ANZICS

2016 ANNUAL REPORT

Advocate for intensive care throughout Australia and New Zealand

ANZICS

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Australia and New Zealand Intensive Care Society

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PRESIDENT'S REPORT

Dear Membership,

The last year has been a busy one at ANZICS, where Office Staff, Board Members and Committees have been advocating for our Craft group on multiple fronts. The primary aim of everyone at ANZICS is to achieve outcomes that enable our membership to perform optimally when providing patient care.

We have extended our membership criteria to be more inclusive of all staff that are involved in the delivery of intensive care to the critically ill. The aim is to become truly representative of intensive care providers and, since 'unity is strength', be able to advocate better. Our membership is expanding and I ask you to please advertise this initiative in your workplace and refer staff to the ANZICS website. The new membership interest groups will be formed from there.

Attending multiple local and overseas meetings it is obvious that people associate Australian and New Zealand Intensive Care with ANZICS, and with this clinical excellence, strong research, excellent benchmarking and quality audit, and cohesiveness amongst ANZ intensive care practitioners. We can all stand proud.

The PricE Committee is under recognised in its work advocating federally for reimbursement for our work and providing guidance and support for the workforce. The adage of 'administrative and management processes don't make the news during times of prosperity' holds true. However "The time to repair the roof is when the sun is shining" (JF Kennedy 1962) – is exactly what is happening behind the scenes at PricE. I would like to thank Mark Nicholls and the PricE Committee for their ongoing efforts.

ANZICS CORE has an enviable international reputation for its data integrity, reports and research generated from this data. The Critical Care Resources Survey has valuable data to reflect current Intensive Care Unit resources and enables future resource planning. The CORE Staff, David Pilcher and Peter Hicks are to be congratulated for their Leadership and my request to the membershipis to engage in CORE activities and access the database for research and planning purposes whilst we expand ANZICS' international profile in this 'era of data'. An international collaboration via a 'Data Hack-a-thon' is being planned for early next year. A strength of ANZICS is its regional (ANZ) leadership, and this shall always remain our focus. We need to present this strength in the global realm. We have had early success in the Middle East with data contributions from Iran and aim to further expand our presence across the Middle East and Asia. Please get involved.

The ANZICS CTG continues to attract high profile grants and deliver valuable research under the guidance of Craig French and the Office Staff. Considering its success to date I am supportive of the CTG fostering more international research collaborations.

The Safety and Quality Committee is an important pillar of ANZICS. Under its stewardship also lies the entity of Medical Emergency and Rapid Response Teams. The recent International Conference in Melbourne addressing this 'Intensive Care Outreach' facet was an excellent one. Thank you to Daryl Jones and all those who gave of their time and effort to showcase the ANZ practice. This meeting reflected the diverse array of professionals that contribute to intensive care services and highlighted the desire of non-medical intensive care staff to be part of the success that is ANZICS. Hence new membership categories have been established. End of Life Care was highlighted at this meeting and the efforts of the Death and Organ Donation Committee and End-of-Life Care Working Groupneed to be commended for providing Guidance and representation at a Federal level to ensure ongoing financial support for intensive care practitioners involved in organ donation.

ANZICS delivers high quality Conferences and the presentation of information relevant to our practice is combined with exposure to existing and novel therapeutic modalities by the trade. The value of collaboration with Industry and the social and networking opportunities afforded by our meetings is very important and binds the Society that is ANZICS. Collegiality that is grown from these meetings make the ANZ intensive care community greater than the sum of its parts. Your support for the conferences by attendance and active participation is highly valued. The ANZICS-Singapore Conference in 2017 and the World Federation of Societies of Intensive Care Medicine in 2019 in Melbourne are ideal platforms to showcase ANZICS' excellence. ANZICS needs to improve its presence in the day to day activities of its Members. To this end we need the help of social media savvy intensive care providers to become active in the Society with the Education Committee so that we can support each other better. Please contact ANZICS if you think you can help.

Financially the Society is sound as is reflected in the audited financial report. ANZICS operated according to Budget in the last financial year. Please take time to read it and also the individual Committee reports. The ANZICS Annual General meeting in Perth on October 21, 2016 will provide an opportunity to engage with the Executive and propose ideas to strengthen ANZICS even further. The AGM will follow an Oration by Geoff Dobb who will share from his wealth of experience. I would like to acknowledge the ANZICS Staff at ANZICS House for their efficient hard work under the management of Mr Tony Tenaglia. Thank you.

Marc Ziegenfuss
ANZICS President

TREASURER'S REPORT

It is a great privilege for me to report to the membership on the current financial state of our Society. ANZICS has delivered some very gratifying results over the last financial year.

The Society requires a strong financial foundation in order to deliver a high quality product to the membership and the critical care professional community. The Executive, Board, General Manager and in particular the Staff, have worked very hard to deliver this year's positive and encouraging result.

ANZICS has delivered a year end bottom line that is better than originally forecast. Prudent management, hard work and progressive thinking has in many ways been responsible for this result. We will continue to aggressively rationalise our expenditure, while maintaining the high standards in order to continually improve the financial state of the society.

The original budget prediction anticipated a $15,000 annual surplus, however thanks in particular to highly successful Safety & Quality Conferences, CORE revenue and the capitalisation of systems that have been developed to capitalise on future potential, the actual surplus was in the order of $380,000. Whilst most of this was due to capitalisation gains, we still achieved $22,000 surplus overall.

ANZICS remains a relatively small, not-for-profit Society whose purpose to deliver services must be balanced against operating within its means. It should be noted however, that in terms of equity versus liabilities, ANZICS has a ratio of almost 6 to 1. This means that ANZICS can cover its liabilities six times over. This provides a solid base from which returns and value from our operations can continue to reliably grow. The Board, Executive and General Manager are actively exploring other cost efficiencies and wealth generating opportunities.

A recent review of our Investment Strategy has confirmed the Board's view that appropriate decisions are 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. Thus far it continues to perform within expected parameters and has held its ground admirably during a volatile global financial environment characterised by continuing rate reductions. The exploration and implementation of more services, education initiatives, including the promotion of ANZICS capabilities in the global arena has already generated positive outcomes.

In summary, ANZICS achieved $2,754,697 in revenue during 2016 and spent a total of $2,374,038. This results in a net overall surplus of $380,659.

Overall we have had a very successful year and the Society continues to secure its future, but we all need to consistently work hard to increase our membership base and appropriately expand our services and opportunities.

Thank you to all the members, the Board, the General Manager and the Staff at ANZICS for a successful year.

Anthony Holley
ANZICS Treasurer

ANZICS BOARD OF DIRECTORS

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GENERAL MANAGER'S REPORT

The 2015-2016 year was one where ANZICS has continued to consolidate its position as the lead advocate for the provision of intensive care service in Australia and New Zealand. Indeed it is quite apparent that ANZICS' elite reputation extends beyond our two countries' national borders. The Emirates, the Thai's, the Americans and the Europeans have all engaged, or sought to engage us across a range of our areas of expertise. The CORE Benchmarking services, the Clinical Trials Group and Safety and Quality have all extended their reach during the last twelve months and will continue to drive activity into the foreseeable future.

The interest from these international societies has resulted in the further continuation of ANZICS' international expansion in key areas, in particular with CORE. This activity, whilst laudable is being undertaken slowly and with appropriate contributions of international funding to ensure ANZICS' modest resources are not taxed and the quality of output and delivery are uncompromised. It is rewarding to see that the expertise built up over the last 41 years can be accessed positively to improve services not only within our own region but globally.

ANZICS' current international forays, partnerships and activities are aligned to our preparations for the World Congress event in 2019. These interactions are critical in ensuring the attraction of delegates from all over the world as we develop the 2019 offering over the next three years. Dr Stephen Warrillow, as the 2019 World Congress Medical Convenor has commenced the development of this event in partnership with our ACCCN colleagues.

CORE's Enterprise Reporting System (CERS) which underpins the Intensive Care Unit Benchmarking program has been in operation for over twelve months and has performed to expectations. This will continue to grow as the new COMET system, replacing AORTIC comes on line during the next year.

The Clinical Trials Group has continued to generate and support evidence to improve outcomes via better treatment for intensive care patients.

Safety and Quality have again excelled and their recent Rapid Response Conference was a particular highlight of the past year.

The Auckland Annual Scientific Meeting was a success and the Perth event is shaping up to be another positive entry in the 41 years that ANZICS has been providing the educational and networking opportunity.

Our local, as well as international efforts are not however, without challenges on our resources. ANZICS must continue to carefully balance its resources and operational capabilities against its growth opportunities. Our aim will always be to support our Intensivist, Nursing, Allied Health and research Coordinator Members in all aspects of their professional careers to ultimately improve outcomes for patients. This means that our resources must continue to be applied judiciously where "the biggest bang for our buck" can be derived – with the best outcomes sought.

The forthcoming 2016-2017 year will therefore see ANZICS continue its consolidation efforts and carefully apply its growth strategies. These efforts will include an ongoing efficiency review to ensure our resources and capabilities are deployed as effectively as possible, the consolidation and embedding of the key CORE benchmarking systems developed during the last 24 months, and the preparation of future educational events including our annual scientific meetings and ancillary educational events.

ANZICS' growth and accomplishments during the last twelve months would not have happened without the hard work and commitment of the staff at ANZICS. ANZICS is very fortunate to have staff that punch above their weight in delivering our services and I thank them all for their efforts and support during the last twelve months.

In closing, I would also like to thank all of ANZICS' members. We are continuing to explore and expand on the expectations the members have of ANZICS so we can continue to be the best representative body possible for their benefit and ultimately the benefit of those individuals who find themselves in need of Intensive Care services.

Tony Tenaglia
ANZICS General Manager

MEMBERSHIP REPORT

The last twelve months have seen significant changes to the ANZICS Membership. The recategorised membership types has allowed the Society to be more inclusive to the wider intensive care profession and better represent all crafts within the specialty. Expressions of interest were also sought from Trainee members to become part of the Standing 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.

ANZICS continues to offer its Membership educational opportunities, research activities, quality assurance, industrial activity and professional development. The Society has an obligation to continually reassess its role and ensure the value it provides to the Membership.

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 had 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. It is encouraging to see the rise in New Fellow Members and the continued growth of Full Members to the Society.

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

Simon Erickson
Honorary Secretary

Total Members:	843

Country	
Australia:	711
New Zealand:	108
Other:	24

Type	
Full:	478
New Fellow:	58
Trainee:	132
Associate/Overseas:	45
Nurse:	69
Allied Health:	23
Research Coordinator:	5
Honorary:	9
Retired:	22

ANZICS CORE ANNUAL REPORT

Increasing number of contributing sites

The number of sites submitting data to ANZICS CORE continues to grow with now all 40 Tertiary sites across Australia and New Zealand contributing to the Adult Patient Database. The map below shows the profile of all ICU services across Australia and New Zealand in 2015.

A profile of ICU services in Australia and New Zealand in 2015

Building CORE IT capacity – Data collection and Reporting

The major work of ANZICS CORE over the past three years has been to develop a modern and flexible IT infrastructure to meet the benchmarking requirements for Intensive Care into the future. The first stage was the development of the CORE Enterprise Reporting System launched in 2015, followed by the development of the CORE Outcome, Measurement and Evaluation Tool (COMET), a new web-based data collection tool to be available in 2017.

COMET replacing AORTIC

COMET (CORE Outcome Measurement and Evaluation Tool) will replace AORTIC, the software program used by the majority of ICUs in Australia and New Zealand to collect data for over 20 years. Very few software products can claim to have lasted this long. However soon AORTIC will no longer be supportable by many of the Windows based IT systems in ANZ hospitals. COMET has been developed so that it can run on all modern IT systems.

COMET will function the same as AORTIC but the look and feel will be much better. For most hospitals, it will be 'hosted' externally which means no installation and no involvement with your IT department. All you need do is open a web browser, which means it will run on a Mac, iPad, PC desktop or laptop. It will be easier to update, and also cheaper to run for us! Reporting and querying of data will also be different, but if you want to know more, come to one of our Data Collection Workshops!

This development has allowed us to update and do the first major changes to the ANZICS dataset in 10 years.

- Variables not used for reporting or risk adjustment (e.g. respiratory arrest & smoking) have been dropped.
- New variables such as 'frailty' and outcomes such as delirium and pressure injury have been added.
- Information on therapies, which have been collected at many sites for a long time, will now also be sent centrally to ANZICS. These will allow us to provide comparative reports on the therapies (e.g. ventilation, tracheostomy, renal replacement) for the first time.

Up-date on CERS

Now we are into the second year of CERS which has seen the addition of readmission funnels plots and the after hour's caterpillar graph. Over the next 12 months we will be working with the Jurisdictional Advisory Group and the CORE Committee to prioritise new reports aligned with contemporary Intensive Care practice. Much of the work in developing the reports is through collaboration with the clinical researchers to ensure the ongoing high standards and robustness of the reports. Work currently in progress is the development of efficiency plots for adult ICUs similar to those that ANZPIC have developed.

ANZICS CORE Supporting Research

The value of registry data for research is being increasingly recognised through many influential groups such as the Australian Clinical Trials Alliance, of which ANZICS CORE is a member. Provision of data for research has been an important component of CORE's activities.

ANZICS CORE Workshop – 'Getting to the MATTER of CORE'

The ANZICS CORE Workshop held in Noosa prior the CTG meeting was a collaborative effort between CORE and the CORE Research and Publication Working Group. Our thanks go to Andrew Udy for his assistance and his creative program.

The day focussed on how best to use registry data for research starting with the answers to the 'where do I start?', 'who do I ask?' and 'what is the process?' for those wanting to embark on Intensive Care research. A number of projects were presented to demonstrate the scope of possible research themes using data from the CORE Registries which included development of prediction tools, exploring alternative research models to inform workforce activity, data linkage projects and models to determine ICU efficiency.

Prof. Kathy Rowan from ICNARC shared her valuable insights into how ICNARC integrates registry data into clinical trials and the levers that drive their clinical research undertaken.

High profile publications and presentations

During 2015 the ANZICS CORE team had the opportunity to work with Jack Iwashyna from Michigan to explore the persistent chronic illness in the Intensive Care setting. In short……..on average, the outcomes of patients who have been in the ICU for more than 10 days, are more determined by chronic health conditions than by their acute severity of illness at presentation.

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

If you have ever thought that your patient looked 'sicker than expected' when they arrive in the ICU after cardiac surgery, then Tim Coulson's paper not only tells you how to objectively measure this but also that when you do, you can work out which cardiac surgery units have the best outcomes.

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

Congratulations go to Lahn Straney, Andreas Schibler, Jan Alexander, Tony Slater, Luregn Schlapbach and other ANZPIC authors who won one of the top 4 oral presentations at the Toronto Paediatric World Congress held in June 2016 for Burden and Outcomes of Severe Pertussis Infection in Critically Ill Infants

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

And finally...

Thank you to all those collecting data within the ICU, to the staff at ANZICS CORE for their persistence, hard work and innovation and to our colleagues on the CORE management committee, Peter Hicks and Johnny Millar for their constant support and enthusiasm.

David Pilcher
Chair, CORE

Appendix - ANZICS CORE Publications 2015-16

Adult Patient Database

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

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

Hay A, Bellomo R, Pilcher D, Jackson G, Kaukonen KM, Bailey M. Characteristics and outcome of patients with the ICU Admission diagnosis of status epilepticus in Australia and New Zealand. J Crit Care. 2016 Mar 9.

Paul E, Bailey M, Kasza J, Pilcher D. The ANZROD model: better benchmarking of ICU outcomes and detection of outliers. Crit Care Resusc. 2016 Mar;18(1):25-36.

McQuilten ZK, Andrianopoulos N, van de Watering L, Aubron C, Phillips L, Bellomo R, et al. Introduction of universal pre storage leukodepletion of blood components, and outcomes in transfused cardiac surgery patients. J Thorac Cardiovasc Surg. 2015 Jul;150(1):216–22.

Iwashyna TJ, Hodgson CL, Pilcher D, Bailey M, Bellomo R. Persistent critical illness characterised by Australian and New Zealand ICU clinicians. Crit Care Resusc. 2015 Sep;17(3):153–8.

Iwashyna TJ, Hodgson CL, Pilcher D, Orford N, Santamaria JD, Bailey M, et al. Towards defining persistent critical illness and other varieties of chronic critical illness. Crit Care Resusc. 2015 Sep;17(3):215–8.

Udy AA, Scheinkestel C, Pilcher D, Bailey M; Australian and New Zealand Intensive Care Society Centre for Outcomes and Resource Evaluation. The Association Between Low Admission Peak Plasma Creatinine Concentration and In-Hospital Mortality in Patients Admitted to Intensive Care in Australia and New Zealand. Crit Care Med. 2015 Oct 15.

Sanagou M, Leder K, Cheng AC, Pilcher D, Reid CM, Wolfe R. Associations of hospital characteristics with nosocomial pneumonia after cardiac surgery can impact on standardized infection rates. Epidemiol Infect. 2015 Oct 9:1-10.

Venkatesh B, Pilcher D, Prins J, Bellomo R, Morgan TJ, Bailey M. Incidence and outcome of adults with diabetic ketoacidosis admitted to ICUs in Australia and New Zealand. Crit Care. 2015 Dec 29;19(1):451.

Australian and New Zealand Paediatric Intensive Care Registry

Beca J, McSharry B, Erickson S, Yung M, Schibler A, Slater A, Wilkins B, Singhal A, Williams G, Sherring C, Butt W; Pediatric Study Group of the Australia and New Zealand Intensive Care Society Clinical Trials Group. Hypothermia for Traumatic Brain Injury in Children-A Phase II Randomized Controlled Trial. Crit Care Med. 2015 Jul;43(7):1458-66.

Namachivayam SP, Alexander J, Slater A, Millar J, Erickson S, Tibballs J, et al. Five-Year Survival of Children With Chronic Critical Illness in Australia and New Zealand. Crit Care Med. 2015 Sep;43(9):1978–85.

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

Five-Year Survival of Children With Chronic Critical Illness in Australia and New Zealand. Crit Care Med. 2015 Sep;43(9):1978-85.

CLINICAL TRIALS GROUP

The Clinical Trials Group continues to thrive and flourish. It is an incredible and outstanding community of Clinician Researchers that inspires, amazes, and sometimes challenges peers within and beyond our region. We can be rightly proud and celebrate our achievements: our trials have changed practice here and internationally.

In October 2015 the results of three major CTG trials were presented at the European Society of Intensive Care Medicine meeting in Berlin: SPLIT (Saline vs. Plasmalyte); EPO-TBI (Epoetin alfa in traumatic brain injury); and HEAT (paracetamol in critically ill patients). These three trials were simultaneously published in JAMA, the Lancet, and the New England Journal of Medicine. It is difficult recall any other collaborative trials group publishing three landmark randomized controlled trials in the world's leading medical journals in the same week. I thank all involved in the conduct of these studies.

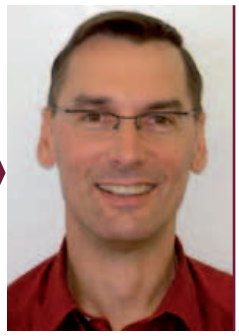
We have many ongoing studies designed to answer important questions for clinicians at the bedside: TRANSFUSE (fresh vs. standard age red cells) and ADRENAL (hydrocortisone for septic shock) are progressing well with recruitment anticipated to finish by early next year. POLAR (prophylactic hypothermia for traumatic brain injury) and PHARLAP (open lung strategy for ARDS) are difficult and challenging studies to conduct. It is hoped recruitment will be complete for both by the end of 2017. I encourage all members of the intensive care community to make a special effort to identify eligible participants for these trials. This will facilitate their completion. The SPICE (goal directed sedation) study has had its challenges too. The consent process in New South Wales is now finalised after a protracted period of uncertainty. TARGET (augmented vs. standard dose enteral nutrition) has commenced and is recruiting well despite Greek lumpy cows and a shortage of red plastic bags in Europe! If that isn't enough multicenter research we have PLUS (balanced electrolyte vs. Saline) and SuDICCU (selective decontamination) starting in the next six months.

The CTG is also an advocate for the interests of Clinician Researchers. In early 2016 the International Committee of Journal Editors published a position statement on open access data. The CTG acknowledges the importance of data sharing and many of our community have been part of such collaborations. It is important that the rights of participants, researchers, and sponsors are acknowledged and recognised - these and other general principles were described in our submission. This year the NHMRC announced a review of its grants program and the Medical Research Future Fund was announced. The CTG has been active in promoting the interests of clinician researchers to these bodies.

I thank all our sponsors for their generous support. Their participation ensures the success of our scientific meetings. The whole CTG community congratulates our Executive Assistant, Simone Rickerby, following the safe arrival of her daughter Amira. Simone will return from Maternity Leave in the New Year. To our extraordinary Executive Officer, Donna Goldsmith – Thank you. Finally thank you to our research community - the Investigators, Research Coordinators and Clinical Staff at over 65 intensive care units throughout Australia and New Zealand.

Craig French
CTG Chair

DEATH AND ORGAN DONATION



DODC Activity

The DODC has published a statement on Circulatory Death Determination in response to an article on DCD heart transplantation published by the Australian Financial Review (AFR). This statement along with the ANZICS Statement on Death and Organ Donation edition 3.2 is available on the ANZICS website under Committees - Death and Organ Donation.

During 2016 the ANZICS DODC was approached to provide feedback to the Department of Health regarding the Ernst & Young review of the implementation of the national reform agenda on organ and tissue donation and transplantation and I had the opportunity to discuss the review and its recommendations with the responsible Minister, Senator Fiona Nash.

The New Zealand Ministry of Health are also in the process of reviewing deceased organ donation and transplantation to identify what can be done to increase deceased organ donation rates in NZ. ANZICS have been approached to provide feedback on preliminary proposals relating to the initial phase of the review.

Additionally, I and fellow ANZICS members Dr Yee Yong Lee, and A/ Professor Frank van Haren developed an online bi-national survey endorsed by ANZICS, and the Australian Organ and Tissue Authority. The survey related to Australian and New Zealand intensive care doctors' attitudes, perceptions and self-reported end-of-life care practice regarding organ donation after circulatory death.

The DODC is awaiting a review by the ANZ Society of Neuroradiologists (ANSNR) of the current guidelines regarding radiological diagnosis of brain death in the ANZICS Statement on Death and Organ Donation. The ANZSNR assisted with the current edition and kindly agreed to this review, particularly regarding CTA and MRI scanning.

The DODC will meet by teleconference prior to the October ASM.

End-of-Life Care Working Group (EOLCWG)

ANZICS Statement on Care and Decision Making at the End-of-Life for the Critically Ill was released and endorsed by the ANZICS Board late in 2014. The Statement is a culmination of a large body of work by the End-of-Life Care Working Group and broad consultation of the ANZICS membership and external bodies. Since its publication, this publication has been promoted on Radio National's Health report with Dr. Norman Swan, via a podcast with Neil Orford and an article published in the Australian Hospital and Healthcare Bulletin. ANZICS also continues to receive regular requests to reference the Statement for the development of related educational resources.

The Statement will periodically be reviewed by the EOLCWG to ensure it remains relevant and up to date and we continue to encourage any comments through ANZICS. The EOLCWG will meet by teleconference prior to the October ASM.

William Silvester
Chair, DODC and EOLCWG

EDUCATION COMMITTEE

The work of ANZICS has a reputation around the world, not only for members but for others with an active interest in Intensive Care. While there are numerous ANZICS meetings and workshops each year, such as the ASM, Safety and Quality Conference, CTG forums, and regional events, in the past our reach has been somewhat limited to those that have the ability and flexibility in their schedules to attend these events. To ensure our members have access to some of these materials, ANZICS has commenced sharing resources via the ANZICS YouTube channel and the ANZICS website. Additionally, this year through the work of ANZICS members Daryl Jones, Sam Radford, Alex Psirides and Sumeet Rai ANZICS was able to produce a 2016 Training DVD on RRT and MET.

The ANZICS New Fellows Satellite Workshop will run the morning of the 2016 ASM in Perth. The workshop covers a wide range of challenges that can test a new and emerging Intensivist and is intended as an introduction for Senior Registrars, ICU fellows and Junior Consultant Intensivists on various relevant topics. The Committee is dedicated to continuing to engage new consultants and trainees in this course and other educational ANZICS programs. The Committee are looking forward to running the course this year and at future ASM's.

ANZICS has assisted, supported and promoted many educational events throughout 2016. The Events Calendar featured on the ANZICS website lists a variety of events, local and international. The Committee will also be involved in the development and delivery of the second ANZICS & Eastern Health In Case of Emergency (ICE) Course which received highly positive feedback in 2015. The ICE Course is similar to the previously run ANZICS ICM course that was impeccably convened by the late A/Professor Ramesh Nagappan.

The Ramesh Nagappan Education Award was established by ANZICS in 2014 to recognise those who contribute to the training and education of Australasian Intensivists. This year's award will be presented at the ASM in Perth, the recipient will be the third following Gerard Fennessy in 2015 and Cameron Knott in 2014.

The ANZICS Communications & Social Media Working Group, a subcommittee of the Education Committee, worked throughout 2016 to develop and maintain effective communication strategies and successfully promote the ANZICS brand via social media. The Education Committee will continue to implement effective use of social media and promote web based educational opportunities for members to ensure the Organisation remains current.

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

Sam Radford
Chair, Education Committee

PAEDIATRIC REPORT

The last year has been a busy one, with June's World Congress in Toronto being the major event on the calendar. Our region was very well-represented at the meeting, and Stephen Jacobe (Children's Hospital Westmead) continues to serve as the ANZICS representative of the Board of the World Federation. One of the Pre-Congress Meetings was an inaugural/planning meeting of the Asian Paediatric Critical Care Network, attended by representatives from many countries throughout Asia. I spoke about the ANZICS paediatric model and regional opportunities for clinical, quality and research collaboration. Hopefully some of these new relationships can be forged with involvement in the ANZICS-SG meeting in 2017 and the 2018 World Congress, both to be held in Singapore. Many members have also taken major teaching roles on the burgeoning international paediatric ICU BASIC course programme; in the last 12 months the course has been run in multiple sites in Asia and the Caribbean.

Paediatric Studies group

This year saw Rino Festa (Children's Hospital Westmead) take over as chair of the PSG. Rino has taken the helm at a time when PSG activity is greater than ever. This group continues to foster excellent collaboration between the PICU's in our region and collaboration with other international paediatric critical care research groups.

The group has recently completed the Baby-SPICE pilot study of goal-directed sedation, led by Deb Long (Lady Cilento Children's Hospital) and Simon Erickson (Queen Margaret Hospital) and is considering the planning of a larger trial. The results of the SAFE-EPIC point prevalence study (Rino Festa, Children's Hospital Westmead) are being used to inform the design of a multicentre fluid resuscitation trial. An NHMRC grant application was submitted this year for a multicentre trial of nitric oxide administration during cardiopulmonary bypass, led by Andreas Schibler (Lady Cilento Children's Hospital). A multicentre study of moral distress in PICU (Johnny Millar, Royal Children's Hospital) will start this year, hopefully in collaboration with the Canadian Critical Care Group.

ANZPIC Registry

The CORE Enterprise Reporting System (CERS) paediatric capacity was launched at the end of 2015. This means that centres can now view their data, with refinable reports and plots in comparison to Registry data, via the on-line portal. At this stage there are limited numbers of reports available, but this will be added to in the future.

Registry data from 2015 have been finalised. Again, the numbers of admissions recorded has increased, with 12,000 episodes of intensive care for children in the calendar year. The Annual Report will be published electronically in coming months.

Research using registry data continues, with several prominent publications in the last 12 months, a top oral presentation award at the World Congress (Lahn Straney, ANZIC-RC), and increasing interest in data linkage projects to look at long-term outcomes.

Johnny Millar
Chair, Paediatric Committee

PRICE REPORT

Department of Health MBS Item Reviews

The main area of focus for the last year has been the MBS Reviews. The ICU/ED Clinical Committee has formed and commenced meetings. (Australian Government Department of Health, Medical Benefits Division, 2015). From the Clinical Committee three working groups have formed. They are the Emergency Medicine Working Group, Intensive Care Working Group and End of Life Working Group. The members of the Clinical Committee and Working Groups can be found on the MBS website. Further information on the progress of the Committee and working groups will be available later in the year. In the upcoming months the outcome of the meeting will enter the consultation stage. We will contact the intensive care community for feedback at that stage.

Burn-out

Following the publication of 'Burnout Syndrome in Critical Care Health-care Professionals' published simultaneously in three journals (Moss et al., 2016a, 2016b, 2016c), PRICE will work on a similar collaborative document for the Australian and New Zealand Community. There has been a request for expressions of interest from trainees for a repeat of a previous survey.

Ranald Pascoe

Ranald Pascoe who has had a long association with the PricE Committee has recently stepped down. We have greatly valued his experience and wisdom. Ranald is a graduate of the University of Queensland is a FANZCA and FCICM. He is an outstanding Clinician and held in high regard. For a period of time he worked as a Director at St. Henry's in Melbourne. Following this, Ranald joined the Wesley in 1994 as Director. Over the last 20 years, Ranald has made major contributions to both the Wesley and to the development of ICU in the country. He was involved in the design, development and setup of the new unit, resulting in magnificent infrastructure, which set the Wesley apart and ahead of most ICUs in the country. Wesley is one of the largest private ICUs in the country with outcomes comparable to any tertiary center. At both a Queensland level and National level, Ranald was heavily involved in training and education. He was the chair of the Queensland Regional Intensive Care Medicine Committee and represented Queensland on the National Board. Ranald was the Chair of the Organising Committee for the ANZICS meeting held in Brisbane in 1995. We greatly thank him for his involvement and wish him the best in the future.

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Department of Health | Intensive Care and Emergency Medicine Clinical Committee of the Medicare Benefits Schedule Review Taskforce (n.d.). Available from: http://www.health.gov.au/internet/main/publishing.nsf/content/MBSR-committees-intensive (accessed 25 July 2016).

Mark Nicholls
Chair, PricE Committee

SAFETY AND QUALITY

In 2015/2016 the Safety and Quality Committee has continued to strive towards promoting safe high quality care in Australian and New Zealand Intensive Care Units. The Committee meets regularly throughout the year, reporting back to ANZICS members via the Intensivist Newsletter.

The Committee enacted its Terms of Reference in October 2015 leading to a change in some members of the Committee. I would like to make a special mention of the Immediate Past Chair Angus Carter for his contribution to the Committee in the role of Chair for the past 2 years. Angus' corporate knowledge and support of the Committee continues in his positon of Immediate Past Chair. I would like to acknowledge and thank the outgoing Committee members including: Alex Kazemi (NZ), Krish Sundararajan (SA); Krishna Ponasanapolli (WA); Deborah Tooley (TAS); David Schell (Paed); Ian Seppelt (NSW), and Bernadette Grealy (ACCCN).

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 is 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). The Committee will continue to work within their regions through the next reporting period to improve the response rate and feedback the results to the membership.

The Committee was responsible for maintaining the CLABSI.com.au website. This website was set up during the national CLABSI prevention project in 2012. The site provided information and resources to assist with preventing and surveillance of CLABSI in Australian ICUs. In early 2016 a review of the site including currency and usefulness of information and resources, how often the site was accessed, how often the resources were downloaded and the logistical and financial costs of maintaining the website was undertaken. As a result of this review the decision was made to no longer support the CLABSI.com.au website. The information and resources are now conveniently available on the CLABSI pages on the ANZICS website. In addition to raising awareness of sepsis in short term intravascular devices, the CLABSI prevention project was very successful in bringing down the rate of this important infection in our ICUs.

The Committee is committed to developing closer relationships with external stakeholders including CICM in documenting and promoting safe, high quality care. ANZICS and CICM are working 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. It is expected that the final document will be available in early 2017.

I would like to acknowledge the work of A/Prof Daryl Jones and the Organising Committee including: Alex Psirides, Angus Carter, David Pilcher, Deepak Bhonagiri, Gerard Fennessy, Graeme Hart, Jenny Holmes (ANZICS), Judy Currey, Ken Hillman, Liz Fugaccia, Manoj Singh, Rinaldo Bellomo, Sumeet Rai who provided us with two exceptional events on recognising and responding to the deteriorating patient and a publication on the findings from the 2014 Safety and Quality Conference: The role of intensive care with rapid response teams in Anaesthesia and Intensive Care. The role of intensive care with Rapid Response Teams was published in Anaesthesia and Intensive Care: Jones et al, Findings of the first ANZICS conference on the role of intensive care in Rapid Response Teams Anaesth Intensive Care 2015; 43:369-379.

The 2015 Safety and Quality Conference: The Deteriorating Patient was held at the purpose built conference centre at Sea World on 6 – 7 July. The conference welcomed guest speaker, Dr Michael DeVita, inaugural President of the International Society of Rapid Response Systems. The Conference was an overwhelming success with 322 delegates attending and a record number of 43 abstract submissions. The Conference included practical sessions on Rapid Response Team Training as well as covering topics on strategies to prevent rapid response team calls and a popular session on the role of Rapid Response Teams and end of life care. Conference presentations are available on the ANZICS YouTube channel https://www.youtube.com/channel/UCVU_LWubvrXrNklrEHcv7jA

The 12th International Conference on Rapid Response Systems and Medical Emergency Teams took place on 2 – 3 May 2016 at the Melbourne Convention Centre. There were 580 registered delegates. The Organising Committee prepared an excellent educational program for those involved in the recognition and management of deteriorating patients across the acute care setting, mental health, obstetrics, paediatrics and mental health deterioration. The Organising Committee again received a record number of abstract submissions 66 oral, 18 poster. 18 Oral abstracts were accepted for oral presentation during the Conference with the remaining offered poster presentation. It is anticipated that the 18 oral abstracts will be submitted for publication in Anaesthesia and Intensive Care. Many of the presentations were again recorded and will be uploaded over time onto the ANZICS/ISRRS YouTube Channel https://www.youtube.com/channel/UCVU_LWubvrXrNklrEHcv7jA. Industry support through sponsorship and exhibition exceeded expectations, in particular our conference partner – VMIA, gold sponsors Medtronic, Philips and Stryker.

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) and Mary Pinder (CICM).

I would also like to recognise the contribution of all ANZICS members in providing feedback to the Safety and Quality Committee via the surveys we distribute. Results of the surveys help us define and develop the activities the Committee undertakes. The Committee is open to any comments or suggestions you may have and we invite you to be in touch by contacting: safetyandquality@anzics.com.au.

John Gowardman
Chair, Safety and Quality Committee

VICTORIA

It might well be said that change is the only constant and that is certainly the case for intensive care across Victoria. Several early-career and mid-career intensivists alike have moved between institutions, and many units have undergone changes in leadership. While a certain amount of such activity is certainly normal, it's fair to say that the last twelve months have been unusual in this regard. The reasons for this are clearly complex and highly variable, but for many it has certainly been a rather challenging period. As the major advocate for intensive care practice in our region, ANZICS exists to advance practice, with a particular role to support individual society members and intensive care units. Throughout this time, the Victorian intensive care community has nonetheless managed to maintain a considerable amount of collaborative activity and remained a vibrant and positive force in acute care.

With the support of colleagues at the Royal Children's Hospital, a 'paediatric meets adult' education evening was conducted, utilising a case-based interactive format. This approach was highly engaging and emphasised the utility of fundamental assessment and management skills that are common to critical care practice across all age groups. In light of the success of this event, another is planned for late 2016 and details will be circulated in the next few months.

The Victorian Intensive Care Education Network (VICEN) has expanded to now include every metropolitan adult intensive care unit. ANZICS has continued to support this endeavour through the coordinating website and its new associated app. Ashwin Subramanian has done a great job of steering VICEN through the last year and will now hand over to Manisa Ghani for the coming twelve months. Special thanks to Julia De Marchi from Austin Health for her continued assistance with outstanding administrative and IT support for the program. The 2017 program is currently being finalised and will include a mix of practical skill teaching, clinical simulation, exam oriented preparation and lecture based content across a range of sites around Melbourne.

Victorian intensivists have been especially active in supporting the Society's engagement with critical care institutions around the world. In particular, a team representing ANZICS once again visited several sites in the Middle East to further cement ties and explore opportunities for collaborative opportunities relating to quality assurance, bench marking and research. David Pilcher and David Ku have been particularly instrumental in these efforts and have worked hard as committed ambassadors for the Society. It is hoped that in due course this work will lead to mutually beneficial alliances that enhance standards of care and promote the very best in patient centred outcomes.

The Women in Intensive Care Network (WIN) is now a very active force in Victoria and has done excellent work to bring issues of workforce and gender balance to the fore. Through a range of activities, WIN has successfully engaged a broad range of trainees and intensivists. Events have included education evenings that incorporate a clinical theme as well as a professional development component and have great relevance to male and female clinicians alike. WIN has also generated considerable interest outside of Victoria, with similar groups now well established in other states and several journal publications as well as sessions at scientific meetings.

Planning for the 2019 WFSICCM World Congress in Melbourne is progressing well, with the establishment of the Convening Committee and selection of Conference Organiser. This event will be a collaborative effort with the ACCCN and will incorporate the 2019 ANZICS/ACCCN annual scientific meeting. Going forward from now, a process of building awareness and interest is essential to ensure good attendance from international intensivists. ANZICS members who are presenting at overseas meetings are invited to contact the Society in order to obtain the latest World Congress update for us to promote the event where appropriate.

The Victorian Regional Committee received great support from the ANZICS staff and would like to thank each member of the team for their enthusiastic assistance, advice and practical help with the various activities outlined above. Without their tireless efforts behind the scenes, most of the Society's achievements would not be possible.

Stephen Warrillow
Chair, Victoria

SOUTH AUSTRALIA

It is a time of much change within SA Health. Ongoing health reforms and the restructuring of existing hospital services continue. The move to the new Royal Adelaide Hospital, which was originally planned for 2016, is now delayed until next year and building is nearing completion. Undoubtedly, the year ahead will hold many challenges for all intensive care units in South Australia. The move to the new Royal Adelaide Hospital will involve a ramp down of services at the RAH and concurrently increased activity at other sites. Meanwhile, the new patient electronic health record system is being rolled out sequentially at various sites across SA. It has most recently been introduced at The Queen Elizabeth Hospital and staff members have required additional training in order to utilise the record.

ANZICS has had a successful year locally on the educational front and organised a number of educational events. The annual ANZICS Tub Worthley Scholarship Dinner in May provided an excellent opportunity for SA's ICU Registrars to present the results of their formal College projects. The biannual SA Intensive Care Association/ANZICS Registrar series also continued this year and was very successful. Thank you to all those speakers who gave their time to provide additional teaching to the Registrars. Professor Steve McClave, University of Louisville, was also a guest speaker at an ANZICS educational dinner earlier this year. It was encouraging that the dinner was well attended by medical and allied health staff from all of SA's major hospitals. I hope to see the local activities that have been held this year continue over the next year.

Thank you to all the ANZICS members who have contributed to the local activities and represented ANZICS on the various Committees in 2016. These members have contributed a large amount despite their busy clinical schedules. The year ahead will be full of changes in SA Health and it remains very important to keep intensive care represented in 2017, with involvement of representatives from all of the state's hospitals. Please feel free to discuss with me any areas in which you would like ANZICS to be more active in the future.

Yasmine Ali Abdelhamid
Chair, SA Regional Committee

TASMANIA

State-wide health services restructuring, amidst increasing demand and static funding, remains the dominant issue in Intensive Care and more broadly in Tasmanian healthcare. The new Tasmanian Health Organisation (THO) Board and CEO are currently considering detailed business cases for specialty services to be shifted to State-wide models of care, across the three major hospitals in Hobart, Launceston and Burnie. This is not without significant challenges, due to the geographical separation and distance between these centres, complex transportation logistics and a relatively small state population - which in itself impacts local procedural case load and hence relates directly to quality of care and outcome.

High level Intensive care services are most likely to be focused in Launceston and Hobart in the future, with lower level services in Burnie. Recruiting staff to smaller and more remote locations is an ongoing challenge. The ICU Clinical Advisory Group has largely completed its tasks and we await details of state-wide clinical governance structures for Intensive Care and the other specialties. This will include a State Director for Intensive Care and most likely state-wide roles in Safety and Quality and Research for Intensive Care.

Demand for ICU beds remains high and the two major ICUs largely run at above funded bed capacity. Emergency Medicine and Surgery, our main two admission sources, remain under significant stress across the state, impacting directly on ICU workload and stress. The THO re-structure is yet to fully play out, but we anticipate demand will continue to increase at major centres. We will continue monitoring the impact of these changes and collectively advocate for safe, high quality intensive care for our patients. Data provided via ANZICS CORE, such as the CCR reports and our SMR data, continues to help us support arguments for change. Clearly, lots of challenges remain.

Intensive Care Training in Tasmania remains popular with local graduates and those from interstate and overseas. We consistently provide a wide range of interesting and challenging clinical cases, access to non-ICU training rotations, rural and regional critical care experience and Senior Registrar posts with on-call components. State-wide training rotations continue to be a long term goal, and perhaps this will be one outcome of the system reform currently underway.

Society Membership has been stable in Tasmania for many years, as have the small number of specialists in the state. Without bed expansion and new job positions, this is unlikely to change in the near future. I would like to thank the Tasmanian Intensivists who give their valuable time to work with ANZICS Committees - we are few and spare time is increasingly hard to find. This work is important for the development and profile of our specialty and I hope you will continue your generosity into the future.

At the 2016 ASM Andrew Turner will retire from the ANZICS Board after 18 years. On behalf of Tasmanian members, I would like to thank him, and acknowledge the enormous commitment, time and effort Andrew has given to ANZICS over this time. His 18 years on the Board include 4 years as Tasmanian Chair and 14 years on the ANZICS Executive, as well as work on numerous ANZICS Committees along the way. This culminated in being ANZICS President and Immediate Past President for the past three years. There was considerable change in Intensive care in Australia and New Zealand during his time on the Board, and he was a key leader in steering ANZICS and the specialty of Intensive Care throughout this period. Always willing to question and challenge the status quo, and to advocate for change and progress, Andrew's contribution at Board level was outstanding. Andrew is true believer in the role of the Society as advocate and leader for all those who work in Intensive Care in Australasia, and he is an enthusiastic supporter of our multidisciplinary ASM. He leaves the Board much stronger for his service and he will surely be missed. I am sure he will remain busy in his many other roles, both within Tasmania and nationally.

David Rigg
Chair, Tasmania Regional Committee

NEW ZEALAND

The 2015-2016 year has been another productive one for the New Zealand Region of ANZICS.

The 2015 ASM was held in Auckland, eight years since the last time the ASM was held in New Zealand in Rotorua. This meeting was a great success, due to the efforts of the whole Organising Committee, especially the Medical Convenors Alex Kazemi and Nic Randall, Nursing Convenors Debbie Massey and Alison Pirret and the Paediatric Convenors Fiona Miles and Nicola Gini. There were well over 1,000 delegates, including many from nursing and allied health, making this a financial success too. And to top it all, many of us were up early on the Sunday morning after the Gala Dinner to watch the All Blacks retain the Webb Ellis Cup!

The 2016 New Zealand ASM was held in Rotorua with the theme "Should I stay or should I go?" The main organisers were Jonathan Albrett (Medical) and Adele Ferguson (Nursing), who provided an excellent example of how to run a high quality scientific meeting outside the main centres: informative, good networking, great entertainment and profitable!

Next year it's the turn of the Capital City, with the New Zealand ASM to be held at The Museum of New Zealand, Te Papa Tongarewa in Wellington on Wednesday 5th – Friday 7th April. We are expecting this to be a popular one, so get your leave booked early!

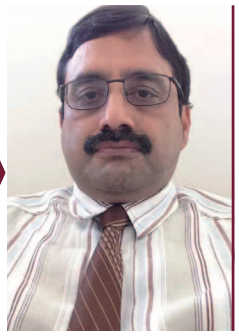
We also have the Third Biennial New Zealand Intensive Care Research Symposium being held in Wellington on 16th – 17th November 2016, once again organised by Rachael Parke and Shay McGuinness. This meeting has greatly helped to increase the contribution to Intensive Care Research made by New Zealand researchers, providing a forum for medical and nursing staff to discuss current and future research directions.

I can also report that two educational activities that were given a financial kick-start by NZ ANZICS are thriving. The 6th Wellington Intensive Care Medicine Examination Course was held at the end of June. By the rate at which places are filled by candidates from both sides of the Tasman (and beyond), the Course looks to be well on track to achieving the goal of being the best FCICM preparation course. Well done in particular to Chris Poynter and Fiona Wild for organising the Course. The NZ branch of the Intensive Care Network also continues to develop, with plans for another meeting in Auckland later this year with future meetings mooted for Wellington & Christchurch. Thanks to Rob Bevan and Ywain Lawrey for this.

Having the ASM held in New Zealand last year has boosted membership with the number breaking through the 100 mark after hovering just below for some time. We now have around 110 New Zealand ANZICS members. Please encourage all your colleagues whether medical, nursing or allied health and especially your trainees to consider joining us.

Ben Barry
Chair, New Zealand Regional Committee

QUEENSLAND



The last twelve months have been reasonably busy for ANZICS Queensland. Industrially, it has been relatively quiet year. The individual contracts are gone and all ICU Specialists are under the new Medical Officers Certified agreement (MOCA4) with no bindings KPIs (Key Performance Indicators). This is a really good development. The new agreement also protects us from being forced into "extended hours work". However, I believe that we, all ANZICS members, need to be vigilant.

There is a draft document on Hospital 24/7 discussed at the Committee level in QLD health. While an individual Doctor is protected due to the wording of the MOCA4, there is a strong possibility of the Hospital Administrators asking Intensivists to help them to cover the hospital wards for afterhours cover.

I believe that we need to stick to delivering high standard of care to critically ill patients in ICU and expand our ICUs for future needs. However, I do not believe it is in the best interests of the speciality to participate in looking after ward patients.

The Queensland Region has been awarded the privilege of organising the 42nd ANZICS/ACCCN ASM to be held 11-13 October 2017 at Gold Coast Convention & Exhibition Centre. Queensland ANZICS has been active in last few months with regard to this very important event for Queensland.

As part of this organisation, ANZICS and ACCCN conducted interviews for the PCO (Professional Conference Organiser) at the Gold Coast Convention Centre on 26th April 2016. After further deliberations, EECW has been selected as the PCO for the ASM. We also visited potential venues for the conference as well as the social events associated with the ASM.

The Organising Committee for the Gold Coast Conference has now been formed with Dr Jeremy Cohen as the Chair of the Scientific Committee. The first meeting of the Organising Committee was held on 11th August, 2016 at the Royal Brisbane and Women's Hospital. The main agenda of the meeting was the introduction of the members and a briefing from EECW as the PCO. There was preliminary discussion about the theme for the meeting. There are further monthly meetings planned and Queensland ANZICS is confident that the Organising Committee will leave no stone unturned to make this important event for Queensland a success.

Rajeev Hegde
Chair, Queensland Regional Committee

WESTERN AUSTRALIA

Ian Jenkins, after a long (and distinguished) tenure as Regional WA Chair and past ANZICS President, has stepped back a little and handed on the WA Chair role to myself. Thank you to Ian for all your hard work. Ian stays as active as ever within ANZICS as a member of the PricE Committee, always offering his support and expertise.

The year for health in general in Western Australia has been interesting with a period of unparalleled infrastructure investment starting to come to a close.

Fiona Stanley is now a fully functioning impressive modern Intensive Care Unit, (albeit with 10 beds remaining closed indefinitely), Midland SJOGH Public-Private partnership has opened with a level one ICU and Joondalup Hospital has expanded theatres with the Intensive Care Unit becoming busier. The transition to three separate health divisions (North, South and East) remains the latest overall health plan.

The Perth Children's Hospital, after several delays and extensive media coverage regarding those delays, is still yet to open with a current plan to open later in 2016 (at this stage). This move will involve some expansion of ICU capacity. At Sir Charles Gairdner Hospital, we look forward to having our Paediatric colleagues on the same campus.

The changing landscape has provided opportunity for changes, merging of departments and at times perhaps greater inter-departmental discussions.

The winter has again brought another period of hospitals functioning at or over capacity with the ICUs being consistently full and bed pressure at times creating a difficult working environment.

With the relative isolation of Western Australia, we have sought to develop stronger research ties between departments to progress local investigator led projects while supporting larger ANZICS trials. Trying to navigate the roadblocks and resistance from administration, while not unique to research, has been at times frustrating but forward progress continues to be made. Ed Litton continues to do an excellent job as our local representative on the CTG Executive Committee.

The ASM being in Perth allows us the opportunity to showcase the state and deliver an exciting informative meeting. Anthony Tzannes continues to do a great job as the Convenor and the programme looks excellent.

In the realm of education, the Intensive Care Network continues to co-ordinate informative educational evenings and with ongoing planned collaboration with ANZICS, we should see these continue to be a regular feature on the WA calendar.

In other areas, Simon Towler continues on Safety and Quality Committee, Nandkumar Raut on the Death and Organ Donation Committee and Anthony Tzannes on the Education Committee.

ANZICS continues to advocate strongly for Intensive Care in Western Australia, we welcome new members and hope to see as many of you as possible at the ASM later in the year.

Bradley Wibrow
Chair, Western Australian Regional Committee

NEW SOUTH WALES

NSW Intensive Care Coordination and Monitoring Unit (ICCMU)

ANZICS has been invited to recent NSW Intensive Care Coordination and Monitoring Unit (ICCMU) meetings. The first meeting involved the development of intensive care activity projections as part of the review of the NSW Service planning methodology. The most recent was a strategic planning workshop meeting. The aim was to consider ICCMU's purpose and function going forward.

NSW Scope of Practice

NSW Health has a scope of practice project for various specialties in progress at the moment. There are planned workshops looking at intensive care. There are representatives from senior intensive care physicians, CICM and ANZICS. The first meeting will be in November 2016.

ANZICS National Meetings held in NSW

The CTG Winter Research Forum was held at the Crown Plaza, Coogee Beach on August 1st & 2nd 2016. The organisers were Dr Manoj Saxena & Dr Marino Festa.

Local Regional Meeting

The first NSW Regional Dinner Pfizer meeting will be held at the Banjo Paterson Cottage Restaurant, Gladesville on Tuesday 11th October 2016. The speaker will be Marcus West on 'How to present research findings at a meeting'.

Mark Nicholls
Chair, NSW Regional Committee

ANZICS AWARDS

Matt Spence Medal

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

The winners of previous awards follow.

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

Past Presidents

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

ANZICS AWARDS

ASM Oration

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

Perth	2002	Malcolm Fisher	New South Wales
Cairns	2003	Lindsay Worthley	South Australia
Melbourne	2004	Jack Cade	Victoria
Adelaide	2005	Bob Wright	New South Wales
Hobart	2006	Stephen Streat	New Zealand
Rotorua	2007	Geoffrey Parkin	Victoria
Sydney	2008	Frank Shann	Victoria
Perth	2009	David Tuxen	Victoria
Melbourne	2010	Anthony Bell	Tasmania
Brisbane	2011	Brad Power	Western Australia
Adelaide	2012	Neil Matthews	South Australia
Hobart	2013	Felicity Hawker	Victoria
Melbourne	2014	Simon Finfer	New South Wales
Auckland	2015	George Skowronski	New South Wales

Ramesh Nagappan Education Award

Melbourne	2014	Gerard Fennessy	Victoria
Auckland	2015	Cameron Knott	Victoria

ANZICS Honour Roll

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

FINANCIAL REPORT

DIRECTORS' REPORT

The Directors present their report together with the financial report of the Australian and New Zealand Intensive Care Society (the "Society" or "ANZICS") for the financial year ended 30 June 2016 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 Simon Erickson Hon. Secretary
Dr Yasmine Ali Abdelhamid (appointed 3/12/2015)
Dr Craig French
Dr Ian Jenkins (resigned 1/2/2016)
Dr Stewart Moodie (resigned 3/12/2015)
Dr David Pilcher
Dr Stephen Warrillow
Dr Andrew Turner Immediate Past President
Dr Anthony Holley Hon. Treasurer
Dr Ben Barry
Dr Rajeev Hegde
Dr Kenneth John Millar
Dr Mark Nicholls
Dr David Rigg
Dr Bradley Wibrow (appointed 1/2/2016)

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

The short and long term objectives of the Society

Short term objectives

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

Long term objectives

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

Strategy for achieving objectives

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

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

Principal activities

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

DIRECTORS' REPORT

How the principal activities achieve our objectives

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

Qualifications, experience and special responsibilities of the directors

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

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

Dr S Erickson
Qualifications: MBBS, FRACP, FCICM
Experience: Director since Oct 2012
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 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 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 D Pilcher
Qualifications: MBBS/MRACP/FRACP/FCICM
Experience: Director since Jul 2010
Special Responsibilities: Chair – CORE Management

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

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

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

DIRECTORS' REPORT

Directors' meetings

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

Directors	Number eligible to attend	Number attended
Dr Y Ali Abdelhamid (appointed 3/12/2015)	2	2
Dr B Barry	3	2
Dr S Erickson	3	2
Dr C French	3	2
Dr R Hegde	3	2
Dr A Holley	3	2
Dr I Jenkins (resigned 1/2/2016)	1	1
Dr KJ Millar	3	2
Dr S Moodie (resigned 3/12/2015)	1	-
Dr M Nicholls	3	3
Dr D Pilcher	3	3
Dr D Rigg	3	2
Dr A Turner	3	3
Dr S Warrillow	3	3
Dr B Wibrow (appointed 1/2/2016)	2	2
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 $16,380 (2015: $15,240) being 819 (2015: 762) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2016 has been received and can be found on page 30 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

Dr Anthony Holley
Hon.Treasurer

Dated this 24th day of August 2016

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 2016 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 24th day of August 2016
Melbourne.

Liability limited by a scheme approved under Professional Standards Legislation

STATEMENT OF PROFIT OR LOSS AND OTHER COMPREHENSIVE INCOME

FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $	2015 $
Revenue from ordinary activities	2	2,754,697	2,427,247
Employee expenses		(1,463,284)	(1,420,869)
Conference and meeting expense		(316,625)	(297,895)
Administration expenses		(197,493)	(204,699)
Travel and committee expenses		(134,134)	(131,770)
IT and related consultant expenses		(112,139)	(315,068)
Awards, sponsorships and scholarships		(73,319)	(19,227)
Depreciation expense		(54,225)	(52,095)
Other expenses from ordinary activities		(22,819)	(21,628)
Profit (Loss) for the year		380,659	(36,004)
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss:			
Other comprehensive income for the year, net of income tax		-	-
Total comprehensive income (loss) for the year		**380,659**	**(36,004)**

The accompanying notes form part of these financial statements.

STATEMENT OF FINANCIAL POSITION

AS AT 30 JUNE 2015

	Note	2016 $	2015 $
Current Assets			
Cash and cash equivalents	4	1,642,932	1,368,230
Trade and other receivables	5	67,422	92,782
Other current assets	6	34,352	50,963
Total current assets		1,744,706	1,511,975
Non-Current Assets			
Financial assets	7	592,320	575,788
Property, plant and equipment	8	2,536,907	2,586,052
Other current assets	9	360,352	-
Total non-current assets		3,489,363	3,161,840
Total Assets		5,234,069	4,673,815
Current Liabilities			
Trade and other payables	10	597,135	429,218
Employee benefits	11	260,593	245,589
Total current liabilities		857,728	674,807
Non-Current Liabilities			
Employee benefits	11	22,642	25,968
Total non-current liabilities		25,642	25,968
Total Liabilities		880,370	700,775
NET ASSETS		4,353,699	3,973,040
Equity			
Reserves	12	816,723	816,723
Retained profits		3,536,976	3,156,317
TOTAL EQUITY		4,353,699	3,973,040

The accompanying notes form part of these financial statements.

STATEMENT OF CASH FLOWS

FOR THE YEAR ENDED 30 JUNE 2016

	Note	2016 $	2015 $
Cash flows from operating activities			
Receipt of grants		1,577,549	1,113,250
Cash receipts from members and customers		1,431,067	1,335,736
Interest received		48,156	8,542
Payments to suppliers and employees		(2,391,797)	(2,492,698)
Net cash used in operating activities	13	664,975	(35,170)
Cash flows from investing activities			
Purchases of property, plant and equipment		(5,081)	(28,949)
Acquisition of other financial assets		(71,298)	(569,298)
Payments for intangible assets		(360,136)	-
Proceeds from other financial assets		46,238	-
Net cash (used in)/from investing activities		(390,273)	(598,247)
Net decrease in cash and cash equivalents		274,702	(633,417)
Cash and cash equivalents at beginning of financial year		1,368,230	2,001,647
Cash and cash equivalents at end of financial year	4	1,642,932	1,368,230

The accompanying notes form part of these financial statements.

STATEMENT OF CHANGES IN EQUITY

FOR THE YEAR ENDED 30 JUNE 2016

	Related profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2014	3,192,321	816,723	4,009,044
Profit (Loss) attributable to the Society	(36,004)	-	(36,004)
Total other comprehensive income for the year	-	-	-
Balance at 30 June 2015	3,156,317	816,723	3,973,040
Profit (Loss) 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

The accompanying notes form part of these financial statements.

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

The financial statements are for Australian and New Zealand Intensive Care Society (the "Society") as an individual entity, incorporated and domiciled in Australia. The Society is a not-for-profit company limited by guarantee. The registered office and principal place of business of the Society is 10 Ievers Terrace Carlton, Victoria, 3053.

1. Summary of significant accounting policies

Basis of accounting

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

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

The financial statements were authorised for issue on 24 August 2016 by the Board of directors.

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

Accounting policies

(a) Revenue

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

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

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

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

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

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

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

1. Statement of significant accounting policies (continued)

(b) Taxation

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

(c) Property, plant and equipment

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

Property

Freehold land and buildings are shown at their fair value based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings. In periods when the freehold land and buildings are not subject to an independent valuation, the directors conduct directors' valuations to ensure the carrying amount for the land and buildings is not materially different to the fair value.

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

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

Plant and equipment

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

Depreciation

The depreciable amount of all fixed assets including buildings, but excluding freehold land, is depreciated on either a straight line or diminishing value basis over the asset's useful life to the entity commencing from the time the asset is held ready for use.

The estimated useful lives in the current and comparative periods are as follows:

Class of asset	Useful life
• Buildings	40 years
• Plant and equipment	4 – 25 years

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

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

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

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.

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

1. Statement of significant accounting policies (continued)

(iii) Held-to-maturity investments

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

(iv) Available-for-sale investments

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

(v) Financial liabilities

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

Impairment

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

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

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

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

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

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

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.

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

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 will be amortised to the Income Statement over a period of five years once the system commences operation.

(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.

(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.

	2016 $	2015 $
2. Revenue and other income		
Revenue:		
Grants	1,516,427	1,262,157
Subscriptions	493,123	456,553
Surplus from ASM	84,877	171,662
Conferences and meetings	402,282	293,362
Sponsorship	150,048	129,717
	2,646,757	2,313,451
Other income:		
Interest received – cash and cash equivalents	46,877	15,244
Investment dividends and distributions	24,732	52,328
Unrealised gain on investments held	-	12,033
Sundry income	36,331	34,191
	107,940	113,796
Total revenue and other income	2,754,697	2,427,247
3. Expenses		
Unrealised loss on investments held	5,439	-
Loss on disposal of investments	3,085	5,543

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

	2016 $	2015 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	452,632	464,430
Cash on short term deposit	1,190,000	903,500
	1,642,932	1,368,230
5. Trade and other receivables		
Trade receivables	52,049	74,422
Other receivables	15,373	18,360
	67,422	92,782
6. Other current assets		
Prepayments – general	25,637	32,612
Prepayments and deposits - ASM	8,715	18,351
	34,352	50,963
7. Financial assets		
Available for sale financial assets		
- investments in listed Australian securities	333,405	347,776
- investments in managed funds	258,915	228,012
	592,320	575,788
8. Property, plant and equipment		
Land and buildings		
Freehold land – at valuation	1,600,000	1,600,000
Buildings – at valuation	950,000	950,000
Less accumulated depreciation	(55,416)	(31,666)
	849,584	918,334
Total land and buildings	2,494,584	2,518,334
Plant and equipment		
Plant and equipment - at cost	122,898	203,264
Less accumulated depreciation	(80,575)	(135,546)
Total plant and equipment	42,323	67,718
Total property, plant and equipment	2,536,907	2,586,052

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

8. Property, plant and equipment (continued)

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
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
2015			
Balance at 1 July 2014	2,542,084	67,114	2,609,198
Additions	-	28,949	28,949
Depreciation for the year	(23,750)	(28,345)	(52,095)
Balance at 30 June 2015	2,518,334	67,718	2,586,052

(a) Asset revaluation

The freehold land and buildings were independently valued at 24 February 2014 by Opteon. The valuation was based on the fair value less costs to sell. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $100,626 being recognised for the year ended 30 June 2014.

	2016 $	2015 $
9. Intangible assets		
COMET Software Development	360,136	-
10. Trade and other payables		
Trade creditors	103,034	17,095
Sundry creditors and accruals	82,494	52,346
Grants received in advance	34,379	119,739
Subscriptions received in advance	262,489	188,384
Sponsorship & registrations received in advance	114,739	51,654
	597,135	429,218
11. Employee benefits		
Current		
Provision for annual leave	105,585	102,746
Provision for long service leave	155,008	110,312
Other employee benefits	-	32,531
	260,593	245,589
Non-current		
Provision for long service leave	22,642	25,968

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

10. Employee benefits (continued)

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).

	2016 $	2015 $
12. Reserves		
Asset revaluation reserve	816,723	816,723
Balance at the beginning of the year	816,723	816,723
Revaluation increment	-	-
Balance at the end of the year	816,723	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 loss after income tax		
Profit (Loss) from ordinary activities	380,659	(36,004)
Add/(less) non-cash items:		
Depreciation	54,226	52,095
Loss on disposal of investments	3,085	5,543
Unrealised gain on investments held	5,439	(12,033)
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	25,360	86,870
(Increase)/decrease in other current assets	16,611	2,524
Increase/(decrease) in trade and other payables	167,917	(182,261)
Increase/(decrease) in provisions	11,678	48,096
Net cash used in operating activities	664,975	(35,170)

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 Ben Barry, Dr Craig French, Dr Rajeev Hegde, Dr Ian Jenkins, Dr Kenneth John Millar, Dr Mark Nicholls, Dr Stewart Moodie, 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.

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

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:

	2016 $	2015 $
Key management personnel compensation	410,690	396,123

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.

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

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

16. Financial risk management (continued)

(c) Liquidity risk

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

(d) Interest rate risk

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

(e) Capital management

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

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

	2016 Carrying amount $	2016 Fair value $	2015 Carrying amount $	2015 Fair value $
Cash and cash equivalents	1,642,932	1,642,932	1,368,230	1,368,230
Trade and other receivables	67,422	67,422	92,782	92,782
Other current assets	34,352	34,352	50,963	50,963
Financial assets	592,320	592,320	575,788	575,788
Trade and other payables	597,135	597,135	429,218	429,218

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

NOTE TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

17. Financial instruments (continued)

(c) Interest Rate Risk

	Carrying amount	
	2016	2015
	$	$
Floating rate instruments		
Cash and cash equivalents	452,932	464,730
Fixed rate instruments		
Cash and cash equivalents	1,190,000	903,500

Fair value sensitivity analysis

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

Cash flow sensitivity analysis

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

(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	
	2016	2015
	$	$
Loans and receivables	67,422	92,782

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.

NOTES TO THE FINANCIAL STATEMENTS

FOR THE YEAR ENDED 30 JUNE 2016

17. Financial instruments (continued)

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 $
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
2015							
Trade receivables	74,422	-	70,052	-	-	4,370	70,052
Other receivables	18,360	-	18,360	-	-	-	18,360
Total	92,782	-	88,412	-	-	4,370	88,412

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 2016 or the previous financial year.

(e) Liquidity Risk

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

	Carrying amount $	Contractual cash flows $	6 mths or less $	6–12 mths $	1–2 years $	2–5 years $	More than 5 years $
30 June 2016							
Payables	597,135	597,135	465,891	131,244	–	–	–
30 June 2015							
Payables	429,218	429,218	335,026	94,192	–	–	–

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 2016 (2015: $Nil).

DIRECTOR'S DECLARATION

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

(a) the Society is not publicly accountable;

(b) the financial statements and notes that are set out on pages 31 to 47, are in accordance with the Australian Charities and Not-for-profits Commission Act 2012 including;

(i) giving a true and fair view of the Society's financial position as at 30 June 2016 and of its performance, for the financial year ended on that date; and

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

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

Signed in accordance with a resolution of the Directors.

Dr Marc Ziegenfuss
President

Dr Anthony Holley
Hon. Treasurer

Dated this 24th day of August 2016

INDEPENDENT AUDIT REPORT TO THE MEMBERS OF AUSTRALIAN AND NEW ZEALAND INTENSIVE CARE SOCIETY

Report on the Financial Report

We have audited the accompanying financial statements of Australian and New Zealand Intensive Care Society, which comprises the statement of financial position as at 30 June 2016, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended, notes comprising a summary of significant accounting policies and other explanatory information and the directors' declaration.

Directors' Responsibility for the Financial Report

The directors of the company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the 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 is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial report. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial report, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the company's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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

Independence

In conducting our audit, we have complied with the independence requirements of the Australian Charities and Not-for-Profits Commission Act 2012.

Audit Opinion

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

(i) giving a true and fair view of the company's financial position as at 30 June 2016 and of its performance for the year ended on that date; and

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

C.W. Stirling & Co.
Chartered Accountants

John A Phillips
Partner

Dated this 24th day of August 2016 Melbourne.

Liability limited by a scheme approved under Professional Standards Legislation

ANNUAL GENERAL MEETING

4:45pm Friday 30th October 2015

Auckland Room 1&2, SkyCity Convention Centre, Auckland, New Zealand

CONFIRMED MINUTES

1. WELCOME, PRESENT & APOLOGIES

President

Present

A/Prof Andrew Turner (President)
Dr Marc Ziegenfuss (Vice President)
Dr Anthony Holley (Hon Treasurer)
Dr Simon Erickson (Hon Secretary)
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 Adam Deane
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
A/Prof Michael O'Leary
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

Dr Lewis Campbell
Dr Angus Carter
A/Prof Theresa Jacques
Dr James Judson
Dr Anne Leditschke
Dr Stewart Moodie
Prof John Myburgh
Dr Gerry O'Callaghan
Dr Ian Seppelt
A/Prof William Silvester
Dr Wade Stedman

In Attendance

Brent Kingston (Minutes)
Tony Tenaglia (ANZICS General Manager)
Justin Williams (ANZICS CEO)

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 10th October 2014 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: Marc Ziegenfuss
Seconded: John Santamaria

Motion Carried

3. PRESIDENT'S REPORT

AT advised the Presidents Report would be taken as read.

AT updated on the ANZICS General Manager, Mr Justin Williams, being promoted by the ANZICS Executive to become the Chief Executive Officer. AT advised that JW had recently resigned from the Society with the contract officially ending following the 2015 AGM.

AT welcomed Mr Tony Tenaglia, recently beginning the role of ANZICS General Manager in the 4 weeks prior.

The imbalance in ANZICS Membership for Gender, Age and Trainee representation within the Society was highlighted at the recent ANZICS Board Meeting and avenues to address this are being sought.

Intention to increase the profile of ANZICS and allow a Trainee Representatives across the standing ANZICS Committees was noted, requiring a change to the ANZICS Regulations. AT advised the group of Trainees would then form a Trainee Committee and nominate a Representative to sit on the ANZICS Board.

An update on recent changes to ANZICS Membership following discussion at the ANZICS Board Meetings was provided. AT noted the changes to the ANZICS Affiliate Membership to specifically specify the Nursing, Allied Health & Research Coordinators Membership Categories.

Mary White queried the direction of the Affiliate Membership changes and how it impacts the Society. AT noted the erosion of the impact of ACCCN on the Nurses and the loss of importance. AT advised that encouraging Nurses to join the Society would then allow ANZICS to better represent the entire specialty.

AT advised that by expanding the Affiliate category to Nursing & Allied Health it allows ANZICS to better represent the entire Intensive Care Profession and increase influence.

AT highlighted that no further progress had taken place other than the amendment of the category titles.

David Tuxen highlighted the issues around the expansion to ensure Intensivists remain the core representation and how workforce issues, negotiating fees, negotiating standards of intensive care and for professional reasons why they need to remain distinct.

SE noted that the current Affiliate Membership currently had no representation from the Society and advised that the other professions influence and change the ICU environment for Intensivists. The current category name is too broad to attract interest from the other craft groups.
Ian Jenkins advised that Affiliate Members currently have no voting rights at ANZICS AGM's and there is no intention to change this. AT advised if there was a large mass of Nurses joining the Society there will be a need to seek ways of providing for the craft group, potentially CPD etc.

Elizabeth Fugaccia queried if these other categories are likely to have representation on the ANZICS Board, AT advised that this would be decided by the Membership if required in future.
Ian Jenkins noted that the ANZICS Board is currently a large size so this would require further thought.

David Tuxen queried if the membership did expand whether the Society would become the representation across all aspects of the craft.

Adam Deane questioned if the current strategy would alienate the targeted Trainee Members and if this change would affect the issues in retaining Trainees further.

4. TREASURER'S REPORT

Anthony Holley (AH) presented the Treasurer's Report, highlighting the Key Revenue Items in the report, mainly attributed to membership, CTG subscriptions, CORE Funding and the ASM and associated ANZICS Conferences.

It was noted the investments were assisting ANZICS to be in a positive position along with revenue from additional activities.

AH updated on the forecast deficit of the Society at -$84,000 to -$36,000, noting the siginificant improvement on the previous financial year.

AH highlighted the conservative expected surplus forecast of $15,000 for the 2015/16 Financial year and a return to surplus.

AH requested that the 2014/15 ANZICS Financial Report be proposed and passed by the ANZICS Membership.

Motion: The 2014/15 Financial Report was accepted as a true and accurate record by the ANZICS Membership.
Proposed: Rajeev Hegde
Seconded: David Rigg

AH requested that the Auditor be changed from KPMG to C.W. Stirling & Co. in a bid to decrease fees.

Motion: CW Stirling & Co. be the contracted Auditor for the Society for the forthcoming year.
Proposed: Adam Deane
Seconded: Gill Hood

5. MEMBERSHIP REPORT

SE presented the Membership Report, highlighted the increase in the Full Membership to 523. It was advised that some members had been removed due to outstanding fees.

SE updated on the recent revision to implement an incremental fee increase when upgrading from Trainee to Full Members to alleviate the cost increase between the two categories and also the employment considerations for early career Intensivists.

SE noted CICM's approximate Trainee total of 500 and ANZICS' limited capture of 154 Trainees. It was noted the intention for the College to assist with mailouts to help target Trainee members in an attempt to close the gap.

SE updated on Robert Wright's awarding of ANZICS Honorary Membership due to his incredible contribution to the Society and Australian Intensive Care.

Adam Deane queried if the ANZICS brand had been appropriately leveraged internationally to appeal to the overseas audience. SE advised that the decrease in Associate/Overseas Membership fees will potentially bring in greater overseas members, along with exposure and interactions with international interest on the benchmarking service.

6. ELECTION OF OFFICE BEARERS

AT updated on the nominations received for the ANZICS Office-bearer positions, advising that the following positions received interest as follows:

President: Marc Ziegenfuss
Honorary Treasurer: Anthony Holley
Honorary Secretary: Simon Erickson

AT called for the membership to ratify the ANZICS Office-bearer positions.

> **Motion:** The nomination received for ANZICS President from Marc Ziegenfuss be accepted and ratified by the ANZICS Membership.
> **Proposed:** Mark Nicholls
> **Seconded:** Mary White

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:** Ranald Pascoe
> **Seconded:** Mary White

Unanimous vote in support of the ratification.

> **Motion:** Simon Erickson's nomination for the role of Honorary Secretary be accepted and ratified by the ANZICS Membership.
> **Proposed:** Mark Nicholls
> **Seconded:** David Rigg

Unanimous vote in support of the ratification.

7. ANZICS HONOUR ROLL

Following recommendation from the ANZICS Regional Chairs, the following members were added to the ANZICS Honour Roll to recognise outstanding contribution to the Intensive Care Medicine Specialty and outputs above and beyond a dedicated Clinician:

Helen Opdam
Jack Havill
John Santamaria

8. PROFESSIONAL PRACTICE

8.1 Practice and Economics Committee

Mark Nicholls updated on the MBS reviews, the MSAC Submissions currently underway and the construction of a Scope of Practice Document. It was advised that a planned review of 100 items would be completed by the end of the year of the 5800 total items.

MN noted that the Committee had opted to pursue two MBS Items; ECMO Insertion and Extended Family Discussion for Organ Donation. Noting was made to the extended MSAC Process and the expected negotiation to take years.

8.2 ANZICS Centre for Outcome and Resource Evaluation

David Pilcher presented the ANZICS CORE Report.

DP advised that there was more beds per population in Australia than in New Zealand. 140,000 Adult admissions were submitted the Adult Patient Database per year, with 20,000 Paediatric admissions.

At present, CORE is currently submitted to by 207 Intensive Care Units. It is estimated that there are 15,000 – 20,000 adult admissions not entered by the APD. The Outlier Working Group and the Research and Publication Working Group are the two current working groups produced by ANZICS CORE.

The CERS Project has now completed it's first phase. DP thanked Sue Huckson, ANZICS CORE Manager for the management of the team and Allison van Lint, ANZICS CORE Project Lead for the oversight and management of the CORE Projects.

The next focus for ANZICS CORE will be the redevelopment of AORTIC, from which funding was received by the jurisdictions. Although funding was received, there are shortfalls from Queensland Health and New Zealand. These affect the abilities of ANZICS CORE and the capable outputs.

8.3 ANZICS Clinical Trials Group

The report was taken as read.

8.4 Safety & Quality Committee

The report was taken as read.

8.5 Death and Organ Donation Committee

The report was taken as read.

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.

9. INTENSIVE CARE FOUNDATION

Gill Hood presented an update on the Intensive Care Foundation.

10. OTHER BUSINESS

Michael O'Leary updated on the SG-ANZICS 2015 Conference, noting that 100 delegates attended from Australia and New Zealand, a significant increase on 2013. Feedback received from delegates noted that the meeting was of high quality.

MOL called for interest from any ANZICS Members to be involved in the 2017 conference, noting the need to gain new members on the Committee, who had run the past 3 conferences. Any interest to be sent to the ANZICS Office.

AT advised of the need to seek ways to enable Doctors from third world countries to attend such events.

11. FUTURE MEETINGS

41st ANZICS/ACCCN Intensive Care Annual Scientific Meeting (ASM) Perth Convention and Exhibition Centre, Perth, Western Australia 20th – 22nd October 2016

NOTES

Advocate for intensive care throughout Australia and New Zealand