ANZICS

2015 ANNUAL REPORT

Advocate for intensive care throughout Australia and New Zealand

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Australia and New Zealand Intensive Care Society

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President's Report

The 2014-15 year has seen the Society continue to develop its core businesses including advocacy, research, quality assurance, death and organ donation, and education. The outputs of the Society have continued to grow in all these areas, despite a fixed income base from member subscriptions.

Our advocacy role has included activity at local hospital, state, and Commonwealth levels. This activity is at the heart of Society business, and the long term well-being of our craft group is dependent on ANZICS continuing to maintain this role.

The PricE Committee has been active following the rejection of the proposed changes to the MBS schedule. Work has commenced on a scope of practice document and the committee has begun investigating an appropriate response to the continued freeze on Medicare Schedule payments. The PricE Committee survey showed a trend to employ junior intensivists on fractional appointments, and strategies to minimise the indiscriminate use of this practice are being considered.

During the year ANZICS joined with the College to co-host a workforce summit to discuss a response to the likely oversupply of Intensivists in the near future. The recent changes to the College training program appear to have ameliorated the issue somewhat and it was agreed to continue to monitor the issue and other Colleges who are in a similar situation.

The Society has agreed to join with the College and participate in the Choosing Wisely Australia process, in order to identify test and treatments that are of limited value. This process has been previously undertaken in other countries, and Society input is vital to obtain the best outcome.

The Safety and Quality Committee has set a goal for ANZICS to become the world leader in Rapid Response Teams. A training and education framework and package is being produced, and along with PricE the Committee is in the process of developing a joint position statement with the College that will address minimum standards for the provision of these services. Daryl Jones has been central to the Society alignment with Rapid Response Teams and this work will have a significant influence over the continued evolution of these systems across our two countries.

The Safety and Quality Committee has also been active in understanding Australian noradrenaline prescribing practice and is working with the supplier to produce a standardised formulation to match that which is most commonly prescribed.

The CORE Committee has completed the CERS project and the database portal is now functional. CORE has been reshaped with two new committees ratified to oversee the database, and support research. The CTG Committee has continued to generate high level multi-centre trials with a number of newly endorsed trials, significant NHMRC funding, and publications during the year. The Society continued to be a world leader in intensive care research publications with the Registry data now an important source of high quality research publications, complementing the outputs of the CTG.

The ANZICS Statement on Care and Decision Making at the End-of-Life for the Critically Ill was published during the year, and is becoming an important reference document. The Death and Organ Donation Committee continued to work with the Organ and Tissue Authority in order to improve organ donation outcomes in Australia.

The Society continued to run highly successful meetings including the ASM and the CTG meeting in Noosa. The Education Committee has been revamped in order to take a more strategic view of Society education outputs and to assist Convenors with identification of speakers and themes. This year the Society once again co-hosted the SG-ANZICS meeting in Singapore, which has grown in size and influence in our region. Society attendance at this meeting and in the Middle East have shown that there is significant interest in ANZICS internationally, particularly our registry and systems that support research and quality and safety. In recognition of the importance of this for both the Society and the development of ICU in these countries the Board have created an International Liaison portfolio, and Stephen Warrillow has been elected to this position.

Other changes to the Board of the Society during the year comprised Marc Ziegenfuss elected as Vice President; Anthony Holley as Treasurer; Craig French replaced Colin McArthur as Chair of the CTG; Mark Nicholls replaced Deepak Bhonagiri as NSW Regional Chair and Ian Jenkins as Chair of PricE Committee; Rajeev Hegde was elected as Queensland Regional Chair; and Mary White retired from the Executive. On behalf of the ANZICS members I would like to thank all Directors, recent Directors of the Society, and Committee Chairs for their commitment and dedication to our craft group, and acknowledge that this work is undertaken pro bono often at the expense of family and work life.

Finally I would like to remind our members that the Society continued to provide significant benefits to intensive care in both our Countries, however once again we have traded at a small loss. Our subscriptions contribute a fraction of Society income and we are dependent on income generated from meetings, CTG member ICUs, and New Zealand and Australian jurisdictions. This financial environment prevented the Society from developing new projects which required significant capital. Unfortunately, the Board cannot support projects without a likelihood of income generation to offset cost, unless a decision is made to utilise Society capital to support projects of significant benefits to the craft. The Board has recognised this and the risk to ICU should ANZICS' role diminish over time, and has commenced development of a strategic plan to strengthen the Society and our position as the advocate for intensive care across our two countries.

Once again, I recommend that all members read the detailed Committee Reports and financials that follow.

Andrew Turner
ANZICS President

Treasurer's Report

It is a great privilege for me to report to our membership on the financial state of our Society. Despite a relatively volatile global and national economy, ANZICS has delivered some pleasing results over the last financial year. Recognising the need for the Society to have a strong financial foundation in order to deliver to the membership, services to critical care medicine they expect, the Executive, Board and General Manager have worked hard to deliver results. Despite significant mandatory expenditure through the year, the year-end position of ANZICS is substantially better than original predictions. We have aggressively sought to minimise our expenditure by frugal cost containment and have been very successful in this regard.

The original budget prediction anticipated an $85,000 annual deficit, but thanks to a highly successful Melbourne ASM and Safety & Quality Conference, the predicted deficit was reduced to $36,000.

ANZICS is a relatively small, not-for-profit Society and is therefore vulnerable, but despite this situation we have avoided simply increasing membership subscriptions to generate revenue, but rather the board and executive have looked for other wealth generating opportunities.

Last year the Board approved an investment strategy which has delivered good results in a somewhat volatile global environment. This diversification is simply one of the innovative strategies adopted to secure and strengthen our Society. We should however, not stop there, we need to explore other avenues for the generation of revenue which may include provision of more services, education initiatives and possibly taking our Society into the global arena.

Financial Summary

	Original Budget $'000	Actual $'000	Var. $'000
Income	2,258	2,427	169
Expenditure	2,343	2,463	(120)
Surplus (Deficit)	(85)	(36)	49

Overall we have had a very successful year and the Society continues to secure its future, but we all need to work hard to increase our membership base. We need to do the small things well and now is the time to possibly think outside the usual paradigm. Thank you to all the members, the board, the General Manager and all the staff at ANZICS for a successful year.

Anthony Holley
Honorary Treasurer

ANZICS Board of Directors

President
Andrew Turner

Vice President
Marc Ziegenfuss

Honorary Treasurer
Anthony Holley

Honorary Secretary
Simon Erickson

Paediatrics
Johnny Millar

Centre for Outcome and Resource Evaluation (CORE)
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Clinical Trials Group (CTG)
Craig French

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Tasmania Regional Chair
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Victoria Regional Chair
Stephen Warrillow

New South Wales Regional Chair
Mark Nicholls

Queensland Regional Chair
Rajeev Hegde

Western Australia Regional Chair
Ian Jenkins

South Australia Regional Chair
Stewart Moodie

Chief Executive Officer's Report

The past year has been of consolidation and of positioning ANZICS. Safety and Quality, CTG and CORE have continued to position the Society, and strongly represent the interests of our members nationally and internationally. Also of note is the interest from international Societies to partner and collaborate with ANZICS. During the financial year there have been multiple touch points with international groups with the aim to strengthen ANZICS' position and share the knowledge that has been built up over the last 40 years that ANZICS has been in existence.

From a year in review perspective, it has seen the continuing development of internal capability to better service members and your interests. CORE have now launched the CORE Enterprise Reporting System (CERS) which underpins the Intensive Care Unit benchmarking program. CTG continues to lead the world in the generation of evidence to guide treatment and improve outcomes for those admitted to intensive care. Safety and Quality and in particular their annual conference has gone from strength to strength.

At the Melbourne ASM last year, ANZICS released the End-of Life-Care Statement. This statement had been the product of focused work conducted by the Death and Organ Donation Committee – this statement has been picked up nationally and internationally, with other groups citing various parts of the statement.

During the last year, with the guidance and assistance of ANZICS members, a new ANZICS website was deployed – our focus in doing this is to improve the information flow to you the members. Additionally, and in response to demand, ANZICS has created a Social Media and Communications Working Group to ensure that how we communicate is prioritised.

Following ANZICS (and ACCCN) winning the rights to host the 2019 World Congress preparation has now commenced and I am pleased to announce that Dr Stephen Warrillow, Medical Convenor of the Melbourne ASM has agreed to be the Program Convenor. The environment in which the ASM operates continues to provide challenges and those closely involved will understand when I say that without the determination of the Organising Committee the ASM would not be possible. Thank-you to those that have been part of an ASM Organising Committee – without your support the ASM would not be possible.

I was fortunate to have attended the ANZICS-SQ Conference this year and highly commend the organising committee for having run such an excellent event. The event showcased much of what ANZICS stands for and provided an excellent platform for ANZICS and individual Intensivists to connect to new audiences.

As always, the considerable growth and accomplishments that provide a solid platform for future relevance and expansion would not be possible without the hard work and commitment of the staff at ANZICS and the members. I would like to thank all of the staff at ANZICS House for their commitment to ensuring that ANZICS delivers to the members expectations.

Justin Williams
ANZICS CEO

Membership Report

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

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

While we have seen an 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 1st Year Free Trainee 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.

Simon Erickson
Honorary Secretary

Total Members:	762
Country	
Australia:	642
New Zealand:	101
Type	
Full:	524
Trainee:	149
Associate:	37
Affiliate:	54
Honorary:	9

Centre for Outcome and Research

Data on over 160,000 adult and paediatric ICU admissions every year is processed, cleaned, analysed and reported by dedicated staff at the CORE offices in Brisbane and Melbourne. The same staff also produce analyses on potential outlier ICUs, reports for health departments, assist researchers working with CORE data, promote CORE's activities within Australia and New Zealand, and answer a wide range of queries from "How do I turn AORTIC on?" to "What is the correct diagnostic code for crocodile attack?" (The answer is under "Trauma" by the way). This report summarises not only the huge amount of work produced by these 9 individuals over the past year but also the activities of all clinicians, policy makers and researchers who work with CORE.

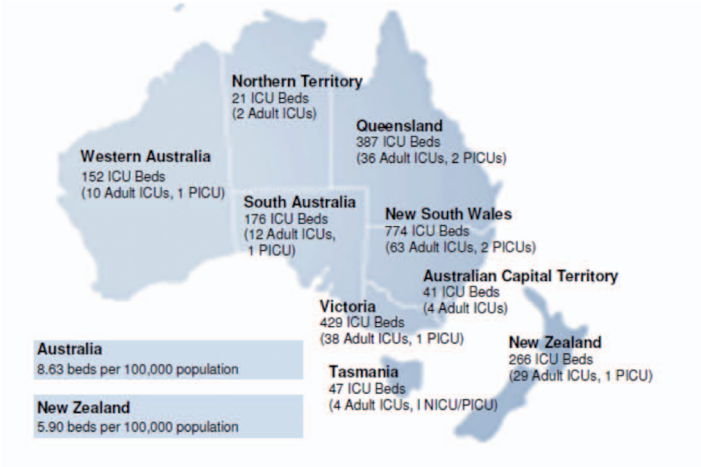

Figure 1: A profile of ICU services in Australia and New Zealand

The ANZICS CORE Reporting Portal Launched

After two years of development, the new ANZICS CORE Reporting Portal was launched in February 2015. Users can not only examine overall patient outcomes but can also filter reports to look at major diagnostic groups such as cardiothoracic, sepsis, trauma, medical/surgical, ED/ward/OT admissions. Gradually over time more reports and tables will be added including paediatric ICU reports which will be available in late 2015. If you want to know how your ICU compares (mortality outcomes, severity of illness, readmissions, after-hours discharges, length of stay) please log on at https://coreportal.anzics.com.au or contact us at anzics.core@anzics.com.au.

Figure 2: Example of ANZICS CORE portal report (ANZROD funnel plot)

The ANZICS CORE – CTG Health Services Research day

In March 2015, the CTG and CORE combined to host a meeting in Sydney to focus the Intensive Care community on Health Services Research. The day brought together experienced researchers from within Intensive Care and other health disciplines, including Adam Elshaug, Jeffrey Braithwaite, Steve Webb, Tim Churches, Jeff Presneill and Robert Herkes. The meeting generated a lot of interest both through traditional channels and through social media (#anzicshsr2015).

ANZROD and APACHE III

This year, ANZROD (The Australian and New Zealand Risk Of Death) replaced APACHE III as the main risk adjustment model for benchmarking mortality outcomes. For some time APACHE III has over-estimated the true risk of death of a patient admitted to ICU in Australia or New Zealand. ANZROD provides much more accurate mortality risk predictions for all major groups including trauma and cardiothoracic patients. Although APACHE III reports will continue to be available, ANZROD is now the primary method for identification of outlier ICUs.

Engaging the ICU Community: New CORE Working Groups

With growing interest from the clinical community to be more engaged in CORE activities, this year saw the formation of the Outlier Review Working Group and the Research and Publication Working Group.

The ANZICS CORE Outlier Working Group

Every quarter, comparative plots of annual standardised mortality ratios (SMRs) for ICUs in Australia and New Zealand are produced. Inevitably, from time to time, an ICU will appear with an SMR higher than their comparison peer group. This leads to further analysis and production of an Outlier report by CORE. The report goes as far as it can to explain the SMR, but does not offer advice or recommendations about action. The Outlier Working Group will supervise and assist in the production of these reports.

The ANZICS CORE Research and Publication Working Group

Research output from ANZICS CORE has progressively increased over recent years. This has required careful data governance, high levels of input (often unfunded) from interested Clinicians and Statisticians. This group was established to further promote CORE's research role and provide guidance for guide new Researchers.

New Working Environments for Researchers using CORE Data

CORE has joined with the SAX Institute in Sydney to set up secure on-line data working environments which will allow researchers direct access to research data sets from throughout Australia and New Zealand. More information can be found on the CORE web pages http://www.anzics.com.au/Pages/Information-Requests.aspx

High profile publications

Congratulations go to Maija Kaukonen for her publication "The Impact of the Systemic Inflammatory Response Syndrome Criteria in Defining the Presence of Severe Sepsis after ICU Admission" in the New England Journal of Medicine (http://www.nejm.org/doi/full/10.1056/NEJMoa1415236). Other high profile publications have included papers by Dashiell Gantner on After-hours Discharges from ICU in Intensive Care Medicine (http://www.ncbi.nlm.nih.gov/pubmed/25118868), and by Luregn Schlapbach describing sepsis outcomes in the paediatric ICUs published in The Lancet – Infectious Diseases (http://www.ncbi.nlm.nih.gov/pubmed/25471555).

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 my colleagues on the CORE Management Committee, Sue Huckson, Peter Hicks and Johnny Millar for their constant support and enthusiasm.

David Pilcher
Chair, CORE

ANZICS CORE Publications 2014-15

Kaukonen, Kirsi-Maija; Bailey, Michael; Pilcher, David; Cooper, D Jamie; Bellomo, Rinaldo; Systemic inflammatory response syndrome criteria in defining severe sepsis. New England Journal of Medicine 2015; 372 (17): 1629-1638

Schlapbach LJ, Straney L, Alexander J, MacLaren G, Festa M, Schibler A, et al. Mortality related to invasive infections, sepsis, and septic shock in critically ill children in Australia and New Zealand, 2002-13: a multicentre retrospective cohort study. Lancet Infect Dis. 2014 Nov 28; 6

Gantner D, Farley K, Bailey M, Huckson S, Hicks P, Pilcher D. Mortality related to after-hours discharge from intensive care in Australia and New Zealand, 2005-2012. Intensive Care Med. 2014 Oct;40(10):1528–35

Moran JL, Solomon PJ, ANZICS Centre for Outcome and Resource Evaluation (CORE) of the Australian and New Zealand Intensive Care Society (ANZICS). Fixed Effects Modelling for Provider Mortality Outcomes: Analysis of the Australia and New Zealand Intensive Care Society (ANZICS) Adult Patient Data-Base. PLoS ONE. 2014;9(7):e102297.

Sutton ADJ, Bailey M, Bellomo R, Eastwood GM, Pilcher DV. The association between early arterial oxygenation in the ICU and mortality following cardiac surgery. Anaesth Intensive Care. 2014 Nov;42(6):730–5.

Nanayakkara S, Weiss H, Bailey M, van Lint A, Cameron P, Pilcher D. Admission time to hospital: a varying standard for a critical definition for admissions to an intensive care unit from the emergency department. Aust Health Rev. 2014 Nov;38(5):575–9.

Coulson TG, Bailey M, Reid CM, Tran L, Mullany DV, Smith JA, et al. Acute Risk Change for Cardiothoracic Admissions to Intensive Care (ARCTIC index): A new measure of quality in cardiac surgery. J Thorac Cardiovasc Surg. 2014 Dec;148(6):3076–81.e1.

Bihari S, Peake SL, Bailey M, Pilcher D, Prakash S, Bersten A. Admission high serum sodium is not associated with increased intensive care unit mortality risk in respiratory patients. J Crit Care. 2014 Dec;29(6):948–54. 2015

Forbes AB, Akram M, Pilcher D, Cooper J, Bellomo R. Cluster randomised crossover trials with binary data and unbalanced cluster sizes: application to studies of near-universal interventions in intensive care. Clin Trials. 2015 Feb;12(1):34–44.

Jones, D; Hicks, P; Currey, J; Holmes, J; Fennessy, GJ; Hillman, K; Psirides, A; Rai, S; Singh, MY; Pilcher, DV; Findings of the first ANZICS conference on the role of intensive care in Rapid Response Teams. Anaesthesia and Intensive Care. 2015;43 (3): 369-379

Saxena, Manoj; Young, Paul; Pilcher, David; Bailey, Michael; Harrison, David; Bellomo, Rinaldo; Finfer, Simon; Beasley, Richard; Hyam, Jonathan; Menon, David; Early temperature and mortality in critically ill patients with acute neurological diseases: trauma and stroke differ from infection. Intensive Care Medicine 2015;41(5): 823-832

McQuilten, Zoe K; Andrianopoulos, Nick; van de Watering, Leo; Aubron, Cecile; Phillips, Louise; Bellomo, Rinaldo; Pilcher, David; Cameron, Peter; Reid, Christopher M; Cole-Sinclair, Merrole F; Introduction of universal prestorage leukodepletion of blood components, and outcomes in transfused cardiac surgery patients. The Journal of Thoracic and Cardiovascular Surgery. Epub on line 15th March 2015

Weinkove R, Bailey M, Bellomo R, Saxena MK, Tam CS, Pilcher DV, Beasley R, Young PJ.

Association between early peak temperature and mortality in neutropenic sepsis. Ann Hematol. 2015 May;94(5):857-64. doi: 10.1007/s00277-014-2273-z. Epub 2014 Dec 18.

PMID:25516454

Clinical Trials Group

This year the CTG celebrated its 21st birthday. We continue to facilitate and promote investigator initiated collaborative clinical research in Australia and New Zealand and were awarded competitive grant funding from the New Zealand HRC and Australian NHMRC. The CTG's track record of success with these bodies is unparalleled. The group's publication record continues to grow; high impact journals, including the New England Journal of Medicine (NEJM), are the primary target of our multicentre randomised trials. Our group is seen as a leader within and outside our region; we share our knowledge with emerging trials groups (within and external to intensive care medicine).

The ARISE (early goal directed resuscitation in sepsis vs standard care) study was published in October 2014 in the NEJM and presented at the European Society of Intensive Care Medicine Annual scientific meeting. This trial presented many challenges to the management committee, investigators and research coordinators. I acknowledge the commitment all demonstrated to successfully complete ARISE. In particular the CTG community thanks A/Prof Sandra Peake for the leadership she provided.

Heat (paracetamol versus placebo for fever) and EPO-TBI (erythropoietin for traumatic brain injury) have completed recruitment. It is expected that both these studies will present their results in October 2015 with publication in leading journals shortly after. Current actively recruiting large randomised studies include ADRENAL (low dose hydrocortisone for septic shock), TRANFUSE (fresh vs standard aged red cells), POLAR (prophylactic hypothermia for traumatic brain injury), PHARLAP (open lung strategy for ARDS) and, RELIEF (restrictive vs. liberal fluid use peri-operatively, jointly with the ANZCA Clinical Trials Group), SPICE-III (goal directed protocol sedation)and PATCH (prophylactic tranexamic acid in trauma, jointly with ambulance services and emergency medicine).

In 2014 the NHMRC awarded SuDICCU (cluster randomised controlled trial of gut selective decontamination a project grant of $3.9 million, Target (augmented vs. reduced goals for energy delivery) $3.5 million. We thank Ian Seppelt (SuDICCU) and Marianne Chapman (TARGET) for the effort expended to achieve this and congratulate them and the management committees on their funding success. In 2015 the CTG endorsed PLUS (balanced electrolyte versus normal saline). This application's outcome will be known later this year

The CTG remains grateful to the Intensive Care Foundation that continues to support early stage research. Funding for this vitally important component of a research program is difficult to obtain and the Foundation Grants, which are announced annually at the Annual Scientific Meeting, are appreciated by the broader ICU community. The projects they support provide essential preliminary data that drives and supports large studies designed to answer clinically relevant questions with patient centred outcomes.

Over the last twelve months one major challenge to the conduct of critical care research emerged. While the immediate implications were limited to jurisdiction, New South Wales, the potential for generalisation existed. Two decisions by the Guardianship Division of the New South Wales Civil and Administrative Tribunal (NCAT) caused uncertainty among investigators and Human Research Ethics Committees. The management committees of ADRENAL, TRANSFUSE and PHARLAP, after obtaining legal advice, elected to suspend recruitment into their studies and make urgent applications to the NCAT. The issues were complex and related to the definition of what a clinical trial is and who may provide consent. After two hearings, a number of anxious months, and substantial investments in time and money clarification was provided and all trials have now recommenced recruitment in NSW. While the challenges for existing studies are resolved concern remains regarding our ability to conduct future research in NSW. The CTG, together with The George Institute and the ANZIC-RC, will continue to liaise with the NSW Office for Medical Research and pursue legislative of regulatory change that facilitates the conduct of research in patients who are unable to provide consent.

On behalf of the CTG I thank Colin McArthur who recently retired as Chair and Diane Stephens who retired from the Committee after many years of service; both have made a substantial and lasting impact. I also thank Donna Goldsmith, our Executive Officer, and Simone Rickerby, Executive Assistant. They run the office, coordinate our activities, and respond to what a times are "stretch demands". Their commitment to the CTG is highly valued and respected. Finally, I would like to thank you- the investigators, research coordinators, medical, nursing and allied health staff who are the ANZICS CTG. We can be proud to be recognised as one of the world's leading clinical trials groups.

Craig French
Chair, CTG

Death and Organ Donation

DODC Activity

In 2014 the DODC worked closely with the College of Intensive Care Medicine (CICM) and The Australian Organ & Tissue Authority (AOTA) on a number of projects, such as developing a new course that will replace Medical ADAPT in Australia. During this time a tripartite Memorandum of Understanding was also developed between ANZICS, CICM and AOTA. The ANZICS DODC along with CICM reviewed the revised the workshop developed by AOTA and provided feedback based on the learning materials and pilot workshop. The DODC also continues to work with CICM to develop relevant on-line teaching materials for trainees and fellows. ANZICS and CICM retain extended representation on the OTA Family Conversation Steering Group.

A reminder to all members that The ANZICS Statement on Death and Organ Donation edition 3.2 is available on the ANZICS website under Committees - Death and Organ Donation.

AOTA Activity

Some of you may be aware of the recent government announcement to review OTA's organ donation and transplantation programme. ANZICS released a statement in support of OTA and the organ donation and transplantation programme, this was sent to the media, ANZICS members and is available on the ANZICS website. I attended the review at Ernst and Young with representatives of DonateLife Victoria, the Lions Eye Bank, the Victorian Tissue Bank, a kidney, liver and thoracic transplantation, the Transplant Nurses Association and CICM. There was broad and open discussion covering many areas of organ donation and transplantation.

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, I have had the opportunity to promote the statement 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. The Statement will periodically be reviewed by the EOLCWG to ensure it remains relevant and up to date and I encourage any comments or feedback to be submitted to ANZICS. On behalf of the EOLCWG, I wish to thank the ANZICS membership for their vital input and support.

William Silvester
Chair, DODC and EOLCWG

Education Committee

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

The 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 and CTG forums, in the past our reach has been somewhat limited to those that have the ability and flexibility in their schedules to attend these events. An initiative of the Education Committee in throughout 2015 and 2016 is to further develop an online educational video resource that can be accessed by all members from around the globe. The content on the channel so far has come from a variety of areas such as past ASM's, Safety and Quality and other ANZICS educational events.

To assist in spreading the ANZICS brand the formation of an Educational subcommittee, the ANZICS Communications & Social Media Working Group has recently been formed. This working group will assist the Education Committee in developing and maintaining effective communication strategies to ensure the organisation remains current and implements effective use of social media as well as ensuring the promotion of web based educational opportunities for members.

Following the success of the Foundation Workshop for the New Intensivist at the 2014 ASM, planning is underway for inclusion at future meetings. The workshop is designed to complement the content of transition to consultant courses which are now mandatory for Fellows of the College of Intensive Care Medicine, and is intended as an introduction for Senior Registrars and new Consultants on how best to utilise the tools that the Society offers. 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.

The ANZICS ICM course that was impeccably convened by the late A/Professor Ramesh Nagappan for 7 years was postponed in 2014 due to his untimely passing and a full clinical training calendar. The Education Committee is currently in discussions with Eastern Health regarding the development and convening of a quality course for 2015 and future years.

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

Stephen Warrillow
Acting Chair, Education Committee

Paediatric Committee

The last year has seen considerable work to rejuvenate the ANZICS Paediatric Committee. The Committee provides a forum for discussion of topics pertinent to paediatric ICU and a means to ensure paediatric representation on various ANZICS standing committees. A new Committee, with regional representation, has been assembled, and new Terms of Reference for the Committee were ratified at the June Board meeting. It is hoped that the first face-to-face meeting will occur at the ASM in Auckland later this year. The Committee will provide ongoing engagement, with a relevant and representative voice for the paediatric intensive care community.

ANZPIC Registry

This has been a very busy year for the Registry, with CORE staff working extremely hard towards the ANZPICR launch of CERS – the CORE Enterprise Reporting System. CERS is already up and running for the Adult Patient Database, and extensive testing of the ANZPICR build is underway; we are hoping to go live within the next few months. This exciting development will give contributing hospitals a web-based means of submission of Registry data and access to tables, figures and reports. The initial suite of on-line reports will be limited, however we anticipate that reporting capabilities will increase over the next few years.

All data have been received and finalised for 2014. Once again the number of paediatric admissions to intensive care has exceeded all previous years, with more than 11,000 admissions documented for last year. The Annual Report is being worked on and will be published in the coming months.

Research using Registry data has been increasing over the last few years, and several high-quality publications based on analysis of Registry data have boosted the profile of ANZPICR. Requests for data and research proposals are welcomed by the Registry; the processes for application and use of Registry data were recently revised, and will be available on the ANZICS website soon, as the CORE Data Access and Publication Policy.

Paediatric Studies Group

The Paediatric Study Group has had a busy period, having completed a number of studies and embarking on several new projects. The committee has been stable now for a number of years and has managed to oversee a period of excellent collaboration between the 8 paediatric ICU's in Australia and New Zealand. In addition, strong collaborative links have been forged with international PICU research groups and with our own CTG.

The BABY-Spice pilot study of early goal-directed sedation in PICU is currently running in 5 PICU's and has enrolled more than 50% of its proposed total patients. The results of this study, being led by Simon Erickson (Princess Margaret, Perth), will be used to inform the design of and grant application for a large randomised, controlled trial the following year.

The Hypothermia in Traumatic Brain Injury in Children (HITBIC) study has just been published and represents an excellent collaborative effort by the PSG.

Multiple other studies are in various stages of development and execution, and the output from the Group is gaining in volume and momentum. At a strategic planning day held in February, there was a lively and productive discussion about future research programme identification and development and the approach to successful and secure funding of future research.

ASM

Preparations are well under way for the paediatric section of this year's ASM, to be held in Auckland at the end of October. Fiona Miles from Starship Children's Hospital has been working hard on the programme and we hope to see many of the PICU community there. Professor Andy Wolf, from Bristol, and Professor Martha Curley, from Philadelphia, will be the Paediatric Keynote speakers.

Johnny Millar
Chair, Paediatric Committee

PricE Report

MBS Items

There are over 5600 MBS items in the MBS schedule. The Federal Department of Health is about to commence a review of MBS items using a rapid review process developed in Ontario, Canada. An AMA Forum was held in Canberra on the 19th of August. The aims of the forum were to have a coordinated response to the reviews and avoid playoff of one specialty against another. Representatives from almost 60 societies and colleges attended. Brian Owler, the Federal AMA President chaired the meeting. Since 2008, there have been very few additions (<40 per year) with a limited number of reviews of existing MBS items. Using the rapid review process, the Federal Health Department is planning now do up to 100 reviews before the end of this year.

At the AMA Forum, the chair of the MBS review taskforce, Professor Bruce Robinson, did a presentation outlining the rapid review process. The members of the taskforce are Professor Bruce Robinson, Ms. Rebecca James, Professor Paul Glasziou, Dr Lee Gruner, Professor Micael Besser, Dr Michael Coglin, Dr Steve Hambleton, Professor Michael Grigg, Dr Bev Rowbotham, Professor Nick Talley, Dr Michael McConnell, Dr Matthew Andrews and Associate Professor Adam Eishaug. The planned approach is the formation of MBS review working groups that report to the taskforce. Each team will comprise a Chair from relevant in-scope discipline and <50% members from the main in-scope discipline. Decisions will be made using a >60% majority of the group. The Early Clinical Committees and Review Working Groups will focus on diagnostic imaging, Obstetrics, Ear, Nose and Throat, Haematology, Respiratory and Endoscopy/Colonoscopy. The taskforce will seek representatives for the Committees from the in-scope Colleges and Societies and the AMA. The taskforce has already sought representatives from the CICM and ANZICS. Independent of the current review process we are in the early stage looking at MSAC submissions related to new procedures in intensive care.

Private Health Funds

Medibank Private has taken an aggressive approach to negotiation with private hospitals. Medibank Private's approach, which has unilaterally imposed contract terms that would penalise hospitals for events that do not take account of either clinical context or the risk profile of patients, is deeply disappointing. Under the guise of patient safety they have, Medibank has a list of 165 such events it calls 'highly preventable adverse events' which it says it will not pay for, this list can now be found on the Medibank Private website. Recently there has been an agreement between Medibank Private and the Calvary Group of hospitals. The impact on payment of Doctor fees caring for patients when there is an adverse event is still unclear.

Intensivist Scope of Practice Document

The Committee is preparing for a face to face meeting in Melbourne in late September. We are writing an Intensive Care Specialist scope of practice document for submission to the ANZICS and CICM Boards this year.

PricE Survey

The annual PricE Survey has recently been circulated and almost 100 people completed the survey in the first 24 hours. We have to strike a balance between the number of questions and a high survey completion rate. Please take time to complete the survey and send any comments or suggestions to improve the survey to ANZICS.

The PricE Committee is committed to improving the status of the specialty, ensuring adequate remuneration for intensive care specialists and monitoring the well-being of all Intensivists. If you have any comments or concerns please speak to your local representative on the Committee. Active involvement and engagement with the Committee will only strengthen it. On that note I would like to thank Michael O'Leary who has been actively involved with PricE for many years. His increasing involvement with DonateLife has forced him to step down from the Committee recently.

Mark Nicholls
Chair, PricE Committee

Safety and Quality

In 2014/2015 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 has had a very stable year, meeting regularly and reporting back to ANZICS members via the Intensivist Newsletter and Special Bulletins.

The Committee aims to promote safe, high quality care practice in Australian and New Zealand Intensive Care Units. In 2014/15 the Committee investigated members' concerns regarding the change in Noradrenaline ampule concentration and the subsequent variation in final infusion concentrations. A survey was conducted of Australian and New Zealand ICU Directors and the broader ANZICS membership to determine the current practice and interest for standardisation across Australian and New Zealand intensive care units. The results of the survey and discussion were distributed to all ANZICS members by way of a special bulletin in December 2014.

In order to meet the Committee aim to promote the use of appropriate clinical indicators when measuring and comparing practice the Committee is working more closely with CORE in regards to 'safety and quality' data. Using the ACSQHC National Standards as a guide, Jonathan Barrett took a lead role in representing the Committee and working with ANZICS CORE in reviewing and amending the questions in the annual Critical Care Resources Survey. Jonathan is also representing the Committee in the preliminary discussions with relevant stakeholders regarding the feasibility of developing a national Rapid Response System database. This project will form a major piece of work moving into the 2015/2016 year.

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) planned for submission by the end of 2015. The Steering Committee has developed questions to be answered by working parties. A letter of invitation calling for nominations for members of the working parties has been distributed to Regional Chairs and Special Interest Groups. In addition, the Steering Committee will consider applications from individuals to ensure that the most appropriate members are identified from the intensive care community. The working parties will be made up of experts in the field of RRS. The overall aim is to produce a high quality document which will provide guidance for intensive care units across Australia and New Zealand in the provision of care to the deteriorating ward patient.

The 2014 ANZICS Safety and Quality Conference: The role of intensive care with rapid response teams was held at The Park Hyatt Melbourne in July 2014. The Conference was an overwhelming success in terms of program, delegate numbers, budget and outcomes. Due to the overwhelming popularity and the capacity of the venue the organising committee were required to cap the number of delegates. This in turn led to Conference producing a better than expected profit for ANZICS. The program was designed to explore the broader role of patient safety covering topics including resourcing and staffing of RRTs. Effect on ICU workload, RRT models, and patient outcomes of RRT calls. The findings of the Conference were 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 Organising Committee was eager to provide ANZICS members and those unable to attend the Conference with opportunities to view recordings of the presentations, now many of them are available via YouTube link: https://www.youtube.com/channel/UCVU_LWubvrXrNklrEHcv7jA

I would like to acknowledge and thank all members of the Committee for all their hard work including: Alex Kazemi (NZ), Bernadette Grealy (ACCCN), David Schell (Paed), Deborah Tooley (TAS), Deepak Bhonagiri (Immediate Past Chair), Ian Seppelt (NSW), Jonathan Barrett (VIC) Krish Ponasanapolli (WA), Krishna Sundararajan (SA) and Mary Pinder (CICM) I would also like to recognise the contribution of all ANZICS members in providing feedback to the Safety and Quality Committee via the surveys we distribute. Results of the surveys help us define and develop the activities the Committee undertakes. The Committee is open to any comments or suggestions you may have and we invite you to be in touch by contacting: safetyandquality@anzics.com.au.

Angus Carter
Chair, Safety and Quality Committee

Victoria

It has been an interesting year for intensive care in Victoria, with a range of new initiatives and the re-invigoration of several existing events.

Following on from the extremely successful Melbourne ASM last year, a further major event was conducted as a collaboration between the ACCCN and ANZICS in May. The Critical Care Collaborative was a well-attended single day meeting, which explored a broad range of critical care issues in a highly engaging and often entertaining way. Feedback was very positive and many ideas will be examined for incorporation into possible future events.

Work is underway to hold a combined Adult/Paediatric Critical Care education night. It has been several years since the last highly successful event of this type and a range of topics of mutual interest will be discussed. Further details will be provided as soon as they become available.

The Victorian Intensive Care Education Network continues to be a highly successful initiative that is supported by ANZICS. Thirteen hospitals participate on a collaborative basis to provide comprehensive monthly training days for critical care trainees across Melbourne. Participating units incorporate a range of teaching styles, including small group simulation, exam preparation, communication role-plays, didactic lectures and hand-on skill labs to cover all domains of critical care practice. The annual planning meeting will be held in August to address the benefits and challenges of an expanding educational network and explore opportunities to enhance the program for participants.

The role and scope of ANZICS as it engages with international counterparts are increasingly important considerations. A number of Victorian Intensivists have contributed to strategic developments that will assist ANZICS in taking a greater role as advocate for critical care practice at a global level. This work has involved utilising existing collaborations and deepening engagement where there is mutual benefit across the domains of advancing clinical practice, research, quality & governance and training. Much of this work remains very much in progress, but it is expected that considerable progress will occur in the near term and that ANZICS will cement its role as a regional leader in critical care.

Recent months have seen the formation of a group of well-organised intensive Care Specialists and Trainees who aim to advance the role of female Intensivists. Gender imbalance across the intensive care medical workforce is a fairly stark reality and strategies to address this situation are arguably overdue. The Women in Intensive Care Group is working with the support of ANZICS to better understand the challenges facing women's advancement through training and career development in order to develop practical strategies that can lead to improved opportunities across all facets of the speciality. The ultimate aim of this endeavour is to achieve outcomes that ensure all intensive care specialists have the opportunity to achieve their full potential, regardless of gender. Several events are currently being planned and details will be circulated as soon as specific information becomes available.

In 2019, ANZICS and the ACCCN will host the WFSICCM World Congress of Intensive Care at the Melbourne Convention and Exhibition Centre. This will draw critical care delegates from around the world and provide an exciting opportunity to showcase Australasian practice and achievements. Planning for this event has commenced with a range of key decisions and strategies being organised even at this early stage. There will be ample opportunities for ANZICS members to contribute to this significant event and the organising committee will seek expressions of interest for a range of important tasks in due course.

The Victorian Regional Committee is extremely grateful for the energetic support of ANZICS staff in providing administrative assistance, advice and are range of practical supports for all of the endeavours outlined above and many more besides. The Society is extremely fortunate to have such an effective team ensuring that these vital undertakings.

Stephen Warrillow
Chair, Victoria

South Australia

Thank you to all the ANZICS members who have contributed to activities and represented ANZICS on the Committees and other Working Groups throughout the year. A great deal of work gets done behind the scenes to keep intensive care represented in the ever-changing health landscape.

I hope that the local activities that have occurred this year will continue over the next year, specifically the trainee lecture series that was a resounding success. The Organising Group would like to maintain the broad representation from each of the hospitals and would be keen to hear from senior members who would like to contribute. Other activities have included the Annual Tub Worthley Travelling Scholarship and meetings of the local ANZICS Executive to discuss future plans.

The year ahead will undoubtedly hold challenges for all intensive care units in South Australia. The move to the new Royal Adelaide Hospital is planned for early next year and will involve a ramp down of services at the RAH and consequentially increased activity at the other sites. Key elements of the move, including the establishment of the new electronic patient records in the existing RAH site prior to the move have failed to materialise. The building itself looks impressive and is nearing completion, however many clinicians are concerned by the resignation or retirement of several key senior executives who were the architects of the 2007-2016 SA Health Plan.

I look forward to seeing those who are going to Auckland for the ASM and please discuss with me any areas where you wish ANZICS to be more active locally.

Stewart Moodie
Chair, SA

Tasmania

The dominant issue in Tasmanian healthcare over the past year is the review and restructuring of health services into one "Tasmanian Health Organisation" (THO). A single THO came into being on July 1st 2015, with the three major hospitals overseen by a single Board. Senior Clinicians have long considered this a "no brainer" in a state with a widely dispersed population of only 500K, where three separate health services resulted in "siloed care", much duplication, inefficiency and inappropriate spending and some significant safety and quality concerns.

Over the past 12 - 18 months, Senior Clinicians from across Tasmania have engaged in detailed consultation with health officials through a system of state-wide, specialty-based, multidisciplinary 'Clinical Advisory Groups' (CAGs). The CAGs provided structured advice on both minimum standards and how to re-configure clinical services – the aim being an optimally cost effective, safe and sustainable health system. Finding the right balance of service availability, proximity to patients and adequate case volume for safety and quality provides considerable challenges. The result of the consultation process was a "Tasmanian Role Delineation Framework" and a "White Paper", which were both released in May and are available on the THS website. The CAGs now have ongoing advisory roles, providing a multidisciplinary collective voice from those at the front line.

The Intensive Care CAG includes the Tasmanian ANZICS Chair, all ICU Directors and Nurse Managers, CNC's, Liaison Nurses, ICU Pharmacists, Physiotherapists, and Dieticians, and Retrieval and Emergency Specialists. We provided advice for safe provision of intensive care services and outlined a clear set of recommendations for future resourcing, staffing, education and training standards. This was based around published CICM and ACCCN standards, along with local system knowledge and practices. The highly effective, collegial and collaborative functioning of this group was commended by health department officials as an example to others.

There are changes planned for surgical, trauma and emergency services that are likely to affect ICU demand around the state. This may well result in increased demand for ICU beds at both Launceston and Hobart, and possibly reduced demand in the North West. Whilst there is a commitment to maintain ICU services at Burnie, they face many challenges maintaining safe staffing and adequate caseload to maintain clinical skills. We will continue to monitor the impact of these changes in all centres, and the ICU CAG will continue to meet to advise and advocate for safe, high quality intensive care for our patients.

In addition to the restructuring of health services, we presently face a significant imbalance between demand and resources across all acute health services in Tasmania. This is especially so in Intensive Care, Emergency Medicine and Surgery. It is of concern that our main two patient sources, ED and Surgery, are simultaneously under significant stress. Health budget cuts over the past three years have occurred alongside increased demand for ICU beds in our major ICUs at Launceston General and Royal Hobart Hospitals. A big part of the workload in these two centres comes from the North West Regional Hospital, which may increase with the restructuring. Additionally, we are seeing rapidly rising MET workloads without additional resources.

Clearly, considerable challenges remain. We are fortunate to have supportive working relationships and collaboration between the three ICUs, both generally and via the CAG, and agree on many issues. Data provided via ANZICS CORE continues to help us support arguments for change. On the more positive front, we have had major upgrades to the ICU facilities and equipment at both LGH and RHH in the past couple of years. These were very much overdue, and whilst extra bed spaces aren't funded, there are more physical beds now than ever before. Staff at both units are enjoying working in their new environments.

Intensive Care training continues to be popular in Tasmania. We can consistently provide a wide range of interesting and challenging clinical cases, access to non-ICU training rotations, as well as rural and regional critical care experience and proper Senior Registrar posts with on-call components. We are in discussions about state-wide rotations to assist those wanting to do all their training here in Tasmania. BASIC courses have now been run several times in both Hobart and Launceston and are proving very popular with locally trained junior staff planning careers in one of the acute care specialties. State-wide education meetings are held from time to time, sometimes combined with ANZICS/CICM business meetings and others co-organised with ACCCN.

Society Membership has been strong and stable in Tasmania for many years now. Despite the small number of Specialists in the state, interest and enthusiasm for ANZICS Committee work has remained strong. I would like to thank all 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 or the development and profile of our specialty and I hope you will continue your generosity into the future.

David Rigg
Chair, TAS

New Zealand

The 2014-2015 year has been a good one for NZ ANZICS. Our profile in supporting education nationally continues to expand and NZ representation within ANZICS remains strong.

In November 2014, the second Biennial NZ ANZICS Research Symposium was held in Wellington, again convened by Rachael Parke and Shay McGuinness, and again providing an excellent forum for exchange of ideas between research staff from around the country. We have also supported the Wellington Intensive Care Medicine Course, convened by Chris Poynter, for a fifth year and are delighted to see that it continues to develop and expand. This year has also seen the start-up of the New Zealand branch of The Intensive Care Network, led by Rob Bevan & Ywain Lawrey, with two meetings already held in Auckland.

Several NZ ANZICS members continue to contribute much to ANZICS, notably Colin McArthur as Immediate Past Chair of the CTG. We are greatly appreciative of all the hard work done in this role by Colin. Meanwhile, Peter Hicks continues as CCR Director at CORE and Alex Psirides has done a great deal to spread the word of how NZ has developed Rapid Response Teams, and the means to provide appropriate training in the management of MET calls. Shay McGuiness (NZ Representative on the CTG), and Rachael Parke continue to produce notable research output from CVICU, Auckland. Paul Young from Wellington similarly continues to generate yet more research, questioning what we do in ICU and being invited to present at meetings such as the ISICEM in Brussels and SMACC; we currently await publication of the SPLIT Trial (Plasmalyte vs. Saline) which was done in NZ.

It has also been a very big year for our Nursing Colleagues, with the establishment of the New Zealand College of Critical Care Nurses. The ties that we have developed with the Nurses over the years, in their previous incarnation of the Critical Care Nurses Section of the NZNO will no doubt be further strengthened with the greater independence that comes with establishment of the College.

Our greatest event for this year is hosting the 40th ANZICS ASM at SkyCity in Auckland in October. The ASM is being convened largely from Middlemore Hospital, with Paediatric input from Starship. The theme is "Intensive Care-Under Pressure", with great Scientific and Social programmes to look forward to. I hope to see many of you there.

Most importantly, please remember to remind your colleagues and trainees of the good work that ANZICS does and the benefits of being a part of it by becoming a member.

Ben Barry
Chair, NZ Regional Committee

Queensland

It has been an eventful year for Queensland ANZICS. The ICU Specialists became employees of Individual Hospital and Health services while previous employment was with Queensland Health. We were all put on entirely different remuneration frameworks with individual "high income guarantee contracts". Certain benefits (Tier 3 – 25% of base salary) were set under Key Performance Indicators (KPIs) with regular review and a potential threat of losing the benefit.

However early in 2015, a Queensland state election produced a surprising result with Labour ousting the LNP government with the support of minor parties. This result has been generally good for the public hospital Doctors in Queensland. The Labour government had promised before the election that they would remove the individual contracts, re-establish independence of Queensland Industrial Relations Commission (QIRC) and reinstate collective bargaining through unions.

On 7 May 2015, the Treasurer, Minister for Employment and Industrial Relations and Minister for Aboriginal and Torres Strait Islander Partnerships introduced the Industrial Relations (Restoring Fairness) and Other Legislation Amendment Bill 2015 into the Queensland Parliament. This bill was passed on the 4th June 2015 with some amendments.

The policy objectives of the bill are as follows:

1. Restoring Fairness for Government Workers', by:

   a. reinstating employment conditions for Government workers that were lost as a result of changes to the Industrial Relations Act 1999 (IR Act) made in 2012 and 2013;

   b. re-establishing the independence of the Queensland Industrial Relations Commission (The Commission) when determining wage cases;

   c. returning The Commission to its position as a layperson's tribunal where employees and union advocates operate on a level playing field with employers; and

2. Restoring the ability of industrial organisations and their representatives to freely organise and access members so as to enhance and protect their industrial interests.

ASMOFQ (Australian Salaried Medical Officers Federation Queensland) is presently negotiating with the Department of Health and Queensland Government, a Medical Officers Certified Agreement (MOCA 4).

There was significant concern amongst the ICU Specialists that we may be forced into extended hours roster, including the weekend, with this agreement.

Queensland ANZICS was very active in lobbying ASMOFQ for the best interests of ICU Specialists in Queensland. Please note the following points:

Queensland ANZICS organised a meeting on the 10th July 2015 with ASMOFQ leadership to inform them about the concerns of ICU Specialists.

When the initial draft (section on "rostering for clinical need") was released, Queensland ANZICS, through its Chair and Deputy Chair, lobbied ASMOFQ strongly to change the wording of the draft agreement. The specific request was made that any roster changes will require agreement of the Individual ICU Specialist.

The latest draft released on 23rd July 2015 clearly states - "The written agreement of individual Senior Medical Officers will be required before they are rostered to work the proposed shifts", we believe, this clause will protect ICU Specialists and prevent individual Hospital Administrators from enforcing shift work on any Specialists.

Please note this agreement does not prevent an individual ICU to have an extended hours roster with agreement from ICU Specialists.

Queensland ANZICS will keep the members informed about this issue once the new MOCA 4 agreement is in place.

For the details of the offer, please access the following link:
HYPERLINK "https://www.health.qld.gov.au/employment/conditions/awards-agreements/senior-doctors/default.asp"
https://www.health.qld.gov.au/employment/conditions/awards-agreements/senior-doctors/default.asp

Please note the important educational activities that have taken place during this year:

ANZICS co-sponsored the CICM trainee project presentation on the evening of 7th November 2014. Dr Mbakise Pula Matebele won the prize for the best presentation, sponsored by ANZICS, to attend the ANZICS CTG meeting in Noosa.

Queensland ANZICS held an ANZICS Education Forum on Monday 2nd March, 2015. Michael Van Egdom, Portfolio Specialist, anti-infectives, Pfizer sponsored this well attended event. Dr Marion Woods, Senior Infectious Diseases Physician from the Royal Brisbane and Women's Hospital gave ICU Specialists and Trainees an update on Ebola with discussion on the importance of PPE (personal protective equipment).

Rajeev Hegde
Chair, QLD

Western Australia

During 2014-2015, Intensive Care Medicine in Western Australia has not been immune to the winds of change that have affected tertiary health care generally in this state. The two major themes have been a significant tightening of the state's finances and an enormous reconfiguration of health services, particularly in the southern and eastern corridors of Perth. The fiscal tightening is on the back of a record-breaking spell of public infrastructure spending coupled with a rapid deterioration in government revenue due to the precipitous fall in iron ore prices and consequent drastic reduction in State mining royalties. Over the last twelve months Fiona Stanley Hospital has been commissioned, Fremantle Hospital has been reduced to a specialist elective surgical, aged care, rehabilitation and psychiatric hospital, Royal Perth Hospital has been reduced in bed numbers and had services relocated and the opening of the Perth Children's Hospital has been delayed. Each of these changes has had significant impact on intensive care services and those that provide them, both in where they work and how they perform those duties.

One of the highlights has been to observe how ANZICS members, both Full and Trainee, have come together from differing sites to rapidly form a single cohesive, functional department, along with Nursing and Allied Health staff. As if the pressure of this was not enough, a clinical information system (CIS) has been developed, configured installed and commenced operations within the twelve months.

From an ANZICS perspective, one of the disappointments has been the obstruction, amongst hospital management in the new order, to clinical research. Western Australian ICUs have a fine tradition of participating in both large multi-centre trials and local investigator-initiated studies- this has been made much harder by the dysfunctional risk aversion of senior hospital staff, in addition to the problems faced at some sites of not being allowed to utilise deferred or proxy consent to trial enrolment.

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

The Intensive Care Network, led by Dr Anthony Tzannes in Western Australia has commenced holding evening educational meetings, which are proving to be very popular with both senior staff and trainees.

Western Australia is not alone in grappling with the issue of trainee numbers, the subject of a Joint ANZICS/CICM Workforce Summit last November. Department of Health figures predict a surplus of Intensivists in WA by 2021, based just on current trainee levels. Certainly, trainees should be strongly encouraged to undertake 'dual training'- although prospects in the 'other' specialty are not often definite, especially if that specialty is Emergency Medicine.

We now look forward to hosting the 2016 ANZICS/ACCCN Annual Scientific Meeting next October in Perth. Anthony Tzannes has accepted the daunting task of Medical Convenor, with Simon Erickson providing the Paediatric guidance and leadership. As in 2009, we have the responsibility of organising an exciting programme that will entice participants to make the long trip across the Nullabor.

Ed Litton continues as our CTG Executive member, whilst Krishna Ponasanapalli will be replaced by Melanie Saw as the Safety and Quality Committee member. Greg McGrath remains as our PricE representative and I remain as PricE Committee Immediate Past-Chair. There are always opportunities within ANZICS for young Specialists to step up and get involved.

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

Ian Jenkins
Chair, Western Australia

New South Wales

The Sydney Convention and Exhibition Centre is currently closed, with the redevelopment of the venue due for completion in late 2016. Hopefully the ANZICS/ACCCN ASM will then be able to return to Sydney.

There is agreement in the NSW Regional Committee that regional meetings be 'business of medicine' events with visitors of note, as the previous hospital meeting formats had inconsistent attendance. Four years ago there was concern within the membership relating to medical and drug company support. Lack of funding did not help improve attendance at meetings. NSW intensive care medical education is an incredibly full market and there are many courses and training opportunities. There was agreement that the educational focus be on topical local affairs, professional affairs, remuneration, financial discussion, advocacy and workforce. Additionally, there will always be merit in the occasional visiting speaker. Future meetings are being scheduled with the first planned for early October and then 3-4 times per year. Dinner will be sponsored.

A regional meeting was held in May 2015 with an international speaker, Dr Xavier Guasch, whose presentation "Brain Death and Organ Donation - What Can Australia Learn from Spain?" was well received. Over 20 people attended the dinner meeting which was sponsored by the NSW Organ and Tissue Donation Service.

From NSW Health there are no major issues to report. The NSW government is in the early phases of implementing iMDSoft Metavision Version 6. The system has been renamed ERIC, Electronic Record for Intensive Care, and has been delayed due to an upgrade to version 6. The early lead sites are St George Hospital, The Children's Hospital Westmead and Blacktown Hospital.

The NSW State Scope of Clinical Practice (SoCP) Unit released a discussion paper in April. The purpose is to assist NSW Health Local Health Districts and Specialty Networks (LHD/SNs) to appropriately define the scope of clinical practice of their senior medical and dental practitioners (SMDPs) by developing model SoCPs for each medical and dental specialty. The ANZICS PricE Committee is currently developing a Scope of Practice document related to Intensive Care.

A strong member base increases the strength of ANZICS as an advocate for intensive care. We need to continue to advocate for our more junior members and we will be in contact with local hospital ANZICS members to help further facilitate membership. Please do not hesitate to contact me or other members of the committee if you have any questions, comments or concerns.

Mark Nicholls
Chair, NSW

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

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

Ramesh Nagappan Education Award

Melbourne	2014	Gerard Fennessy	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 2015 and the auditor's report thereon.

Directors

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

Dr Andrew Turner President
Dr Simon Erickson Hon. Secretary
Dr Ben Barry
Dr Rajeev Hegde (appointed 6 October 2014)
Dr Kenneth John Millar
Dr Mark Nicholls (appointed 6 October 2014)
Dr David Rigg
Dr Satyadeepak Bhonagiri (resigned 6 October 2014)
Dr Mary White (resigned 6 October 2014)
Dr Marc Ziegenfuss Vice President
Dr Anthony Holley Hon. Treasurer
Dr Craig French (appointed 3 June 2015)
Dr Ian Jenkins
Dr Stewart Moodie
Dr David Pilcher
Dr Stephen Warrillow
Dr Colin McArthur (resigned 3 June 2015)

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

The short and long term objectives of the Society

Short term objectives

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

Long term objectives

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

Strategy for achieving objectives

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

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

Principal activities

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

Directors' Report

How the principal activities achieve our objectives

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

Qualifications, experience and special responsibilities of the directors

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

Dr M Ziegenfuss
Qualifications: FCICM/FRCS
Experience: Director since 2008
Special Responsibilities: Vice 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 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 I Jenkins
Qualifications: BHB/MBChB/FCICM
Experience: Director since March 2010
Special Responsibilities: Chair – WA Region

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

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

Dr M Nicholls
Qualifications: MBChB/FRCA/FCICM
Experience: Director since Oct 2014
Special Responsibilities: Chair – NSW Region

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

Directors' Report

Directors' meetings

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

Directors	Number eligible to attend	Number attended
Dr B Barry	3	3
Dr S Bhonagiri (resigned 6 October 2014)	1	-
Dr S Erickson	3	3
Dr C French (appointed 3 June 2015)	-	-
Dr R Hegde (appointed 6 October 2014)	2	2
Dr A Holley	3	2
Dr I Jenkins	3	3
Dr C McArthur (resigned 3 June 2015)	3	3
Dr KJ Millar	3	3
Dr S Moodie	3	2
Dr M Nicholls (appointed 6 October 2014)	3	3
Dr D Pilcher	3	3
Dr D Rigg	3	2
Dr A Turner	3	3
Dr S Warrillow	3	3
Dr M White (resigned 29 October 2014)	1	1
Dr M Ziegenfuss	3	3

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

The Society is incorporated under the Corporations Act 2001 and is a company limited by guarantee. Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member, for payment of the debts and liabilities of the Society (contracted before he/she ceases to be a member) and of the charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $15,240 (2014: $15,020) being 762 (2014: 751) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2015 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 Andrew Turner
President

Dr Anthony Holley
Hon.Treasurer

Dated this 17th day of September 2015

KPMG

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

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

I declare that, to the best of my knowledge and belief, in relation to the audit for the financial year ended 30 June 2015 there have been:

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

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

KPMG

Darren Scammell
Partner

Melbourne

17 September 2015

Statement of Profit or Loss and other Comprehensive Income

FOR THE YEAR ENDED 30 JUNE 2015

	Note	2015 $	2014 $
Revenue from ordinary activities	2	2,427,247	2,496,976
Employee expenses		(1,420,869)	(1,443,638)
Administration expenses		(529,775)	(550,802)
Conference and meeting expense		(287,888)	(266,240)
Travel and committee expenses		(131,770)	(181,796)
Depreciation expense		(52,095)	(38,706)
Other expenses from ordinary activities		(40,854)	(68,557)
Loss for the year		36,004	52,763
Other comprehensive income			
Items that will not be reclassified subsequently to profit or loss:			
Gains on revaluation of land and building	8(a)	-	100,626
Other comprehensive income for the year, net of income tax		-	100,626
Total comprehensive loss/(income) for the year		36,004	(47,863)

The accompanying notes form part of these financial statements.

Statement of Financial Position

AS AT 30 JUNE 2015

	Note	2015 $	2014 $
Current Assets			
Cash and cash equivalents	4	1,368,230	2,001,647
Trade and other receivables	5	92,782	179,652
Other current assets	6	50,963	53,487
Total current assets		1,511,975	2,234,786
Non-Current Assets			
Financial assets	7	575,788	-
Property, plant and equipment	8	2,586,052	2,609,198
Total non-current assets		3,161,840	2,609,198
Total Assets		4,673,815	4,843,984
Current Liabilities			
Trade and other payables	9	429,218	611,479
Employee benefits	10	245,589	192,003
Total current liabilities		674,807	803,482
Non-Current Liabilities			
Employee benefits	10	25,968	31,458
Total non-current liabilities		25,968	31,458
Total Liabilities		700,775	834,940
NET ASSETS		3,973,040	4,009,044
Equity			
Reserves	11	816,723	816,723
Retained profits		3,156,317	3,192,321
TOTAL EQUITY		3,973,040	4,009,044

The accompanying notes form part of these financial statements.

Statement of Cash Flows

FOR THE YEAR ENDED 30 JUNE 2015

	Note	2015 $	2014 $
Cash flows from operating activities			
Receipt of grants		1,113,250	1,364,007
Cash receipts from members and customers		1,335,736	984,586
Interest received		8,542	77,321
Payments to suppliers and employees		(2,492,698)	(2,613,410)
Net cash used in operating activities	12	(35,170)	(187,496)
Cash flows from investing activities			
Purchases of property, plant and equipment		(28,949)	(49,956)
Acquisition of other financial assets		(569,298)	-
Proceeds from other financial assets		-	83,001
Net cash (used in)/from investing activities		(598,247)	33,045
Net decrease in cash and cash equivalents		(633,417)	(154,451)
Cash and cash equivalents at beginning of financial year		2,001,647	2,156,098
Cash and cash equivalents at end of financial year	4	1,368,230	2,001,647

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

FOR THE YEAR ENDED 30 JUNE 2015

	Note	Related profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2013		3,245,084	716,097	3,961,181
Profit (Loss) attributable to the Society		(52,763)	-	(52,763)
Total other comprehensive income for the year	8(a)	-	100,626	100,626
Balance at 30 June 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

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

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 17th September 2015 by the Board of directors.

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

Accounting policies

(a) Revenue

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

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

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

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

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

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

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

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 2015

1. Statement of significant accounting policies (continued)

(d) Financial instruments

Initial recognition and measurement

Financial assets and financial liabilities are recognised when the entity becomes a party to the contractual provisions to the instrument. For financial assets, this is the equivalent to the date that the Society commits itself to either purchase or sell the asset (i.e. trade date accounting is adopted). Financial instruments are initially measured at fair value plus transaction costs except where the instrument is classified 'at fair value through profit or loss' in which case transaction costs are recognised immediately as expenses in profit or loss.

Classification and subsequent measurement

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

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

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

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

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

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

(ii) Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market and are subsequently measured at amortised cost. Gains or losses are recognised in profit or loss through the amortisation process and when the financial asset is derecognised.

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

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 2015

1. Statement of significant accounting policies (continued)

Derecognition

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

(e) Impairment of assets

At the end of each reporting period, the Society assesses whether there is any indication than an asset may be impaired. If such an indication exists, an impairment test is carried out on the asset by comparing the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, to the asset's carrying value. Any excess of the asset's carrying amount over its recoverable amount is recognised immediately in profit or loss, unless the asset is carried at a revalued amount in accordance with another Standard (e.g. in accordance with the revaluation model in AASB 116). Any impairment loss of a revalued asset is treated as a revaluation decrease in accordance with that other Standard. Where it is not possible to estimate the recoverable amount of an individual asset, the Society estimates the recoverable amount of the cash-generating unit to which the asset belongs.

(f) Employee benefits

Provision is made for the Society's liability for employee benefits arising from services rendered by employees to the end of the reporting date. Employee benefits that are expected to be settled within one year have been measured at the amounts expected to be paid when the liability is settled. Employee benefits payable later than one year have been measured at the present value of the estimated future cash outflows to be made for those benefits. In determining the liability, consideration is given to employee wage increases and the probability that the employee may not satisfy vesting requirements. Those cash outflows are discounted using market yields on government bonds with terms to maturity that match the expected timing of cash flows.

(g) Cash and cash equivalents

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

(h) Trade and other payables

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

(i) Goods and services tax (GST)

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

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

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

1. Statement of significant accounting policies (continued)

(j) Comparative figures

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

(k) Critical accounting estimates and judgments

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

(l) 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 Foundation. The Foundation 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 Foundation's financial statements, however it is impracticable at this stage to provide a reasonable estimate of such impact.

	2015 $	2014 $
2. Revenue and other income		
Revenue:		
Grants	1,262,157	1,472,370
Subscriptions	456,553	463,230
Surplus from ASM	171,662	105,662
Conferences and meetings	293,362	224,053
Sponsorship	129,717	107,220
	2,313,451	2,372,535
Other income:		
Interest received – cash and cash equivalents	15,244	67,597
Investment dividends and distributions	52,328	-
Unrealised gain on investments held	12,033	-
Sundry income	34,191	56,844
	113,796	124,441
Total revenue and other income	2,427,247	2,496,976
3. Expenses		
Loss on disposal of investments	5,543	-

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

	2015 $	2014 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	464,430	2,001,347
Cash on short term deposit	903,500	-
	1,368,230	2,001,647
5. Trade and other receivables		
Trade receivables	74,422	179,607
Other receivables	18,360	45
	92,782	179,652
6. Other current assets		
Prepayments – general	32,612	35,022
Prepayments and deposits - ASM	18,351	18,465
	50,963	53,487
7. Financial assets		
Available for sale financial assets		
- investments in listed Australian securities	347,776	-
- investments in managed funds	228,012	-
	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	(31,666)	(7,916)
	918,334	942,084
Total land and buildings	2,518,334	2,542,084
Plant and equipment		
Plant and equipment - at cost	203,264	220,534
Less accumulated depreciation	(135,546)	(153,420)
Total plant and equipment	67,718	67,114
Total property, plant and equipment	2,586,052	2,609,198

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

8. Property, plant and equipment (continued)

Movements in carrying amounts

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

(I) 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 Foundation. The Foundation 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 Foundation's financial statements, however it is impracticable at this stage to provide a reasonable estimate of such impact.

(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.

	2015 $	2014 $
9. Trade and other payables		
Trade creditors	17,095	8,022
Sundry creditors and accruals	52,346	19,847
Grants received in advance	119,739	268,646
Subscriptions received in advance	188,384	258,464
Sponsorship & registrations received in advance	51,654	56,500
	429,218	611,479
10. Employee benefits		
Current		
Provision for annual leave	102,746	90,205
Provision for long service leave	110,312	68,243
Other employee benefits	32,531	33,555
	245,589	192,003
Non-current		
Provision for long service leave	25,968	31,458

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

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).

	2015 $	2014 $
11. Reserves		
Asset revaluation reserve	816,723	816,723
Balance at the beginning of the year	816,723	716,097
Revaluation increment (Note 8)	-	100,626
Balance at the end of the year	816,723	816,723

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

12. Notes to the Statement of Cash Flows		
Reconciliation of cash flow from operations with loss after income tax		
Loss from ordinary activities	(36,004)	(52,763)
Add/(less) non-cash items:		
Depreciation	52,095	38,706
Loss on disposal of investments	5,543	-
Unrealised gain on investments held	(12,033)	-
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	86,870	(116,251)
(Increase)/decrease in other current assets	2,524	43,508
Increase/(decrease) in trade and other payables	(182,261)	(50,074)
Increase/(decrease) in provisions	48,096	32,379
Increase/(decrease) in other liabilities	-	(83,001)
Net cash used in operating activities	(35,170)	(187,496)

13. Related Parties

Directors

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

Dr Andrew Turner, Dr Mary White, Dr Marc Ziegenfuss, Dr Simon Erickson, Dr Ben Barry, Dr Satyadeepak Bhonagiri, Dr Craig French, Dr Rajeev Hegde, Dr Anthony Holley, Dr Ian Jenkins, Dr Colin McArthur, Dr Kenneth John Millar, Dr Mark Nicholls, Dr Stewart Moodie, Dr David Pilcher, Dr David Rigg, Dr Stephen Warrillow.

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

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

14. Key management personnel compensation

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

	2015	2014
	$	$
Key management personnel compensation	396,123	384,731

15. Financial risk management

(a) Overview

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

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

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

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

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

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

(b) Credit Risk

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

Trade and Other Receivables

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

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

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

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

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

15. 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.

16. Financial instruments

(a) Financial Assets:

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

(b) Fair value versus carrying amount

	2015 Carrying amount $	2015 Fair value $	2014 Carrying amount $	2014 Fair value $
Cash and cash equivalents	1,368,230	1,368,230	2,001,647	2,001,647
Trade and other receivables	92,782	92,782	179,652	179,562
Other current assets	50,963	50,963	53,487	53,487
Financial assets	575,788	575,788	-	-
Trade and other payables	429,218	429,218	611,479	611,479

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

Notes to the Financial Statements

FOR THE YEAR ENDED 30 JUNE 2015

16. Financial instruments (continued)

(c) Interest Rate Risk

	Carrying amount	
	2015	**2014**
	$	**$**
Floating rate instruments		
Cash and cash equivalents	464,730	2,001,647
Fixed rate instruments		
Cash and cash equivalents	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	
	2015	**2014**
	$	$
Loans and receivables	92,782	179,652

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 2015

16. 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 $
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
2014							
Trade receivables	179,607	-	178,527	-	-	1,080	178,527
Other receivables	45	-	45	-	-	-	45
Total	179,652	-	178,572	-	-	1,080	178,572

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 2015 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 2015							
Payables	429,218	429,218	335,026	94,192	–	–	–
30 June 2014							
Payables	611,479	611,479	347,924	263,555	–	–	–

17. Events subsequent to reporting date

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

18. Contingent Liabilities

There are no contingent liabilities as at 30 June 2015 (2014: $Nil).

Directors' 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 2015 and of its performance, for the financial year ended on that date; and

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

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

Signed in accordance with a resolution of the Directors.

Dr Andrew Turner
President

Dr Anthony Holley
Hon. Treasurer

Dated this 17th day of September 2015

KPMG

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

Report on the financial report

We have audited the accompanying financial report of Australian and New Zealand Intensive Care Society (the Society), which comprises the statements of financial position as at 30 June 2015, and statements of profit or loss and other comprehensive income, statements of changes in equity and statements of cash flows for the year ended on that date, notes 1 to18 comprising a summary of significant accounting policies and other explanatory information and the directors' declaration of the Society.

This audit report has also been prepared for the members of the Society in pursuant to *Australian Charities and Not-for-profits Commission Act 2012* and the *Australian Charities and Not-for-profits Commission Regulation 2013* (ACNC). *Directors' responsibility for the financial report*

The Directors of the Society are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the ACNC. The Directors' responsibility also includes such internal control as the Directors determine necessary to enable the preparation of the financial report that gives a true and fair view and is free from material misstatement whether due to fraud or error.

Auditor's responsibility

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

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

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

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

Independence

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

Auditor's opinion

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

(a) giving a true and fair view of the Society's financial position as at 30 June 2015 and of its performance for the year ended on that date; and

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

KPMG

Darren Scammell
Partner

Melbourne

17 September 2015

Appendix One - Annual General Meeting

4:45pm Friday 10th October 2014

Plenary Hall 3, Melbourne Convention and Exhibition Centre, Melbourne, Victoria

DRAFT MINUTES

1. WELCOME, PRESENT & APOLOGIES

President

Present

A/Prof Andrew Turner (President)
A/Prof Mary White
(Immediate Past President)
Dr Marc Ziegenfuss
(Hon Treasurer)
Dr Stuart Baker
Dr Jonathan Barrett
Dr Ben Barry
Dr Satyadeepak Bhonagiri
A/Prof John Botha
Prof John Cade
A/Prof Marianne Chapman
Dr David Crosbie
Dr Graeme Duke
Dr Ross Freebairn
Dr Elizabeth Fugaccia
Dr Con Giannellis
Dr Belinda Gowen (Trainee)
Dr Rajeev Hegde
Dr Kwok Ming-Ho
Dr Anthony Holley
Dr Gill Hood
Dr Ian Jenkins
Dr Daryl Jones
Dr James Judson
Dr Alex Kazemi
Dr Cameron Knott
Dr David Ku
Dr Ed Litton
Dr Emma Merry
Dr Stewart Moodie
Dr Gerry O'Callaghan
Dr Harn-Yih (Honey) Ong
Dr Laven Padayachee
Dr Vijayanand Palaniswamy (Trainee)
Dr Mathew Piercy
Dr David Pilcher
Dr Jeff Presneill
Dr Sam Radford
Dr Sumeet Rai
Dr Nicholas Randall
Prof Michael Reade
A/Prof Brent Richards
Dr David Rigg
Dr Allan Robert
Dr John Santamaria
Dr Manoj Saxena
Dr Geoff Shaw
Dr William Silvester
Dr Scott Simpson
Dr Andrew Spiers
Dr Sarah Yong (Trainee)
Dr Robert Young
A/Prof David Tuxen
Dr Stephen Warrillow

Apologies

Dr Ron Trubuhovich
Dr Simon Erickson
(Hon Secretary)
Dr Jonathan Casement
Dr Louise Trent
Dr Barbara Trytko
Dr Wade Stedman
Prof John Myburgh
Dr Louise Cole
Dr Ian Seppelt

In Attendance

Brent Kingston (Minutes)
Justin Williams (ANZICS
General Manager)

2. MINUTES OF PREVIOUS MEETING

President

Andrew Turner (AT) proposed the Minutes of the previous AGM, held Friday 18th October 2013 be accepted.

> **Motion:** The minutes are accepted as a true and accurate record of the meeting.
> **Proposed:** Mary White
> **Seconded:** Marc Ziegenfuss

Motion Carried

3. PRESIDENT'S REPORT

Hon Treasurer

AT updated on the following recent changes within the Committees of the Society:
Deepak Bhonagiri stepped down as Chair of Safety & Quality, advised Angus Carter had been elected.
Deepak Bhonagiri stepped down as Regional Chair of New South Wales, Mark Nicholls had been elected.
Rajeev Hegde is now Queensland Chair following Anthony Holley moving onto the ANZICS Executive.
Anthony Slater has stepped down as ANZPIC Chair, Johnny Millar elected.

AT updated on the ANZICS CTG celebrating their 20th Anniversary, noted the significant achievements of the group.

AT highlighted the recent awards received by ANZICS Members, John Myburgh, Order of Australia, Barry Baker and Felicity Hawker.

AT highlighted the success of the Safety & Quality Conference on Rapid Response Teams, it was noted that the 2015 event will continue the theme.

AT advised that the CTG Meetings and 2013 ASM held in Hobart were both financially successful for ANZICS.

AT updated on the proposed ANZICS/CICM Joint Workforce Summit to be held in Melbourne in November. AT advised the aim of the Summit is to evaluate the magnitude of the current workforce issue where there are a limited number of positions for Trainees. AT noted that ideally a strategy to mitigate the problem will be developed between the organisations and ensure the future of the Intensive Care Workforce.

AT advised of the proposal to create a joint working party with CICM with the aim to produce a statement or guidelines on evidence, reflectiveness and minimum standards for models of care, training, resourcing and governance.

AT noted the involvement from ANZICS over the past year, advocating during the Queensland contracts dispute and dealings with the Independent Heath Pricing Authority (IHPA) regarding ICU funding.

AT updated on the development of an MOU between ANZICS and the ANZIC-RC, noted the framework will then be used for other centres interested in collaboration.

4. TREASURER'S REPORT

Hon Treasurer

4.1 Auditors Report for 2013/2014

Marc Ziegenfuss (MZ) highlighted the higher than forecast end of year result, inclusive of unexpected costs during the financial year.

MZ attributed the increased result due to revenue generation from a strong membership drive, and conferences including the 2013 ASM and the Safety & Quality Conference.

MZ noted the need to continue encourage people to become involved in ANZICS as financial members and also through contribution to the profession.

MZ updated on the strategic change to place funds into interest gaining accounts in place of the standard accounts.

MZ advised that forthcoming financial budget has been set, with an expected $84,000 deficit. MZ noted that the ASM and Safety & Quality Conference were anticipated to produce/had produced higher than expected profits.

MZ gave thanks to Justin Williams, Brent Kingston, Joy Najm, Alexandra Reade, Don Stewart and the Executive Committee for the operational work at ANZICS House.

MZ proposed the following motion for acceptance by the Society:

Motion: The Treasurer's Report be accepted.
Proposed: Marc Ziegenfuss
Seconded: Mary White

Motion Carried

4.2 Appointment of Auditors for 2014/15

MZ proposed that KPMG remain the Society's appointed Auditors for the forthcoming year. MZ advised that the current arrangement where $5000 is paid to KPMG and $5000 is donated to the Intensive Care Foundation will no longer continue, with all funds paid directly to KPMG.

Motion: MZ proposed that KPMG remain the Society's appointed Auditors for the forthcoming year.
Proposed: John Santamaria
Seconded: David Tuxen

4.3 Membership Subscriptions 2015/16

MZ advised of the recent decision to increase ANZICS Membership prices for the first time in 7 years in line with the Consumer Price Index of 3-3.5% (CPI).

MZ noted Full Members would increase from $770 to $795, with Associate Members $320 to $350, Affiliate $100 and Trainee $100 as a conventional increase.

Motion: The proposed membership fee be increased to Full $795, Associate $350, Affiliate $100 and Trainee $100.
Proposed: Marc Zeigenfuss
Seconded: Mary White

The membership voted unanimously in support of the pricing increase.

5. MEMBERSHIP REPORT *President*

AT presented the Membership Report due to the absence of Simon Erickson.

AT highlighted the moderate growth in membership for the year. The report was taken as read.

6. ELECTION OF OFFICE BEARERS *President*

AT presented the results of the call for office-bearer positions, noted Andrew Turner (President), Marc Ziegenfuss (Vice President), Anthony Holley (Honorary Treasurer), Simon Erickson (Honorary Secretary).

Andrew Turner called for the proposal that the office-bearers be accepted by the membership.

Motion: That the nominated ANZICS Office-Bearers be accepted by the ANZICS Membership.
Proposed: John Santamaria
Seconded: Deepak Bhonagiri

Unanimous vote in support for the positions.

AT highlighted the end of the term for Mary White in the position of Immediate Past President. AT noted MW had been on the ANZICS Board since 2003 and a part of the Executive from 2009.

AT commended MW for her tireless efforts in representing and leading the Society, noting Mary White as a true ambassador for the work of ANZICS.

Motion Carried

7. ANZICS HONOUR ROLL *President*

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

- Dr Ramesh Nagappan
- Dr James Judson

AT highlighted the work completed by Ramesh with ANZICS and the ICM Course, also noting the sadness in his sudden passing.

AT presented James Judson with his previously received award in 2010, noting his absence for the presentation during that year.

8. PROFESSIONAL PRACTICE

8.1 ANZICS Clinical Trials Group *CTG Chair*

The report was taken as read.

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

The report was noted and taken as read.

DP updated on the recent decrease in the number of submissions for the CORE Dataset due to a reductionin funding from Queensland. DP advised that an increase in submissions from New Zealand over the past year had contributed to the data.

DP highlighted the efforts of Tony Slater as the Paediatric Chair over the past 15 years. DP advised that Johnny Millar has taken over as the ANZPIC Chair and will be a strong addition to the Paediatric Componentof CORE.

DP advised of a new Working Group of Clinicians to evaluate and assist when a hospital is identified as astatistical outlier. DP noted that an expression of interest would go out to the membership for the group.

DP noted a Committee evaluating the Research and Publications of CORE would also be formed via an expression of interest from the membership.

DP updated on the CERS Project, highlighting the improvements of the new system for the membership and the Intensive Care Community.

DP advised that a tender had been released for the redevelopment of AORTIC, noting the software is now out of date.

8.3 Practice and Economics Committee *PricE Chair*

Mark Nicholls (MN) noted limited success in fees when dealing with the Government over the last 10 years.

MN highlighted workforce, the out of ICU standard consultation rate, remuneration rates for the current or new ICU procedures, the ongoing issue of financial consent from the patient and the relationships with the private health funds.

The report was noted and taken as read.

8.4 Safety and Quality Committee *S&Q Chair*

The report was noted and taken as read.

8.5 Death and Organ Donation Committee *DODC Chair*

The report was noted and taken as read.

AT thanked the Committee and commended the large amount of work over the period of 4 years to create the End-of-Life Care Working Group Statement.

Bill Silvester (BS) thanked the ANZICS Board on behalf of DODC and EOLCWG for the support in creating the statement.

BS noted the large amount of time and work in creating the Statement and thanked; Stewart Moodie (Vice-Chair), Charlie Corke (CICM Rep, VIC), Malcom Fisher (NSW), Peter Saul (NSW), StephenJacobe (Paed), Dominic Wilkinson (SA), Theresa Jacques (NSW), James Judson (NZ), Stephen Streat (NZ),Brent Richards (QLD), Penny Stewart (Rural and Regional).

BS updated on the review completed by DODC in reviewing the OTA Core Family Donation Conversation Workshop.

8.6 Education Committee *Education Chair*

The report was noted and taken as read.

Gerry O'Callaghan (GOC) thanked the Education Committee and Jessyca Menzel (ANZICS) for the work completed over the past year.

GOC advised the Intensive Care Medicine Course would continue to run with the necessary support from Graeme Duke and Mary White.

GOC advised that the course is likely to be scheduled later in the year due to the increasingly congested training calendar.

11. FUTURE MEETINGS

– *40th ANZICS / ACCCN Intensive Care Annual Scientific Meeting (ASM) Skycity Convention Centre, Auckland, New Zealand 29th – 31sh October 2015*

12. OTHER BUSINESS *President*

No further business noted.

13. DATE OF NEXT MEETING

– *Friday 30th October 2015, Skycity Convention Centre, Auckland, New Zealand*

Notes

Advocate for intensive care throughout Australia and New Zealand