ANZICS

2012 Annual Report

Advocate for intensive care throughout Australia and New Zealand

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ANZICS

Advocate for intensive care throughout Australia and New Zealand

Presidents Report

The strength of our Society lies in the efforts of the members. Nowhere is this more evident than in the output of the Committees. ANZICS CORE, CTG and the Death and Organ Donation Committee continue to be major players on the national and international intensive care stage. Safety and Quality had a tremendously successful meeting in July. The Large Unit Workshop which preceded the meeting will, one hopes become a regular feature on the ANZICS calendar. The PricE Committee in response to member's requests has established a workforce interest group which we hope will help to inform us about current and future workforce numbers and working conditions. Our recently formed Education Committee is currently engaged in some really good work in informing and guiding the direction of future ASMs.

All of these endeavours are dependant on the hard work of our members but the outputs are also about answering our member's needs. In particular the Education Committee and our ongoing efforts to support our Rural and Regional members with the e-mail list and Linkpersons group have been in response to those needs. We have also put more administrative support in place to support the Committees. There is now an administrative officer at ANZICS House to support Education and DODC and we have secured ongoing support for the CLABSI project in the Safety and Quality officer. Our membership numbers are increasing and we are attracting many more trainee members. I would like to encourage members to become involved in the Committees. One of the great strengths of our Society is our regional basis and with the wealth of talent that is out there in ANZICS we should capitalize on it at every opportunity.

There have been a number of changes during the year. The ACCCN moved out of ANZICS House and we are in the midst of negotiations over the proposed move of CORE to Monash. The move to Monash appears to have been on the agenda for quite some time and is taking longer than was anticipated. It is the duty of the Board to ensure that any major change such as this is in the best interest of the Society and the members and that it is effected with minimal risk to the Society particularly in terms of finance and potential loss of intellectual property. Having said that the move to Monash has the full support of the Board.

I would ask you to read the report from our Treasurer Marc Ziegenfuss. We have had a period of relative financial stability over the past four years and have returned surpluses. We have endeavoured to use those surpluses as I have described with our new Education Committee and increased infrastructure to support all of the Committees. We are now facing a number of financial challenges. Our ASM surplus is not guaranteed. There are a number of reasons for this including increasing competition from other meetings and falling sponsorship money. There are other financial risks faced by the Society. Queensland Health has changed its funding model with a reduction of 40% in the funds paid to CORE. These same challenges are faced by many not-for-profit organisations in the current financial climate.

Currently the House is our main financial asset. Following the changes with the ACCCN and the proposed relocation of CORE the Society will have to make some decisions over the next while regarding the future of the House. For the moment therefore the Board is adopting a conservative approach to expenditure whilst we attempt to deal with some of the risks described.

The Boards of ANZICS and CICM attended an education day for Company Directors in February. There was general agreement that this was an extremely useful and informative exercise. Strong themes throughout the day seemed to me to be those of good governance and fiduciary responsibility. To that end the Board has decided to reactivate the Finance Risk and Audit committee.

The objective of that committee is to assist the Board in the discharging of all of it responsibilities with respect to overseeing all aspects of financial and non-financial management, reporting, risk control and audit functions. The membership consists of the Executive and the chairs of CORE, CTG and PricE with an additional co-opted external member.

The Independent Hospital Pricing Authority (IHPA) has recently been tasked with coming up with a funding model for ICUs. There are two aspects to this process. The first is to identify what is a 'true' ICU and the second is the payment of an additional loading which would be linked to patient complexity. As there is no single comprehensive list of intensive care units the IHPA had planned to use ANZICS CORE data. The proposed funding model was to be based largely on the College of Intensive Care Medicine classification of units as reported in the CCR survey with the additional loading being paid only to Level 3 units.

The CORE management committee and the Executive have some major concerns about this model. The CCR survey is entirely voluntary and a number of units do not participate. These units would be at a significant disadvantage as would any unit classified as Level 2 or Level 1 as they would not receive any extra funding linked to a CICM Level 3 classification. In addition, for those units who do participate in the survey ANZICS does not audit compliance with CICM standards, does not cross check self reported classifications and has no responsibility or jurisdiction for determining or maintaining CICM classifications. We shared those concerns with the IHPA, in writing on a number of occasions and at a teleconference with Dr. Tony Sherbon (Acting CEO of the IHPA).

In spite of these strongly expressed concerns the IHPA has decided to proceed with the funding model as originally

planned. They have indicated to us that they have been in communication with the states and territories and that they 'were generally supportive of using the CICM criteria in the first year'. However in response to the concerns raised for the first two funding periods 2012/2013 and 2013/2014 the IHPA has invited the jurisdictions to include any additional hospitals where they see fit. We will continue to engage with the IHPA. I believe that such engagement is important from a strategic viewpoint as we endeavour to look after our member's interests.

The ANZICS India Knowledge Exchange Initiative which took place in April was a great success. Charlie Corke, Tony Burrell, Stuart Lane and Jeremy Cohen kindly agreed to present on the Society's behalf. They each presented two talks in four different cities in India over a ten day period. It was clearly a very exhaustive programme and I am very grateful to all the speakers. I would also like to thank Deepak Bhonagiri for his hard work in bringing this initiative to fruition.

Finally I would like to thank all those who have helped me during my first term as President. First and foremost, our General Manager Erin O'Sullivan and all of her team at ANZICS House who have been a tremendous support in a task that I have at times found to be challenging but also rewarding. I am also very grateful to my colleagues on the Executive, Michael O'Leary, Andrew Turner, and Marc Ziegenfuss, the Chairs of the ANZICS Committees and our Regional Chairs on the Board. Thank you most importantly to all of the ANZICS members. After all it is about you.

Mary White
President

Treasurer's Report

The worldwide financial turmoil continues ultimately affecting all of us, however I am happy to report that the financial position of your Society is sound.

I want to congratulate the Executive and the Board for maintaining a prudent fiscal strategy in these uncertain times. Nonetheless, without the excellent leadership and management of our General Manager we would not be able to provide the financial efficiencies that we have – thank you to all office bearers and central office.

The KPMG audited financial report is included and reflects your Societies financial dealings up to June 30, 2012. I will not elaborate on this but remain open to comments.

Over the last decade, the net Assets of the Society have grown from $2.39M to $3.98M, with a 14.4% growth in the last financial year. We continue to hold significant cash reserves. Since the Society is owned by its membership we feel that members should benefit by keeping membership fees static – there has been no increase in fees since 2007.

Generally ANZICS runs a tight ship with regards to its finances and all divisions acknowledge their responsibility to the membership from the perspective of efficiency and accountability. We will look at consolidating and diversifying our revenue streams – particular areas are membership, conferences and CORE – whilst simultaneously ensuring that our operational outputs remain cost effective and are maximised. We will look at investing in projects that ensure the viability of our profession – to this end co-operative partnerships will be sought. Overall we aim to take a conservative view until the turbulences of the financial world settle.

Marc Ziegenfuss
Honorary Treasurer

ANZICS Board of Directors

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Mary White

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General Managers Report

For the past three years I have opened my report summarising the achievements of the Society over the past year. This year is no different. In what seems like only a short time, not a full 12 months, we have produced a number of key achievements and outcomes. Our continued, shared focus across the Society has been furthering the strategic plan and objectives identified by the Board at its 2010 Strategic Planning Workshop.

One of the key strategic objectives was the creation of the Education Committee. In the past 12 months the committee has undertaken an important body of work in the review of the Annual Scientific Meeting and developing a range of tools for future convenors. The recent appointment of an Administrative Assistant to support the work of the Education and Death and Organ Donation committees will see a further increase in outputs for the coming year. Similarly, the appointment of an Executive Officer to the Safety & Quality Committee has enabled the implementation of a comprehensive work plan for the committee. We have already noted an increase in capacity and outputs for the respective committees.

Once again I am happy to report that this year has been successful in respect to the productivity of the committees and regions. The ANZICS CORE Management Committee undertook to progress with the proposed relocation of ANZICS CORE to Monash University and the delivery of the current reporting system upgrade project. Both projects are key to ensuring the ongoing sustainability and future proofing of ANZICS CORE and are recognised by the Board as a high priority in the coming year. The PricE, Death and Organ Donation, Paediatric Committees and Clinical Trials Group all continued their significant work throughout the year. The achievement of the committees in representing members in professional issues is a credit to those involved and something which should be reflected on with pride. The full extent of the Committees activities and impact is evidenced throughout this report.

Increased member engagement remained a key objective. Throughout the year we sought to widen our focus in an effort to ensure that we continued to not only meet our members' needs but to also be in a position to respond to arising requests. It is encouraging therefore to see the growth in membership numbers across the regions and membership categories. This steady increase, together with the increased activity within the regions is evidence of the continued relevance of the Society to its members.

The 2011/2012 period, again saw a number of successful ANZICS meetings. The centre point of the Society's year the 36th Annual Scientific Meeting (ASM) held this year in Brisbane was a notable success. Ensuring the ongoing quality in content and relevance of the ASM to members has been identified as an important consideration by the Board and Education Committee. Each of the ANZICS meetings are central to promoting the Society and increasing its national and international profile.

Once again I would like to take this opportunity to thank the hard working staff of the Society. Their hard work and commitment ensure that the Society continues to prosper.

Erin O'Sullivan
General Manager

Membership Report

The Society has continued to grow during the financial year, with a membership of 713 across the two countries, representing an increase of over 4% over the twelve months. Membership is divided between the two countries, with 599 members in Australia and 92 in New Zealand.

The Society recognises that its future lies with current trainees and new Fellows and strategies are being developed to increase relevance for these groups. The current situation where current trainees can be disadvantaged by changes in RACP rules demonstrates the need for an active Society which can provide an independent voice for disadvantaged groups.

The Society continues to benefit all members with educational opportunities, professional development, workforce planning, industrial activities as well as research and quality assurance. As always the Society remains dependant on membership subscription income to support its works, and once again I wish to express my appreciation to all our members, Regional Chairs, LinkPersons and committee members who have helped promote and spread the word of ANZICS and the work it does for its members.

A reminder to those members with outstanding subscriptions that they can be paid online via the ANZICS website and for anyone considering joining the Society, membership forms can be downloaded from the website.

Current membership figures

Full	475
Trainee	85
1st Year Free Trainee	53
Associate	46
Affiliate	47
Honorary	7

Andrew Turner
Honorary Secretary

Committee Reports

ANZICS Centre for Outcome and Resource Evaluation

The past year has seen us enter the first year of this triennium of funding and during this year changes have begun which may significantly affect the way in which CORE is run in the future and potentially the funding structure for all of CORE's future activities.

ANZICS CORE now effectively runs four registries:

- The Adult Patient Database (APD)
- The Critical Care Resource Registry (CCR)
- The Australian and New Zealand Paediatric Intensive Care Registry (ANZPIC)
- Central Line Associated Blood Stream Infection (CLABSI) Surveillance Reporting System (new)

Over 110,000 patient episodes are submitted to the APD each year from over 140 ICUs. This includes 35 of the 37 tertiary ICUs in Australia and New Zealand. One of these is about to start submitting which leaves only one major ICU based in NSW which does not contribute data. Over 150 ICUs report to the Critical Care Resources Registry annual survey and 8 paediatric ICUs and 17 mixed adult/paediatric ICUs contribute to the Paediatric Registry.

Management and Personnel Changes

Over the past year we have said goodbye to a number of the CORE team.

Jo Craven, the Project Officer for the Critical Care Resource Survey has recently left to travel the world and we are now recruiting for this post.

Allison van Lint is away on maternity leave but we look forward to her return later this year.

In October Gail Adams who had been the manager of CORE for the previous year left to pursue new career paths. In her place we were joined by Sue Huckson who brings with her a wealth of experience working with the National Institute of Clinical Studies at the NHMRC and a focus on standards and implementation.

Kerry Lavery joined as the project officer responsible for the Adult Patient Database and focusing on outlier management.

Shaila Chavan returned from maternity leave to her position with the APD overseeing the data requests and Tamara Bucci continues to run the audit.

Jostein Saethern continues to provide programming support for AORTIC but has also more recently supported deployment of the CLABSI surveillance reporting system and has developed the new web based Critical Care Resource Registry Survey.

Jan Alexander and Shelley Treaga continue to smoothly run the Paediatric Registry from Brisbane.

Web-Based Critical Care Resource (CCR) Registry

The Critical Care Resource (CCR) Registry Survey was released earlier this year in its new web based format. The most recent CCR Report was also released in April (available on line at http://www.anzics.com.au/core/reports) and now not only includes a comprehensive overview of the resource profile of Intensive Care Medicine in Australia and New Zealand but also details changes in activity over the time. Over the five years leading up to July 2010, there has been an increase in admissions to ICU (8.3%) and bed days (10.6%) which roughly parallels the increase in population (9.6%). There has also been a corresponding increase in available ICU beds. Increases in admission numbers and available beds have been proportionately higher in New Zealand than in Australia. Both medical and nursing staffing numbers have seen greater proportional increases than the changes observed in the numbers of ICU admissions and overall population. Markers of access in and out of ICU (cancelled elective surgery and late discharge from ICU) have not changed markedly.

Central Line Associated Blood Stream Infection (CLABSI) Surveillance System

In partnership with the Clinical Informatics and Data Management Centre at Monash University, CORE has completed development on the ANZICS CLABSI Surveillance System. This forms part of a larger process to reduce CLABSIs throughout Australia and New Zealand being led by ANZICS and The Australian Commission for Safety and Quality in Healthcare. The system went live in July. Data on CLABSI rates are being submitted to ANZICS CORE either directly from participating hospitals or from jurisdictional infection control bodies. Reports will be created and made available to view later this year on the ANZICS CLABSI website (http://www.anzics.com.au/safety-quality/clab).

ANZICS CORE Annual Report

The ANZICS CORE Annual Report for 2010 was released in 2011. This detailed the activities of the ANZICS CORE registries and provided an overview of Intensive Care Medicine in Australia and New Zealand in 2010. Contributing hospitals continue to increase. Over 100,000 patient episodes were submitted to the Adult Patient Database and over 9000 to the Paediatric Registry. The report is available on line at http://www.anzics.com.au/core/reports

The 'Monash Move'

Considerable discussion has taken place over the past two years regarding the relocation of ANZICS CORE to become part of the registries group at Monash University. It is proposed that ANZICS will transfer resources (staff and technology) to The School of Public Health and Preventive Medicine at Monash University. ANZICS CORE will continue to provide registry service for the Intensive Care community but will do so now as part of the larger registry group within the university. ANZICS CORE will retain its identity within The School of Public Health and Preventive Medicine. The activities of ANZICS CORE at The School of Public Health and Preventive Medicine at Monash University will continue to be funded through agreements between ANZICS and jurisdictional health departments in Australia and New Zealand. Despite the in-principle support from the ANZICS Board, finalising agreements over governance structure, financial arrangements with Monash University and drawing up contracts are proving difficult to complete and time consuming. However this remains a priority for ANZICS and is extremely important for the sustainability and development of CORE.

Research and Publications

The research output from CORE has grown progressively over the past few years. There is now a commitment to facilitate and encourage research using CORE data. This has led to a progressive increase in publications which are listed below. Eldho Paul continues his PhD studies developing a new mortality risk model for Australia and New Zealand which we hope to be able to 'test' over the forthcoming year. The PIM3 model for Paediatric Intensive Care practice is under review for publication and numerous other research projects are in various stages of development. Over two-thirds of all CORE research projects are done in conjunction with The Australian and New Zealand Research Centre at Monash University. This collaboration and in particular the statistical input from A/Prof Michael Bailey have been pivotal in the growth of CORE's research output.

Funding Developments – A New Funding Model for Queensland and others?

ANZICS CORE is funded through agreements with jurisdictional health departments. Last year Queensland Health decided to fund only contributions from public hospitals in the state and has thus withdrawn 40% of its previous funding to ANZICS CORE. CORE has thus developed a new funding model which could be applied to private hospitals in Queensland, based on $600 per available ICU bed per year. Based on the principle that the value of an ICU bed for reporting services should be the same throughout all regions of the two countries, this figure of $600 could be applicable to all ICUs throughout Australia and New Zealand, were other jurisdictions to adopt this funding model.

Future Developments at CORE

The CORE Enterprise Reporting System is a major upgrade to the data submission and reporting processes at ANZICS CORE. This is funded by the jurisdictional governments and is likely to be developed together with The Clinical Informatics and Data Management Centre at Monash University. This is the highest priority activity for CORE over the next year. However in addition, CORE also hopes to develop collaborations with both the College of Intensive Care Medicine and the Australian Organ and Tissue Donation and Transplantation Authority.

A final word

The developments in Queensland may have huge ramifications for the way in which CORE is funded in future. As yet we do not know how many other jurisdictions would want to adopt this model. We now practise in an era where clinical governance is paramount. It is only through ongoing contribution to quality assurance and monitoring programs provided by ANZICS CORE that we can benchmark the outcomes of patients admitted to all hospitals public and private, throughout our region.

David Pilcher
Chair ANZICS CORE

APPENDIX

Scientific Publications 2011/2012

1 **Early peak temperature and mortality in critically ill patients with or without infection.** Young PJ, Saxena M, Beasley R, Bellomo R, Bailey M, Pilcher D, Finfer S, Harrison D, Myburgh J, Rowan K. *Intensive Care Med. 2012 Jan 31.*

2 **Arterial oxygen tension and mortality in mechanically ventilated patients.** Eastwood G, Bellomo R, Bailey M, Taori G, Pilcher D, Young P, Beasley R. *Intensive Care Med. 2012 Jan;38(1):91-8.*

3 **A Two-Compartment Mixed-Effects Gamma Regression Model for Quantifying Between-Unit Variability in Length of Stay among Children Admitted to Intensive Care.** Straney L, Clements A, Alexander J, Slater A. *Health Services Research 2012 May 17 [cited 2012 May 28] doi/10.1111/j.1475-6773.2012.01421.x/abstract*

4 **Mortality and intensive care volume in ventilated patients from 1995 to 2009 in the Australian and New Zealand binational adult patient intensive care database.** Moran JL, Solomon PJ. Critical Care Medicine. 2012 Mar;40(3):800–12.

5 **Prognostic models based on administrative data alone inadequately predict the survival outcomes for critically ill patients at 180 days post-hospital discharge.** Bohensky MA, Jolley D, Pilcher DV, Sundararajan V, Evans S, Brand CA. *J Crit Care. 2012 May 15. [Epub ahead of print]*

6 **Treatment limitations at admission to intensive care units in Australia and New Zealand: Prevalence, outcomes, and resource use.** Godfrey G, Pilcher D, Hilton A, Bailey M, Hodgson CL, Bellomo R. *Crit Care Med. 2012 May 11. [Epub ahead of print]*

7 **Relationship between illness severity scores in acute kidney injury.** Schneider AG, Lipcsey M, Bailey M, Pilcher DV, Bellomo R. *Crit Care Resusc. 2012 Mar;14(1):53-5.*

8 **Differences in mortality based on worsening ratio of partial pressure of oxygen to fraction of inspired oxygen corrected for immune system status and respiratory support.** Miles LF, Bailey M, Young P, Pilcher DV. *Crit Care Resusc. 2012 Mar;14(1):25-32.*

9 **The association between early arterial oxygenation and mortality in ventilated patients with acute ischaemic stroke.** Young P, Beasley R, Bailey M, Bellomo R, Eastwood GM, Nichol A, Pilcher DV, Yunos NM, Egi M, Hart GK, Reade MC, Cooper DJ; Study of Oxygen in Critical Care (SOCC) Group. *Crit Care Resusc. 2012 Mar;14(1):14-9.*

10 **Rapid Response Team composition, resourcing and calling criteria in Australia.** ANZICS-CORE MET dose Investigators, Jones D, Drennan K, Hart GK, Bellomo R, Web SA. *Resuscitation. 2012 May;83(5): 563-7. Epub 2011 Nov 6.*

11 **Mortality and intensive care volume in ventilated patients from 1995 to 2009 in the Australian and New Zealand binational adult patient intensive care database.** Moran JL, Solomon PJ; for the ANZICS Centre for Outcome and Resource Evaluation (CORE) of the Australian and New Zealand Intensive Care Society (ANZICS). *Crit Care Med. 2012 Mar; 40(3):800-12. Epub 2011 Nov 10*

12 **Omission of early thromboprophylaxis and mortality in critically ill patients: a multicenter registry study.** Ho KM, Chavan S, Pilcher D. *Chest. 2011 Dec;140(6):1436-46. Epub 2011 Sep 22.*

13 **Factors associated with increased risk of readmission to intensive care in Australia.** Renton J, Pilcher DV, Santamaria JD, Stow P, Bailey M, Hart G, Duke G. *Intensive Care Med. 2011 Nov;37(11):1800-8. Epub 2011 Aug 16.*

14 **Postoperative hypothermia and patient outcomes after elective cardiac surgery.** Karalapillai D, Story D, Hart GK, Bailey M, Pilcher D, Cooper DJ, Bellomo R. *Anaesthesia. 2011 Sep; 66(9):780-4. doi:10.1111/j.1365-2044.2011.06784.x. Epub 2011 Jun 21.*

15 **Pandemic H1N1 in children requiring intensive care in Australia and New Zealand during winter 2009".** Yung, M., Slater, A., Festa, M., Williams, G., Erickson, S., Pettila, V., Alexander, J., Howe, B., Shekerdemian, L., on behalf of the Australia and New Zealand Intensive Care Influenza Investigators, the Paediatric Study Group of the Australia and New Zealand Intensive Care Society (ANZICS) and the Clinical Trial Group of ANZICS. (2010) *Pediatrics. 2011;127;e156-e163;*

ANZICS CORE Committees

CORE Management Committee

David Pilcher (Chair & Director Adult Patient Database)
Anthony Slater (Director ANZPIC Registry)
Peter Hicks (Director Critical Care Resource Registry)
Sue Huckson (CORE Manager)
Erin O'Sullivan (ANZICS General Manager)

The National Intensive Care Registry Steering Committee

Membership of this Committee includes representatives of the jurisdictional funding bodies, members of the Australian Commission for Safety and Quality in Health Care and representatives of ANZICS. The Committee provides a mechanism for CORE to report its activities directly back to the funding bodies.

The ANZICS CORE Advisory Committee

Membership of this Committee includes regional ANZICS representatives and representation from the National Intensive Care Registry Steering Committee. The Committee provides general oversight and direction for ANZICS CORE's activities.

Paediatric Committee

I would like to begin by thanking Simon Erickson for his efforts as Chairman of the Paediatric Committee for the last five years. Simon has been very energetic and effective in representing paediatric ICU and raising issues that are important to us both within ANZICS and beyond. Fortunately Simon's involvement with ANZICS shall continue as he remains chairman of the Paediatric Study Group.

ANZPIC Registry

This year saw the publication of the 10th Annual Report of the ANZPIC registry. Commensurate with the ongoing success and growing stature of this publication, the 2010 Report contained data from not only all the stand-alone PICUs in our region, but a record number of adult or mixed ICUs that care for children. The Registry team is now busy analysing the 2011 data, with preliminary data having already been sent to contributing units. We look forward to formal publication later this year.

ANZPICR Clinical Advisory Committee

A more structured body has been proposed to provide input into strategic planning and peer review of unit identified data from the Registry. To this end the Clinical Advisory Committee has been recently convened and is comprised of representatives from each of the major PICUs in Australia and New Zealand along with a representative from an adult unit that cares for children. The first task for this newly-formed group is to review last year's data in an identifiable format prior to publication. Further objectives include the provision of advice on quality-related issues and the development of a policy for identification and management of outliers within the dataset. The Committee will report to ANZICS via the Chair of the Paediatric Committee.

Paediatric Index of Mortality (PIM) 3

The latest refinement of PIM is almost ready. Further analyses are being completed in response to reviewers' comments on the submitted manuscript.

Risk-Adjustment for Congenital Heart Surgery (RACHS)

A lot of work has been undertaken to build and validate a local RACHS model. A draft of the RACHS manuscript is almost complete.

Paediatric Studies Group

There has been a conscious move towards greater cooperation and closer association with the CTG. Ian Seppelt has been co-opted onto the PSG from the CTG Executive Committee and the PSG is looking forward to working with Ian as this collaboration develops. In addition the PSG will now have a representative on the Intensive Care Research Coordinators Interest Group (ICRCIG) Executive Committee. Claire Sherring and Carmel Delzoppo shall share this role.

Meetings

The paediatric component at the CTG meeting in Noosa was integrated with the adult meeting this year. There were five paediatric presentations in the program and this approach was very well received. A PSG business meeting was also held at Noosa with excellent attendance.

Studies

Brain Injury Studies: The Hypothermia in Traumatic Brain Injury in Children (HITBIC) manuscript is currently in preparation. Remaining funds will be used to assist in ongoing patient follow-up. The CoolKids manuscript is also close to submission. Following publication of these two trials it is likely that a meta-analysis of hypothermia trials in paediatric traumatic brain injury will be undertaken. The serum biomarkers in traumatic brain injury study is underway in some centres, with others likely to be recruiting soon.

CTG Point prevalence programme: The third combined adult and paediatric point prevalence day was completed in May 2012. Dr. Marino Festa presented an update on the Point Prevalence programme at the CTG meeting in Noosa. Dr. Festa is also planning an international point prevalence study (SAFE-EPIC), for which ANZICS have provided a seed grant of $10,000.

CLOTS study: Randomised trial of heparin versus placebo to prevent thrombosis and infection in central lines in PICU. The study is funded by a grant from the SA Womens' and Childrens' Hospital Foundation. Dr. Michael Yung is the PI. This study is currently recruiting at the 4 centres with another centre planning to begin recruiting this year.

SPICE (Sedation practices in ICU): The SPICE-paeds proposal was presented at the CTG meeting in Noosa. This is planned to be the first CTG endorsed combined adult/paediatric CTG study. The SPICE investigators have submitted a grant application to the NHMRC and are awaiting a decision. A paediatric NHMRC grant application is in preparation and will be submitted in February 2013.

ANZICS ASM

The Adelaide ASM will have a paediatric half-day preceding the opening of the adult program. The paediatric stream will then run concurrently with the rest of the meeting for the following one and a half days. Michael Yung and Peter Prager have organised the paediatric programme and have secured major international speakers in Brian Kavanagh from Toronto and Kathryn Maitland from Kenya, the principal investigator of the FEAST study.

Johnny Millar
Chair, ANZICS Paediatric Committee

Clinical Trials Group Report

The ANZICS CTG continues to be recognised as a group that conducts high quality research that is utilised by clinicians throughout the world to guide their clinical practice. In the last year, two landmark studies have been completed; the CHEST study of hydroxyethyl starch compared with normal saline for volume resuscitation and the EarlyPN study of early parenteral nutrition for patients who were not otherwise able to receive immediate enteral nutrition. These studies will be published in the near future.

The number of ICUs that are members of the CTG for 2011/12 continues to increase with 73 paid-up member units. The income from these units is essential for the CTG to operate and it is noteworthy that for every $1 in subscription income from member units over $50 has been

acquired from competitive grant funding, most of which has flown back to ICUs to support the salaries of ICU research coordinators.

On behalf of the CTG Executive I would like to thank all the member unit site investigators, in particular the research co-ordinators and the bedside clinical staff in the many ICUs, predominantly in Australia and New Zealand, for their hard work and dedication to our mission of promoting excellence in intensive care medicine and improving patient-centered outcomes. The CTG is also grateful for the wonderful relationship that has been formed with trial coordinating centres at the George Institute for International Health and the Australian and New Zealand Intensive Care Research Centre (ANZIC RC).

I would like to thank Peter Kruger and Michael Buist, who stepped down from the CTG Executive in 2011, for their contribution to the CTG over many years, but also welcome new members of the CTG Executive, Jeffrey Presneill and Scott Parkes, as representatives for Queensland and Tasmania, respectively. The workload for members of the CTG Executive is substantial and that there continues to be competition for places on the CTG Executive reflects well on the role that the committee plays in promoting research in our ICUs.

The CTG has endorsed over 70 projects and all endorsed projects that have been funded are either completed or on a pathway to completion. At this time there are 18 studies that are either funded and in start-up, recruiting, or in active follow-up and the group has now randomised more than 28,000 patients in clinical trials- substantially more patients than any other ICU-based trials network.

A large number of CTG studies are recruiting patients, including:

ARISE (early-goal directed care vs standard care for patients with severe sepsis) is well past its half-way point, with likely completion of recruitment towards the end of 2013. An interim analysis was conducted after 800 patients had been recruited and the Data Safety and Monitoring Board have recommended continuation of the trial without any type of modification.

The traumatic brain injury studies, POLAR (early hypothermia) and EPO-TBI (erythropoietin), are both recruiting well but will have an increasing number of sites outside Australia and New Zealand to facilitate recruitment and generalizability.

ADRENAL (hydrocortisone versus placebo for septic shock) went live successfully on the 13 of June 2012 and the first two patients were randomized almost instantly. Whilst this is only the pilot phase, it won't be too long before the full study commences at all sites.

More recently funded studies, TRANFUSE (fresh vs standard aged red cells), PHARLAP (open lung strategy for ARDS), BLING (infusion of beta lactam antibiotics), and HEAT (paracetamol versus placebo for fever) are all preparing to/or have commenced recruitment.

In the 17 years since the group was established it has received over $55 million in grant funding and published seven manuscripts in the New England Journal of Medicine. This represents about one quarter of all original publications in this journal in the last 10 years from Australia and New Zealand.

The quality and impact of the output of the group is a reflection of the strength of the culture of research within ICUs in Australia and New Zealand.

The publications in last year were:

- Anesthesia and Analgesia: Fluid resuscitation with 6% hydroxyethyl starch (130/0.4) in acutely ill patients: an updated systematic review and meta-analysis.
- Critical Care and Resuscitation: Enteral nutrition in Australian and New Zealand Intensive Care Units: a point prevalence study of energy delivery practices.
- Critical Care and Resuscitation: Statistical analysis plan for the Crystalloid Versus Hydroxyethyl Starch Trial (CHEST).
- Critical Care Medicine: A multicenter, randomized controlled trial comparing early nasojejunal with nasogastric nutrition in critical illness
- Critical Care Medicine: An observational study fluid balance and patient outcomes in the Randomized Evaluation of Normal vs. Augmented Level of Replacement Therapy trial.
- Critical Care Medicine: Rates and Determinants of Informed Consent in an International Thromboprophylaxis Trial
- http://www.ncbi.nlm.nih.gov/pubmed/22487223" \o "Influenza and other respiratory viruses. The impact of bacterial and viral co-infection in severe influenza.
- Journal of Critical Care: Research ethics board approval for an international thromboprophylaxis trial.

A total of four CTG endorsed project were submitted to the NHMRC for Project Grant funding. These projects were SPICE, RELIEF, IPHIVAP, and BLISS.

- SPICE is proposed to be a large scale phase III RCT that will test whether targeted light sedation, using dexmedetomidine as the sole or predominant sedative agent, will improve survival compared to standard care sedation, as otherwise specified by the treating clinician.
- RELIEF is collaboration between the ANZICS CTG and the Australian and New Zealand College of Anaesthetists Trials Group that will randomise patients undergoing elective high-risk abdominal surgery to either a conservative or a liberal fluid strategy in the operating theatre that then continues into the post-operative period including in high-dependency and intensive care areas.
- IPHIVAP is a RCT that evaluates the effectiveness of inhaled heparin to prevent ventilator-associated pneumonia.

- The BLISS Investigators have submitted for additional ongoing funding for their project. As a sub-study of ARISE, the project collects blood samples from the ARISE participants to determine if the burden of bacteria in the bloodstream of patients with septic shock is a determinant of mortality and severity of organ dysfunction.

A very substantial amount of work goes into these applications and I wish the investigators the best of luck with their applications.

The CTG was pleased to be able to announce the following studies were successful in this years round of funding from the Health Research Council of New Zealand.

- TRANSFUSE ('freshest available' vs 'standard issue' RBCs) – successful – NZ$776,000
- ADRENAL (hydrocortisone vs placebo in septic shock) – successful – NZ$775,000
- PHARLAP (lung recruitment protocol RCT in ALI/ARDS) – successful – NZ$350,000

The conference year started off on a great note with the 2nd annual ANZICS CTG Winter Research Forum being held in the Hunter Valley in August 2011. This was followed by the Spring Research Forum which was held in Brisbane in October 2011.

The highlight of the conference calendar was the 14th annual meeting on clinical trials in intensive care held in March 2012 at the Sheraton Noosa Resort & Spa. This was a busy working meeting in which new projects were presented and discussed, as well as existing studies providing updates on their progress. This was the largest meeting ever, with 88 delegates attending the Research Coordinators meeting and 207 delegates attending the main CTG meeting. A total of seven projects presented the first release of results including the Early PN trial. Niall Ferguson, from Sunnybrook in Toronto, made a fabulous contribution to the meeting, leading much of the meeting's discussion as well giving four presentations over the four days. The meeting was notable for the large number of new programmes of research that are under development in which the research question is 'home-grown'. The CTG has made the transition from a group that has excelled at undertaking large trials of questions that were developed by other investigators to now being focused predominantly on our own questions. Congratulations to David Tuxen who was awarded the 2012 Randy Chesnut Medal.

The CTG office was busier than ever with a constant stream of project and manuscript endorsements. I would also like to thank members of the research community, including many research coordinators, who now undertake project and manuscript reviews as part of the CTG endorsement process.

Sadly in November 2011 we bid farewell to our extraordinary Executive Officer, Rhiannon Tate, after almost six years of service. Thankfully Rhiannon is not lost completely to the CTG community as she is has been seen at the ANZIC-RC of late. We would like to thank Rhiannon for her dedication to the CTG mission over those years and wish her every success in the future.

In December 2011 we welcomed Donna Goldsmith to the role of Executive Officer. Donna is well known and widely respected within the ICU research community having been the Research Co-ordinator at the Austin Hospital for 10 years and the MERIT and CHEST Victorian monitor. Donna has worked more recently as the Screening and Nurse Unit Manager at Nucleus Network, Centre for Clinical Studies, a phase I clinical trial unit, in Melbourne.

The transition between executive officers has been a smooth one, facilitated by the fantastic support that Simone Rickerby our Executive Assistant provides. Thank you Simone for another fantastic year of service.

It looks like 2012/13 will be as busy as 2011/12. Keeping our mission and values in mind, we look forward to an exciting year ahead. The year will include the strategic planning day for the Executive Committee on February 20 2013. This is always a full day where we set the strategy for the CTG for the next three years.

Finally, we are also excited to announce a fresh approach to the ANZICS CTG 15th Annual Meeting on Clinical Trials in Intensive Care. Following consultation with the CTG community, the meeting will still take place in Noosa Heads; however the venue for 2013 will be the newly completed Outrigger, Little Hastings Street. The meeting will also be spanning over three full days from Thursday 7 to Saturday 9 March 2013 inclusive to accommodate for an ever increasing demand for presentation time. The research co-ordinators day will take place on Wednesday 6 March 2013. We look forward to updating you further on this conference as it draws closer.

Steve Webb
Chair, ANZICS CTG

Death and Organ Donation Committee

WHO Meeting

Geoff Dobb represented the ANZICS DODC at a forum in Montreal, 30-31 May, co-sponsored by the World Health Organization (WHO) and the Canadian Blood Services. The purpose of the forum was to develop international guidelines for the determination of death. This initiative was taken by WHO following requests from a number of countries to provide international guidelines to improve deceased organ donation. The intention of this first forum was to focus on the biological/physiological determination of death. A number of conclusions were reached and we await a full forum report, including notification of subsequent meetings. Future representation of ANZICS is welcomed.

AOTA Activity

The Australian Organ & Tissue Authority (AOTA) are progressing the development of a three-stage professional education package for family donation conversations (FDC). The stages are as follows:

Stage 1 Medical and general ADAPT

Stage 2 FDC Core workshops

Stage 3 FDC Practical workshops.

Ten FDC core workshops have been held around Australia with a total attendance of 300 clinicians (intensivists, ICU nurses, organ donor coordinators). The feedback has been unanimously positive. Both ANZICS (by W Silvester) and The College of Intensive Care Medicine (CICM) (by C Corke) are represented on the Family Conversation Steering Group to ensure that the central role of intensive care doctors in the care of critically ill patients and their families is maintained. There is also progress on the development of the 'collaborative' model of obtaining consent for organ donation, (an organ donation 'expert' conducting the organ donation discussion in collaboration with the treating intensivist) and in the 'designated requester' model (an organ donation 'expert' conducting the organ donation discussion without the treating intensivist). The former model is being developed by AOTA and will be piloted throughout Australia apart from NSW and the latter is being developed by R Herkes and will be piloted in NSW. The evaluation of both models is being supervised by an AOTA sponsored steering group (J Gillis, C Corke, H Opdam, R Herkes, W Silvester).

Medical ADAPT

The CICM have made a recommendation to radically revamp the mode of teaching of Medical ADAPT, focusing on the content theory and the competency required to diagnose brain death and transferring the teaching of the communication skills to the AOTA sponsored communication workshops. My verbal response to C Corke and D Stephens was a) one of 'in principle' support but that the proposed change would need to be endorsed by the DODC and the ANZICS Board and b) that it would be important to have adequate representation of the DODC on the CICM working party charged with changing the Medical ADAPT training. This was supported by C Corke and D Stephens.

DODC Meeting

The DODC will be meeting by teleconference in the near future to discuss the WHO meeting, the AOTA activity, the proposed changes to Medial ADAPT and the proposed changes to the chapter on diagnosis of brain death in the ANZICS Statement on Death and Organ Donation.

EOLCWG

The End of Life Care Working Group is designing a survey of ANZICS members to assess knowledge, attitudes and practice around end of life care. We wish to distribute this survey through the ANZICS email distribution list as a survey monkey. The results will inform the next meeting of the working group, at which time draft sections of the future Statement on End of Life Care, prepared by group members, will be reviewed. I welcome the provision of ANZICS administrative support for both committees and I am due to meet with Erin O'Sullivan and Chris Nash to discuss the next six months' priorities.

Bill Silvester
Chair, ANZICS DODC

Safety and Quality Committee

2011/2012 has been a year of consolidation for the Safety and Quality Committee. The Committee rewrote their Terms of Reference, including the structure and governance under which the Committee operates. In October 2011 the Committee enacted the amended Terms of Reference and called for expressions of interest from the ANZICS membership in order to reform the Committee. I wish to thank the outgoing committee members for all their hard work. I especially wish to thank Tony Burrell for his untiring dedication as a founding member in establishing the Committee but also for leading the Committee for the past six years. I am grateful Tony has agreed to continue to contribute to the Committee's work as Immediate Past Chair.

Prevention of Ventilator Associated Pneumonia in a Mechanically Ventilated Patient Consensus Statement

The Committee continues to develop the 'Prevention of Ventilator Associated Pneumonia in a Mechanically Ventilated Patient Consensus Statement'. The basis of this document is from a survey of ANZICS members in 2009 where the Committee asked members to rate recommendations they believed prevented VAP. In early 2011 the Australian Commission of Safety and Quality in Health Care published its Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010). This document recommends a number of strategies for minimising Ventilator Associated Pneumonia. The Safety and Quality Committee agreed it was important to respond to these recommendations. The Committee

aims to resurvey the ANZICS membership to confirm the recommendations made in the document.

CLABSI Prevention Project

The CLABSI Prevention Project received additional funding from the Australian Commission on Safety and Quality in Health Care (ACSQHC) to extend the project to the end of June 2012. The collaboration between the ACSQHC and ANZICS led to this successful national quality improvement project. The primary aim of the project was to reduce CLABSI in all Australian ICUs to <1/1000 line days. At the end of the project it is unclear whether this primary aim was achieved due to delays in establishment and implementation of the national database, although as jurisdictions submit their data over the coming months this will be determined. The secondary aims to facilitate a process for accurate and consistent measurement and reporting of CLABSI in ICUs throughout Australia, implementation of an agreed and evidence based guideline were achieved with the added benefit of building on many existing processes. The CLABSI website (http://www.CLABSI.com.au) has been launched and is intended to be a primary source of information and resources including the ANZICS Central Line Insertion and Maintenance Guideline, Insertion checklist and compliance calculator.

SQAO 2011 Hunter Valley NSW

The 5th International Conference on Safety, Quality, Audit and Outcomes Research in Intensive Care (SQAO) was held in the Hunter Valley, New South Wales in August 2011. This year the Committee hosted the 'Care of the Ventilated Patient Workshop'. This workshop generated lively discussion on the recommendations proposed for further development of the Consensus Statement. The forum for the workshop provides registrants with an opportunity to discuss their own work place practices with others and take the recommendations back to their institutions to promote safer, higher quality care. The success of the workshop has inspired the Committee to promote a similar workshop for the 2012 SQAO Conference. Also a first for the Committee at SQAO 2011 a 'seed grant' was offered to support research into a safety and quality project. The grant was offered to Dr Ravi Tiruvoipati for his project titled 'Evaluation of clinical outcomes and cost consequences of delayed discharge from intensive care: A multicentre prospective observational study'. The Safety, Quality, Audit and Outcomes conference again collocated with the CTG Winter meeting to produce a stimulating week of academic and practical presentations. There were over 80 registrants to SQAO this year and feedback indicated that both events were a success. The SQAO 2012 conference will be held at the Grand Hyatt in Melbourne.

Communication

The Committee has begun developing a communication strategy including establishing an ANZICS Safety and Quality BLOG located on the ANZICS website, with its own email address; safetyandquality@anzics.com.au, and can be followed on Twitter; @ANZICS_Safety.

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

Deepak Bhonagiri
Chair, S&Q Committee

PricE Committee

The PricE Committee has continued to be active over the past 12 months with a number of activities- around providing a forum for members to debate and discuss workforce issues, continuing negotiations with the Department of Human Services and with Medicare and other governmental agencies about new and existing item numbers in the Medicare schedule, and with dealing with various professional matters ranging from individuals' issues with respect to billing or rostering, to agency requests for information or assistance on a wide range of topics from coronial and medico-legal matters to informed financial consent.

Medicare Matters

Last year I reported that our Medicare submission had been essentially rejected, save for the probability that an item number relating to ward consultations would be introduced. Whilst there has been some progress on this, it has been very slow. It is likely that there eventually will be recognition of the complexity and effort required in ward consultations of acutely unwell and critically ill patients, with the introduction of an item number for Intensivist ward consultations – but there is much negotiation to be done.

The Department of Human Services (DHS) will only countenance changes to existing rebates or the creation of new item numbers, based on evidence that population-wide health-based outcomes are improved. It is exceedingly difficult to provide hard data to support arguments around practices that are intuitively beneficial, current standard of practice or simply part of the way we 'do business' e.g. MET team consultations on the ward. In addition there has been a move by the DHS over the past 12 months to start to examine existing practices and rebates. The most relevant to us in this regard was the report commissioned on the benefit or otherwise of right heart catheterisation i.e. Swan-Ganz catheterisation. The report, a link to which was provided in the last Intensivist, concluded that the benefit

and the cost-benefit of pulmonary artery catheterisation could be neither refuted nor confirmed- there will undoubtedly be no change to current arrangements. What is frustrating is the time and resources your organisation is obliged to commit to these bureaucratic cul-de-sacs to ensure a satisfactory outcome for members.

There has been no change in the definition of an ICU in the Medicare schedule despite massive changes in the way ICUs operate over the last 25 years or so. Some of the changes proposed to the definition for an ICU were not welcomed by all members- although some of the angst was due to misunderstanding as to how the changes would affect their own individual practices, when in reality very little would alter with a change to anachronistic parts of the Medicare Schedule.

Just recently we have learned, in discussions with the Australian Society of Anaesthetists (ASA) that Medicare will be removing access to the rebate for ultrasound guidance for nerve blocks and vascular access in association with anaesthesia. Partly this is in response to the large increase in use of the relevant item number. We are a relatively much smaller group an d thus a much smaller 'ship on the horizon' but it would be hard to defend many of the aspects of care that we get funded for, based on hard science and patient-based outcomes data. We must be vigilant that we are not targeted for cuts to Medicare funding that the DHS would dearly like to see enacted.

Workforce

The PricE Committee is committed to ensuring that there is a wide discussion and debate about workforce matters within the Intensive Care community and that we ensure that jurisdictions, health departments and indeed the College of Intensive Care Medicine are kept informed with fact and form policy and make decisions that affect workforce matters based on the reality in the workplace. Over the past twelve months it has become clear that there are more graduating Fellows than new full-time public hospital positions, and that Intensive Care Medicine is an increasingly popular training programme amongst junior doctors, whose numbers are increasing by up to three-fold in some States, such as Western Australia. ANZICS is the advocate for Intensive Care Medicine in Australia and New Zealand and the PricE Committee recognizes that workforce issues are important to many members and will gather data and opinions and present this information to key stakeholders. We have recently formed a mailing list, similar to the mailing lists of other committees within ANZICS to provide a forum for workforce-related discussion amongst members.

Future Directions for PricE Committee

There is a clear message from the membership that it wants ANZICS to be involved in workforce debate- discussion about what we do, where we do it and how many of us does it take to do the work and this will be the focus of the committee over the next 12 months. We will continue to work with Medicare to try to ensure meaningful outcomes in the areas discussed above. PricE will also be working to deal with smaller professional issues that may arise from time to time in an Intensivists professional life.

Ian Jenkins
Chair, PricE Committee

Education Committee

One of the core philosophies underlying the goals of the Education Committee is a simple question "How can we continually find ways in which ANZICS can offer more to its members"? It was a simple question, that the ANZICS Board felt needed careful consideration and review, and which ultimately led to the inception of the Education Committee. In this spirit, the Committee aims to continually review various facets of the complex intensive care landscape, to assist ANZICS in being a dynamic and responsive Society as it proceeds into the future. With extra administrative resources being made available to ANZICS, in the form of a new part time staff role, the Committee can set benchmarks and refine and improve the services offered by ANZICS. Administrative support, however, only goes halfway to addressing to the needs of the Committee. While the goal of the Education Committee is to serve members, we are also reliant on the feedback and active participation in the various reviews planned. Understanding just how pressured everyone is for time, the Committee would like to thank the ANZICS membership, in advance, for participation in this process. In exchange for this, we will ensure that your comments and feedback are utilised effectively to produce the outcomes that are to the mutual success of the membership and the Society. Below are some of the initiatives that have been undertaken already, and are planned for the next 12 months, to help achieve these ends.

ASM Review

Following the 2011 ASM in Brisbane, the Education Committee conducted an initial survey to gather baseline information regarding the experience, and demographic characteristics of delegates. The results were used to form some key recommendations that ANZICS can implement to help to improve both the content and form of the ASM for ANZICS members, including consideration of ways different demographics within the clinical

intensive care community can be engaged. While this in and of itself was a valuable endeavour, this is only one review. Now that we have conducted our first survey, we are more comfortably positioned to review the 2012 ASM, and begin targeting more specific information. This will become an ongoing and dynamic review and feedback cycle, whereby the Education Committee will be a conduit for ANZICS members to express their views, and help shape the future of the ANZICS/ACCCN ASM. For all who responded to surveys in 2011, either in person at the ASM, or by online survey following the meeting, we would like to thank-you for your participation. In the coming months leading up to the 2012 ASM the Committee will be appealing again for the help of the membership, and providing information on how members can become involved in this strategic review process.

ASM Database

The Education Committee would like to congratulate Liz Fugaccia and Dhaval Ghelani for all their efforts in creating a new resource for ANZICS and its members, but more specifically, for future ASM Organising Committees. Elizabeth and Dhaval have compiled a database which outlines speakers, presentation titles and subjects, for the ANZICS/ACCCN ASM for the last five years. This has been a commendable achievement for the Committee, and all the members offer their thanks to Liz and Dhaval for their work. This database currently resides at ANZICS Central, however creating online access for this database is currently being investigated, with the intention to make this available as soon as possible. It is the intention of the Committee to continue to develop this tool, and investigate platforms with which to propagate the content generated by other groups within the Society, in an active fashion, so that the experts who speak at the ASM, the Safety and Quality Committee, CTG etc become accessible to all members who may not be able to attend a particular meeting.

ANZICS LinkPersons and CME Stocktake

We have now published the ANZICS LinkPersons list on our website, available at http://www.anzics.com.au/committees/education/anzics-linkpersons. ANZICS members are encouraged to check the LinkPersons list to identify your local liaison colleague. These members are intended to be another way in which members and other intensivists can gather further information about the Society and its initiatives.

Another of the goals of the Education Committee is to position ANZICS as a first stop for its members, and other intensivists, to come and get informed about what CME is available. With this goal in mind the Committee will be conducting a review of what education and training is currently being undertaken by Committee members, LinkPersons, and colleagues. This stocktake will be in a user friendly format, allowing ease of participation. This, again, is a strategic process which will unfold over the course of this 2012 financial year, and will be an important outcome for the Committee.

If you are an expert in education and training, or simply interested in getting involved, we would like to invite you to get in touch with us by contacting; anzics@anzics.com.au and express your interest for either a future position with the Committee, or in joining the LinkPersons group.

Gerry O'Callaghan
Chair, Education Committee

Regional Reports

New South Wales Committee

ANZICS NSW has had another busy year and it is heartening to see an increased interest in the Society's activities, as well as an increase in membership applications, particularly from younger fellows. ANZICS NSW members are very active in the CTG, Safety and Quality, PricE and other ANZICS activities.

Since our last report we have conducted five education sessions. Some sessions were co-badged with CICM and attendance was good. Sessions are coordinated by individual hospitals and we try to maintain a clinical theme to most of them. We reviewed the CICM curriculum change this year at a meeting and feedback from this meeting was provided to the CICM to influence the direction of ICU training in future.

There is broad support in NSW for ANZICS to maintain an ongoing role in the professional development and welfare of intensivists. The ANZICS LinkPersons initiative has been developed to address this issue and we now have LinkPersons in a number of NSW ICUs.

We hope to conduct regional meetings in the coming year and, as always, we are keen for enthusiastic members to volunteer to become involved with ANZICS Committees at a state or bi-national level. If you are interested in joining a Committee or you have some suggestions, please don't hesitate to contact one of those named below.

Deepak Bhonagiri
Chair, NSW Regional Committee

New Zealand Committee

During the past year the membership of NZ ANZICS has continued to grow and it is particularly exciting to see the increase in trainee members which now totals 15. It is essential that we keep encouraging new intensivists to join our expanding speciality which, according to CORE data, is now growing at a rate comparable with our Australian cousins.

The annual NZ ANZICS meeting was held in Waikato in late March and was well received by those who attended. It is always encouraging to see the multidisciplinary nature of these meetings and it represents a unique opportunity to showcase 'Kiwi' critical care. The next couple of years will be a particularly busy time for conferences in New Zealand with the full CICM meeting and the federal ANZICS ASM occurring in Wellington and Auckland. It is vital that we continue to support our local meetings and I look forward to seeing you all in Dunedin (13-15 March 2013) for 'Intensive Care – At the edge'.

As the number of CTG trials and concomitant acronyms expands we find ourselves at the forefront of recruitment in multiple high quality clinical trials. For many of us, the large numbers of studies and the process of each individual study can appear daunting. As a result, there has been a call for this year's November one-day meeting to be research focused. This is currently under negotiation so please watch and use the anzics_nz email list to have your voice heard.

The annual flu season threatened to be a challenge for parts of the country and the intravenous vitamin C question was raised once again. The position of New Zealand intensivists was at least partially clarified by the Health and Disability commissioner, Anthony Hill, in a commentary piece which appeared in the June edition of the New Zealand Hospital Doctor newspaper. Those non subscribers can find the article 'Complementary choices clarified' at nzdoctor.co.nz.

Finally, I would like to congratulate James Judson who has been awarded the MNZM – 'Member of the Order' in the recent Queen's Birthday honours for his contribution to intensive care medicine.

David Knight
Chair, NZ Regional Committee

Queensland Committee

In March 2012 the Queensland State elections witnessed a landslide victory for Campbell Newman and his conservative government. Labour suffered one of the worst defeats of a state government since Federation, and the worst defeat of a sitting government in Queensland's history. With their overwhelming majority, the Newman government is introducing tough economic measures in an attempt to restore Queensland's financial health, warning us it will take several years. This will undoubtedly impact on the practice of intensive care in our state. First we saw the withdrawal of state funding for private Queensland intensive care unit ANZICS data collection. The new model calls for private hospitals to fund their own ICU data submissions to ANZICS CORE. Hospitals throughout the state are faced with significant budget cuts, but with the expectation they will continue to provide the same level of care to Queenslanders. Already non clinical service providers have been axed and almost certainly more are to follow. Sadly we have also lost the Queensland Trauma Registry (QTR). Despite the best efforts of the Centre of National Research on Disability and Rehabilitation Medicine (CONROD) and the Queensland Trauma Registry, the decision was made to cease funding of the QTR beyond 30 June 2012. It is in this financial climate that conditions of service for Queensland State doctors are currently being renegotiated and an agreement satisfactory to all stakeholders will hopefully be very close.

The Queensland Medical community has again been the subject of whistleblower allegations of gross and largely ignored medical malpractice within the state health system. The parliamentary crime and misconduct committee recently released Judge Richard Chesterman's report recommending the appointment of a criminal lawyer to review all cases where patients have been injured or died in Queensland over the past five years and where doctors have been disciplined. The intention of the review is to determine whether criminal charges are required. Intensive care medicine, by virtue of frequently being integral in end of life care, is particularly vulnerable. It behoves each and every one of us to be thoughtful, consultative, follow due process while always respecting the wishes and dignity of our patients.

This year has seen a number of intensivist appointments to regional and rural Queensland. Possibly a sign of the increasing intensivist numbers, furthermore many of these positions have been highly competitive. The presence of specialist intensivists in regional Queensland will surely see an improvement of care of the critically ill in these centres.

The Queensland training Pathway has continued to very effectively coordinate the state-wide intensive care training scheme. The advantages of such a system have been clear to all involved. Individual trainees have been assisted to navigate through appropriate hospitals and departments to maximise their training experience. Opportunities for trainees have been created in a range of facilities and this centrally directed process has ensured Queensland remains a popular state for registrars to undertake their training.

The state-wide ICU CIS continues to be rolled out and not unexpectedly such a huge change in practice is accompanied by teething problems. An updated software for prescribing medications should resolve most of the users' concerns.

Queensland is blessed with a very active intensive care research group, who continue to generate world class research and attract major grant funding. In this regard special thanks must go to Dr Peter Kruger who did a tremendous job as the Queensland ANZICS CTG representative. We welcome Dr Jeffery Presneill to the position and commend the enthusiasm he has already demonstrated.

This year the co-badged CICM /ANZICS Registrar Research Forum was again run in November, designed to encourage an interest in research among Queensland registrars and specialists. The forum provides an opportunity for established researchers to mentor and encourage new researchers. Not only was the meeting well received it also provided an excellent venue for formal projects to be presented. Queensland ANZICS has a strong and stable membership that represents the members' interests in a range of activities, including safety, quality, research and private practice. In the current climate, membership is more relevant than ever.

Anthony Holley
Chair, QLD Regional Committee

South Australia Committee

For much of 2012 ANZICS SA has remained focused on the upcoming 37th ASM. The Committee, chaired by Ken Lee, has been very busy organising what hopefully will be a successful meeting. We look forward to presenting a packed scientific and social program in the beautiful city of Adelaide. For the scientific program Adam Deane has put together an excellent mix of respected international and national speakers that I imagine will leave the delegates spoilt for choice. This will be matched by an exciting social program, organised by Nick Edwards, that aims to embrace the theme 'ICU- It's not all black and white'. Sponsorship has been slow which partly reflects the tougher economic conditions all industries are facing, it does however highlight the need for perhaps a more imaginative approach to attracting the trade and maybe a more structured approach in engaging potential sponsors.

Other Adelaide ANZICS activities have included the 5th annual Tub Worthley travelling scholarship, which continues to produce high quality registrar presentations. This event is always well attended and provides a great platform for registrars to present their work in a formal setting. Many of the participants have subsequently gone on to present at the ASM including success at the Matt Spence medal. Equally, a co-badged meeting with CICM to discuss the new curriculum was well attended and productive, members however remain interested to see the impact of the extra workload on the teachers and SOT's.

Local matters that ANZICS remains involved with include the change in intensive care services that are associated with the new SA health plan. Many matters remain unresolved but ANZICS SA will closely follow developments. ANZICS SA members remain supportive of those trainees affected by the recent RACP decision on dual training. Such changes will have a huge effect on those individuals affected and ANZICS SA remains hopeful that the final decision will allow them to complete their training under the same rules they embarked with.

Stewart Moodie
Chair, SA Regional Committee

Tasmania Committee

Tasmanian ANZICS membership remains strong, considering there are only a dozen Intensive Care Specialists spread across three units. To maintain viable critical care services, support from our Anaesthetic colleagues is essential at both Launceston and North West Regional Hospitals. ANZICS educational support for these colleagues is important and we are considering ways to develop more engagement and education with them moving forward.

Enthusiasm for involvement in ANZICS affairs by our small pool of specialists is encouraging, with Scott Parkes recently joining the ANZICS CTG Executive and both Mike Buist and Benoj Varghese on the Safety and Quality Committee. Andrew Turner has been a member of the ANZICS Executive in different roles for many years now and his contributions there have been significant. Alan Rouse has been our CORE representative for several years now.

Health system restructuring and massive budget cuts, widely reported over the past year, continue to pose much pressure on critical care service across Tasmania, and many challenges remain. This remains very frustrating for all those working in critical care in Tasmania, with services being maintained through dedication and much hard work from our nursing and medical colleagues despite significant cuts.

Over the past year significant progress has been made in the Royal Hobart Hospital redevelopment and the new facility should be open by the end of the year. This has posed unique challenges with the current ICU needing to fully function as the re-build occurs both around and within the current workspace.

Interest in intensive care training in Tasmanian hospitals continues to increase and our trainees are also joining as ANZICS members. Interest from specialists in training and education remains strong, with plans to introduce BASIC courses next year and ongoing discussion around a statewide training rotation scheme, which would fit nicely with the new CICM curriculum.

Statewide meetings continue to be run in conjunction with College affairs, with plans for this year's AGM in September.

The 2013 ANZICS ASM will be held in Hobart. Andrew Turner and I are leading the local organizing Committee and are engaging with the new ANZICS Education Committee to develop an innovative and exciting scientific program. Hobart is a small vibrant city and past meetings have always been well remembered for exceptional social events. This promises to be an exciting event once again.

David Rigg
Chair, TAS Regional Committee

Victoria Committee

The last 12 months have seen a range of interesting developments for Victorian Intensivists. These range from expanded conjoint educational opportunities through to advocating for members affected by changing recognition of specialist qualifications.

Melbourne's bid to host the WFSICCM 2015 or 2017 Congress was not successful, but given the highly positive feedback provided by the World Federation board, another bid will be organised in an attempt to win the 2019 event. The considerable support from government, specialist colleges, industry and ANZICS members is sound justification for taking on this considerable task and promoting Australia as a worthy host for this prestigious event.

Critical Care education has been well served with a range of activities in the last year. Several evening sessions have been conducted and provide excellent opportunities to learn beyond the usual boundaries of speciality craft groups. A session exploring important issues of relevance to paediatric and adult intensivists was highly successful and demonstrates further potential for cross-over in future. The Royal Children's PICU team provided a stimulating and challenging perspective on several critical care themes which provoked a great deal of discussion within the largest attendance achieved thus far at such a forum. An up coming event shared with the Thoracic Society is expected to achieve similar success. Ramesh Nagappan convened another well-attended Intensive Care Medicine Course, with registrants from emergency medicine, anaesthesia, internal medicine and intensive care. The course seeks to provide a broadly comprehensive update on relevant topics, which invites attendees to reflect on evidence and clinical practice. The monthly citywide trainee education days continue to be successful with the involvement of six centres. The varied program and utilisation of centre-specific expertise remains a strong factor contributing the program's effective engagement with trainees.

Victorian ANZICS members have provided feedback to colleges including the CICM and the RACP in recent times on a range of issues relating to training and specialist qualifications. These issues have the potential to have a significant impact on the future of critical care practice and are of keen interest to all intensivists. As the leading advocate for intensive care, ANZICS members play an important role in identifying and supporting strategies that strengthen and protect the current high standards of critical care within our region.

The next year will no doubt see further challenges for intensive care arising from diverse pressures including economic, ethical and technological. The vibrant and collegial nature of intensive care practice in Victoria suggests we are well placed to meet them. On behalf of all Victorian members I would like to thank the ANZICS executive and staff for their unwavering enthusiasm and support this year.

Stephen Warrillow
Chair, VIC Regional Committee

Western Australia Committee

During the 2011-2012 period, Western Australians continued to fill many busy roles within ANZICS , as well as representing the interests of Intensivists at various levels. Prof Geoff Dobb, a past ANZICS President was re-elected to the position of Vice President of the Australian Medical Association, the first Intensivist to hold such a high office in the AMA. He has also, within Western Australia, been appointed as Chair of the Southern Country Health Service Governing Council. Prof Steve Webb continues as the incumbent CTG Chair; our current CTG Executive member remains Ed Litton, whilst KM Ho is the CORE member and John Lewis has replaced Brad Power as the Safety and Quality committee representative. I would like to take this opportunity to thank Brad for his long and enthusiastic service and astute input into the S&Q committee as Western Australia's representative. Greg McGrath is Western Australia's PricE Committee representative whilst I occupy the Chair of that committee.

Locally we have had excellent research meetings throughout the year at which our research coordinators,

research directors from the tertiary centres, the CTG Chair and Executive representative and other parties interested in research all meet. These evening meetings, which are kindly supported by industry, are superbly organised and scheduled by Brigit Roberts from Sir Charles Gairdner Hospital.

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

We have continued to have meetings of the HODs of the three adult tertiary ICUs and one paediatric ICU in Perth during the past year to discuss a range of common issues such as the future planning of ICU services, rural and regional patient transfer to the metropolitan area, development of HDU/Level I ICUs at metropolitan hospitals, training and workforce and a uniform CIS across all urban ICUs.

Western Australia ANZICS continues to represent members interests at a state level as an advocate for Intensive Care. The limited size of the committee does make it difficult to represent our interests at a state level if and when opinions are sought by various bodies including government. Instead, as in many states, individuals are approached to represent our craft group at different times and levels.

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

Ian Jenkins
Chair, WA Regional Committee

ANZICS Awards

Matt Spence Medal

The Matt Spence Award is 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 Vankatesh	Brisbane
1997	Dr D Blythe	Perth
1998	Dr N Edwards	Adelaide
1999	Dr V Pellegrino	Melbourne
2000	Dr I Seppelt	Canberra
2001	Dr R Fregley	Waikato
2001	Dr B Mullan (special)	Sydney
2002	Dr D Collins	Perth
2003	Dr N Blackwell	Cairns
2004	Dr V Campbell	Melbourne
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

Past Presidents

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

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

ANZICS Honour Roll

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

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 2012 and the auditor's report thereon.

Directors

The names of each person who has been a director of the Society at anytime during or since the end of the year and the period for which the person was a director are as follows:

Dr Mary G White President
Dr Michael O'Leary Immediate Past President
Dr Andrew J Turner Hon. Secretary
Dr Marc Ziegenfuss Hon.Treasurer
Dr Satyadeepak Bhonagiri
Dr Anthony Holley
Dr Ian Jenkins
Dr David Knight *(appointed 20 Feb 2012)*
Dr Kenneth John Millar *(appointed 20 Feb 2012)*
Dr Stewart Moodie *(appointed 20 Feb 2012)*
Dr David Pilcher
Dr David Rigg
Dr Stephen Warrillow
Dr Steven Webb
Dr David Durham *(resigned 20 Feb 2012)*
Dr Simon Erickson *(resigned 20 Feb 2012)*
Dr Janet Liang *(resigned 20 Feb 2012)*

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

The short and long term objectives of the Society

Short term objectives

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

Long term objectives

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

Strategy for achieving objectives

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

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

Principal activities

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

Directors' Report

How the principal activities achieve our objectives

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

Qualifications, experience and special responsibilities of the directors

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

Dr M O'Leary
Qualifications: MRCS/LRCP
Experience: Director since 2004
Special Responsibilities: Immediate Past President

Dr A J Turner
Qualifications: MBBS/BMed Sci/FRACP/FCICM
Experience: Director since 1999
Special Responsibilities: Hon. Secretary

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

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

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

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

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

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

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

Dr S Webb
Qualifications: MBBS/PhD/FJICM/FRACP
Experience: Director since July 2009
Special Responsibilities:
Chair – Clinical Trials Group Committee

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

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

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

Directors' Report

Directors' meetings

The numbers of directors' meetings and number of meetings attended by each of the directors of the Society during the financial year were:

Directors	Number eligible to attend	Number attended
Dr S Bhonagiri	3	2
Dr D Durham *(resigned 20 Feb 2012)*	2	1
Dr S Erickson *(resigned 20 Feb 2012)*	2	2
Dr C French *– Proxy for Dr S Webb*	2	2
Dr A Holley	3	2
Dr I Jenkins	3	3
Dr J Liang *(resigned 20 Feb 2012)*	2	1
Dr D Knight *(appointed 20 Feb 2012)*	2	2
Dr KJ Millar *(appointed 20 Feb 2012)*	2	2
Dr S Moodie *(appointed 20 Feb 2012)*	2	2
Dr M O'Leary	3	3
Dr D Pilcher	3	3
Dr D Rigg	3	2
Dr A J Turner	3	3
Dr S Warrillow	3	1
Dr S Webb	3	1
Dr M G White	3	3
Dr M Ziegenfuss	3	3

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

Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member, for payment of the debts and liabilities of the Society (contracted before he/she ceases to be a member) and of the charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $14,060 (2011: $13,640) being 703 (2011: 682) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2012 has been received and can be found on page 4 and forms part of the directors' report.

Signed in accordance with a resolution of the Board of Directors.

Dr Mary White
President

Dr Marc Ziegenfuss
Hon.Treasurer

Dated this 31st day of August 2012.

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

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

I declare that, to the best of my knowledge and belief, in relation to the audit for the financial year ended 30 June 2012 there have been:

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

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

KPMG

Darren Scammell
Partner

Melbourne

31 August 2012

Statement of Comprehensive Income

for the year ended 30 June 2012

	Note	2012 $	2011 $
Revenue from ordinary activities	2	2,321,610	2,210,365
Employee expenses		(1,122,687)	(1,092,672)
Administration expenses		(466,701)	(334,420)
Conference and meeting expense		(313,100)	(279,700)
Travel and committee expenses		(116,736)	(145,022)
Depreciation expense		(46,449)	(52,756)
Other expenses from ordinary activities		(41,262)	(83,756)
Profit for the year		214,675	222,039
Other comprehensive income			
Net gain on revaluation of non-current assets	8	288,005	-
Other comprehensive income for the year, net of income tax		288,005	-
Total comprehensive income for the year		502,680	222,039

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2012

	Note	2012 $	2011 $
Current Assets			
Cash and cash equivalents	4	2,107,514	1,701,895
Trade and other receivables	5	183,044	216,008
Other investments	6	81,026	95,434
Other current assets	7	90,297	103,117
Total current assets		2,461,881	2,116,454
Non-Current Assets			
Other investments	6	16,521	15,724
Property, plant and equipment	8	2,519,439	2,267,846
Total non-current assets		2,535,960	2,283,570
Total Assets		4,997,841	4,400,024
Current Liabilities			
Trade and other payables	9	784,367	682,834
Employee benefits	10	119,163	113,306
Total current liabilities		903,530	796,140
Non-Current Liabilities			
Employee benefits	10	37,009	34,854
Income fund liability	6	81,026	95,434
Total non-current liabilities		118,035	130,288
Total Liabilities		1,021,565	926,428
Net Assets		3,976,276	3,473,596
Equity			
Reserves	11	716,097	428,092
Retained profits		3,260,179	3,045,504
Total Equity		3,976,276	3,473,596

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2012

	Note	2012 $	2011 $
Cash flows from operating activities			
Receipt of grants		1,318,281	1,155,302
Cash receipts from members and customers		1,094,864	1,026,300
Interest received		126,907	66,269
Payments to suppliers and employees		(2,124,395)	(1,807,794)
Net cash provided by operating activities	12	415,657	440,077
Cash flows from investing activities			
Purchases of property, plant and equipment		(10,038)	(6,603)
Net cash used in investing activities		(10,038)	(6,603)
Net increase in cash and cash equivalents		405,619	433,474
Cash and cash equivalents at beginning of financial year		1,701,895	1,268,421
Cash and cash equivalents at end of financial year	4	2,107,514	1,701,895

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2012

	Note	Retained profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2010		2,823,465	428,092	3,251,557
Profit attributable to the Society		222,039	-	222,039
Total other comprehensive income for the year		-	-	-
Balance at 30 June 2011		3,045,504	428,092	3,473,596
Profit attributable to the Society		214,675	-	214,675
Total other comprehensive income for the year	8	-	288,005	288,005
Balance at 30 June 2012		3,260,179	716,097	3,976,276

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

for the year ended 30 June 2012

The financial statements are for Australian and New Zealand Intensive Care Society (the "Society") as an individual entity, incorporated and domiciled in Australia. The Society is a company limited by guarantee. The registered office and principal place of business of the Society is 10 levers Terrace Carlton, Victoria, 3053.

1. Summary of significant accounting policies

Basis of Preparation

Australian and New Zealand Intensive Care Society has elected to early adopt the Australian Accounting Standards – Reduced Disclosure Requirements as set out in AASB 1053: Application of Tiers of Australian Accounting Standards and AASB 2010-2: Amendments to Australian Accounting Standards arising from Reduced Disclosure Requirements. As a consequence, the entity has also adopted AASB 2011-2: Amendments to Australian Accounting Standards arising from the Trans-Tasman Convergence Project – Reduced Disclosure Requirements. This is because the reduced disclosure requirements in AASB 2011-2 relate to Australian Accounting Standards that mandatorily apply to annual reporting periods beginning on or after 1 July 2011.

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards – Reduced Disclosure Requirements of the Australian Accounting Standards Board and the Corporations Act 2001. The company is a not-for-profit entity for financial reporting purposes under Australian Accounting Standards.

Australian Accounting Standards set out accounting policies that the AASB has concluded would result in a financial report containing relevant and reliable information about transactions, events and conditions. Material accounting policies adopted in the preparation of this financial report are presented below and have been consistently applied unless otherwise stated. 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 financial statements were authorised for issue on 31st August 2012 by the directors of the company.

Accounting policies

(a) Revenue

Revenue from the sale of goods is recognised upon delivery of goods to customers. 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.

Grant revenue is recognised in the income statement 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 balance sheet as a liability until the service has been delivered to the contributor, otherwise the grant is recognised as income on receipt.

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

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

(b) Taxation

The Society is endorsed as an income tax exempt charity under Subdivision 50-B of the Income Tax Assessment Act 1997. As such, the financial statements make no provision for income tax.

(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.

Land and buildings

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.

Increases in the carrying amount arising on revaluation of land and buildings are credited to a revaluation reserve in equity. Decreases that offset previous increases of the same classes of assets are charged against revaluation reserves directly in equity; all other decreases are charged to the Statement of Comprehensive Income.

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 a cost basis less accumulated depreciation and impairment losses.

The carrying amount of plant and equipment is reviewed annually by directors to ensure it is not in excess of the recoverable amount from these assets. The recoverable amount is assessed on the basis of the expected net cash flows that will be received from the assets employment and subsequent disposal. The expected net cash flows have been discounted to their present values in determining recoverable amounts.

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 each balance sheet date.

(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 expensed to profit or loss immediately.

Classification and subsequent measurement
Financial instruments are subsequently measured at either fair value, amortised cost, using the effective interest rate method or cost. Fair value represents the amount for which an asset could be exchanged or a liability settled, between knowledgeable, willing parties. 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; plus or minus the cumulative amortisation of the difference, if any, between the amount initially recognised and the maturity amount calculated using the effective interest rate method; and less any reduction for impairment.

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 value with a consequential recognition of an income or expense in profit or loss.

(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, or where they are 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.

(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 entity's intention to hold these investments to maturity. They are subsequently measured at amortised cost.

(iv) Available-for-sale financial assets
Available for sale financial assets 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.

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

Impairment
At each reporting date, the entity assesses whether there is objective evidence that a financial instrument has been impaired. In the case of available-for-sale financial instruments, a prolonged decline in value of the instrument is considered to determine whether an impairment has arisen. Impairment losses are recognised in the Statement of Comprehensive Income.

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 entity 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 either discharged, cancelled or 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 each reporting date, the entity reviews the carrying values of its tangible and intangible assets to determine whether there is any indication that those assets have been impaired. If such an indication exists, the recoverable amount of the asset, being the higher of the asset's fair value less costs to sell and value in use, is compared to the asset's carrying value. Any excess of the asset's carrying value over it's recoverable amount is expensed to the Statement of Comprehensive Income.

Where the future economic benefits of the asset are not primarily dependent upon the asset's ability to generate net cash inflows and when the entity would, if deprived of the asset, replace its remaining future economic benefits, value in use is determined as the depreciated replacement cost of an asset. Where it is not possible to estimate the recoverable amount of an asset's class, the entity estimates the recoverable amount of the cash-generating unit to which the class of assets belong. Where an impairment loss on a revalued asset is identified, this is debited against the revaluation reserve in respect of the same class of asset to the extent that the impairment loss does not exceed the amount in the revaluation reserve for that same class of asset.

(f) Employee benefits

Provision is made for the entity's liability for employee benefits arising from services rendered by employees to balance sheet date. Employee benefits expected to be settled within one year together with benefits arising from wages, salaries and annual leave which may be settled after one year, have been measured at the amounts expected to be paid when the liability is settled. Other employee benefits payable later than one year have been measured at the net present value.

Contributions are made by the entity to an employee superannuation fund and are charged as expenses when incurred.

(g) Cash and cash equivalents

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

(h) 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. In these circumstances the GST incurred is recognised as part of the cost of acquisition of the asset or as part of an item of the expense. Receivables and payables in the Statement of Financial Position are shown inclusive of GST. Cash flows are included in the statement of cash flows on a gross basis, except for the GST component of investing and financing activities, which are disclosed as operating cash flows.

(i) Comparative figures

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

(j) Trade and other payables

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

(k) Critical accounting estimates and judgments

The directors evaluate estimates and judgments incorporated into the financial report 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.

Impairment
The Society assesses impairment at each reporting date by evaluation of conditions and events specific to the Society that may be indicative of impairment triggers. Recoverable amounts of relevant assets are reassessed using value-in-use calculations which incorporate various key assumptions.

Notes to the Financial Statements
for the year ended 30 June 2012

	2012 $	2011 $
2. Revenue and other income		
Revenue:		
Grants	1,124,499	1,038,524
Subscriptions	448,748	466,799
Surplus from ASM	137,236	178,805
Conferences and meetings	324,909	228,951
Sponsorship	142,182	141,141
	2,177,574	2,054,220
Other income:		
Interest received – cash and cash equivalents	101,977	86,960
Interest received – held to maturity investments	1,141	1,099
Rent received	14,771	23,794
Sundry income	26,147	44,292
	144,036	156,145
Total revenue and other income	2,321,610	2,210,365

3. Auditor's remuneration

The auditors of the Society for the year ended 30 June 2012 are KPMG whose fee is waived on the provision that the Society donates $10,000 to the Australian and New Zealand Intensive Care Foundation on KPMG's behalf. This arrangement remains unchanged from the year ended 30 June 2011.

	2012 $	2011 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	386,554	363,693
Cash on short term deposit	1,720,660	1,337,902
	2,107,514	1,701,895
5. Trade and other receivables		
Trade receivables	178,492	188,734
Other receivables	4,552	27,274
	183,044	216,008

Notes to the Financial Statements
for the year ended 30 June 2012

6. Financial assets

Current:

Held to maturity financial assets		
- Australians Donate Education Fund (i)	81,026	95,434

(i) ANZICS manages a grant provided by Australians Donate Inc. for the establishment of an Australians Donate Education Fund to be used for educational purposes with the aim of improving the quality of Human Organ and Tissue Donation. The funds are held in trust by ANZICS, and are expended at the discretion of an "allocation group" established to approve submissions for the allocation of funds. ANZICS cannot use the funds for administrative costs or travel or meeting expenses, and any interest accrued on the funds must be used for the specific purposes described above. Funds on hand have been invested in a 6 month term deposit with ANZ at 4.75% p.a.

	2012 $	2011 $

6. Financial assets *(continued)*

Non-current:

Held to maturity financial assets		
- NZ Debentures (Balanced Fund)	16,521	15,724

7. Other current assets

Prepayments – general	86,797	72,850
Prepayments and deposits - ASM	3,500	30,267
	90,297	103,117

8. Property, plant and equipment

Land and buildings

Freehold land – at valuation	1,540,000	1,210,000
Buildings – at valuation	970,000	1,099,000
Less accumulated depreciation	(20,208)	(82,425)
	949,792	1,016,575
Total land and buildings	2,489,792	2,226,575

Plant and equipment

Plant and equipment - at cost	208,915	205,359
Less accumulated depreciation	(179,268)	(164,088)
Total plant and equipment	29,647	41,271
Total property, plant and equipment	2,519,439	2,267,846

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
2012			
Balance at 1 July 2011	2,226,575	41,271	2,267,846
Additions	-	10,037	10,037
Revaluation increment	288,005	-	288,005
Depreciation for the year	(24,788)	(21,661)	(46,449)
Balance at 30 June 2012	2,489,792	29,647	2,519,439
2011			
Balance at 1 July 2010	2,254,050	60,788	2,314,838
Additions	-	6,603	6,603
Disposals/write-offs	-	(839)	(839)
Depreciation for the year	(27,475)	(25,281)	(52,756)
Balance at 30 June 2011	2,226,575	41,271	2,267,846

8. Property, plant and equipment *(continued)*

Asset revaluations

The freehold land and buildings were independently revalued on 23 August 2011 by Opteon. The critical assumptions adopted in determining the valuation included the location of the land and buildings, the current demand for land and buildings in the area and recent sales data for similar properties. The valuation resulted in a revaluation increment of $288,005 being recognised in the asset revaluation reserve for the year ended 30 June 2012.

	2012 $	2011 $
9. Trade and other payables		
Trade creditors	34,301	25,786
Sundry creditors and accruals	37,453	95,079
Grants received in advance	367,460	173,678
Subscriptions received in advance	285,070	309,332
Sponsorship & registrations received in advance	60,083	78,959
	784,367	682,834
10. Employee benefits		
Current		
Provision for annual leave	89,649	77,246
Other employee benefits	29,514	36,060
	119,163	113,306
Non-current		
Provision for long service leave	37,009	34,854

Notes to the Financial Statements
for the year ended 30 June 2012

Provision for long-term employee benefits

A provision has been recognised for employee entitlements relating to long service leave. 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 on historical data. The measurement and recognition criteria relating to employee benefits have been included in Note 1 to this report.

	2012 $	2011 $
11. Reserves		
Asset revaluation reserve	716,097	428,092
The asset revaluation reserve records the revaluations of non-current assets.		
Balance at the beginning of the year	428,092	428,092
Revaluation increment (Note 8)	288,005	-
Balance at the end of the year	716,097	428,092
12. Notes to the Statement of Cash Flows		
Reconciliation of cash flow from operations with profit after income tax		
Profit from ordinary activities	214,675	222,039
Add/(less) non-cash items:		
Depreciation	46,449	52,756
Loss on disposal of non-current assets	-	840
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	32,965	(61,885)
(Increase)/decrease in other current assets	12,023	(56,693)
Increase/(decrease) in trade and other payables	101,533	265,971
Increase/(decrease) in provisions	8,012	17,049
Net cash provided by operating activities	415,657	440,077

13. Related Parties

Directors

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

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

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

14. Key management personnel compensation

Any person(s) having authority and responsibility for planning, directing and controlling the activities of the company, directly or indirectly, including any director (whether executive or otherwise) of that company is considered key management personnel.

Notes to the Financial Statements
for the year ended 30 June 2012

The totals of remuneration paid to key management personnel of the company during the year are as follows:

	2012 $	2011 $
Key management personnel compensation	306,348	265,343

15. 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.

16. Financial risk management

(a) Overview

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

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

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

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

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

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

(b) Credit Risk

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

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

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

The carrying amount of financial assets represents the maximum credit exposure. The maximum exposure to credit risk at the reporting date is disclosed in Note 17.

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

(c) Liquidity risk

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

(d) Interest rate risk

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

(e) Capital management

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

Notes to the Financial Statements
for the year ended 30 June 2012

17. Financial instruments

(a) Financial Assets:

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

(b) Fair value versus carrying amount

	2012 Carrying amount $	2012 Fair value $	2011 Carrying amount $	2011 Fair value $
Cash and cash equivalents	2,107,514	2,107,514	1,701,895	1,701,895
Trade and other receivables	183,044	183,044	216,008	216,008
Other current assets	90,297	90,297	103,117	103,117
Trade and other payables	784,367	784,367	682,834	682,834

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

(c) Interest Rate Risk

	Carrying amount 2012 $	2011 $
Floating rate instruments		
Cash and cash equivalents	2,107,514	1,701,895

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.

Notes to the Financial Statements
for the year ended 30 June 2012

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

	Carrying amount 2012 $	2011 $
Loans and receivables	183,044	216,008

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

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

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

	Gross amount $	Past due and impaired $	Past due but not impaired (days overdue) <30 $	31-60 $	61-90 $	>90 $	Within initial trade terms $
2012							
Trade receivables	178,492	-	151,305	7,700	12,375	7,112	151,305
Other receivables	4,552	-	1,187	3,077	-	288	4,552
Total	183,044	-	152,492	10,777	12,375	7,400	155,857
2011							
Trade receivables	188,734	-	108,056	7,370	8,800	64,508	108,056
Other receivables	27,274	-	27,274	-	-	-	27,274
Total	216,008	-	135,330	7,370	8,800	64,508	135,330

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 2012 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 2012							
Payables	784,367	784,367	641,833	142,534	–	–	–
30 June 2011							
Payables	682,834	682,834	528,168	154,666	–	–	–

Directors Declaration

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

(a) the financial statements and notes in the Directors' report, set out on pages 5 to 21, are in accordance with the Corporations Act 2001 including;

(i) giving a true and fair view of the Society's financial position as at 30 June 2012 and of the Society's performance, for the financial year ended on that date; and

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

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

Signed in accordance with a resolution of the Directors.

Dr Mary White
President

Dr Marc Ziegenfuss
Hon. Treasurer

Dated this 31st day of August 2012.

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 Company), which comprises the statement of financial position as at 30 June 2012, and the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date, notes 5 to 21 comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

Directors' responsibility for the financial report

The directors of the Company are responsible for the preparation of the financial report that gives a true and fair view in accordance with Australian Accounting Standards – Reduced Disclosure Requirements and the *Corporations Act 2001* and for such internal control as the directors determine is necessary to enable the preparation of the financial report that is free from material misstatement, whether due to fraud or error.

Auditor's responsibility

Our responsibility is to express an opinion on the financial report based on our audit. We conducted our audit in accordance with Australian Auditing Standards. 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 entity's preparation of the financial report that gives a true and fair view in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of accounting estimates made by the directors, as well as evaluating the overall presentation of the financial report.

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

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

Auditor's opinion

In our opinion the financial report of Australian and New Zealand Intensive Care Society is in accordance with the *Corporations Act 2001*, including:

(a) giving a true and fair view of the Company's financial position as at 30 June 2012 and of its performance for the year ended on that date; and

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

KPMG

Darren Scammell
Partner

Melbourne

31 August 2012

Appendix One

Annual General Meeting

Friday 14th October, 2011
5.30pm

Great Hall 4,
Brisbane Convention and Exhibition Centre

Unconfirmed Minutes

1. Welcome, present & apologies

Michael O'Leary welcomed members to the meeting and noted the attendance and apologies.

Present

Michael O'Leary (President)
Mary White (Vice President)
Andrew Turner (Secretary)
Marc Ziegenfuss (Treasurer)
Dr Deepak Bhonagiri
Prof Jamie Cooper
Dr Peter Harrigan
A/Prof Graeme Hart
Dr Amod Karnik
Dr Colin McArthur
Dr David Pilcher
Dr David Blythe
Dr John Cade
Dr Dick Dinsdale
Dr George Downward
Dr David Fraenkel
Dr Mike Hunter
Dr Ian Jenkins
Dr Gerry O'Callaghan
Dr John Santamaria
Dr Andrew Spiers
Dr Sanjiv Vij
Dr Stephen Warrillow
Dr Anthony Burrell
Dr Elizabeth Fugaccia
Dr Anthony Holley
Dr Craig Hourigan
Dr Kenneth Lee
Prof Jeff Lipman
Dr Ranald Pascoe
Dr Sam Radford
Dr James Walsham
Dr Ann Whitfield
Dr Alex Wurml
Dr Shailesh Bihari
Dr Aidan Burrell

Apologies

Prof John Myburgh
Dr Alex Kazemi
Dr Nicholas Barnes
Dr Annette Forrest
Dr Nigel Rankin
Dr Roberto Citroni
Dr Michael Kalkoff
Dr Katrina Ellem
Dr Troy Browne
A/ Prof David Ernest
Dr Cameron Knott
Dr Jonathan Casement
Dr Stephen Streat
Dr Michael Park
Dr Robert Bevan
A/Prof Theresa Jacques
Dr Jeremy Fernando
Dr Andrew Cheng
Dr Kerry Benson-Cooper
Dr Annette Turley
Dr Ian Seppelt
Dr Matthew Bailey
Dr Heather Low
Dr Emma Merry
Dr Arthas Flabouris

In Attendance

Erin O'Sullivan (General Manager)

2. Minutes of previous meeting

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

3. President's report

Michael O'Leary (MOL) presented the Presidents report and provided a summary of the Society's activities.

MOL noted the formation of the Education Committee to review the Society's current education program and assess member's educational requirements. MOL noted the importance of the Committees function aligning with the College of Intensive Care Medicine (CICM) new Continuing Education Program. MOL reported that the Board had considered the possibility of a co-location with the CICM and had determined that such a move would not be possible in the time scale required and noted that the proposal was no longer under consideration by the Board. MOL reiterated the Boards recognition of the importance of maintaining an ongoing relationship with the CICM in to the future.

Appendix One

MOL noted the Boards concern over the current lack of representation of rural and regional members and issues following the disbandment of the joint ANZICS/CICM Rural and Regional Committee. MOL reported that the Board had created a Rural and Regional Special Interest Group email discussion list to facilitate discussion on rural and regional issues and had invited members of the CICM, ACEM and RACP to join. MOL reported on the LinkPersons scheme established to facilitate communication between members and the Society and thanked the LinkPersons in participating hospitals.

MOL provided an overview of the successful Singapore-ANZICS Intensive Care Forum held in Singapore in March 2011. MOL advised that the meeting would be held again in 2013 in conjunction with the Singaporean Society. MOL noted that the ANZICS-India Scientific Exchange lead by Deepak Bhonagiri would be held in India in April 2012 and would be attended by a number of ANZICS speakers.

MOL reported that the Board and CORE Management Committee were continuing to pursue the proposal for the relocation of ANZICS CORE to Monash University.

MOL thanked the members of the Executive Committee and Board and those who had supported him during his term as President.

4. Treasurer's Report

Marc Ziegenfuss (MZ) presented the Treasurers report. MZ reported that the Society was currently in a strong financial position. MZ thanked Don Stewart (ANZICS Accountant) and Erin O'Sullivan (General Manager) for their efforts in managing the Society's financial position.

MZ reported that income was 7% higher in the current financial year compared to same time last year and noted that grant and subscription income was stable. MZ noted that operational expenditure had remained stable throughout the year. MZ noted that the Board had recently received an independent valuation of the property at ANZICS House of $2.5M.

MZ reported that the Board had approved the 2011/12 operational budget with a deficit of approx $30,000 based on conservative ASM profit distribution.

Motion: That KPMG be appointed as auditors for the financial year ended 30 June 2012.
Proposed: Marc Ziegenfuss
Seconded: Michael O'Leary
Motion Carried

Motion: That membership subscriptions remain the same for the financial year ended 30 June 2012.
Proposed: Marc Ziegenfuss
Seconded: Ian Jenkins
Motion Carried

5. College of Intensive Care Medicine Report

Amod Karnik (AK) presented the College of Intensive Care Medicine (CICM) report on behalf of John Myburgh.

AK reported that it had been a busy year for the College with the Australian Medical Council Accreditation process, development of a new Continuing Professional Development Framework, curriculum review and hospital accreditation review.

AK reported an increase in the number of candidates sitting the CICM examinations.

AK noted that the 2012 CICM ASM had been held in Canberra and the 2011 ASM in Melbourne.

6. Membership

MOL presented the Membership report.

MOL reported that the total membership was currently 692. MOL reported an increase in full and trainee members in 2011/12.

7. ANZICS Honour Roll

The following Honour Roll recipients were presented to the meeting:

Graeme Hart
Rinaldo Bellomo
Brad Power
Jeff Lipman
Simon Finfer
Ken Hillman
Mike Hunter

8. Professional Practice

8.1 ANZICS Clinical Trials Group

Colin McArthur (CM) presented the Clinical Trials Group (CTG) report.

CM reported that the CTG membership continues to grow with a current total of 71 member units. CM noted that the CTG had held a number of successful meetings in the past year including two Research Development Workshops in Hong Kong and Singapore.

CM noted that a number of CTG studies had received significant funding in 2010/11 bringing the CTG total aggregate funding to over $50m.

CM thanked the research community for their continued support of the CTG.

Appendix One

8.2 ANZICS Centre for Outcome and Resource Evaluation

David Pilcher (DP) presented the Centre for Outcome and Resource Evaluation (CORE) report.

DP provided a summary of COREs activities and noted the CORE Annual Report would be published shortly.

DP advised that the CORE Management Committee and Board remained engaged in discussions with Monash University representatives regarding the proposed relocation of ANZICS CORE to Monash University. DP thanked the CORE staff and CORE Management Committee for their efforts over the past year.

8.3 ANZICS Practice and Economics Committee

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

IJ referred members to the summary of the Committees activities in the 2011 Annual Report and the Committee page on the ANZICS website.

8.4 ANZICS Safety and Quality Committee

Tony Burrell (TB) presented the ANZICS Safety and Quality Committee report.

TB reported that the Committee had been formally spilled and reformed. TB noted that the Committee had secured ongoing funding for a dedicated Executive Officer to support the Committee for a 12 month period. TB noted that the Committees current work plan included the ongoing development of a Statement on the Care of the Ventilated Patient and the Central Line Associated Blood Stream Infection (CLABSI) Prevention Project.

8.5 ANZICS Death and Organ Donation Committee

Bill Silvester (BS) presented the ANZICS Death and Organ Donation Committee report.

BS advised that he had taken over the position of Committee Chair from Geoff Dobb and thanked Geoff for his time in the position.

BS referred members to the summary of the Committees activities in the 2011 Annual Report. BS noted that the Committee was currently in the process of reviewing the ANZICS Statement on Death and Organ Donation.

8.6 ANZICS Education Committee

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

GOC summarised the Committees work program. GOC noted that the Committees main priority is completing a review of the current educational activities available and undertaking a gap analysis to ensure members needs are met in the future.

9. Intensive Care Foundation

Yahya Shehabi (YS) presented the Intensive Care Foundation (ICF) report.

YS reported that 2011/12 has been a period of increased activity for the ICF. YS noted that the 2011 Annual Report had recently been published and is available to download from the ICF website.

10. Future Meetings

The location of the following meetings was noted and members encouraged to attend:

- 2012 ANZICS/ACCCN 37th ASM – South Australia
- 2013 ANZICS/ACCCN 38th ASM- Tasmania

11. Election Of Office Bearers

MOL advised that Marc Ziegenfuss has been nominated unopposed as Honorary Treasurer, Andrew Turner appointed unopposed to the position of Honorary Secretary, and Mary White appointed unopposed as President. It was noted that Michael O'Leary will assume the role of Immediate Past President for a term of one year.

12. Other Business

No discussion noted.

13. Date Of Next Meeting

5.00pm Friday 26th October 2012, Adelaide.

inside back cover

ANZICS

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