ANZICS

Annual Report 2010

Advocate for intensive care throughout Australia and New Zealand

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ANZICS

Advocate for intensive care throughout Australia and New Zealand

President's Report

I am pleased to be able to report to members that the Society has finished the 2010 Financial Year again in surplus, and we therefore enter the current year on a strong footing.

For 2010-11 the Board believes that we will be able to cover all of our normal activities within a conservatively set budget, and are confident that after a few difficult years we now have established a relatively stable financial model on which the Society is run. In addition to normal activities, however, the current Financial Year will see some extraordinary expenses in relation to upkeep of the House and redesigning the CORE AORTIC software. We took the decision during the past year not to continue to seek a tenant for the second floor of the House as it became clear that income would only cover costs and that new Safety & Quality projects meant that the additional space would probably be required for our own activities.

Some members might question the level of surplus reported this year, however the Society still relies heavily on any profit from the ASM to finance general activity and as this income is not guaranteed, significant annual surpluses probably remain occasional and are important in offsetting the effect of lower ASM profits in subsequent years.

As President of the Society I am struck by the breadth of our activity and by the level of our success. The Clinical Trials Group and CORE are world leaders in their respective fields. Our Safety & Quality Committee is continuing to gain traction with imminent publication of important clinical guidelines, a now established and successful annual meeting and recurrent funding from government and industry. The Death & Organ Donation Committee is recognised as the peak authority on the process of managing organ donation. The PricE Committee continues to work tirelessly to achieve for our members a fair recognition for their work. Our Annual Scientific Meeting, run in partnership with ACCCN, continues to hold its place as the premier intensive care meeting in Australia and New Zealand and is the jewel in the crown of our educational and continuing professional development activities. I suspect that many members would be interested to note that 10 years ago the Society reported a surplus of almost $7000 on expenses of around $225,000, compared to our surplus approaching $70,000 this year on expenses of over $2M. Our asset base has increased over the same period from just over $1M to over $3M.

It must not be forgotten, however, that we are a volunteer organisation and consequently that the success of our endeavours is vitally dependent on the hard work and dedication of Committee Chairs, members and of course the rank-and-file membership. Far too infrequently are people thanked and shown appreciation for this work, and I would like to take the opportunity in this report to formally extend the thanks of the entire ANZICS community to all those that give up their time to work on our behalf. I would also like to extend my thanks those members that have volunteered as linkpersons in hospitals and departments across the country. I hope that we will be able to develop the linkperson scheme to be the main avenue of communication between the Society and the membership and vice-versa.

Supporting the Committees, Board and Executive are the ANZICS House staff. We now have a cohesive and hard working administration, guided with great skill by our General Manager Erin O'Sullivan. Erin was previously our Executive Assistant and was appointed to the General Manager position in November 2009 in succession to Kathy Muscat who had resigned for personal reasons. Erin has demonstrated that she has an excellent global understanding of the Society and has proved to be a great resource to the Executive and Committees over the past year.

Our Society has a significant international profile and I am keen to ensure that we maintain this or even increase our profile and influence. We have a number of close international collaborations in relation to research and Safety & Quality. In addition to these, however, I am working to improve our relationship with ESICM and SCCM. Members will be aware that we have negotiated an agreement with ESICM such that ANZICS members can obtain a discounted international rate membership of that organisation. We have recently met by teleconference with the Executive of the SCCM and are investigating the possibility of drawing up

President's Report

a Memorandum of Understanding with that Society to deliver further benefits to members. ANZICS has agreed to become an inaugural supporting organisation to the Global Sepsis Alliance and in September I will be attending the first Congress of this group in New York. We remain committed to improving our links with colleagues in our region and to this end I will also be attending the APACCM Congress in Manila in October. The Board is keen to help develop educational opportunities across the region and this year donated $10,000 to Dr Charles Gomersall to support the BASIC course. Further, arrangements for our combined meeting with the Singapore Society for Critical Care Medicine next April are now well advanced.

Alongside all of this activity and success, we have also seen a significant increase in membership over the past year. Given that the Society currently appears to be very strong and to be expanding in influence and activity it might be easy to sit back and simply bask in our success. On the contrary, however, I believe we now have an important opportunity to strategically re-evaluate our Society and to set a course for the future that will build on our successes and ensure we add value for our members. I believe that this is particularly important today, as our working environment has changed with the formation of CICM in January 2010.

Members were sent a Discussion Paper in July and the Board received a number of responses for consideration. In August the Board held a Strategic Planning Day at ANZICS House and from this a 5-year Strategic Plan will be developed for presentation to the Annual General Meeting in October. In addition, a Board working group will be tasked to review the structure of the Board with the dual purposes of improving the functionality of the Board and re-invigorating regional representation and activity, and the Education Sub-committee will be expanded to better co-ordinate central and regional meetings and educational activities.

As part of the strategic review the Executive will begin a formal process of contact with CICM to review the Memorandum of Understanding that we previously had with JFICM. As part of this process we will also conduct a formal evaluation of our costs and assets in order to ensure that we are appropriately minimising costs and making maximum use of assets. This process will include consideration of options for cost and asset sharing with CICM where this might be appropriate or possible, given that overall the intensive care community in these islands is small and both organisations should strive to provide best service to members and Fellows as economically as possible.

As President of ANZICS I also represent the Society on some important external bodies. The ANZIC Research Centre at Monash University deserves particular mention in light of its amazing success in being awarded ongoing and increased funding from the NHMRC for the next 3 years. This is a significant achievement for the principal investigators, Rinaldo Bellomo and Jamie Cooper, who deserve our congratulations. The Research Centre has now established itself as a vital resource for our community, providing high quality clinical trials support for many CTG studies and local unit-based research initiatives.

The ANZICS President is also a member of the company structure underpinning the Intensive Care Foundation. The Foundation has had a difficult few years given the effect of the global financial crisis on charitable organisations, however I think it is really important to us all that the Foundation continues to receive our enthusiastic support and we all work as hard as possible to advance its mission to raise funds to support our research efforts. Many of the studies that have brought so much success to the CTG have had their roots in modest Foundation grants, so the impact of this support cannot be overestimated. The ANZICS Board made a special donation of $20,000 to the Intensive Care Foundation this year.

Our Society has a significant international profile and I am keen to ensure that we maintain this or even increase our profile and influence. We have a number of close international collaborations in relation to research and Safety & Quality. In addition to these, however, I am working to improve our relationship with ESICM and SCCM.

A problem that we have consistently faced is the low profile of our specialty in the community in general. This not only affects our ability to raise charitable donations, but also probably impacts on our success in negotiation with government, health funds and other bodies. We have given much thought to this over the years and there does not seem to be an easy answer. The SCCM, for example, has spent a considerable amount on promotion of critical care to the community with little benefit, so I do not believe that employment of publicists or lobbyists is worthwhile. What is clear, however, is that we as a Society and as a specialty frequently fail to trumpet our successes, be they in the clinical, research or quality arenas, and we should take every opportunity that we can to do so.

ANZICS holds a position on the Editorial Board of the Internal Medical Journal and I currently occupy that role. I am pleased that there has been a consistent trickle of submissions over the past year, and whilst I recognise that members have a number of options when considering journal submissions I would like to encourage authors to consider the IMJ for papers that are likely to be of interest to a generalist readership particularly within Australia and New Zealand. This would be an additional way to maintain the profile of the specialty amongst local colleagues.

This year we are returning to Melbourne for our ASM and AGM, 35 years after the first ANZICS Annual General Meeting was held in that city back in 1975. We have certainly come a long way as a Society and a specialty in that time, and this year as we gather we can be very proud that we do so with our own independent College of Intensive Care Medicine finally in place. The issues discussed and (most of) the faces may have changed, but nonetheless I am sure that the level of enthusiasm for the specialty and Society will be the same. I look forward to celebrating our first 35 years with you all in Melbourne.

Michael O'Leary
President

Treasurer's Report

The Society performed well against budget this financial year. Efforts to increase membership by attracting new members and retaining current members have led to an increase in subscription income to $402k. The ASM maintained its status as the most attractive Australian intensive care meeting for trade and sponsorship, generating a profit to the Society of $193k. CORE continued to fund its good works through government grants, and the CTG via subscriptions from intensive care units. Other income was generated from education meetings, rent, interest, and advertising. Total revenue was $2.06M down somewhat from 2009 FY as a result of a decrease in government grants and smaller ASM profit.

The Society's activities continue to grow with active research, quality assurance, education, guideline creation, industrial and local activities. As a result our staff expenses are over $1M per annum, and total running expenses around $2M per year.

The Society has performed admirably providing high quality outputs with a value for money approach with regards to subscription income. Given the formation of CICM and with it a change in the Society's relevance to the craft group, a small profit is appropriate, utilising as much income as possible to generate outputs, with little need to retain profit at present. The profit for the year was $69k (or 3.4% of income).

As at June 30 2010 the society had retained assets of $3.25M, of which property and plant amount to $2.31M. At present the Society is housed at ANZICS House which provides more than adequate accommodation. There is little need for a large cash reserve other than to ensure adequate cash flows. To put the Society's position into context our total assets at 30 June 2000 was $1.04M, and we have shown continuous growth in size and output since then

Priorities for the future of the Society are currently being discussed by the Board. I believe that the ASM and our relationship with ACCCN must be cultivated. As mentioned previously this meeting is extremely attractive to the trade as unlike other intensive care meetings in Australia it gives an opportunity to exhibit items to all ICU staff. As such whilst the format continues it will continue to draw the trade and with it a profit. There continues to be speculation about a possible fall in profit from the ASM, but the profit has been consistent from year to year and I am confident that this will continue to be the case. As a result the ANZICS budget can include a conservative ASM profit with a degree of certainty, hence minimising our need for subscription income.

Our investment strategy has been conservative and as a result left us unscathed from the GFC. As always our investment strategy will be reviewed, however, there is no need to take risk as the ANZICS budget for this FY has been set and will result in a small profit.

The Society will likely take a greater role in education over the next few years. A committee to oversee this will have a small impact on "bottom line" for a year or two. However, in time these activities will be beneficial to the Society by raising awareness of our role with trainees, hence increasing subscriptions, and by generating revenue through access to the resources.

Another priority for the Society will be an increase in our Advocacy role. This will see an increase in activity at a national, regional and local level, with associated costs. However, this is an area where the Society can directly benefit its members and increase its relevance to the craft group.

The attached audited statements by KPMG give an accurate and true reflection of the affairs of the Australia and New Zealand Intensive care Society at June 30 2010.

Andrew Turner
Honorary Treasurer

General Managers Report

The past year has been one of considerable growth and consolidation for the Society. Whilst sounding slightly contradictory this accurately encapsulates the Society's ongoing focus on meeting its members needs, expanding the scope of its activities and establishing a strong foundation for the future.

In recognising the importance and value of the membership, one of the main objectives set for the year was to strengthen communication and increase engagement with both existing and new members. Through a number of avenues including membership email lists, publications, conferences, events and the efforts of the regional chairpersons this objective was achieved with a considerable degree of success. An encouraging number of new membership applications were processed and a number of outstanding subscriptions renewed.

In respect to the outputs and achievements of the committees and regions, 2009/10 has been a particularly successful year. As well as maintaining a consistent level of activity and output the committees have each pursued alternative avenues of development and expansion with notable success. This success has resulted in the commencement of a number of new projects and initiatives. The diversification and development of such activities is a credit to the committee chairs, committee members and staff involved and would not have been possible without the continued commitment.

The year also brought with it a number of changes within ANZICS House. In the course of the year we have farewelled a number of staff and in turn welcomed new staff who have brought a new skill set and perspective. Despite these changes ANZICS staff have continued to achieve and deliver on the objectives and targets set for them to the highest level. The results of their commitment and effort are evident throughout this report.

The activities of this past year have also signalled a widening of focus for the society whereby we have continued to look outside our bi-national boundaries and engage with other societies and organisations in an international context. Continued engagement and exposure of this kind can only result in positive outcomes and benefits to the Society. The joint Singapore-ANZICS meeting to be held in Singapore in 2011 and the attendance of renowned international guests and speakers at ANZICS events is a testament to the benefits and success of such engagement.

As stated at the beginning of my report the considerable growth and accomplishments that have characterised this year have provided a solid platform from which we can continue to expand, develop and deliver to our member and stakeholders in the future, continuing the success of the past year.

Erin O'Sullivan
General Manager

ANZICS Activities 2009/10

Intensive Care Medicine Course
Melbourne July 2009

ANZICS/ACCCN Annual Scientific Meeting
Perth October 2009

ANZICS New Zealand
Hawkes Bay March 2010

Clinical Trials Group Research Development Day
Sydney June 2010

3rd International Conference on
Safety Quality Audit and Outcomes
Queenstown August 2009

Clinical Trials Group Scientific Meeting
Perth October 2009

12th Annual Meeting on
Clinical Trials in Intensive Care
Noosa March 2010

Membership Report

2009 has been a relatively successful year from a membership perspective. With the current membership reaching 647 members, including over 60 new members, it is a positive indication that in the changing landscape of intensive care the Society continues to be well supported by the community. However, as it is often stated, the Society relies totally on the support of its members through their subscriptions to facilitate the continuation of the Society's many and varied activities.

As always the face to face meetings such as the successful Intensive Care Medicine course run by Ramesh Naggapan and the ANZICS/ACCCN ASM in October continue to provide opportunities to engage old and new members alike.

This year has seen concerted effort by ANZICS staff to secure the large number of outstanding subscriptions. Whilst this has been a relatively successful endeavour, a number of outstanding subscriptions remain. At the February 2009 meeting, the ANZICS Board resolved to rescind the membership of members with three or more outstanding subscriptions. On this basis a small number of memberships were terminated this financial year.

Whilst regrettable this ensures that the Society can focus on delivering to its active and supportive members in all aspects of intensive care practice through ongoing clinical research, analysis of critical care resources, professional education and industrial issues.

A reminder to those with outstanding subscriptions that these can now be paid online at www.anzics.com.au by phone on 03) 9340 3400 or email: anzics@anzics.com.au

Mary White
Membership Director

Full	443
Associate	54
Affiliate	48
Trainee	102
TOTAL	647

Working Committee Reports

CORE 2010 Annual Report

2009/10 has been a year of continuing evolution for CORE with a number of key personnel changes, an external review and plans for further enhancement and restructuring.

This is my last annual report as I'm standing down as Chair of the CORE committee in light of increasing hospital commitments and the internal restructure.

Personnel

CORE continues to benefit from its very dedicated staff. Despite the uncertain times associated with the loss of our previous Manager, Ashley Fletcher, and the external review by Kathy Rowan, the CORE staff have excelled in continuing to meet all of our deadlines and have contributed greatly to the structural and strategic planning processes currently underway. Kelly Drennan, together with Peter Hicks and myself, developed a modified CCR survey examining the impact of the influenza pandemic on the role and function of intensive care units around Australia and New Zealand, and administered a MET dose study in conjunction with Dr Daryl Jones, with funding received from the ACQSHC. Allison van Lint continues to develop the education and audit process for the APD, and generated the first substantive report on data quality in early 2010 (see the web site for a copy). Our data management and programming team, Marcela Forero and Jostein Saethern have collectively issued an upgrade to aortic data collection software and continue to refine and develop our internal customer relations software and the SAS data management system. In addition, they, together with Jan Alexander, are redesigning our data systems to ensure greater flexibility, ease of administration and data integration. Shaila Chavan continues to do great service leading the education program and performing numerous data request extractions. We have also been ably supported by both Erin O'Sullivan, ANZICS General Manager, and Chris Nash, Executive Assistant, who has stepped up to assist in a customer relations and support role.

External Review

In 2009, Kathy Rowan of ICNARC was contracted to perform a review of the operations of CORE as part of our obligations to the National Intensive Care Registry Steering Committee (NICRSC). Kathy found the performance to be of international standing, but did identify a number of improvement opportunities relating to governance, internal and committee structure, and some technical issues. She also identified significant opportunities for closer relationships between CORE, ANZICS RC, and the statistical support available from the Monash Department of Epidemiology And Preventive Medicine (DEPM). The External Review report and the CORE response to the report were tabled and endorsed at the National Intensive Care Registry Steering Committee and by the ANZICS Board.

Restructure

It has been decided to disband the current representative committee and split responsibilities into two components. An *operational committee* of four people representing APD, ANZPIC and CCR will form the basis of support for CORE staff and will meet frequently by telephone or in person. An *advisory committee* will incorporate elements of ANZICS jurisdictional representation and consumer representation, and will initially be chaired by Professor John McNeil from the DEPM at Monash University. This committee will help to set strategic directions, facilitate liaison with government and private sector jurisdictional delegates and be able to co-opt members to facilitate important new activities as required. It is envisaged this committee will meet three to four times per year as currently happens with the present committee. I will continue to sit on this committee and provide ongoing support particularly with government relations.

The advisory committee and CORE staff are currently investigating the potential benefits of relocating CORE to Monash University offices at the DEPM. This has the potential to provide much greater interaction with the ANZIC-RC, with statisticians and other registry staff and will potentially provide a much greater supportive framework for our staff. Members will be advised in due course as to the committee's decision.

Working Committee Reports

Budget and Finance

The CORE operational budget remains in a healthy condition with a reserve corpus of around six months of salaries. The next triennial budget is being prepared with a view to achieving an index increase over our current expenditure together with targeted supplemental income for specific projects such as the redevelopment of the data submission software, redevelopment of the reporting framework, and development of the data linkage capability.

Key Deliverables 2009/10

Operational reports

- CORE annual report
- ANZPIC report
- CCR pandemic report
- Data Quality and Audit Report
- Response to External Review

Publications

Pilcher, D.V., *et al.* **Risk-adjusted continuous outcome monitoring with an EWMA chart: could it have detected excess mortality among intensive care patients at Bundaberg Base Hospital?** *Crit Care Resusc* 12, 36-41 (2010).

McNamee, J.J.,*et al.* **Mortality prediction among burns patients in Australian and New Zealand intensive care units.** *Crit Care Resusc* (2010) *(accepted for publication)*

Straney, L., *et al.* A. **Quantifying variation of paediatric length of stay among intensive care units in Australia and New Zealand.** *Qual Saf Health Care* (2010).

Bhonagiri, D., *et al.* **Increased mortality associated with after- hours and weekend admissions to ICU is mainly seen in patients admitted after elective surgery.** (2010). *Intensive Care Med (submitted for publication)*

Renton, J., *et al.* **Factors associated with increasing risk of readmission to Intensive Care in Australia.** *Intensive Care Med (submitted for publication)*

Carter, A., *et al.* **Is ED length of stay before ICU admission related to patient mortality.** *Emergency Medicine Australasia* 22, 145-150 (2010).

Drennan, K., *et al.* **Impact of the Influenza A H1N1 Panedmic (2009) on Australasian Critical Care Units.** *Crit Care Resusc* (2010).

Moran, J,. *et al.* **Conventional and advanced time series estimation: application to the Australian and New Zealand Intensive Care Society (ANZICS) adult patient database, 1993-2006.** *J.Eval.Clin.Pract 15* (2010).

Safety Quality Audit and Outcomes Research in Intensive Care 2009, Queenstown, NZ.

SQAO 2009 was once again an outstanding academic meeting in a fabulous venue. The combined content and obvious synergies between the safety and quality committee work and CORE were once again in evidence. Unfortunately, registrations continued to be disappointing and together with the global financial crisis, which impacted on sponsorship and the support available for staff travelling overseas from Australia, the committee decided to bring the 2010 meeting to mainland Australia.

Finally

I would like to especially thank David Pilcher and Peter Hicks for their outstanding commitment over the years to CORE and for their ongoing commitment as part of the restructured management committee. I would like also thank the rest of the committee for their hard work and support, Steve Webb for his commitment and increasing collaboration on behalf of the Clinical Trials Group, and Tony Burrell for his never-ending support and commitment to improving safety and quality of care and to the ongoing relationship between the safety and quality committee and CORE. Externally we also are very grateful for the support we have received from Professor Chris Baggoley CEO of the Australian Commission for Safety and Quality in Healthcare, who currently chairs The National Intensive Care Registry Steering Committee.

Graeme Hart
Chair, CORE

Working Committee Reports

Paediatric Report

The paediatric division of ANZICS continues to be active in research with several exciting initiatives on the horizon. As has been the case for several years, the ANZPIC registry continues to perform strongly. The paediatric ICU community is also looking forward to hosting the World Congress In Pediatric Intensive Care in April 2011; the first time the World Congress in PICU has been held in Australasia.

Paediatric Study Group

a) The Hypothermia in Traumatic Brain Injury in Children (HITBIC) pilot has been completed. All PICU's in Australia and New Zealand will be involved in the Cool Kids Trial, a multinational trial in Paediatric Traumatic Brain Injury which is funded by the US National Institute of Health. The HITBIC pilot is currently being analysed and results will be reported. Safety data has already been useful in ethical applications for the Cool Kids Trial.

b) The Aminophylline study has been abandoned. It was felt that the study has become untenable with very poor recruitment, organisational problems and unavailability of study drug in some centres for much of the bronchiolitis season. The remaining money from the successful ANZICS Foundation Grant will be returned to the Foundation.

c) Calfactant study commenced in May 2009. An interim analysis by the trial investigators recommended that the study be ceased in children due to the likelihood of futility and children are now not being recruited.

d) Safe-EPIC Proposal: 3 day point prevalence study completed in December 2009 to assess resuscitation fluids used in PICU. Dr. Marino Festa has attained an ANZICS seed grant to perform statistical analysis on this work and develop an international proposal.

f) CLOTS study. Randomised trial of heparin vs. placebo to prevent thrombosis and infection in central lines in PICU. All centres have ethics approval and the study will be commencing shortly. Study is funded by a grant from the SA Womens' and Childrens Hospital Foundation and Dr. Michael Yung is the PI.

g) Paediatric H1N1 study. Collaboration between the INFINITE investigators, Paediatric Study Group to report on the PICU burden of the H1N1 pandemic. Manuscript has been accepted for publication in Pediatrics.

ANZPIC Registry

The ANZPIC registry continues to work productively in ensuring safety and quality in PICU in Australia and New Zealand. The 2008 Registry report has been published and as usual is an outstanding effort by Tony Slater and Jan Alexander.

A subcommittee of ANZICS will be looking at ways to streamline data collection for the adult and paediatric database, which is a welcome initiative.

World Congress Sydney 2011

The scientific programme is almost finalised for this exciting event which will provide a fantastic opportunity for the paediatric intensive care community in Australia and New Zealand as well an ideal opportunity to showcase Sydney to the world.

Sponsorship plans are going well with Draegar having come on as a platinum sponsor. On line registrations now operational. Website includes scientific programme, accommodation, social programme and satellite courses.

Melbourne ASM 2010

The paediatric convenors are Dr. Warwick Butt and Stephen McKeever. The scientific programme finalised.

Paediatric keynote speaker (Allan Goldman) has withdrawn and been replaced by Brian Kavanagh (Toronto University and Hospital for Sick Kids).

Inhaled Nitric Oxide

An application for nitric oxide to be funded as an orphan drug by the Federal Government for use in neonatal and paediatric intensive care for limited indications has been submitted.

This issue continues to develop with high level meetings continuing. Ikaria (patent holder) has put in the submission to the Federal Government and this has been tabled in parliament. A decision by the Federal Government is awaited but feedback to date has been positive.

Committee Membership

Chair Simon Erickson (WA)

Committee Michael Yung (SA), Andrew Numa, Marino Festa (NSW), Warwick Butt (Vic), Andreas Schibler, Tony Slater (Qld), John Beca, Gabrielle Nutthal (NZ)

Simon Erickson
Chair, Paediatrics

Working Committee Reports

CTG Report

The last 12 months has been hugely successful for the ANZICS CTG. Major studies that provide definitive evidence to guide clinical practice and health care policy have been published including the RENAL study of high versus standard dose of renal replacement therapy and several manuscripts that described the impact of pandemic influenza. Established studies continue to recruit well and the track record of consecutive funding from the National Health and Medical Research Council (NHMRC) has been maintained.

A strategic planning cycle was completed this year and I would like to thank and acknowledge Stephen Streat who chaired a strategic planning meeting of the CTG Executive providing superb guidance and insight. The major outcomes from that planning process are:

- an increased emphasis on achieving early engagement between the research community and new proposed studies,
- a review of the endorsement process for projects with a stronger focus on feasibility and the impact of studies on the sites that participate in CTG research,
- a continued emphasis on preserving existing research capacity and supporting new sites to participate in research,
- a strategy to improve communication between the CTG Executive and the research community,
- improved pathways for site investigators and Research Coordinators to contribute to new research through membership of study management committees,
- a commitment to strengthen the role that Research Coordinators play within the CTG research community,
- the formation of new working groups to develop standardised study tools for CTG studies, to study the impact of research conducted by the CTG on clinical practice and to identify opportunities for translational research in which advances in basic science can be converted into new clinical trials.

On behalf of the CTG Executive I would like to thank Rhiannon Elliott and Simone Rickerby for the tireless and fantastic work that they undertake on behalf of the CTG. The workload of the trials group has been increasing exponentially and yet the executive office in ANZICS House functions with smooth efficiency. Both Rhiannon and Simone drive and deliver innovative solutions that allow the CTG to achieve its mission to promote excellence in Intensive Care medicine through collaborative clinical research focused on improving patient-centred outcomes. I would also like to thank Jean Walton for her work as acting Executive Officer whilst Rhiannon was on maternity leave. Finally, I would like to acknowledge Erin O'Sullivan and the Board of ANZICS for their support and the substantial assistance that they provide to facilitate the activities of the CTG.

Membership

The CTG office continues to be supported almost entirely through membership subscriptions received from ICUs. Tremendously, we have continued to see new units supporting the CTG and in the 2009 calendar year there were a record 56 adult and 7 paediatric units who were members. 2010 will be the last year of calendar membership as we move to align with the financial year. I encourage all ICUs who participate in research, would like to become involved in research or would like to support ANZ ICU research to consider CTG membership. A full list of member units can be found at www.anzics.com.au/clinical-trials-group

Studies with completed recruitment

ENTERIC
HiTBIC Pilot
STATinS
PROTECT
DECRA
SAFE TBI II
STATinS TIMES

Studies undertaken within the CTG Point Prevalence Program

- Physiotherapy Practices in Intensive Care
- Sedation, Analgesia and Delerium in Intensive Care
- Steroids in Sepsis
- Withdrawal of Therapy
- Update on Fluid Resuscitation
- SAFE EPIC Pilot Study (Paediatric)
- Compliance with Process of Care in Paediatric Intensive Care

Working Committee Reports

Ongoing Studies

ANZIC Influenza Investigators Registry
ARISE
ARISE Health Economic Evaluation
CHEST
DARE
DAHLIA
Early PN
EPO-TBI
NICE-TBI
Point Prevalence Program
POLAR
POLAR BEAR
POST-RENAL
PREDICT
Pro-GUARD
SPICE
TAME

For further information about CTG studies please don't hesitate to contact the CTG office.

Research Project Grants

1 *Crystalloid versus Hydroxy-Ethyl Starch Trial.* NHMRC $2,169,500, NSW Dept of Health $200,000.

2 *Prolonged Outcome Study–RENAL.* NHMRC $625,000.

3 *Erythropoeitin in Traumatic Brain Injury.* Victorian Neurotrauma Initiative $1,416,130.

4 *Prophylactic Hypothermia in Traumatic Brain Injury.* Victorian Neurotrauma Initiative $669,970.

5 *Procalcitonin Guided Antibiotic Rational Decision Making in ICU patients Intensive Care.* Foundation $109,000.

6 *Patient Comfort and Safety Practices in ICU.* Intensive Care Foundation $10,000.

Publications

1 The Blood Observational Study Investigators on behalf of the ANZICS Clinical Trials Group. **Transfusion practice and guidelines in Australian and New Zealand intensive care units.** *Intensive Care Med;* Epub May 4 2010.

2 Chen J, Bellomo R, Hillman K, Flabouris A, Finfer S and the MERIT Study Investigators for the Simpson Centre and the ANZICS Clinical Trials Group. **Triggers for emergency team activation: A multicenter assessment.** *J Crit Care;* June 2010; 25(2): 359 e1-7.

3 Robertson MS, Nichol AD, Higgins AM, Bailey MJ, Presneill JJ, Cooper DJ, Webb SA, McArthur C, MacIsaac CM and the VTE Point Prevalence Investigators for the Australian and New Zealand Intensive Care Research Centre (ANZIC-RC) and the Australian and New Zealand Intensive Care Society Clinical Trials Group (ANZICS CTG). **Venous thromboembolism prophylaxis in the critically ill: a point prevalence survey of current practice in Australian and New Zealand intensive care units.** *Crit Care Resusc;* March 2010; 12(1): 9-15.

4 Flabouris A, Chen J, Hillman K, Bellomo R, Finfer S and The MERIT Study Investigators from the Simpson Centre and the ANZICs Clinical Trials Group. **Timing and interventions of emergency teams during the MERIT study.** *Resuscitation;* January 2010; 81(1): 25-30.

5 Bellomo R, Pettilä V, Webb SAR, Bailey M, Howe B and Seppelt IM. **Acute Kidney Injury and 2009 H1N1 Influenza-Related Critical Illness.** *Contrib Nephrol;* 2010; 165:310-14.

6 The ANZIC Influenza Investigators and Australasian Maternity Outcomes Surveillance System. **Critical illness due to 2009 A/H1N1 influenza in pregnant and postpartum women: population based cohort study.** *BMJ,* 2010; 340:c1279.

7 Bellomo R, Morimatsu H, Presneill J, French C, Cole L, Story D, Uchino S, Naka T, Finfer S, Cooper DJ and Myburgh J, on behalf of the SAFE Study Investigators and the Australian and New Zealand Intensive Care Society Clinical Trials Group. **Effects of saline or albumin resuscitation on standard coagulation tests.** *Crit Care Resusc,* 2009; 11: 250-256.

Working Committee Reports

8 Chen J, Flabouris A, Bellomo R, Hillman K, Finfer S, MERIT investigators for the Simpson Centre and the ANZICS Clinical Trial Group. **Baseline hospital performance and the impact of medical emergency teams: Modelling vs. conventional subgroup analysis.** *Trials;* December 2009; 10:117.

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10 The RENAL Replacement Therapy Study Investigators. **Intensity of Continuous Renal Replacement Therapy in Critically Ill Patients.** *N Engl J Med.* October 2009; 361(17):1627-38.

11 Webb SAR and Seppelt IM for the ANZIC Influenza Investigators. **Pandemic (H1N1) 2009 influenza ("swine flu") in Australian and New Zealand intensive care.** *Crit Care Resusc;* September 2009; 11(3):170-172.

12 Peake SL, Bailey M, Bellomo R, Cameron PA, Cross A, Delaney A, Finfer S, Higgins A, Jones DA, Myburgh JA, Syres GA, Webb SA, Williams P, ARISE Investigators for the Australian and New Zealand Intensive Care Society Clinical Trials Group. **Australasian resuscitation of sepsis evaluation (ARISE): A multi-centre, prospective, inception cohort study.** *Resuscitation;* Jul 2009; 80(7): 811-8.

CTG Meetings

The CTG has now moved to a calendar comprising three scientific meetings. The Spring Research Forum was held in conjunction with the ANZICS/ACCCN ASM in Perth in October 2009, the Noosa Meeting in March 2010 and the new Winter Research Forum will be held in August. This year's Noosa meeting was highly successful with strong attendance. The program was packed with new project proposals, all of which were of high-quality. We were very fortunate to have Brian Cuthbertson from Toronto, and formerly of Aberdeen, as the international invited speaker, and Dr Belinda Gabbe from Monash University as the IRCIG invited speaker. I would like to thank and acknowledge the fabulous work done by Sandy Peake as the CTG Meeting Convenor. The meetings are a critically important component of the development of new projects and Sandy plays a major role in ensuring that new projects can maximise the benefits associated with presenting their concept to the CTG research community.

The 2nd CTG Research Development Day was held as a satellite to the CICM ASM in Sydney in June 2010. Seven study proposals were presented this year and feedback from those attending was tremendously positive. This now looks to be a regular part of the meeting calendar providing a forum for early-stage investigators to present project proposal in conjunction with mentoring from senior members of the research community. Many thanks to Ian Seppelt for organising another highly successful day.

Changes to the Executive Committee

NZ Representative Dr Shay McGuinness
ACT Representative Dr Imogen Mitchell
Tas Representative Dr Michael Buist

Collaborations

The CTG is proud to support the Intensive Care Research Coordinators Interest Group (IRCIG) and I would like to thank Stephanie O'Connor for her contribution as IRCIG representative on the CTG Executive. We continue to work closely with two dynamic methods centres; The George Institute (TGI) and the Australian and New Zealand Intensive Care Research Centre (ANZIC-RC) at Monash University who provide project and data management for many CTG endorsed studies. Of particular note is that the ANZIC-RC was successful in obtaining a further $2.5 million from the NHMRC as a continuation of their previous Enabling Grant. The CTG has also established solid collaborative relationships with several international trials groups and is likely to be a foundation member of the International Forum of Acute Care Trialists (InFACT).

Summary

The highlight for 2009-2010 has been the publication of the RENAL study and ANZIC Influenza Investigator Registry observational study of pandemic influenza in the New England Journal of Medicine. Several studies have completed recruitment including STATINS, DECRA, ENTERIC, and PROTECT. It is hoped that both STATINS and DECRA will present their results at the Noosa meeting in March 2011. ARISE is now recruiting well with 33 sites participating including sites in Hong Kong and Finland. CHEST is recruiting as projected and will be the next CTG mega-trial to be completed. Two trials that enroll patients with traumatic brain injury, POLAR and EPO-TBI, have commenced recruitment.

Working Committee Reports

Death and Organ Donation Report

Newly endorsed projects include DahLIA (a RCT of dexmedetomidine in patients with agitated delirium), SPICE (an observational study of sedation practices that will be used to inform the design of RCTs related to sedation), POST-RENAL (a long-term outcome study of patients in the RENAL Study), POLAR-BEAR (a sub-study of POLAR related to nutrition), Pro-GUARD (a phase II RCT of pro-calcitonin guided antibiotic cessation) and the PREDICT study (an observational study of withdrawal of treatment). A 3,500 patient trial testing the effectiveness of low dose hydrocortisone in patients with septic shock has been proposed to the NHMRC and the outcome of this application will be known later in the year.

On behalf of the CTG Executive I would like to thank all the member units, the investigators, methods centres and the Research Coordinators for their commitment and contribution to improving patient outcomes by generating new evidence.

Steve Webb
Chair, CTG

The last 12 months have been a year of consolidation for activity relating to organ and tissue donation in Australia after the establishment of the Australian Organ and Tissue Authority. As its programs have been rolled out there has inevitably been a shift of leadership in this area to its national and state/territory Medical Directors. Nevertheless, the ANZICS Committee continues to have a key role and substantial overlap with those who have roles within the AOTA network as well as including intensive care clinicians who are not part of the AOTA network and our New Zealand representatives.

Edition 3.1 of the ANZICS Statement on Death and Organ Donation has been published with positive feedback, but no corrections or negative feedback received so far. The 'Statement' remains a 'living' document, with the most current version being that available on the website. The detailed work of the Committee in maintaining the document and researching potential modifications is greatly appreciated.

By the end of 2010 it is hoped to have an updated DVD on the clinical determination of brain death. The DVD is currently in production in Auckland with Stephen Streat as the driving force behind this undertaking. When completed it will be a valuable and contempory educational resource that will be incorporated into the ADAPT course. The project is supported by an educational grant administered through ANZICS.

Although it has taken somewhat longer than expected, the Australian National Protocol for Donation after Cardiac Death, prepared through the National Institute for Clinical Studies with a group that included several members of this Committee, should be available by the time the ANZICS Annual Report is published.

The other major focus for the Committee has been revision of the medical ADAPT program. The work has been carried out by a sub-committee with Charlie Corke co-opted as a representative of the College and Krishna Sandavarajan co-opted as a 'newer' Fellow.

Working Committee Reports

Safety and Quality Report

Secretariat services have been provided by AOTA who are also resourcing the developments of web-based components and a 'train the trainer' workshop. While this started on a relatively informal basis, the arrangement is to be formalised by a Memorandum of Understanding between ANZCIS and AOTA. The 'new' ADAPT should be available early in 2011 and it is likely it will include an expanded pool of bereavement consultants to deliver those key parts of the face-to-face workshop.

The remaining part of the Committee's work plan is revision of the ANZICS Statement on Withholding and Withdrawing Treatment. The detail work is to be undertaken by a different sub-committee under the leadership of Bill Silvester. We look forward to this project progressing over the next few months.

Geoff Dobb
Chair, Death and Organ Donation

The SQAO meeting was held in Creswick, Victoria in August. The meeting was collocated with the first CTG Winter Meeting and attracted the largest number of registrants yet. Feedback indicates that the meeting is of practical relevance. The 2011 meeting will be held in NSW, venue to be decided.

The Percutaneous Tracheostomy Consensus Statement has now been revised following the results of the survey of members. One hundred and seventeen members responded and there was quite a variation in opinion especially about bronchsoscopy. Once reviewed by the Board, the final draft and the results of the survey will be distributed to all members.

Following discussion at successive SQAO meetings about VAP, a consensus statement on care of the ventilated patient is being drafted which will build on the earlier VAP survey. It is intended that the draft statement will be subject to the same process of evaluation as the PDT statement.

Over the last few months there has been discussion between the Australian Commission for Safety and Quality in Healthcare and the S&Q Committee about a national Central Line Associate Bacteraemia project. A preliminary survey has indicated wide variations between jurisdictions. Gabby Hanlon is now installed at ANZICS House. David Charlesworth is the lead medical clinician. They are/will be making contact with key clinicians in each state and asking for expressions of interest.

Members of the Committee have had input into a review of the ACHS Intensive Care indicators (Vers 4) which will be released soon.

A generous grant from Baxter will allow the ANZICS to appoint a part time Executive Officer later this year. The position will be advertised soon. Baxter have also made available funds to be made available as seed funding for projects sponsored by the Committee.

Tony Burrell
Chair, Safety and Quality

Working Committee Reports

PRICE Report

The major activity of the Committee has been ongoing negotiation with the Department of Health and Aging in Canberra in an effort to ensure that our 2009 fees submission is accepted and entered into the MBS. Unfortunately, despite continuing positive feedback from the Department and a number of face-to-face meetings the matter has not progressed. The principal issue holding up progress appears to be the necessity for the Department to identify "offsets" from elsewhere in the MBS to cover the value of our proposed adjustments. The fees submission has now been in discussion with the Department in some regard or another for in excess of two years. The Committee is, at time of writing, considering options to escalate our approach to the Department regarding this matter.

The Committee was invited to provide feedback to the Department on the MBS Quality Framework, a new process by which items on the MBS will be assessed prior to listing. In addition it is proposed that in time existing items will be subject to this process – indeed the Department has pointed out that currently less than 3% of all MBS items have been formally assessed against contemporary evidence for safety, effectiveness and cost-effectiveness. A written response was provided, and Dr Yahya Shehabi was nominated for consideration to the Department as a member of one or more of the advisory committees that are being formed to guide this new process. The outcome of the consultative period and nominations is not yet known.

The Department identified MBS items related to pulmonary artery catheterisation as one of the first groups to be assessed using the Quality Framework process and invited ANZICS to participate in a clinical working group. CICM, anaesthesia, cardiac surgery and cardiology representatives were also invited. The process is currently ongoing and regardless of the outcome will be of considerable interest, as it will illustrate how the Department envisages the Quality Framework will work.

The Committee obtained clarification from the Department regarding billing for procedural items performed by resident staff as "essential assistance", and this was disseminated to the membership in "The Intensivist" and is available at http://www.anzics.com.au/downloads/cat_view/41-the-intensivist. The Committee also has published guidelines for members in relation to the provision of intensive care services to private hospitals.

The Committee is always available to assist members where there are problems relating to billings, either involving Medicare Australia or individual health funds, and has dealt with a small number of such issues in the past year. Furthermore, the Committee is willing to consider requests for assistance from ANZICS members where there are local industrial matters of dispute that might fall within the remit of the Committee's Terms of Reference.

Yahya Shehabi represented the Committee and ANZICS in general on the National Health Workforce Research Collaboration – Intensive Care Medicine Expert Working Party. Unfortunately only one meeting was held, in late 2009, the follow-up meeting being cancelled and no further meetings scheduled to date. ANZICS and CICM have agreed to work together to study workforce planning, and the PricE Committee will be considering whether it is best placed to manage this issue from the ANZICS side.

Committee membership

Acting Chair – Michael O'Leary (NSW)
Warwick Butt (Vic)
Nick Edwards (SA)
Ian Jenkins (WA)
Chris MacIsaac (Vic)
Mark Nicholls (NSW)
Ranald Pascoe (Qld)
Yayha Shehabi (NSW)

Michael O'Leary
Interim Chair, PricE

Regional Reports

ANZICS New South Wales Regional Committee

ANZICS NSW has been busy with an increase interest and membership applications especially from trainee members. An education session, titled 'H1N1 2009- Lessons learnt and what to expect in 2010', was conducted on the 13th of May. Case review, an audit of ECMO use, the ANZICS influenza investigators report and the NSW Department of Health planning and response were presented at this well attended meeting. A further meeting in September 2010 will debate the current views of practicing intensivists on the need for 24/7 intensivist presence.

There is broad support in NSW for ANZICS to maintain an ongoing role in the professional development and welfare of Intensivists and we plan on increasing communication by nominating ANZICS Linkspersons in all ICUs. Thus far 6 ICUs have ANZICS Linkspersons and efforts are underway to increase coverage. We hope to conduct regional meetings in the next year and as always we are keen for enthusiastic members to volunteer to become involved with State or Federal Committees. If you are interested, or just have some ideas, please don't hesitate to get in touch with one of those named below.

ANZICS NSW Regional Committee

Chair Deepak Bhonagiri

Members Mark Nicholls, Mark Lucey, Michael O'Leary

ANZICS Committee representation, NSW

Executive Michael O'Leary President

PRiCE Committee Michael O'Leary, Mark Nicholls – Members

ANZICS CTG Ian Seppelt, Peter Harrigan

ANZICS S&Q Committee Tony Burrell – Chair

ANZICS CORE Tony Burrell

ANZICS Organ & Tissue Donation Committee Deepak Bhonagiri

Deepak Bhonagiri
NSW Regional Chair

ANZICS New Zealand Regional Committee

The NZ regional ANZICS meeting in Hawkes Bay ("Why I see you's different") in March was a great success, primarily due to much hard work by Ross Freebairn and his team. During the AGM at this meeting, it was decided that a portion of profit from future NZ regional conferences would be donated to the Critical Care Nurses Section (CCNS), to be used to facilitate their members to attend and contribute to future NZ regional ANZICS meetings.

A NZ Ministry of Health funded meeting was held in May in Auckland to discuss H1N1 ICU planning, particularly with regards to ICU workforce. There were representatives from almost all NZ ICUs present. Discussion was productive in terms of producing and updating guidelines, and regular teleconference discussions continue during the H1N1 season.

Wellington is about to host the 2010 NZ ANZICS/CICM ICM registrars meeting on September 8-10. This will be associated with a short ICU simulation course. Waikato have indicated they would be interested in running the course in 2011.

The one day NZ regional ANZICS meeting will be in Auckland on November 3, hosted by the Department of Critical Care Medicine (Auckland Hospital). It will primarily be on critical care nutrition. Prior to this there will be a meeting to discuss setting up a NZ ICM educational website, probably as a repository of presentations/ lecture notes/ videos on subjects relevant to most of, not all, ICUs.

Finally, I would encourage members to encourage ICM trainees and other clinicians to join ANZICS, and also to take an active part in the society. It is here to represent you and needs your input to do this.

NZ Office bearers

Chair Janet Liang

Members Ben Barry, David Knight, Simon Scothern

ANZICS Committee representation, NZ

ANZICS CTG Colin McArthur, Shay McGuiness

ANZICS S&Q Committee Nigel Rankin, Tony Williams

ANZICS CORE Peter Hicks

ANZICS Organ & Tissue Donation Committee Stephen Streat, James Judson

Janet Liang
NZ Regional Chair

Regional Reports

ANZICS Queensland Regional Committee

The main item on our regional committee agenda is the 2011 ANZICS/ACCCN ASM to be held in Brisbane. The organising committee has been formed and sub-committees are hard at work to meet the high expectation of ASM delegates. Dr J Presneill is the chair of the medical scientific committee and has drafted, together with our nursing colleagues, an excellent program. International speakers are currently being invited.

A Registrar Research Forum - co-badged with the CICM Qld regional committee is due to be held on November 18. Please contact Dr Udy at RBWH or Dr M Cartner at GCH for details.

The aim of this day is to introduce our diverse group of Intensive Care Researchers in Queensland to Intensive Care Trainees and each other, in order to encourage research amongst trainees and specialists alike.

A survey of Qld ICU's highlights the paucity of specialists in regional areas, and metropolitan units should encourage trainees to make use of new CICM regulations and rotate to regional units and have some of their time accredited. Exposure to regional units will hopefully encourage new specialists to consider a career in smaller centres as the South-East corner is relatively well staffed with Intensivists.

Marc Ziegenfuss
QLD Regional Chair

ANZICS South Australian Regional Committee

South Australia continues to rely on a close cooperation between ANZICS and the CICM, as do most smaller regions; the combined annual meeting of the two was held on 12th of May 2010. It is anticipated that this will continue and we can enjoy the professional and social synergies that result.

The SA DOH is establishing a working party to advise on end-of-life decision making, and an expert panel has been set up, with ANZICS represented by Mary White, Rob Young and Toby Thomas, with Pete Sharley representing the CICM.

The SA region has expressed concern at recent suggestions that bronchoscopy should be mandatory for percutaneous tracheostomy. Our new Safety and Quality representative, Brett Sampson, has been helping Tony Burrell formulate guidelines that will be released soon, and should allay the local concerns.

The third annual Tub Worthley Travelling Scholarship meeting was held in June, at which registrars present current research projects. From a variety of excellent presentations, this year's winner was Shailesh Bihari, from Flinders Medical Centre, with "Analysis of the amount of sodium administered to patients requiring prolonged mechanical ventilation." Exam pressures will prevent him from presenting this at the ANZICS ASM but he hopes to have it accepted for publication. This meeting always makes a great social event as well as a useful training experience for the presenters and valuable CME for the rest of us.

SA Office bearers

Chair David Durham
Vice-chair Ken Lee
Secretary and Treasurer Adam Deane

SA representatives on committees

CTG Sandy Peake
Abstract review Marianne Chapman
PricE Nick Edwards
Safety and Quality Brett Sampson
CORE John Moran
Organ and tissue donation Stewart Moodie
ARC Stuart Baker

David Durham
SA Regional Chair

Regional Reports

ANZICS Tasmanian Regional Committee

ANZICS continues to have strong membership support in Tasmania, despite a relatively small number of intensive care beds and specialists. We are also well supported by local anaesthetists in the north of the state. Increasing numbers of advanced trainees are now choosing to pursue their careers in Tasmania, enjoying the excellent lifestyle, broad case mix and the personal attention to training afforded by smaller units. We have achieved excellent exam success in recent years. In 2010, both LGH and RHH were well regarded at College accreditation, and maintained C12 and C24 training status respectively.

Plans for redevelopment at Royal Hobart Hospital are well under way, with tenders now out for building work. The new unit will have up to 25 ICU beds. This should positively impact on the delivery of intensive care services in the state, where, like elsewhere, there has been significant and increasing bed pressure in recent years. This project preceded the most recent federal political upheaval. With new funds being earmarked for redevelopment work at RHH since the recent election, we hope this new political climate will have additional positive impacts on health services for all of Tasmania, RHH being the state's tertiary referral centre.

Education meetings are all run jointly with the CICM Regional Committee.

With limited ability to meet face to face due to small numbers and distance, we have been utilising teleconferencing more frequently over the past year. Successful education sessions and business meetings have been conducted using this forum. At least once per year dinner meetings are conducted in Launceston, and this year included presentations from some of our trainees. We were privileged this year to have the 2009 Matt Spence medal winner, Dr Matt Brain from LGH, present his work to us.

The 2010 annual Tasmanian ANZICS/ACCCN Continuing Education Meeting was held recently in Launceston. It was a sepsis-themed event, organised by Mike Anderson and ACCCN representatives from Launceston General Hospital. It included several interstate speakers and was well supported and well received by all who attended.

Andrew Turner is the Tasmanian Medical Director for organ and tissue donation. We have seen steady progress in this area over the past year in Tasmania. Currently, organ donations occurring in Tasmania are coordinated out of Melbourne. The national initiatives have allowed the progressive development of local services in each of the three major centres, and in the very near future Tasmanian-based donor coordinators will fully take over this role. We are already seeing positive results from these changes.

Assoc. Prof. Marcus Skinner recently left the North West Regional Hospital in Burnie, after more than 13 years service, to take up the post of Director of Anaesthesia at Royal Hobart Hospital. As former Director of the Division of Critical Care at Burnie he lead the development of Intensive Care services in North West Tasmania over this period. We wish him well in his new role.

ANZICS Tasmania Regional Committee

Chair David Rigg

ANZICS Hospital Contacts

RHH David Rigg
NWRH Alan Rouse

Tasmanian committee representation

ANZICS Executive Andrew Turner – Treasurer
ANZICS CTG Michael Buist
ANZICS CORE Alan Rouse

David Rigg
TAS Regional Chair

Regional Reports

ANZICS Victorian Regional Committee

ANZICS ASM Melbourne 2010

The Victorian Region has been largely occupied with arrangements for the upcoming 2010 ASM which is being hosted in Melbourne. Our theme, 'Intensive Care – getting it right: the right treatment, for the right patient, at the right intensity', reflects what we feel is an important emerging need for optimised targeting of critical care interventions and support. Planning of scientific program has been completed with an excellent calibre of international, interstate and local speakers confirmed to attend. The abstract review process is now also completed and sessions have been allocated to successful investigators. Sponsorship and industry participation has been pleasing and continues to progress towards predicted targets. The social program is currently being finalised and looks set to meet the high expected standards that have been achieved at previous successful meetings.

Coordination of Shared Educational Resources

As part of an initial trial, four hospitals (Northern, Austin, Box Hill and St. Vincent's- NABS) in Melbourne's north-east have committed to share training resources and opportunities for registrars. On a monthly basis, advanced trainees and other registrars working in the ICU are released for a full day of education and training which is hosted by one of the four sites. In addition to didactic teaching, practical bedside sessions are also included to provide necessary skill and examination training. The program has been embraced by trainees and the hosting hospitals, although challenges remain. The most important issue relates to managing service delivery commitments and cover in order to release registrars to attend. Work to address this issue is ongoing. Expressions of interest from other hospitals who may be interested in joining for 2011 will be sought shortly.

Committee Membership

S. Warrillow (Chair)

R. Citroni (Deputy-Chair)

D. Charlesworth (Secretary)

Stephen Warrillow
VIC Regional Chair

ANZICS Western Australian Regional Committee

Early this year David Blythe resigned after three years as the Western Australian representative on the Board of Directors of ANZICS. I would like to thank David for all the hard work and enthusiasm he put into the position, especially as much of it was whilst he was also serving as the CTG representative. Our current CTG executive member is Ed Litton, whilst KM Ho is the CORE member and Brad Power remains as the Safety and Quality committee member. Steve Webb is the incumbent CTG Chair, whilst Geoff Dobb is Chair of the Death and Organ Donation Committee and Simon Erickson is the Paediatric representative on the ANZICS Board. This makes three of the six ANZICS Committees being chaired by Western Australians. I remain as a member of the Practices and Economics (PricE) Committee.

Whilst, as a state, we are over-represented at bi-national level, we function without a local committee. This is a pattern seen in many jurisdictions – it is a satisfactory state of affairs in one sense, if local meetings are organised and members' welfare is attended to by the regional Chair. However it 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. The second area of traction for a regional committee is to make our organisation more visible to trainees and non-members and thus promote membership. However the pace of professional life seems to be interminably quickening and finding committee members with time to contribute gets more difficult each year.

The highlight in WA over the previous year was the hosting of the ANZICS-ACCCN Annual Scientific Meeting last October; academically, socially and financially this was a resounding success. I wish to thank the organising committee and especially Brad Power as Medical Convenor who worked very hard and smart for the benefit of all those who attended and all ANZICS members. By the time of the next Perth ASM in 2016 it will be 23 years since someone other than Brad has been Medical Convenor, as he filled the role in 2002 as well.

Regional Reports

We have reinstituted our quarterly evening education sessions. The large attendance, especially by trainees, as a meeting in May, demonstrated the support and desire for these events. In addition, Brigit Roberts, at Sir Charles Gairdner Hospital continues to organise and coordinate highly successful research meetings where CTG-endorsed, single-centre and commercial trials conducted in WA are discussed and relevant information from CTG-central is disseminated. These meetings are invaluable for the way they unite ICU research efforts across the city. Both the evening educational meetings and the CTG gatherings are kindly supported by industry, for which we are grateful.

Whilst ICU beds remain centralised within the greater metropolitan area in Western Australia, Perth is undergoing an expansion of number of ICU beds with so-called Level I ICUs being established at two smaller general hospitals on the outskirts of town. Along with our rapidly growing and aging population, current under-supply of ICU beds and the relative paucity of ICU specialists in WA, these factors will provide some interesting and difficult workforce challenges in the near future. I trust that ANZICS, as advocate for Intensive Care, both the patient and practitioner, will be involved in a constructive way in planning a solution.

Ian R Jenkins
WA Regional Chair

Conjoint Rural Committee of ANZICS & CICM

The Conjoint Rural Committee (CRC), formed jointly by ANZICS and CICM (and its immediate fore-runner JFICM) continues in its endeavours to raise the profile of 'rural' Intensive Care Medicine (ICM), and to attempt to positively influence various aspects of 'rural' ICM practice.

One of the key difficulties that we face is the heterogeneous nature of 'rural' practice itself, as well as the heterogeneity of the problems that Clinicians encounter in such locations. The inherent breadth and diversity contribute to the difficulty in bringing focussed efforts to bear, and to the difficulty in gauging our impact. The bi-National nature of our parent organisations serves to amplify this heterogeneity.

To date in 2010, CRC has had one teleconference (20-4-10; inquorate), plus one 'face-to-face' meeting that was held at the CICM ASM. Despite relatively low attendance numbers, both were useful information and discussion forums. Such meetings continue to assist with advancing the Committee's objectives.

The CRC's revised Terms of Reference were received by the Boards of both parent bodies at the end of 2009. A copy of these Terms of Reference can be obtained upon request. As befits the 'rural' lifestyle that it represents, there has been a continuing relative informality in the conduct of the Committee that is counter-balanced by the enthusiasm and commitment of those who are prepared to offer their time and ideas. Input from any and all 'rural' Practitioners is welcomed.

Through formal correspondence (principally with the Board of CICM, but one also 'copied' to ANZICS Board), and a Letter to the Editor (*Anaesthesia and Intensive Care,* 2010;38:778-779) we have striven to advance the Committee's objectives and to keep rural ICM 'on the radar'. Topics that have been addressed include: rural training rotations; content of general Fellowship training (paediatric content; 'core' ICM time); structure, standards and framework of rural Specialist ICM practice; and rural Specialist recruitment. It is pleasing to note that CICM have introduced a voluntary 3 month rural rotation within the non-continuous ATY. We are awaiting formal responses to our letters, and we trust that constructive engagement will ensue.

Gerard McHugh
Co-Chair, CRC – Palmerston North, New Zealand

Penny Stewart
Co-Chair, CRC – Alice Springs, NT, Australia

Financial Report

Australian And New Zealand Intensive Care Society
ABN 81 057 619 986

Directors' Report

The directors present their report together with the financial report of the Australian and New Zealand Intensive Care Society (the "Society" or "ANZICS") for the financial year ended 30 June 2010 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 Michael O'Leary *President*
Dr Peter Hicks Immediate *Past President*
Dr Andrew J Turner *Treasurer*
Dr Mary G White *Hon. Secretary*
Dr Satyadeepak Bhonagiri *(appointed 15 March 2010)*
Dr David Durham *(appointed 15 March 2010)*
Dr Simon Erickson
Dr Ian Jenkins *(appointed 15 March 2010)*
Dr Janet Liang
Dr David Pilcher *(appointed 13 July 2010)*
Dr David Rigg *(appointed 23 November 2009)*
Dr Stephen Warrillow *(appointed 15 March 2010)*
Dr Steven Webb *(appointed 17 July 2009)*
Dr Marc Ziegenfuss

Dr Jamie Cooper *(resigned 17 July 2009)*
Dr David Blythe *(resigned 15 March 2010)*
Dr Craig Hore *(resigned 15 March 2010)*
Dr Chris MacIsaac *(resigned 15 March 2010)*
Dr Yahya Shehabi *(resigned 15 March 2010)*
Dr Ram Sistla *(resigned 23 November 2009)*
Dr Graeme Hart *(resigned 13 July 2010)*

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 educational to its members and stakeholders.

Directors' Report

How the principal activities achieve our objectives

The principle 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 O'Leary
Qualifications: MRCS/LRCP
Experience: Director since 2004
Special Responsibilities: President

Dr P Hicks
Qualifications: MBChB
Experience: Director since 2004
Special Responsibilities: Immediate Past President

Dr A J Turner
Qualifications: MBBS
Experience: Director since 1999
Special Responsibilities: Treasurer

Dr M G White
Qualifications: MBBS/BSc/ChB
Experience: Director since 2002
Special Responsibilities:
Hon. Secretary, Chair – S.A. Region

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

Dr D Durham
Qualifications: MBBS
Experience: Director since March 2010
Special Responsibilities: Chair – S.A. Region

Dr S Erickson
Qualifications: MBBS
Experience: Director since 2007
Special Responsibilities: Paediatric Representative

Dr Ian Jenkins
Qualifications: BHB/MBChB
Experience: Director since March 2010
Special Responsibilities: Chair – W.A. Region

Dr J Liang
Qualifications: ChB/BSc
Experience: Director since 2008
Special Responsibilities: Chair New Zealand Region

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

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

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

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

Dr M Ziegenfuss
Qualifications: MBCLB/BSc
Experience: Director since 2008
Special Responsibilities: Chair – Queensland 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 M O'Leary	3	3
Dr P Hicks	3	3
Dr A J Turner	3	2
Dr M G White	3	3
Dr S Bhonagiri *(appointed 15 March 2010)*	1	1
Dr D Blythe *(resigned 15 March 2010)*	2	1
Dr J Cooper *(resigned 17 July 2009)*	-	-
Dr D Durham *(appointed 15 March 2010)*	1	1
Dr S Erickson	3	3
Dr G Hart *(resigned 13 July 2010)*	3	2
Dr C Hore *(resigned 15 March 2010)*	2	1
Dr I Jenkins *(appointed 15 March 2010)*	2	2
Dr J Liang	3	2
Dr C MacIsaac *(resigned 15 March 2010)*	2	-
Dr D Pilcher *(appointed 13 July 2010)*	-	-
Dr D Rigg *(appointed 23 November 2009)*	2	1
Dr Y Shehabi *(resigned 15 March 2010)*	2	2
Dr R Sistla *(resigned 23 November 2009)*	1	-
Dr S Warrillow *(appointed 15 March 2010)*	1	1
Dr S Webb *(appointed 17 July 2009)*	3	2
Dr M Ziegenfuss	3	2

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. In that case, the contribution is to be used for payment of 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 contribution amount, such as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $12,480 (2009: $12,040) being 624 (2009: 602) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2010 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 Michael O'Leary
Director

Dr Andrew Turner
Director

Dated this 3rd day of September 2010.

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 2010 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

KPMG

Mitch Craig
Partner

Melbourne

3 September 2010

Statement of Comprehensive Income

for the year ended 30 June 2010

	Note	2010 $	2009 $
Revenue from ordinary activities	2	2,068,418	2,611,599
Employee expenses		(1,026,720)	(1,038,893)
Conference and meeting expense		(338,673)	(522,946)
Administration expenses		(340,249)	(540,384)
Depreciation expense		(55,611)	(76,269)
Travel and committee expenses		(143,448)	(142,857)
Finance expenses		(268)	(1,336)
Other expenses from ordinary activities		(94,214)	(32,412)
Profit for the year		69,235	256,502
Other comprehensive income			
Other comprehensive income for the year, net of income tax		-	-
Total comprehensive income for the year		69,235	256,502

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2010

	Note	2010 $	2009 $
Current assets			
Cash and cash equivalents	4	1,268,421	775,136
Trade and other receivables	5	154,124	530,175
Other current assets	6	46,148	167,831
Total current assets		1,468,693	1,473,142
Non-current Assets			
Financial assets	7	16,000	15,358
Property, plant and equipment	8	2,314,838	2,350,373
Income fund	9	92,342	97,340
Total non-current assets		2,423,180	2,463,071
Total Assets		3,891,873	3,936,213
Current Liabilities			
Trade and other payables	10	520,812	641,427
Total current liabilities		520,812	641,427
Non Current Liabilities			
Employee benefits	11	27,162	15,124
Income fund liability	9	92,342	97,340
Total non-current liabilities		119,504	112,464
Total Liabilities		640,316	753,891
Net Assets		3,251,557	3,182,322
Equity			
Reserves	12	428,092	428,092
Retained profits		2,823,465	2,754,230
Total Equity		3,251,557	3,182,322

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2010

	Note	2010 $	2009 $
Cash flows from operating activities			
Cash receipts from members and customers		2,627,222	2,644,942
Interest received		32,439	27,147
Payments to suppliers and employees		(2,145,024)	(2,516,169)
Interest paid		(268)	(1,273)
Net cash provided by operating activities	14	514,369	154,647
Cash flows from investing activities			
Purchases of property, plant and equipment		(21,084)	(23,033)
Net cash used in investing activities		(21,084)	(23,033)
Net increase in cash		493,285	131,614
Cash at beginning of financial year		775,136	643,522
Cash at end of financial year	4	1,268,421	775,136

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2010

	Retained profits $	Asset revaluation reserve $	Total $
Balance at 1 July 2008	2,497,728	428,092	2,925,820
Profit attributable to the Society	256,502	-	256,502
Total other comprehensive income for the year	-	-	-
Balance at 30 June 2009	2,754,230	428,092	3,182,322
Profit attributable to the Society	69,235	-	69,235
Total other comprehensive income for the year	-	-	-
Balance at 30 June 2010	2,823,465	428,092	3,251,557

The accompanying notes form part of these financial statements.

Note to the Financial Statements

for the year ended 30 June 2010

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.

1. Summary of significant accounting policies

The financial statements are general purpose financial statements that have been prepared in accordance with Australian Accounting Standards (including Australian Accounting Interpretations) and the Corporations Act 2001.

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 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.

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 values 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 fair value 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 the cost basis less 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.

Note to the Financial Statements

for the year ended 30 June 2010

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.

Note to the Financial Statements

for the year ended 30 June 2010

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.

Note to the Financial Statements

for the year ended 30 June 2010

Key estimates

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.

(I) New accounting standards and interpretations not yet adopted

The following amendments have been identified which may impact the entity in the period of initial application. These are available for early adoption at 30 June 2010, but have not been applied in preparing these financial statements:

AASB 1053 *Application of Tiers of Australian Accounting Standards* includes traditional provisions for various different situations including for entities that previously prepared special purpose financial statements and are now required to prepare financial statements under either Tier 1 or 2 as well as for those entities transitioning between the different tiers AASB 1053 will become mandatory for the year ended 30 June 2014. The entity has not yet determined the potential effect of the standard.

AASB 9 *Financial Instruments* includes requirements for the classification and measurement of financial assets resulting from Phase 1 of the project to replace AASB 139 *Financial Instruments: Recognition and Measurement.* AASB 9 will become mandatory for the entity's 30 June 2014 financial statements. Retrospective application is generally required, although there are exceptions, particularly if the entity adopts the standard for the year ended 30 June 2012 or earlier. The entity has not yet determined the potential effect of the standard.

AASB 124 Related Party Disclosures (revised December 2009) simplifies and clarifies the intended meaning of the definition of a related party and provides a partial exemption from the disclosure requirements for government-related entities. The amendments, which will become mandatory for Society's 30 June 2012 financial statements, are not expected to have any impact on the financial statements.

AASB 2009-5 *Further amendments to Australian Accounting Standards arising from the Annual Improvements Process* affect various AASBs resulting in minor changes for presentation, disclosure, recognition and measurement purposes. The amendments, which become mandatory for the Society's 30 June 2011 financial statements, are not expected to have a significant impact on the financial statements.

	2010 $	2009 $
2. Revenue and other income		
Revenue:		
Grants	942,716	991,967
Subscriptions	402,141	383,809
Surplus from ASM	193,939	537,467
Conferences and meetings	305,286	419,445
Sponsorship	95,332	132,788
	1,939,414	2,465,476
Other income:		
Interest received	37,804	29,816
Rent received	24,331	21,171
Sundry income	66,869	95,136
	129,004	146,123
Total revenue and other income	2,068,418	2,611,599

Note to the Financial Statements

for the year ended 30 June 2010

		2010 $	2009 $
3. Profit for the year			
Expenses			
Depreciation	- buildings	27,475	27,475
	- plant and equipment	28,136	48,794
		55,611	76,269

Auditor's remuneration:
The auditors of the Society for the year ended 30 June 2010 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 2009.

	2010 $	2009 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	660,642	774,836
Cash on short term deposit	607,479	-
	1,268,421	775,136
5. Trade and other receivables		
Trade receivables	147,494	529,808
Other receivables	6,630	367
	154,124	530,175
6. Other current assets		
Prepayments – general	35,881	12,074
Prepayments and deposits – ASM	10,267	155,757
	46,148	167,831
7. Financial assets		
Held to maturity financial assets	16,000	15,358
- comprises NZ Debentures (Balanced Fund)		

Note to the Financial Statements

for the year ended 30 June 2010

	2010 $	2009 $
8. Property, plant and equipment		
Land and buildings		
Freehold land – at valuation	1,210,000	1,210,000
Buildings – at valuation	1,099,000	1,099,000
Less accumulated depreciation	(54,950)	(27,475)
	1,044,050	1,071,525
Total land and buildings	2,254,050	2,281,525
Plant and equipment		
Plant and equipment – at cost	208,718	249,814
Less accumulated depreciation	(147,930)	(180,966)
Total plant and equipment	60,788	68,848
Total property, plant and equipment	2,314,838	2,350,373

Revaluation of property

The freehold land and buildings were revalued on 10 June 2008 by independent valuers, Market line Property Valuations.

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
2009			
Balance at 1 July 2008	2,309,000	103,572	2,412,572
Additions	-	23,033	23,033
Disposals/write-offs	-	(8,963)	(8,963)
Depreciation for the year	(27,475)	(48,794)	(76,269)
Balance at 30 June 2009	2,281,525	68,848	2,350,373
2010			
Balance at 1 July 2009	2,281,525	68,848	2,350,373
Additions	-	21,084	21,084
Disposals/write-offs	-	(1,008)	(1,008)
Depreciation for the year	(27,475)	(28,136)	(55,611)
Balance at 30 June 2010	2,254,050	60,788	2,314,838

Note to the Financial Statements

for the year ended 30 June 2010

	2010 $	2009 $
9. Income Fund		
Australians Donate Education Fund	92,342	97,340

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. $73,283 has been invested in a 120 day term deposit with ANZ at 5.0% p.a. The balance is held in the ANZICS bank account pending payment of funds.

	2010 $	2009 $
10. Trade and other payables		
Sundry creditors and accruals	114,891	172,015
Grants received in advance	56,900	243,479
Subscriptions received in advance	215,635	129,497
Sponsorship & registrations received in advance	65,497	17,500
Employee entitlements – current	67,889	78,936
	520,812	641,427

11. Employee benefits

Non-current

Provision for long service leave	27,162	15,124
Opening balance at 1 July 2009	15,124	
Increase in provision during the year	12,038	
Balance at 30 June 2010	27,162	

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.

Note to the Financial Statements

for the year ended 30 June 2010

	2010 $	2009 $
12. Reserves		
Asset revaluation reserve	428,092	428,092

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

13. Members' Guarantee

Every member of the Society undertakes to contribute to the property of the Society in the event of the same being wound up while he/she is a member, or within one year after he/she ceases to be a member. In that case, the contribution is to be used for payment of 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 contribution amount, such as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $12,480 (2009: $12,040) being 624 (2009: 602) members with a liability limited to $20 each.

	2010 $	2009 $
14. Notes to the Statement of Cash Flows		
Reconciliation of cash flow from operations with profit after income tax		
Profit from ordinary activities	69,235	256,502
Add/(less) non-cash items:		
Depreciation	55,611	76,269
Loss on disposal of non-current assets	1,008	8,963
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	376,051	(123,101)
(Increase)/decrease in other current assets	121,683	(21,187)
(Increase)/decrease in financial assets	(642)	(863)
Increase/(decrease) in trade and other payables	(120,615)	(11,120)
Increase/(decrease) in provisions	12,038	(30,816)
Net cash provided by operating activities	514,369	154,647

15. Related Parties

Directors

The following persons held the position of Director of the Society during the financial year:
Dr Michael O'Leary, Dr Peter Hicks, Dr Andrew J Turner, Dr Mary G White, Dr Satyadeepak Bhonagiri, Dr David Durham, Dr Simon Erickson, Dr Ian Jenkins, Dr Janet Liang, Dr David Rigg, Dr Stephen Warrillow, Dr Steven Webb, Dr Marc Ziegenfuss, Dr Jamie Cooper, Dr David Blythe, Dr Craig Hore, Dr Chris MacIsaac, Dr Yahya Shehabi, Dr Ram Sistla and Dr Graeme Hart.

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

Note to the Financial Statements

for the year ended 30 June 2010

16. Key management personnel compensation

	Short-term benefits $	Post employment benefits $	Total $
2010			
Total compensation	283,619	23,663	307,282
2009			
Total compensation	281,887	24,991	306,878

17. Events subsequent to reporting date

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

18. Society details

The registered office and principal place of business of the Society is: 10 levers Terrace, Carlton, Victoria 3053

19. 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:

(i) Sponsorship – Written applications are signed by all sponsors stating the amount that is owed to the Society and the relevant payment terms.

(ii) Membership Fee – Written renewal invoices are provided to members each year, and membership renewal is not brought to account unless the member has paid. New member application forms are signed by all members, and invoices are sent to new members on receipt of their application. New membership is not brought to account unless the new member has paid.

(iii) Registration Fee – Course registration is managed both online and by written application. Written course registration forms are signed by all participants stating the amount that is owed to the Society and the relevant payment terms. Generally the registration fees are

Note to the Financial Statements

for the year ended 30 June 2010

collected in advance before the commencement of the courses, either by EFTPOS, credit card or cheque. Registrations are generally 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 20.

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.

20. Financial instruments

(a) Financial Assets:

Financial Instruments	Accounting Policy	Terms and 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

	2010 Carrying amount $	2010 Fair value $	2009 Carrying amount $	2009 Fair value $
Cash and cash equivalents	1,268,421	1,268,421	775,136	775,136
Trade and other receivables	154,124	154,124	530,175	530,175
Trade and other payables	520,812	520,812	641,427	641,427

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

Note to the Financial Statements

for the year ended 30 June 2010

(c) Interest Rate Risk

	Carrying amount 2010 $	2009 $
Floating rate instruments		
Cash and cash equivalents	1,268,421	775,136

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

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

(d) Credit Risk

The Australian and New Zealand Intensive Care Society's exposure to credit risk at balance date in relation to each financial asset is the carrying amount of those assets as indicated on the Statement of Financial Position.

Exposure to credit risk
The carrying amount of the entity's financial assets represents the maximum credit exposure.

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

	Carrying amount 2010 $	2009 $
Loans and receivables	154,124	530,175
Cash and cash equivalents	1,268,421	775,136
	1,422,545	1,305,311

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.

Note to the Financial Statements

for the year ended 30 June 2010

	Gross amount $	Past due and impaired $	Past due but not impaired (days overdue) <30 $	31-60 $	61-90 $	>90 $	Within initial trade terms $
2010							
Trade receivables	147,494	-	51,682	35,657	44,200	15,955	51,682
Other receivables	6,630	-	6,630	-	-	-	6,630
Total	154,124	-	58,312	35,657	44,200	15,955	58,312
2009							
Trade receivables	529,808	-	295,970	14,080	5,940	213,818	295,970
Other receivables	367	-	367	-	-	-	367
Total	530,175	-	296,337	14,080	5,940	213,818	296,337

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 2010 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 2010							
Payables	520,812	520,812	520,812	–	–	–	–
30 June 2009							
Payables	641,427	641,427	641,427	–	–	–	–

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 22, 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 2010 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 Michael O'Leary
Director

Dr Andrew Turner
Director

Dated this 3rd day of September 2010.

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

Report on the financial report

We have audited the accompanying financial report of Australian and New Zealand Intensive Care Society (the Society), which comprises the statement of financial position as at 30 June 2010, and the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year ended on that date, a summary of significant accounting policies and other explanatory notes 1 to 20 and the directors' declaration.

Directors' responsibility for the financial report

The directors of the Society are responsible for the preparation and fair presentation of the financial report in accordance with Australian Accounting Standards (including the Australian Accounting Interpretations) and the *Corporations Act 2001*. This responsibility includes establishing and maintaining internal control relevant to the preparation and fair presentation of the financial report that is free from material misstatement, whether due to fraud or error; selecting and applying appropriate accounting policies; and making accounting estimates that are reasonable in the circumstances.

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 and fair presentation of the financial report 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 (including the Australian Accounting Interpretations), a view which is consistent with our understanding of the Society's financial position and of its performance.

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

KPMG

Independence

In conducting our audit, we have complied with the independence requirements of the *Corporations Act 2001*.

Auditor's opinion

In our opinion:

(a) the financial report of Australian and New Zealand Intensive Care Society is 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 2010 and of its performance for the year ended on that date; and

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

KPMG

Mitch Craig
Partner

Melbourne

3 September 2010

Appendix One

Annual General Meeting

5.00 p.m. Friday 30th October, 2009

Riverview Room 5,
Perth Convention and Exhibition Centre

Draft Minutes

1. Welcome, Present and Apologies

PH welcomed attendees to the meeting and noted the apologies received.

Present

Peter Hicks (President)
Michael O'Leary (Vice President)
Mary White (Honorary Secretary)
Andrew Turner (Honorary Treasurer)
Deepak Bhonagiri
David Blythe
Jorge Brieva
Tony Burrell
John Cade
Peter Cameron
Marianne Champan
David Charlesworth
Andrew Davies
Dick Dinsdale
John Edington
David Ernest
John Fraser
Robert Frengley
David Gattas
Elizabeth Fugaccia
Peter Harrigan
Graeme Hart
John Lambert
Kenneth Lee
Janet Liang
Jeff Lipman
Tony McDonogh
Paul McGinn
Peter Morley
Gerry O'Callaghan
David Pilcher
Brad Power
John Santamaria
Yahya Shehabi
Peter Saul
David Tuxen
Andrew Udy
Stephen Warillow
Steve Webb
Ann Whitfield
Marc Zeigenfuss

In Attendance

Erin O'Sullivan (Acting General Manager)
Vernon Van Heerden (JFICM)

Apologies

Rinaldo Bellomo
Jonathan Buckmaster
Geoff Guttridge
Andrew Casamento
Michael Parr
Roberto Citroni
Louise Cole
Ray Raper
Arthas Flabouris
James Judson
Barbara Trytko
Nigel Rankin
Brian Pezzutti
Walter Thompson
Peter Cook
Ian Seppelt
Dan Mullany

2. Previous Minutes

Motion: The minutes are accepted as a true and accurate record of the meeting.
Proposed: D. Blythe
Seconded: J. Santamaria
Motion carried

3. Presidents Report

P Hicks presented the Presidents report and provided a summary of the activities undertaken during the year. He reported that the main activities included the closure of the conference and events division, the restructure of the accounts division and the relocation of all staff to level 3 of ANZICS House.

PH advised that the Board had accepted the resignation of the General Manager in September due to ill health

Appendix One

and other reasons. PH recognised the work of Kathy Muscat over the past two years as General Manager and thanked Erin O'Sullivan for standing in following Kathy's resignation.

PH noted that since the implementation of certain strategic decisions the Board has adopted an outward and forward looking perspective. PH reported that the Board at its most recent meeting, made a number of decisions aimed at furthering the work and output of the Society including: sponsoring a speaker at the Asia Pacific Association of Critical Care Medicine Conference in 2010, a donation to the BASIC Course, the development of a New Specialists Course and the 2011 Singapore ANZICS conference.

PH emphasised the important role played by the ANZICS infrastructure through the general email lists, CTG and CORE during the swine flu epidemic.

PH advised that the Society is in a sound financial position and tracking well to budget.

PH thanked members for their commitment to the Society over the past two years.

4. Treasurers Report

A Turner presented the Treasurers report. AT reported that subscription revenue increased in the last financial year and has continued to rise in the last two years. He noted that CORE grants have also increased. An approximate profit share of $535,000 was received from the 2008 ASM global surplus.

AT noted that current equity is $2.3m.

AT reported that the Board resolved to divest the Australian Centre for Clinical Leadership and to close the Conference and Events Division. AT noted that the closure of the Conference and Events division has had a marked impact on reducing staff costs for the current financial year.

AT advised that the Finance, Risk and Audit Committee had recently met with the Auditors who had advised that the Society's finances were in good condition and that the audited accounts were received ahead of time.

AT reported that the seasonalised budget was approved by the Board in June 2009 and that the accounts are currently tracking well to budget.

4.1 Auditor's Report for 2008/2009

Motion: That the Honorary Treasurers report be accepted.

Proposed: M O'Leary
Seconded: P Hicks
Motion Carried

Motion: That KPMG be appointed as auditors for the financial year ended 30 June 2010.
Proposed: J Santamaria
Seconded: D Tuxen.
Motion Carried

5. JFICM

V. van Heerden presented the JFICM report. He noted that it had been a busy year for the College negotiating the separation from ANZCA. VvH reported that there were currently 700 fellows and 700 trainees and that invitation for Foundation Fellowship will be sent before the end of the year.

VvH displayed the CICM coat of arms and foundation fellowship certificate.

VvH advised that the CICM has secured premises in Melbourne and presented plans and sketches of the location. He noted that the CICM Board still hoped to collocate with ANZICS within the next three to five years. He advised that the contact details for the CICM had changed and can be found on the new website.

6. Joint JFICM/ANZICS Ultrasound Committee

No discussion noted.

7. Membership

P Hicks reported that there has been a steady increase in membership numbers and attributed the marked increase in trainee numbers to the Intensive Care Medicine Course run by Ramesh Nagappan. PH highlighted the need to ensure access to trainees following their transition to Specialists and noted that it is intended that the New Specialists Course being developed by the Board covers the gap.

PH reported that full membership is at approximately 400 following a cleanup of the membership database and the development of online fee payment.

In response to the suggestion of a membership drive, PH advised that a membership drive had been undertaken two years ago. M O'Leary noted that the Board had recently resolved to send a list of all members to the Regional Chairpersons so that they can potentially distribute lists to ICU Directors to encourage ANZICS membership.

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8. Professional Practice

8.1 ANZICS Clinical Trials Group

S Webb reported that the CTG has had a remarkably successful twelve months specifically noting the three publications in The New England Journal of Medicine.

SW advised that the NHRMRC had recently announced $7.7m including funding for the ANZIC RC for years and $2.1m for the CHEST study, run out of The George Institute.

SW encouraged everyone to attend the CTG meeting in Noosa in 2010.

8.2 ANZICS Centre for Outcome and Resource Evaluation (CORE)

G Hart reported that CORE operations remain on track.

GH reported that a tender has been submitted to the Hong Kong Authority for the provision of peer review and quality assurance services.

GH reported that there have been a number of good research outputs in the past year. He noted that the Critical Care Resources Survey has been cancelled for the current year due to the overlap with the influenza survey.

8.3 ANZICS Practice and Economics Committee

Y Shehabi reported that the final submission has been received by the Department of Health and Ageing, outlining a three-tiered management structure for intensive care management items, including loading and out of ICU consultation.

YS reported that the Board recently approved the ANZICS Statement on Private Practice which will be released shortly via the ANZIS website.

8.4 ANZICS Safety and Quality Committee

T Burrell reported that the 3rd Safety, Quality Audit and Outcomes (SQAO) conference was held in Queenstown, New Zealand. TB noted that the 2010 SQAO conference will be held in Victoria and piggybacked with the Clinical Trials Group winter meeting.

TB referred members to the Safety and Quality Committee report in the ANZICS 2009 Annual Report.

8.5 ANZICS Death and Organ Donation Committee

P Hicks referred members to the Death and Organ Donation report in the ANZICS 2009 Annual Report.

PH noted the change of name and the high level of Committee activity.

9. Intensive Care Foundation

M O'Leary provided a summary of the Intensive Care Foundations activity. MOL noted that a decision was made to restructure the Foundation due to a limited income and high expenses associated with staffing costs. MOL advised that the Managing Director was made redundant and an Executive Officer appointed.

MOL noted that as a result of the restructure the Foundation can continue to grant at previous levels for some time without significant increase in donation income. MOL noted that the strategy moving forward for the Foundation will focus on increasing donation income in the short and long term. MOL advised that Yahya Shehabi will replace George Skowronski as Chair of the Intensive Care Foundation in 2010.

10. Future Meetings

P Hicks noted the following scheduled meetings:

- 2010 ANZICS/ACCCN 35th ASM – Melbourne, Victoria
- 2011 ANZICS/ACCCN 36th ASM – Brisbane, Queensland
- 2011 Australasia-Pacific Postgraduate Course in Neonatal & Paediatric Intensive Care
- 2011 ANZICS Singapore Meeting
- 2012 ANZICS/ACCCN 37th ASM – South Australia

11. Election of Officer Bearers

P Hicks announced the uncontested election of Office Bearers as follows:

Michael O'Leary – President

Peter Hicks –Immediate Past President

Mary White – Hon. Secretary

Andrew Turner – Hon. Treasurer

12. Other Business

No discussion noted.

13. Next Meeting

Friday 15th October, 2010

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