1	1
Dr A Turner *(resigned 21 Oct 2016)*	1	1
Dr S Warrillow	3	3
Dr B Wibrow	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 $17,720 (2016: $16,380) being 886 (2016: 819) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2017 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 Marc Ziegenfuss
President
Dated this 25th day of August 2017

Dr Anthony Holley
Hon.Treasurer

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

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

I declare that, to the best of my knowledge and belief, during the year ended 30 June 2017 there have been:

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

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

C.W. Stirling & Co.
Chartered Accountants

John A Phillips
Partner

Dated this 25th day of August 2017
Melbourne.

Liability limited by a scheme approved under Professional Standards Legislation

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME
FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Revenue from ordinary activities	2	2,275,345	2,754,697
Other income	2	47,628	-
Employee expenses		(1,404,351)	(1,463,284)
Conference and meeting expenses		(198,895)	(316,625)
Administration expenses		(200,405)	(197,493)
Travel and committee expenses		(122,542)	(134,134)
IT and consultant expenses		(97,005)	(112,139)
Awards, sponsorships and scholarships		(29,500)	(73,319)
Depreciation and amortisation expense		(103,264)	(54,225)
Other expenses from ordinary activities		(25,435)	(22,819)
Profit for the year		141,576	380,659
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss:			
Gain on revaluation of land and building		720,754	-
Total other comprehensive income for the year, net of income tax		720,754	-
Total comprehensive income for the year		**862,330**	**380,659**

The accompanying notes form part of these financial statements.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

STATEMENT OF FINANCIAL POSITION
AS AT 30 JUNE 2017

	Note	2017 $	2016 $
Current Assets			
Cash and cash equivalents	4	1,682,065	1,642,932
Trade and other receivables	5	53,121	67,422
Other current assets	6	125,646	34,352
Total current assets		1,860,832	1,744,706
Non-Current Assets			
Financial assets	7	569,882	592,320
Property, plant and equipment	8	3,214,590	2,536,907
Intangible assets	9	426,087	360,136
Total non-current assets		4,210,559	3,489,363
Total Assets		6,071,391	5,234,069
Current Liabilities			
Trade and other payables	10	578,430	597,135
Employee benefits	11	254,248	260,593
Total current liabilities		832,678	857,728
Non-Current Liabilities			
Employee benefits	11	22,684	22,642
Total non-current liabilities		22,684	22,642
Total Liabilities		855,362	880,370
NET ASSETS		5,216,029	4,353,699
Equity			
Reserves	12	1,537,477	816,723
Retained profits		3,678,552	3,536,976
TOTAL EQUITY		5,216,029	4,353,699

The accompanying notes form part of these financial statements.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

STATEMENT OF CASH FLOWS
FOR THE YEAR ENDED 30 JUNE 2017

	Note	2017 $	2016 $
Cash flows from operating activities			
Receipt of grants		1,134,450	1,577,549
Cash receipts from members and customers		1,272,388	1,406,695
Interest received		37,302	48,156
Payments to suppliers and employees		(2,363,606)	(2,391,797)
Net cash from operating activities	13	80,534	640,603
Cash flows from investing activities			
Purchases of property, plant and equipment		(8,425)	(5,081)
Payments for intangible assets		(117,719)	(360,136)
Income from financial assets		28,053	24,372
Acquisition of other financial assets		(58,165)	(71,294)
Proceeds from other financial assets		114,855	46,238
Net cash used in investing activities		(41,401)	(365,901)
Net increase in cash and cash equivalents		39,133	274,702
Cash and cash equivalents at beginning of financial year		1,642,932	1,368,230
Cash and cash equivalents at end of financial year	4	1,682,065	1,642,932

The accompanying notes form part of these financial statements.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

STATEMENT OF CHANGES IN EQUITY
FOR THE YEAR ENDED 30 JUNE 2017

	Retained profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2015	3,156,317	816,723	3,973,040
Profit attributable to the Society	380,659	-	380,659
Total other comprehensive income for the year	-	-	-
Balance at 30 June 2016	3,536,976	816,723	4,353,699
Profit attributable to the Society	141,576	-	141,576
Gains on revaluation of land and building	-	720,754	720,754
Balance at 30 June 2017	3,678,552	1,537,477	5,216,029

The accompanying notes form part of these financial statements.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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

The Society applies Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: *Application of Tiers of Australian Accounting Standards.*

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

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

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

The financial statements were authorised for issue on 25 August 2017 by the directors of the company.

Accounting policies

(a) Revenue

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

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

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

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

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

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

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

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.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

1. Statement of significant accounting policies (continued)

(j) Intangible assets

COMET software development

Costs that are directly attributable to the development of COMET software are recognised as an intangible asset and are amortised to the Income Statement over a period of five years.

(k) Comparative figures

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

(l) 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

Valuation of freehold land and buildings

The freehold land and buildings were independently valued at 21 February 2017 by Opteon. The valuation was based on the fair value less costs of disposal. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current strong demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $720,754 being recognised for the year ended 30 June 2017.

(m) New Accounting Standards for Application in Future Periods

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

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

	2017 $	2016 $
2. Revenue and other income		
Revenue:		
Grants	1,264,017	1,516,427
Subscriptions	491,268	493,123
Surplus from ASM	18,189	84,877
Conferences and meetings	223,127	402,282
Sponsorship	135,050	150,048
	2,131,651	2,646,757
Other revenue:		
Interest received – cash and cash equivalents	43,616	46,877
Investment dividends and distributions	30,581	24,732
Sundry income	69,497	36,331
	143,694	107,940
Total revenue	2,275,345	2,754,697
Other income:		
Unrealised gain on investments held	47,628	-
Total other income	47,628	-
Total revenue and other income	2,322,973	2,754,697
3. Expenses		
Unrealised loss on investments held	-	5,439
Loss on disposal of investments	13,376	3,085
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	682,065	452,632
Cash on short term deposit	999,700	1,190,000
	1,682,065	1,642,932
5. Trade and other receivables		
Trade receivables	22,210	52,049
Other receivables	30,911	15,373
	53,121	67,422
6. Other current assets		
Prepayments – general	123,146	25,637
Prepayments and deposits - ASM	2,500	8,715
	125,646	34,352
7. Financial assets		
Available for sale financial assets		
- investments in listed Australian securities	308,670	333,405
- investments in managed funds	261,212	258,915
	569,882	592,320

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

	2017 $	2016 $
8. Property, plant and equipment		
Land and buildings		
Freehold land – at valuation (a)	2,200,000	1,600,000
Buildings – at valuation (a)	1,000,000	950,000
Less accumulated depreciation	(8,853)	(55,416)
	991,147	894,584
Total land and buildings	3,191,147	2,494,584
Plant and equipment		
Plant and equipment - at cost	131,323	122,898
Less accumulated depreciation	(107,880)	(80,575)
Total plant and equipment	23,443	42,323
Total property, plant and equipment	3,214,590	2,536,907

(a) Asset revaluation

The freehold land and buildings were independently valued at 21 February 2017 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 $720,754 being recognised for the year ended 30 June 2017.

Movements in carrying amounts

	Freehold land and buildings (a) $	Plant and equipment $	Total $
2017			
Balance at 1 July 2016	2,494,584	42,323	2,536,907
Additions	-	8,426	8,426
Revaluation increment	720,754	-	720,754
Depreciation for the year	(24,191)	(27,306)	(51,497)
Balance at 30 June 2017	3,191,147	23,443	3,214,590
2016			
Balance at 1 July 2015	2,518,334	67,718	2,586,052
Additions	-	5,081	5,081
Depreciation for the year	(23,750)	(30,476)	(54,226)
Balance at 30 June 2016	2,494,584	42,323	2,536,907

	2017 $	2016 $
9. Intangible assets		
COMET Software development - at cost	477,855	360,136
Less accumulated amortisation	(51,768)	-
Total intangible assets	426,087	360,136

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

9. Intangible assets (continued)

Movements in carrying amounts

	$
2017	
Balance at 1 July 2016	360,136
Additions	117,719
Amortisation for the year	(51,768)
Balance at 30 June 2017	426,087
2016	
Balance at 1 July 2015	-
Additions	360,136
Amortisation for the year	-
Balance at 30 June 2016	360,136

	2017 $	2016 $
10. Trade and other payables		
Trade creditors	101,746	103,034
Sundry creditors and accruals	61,664	82,494
Grants received in advance	42,750	34,379
Subscriptions received in advance	215,968	262,489
Sponsorship & registrations received in advance	156,302	114,739
	578,430	597,135
11. Employee benefits		
Current		
Provision for annual leave	103,905	105,585
Provision for long service leave	150,343	155,008
	254,248	260,593
Non-current		
Provision for long service leave	22,684	22,642

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).

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

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NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

	2017 $	2016 $
12. Reserves		
Asset revaluation reserve	1,537,477	816,723
Balance at the beginning of the year	816,723	816,723
Revaluation increment	720,754	-
Balance at the end of the year	1,537,477	816,723

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

13. Notes to the Statement of Cash Flows		
Reconciliation of cash flow from operations with profit after income tax		
Profit from ordinary activities	141,576	380,659
Add/(less) non-cash items:		
Depreciation and amortisation	103,264	54,226
Investment income reclassified	(30,581)	(24,372)
Loss on disposal of investments	13,376	3,085
Unrealised loss (gain) on investments held	(47,628)	5,439
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	16,829	25,360
(Increase)/decrease in other current assets	(91,294)	16,611
Increase/(decrease) in trade and other payables	(18,705)	167,917
Increase/(decrease) in provisions	(6,303)	11,678
Net cash used in operating activities	80,534	640,603

14. Related Parties

Directors

The following persons held the position of Director of the Society during the financial year:
Dr Marc Ziegenfuss, Dr Andrew Turner, Dr Simon Erickson, Dr Anthony Holley, Dr Yasmine Ali Abdelhamid, Dr Michael Ashbolt, Dr Ben Barry, Dr Adam Deane, Dr Craig French, Dr Rajeev Hegde, Dr Peter Hicks, Dr David Ku, Dr Kenneth John Millar, Dr Mark Nicholls, Dr David Pilcher, Dr David Rigg, Dr Stephen Warrillow, Dr Bradley Wibrow

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

15. 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:

	2017 $	2016 $
Key management personnel compensation	398,534	410,690

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

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NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

16. 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 17.

(c) Liquidity risk

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

(d) Interest rate risk

Interest rate risk refers to the risk that the fair value of financial instruments or future cash flows will fluctuate due to changes in market interest rates. The Society's interest-bearing financial assets and financial liabilities expose it to

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

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NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

16. Financial risk management (continued)

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.

17. 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

	2017 Carrying amount $	2017 Fair value $	2016 Carrying amount $	2016 Fair value $
Cash and cash equivalents	1,682,065	1,682,065	1,642,932	1,642,932
Trade and other receivables	53,121	53,121	67,422	67,422
Other current assets	125,646	125,646	34,352	34,352
Financial assets	569,882	569,882	592,320	592,320
Trade and other payables	578,430	578,430	597,135	597,135

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

(c) Interest Rate Risk

	Carrying amount 2017 $	Carrying amount 2016 $
Floating rate instruments		
Cash and cash equivalents	682,365	452,932
Fixed rate instruments		
Cash and cash equivalents	999,700	1,190,000

Fair value sensitivity analysis

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

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

17. 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	
	2017 $	2016 $
Loans and receivables	53,121	67,422

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 $
2017							
Trade receivables	22,210	-	16,990	-	5,220	-	16,990
Other receivables	30,911	-	30,911	-	-	-	30,911
Total	53,121	-	47,901	-	5,220	-	47,901
2016							
Trade receivables	52,049	-	33,349	-	2,200	16,500	33,349
Other receivables	15,373	-	10,592	-	-	4,781	10,592
Total	67,422	-	43,941	-	2,200	21,281	43,941

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 2017 or the previous financial year.

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

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NOTES TO THE FINANCIAL STATEMENTS FOR THE YEAR ENDED 30 JUNE 2017

17. Financial instruments (continued)

(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 2017							
Payables	578,430	578,430	470,446	107,984	–	–	–
30 June 2016							
Payables	597,135	597,135	465,891	131,244	–	–	–

18. 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.

19. Contingent Liabilities

There are no contingent liabilities as at 30 June 2017 (2016: $Nil).

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

DIRECTORS' DECLARATION

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

1. The financial statements and notes, as set out on pages 27 to 52, are in accordance with the *Australian Charities and Not-for-profits Commission Act 2012* and:

   (a) comply with Australian Accounting Standards – Reduced Disclosure Requirements; and
   (b) give a true and fair view of the financial position of the Society as at 30 June 2017 and of its performance for the year ended on that date; and

2. There are reasonable grounds to believe that the Society will be able to pay its debts as and when they become due and payable.

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

Dr Marc Ziegenfuss
President

Dr Anthony Holley
Hon. Treasurer

Dated this 25th day of August 2017.

C.W. STIRLING & CO. chartered accountants

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

Report on the Audit of the Financial Report

Opinion

We have audited the financial report of Australian and New Zealand Intensive Care Society, which comprises the statement of financial position as at 30 June 2017, the statement of profit or loss and other comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, and notes to the financial statements, including a summary of significant accounting policies, and the directors' declaration.

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

I. giving a true and fair view of the registered entity's financial position as at 30 June 2017 and of its financial performance for the year then ended; and
II. complying with Australian Accounting Standards and Div 60 of the *Australian Charities and Not-for-profits Commission Regulation 2013*.

Basis for Opinion

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

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

Information Other than the Financial Report and Auditor's Report Thereon

The directors are responsible for the other information. The other information comprises the information included in the registered entity's annual report for the year ended 30 June 2017, but does not include the financial report and our auditor's report thereon. Our opinion on the financial report does not cover the other information and accordingly we do not express any form of assurance conclusion thereon. In connection with our audit of the financial report, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial report or our knowledge obtained in the audit or otherwise appears to be materially misstated. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report in this regard.

Responsibilities of the Directors for the Financial Report

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

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

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

ABN 81 057 619 986

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF

AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

(continued)

Auditor's Responsibilities for the Audit of the Financial Report

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

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

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

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

C. W. Stirling & Co
Chartered Accountants

John Phillips
Director

Dated this 25th day of August 2017.
Melbourne.

ANNUAL GENERAL MEETING

4.45pm Friday 21st October 2016
Riverside Theatre, Perth Convention & Exhibition Centre, Perth, Western Australia

CONFIRMED MINUTES

1. WELCOME, PRESENT & APOLOGIES *President*

Present

Dr Marc Ziegenfuss (President)
Dr Anthony Holley (Hon Treasurer)
Dr Danielle Austin
Dr Ben Barry
Dr Jorge Brieva
Dr Troy Browne
Prof John Cade
Dr Robin Choong
Dr David Cooper
Dr David Crosbie
Dr Rohit D Costa
Dr Naomi Diel
Dr Graeme Duke
A/Prof David Ernest
Dr Elizabeth Fugaccia
Dr David Gattas
Dr John Green
Dr Peter Harrigan
Dr Rajeev Hegde
Dr Gill Hood
Dr Ian Jenkins
Dr Daryl Jones
Dr Myrene Kilminster
Dr David Knight
Dr David Ku
Dr Janet Liang
Dr Mark Nicholls
Dr Helen Opdam
Dr Ranald Pascoe
A/Prof David Pilcher
Dr Sam Radford
Dr Nandkumar Raut
Dr David Rigg
Dr John Santamaria
Dr Manoj Saxena
Dr Isuru Seneviratne
Dr Geoff Shaw
A/Prof George Skowronski
Dr Nathan Smalley
Dr Penny Stewart
Dr Gopal Taori
A/Prof David Tuxen
Dr Stephen Warrillow
A/Prof Mary White
Dr Ron Trubuhovich

Apologies

A/Prof Andrew Turner (Immediate Past President)
Dr Simon Erickson (Hon Secretary)
Dr Adam Deane
Prof Geoff Cutfield
Prof John Myburgh
Dr John Santamaria
Dr Lachlan Doughty
Dr Manoij Saxena
A/Prof Michael O'Leary

In Attendance

Brent Kingston *(Minutes)*
Tony Tenaglia (ANZICS General Manager)

AT welcomed all to the meeting and noted the apologies received for the AGM.

2. MINUTES OF PREVIOUS MEETING *President*

Marc Ziegenfuss (MZ) proposed the minutes of the previous AGM, held Friday 21st October 2016 be accepted as a true and accurate record of the meeting.

Motion: The minutes are accepted as a true and accurate record of the meeting.
Proposed: Mark Nicholls
Seconded: Rajeev Hegde

Motion Carried

3. PRESIDENT'S REPORT

MZ updated on the past 12 months as ANZICS President.

The increase of the ANZICS Membership was noted, following the expansion at the 2015 AGM of the categories to include Allied Health, Nursing and Research Coordinator Members.

A recent change was made to the ANZICS Standing Committee Structure to include Trainee Representation. This was made to better engage with the Early Career Intensivists and also to enable succession planning from within the Society. The loss of touch of the Society with the Trainees was noted and it was intended that this would improve engagement.

ANZICS Representation recently travelled to the United Arab Emirates to advertise the CORE Benchmarking Services for the registries. It was noted that following this trip, Iran have signed up to ANZICS CORE. Collaborations for conferences, data sharing and also research initiatives are also looking to eventuate with the Society of Critical Care Medicine and the European Society of Intensive Care Medicine.

MZ thanked the membership and also those involved with ANZICS for the voluntary work and the additional activities for the Society on top of full-time employment.

The support of lower socioeconomic attendees to attend the ASM is also a current aim of ANZICS. SG-ANZICS is continuing to grow into an internationally recognised meeting and ANZICS is fostering the conference to become the flagship of the region. ANZICS, in partnership with the Singapore Intensive Care Society are offering free/subsidised registrations to nearby lower socioeconomic countries to attend the event.

Noting was made to the gender imbalance within the profession, MZ highlighted the need to encourage female engagement with ANZICS and the Committees. It was advised that there are a number of females present on the ANZICS Committees, however, there is only one present on the ANZICS Board. ANZICS supports the initiatives of the Women in Intensive Care Network (WIN).

4. TREASURER'S REPORT

AH presented the Treasurer's Report to the ANZICS Membership.

ANZICS achieved $2.75 million in revenue for the year, with $380,000 of this as profit.

The increased amount of profit is solely due to the capitalisation of the CORE COMET IT Project. With $360,000 of this spend reflected on the balance sheet as capital assets.

The main points of revenue for the Society were:

- CORE Funding: $1.5 Million
- Safety & Quality Conference
- ASM
- Advertising

The current total assets of the Society are $5.2 million, with the liabilities $880,000 and the net assets at $4.5 million.

Current assets are made up of;

- $2.2 million in term deposits
- $2.5 million in property

3. PRESIDENT'S REPORT

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Current assets are made up of;

- $2.2 million in term deposits
- $2.5 million in property

Motion: Stephen Warrillow's nomination for the role of Vice President be accepted and ratified by the ANZICS Membership.
Proposed: Mark Nicholls
Seconded: Rajeev Hegde

Unanimous vote in support of the ratification.

Motion: Anthony Holley's nomination for ANZICS Honorary Treasurer be accepted and ratified by the ANZICS Membership.
Proposed: Mark Nicholls
Seconded: Rajeev Hegde

Unanimous vote in support of the ratification.

Motion: Adam Deane's nomination for the role of Honorary Secretary be accepted and ratified by the ANZICS Membership.
Proposed: Mark Nicholls
Seconded: Rajeev Hegde

Unanimous vote in support of the ratification.

7. PROFESSIONAL PRACTICE

7.1 Practice and Economics Committee
Mark Nicholls updated on the MBS Items Review Process, it was advised due to confidentiality in depth information could not be provided. ICU, ED and an End of Life represented Intensive Care and ED. Committee members represented individuals in place of organisational or Society representation.

A Public Consultation Document will be released to the public prior to the end of 2017, with feedback to be sent to the Department of Health.

MN highlighted that there is no increase in fees until 2020 due to the items increases frozen until that time. MN thanked Ranald Pascoe for his time and contribution to the PricE Committee over the many years of involvement. Siva Senthuran has now taken over as Queensland Representative on the Committee.

8.2 ANZICS Centre for Outcome and Resource Evaluation
David Pilcher presented the ANZICS CORE Report.

DP provided updates on COMET, advising that the Data Collection Tool would be replacing AORTIC. The program has been built in a way that it allows user platform expansion to increase the reporting functions to ensure that there is capability to add additional data information in the future.

The collaboration with AIHW allows users to access a user hosted portal to login to a secure portal and view data from any location.

16 publications in the recent 12 months have seen CORE maintain the research outputs of the registries.

Current collaborations with CORE are:
- ACSQH – ATLAS Variation to create a global severity of illness score

- MIT: CORE will be hosting a Datathon in March 2017 to engage Trainees, researchers, Biostatisticians and Data Scientists to create projects based on the CORE Dataset, Collective Datasets and the Harvard Dataset.

DP thanked Allison van Lint for her time at ANZICS CORE as CORE Project Lead for the last 7 years and her considerable outputs within ANZICS CORE.

Peter Hicks has advised of intention to step down from CCR Director of ANZICS CORE.

DP advised that all tertiary units in Australia are now submitting data on the same schedule.

8.3 ANZICS Clinical Trials Group
Craig French presented the CTG Update.

CF thanked the CTG Member Units for their continued contribution along with the CTG Committee.

It was noted that a number of units now rely on CTG endorsed studies to fund their research staff.

Updates were provided on the current large CTG Studies by both Jeff Lipman and Adam Deane. Two other CTG Endorsed Studies research a large amount of NHRMC funding.

A review of the Terms of Reference and the review of the Strategic Plan are currently scheduled for early 2017.

CTG Noosa is scheduled for the 6th – 9th March 2017 with invited speaker Tony Gordon. It is anticipated that Howard Bauchner, the current Editor in Chief of JAMA will be speaking also.

The CTG Winter Research Forum will be held in Queenstown in August 2017, with a split style program to allow delegates to enjoy the destination during the day.

8.4 Safety & Quality Committee
Jonathan Barrett provided the Safety & Quality update in John Gowardman's absence.

JB thanked Jennifer Holmes (S&Q Executive Officer) for her efforts in supporting and driving the Committee objectives and the extensive work involved in the Safety & Quality Conference.

There has been ongoing discussion around the objectives and focus of the Committee within the existing resources.

Part of the focus is to define what the existing internal/external relationships of the Committee are, particularly within ANZICS CORE and the CCR Survey.

The Joint ANZICS/CICM Position Statement on Rapid Response Teams was produced, with members of the Committee involved in the creation of the document.

A survey was sent to all units on the minimum datasets or potential support for a National Database on Rapid Response Systems. The response rate was quite low, with only 69 units that have responded.

The 2017 ANZICS Safety & Quality Conference will be held in Sydney on the 7-8 August 2017, with a prominent deteriorating patient theme. There will be also be an increased amount of general Safety & Quality content.

A request for a nominated ACCCN and NZCCCN Representative for the Committee has been sent, with responses still to be received. Tasmania remains unrepresented on the Committee.

JB thank Daryl Jones for his significant efforts and involvement in leading the organisation of the conference.

8.5 Death and Organ Donation Committee
Bill Silvester presented the DODC Report to the Membership.

The recent review of the OTA Model for the Family Donation Conversation has been a large focus of the Committee. With BS and Mary White attending the recent meeting, successfully requesting a number of changes to the model.

The previous version of the model was not endorsed by the Committee due to the minimisation of the role of the Intensivist in the family donation conversations.

The current ANZICS Statement on Death and Organ Donation is scheduled for review, with the first face to face to be held for the end of the year. This requires the review of the current Brain Death and Imaging Guidelines. The Australian and New Zealand College of Neuro-Radiologists are currently engaged to assist in reviewing the guidelines.

A survey was sent to ANZICS members regarding attitudes surrounding end of life care. This data is now being analysed.

Feedback was provided by ANZICS to New Zealand Ministry of Health regarding organ donation set up in New Zealand.

The Committee has been working on updating the DODC Terms of Reference.

The ANZICS End of Life Care Working Group has initiated the review on ANZICS Statement on Care and Decision Making End of Life, due for submission in 2018. Pursuant to this, a survey for ANZICS Members will be dispersed to analyse the Statement's utility and focus, and seek suggestions for improvement.

A suggestion was sent to the Board, requesting EOLCWG prepare a draft ANZICS position Statement on Euthanasia and Doctor Assisted Dying. This has become an increasingly discussed issue in society, therefore it is a wise that ANZICS to prepare a position.

BS thanks the Committee, the Working Group, the Board and ANZICS Staff for their efforts.

8.6 Education Committee
Sam Radford presented the Education Report.

Thanks was made to Gerry O'Callaghan, past Education Chair for the hard work over his term.

Noting was made to the vacancy for a New Zealand Representative on the Committee, with any interest to be sent to the ANZICS Office.

Education Committee has successfully supported the ASM and Trainees. A major goal now is to develop further digital technology to distribute information to Members.

9. OTHER BUSINESS

No further business discussed.

10. FUTURE MEETINGS

42nd ANZICS/ACCCN Intensive Care Annual Scientific Meeting (ASM) Gold Coast Convention and Exhibition Centre, Gold Coast, Queensland, Australia 11th – 13th October 2017

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"ADVOCATE FOR INTENSIVE CARE THROUGHOUT AUSTRALIA AND NEW ZEALAND"