ANZICS

Annual Report 2011

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

As I enter the final couple of months of my term as ANZICS President I am pleased to be able to report that the Society remains strong and vibrant and is continuing to grow its membership and its activities.

Our finances are on a good footing and there are few significant risks on the horizon in the coming financial year. In this setting I present this report, highlighting a selection of our main achievements over the past 12 months.

Sterling work by the administrative team at ANZICS House, led by our General Manager Erin O'Sullivan, has seen our membership increase yet again this year. It is really encouraging to see our trainee membership category significantly increasing as trainees are the future of our specialty and it is therefore vital that we engage with them early in their careers.

Provision of continuing medical education remains the Society's main priority and we have this year inaugurated an Education Committee, which we hope will improve the quality of our CME activities. The Committee will initially concentrate on a review of the Annual Scientific Meeting, focusing on how best to identify quality overseas faculty, enticing themes and cutting edge scientific content. We recognise that the ASM now competes with a number of other events for our members' CME dollars and in order to maintain the meeting as the highlight of the local calendar we must consistently review our performance. With the requirement that we all participate in CME programs under the new national medical registration scheme, the College of Intensive Care Medicine is about to unveil a new CME program for Fellows and other specialists. We will ensure, through the Education Committee, that ANZICS CME activities are aligned with the requirements of the CICM program.

A new initiative we undertook this year to increase the CME options available to members, and to potentially increase the profile of the Society internationally in our region, was our combined meeting in Singapore with the Singapore Society of Critical Care Medicine. This was a great success with over 600 registrants, including 95 from Australia and New Zealand. The meeting returned a small profit to the Society. All involved found the experience of organising and running this meeting very rewarding and plans are already underway to repeat the initiative in 2013.

Deepak Bhonagiri, on behalf of the Board, has been negotiating with an Indian group through a commercial agent, X-rays Biocom, to stage an annual ANZICS-led educational 'road show' in India. A final contract has been signed and we hope that this event will provide useful support to the specialty in India, as well as increase the Society's profile in the subcontinent.

The Executive has spent a substantial amount of time in recent months considering the proposal to relocate the CORE group to the School of Public Health and Preventive Medicine at Monash University. Matters are currently at an advanced stage. Members can be assured that our priority in these negotiations has been to protect the Society from risks, including financial, intellectual property loss and damage to reputation, and to preserve the success of the databases into the future. I am confident as we enter these late stages of negotiation that we have ensured that the interests of ANZICS have remained paramount and will not be damaged.

As the specialty expands, both in numbers of specialists and in its reach within hospitals, fewer and fewer hospitals do not have intensive care services provided by intensive care specialists. It is very likely, and of course very pleasing, that this trend will continue. In Australia and New Zealand the 'tyranny of distance' can leave many of these specialists isolated, and the problems that confront the specialist in a rural, regional or remote location may be quite different to those facing the majority that work in urban locations. We have inaugurated a Rural and Regional Special Interest Group email list that we hope will serve as a sounding board for our rural and regional members and any other specialists covering intensive care services outside urban locations. We are collaborating closely with CICM in this initiative.

Although we anticipate an increased demand for intensive care specialists outside urban locations we have no quality information on likely requirements for specialists into the future across our two countries. Because of this there is no link between trainee

President's Report

numbers and specialist requirement; a situation that many of us consider to be concerning. A priority for the PricE Committee is to investigate some modeling of intensive care specialist numbers and requirements, as part of this we would also like to look at work patterns and the current pressures for change in these. I believe it is important that the Society takes a leadership role in the question of workforce and work-life balance, matters that are consistently rated as of high importance to our members.

Unfortunately, after almost three years of work and numerous meetings in Canberra, the Department of Health and Ageing decided in January not to support the PricE Committee's submission for a revised structure to the intensive care fees in the MBS. This was most disappointing as the work followed directly from the previous fees changes in 2007 that were always considered the first part of a more significant overhaul of intensive care items and, moreover, the submission was prepared directly in response to suggestions from the Department. It is unlikely that there will be any opening to revisit the issue of ICU items and fees with the Department in the near future. In the short term opening negotiations with individual health funds may be more productive; this is a current priority for the PricE Committee.

The Clinical Trials Group has had yet another brilliant year, with highlights being the publication of the DECRA and PROTECT trials in *The New England Journal of Medicine* and further trials receiving research funding from the National Health and Medical Research Council (NHMRC) in Australia and the New Zealand Health Research Council (HRC). The CTG continues to maintain ANZICS at the peak of international intensive care research and much thanks must go to Steve Webb and the entire CTG Committee for their tireless work.

The Safety and Quality Committee now has its own Executive Officer working part-time at ANZICS House, as well as the CLABSI Project Manager. Under Tony Burrell's guidance we now have a series of safety and quality projects underway. I envisage that the Safety and Quality Committee will come to provide an increasingly important interface between the research generated by the CTG, the audit provided by CORE and clinical practice in our intensive care units.

Geoff Dobb will be standing down as Chair of the Death and Organ Donation Committee in July after 11 years service in that role. Geoff has made an absolutely enormous contribution to the complicated and challenging issues of end-of-life care, brain death and organ donation over this period, and the ANZICS Statement will remain as a testament to his expertise and guidance. I am sure that the entire membership will join me in congratulating Geoff for his work over the years and wishing him well in all the new endeavours he plans to take on. I am pleased that Geoff will be remaining a member of the Committee, as this is an area so complex that the work is never finished, but one where, probably more than any other, the voice of experience has much to offer. Bill Silvester has been elected to the Chair as Geoff's replacement.

Finally I would like to thank all those who have helped make my term as President enjoyable and, I hope, reasonably successful. First and foremost, our General Manager Erin O'Sullivan, then of course my colleagues on the Executive, Peter Hicks, Andrew Turner, Mary White and Marc Ziegenfuss, the Chairs of the ANZICS Committees and our Regional Chairs on the Board, all the ANZICS House Staff, and my friend and colleague John Myburgh, who has always worked closely with me to help align ANZICS and CICM interests wherever possible.

Michael O'Leary
President

Provision of continuing medical education remains the Society's main priority and we have this year inaugurated an Education Committee, which we hope will improve the quality of our CME activities.

Treasurer's Report

Firstly I would like to thank Andrew Turner, the outgoing Honorary Treasurer, for his services and his financial guidance of the Society.

The Society's financial position remains strong and the assets have weathered the global financial crisis well with predominantly cash and property holdings, thus safeguarding against the turbulences of the stock markets. For the last financial year, the Society achieved a surplus of $222,039 which was well ahead of budget. This is the third consecutive annual surplus for ANZICS. The Society has performed admirably, providing high quality outputs with a value-for-money approach with regards to subscription income.

Overall revenue was up 7% on last year to $2.2 million, with steady growth across all areas of the Society's activities. There has been a strong growth in subscription income across all ANZICS divisions, with income up $64,000 to $467,000.

The 2010 ASM surplus remained solid and contributed $179,000 to the Society.

Income from term deposits was $88,000, this was up from the $38,000 earned in the previous financial year.

The Society has net assets of $3.47 million represented primarily by ANZICS House, which is owned outright.

Our investment strategy continues to remain conservative and at balance date there was $1.3 million held in term deposits. As always our investment strategy will be reviewed, however, there is no need to take risks as the ANZICS budget for this financial year has been set. Of particular relevance is the future of ANZICS House. With the potential relocation of CORE to Monash a suitable tenant will need to be found for the vacated real estate or consideration given to ANZICS relocating to new premises.

The Society will take a greater role in education and workforce representation over the next few years. An investment in measuring our current contribution to the Australian and New Zealand Health Systems and a survey of scope of future intensive care practice and requirements is necessary to position ourselves as the principle negotiation partner in steering our specialty. The success of the Singapore meeting highlights our status in the region and ANZICS needs to strongly consider extending its membership network accordingly and potentially embrace Asian intensive care societies. This makes sense considering the shift of global financial power to the Indochina region. The potential for research and other collaborative projects is huge. The Society needs to be proactive in this respect.

The KPMG audited financial report is included as part of this annual report. The audit report is unqualified, confirming the Directors' Statement that the financial report presents a true and fair view of the Society's financial position and performance for the year ended 30 June, 2011.

Marc Ziegenfuss
Honorary Treasurer

General Manager's Report

Each year when I sit down to write this article I seem to sum up the year as having been fast-paced and highly productive – a clear indication, I believe, of the continued growth and success of the Society. I am happy to report that this year has certainly been no different.

Over the past 12 months we have undertaken a number of new initiatives, with the aim of realising the Board's vision of being an increasingly active and engaging Society. What was agreed and set in motion a year ago was a plan to develop a number of projects that focus on the delivery of member services.

Recognising that the retention of memberships is equally as important as the acquisition of new members, we undertook a successful membership review project that focussed on the retention of all Society memberships. By communicating directly with our members we were able to highlight the need to ensure the timely renewal of membership subscriptions in order for the Society to continually provide all services and activities. Our members certainly heeded our call and payments were promptly made, resulting in the Society being able undertake a review of our priorities and the best way to provide services to our members going forward.

The subsequent review of the Society's priorities has lead to an increase in activities, including forming a new Education Committee, on the back of the Board's strategic planning workshop. The new Committee is responsible for guiding and developing all ANZICS educational activities through the support and promotion of new and existing educational programs and initiatives. A Rural and Regional Special Interest Group was also created as a way to bring rural and regional practitioners together to identify and workshop the main issues for providing services in remote regional locations throughout Australia and New Zealand. Another project launched during the year was the LinkPersons initiative, which aims to provide a conduit service between the Society and our members.

The past year delivered a number of successful events, including the 4th International Conference on Safety, Quality, Audit and Outcomes in Intensive Care and the 35th ANZICS/ACCCN Annual Scientific Meeting. The Inaugural Singapore-ANZICS Intensive Care Forum, held in conjunction with the Singaporean Society was a particularly successful meeting and a valuable addition to the Society's conference and events program.

Once again I am happy to report that this year has been successful in respect to the outputs and achievements of the committees and regions. Each of the committees has again pursued alternative avenues of development and expansion with notable success. Such outputs are evidence of the involvement of the committee chairs, committee members and staff; without whom such achievements would not have been possible. Thanks also goes to those who have joined new and reformed committees, as this engagement and support is the key to the ongoing growth of the Society.

I would like to take this opportunity to thank the staff of the Society for their dedication and hard work over the past 12 months. Without the committed and highly-skilled team none of the achievements noted in this report would have been possible. Throughout the year we farewelled some staff members and in turn welcomed new members to the team. As we move forward into the new financial year we are in a strong position to continue to build on and expand our successes and contribution to the Society.

Erin O'Sullivan
General Manager

Membership Report

The 2011 financial year has seen membership numbers rise to a record high. The Society realises that its future lies with the current trainees and new Fellows and, accordingly, we have tried increasingly to engage these groups. During the year a further 77 new members have joined, the unpaid membership liability has been reduced and income from subscriptions is at a high.

Current membership numbers by category are listed below.

The membership income raised facilitates all the works done by the Society and provides a constant buffer against changes in income from other revenue sources. With an ever increasing focus on education, professional development, workforce issues and industrial matters, as well as CORE, Safety and Quality, and the CTG, the Society aims to always increase the 'value adding' for intensivists as a craft group in both Australia and New Zealand. The plight of rural and regional members will be re-visited this year and it is hoped that the Society will be able to assist where required and, in turn, increase its own relevance to this group of intensivists.

A reminder to any members with outstanding subscriptions, these can be paid online at www.anzics.com.au or by phoning the Society on (03) 9340 3400. For anyone considering joining the Society, membership forms can be downloaded from the website.

Full	449
Trainee	134
Associate	53
Affiliate	46
Total	682

Andrew Turner
Honorary Secretary

ANZICS Board

Office Bearers

President
Michael O'Leary

Immediate Past President
Peter Hicks

Vice President
Mary White

Honorary Treasurer
Marc Ziegenfuss

Honorary Secretary
Andrew Turner

Paediatrics
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Centre for Outcome and Resource Evaluation (CORE)
David Pilcher

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Queensland Regional Chair
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South Australia Regional Chair
David Durham

Committee Reports

Centre for Outcome and Resource Evaluation Report

2010/2011 has been a year of development for ANZICS CORE, but it is only the beginning.

New Management Structure

This year saw the establishment of a new management structure for ANZICS CORE. The new streamlined CORE Management Committee consists of myself as CORE Chair and Director of the Adult Patient Database (APD), Peter Hicks as Director of the Critical Care Resources Registry, Tony Slater as the Director of the Paediatric Registry, Erin O'Sullivan as General Manager of ANZICS and Gail Adams as Manager of CORE. Graeme Hart, who for many years steered the helm of ANZICS CORE, has stepped down as Chair but remains actively involved through his work on the National Intensive Care Registry Steering Committee and the ANZICS CORE Advisory Committee. These two separate committees provide governance and oversight of ANZICS CORE.

1 *The National Intensive Care Registry Steering Committee*

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

2 *The ANZICS CORE Advisory Committee*

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

Personnel Changes

Personnel changes have lead to a new vibrant atmosphere within the office. Gail Adams was appointed Manager of ANZICS CORE in September 2010 and has settled into the position of overseeing the activities of CORE. Erin O'Sullivan (ANZICS General Manager) remains actively involved and works tirelessly to ensure all of CORE's activities function smoothly. Allison van Lint has stepped up to oversee many of the duties previously filled by others. She has largely been responsible for data requests, organising the education program and supervising the APD Audit. In addition to this she has recently presented scientific findings from the APD Audit at the Safety & Quality Conference in the Hunter Valley. Following the departure of Kelly Drennan, Joanna Craven has been appointed as the ANZICS CORE Registries Project Officer and will oversee the Critical Care Resources Registry. Tamara Bucci has very ably taken on the majority of the APD Audit duties. Jostein Saethern continues to provide programming support for AORTIC, has worked with Allison to develop a web-based audit tool and is working with the Monash University team to develop the CLABSI surveillance reporting system. Marcela Forero, who was responsible for information systems management, left ANZICS at the beginning of 2011 but is yet to be replaced. Shaila Chavan is on extended maternity leave.

Triennial Funding

The Triennial Funding Submission was completed at the end of 2010. This aims to secure approximately $3.4 million in funding for the activities of ANZICS CORE over the next three years and includes a significant commitment to improve and upgrade CORE's IT infrastructure. This infrastructure upgrade will lead to major advances in reporting, which will eventually benefit all those involved and interested in reporting and monitoring the outcomes of intensive care patients throughout Australia and New Zealand. Although contracts vary slightly, presently most jurisdictions have already signed contracts which commit to ongoing funding, with others stating verbal commitment.

Relocation of ANZICS CORE to Monash University

Considerable discussion has taken place over the past 12 months regarding the relocation of ANZICS CORE to become part of the registries group at Monash University. It is proposed that ANZICS will transfer resources (staff and technology) to The School of Public Health and Preventive Medicine and, in partnership with Monash University, will provide the services that ANZICS CORE currently provides. ANZICS CORE will retain its identity within The School of Public Health and Preventive Medicine. The activities of ANZICS CORE at The School of Public Health and Preventive Medicine at Monash University will continue to be funded through agreements between ANZICS and jurisdictional health departments in Australia and New Zealand. In-principle support has been given by the Executive of the ANZICS Board and they are reviewing final proposal documentation prior to drawing up contracts.

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Central Line Associated Bacteraemia Surveillance System

Funded by the Australian Commission on Safety and Quality in Health Care and in partnership with The Clinical Informatics and Data Management Centre at Monash University, ANZICS CORE has begun development of a secure data entry and reporting system for Central Line Associated Blood Stream Infections (CLABSI) throughout Australia and reporting of this data to ICUs, jurisdictions and the Commission. Data will be collected by ICUs and sent either directly to ANZICS CORE or via jurisdictional infection control organisations to ANZICS CORE, who will create and feed comparative reports back to submitting ICUs and jurisdictions. This forms part of a larger strategy to reduce the mortality and morbidity associated with CLABSI throughout Australia. Initial testing of the surveillance reporting system will begin in late August 2011. The system is expected to be operational in early 2012.

Other Activities

CORE again supported the highly successful Safety, Quality, Audit and Outcomes Conference held in the Hunter Valley in August 2011. A number of CORE staff and new researchers presented their work at this meeting to great interest.

The ANZICS CORE Annual Report for 2010 is nearing completion and will provide an overview not only of CORE's activities during the year but also an overview of intensive care practice throughout Australia and New Zealand.

Research

Ongoing research projects include:

- Development of a New Mortality Prediction Tool for Australia and New Zealand

  PhD studies by Eldho Paul

- Monitoring Clinical Outcomes in Paediatric Intensive Care: The Development of a Series of Case-Mix Adjusted Clinical Outcome Measures

  PhD studies by Lahn Straney

- Omission of Early Thromboprophylaxis and Mortality of Critically Ill Patients: A Multicentre Study

  Kwok M Ho, Shaila Chavan, David Pilcher

  Submitted for publication

- Early Peak Temperature and Mortality in Critically Ill Patients With or Without Infection

  Paul Young, Manoj Saxena, Richard Beasley, Michael Bailey, Rinaldo Bellomo, David Pilcher, Simon Finfer, John Myburgh

  Submitted for publication

- Outcomes of Patients Admitted to ICU after Adult Retrieval Victoria Physician Based Transfers

  Visser P, Kennedy M, Bohensky M, Hart GK

- Development of a New International Paediatric Index of Mortality Model – PIM3

  Anthony Slater, Lahn Straney, Jan Alexander, Archie Clements

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Publications

Publications in 2010/2011 have included:

1 Bhonagiri D, Pilcher DV, Bailey MJ. **Increased mortality associated with after-hours and weekend admission to the intensive care unit: a retrospective analysis.** Med J Aust 2011;194(6):287-92.

2 Moran JL, Solomon PJ. **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. 2011 Feb;17(1):45-60. doi:10.1111/j.1365-2753.2010.01368.x. Epub 2010 Aug 30.

3 Ho KM, Hart G, Austin D, Hunter M, Botha J, Chavan S. **Dose-related effect of smoking on mortality in critically ill patients: a multicentre cohort study. Intensive Care Med.** 2011 Jun;37(6):981-9. Epub 2011 Mar 11.

4 Bohensky MA, Jolley D, Sundararajan V, Pilcher DV, Evans S, Brand CA. **Empirical aspects of linking intensive care registry data to hospital discharge data without the use of direct patient identifiers.** Anaesth Intensive Care 2011;39(2):202-8.

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

6 Bellomo R, Bailey M, Eastwood GM, Nichol A, Pilcher D, Hart GK, et al. **Arterial hyperoxia and in-hospital mortality after resuscitation from cardiac arrest.** Crit Care 2011;15(2):R90.

7 Bohensky MA, Jolley, Sundararajan V, Evans S, Pilcher DV, Scott I, Brand CA. **Data Linkage: a powerful tool with potential problems.** BMC Health Serv Res. 2010 Dec;10:346

8 Drennan K, Hicks P, Hart GK. **Impact of pandemic (H1N1) 2009 on Australasian critical care units.** Crit Care Resusc. 2010 Dec; 12 (4):223-9

9 McNamee JJ, Pilcher DV, Bailey MJ, Moore E, Cleland H. **Mortality prediction among burns patients in Australian and New Zealand intensive care units.** Crit Care Resusc 2010 Sept;12:196-201.

10 Straney L., Clements A., Alexander J, & Slater A. for the ANZICS Paediatric Study Group. **Quantifying variation of paediatric length of stay among intensive care units in Australia and New Zealand.** Qual Saf Health Care 2010 Dec; 19(6):e5. Feb 1 [ePub].

11 Straney L., Clements A., Alexander J, & Slater A for the ANZICS Paediatric Study Group. **Measuring efficiency in Australian and New Zealand paediatric intensive care units.** Intensive Care Med 2010 Aug; 36 (8): 1410-6.

12 Martin JM, Hart GK, Hicks P. **A unique snapshot of intensive care resources in Australia and New Zealand.** Anaesth Intensive Care 2010 Dec;38(1):149-58.

I would like to thank Peter Hicks and Tony Slater for their outstanding contribution and for their ongoing commitment to CORE. I would also like to thank the remainder of the Committee and all the staff at CORE for their hard work and support. I would also like to thank Steve Webb for his commitment and increasing collaboration on behalf of the Clinical Trials Group and Tony Burrell for his constant support and commitment to improving safety and quality of care and for the ongoing relationship between the Safety and Quality Committee and CORE. On behalf of ANZICS I would also like to thank Graeme Hart for the work he has contributed to CORE over many years and for the commitment, help and enthusiasm he continues to provide.

David Pilcher
Chair, Centre for Outcome and Resource Evaluation

Committee Reports

Paediatric Report

The past year has been another busy one on the paediatric front, the highlight of which was Sydney hosting the World Congress in Paediatric Intensive Care in March. The meeting was a great success, helped along by the beautiful setting. The meeting was attended by delegates from over 130 countries and the interaction between intensive care medical and nursing staff from differing cultures was remarkable. The scientific program was innovative and thoughtful and participation in interactive sessions was enthusiastic. Years of planning had gone into the meeting and it was a credit to all involved.

Paediatric Study Group

I have been elected as the new Chair of the Paediatric Study Group and the Committee remains unchanged. On behalf of ANZICS I would like to thank Michael Yung for his work in chairing the PSG for the past four years.

Michael Yung convened a multinational meeting of PICU research groups as a satellite meeting with the Sydney World Congress. The meeting was a great success, with research groups from Europe, Canada, USA, Australia and New Zealand all taking part. This meeting will now become a regular event at the World Congress.

Brain Injury Studies: John Beca is currently analysing the results of the HITBIC study and the results should be available for the Brisbane ASM. The Cool Kids trial, which the PSG participated in, was stopped earlier this year on the grounds of futility following an interim analysis. The patients recruited will be followed up and some outcomes may be available.

Safe-EPIC Proposal: The upcoming point prevalence day on saline/fluids will include paediatric units. Marino Festa is the Principle Investigator and will perform statistical analysis on this work (as well as the previous point prevalence day), with the aim to eventually stage an international point prevalence study. ANZICS has provided a seed grant of $10,000, which has allowed Rino to continue his work.

CLOTS Study: Randomised trial of heparin versus placebo to prevent thrombosis and infection in central lines in PICU. The study is funded by a grant from the SA Women's and Children's Hospital Foundation. Michael Yung is the Principle Investigator. The study is currently recruiting at the three centres with a plan to include more centres in Australia and New Zealand.

Paediatric H1N1 Study: Collaboration between the INFINITE investigators and the Paediatric Study Group to report on the PICU burden of the H1N1 pandemic. Manuscript has been published: Pediatrics 2011; 127.

SPICE: The paediatric units are meeting with the SPICE Committee and this will be the first combined adult/paediatric CTG study.

ANZPIC Registry

Tony Slater and Jan Alexander continue to work hard on the Registry. The Registry annual report based on 2010 admission data is currently in production.

Proposals at last PSG meeting:

1 PICUs will be identified in future reports.

2 An audit has recently been performed assessing the correlation between RACHS (cardiac surgical risk category) scoring by intensivists for the ANZPIC Registry and cardiology. The results are currently being analysed and will be presented at the Brisbane ASM.

World Congress Sydney 2011

The PICU World Congress in Sydney in March was a great success. There were between 1,200-1,300 delegates and the scientific program was very well received. Congratulations must go to the convenors David Schell and Tina Kendrick and the entire Committee for their efforts. While sponsorship was good, delegate numbers were at the lower end of expected, which was probably related to the large distances for European and North American delegates and the effect of the global financial crisis.

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Brisbane ASM

The scientific program for the Brisbane ASM includes a two-day paediatric component. The paediatric convenors are Kevin Plumpton, Christian Stocker and Debbie Long. International speakers are Peter Weinstock, Director of the simulation program at the Children's Hospital, Boston and Sharon Irving, a nurse practitioner and lecturer at the School of Nursing, University of Pennsylvania.

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, albeit slowly, with high level meetings continuing. Ikaria (patent holder) has put in the submission to the Federal Government and this has been tabled in parliament. I have been contacted recently by Shayne Neumann, who is the federal member for Ipswich and has taken up the cause and a meeting will be arranged with him shortly.

Committee Membership

Chair Simon Erickson (WA)
Committee Michael Yung (SA), Gary Williams, Marino Festa (NSW), Warwick Butt (Vic), Andreas Schibler, Tony Slater (Qld), John Beca, Gabrielle Nutthal (NZ)

Simon Erickson
Chair, Paediatrics

Committee Reports

Clinical Trials Group Report

The CTG continues to establish itself as one of the leading clinical research organisations in this region and globally. In the 16 years since the group was established it has received over $45 million in grant funding and published seven manuscripts in the *New England Journal of Medicine (NEJM)*. This represents about one quarter of all original publications in this journal in the last 10 years from Australia and New Zealand. The quality and impact of the CTG's outputs are a reflection of the strength of the research culture within ICUs in Australia and New Zealand.

2010 - 2011 Highlights

Major highlights of the last year included the publication of the DECRA and PROTECT trials (both in the *NEJM*) and the attendance and contribution of Professor Jeff Drazen, Editor-in-Chief of the *NEJM,* at the CTG's annual meeting in Noosa.

DECRA is a remarkable achievement on several fronts; it provides critically important information to intensivists and neurosurgeons that a commonly practiced intervention, decompressive craniectomy for refractory intracranial hypertension in patients with diffuse severe traumatic brain injury, worsens long-term neurological outcomes. This is particularly important because the intervention had become widely implemented and without DECRA it would never have been identified as harmful. The lives of many patients with severe brain injury have been improved and the annual savings to the community are likely to be in the order of more than $100 million per year. The study is also remarkable for yet again demonstrating that changes in surrogate intermediate endpoints, in this case intracranial pressure which was dramatically better controlled in the intervention group, cannot be relied upon to predict the impact of an intervention on endpoints that are clinically relevant. I'd like to personally congratulate Jamie Cooper, Lynne Murray and Jeffrey Rosenfeld on their dedication over almost a decade to ensure the completion and publication of this seminal study.

The PROTECT study, undertaken as a collaboration with the Canadian Critical Care Trials Group, demonstrated that low molecular weight heparin resulted in fewer fatal and non-fatal pulmonary emboli than thromboprophylaxis using unfractionated heparin. These studies exemplify that the CTG is achieving its mission *'to promote excellence in intensive care medicine through collaborative research focused on improving patient-centered outcomes'.*

The 2011 annual meeting in Noosa was a remarkable event. This was a working meeting where new projects were presented and discussed and existing studies provided updates on their progress or reported their results. This year delegates were privy to the confidential first presentation of results from three studies that were subsequently published in the *NEJM:* DECRA, PROTECT and a guest presentation of the results of the groundbreaking FEAST trial led by Kath Maitland, along with results from the STATinS, TAME and Spice Observational Studies. That the Editor of the *NEJM* accepted an invitation to travel from Boston to Noosa for a three-day meeting is testament to the influence and impact of the group. Professor Drazen's insights into how clinical evidence shapes clinical practice and policy will be of great benefit to the CTG as it continues to evolve. We were also extremely fortunate to welcome Professor Kathy Rowan, ICNARC Director, as a guest speaker in Noosa this year.

Major strategic initiatives underway include work to evaluate the translation of the results of CTG studies into clinical practice in our ICUs, improve the consistency and ease of use of study tools, optimise research capacity in our two countries, and explore options for program level funding of the CTG's research effort. Initiatives designed to improve the central and site infrastructure for research include a submission to the Australian government's National Collaborative Research Infrastructure Strategy as well as development of a Centres for Research Excellence grant application to the NHMRC in Australia and a Program Grant to the HRC in New Zealand.

A number of key activities aimed at broadening research expertise in critical care were undertaken in 2010-11, including the annual Research Development Day, the launch of a formal mentor program for early-career investigators and a Research Foundations Workshop, which was held in conjunction with the Singapore-ANZICS Intensive Care Forum in April. The aim of the workshop was to provide practical advice and support for the development of multicentre research in intensive care throughout the Asia Pacific region.

Committee Reports

Current Research

During 2010-11 there was a total of 28 CTG endorsed studies that were in the set-up, recruitment or active follow-up during the period. These were:

ANZIC-FLU, ARISE, ARISE HEE, BLISS, CHEST, DahLIA, DECRA, EARLY-PN, EPO-TBI, EPO-TBI AKI, ESCAPE, HEAT, HITBiC, IPHIVAP, NICE TBI, POLAR, POLAR BEAR, POLAR RENAL, POST-RENAL, PREDICT, ProGUARD, PROTECT, SPICE Obs, SPICE Pilot RCT, STATinS, STATinS TIMES, TAME and TARGET.

Grants

In October 2010 the ESCAPE trial was awarded $3.27 million from the NHMRC. The study, to be conducted in 60-70 ANZ ICUs, will randomise 3,800 patients with septic shock to receive hydrocortisone or placebo. Project grants totaling approximately $7 million for the PHARLAP, TRANSFUSE, BLING 2 and ARISE studies were submitted to the NHMRC in March and the outcome of these applications will be known later this year. I'd like to congratulate Paul Young and colleagues for achieving a 'CTG first', having applied successfully to the New Zealand HRC for a phase II randomised controlled trial of fever management in patients with severe sepsis. Although the HRC has funded CTG projects previously, this is the first occasion in which the HRC has been the lead funding agency for a CTG project and this represents an important diversification of funding for CTG research. In collaboration with other international groups it is likely that this trend will be extended with applications to the National Institutes of Health in the USA and the Wellcome Trust in the UK being planned for later this year.

Publications

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2 Knight M, Pierce M, Seppelt I, Kurinczuk JJ, Spark P, Brocklehurst P, McLintock C, Sullivan E on behalf of the UK's Obstetric Surveillance System, the ANZIC Influenza Investigators, and the Australasian Maternity Outcomes Surveillance System. **Critical illness with AH1N1v influenza in pregnancy: a comparison of two population-based cohorts.** BJOG; 2011; 118(2):232-239.

3 The SAFE Study Investigators. **Impact of albumin compared to saline on organ function and mortality of patients with severe sepsis.** Intensive Care Med; 2011; 37:86-96.

4 Davies A, Morrison S, Ridley E, Bailey M, Banks M, Cooper DJ, Hardy G, McIlroy K and Thomson A for the ASAP Study Investigators. **Nutritional therapy in patients with acute pancreatitis requiring critical care unit management: A prospective observational study in Australia and New Zealand.** Crit Care Med; 2011; 39:462-8.

5 Yung M, Slater A, Festa M, Williams G, Erickson S, Pettila V,Alexander J, Howe B and Shekerdemian L; Australia and New Zealand Intensive Care Influenza Investigators and the Paediatric Study Group and the Clinical Trials Group of the Australia New Zealand Intensive Care Society. **Pandemic H1N1 in children requiring intensive care in Australia and New Zealand during winter 2009.** Pediatrics; 2011; 127:e156-63.

6 CooK D, Meade M, Guyatt G, Walter SD, Heels-Ansdell D, Geerts W, Warkentin TE, Crowther, M. **PROphylaxis for ThromboEmbolism in Critical Care Trial protocol and analysis plan.** J Crit Care; 2011; 26(2):223.e1-223.e9.

7 The PROTECT Investigators for the Canadian Critical Care Trials Group and the Australian and New Zealand Intensive Care Society Clinical Trials Group. **Dalteparin versus Unfractionated Heparin in Critically Ill Patients.** N Engl J Med; 2011; 364(14):1305-1314.

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8 Cooper DJ, Rosenfeld JV, Murray L, Arabi YM, Davies AR, D'Urso P, Kossmann T, Ponsford J, Seppelt I, Reilly P and Wolfe R for the DECRA Trial Investigators and the Australian and New Zealand Intensive Care Society Clinical Trials Group. **Decompressive Craniectomy in Diffuse Traumatic Brain Injury.** N Engl J Med; 2011; 364(16):1493-502.

9 Myburgh J, Bellomo R, Cass A, French J, Finfer S, Gattas D, Glass P, Lee J, Lipman J, Liu b, McArthur C, McGuinness S, Rajbhandari D, Taylor C & Webb S. **The crystalloid versus hydroxyethyl starch trial: Protocol for a multi-centre randomised controlled trial of fluid resuscitation with 6% hydroxyethyl starch (130/0.4) compared to 0.9% sodium chloride (saline) in intensive care patients on mortality.** Intens Care Med; 2011; 375(5):816-823.

10 Pettila V, Webb SA, Bailey M, Howe B, Seppelt IM, Bellomo R on behalf of the ANZIC Influenza Investigators and Australian New Zealand Intensive Care Society Clinical Trials Group. **Acute kidney injury in patients with influenza A (H1N1) 2009.** Intens Care Med; 2011; 37:763-7.

11 Pettila V, Westbrook AJ, Nichol AD, Bailey MJ, Wood EM, Syres G, Phillips, LE, Street A, French C, Murray L, Orford N, Santamaria JD, Bellomo R, Cooper DJ for the Blood Observational Study Investigators for the ANZICS Clinical Trials Group. **Age of red blood cells and mortality in the critically ill.** Critical Care; 2011; 15:R116.

On behalf of the CTG Executive I'd like to thank the CTG office staff, Rhiannon Tate and Simone Rickerby, for the fantastic and tireless work that they undertake and the contribution that they make to the ICU community's research effort. There are now five meetings per year that Rhiannon and Simone organise, as well as a constant stream of project and manuscript endorsements that are managed by the CTG office. I would also like to thank members of the research community, including many research coordinators, who now undertake project and manuscript reviews as part of the CTG endorsement process. The work undertaken by research coordinators has been pivotal to the success of the CTG and we are incredibly fortunate to have the world's leading ICU research coordinators represented by the IRCIG working within the CTG network. I would like to acknowledge the tremendous contribution made by Stephanie O'Connor and members of the IRCIG to the CTG over the past 12 months.

The number of ICUs that are members of the CTG continues to increase, with 63 financial members and a further seven units that have committed to membership at the time of this report. The income from these units supports the Executive office and its activities and the CTG continues to be critically dependent on subscription income.

I'd like to thank Peter Harrigan, Dave Blythe, Graeme Hart and Michael Yung for their contribution to the CTG over many years, but also welcome their successors on the CTG Executive - David Gattas, Ed Litton, David Pilcher and Simon Erickson as representatives for NSW, WA, CORE and the PSG respectively. The workload for members of the CTG Executive is substantial and that there continues to be competition for places on the CTG Executive reflects well on the role that the Committee plays in promoting research in our ICUs.

In the early 1990s I listened to Malcolm Fisher talk about the importance of clinical research and how our research effort, at that time, failed to match the quality of clinical intensive care in Australia and New Zealand. That is no longer true and the CTG is largely responsible for our countries now being recognised as world leaders in the generation of high-quality clinical evidence. The CTG has endorsed over 70 projects and all endorsed projects that have been funded are either completed or on a pathway to completion. At this time there are 20 studies that are either funded and in start-up, recruiting, or in active follow-up and the group has randomised more than 23,000 patients into clinical trials.

On behalf of the CTG Executive I would like to thank all the member units, the investigators, the research coordinators and the methods centres at the George Institute for Global Health and the ANZIC Research Centre for their commitment and contribution to improving patient outcomes by generating new evidence.

Steve Webb
Chair, Clinical Trials Group

Committee Reports

Death and Organ Donation Report

The past year has been an interesting and active one for issues relating to organ and tissue donation. Earlier this year the Australian Organ and Tissue Authority (AOTA) appointed a new CEO, Ms Yael Cass, which has resulted in a re-invigoration of its activities. More recently Gerry O'Callaghan stepped down as the inaugural National Medical Director of AOTA to return to full-time clinical practice in intensive care, and has been replaced by Jonathan Gillis. Gerry did a wonderful job as the expert medical leader for organ and tissue donation within AOTA during its difficult early days and I am sure that Jonathan will be an excellent successor.

The figures show that there has been a significant increase in the Australian organ donation rate over the last couple of years, with audits showing very few 'missed' donors. In turn, this has put additional pressure on our donor coordinator colleagues and transplantation teams – pressure, I am sure, they welcome as an opportunity to assist more of the patients on the organ transplant waiting lists.

The Committee has excellent links to AOTA, both informal and formal, with a Memorandum of Understanding underpinning ANZICS' advice on educational matters. One of the outcomes of this has been a review and revision of the ADAPT course. While it is still in evolution, most elements of the new course have been introduced, with further courses to be run before the end of this year. We hope online access to the pre-workshop components will be available in the near future, with additional e-learning components also planned. A further review of the revised course is scheduled for 2012. We have been assured that ADAPT will continue to be available in New Zealand and Hong Kong and have been liaising closely with CICM through their Education Officer Charlie Corke.

The ANZICS Statement on Death and Organ Donation is regularly reviewed in the context of new publications. As a result the section in the ANZICS Statement relating to determination of brain death in patients with hypoxic/ischaemic encephalopathy, where early therapeutic hypothermia is now commonly used, is being amended to provide additional guidance after recent publications highlighted the need to ensure that all of the requirements for the clinical determination of brain death are met, including the elimination of sedative and analgesic drugs in circumstances where elimination may be delayed. When there might be doubt, neuro-imaging to demonstrate absent intracranial blood flow (or more correctly, blood flow below the lower limit of detection), is available. A recent survey by a group at Sir Charles Gairdner Hospital showed a very high level of support for the approach outlined and the criteria set out in the ANZICS Statement for the determination of brain death and we hope to see a formal publication of their results.

Work on the Hormone Resuscitation Project is continuing to progress, with a book chapter by the group submitted for publication and a systematic review in the advanced stages of preparation. The collaboration with Peter Macdonald (St Vincent's, Sydney) on this project has been excellent and should form the basis for ongoing research in the area of potential donor support – an area with a relatively sparse evidence base. A plan for the next stage of this work was presented at the CTG meeting in Noosa.

The major piece of work for members of the Committee in the coming year will be a revision of the ANZICS Statement on Withholding and Withdrawing Treatment. This is being carried out by a working group under the leadership of Bill Silvester. The working group consists of members of the Committee, supplemented by other ANZICS members with recognised expertise in end-of-life care. The result should be robust guidance on this important part of our practice and the accompanying consultation process will have the added benefit of increased awareness of the related issues in the intensive care community.

This will be my last contribution to the ANZICS Annual Report as the Committee Chair. Bill Silvester's appointment as the incoming Chair was ratified by the ANZICS Board and will take effect from 14th July, 2011. The change was overdue as I have been a member of the former Working Group since 1992, Deputy Chairman 1995-2000 and Chairman since 2000. This period covers all the editions of the ANZICS Statement to date. I will remain on the Committee for a period to ensure continuity and will certainly retain my interest in organ and tissue donation. The Working Group and then Committee have exemplified much that is great about participation in ANZICS' activities, including collaboration with an expert and highly motivated group of colleagues. I thank all who have been members of the Committee during my time as Chair for their support, hard work and the outcomes the Committee has achieved.

Geoff Dobb
Chair, Death and Organ Donation

Committee Reports

Safety and Quality Report

The last 12 months have been hugely successful for the ANZICS Safety and Quality Committee. In May 2011 the Safety and Quality Committee took a significant step with the appointment of Jennifer Holmes as Executive Officer. Jennifer will assist the Committee to develop and promote the initiatives of the group.

In the last quarter of 2010 the Percutaneous Tracheostomy Consensus Statement was approved by the ANZICS Board and distributed to members. The statement and the results of the supporting survey are available on the ANZICS website. The Committee anticipates that this document will be a 'living' document and welcomes feedback and potential modifications.

In early 2011 the Australian Commission on Safety and Quality in Health Care published its Australian Guidelines for the Prevention and Control of Infection in Healthcare (2010). This is an impressive document that recommends a number of strategies for minimising Ventilator Associated Pneumonia. The Safety and Quality Committee agreed that it was important to respond to these recommendations. The Care of the Ventilated Patient Consensus Statement was workshopped at the 2011 SQAO meeting and the membership will be surveyed in due course. The Committee is grateful for the ongoing work of Margherita Murgo in developing this statement.

CLABSI Prevention Project

The CLABSI Prevention Project has received additional funding from the Australian Commission on Safety and Quality in Health Care to extend the project to the end of June 2012. Work this year has focused on development of a national CLABSI definition and other elements of surveillance that will enable ICUs to measure their individual results and benchmark against peers nationally. A lot of time has also been devoted to the development of project resources, such as the website, as well as ensuring both the insertion and maintenance guidelines are relevant to the Australian setting.

SQAO 2010 Creswick, Victoria

The 4th International Conference on Safety, Quality, Audit and Outcomes was held in Creswick, Victoria in August 2010. For the first time Safety and Quality collocated with the CTG Winter Meeting to produce a stimulating week of academic and practical presentations. There were over 90 registrants and feedback indicated that the event was a success.

The Safety and Quality Committee is grateful for the generous support of Baxter in providing $15,000 of seed grant funding to support safety and quality projects. Announcement of the successful applicant will be made at the 5th International Safety, Quality Audit and Outcomes Conference 2011.

Committee Membership

Chair Tony Burrell (NSW)

Committee Graeme Hart (VIC), Ranald Pascoe (QLD), Nigel Rankin (NZ), Tony Williams (NZ), Brett Sampson (SA), John Lewis (WA), Steve Webb (CTG), Peter Hicks (NZ / CORE), David Schell (PAED), Michael Buist (TAS), Bernadette Grealy (ACCCN), Felicity Hawker (CICM), Mary Pinder (CICM), Brigit Roberts (Co-opted)

Tony Burrell
Chair, Safety and Quality

Committee Reports

Practice and Economics Report

Earlier this year Yahya Shehabi retired from the position of Chair following more than six years in the role. On behalf of ANZICS I wish to thank him for all his hard work and dedication to the welfare of members through his contribution to the PricE Committee. The Committee has been busy throughout the year with various issues of interest to members.

Medicare Submission

In June 2009 ANZICS filed a submission with the Department of Health and Ageing (DoHA - now known as the Department of Human Services) with respect to Medicare rebates for ICU service items. This submission contained a number of elements:

1 A splitting of ICU daily management items stratified into three categories, based on the acuity of the patient based on physiological scoring, with the least acutely ill rebated at the current daily management rebate, with the 'standard' ICU patient rebated at a higher amount and the most complex patients rebated at a higher amount still.

2 A consultation item for extended family conferences, particularly in situations where there were complex decisions to be made (e.g. withdrawing or limiting care or end-of-life decision making).

3 A consultation item for complex consultations on wards which did not result in an ICU admission.

4 A new, updated definition of intensive care.

Despite multiple communications, both verbal and written, between DoHA and the then Chair of the PricE Committee (Yahya Shehabi) and the subsequent PricE Chair (Michael O'Leary), no progress was made in terms of securing an agreement in 18 months. In fact, DoHA assured us that the submission was strong and they were confident that it would be accepted.

On 28 January, 2011 Michael O'Leary and I travelled to Canberra and met with Jenny Williams, Director, Schedule Production and Review Section, Medical Benefits Division as well as two departmental staff members. It was clear from the meeting that:

1 The submission had not been seriously reviewed until very recently.

2 DoHA's policy was that all 'new' item numbers be evidenced-based via the quality framework mechanism (see below).

3 Despite the fact that the three-tiered structure was initiated at the Department's request, they had no intention of implementing this, unless it was on a strictly cost-neutral basis.

4 They refuted that there had been any agreement, implicit or explicit, previously (in 2005) for a further 8% increase in rebates following the increase that was obtained at the time.

5 They were under tight financial control and would not recommend any initiatives to Treasury that would increase costs.

6 Their view was that family conferencing was funded via the global ICU daily management item.

All in all they demonstrated an enormous lack of good-faith bargaining, given that they had been in receipt of the submission for 18 months.

It appears that the need for a consultation item for complex patients for whom ICU admission is deemed not appropriate or necessary is accepted, although it has recently become clear that obtaining an item number and corresponding rebate will require a full review by their Medical Services Advisory Committee (MSAC); a process that will not be quick, as they will require submission of evidence, presumably from the literature, in support of any new model of care and therefore item number for a matching service.

They accepted the new definition of ICUs; although I pointed out that the work to draft this had been done at the Department's request. Having taken 18 months to reject the bulk of our submission, the Department is only now (August, 2011) circulating the new proposed definition to various third parties for input and feedback. By the time of the Annual General Meeting I will have more to report on the progress, or otherwise, for the updated definition of an ICU in the MBS Explanatory Notes.

Committee Reports

The outcome of our detailed submission was disappointing, but not completely unexpected. It is doubly disappointing considering the enormous amount of intellectual and effort capital invested by both Yahya Shehabi and Michael O'Leary.

MBS Quality Framework

As alluded to above, DoHA has embarked on a process of reviewing the evidence for the clinical efficacy and effectiveness of existing item numbers and applying this methodology to any new procedures or techniques. The first existing procedure to undergo this process was to be pulmonary artery catheterisation. The draft protocol, written by an external consulting agency can still be found at: http://www.health.gov.au/internet/main/publishing.nsf/Content/29FF785813989DA3CA2577A600240064/$File/Draft%20PAC%20review%20protocol%20-%20public%20consultation.pdf

However, after input from many interested and experienced clinicians, including Yahya Shehabi as the ANZICS representative on the stakeholder panel, the process was abandoned and future and further work on item number review returned to MSAC. The only good of this is that review of other ICU item numbers, for which there is not a great body of supporting evidence or literature, is now even further over the horizon; a concern voiced was that this process might be applied to items that are much larger volume and quite difficult to justify on outcome grounds such as invasive pressure monitoring (13876). The PricE Committee will attempt to remain appraised of the work of this group and try to ensure that the intensive care community is protected from any harmful change.

Workforce

Yahya Shehabi had previously represented ANZICS on the PWC-convened National Health Workforce Taskforce, which was later renamed Medical Workforce Australia. He attended one meeting, but since then there has been no further correspondence, other than to inform us that the process has been stalled.

At the same time as this body of work was being performed, CICM were also surveying Fellows about workforce and we await with interest the publication of their Fellows survey. This year PricE will be circulating a short questionnaire with the CORE Critical Care Resources (CCR) Survey resources survey to unit directors in an effort to collect meaningful data that can assist us in workforce planning in the sphere of intensive care.

Workforce planning for ICUs is quite complex and there are at least 10 factors to be taken into account:

1 The ageing, growing population; most ICU patients are now older than 70 years of age. This segment of the population is growing faster than any other age demographic and generates a large proportion of our workload, in public as well as private ICUs.

2 At least in the private sector the age-adjusted rates of ICU admission are increasing, especially in the 70-80 years of age cohort.

3 Although demand is growing, both in the public and private sectors, provision of beds by both the states and private hospitals is spasmodic, delayed and lagging demand.

4 Many specialists, especially younger ones, including those working in ICUs, are not prepared to work in the same way or for as long hours as previous generations of doctors; the so-called work-life balance issue.

5 There is increasing pressure for intensivists to become involved in activity outside ICUs (MET, TPN, cardiac arrest teams etc) and become hospitalists.

6 We are uncertain as to the demand for training positions in ICUs in the medium- and long-term.

7 There is increasing pressure in some quarters for in-house 24/7 intensive care specialist cover.

8 In some states there is decentralisation of ICU services and development of rural and regional ICUs.

9 The role of non-CICM Fellows in ICUs in the future is not certain, especially in rural and regional centres.

10 We are uncertain as to the retirement and transition to retirement aspirations of intensivists.

Unless we can obtain data on each of these factors it is very hard to predict whether we will have a shortage of specialists, an excess, or perhaps an excess of demand, but not enough beds in which trained specialists can treat appropriate patients.

Committee Reports

Informed Financial Consent

ANZICS was approached by the Office of the Health & Community Services Complaints Commissioner in South Australia after they had received more than one complaint from patients regarding the gaps charged by a practitioner or group of practitioners in South Australia. The PricE Committee provided a written response to a number of questions and provided a copy of our IFC policy; to date we have received no feedback from the above named office.

Future Directions for the PricE Committee

With respect to rebates it is clear that DoHA is being required to perform in a very tight fiscal environment. We will not achieve a substantive increase in CMBS rebates in the near or medium term. Instead, our attention should be turned to one other potential ally - the health funds, who may be persuaded to increase gap cover payments to avoid a blow-out in gap charges to their members. The PricE Committee will commence this avenue of endeavour over the coming months, starting with the Australian Health Service Alliance, which is the overarching body assisting 27 or so funds with administration, schedule setting etc.

We need to work with CORE to develop a database to inform our workforce planning. We have very detailed information on bed numbers, admissions, FTE consultants etc. for virtually every ICU in both countries spanning over a decade. We also need to work cooperatively with CICM in workforce planning.

Another future development, not mentioned above, but raised by DoHA when we met, was that of tele-ICU. This has its own implications with respect to workforce planning but there is significant federal interest, and potentially funding, to promote this branch of healthcare.

We have concentrated on Medicare rebates negotiation for quite some time. In the public sector we have been almost completely silent; and yet the pay, conditions and workload in the public sector varies tremendously across our two countries and even between states in Australia. In most states intensivists are paid like any other specialist, but this is significantly different between states. However, I would argue that our work is much more similar between states than between us and other craft groups. Perhaps our Regional Committees need to be assisting their members with negotiations brokered by AMA, NZMA, ASMOF or whoever their industrial negotiator is.

The PricE Committee has also prepared some web pages for the ANZICS website on ICU information for the public and intensive care fees, which are now available at www.anzics.com.au/committees/practices-and-economics.

Committee Membership:

Chair Ian Jenkins (WA)

Committee Michael O'Leary (NSW), Yahya Shehabi (NSW), Mark Nicholls (NSW), Ywain Lawry (NZ), Ranald Pascoe (QLD), Nick Edwards (SA), Chris MacIsaac (VIC), Greg McGrath (WA), Warwick Butt (Paediatrics)

Ian Jenkins
Chair, Practice and Economics

Regional Reports

ANZICS New South Wales Regional Committee

ANZICS NSW has had another busy year and it is heartening to see an increased interest in the Society's activities, as well as an increase in membership applications, particularly from trainee members. We currently have 159 members, 21 of whom are new members this year.

Since our last report we have conducted five education sessions. The sessions were co-badged with CICM and attendance was impressive. Our session regarding 24/7 onsite intensivists was well attended and generated much discussion that continues within ICUs across NSW. The session on 'Reappraising IC-1 - Minimum Standards for ICU' generated important feedback for CICM pertaining to their review of IC-1 and IC-2. Clinical case based discussions on 'Futility and Social Justice in End-of-Life Care Decision Making', coordinated by St George Hospital, and 'Dilemmas of the Heart', coordinated by St Vincent's Hospital, were well received by trainees and intensivists. We also conducted a small group session for trainees in hands-on management of IABP and pacemakers in ICUs.

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

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

Peter Harrigan stepped down as the NSW ANZICS CTG representative this year. We thank Peter for his contribution to promoting CTG research in NSW and welcome David Gattas, who has taken over Peter's role.

Mark Lucey has indicated that he would like to step down from the NSW ANZICS Executive. I would like to thank Mark for his valuable contribution to NSW ANZICS over the last few years. Mark was vital in organising the education session at the Royal Prince Alfred Hospital and his calm and thoughtful input will be missed.

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 Mark Nicholls

ANZICS CTG Ian Seppelt, David Gattas

ANZICS Death and Organ Donation Committee
Deepak Bhonagiri

ANZICS Safety and Quality Committee
Tony Burrell (Chair)

Deepak Bhonagiri
NSW Regional Chair

Regional Reports

ANZICS New Zealand Regional Committee

During the past year ANZICS New Zealand members have continued to actively participate in the Society and the broader intensive care community. Alex Psirides has agreed to be the New Zealand representative on the ANZICS Education Committee.

NZ ANZICS will hold a one-day meeting later in 2011 to review the lessons learnt from the Christchurch earthquake and discuss how New Zealand ICUs might respond to and prepare for any future national disasters. Unfortunately the planned 2011 NZ ICM registrars meeting is not going ahead for various reasons and the Wellington ICM registrars meeting has been postponed until 2012.

The impressive NZ pass rate in the FCICM Part 2 exams earlier this year was, in part, a result of trainees travelling to other regions where the local FCICM trainees/consultants had, with prior warning, organised suitable hot cases and viva practice. Future examinees might keep this resource in mind.

There have been fewer cases in 2011 where high dose IV vitamin C has been requested (by patients or their relatives), presumably due to the reduction in H1N1 cases. One hopes this decline continues.

Continuing dissatisfaction with the present coronial system was voiced at the NZ ANZICS AGM in Taupo. A number of intensivists recently attended a meeting with Law Commission representatives at Wellington ICU, which was orgainised by Paul Young. The Commission is currently reviewing death certification and the coronial system in New Zealand and they appeared to appreciate our opinions on these subjects, in particular how the system could be simplified and/or made more efficient.

I would also like to congratulate Paul Young on securing $1.2 million of funding for the HEAT Study from the NZ HRC. The study will investigate the safety, efficacy and feasibility of a permissive temperature strategy against a paracetamol based usual care strategy in septic critically ill patients. If your ICU is not taking part, please consider doing so.

Within the Auckland region there are plans afoot to revive regional ICM meetings – so watch this space.

Janet Liang
NZ Regional Chair

ANZICS Queensland Regional Committee

Early this year Marc Ziegenfuss moved into the Honorary Treasurer position after three years as the Queensland Regional Chair. I would like to thank Marc for his incredibly hard work while in this position and for the healthy Queensland Committee that I have been privileged to join. The year has certainly provided challenges for both Queensland and its vibrant intensive care community with floods, cyclones and budget cuts!

The Queensland Regional Committee has been largely occupied with arrangements for the upcoming 2011 ASM, which is being hosted in Brisbane. The theme, 'Tools of the Trade - Tips, Tricks and Technology' promises to provide an exciting program that includes a stimulating mix of practical critical care and academic challenges. Jeff Presneill, as the Chair of the Medical Scientific Committee, has worked hard to secure international, interstate and local speakers of an outstanding calibre, thereby guaranteeing a high quality meeting. Sponsorship and industry participation has also been encouraging, continuing to progress towards our predicted targets. Importantly, the social program promises to offer all that has come to be expected from an ANZICS ASM.

This year has also been an exciting one with the Committee establishing a series of 'ANZICS Queensland Lectures – Tapping into Local Expertise', which have received generous sponsorship from industry, allowing talented Australian intensivists to present at dinner meetings. Our first meeting was held in June and we were delighted to have Michael Reade from Victoria address us on 'Sedation – Challenging the Paradigm'. Not only did we beat the Chilean ash cloud that conspired to destroy our meeting, but we also enjoyed a very worthwhile educational evening. The next meeting in September will see Peter Kruger talk about 'Statins in Sepsis Past, Present and Future'. We hope that these worthwhile meetings will also strengthen our ANZICS Queensland membership.

The co-badged CICM /ANZICS Registrar Research Forum was first run in November 2010 to encourage an interest in research among Queensland registrars and specialists. The forum provides an opportunity for established researchers to mentor and encourage new researchers. Not only was the meeting well

Regional Reports

attended, it also provided a wonderful opportunity for the presentation of trainee papers. Given the value of such a meeting, ANZICS will again be supporting the Queensland Registrar Research Forum.

Queensland ANZICS continues to have a strong and increasing membership that represents the members' interests in a range of activities, including safety, quality, research and private practice.

ANZICS Queensland Regional Committee

Chair Anthony Holley

Members Brent Richards (Organ Donation), Dan Mullany (CORE), Ranald Pascoe (PRICE), Peter Kruger (CTG), John Evans (Secretary)

Anthony Holley
QLD Regional Chair

ANZICS South Australian Regional Committee

The ANZICS ASM returns to Adelaide next year – put the dates in your diaries now, 25th – 27th October. Ken Lee and his team are advanced in the planning, with a theme of 'Intensive Care is Not all Black & White'. Adam Deane is the Scientific Convenor, Bernadette Grealy is the Nursing Convenor, and Nick Edwards and Alex Wurm are Social Organisers. International speakers are confirmed and Penny Stewart from Alice Springs is helping to provide an emphasis on indigenous health issues. There will also be plenty of good food and wine opportunities!

The AGM was held in March, again in conjunction with the CICM AGM. The SA ANZICS Regional Chair will be seconded onto the CICM Regional Committee.

The annual Tub Worthley Scholarship meeting was held in May with a good turnout. This year's winner was John Raj from QEH/RAH with his paper 'Does waist circumference predict mortality in Intensive Care?'.

Since last year's report the Safety and Quality Committee's Percutaneous Tracheostomy Consensus Statement has been released, which addressed the SA region's concerns and has been widely supported.

Of considerable local concern has been a somewhat contentious Coroner's Report of regarding the death of Vera Allen. This has given rise to much discussion, locally and at ANZICS Board level, as it may have widespread implications.

David Durham
SA Regional Chair

Regional Reports

ANZICS Tasmanian Regional Committee

Tasmania is currently going through a process of significant change and a restructuring of health services, including critical care. The long-standing need for updating and expanding our intensive care units has started, with building work recently beginning at Royal Hobart Hospital. The overall number of beds and specialists in Tasmania remains small and is spread widely around the state, providing interesting challenges for all of us.

We have gradually built up our advanced training programs over the past few years, utilising the broad and interesting case-mix in our units, the enthusiasm of our specialists for bedside and exam-focussed teaching and opportunities for trainees to complete non-ICU terms. This is reflected in excellent exam results with success at Fellowship over the past three years. As a result we are now attracting more trainees to Tasmania, adding value to both the training and work environments for everyone. This has led to preliminary discussions around developing a state-wide training scheme, but this is a little way off yet. Our trainees have all been encouraged to take up ANZICS membership, and most have done so.

The work of ANZICS and College affairs over the past year has largely been taken up by a small pool of specialists. There has been a fall in ANZICS membership from specialists in Tasmania over the past year. This may be related, in part, to changes in the way our CPD funding works in the current award. This is disappointing as it limits our ability to operate a Regional Committee and share ANZICS related activities around.

Meetings and activities in Tasmania continue to be run in conjunction with College affairs, as in other regions. We are more frequently utilising teleconferencing to overcome difficulty with distance. At least one dinner meeting per year has been held, with both education and business attended to. The annual ANZICS/ACCCN combined education meeting this year was held in Burnie in August and was very well received by all.

David Rigg
TAS Regional Chair

ANZICS Victorian Regional Committee

The Victorian ANZICS membership have continued to be constructively active over the last 12 months. Wide support has been garnered to prepare a bid for the WFSICCM World Congress in 2017. Together with the ACCCN, ANZICS will complete the biding process over the remainder of this year, aided by the Melbourne Convention and Visitors Bureau. This multi-staged process requires a comprehensive work-up of all the necessary elements that combine to host a complex event of this size. Initial feedback regarding our application is positive thus far and we feel confident that we are serious contenders.

Intensive care education remains vibrant within Victoria. The process of expanding inter-hospital registrar teaching continues, with plans for a total of five sites to be engaged in a monthly full-day coordinated training event by the end of this year. Up to 25 critical care trainees regularly attend these teaching and training days, with excellent feedback testifying to the quality of the program and the enthusiasm of participants.

Once again Ramesh Nagappan and Sam Radford conducted the annual ANZICS Intensive Care Medicine Course at Box Hill Hospital. This course continues to evolve and expand with growing attendance by trainees and intensivists. The excellence of the course content and the peerless coordination of all logistical considerations were impressive and all involved deserve thanks.

Twice yearly inter-hospital city-wide education evenings continue, with the next due in November, the theme of which will be announced shortly.

On behalf of all Victorian members, I would like to thank everyone in the ANZICS office team for their great efforts in supporting all ANZICS members.

Stephen Warrillow
VIC Regional Chair

Regional Reports

ANZICS Western Australian Regional Committee

Western Australians continue to fill many busy roles within ANZICS and also represent the interests of intensivists at various levels. Geoff Dobb, a past ANZICS President, was successful in being elected to the position of Vice President of the Australian Medical Association, the first intensivist to hold such a high office in the AMA. He has relinquished the Chair of the ANZICS Death and Organ Donation Committee, having chaired this group for 11 years since 2000 and having been a member since 1992 – some 19 years in total. On behalf of ANZICS I would like to thank Geoff for such a prolonged and intense period of service, for overseeing the most recent revision of the guidelines and also for leaving the Committee in such good functional and intellectual shape with a committee membership that is highly capable and experienced with respect to the sometimes vexed area of organ donation. Steve Webb continues as CTG Chair and Western Australia's current CTG Executive member remains Ed Litton, while Brad Power continues as the Safety and Quality Committee member. Greg McGrath is Western Australia's PricE Committee representative and I occupy the Chair position of that Committee.

Locally we have had excellent research meetings throughout the last year, which have seen the meeting of our research coordinators, research directors from the tertiary centres, the CTG Chair and Executive representative and other parties interested in research. I would like to thank Brigit Roberts for continuing to organise these evening meetings, which are kindly supported by industry.

We have not, however, held as many educational events as I would have liked to have had.

While as a state we are over-represented at bi-national level, we still function without a local committee; this 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.

We have continued to have meetings with the heads of departments of the three adult tertiary ICUs and one paediatric ICU in Perth during the past year to discuss a range of common issues, in particular future planning of ICU services. The following issues have remained germane in Western Australia:

1 Inter-hospital transfer of critically ill patients

2 Rural and regional patient transfer to the metropolitan area

3 Workforce planning

4 Training and workforce

5 Development of HDC/Level I ICUs at metropolitan hospitals

6 Uniform CIS across all urban ICUs

In conclusion, what I wrote last year is still very much relevant and germane – ICU beds remain centralised within the greater metropolitan area but with so-called Level I ICUs being established at two smaller general hospitals on the outskirts of town and along with our rapidly growing and ageing population, current under-supply of ICU beds and the relative paucity of ICU specialists in WA, there will be some interesting and difficult workforce challenges in the near future. I still 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 Jenkins
WA Regional Chair

ANZICS Awards

Matt Spence Medal

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

The winners of previous awards follow.

1981	S Streat
1982	S Gatt
1983	R Raper
1984	N Gibbs
1985	W Griggs
1986	A Bersten
1987	M Oliver
1988	P McQuillan
1989	T Buckley
1990	C McAllister
1991	R Bellomo
1992	S Parkes
1993	R Totaro
1994	No award presented
1995	A Davies
1996	B Vankatesh
1997	D Blythe
1998	N Edwards
1999	V Pellegrino
2000	I Seppelt
2001	R Fregley
2001	B Mullan (special)
2002	D Collins
2003	N Blackwell
2004	V Campbell
2005	P John Victor
2006	M Zib
2007	A Nichol
2008	B Tang
2009	M Brain
2010	R Fischer

Past Presidents

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

ASM oration

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

Perth 2002	Malcolm Fisher	New South Wales
Cairns 2003	Lindsay Worthley	South Australia
Melbourne 2004	Jack Cade	Victoria
Adelaide 2005	Bob Wright	New South Wales
Hobart 2006	Stephen Streat	New Zealand
Rotorua 2007	Geoffrey Parkin	Victoria
Sydney 2008	Frank Shann	Victoria
Perth 2009	David Tuxen	Victoria
Melbourne 2010	Anthony Bell	Tasmania

ANZICS Awards

ANZICS Honour Roll

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

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 2011 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 Mary G White *Vice-President*
Dr Andrew J Turner *Hon. Secretary*
Dr Marc Ziegenfuss *Hon.Treasurer*
Dr Satyadeepak Bhonagiri
Dr David Durham
Dr Simon Erickson
Dr Anthony Holley *(appointed 2 December 2010)*
Dr Ian Jenkins
Dr Janet Liang
Dr David Pilcher *(appointed 13 July 2010)*
Dr David Rigg
Dr Stephen Warrillow
Dr Steven Webb
Dr Graeme Hart *(resigned 13 July 2010)*
Dr Peter Hicks *(resigned 2 December 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 M G White
Qualifications: MBBS/BSc/ChB
Experience: Director since 2002
Special Responsibilities: Vice President

Dr A J Turner
Qualifications: MBBS
Experience: Director since 1999
Special Responsibilities: Hon. Secretary

Dr M Ziegenfuss
Qualifications: MBBCh/BSc
Experience: Director since 2008
Special Responsibilities: Hon. Treasurer

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 A Holley
Qualifications: MBBCh/BSc
Experience: Director since Dec 2010
Special Responsibilities: Chair – QLD

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

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

Directors' Report

Directors' meetings

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

Directors	Number eligible to attend	Number attended
Dr S Bhonagiri	3	2
Dr D Durham	3	3
Dr S Erickson	3	3
Dr G Hart *(resigned 13 July 2010)*	-	-
Dr P Hicks *(resigned 2 December 2010)*	1	1
Dr A Holley *(appointed 2 December 2010)*	2	2
Dr I Jenkins	3	3
Dr J Liang	3	1
Dr D Knight *– Proxy for Dr J Liang*	2	2
Dr M O'Leary	3	3
Dr D Pilcher *(appointed 13 July 2010)*	3	3
Dr D Rigg	3	2
Dr A J Turner	3	3
Dr S Warrillow	3	3
Dr S Webb	3	2
Dr C McArthur *– Proxy for Dr S Webb*	1	1
Dr M G White	3	3
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, for payment of the debts and liabilities of the Society (contracted before he/she ceases to be a member) and of the charges and expenses of winding up and for the adjustment of the rights of the contributories among themselves, such amount as may be required, not exceeding $20. The liability of members at balance sheet date was limited to $13,640 (2010: $12,480) being 682 (2010: 624) members with a liability limited to $20 each.

Auditor's independence declaration

The lead auditor's independence declaration for the year ended 30 June 2011 has been received and can be found on page 33 and forms part of the directors' report.

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

Dr Michael O'Leary
Director

Dr Marc Ziegenfuss
Director

Dated this 2nd day of September 2011.

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

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

I declare that, to the best of my knowledge and belief, during the financial year ended 30 June 2011, 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

Mitch Craig
Partner

Melbourne

2 September 2011

Statement of Comprehensive Income

for the year ended 30 June 2011

	Note	2011 $	2010 $
Revenue from ordinary activities	2	2,210,365	2,068,418
Employee expenses		(1,092,672)	(1,026,720)
Administration expenses		(334,420)	(340,249)
Conference and meeting expense		(279,700)	(338,673)
Travel and committee expenses		(145,022)	(143,448)
Depreciation expense		(52,756)	(55,611)
Finance expenses		-	(268)
Other expenses from ordinary activities		(83,756)	(94,214)
Profit for the year	3	222,039	69,235
Other comprehensive income			
Other comprehensive income for the year, net of income tax		-	-
Total comprehensive income for the year		222,039	69,235

The accompanying notes form part of these financial statements.

Statement of Financial Position

as at 30 June 2011

	Note	2011 $	2010 $
Current assets			
Cash and cash equivalents	4	1,701,895	1,268,421
Trade and other receivables	5	216,008	154,124
Other current assets	6	103,117	46,148
Total current assets		2,021,020	1,468,693
Non-current Assets			
Financial assets	7	15,724	16,000
Property, plant and equipment	8	2,267,846	2,314,838
Income fund	9	95,434	92,342
Total non-current assets		2,379,004	2,423,180
Total Assets		4,400,024	3,891,873
Current Liabilities			
Trade and other payables	10	796,140	520,812
Total current liabilities		796,140	520,812
Non Current Liabilities			
Employee benefits	11	34,854	27,162
Income fund liability	9	95,434	92,342
Total non-current liabilities		130,288	119,504
Total Liabilities		926,428	640,316
Net Assets		3,473,596	3,251,557
Equity			
Reserves	12	428,092	428,092
Retained profits		3,045,504	2,823,465
Total Equity		3,473,596	3,251,557

The accompanying notes form part of these financial statements.

Statement of Cash Flows

for the year ended 30 June 2011

	Note	2011 $	2010 $
Cash flows from operating activities			
Cash receipts from members and customers		2,181,602	2,627,222
Interest received		66,269	32,439
Payments to suppliers and employees		(1,807,794)	(2,145,024)
Interest paid		-	(268)
Net cash provided by operating activities	14	440,077	514,369
Cash flows from investing activities			
Purchases of property, plant and equipment		(6,603)	(21,084)
Net cash used in investing activities		(6,603)	(21,084)
Net increase in cash		433,474	493,285
Cash at beginning of financial year		1,268,421	775,136
Cash at end of financial year	4	1,701,895	1,268,421

The accompanying notes form part of these financial statements.

Statement of Changes in Equity

for the year ended 30 June 2011

	Retained profits $	Asset revaluation reserve $	Total $
Balance at 1 July 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
Profit attributable to the Society	222,039	-	222,039
Total other comprehensive income for the year	-	-	-
Balance at 30 June 2011	3,045,504	428,092	3,473,596

The accompanying notes form part of these financial statements.

Notes to the Financial Statements

for the year ended 30 June 2011

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 value as indicated, less, where applicable, accumulated depreciation and impairment losses.

Land and buildings

Freehold land and buildings are shown at their fair value based on periodic, but at least triennial, valuations by external independent valuers, less subsequent depreciation for buildings.

Increases in the carrying amount arising on revaluation of land and buildings are credited to a revaluation reserve in equity. Decreases that offset previous increases of the same classes of assets are charged against 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.

Notes to the Financial Statements

for the year ended 30 June 2011

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.

Notes to the Financial Statements

for the year ended 30 June 2011

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.

Notes to the Financial Statements

for the year ended 30 June 2011

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 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.

		2011 $	2010 $
2. Revenue and other income			
Revenue:			
Grants		1,038,524	942,716
Subscriptions		466,799	402,141
Surplus from ASM		178,805	193,939
Conferences and meetings		228,951	305,286
Sponsorship		141,141	95,332
		2,054,220	1,939,414
Other income:			
Interest received		88,059	37,804
Rent received		23,794	24,331
Sundry income		44,292	66,869
		156,145	129,004
Total revenue and other income		2,210,365	2,068,418
3. Profit for the year			
Expenses			
Depreciation	- buildings	27,475	27,475
	- plant and equipment	25,281	28,136
		52,756	55,611

Notes to the Financial Statements

for the year ended 30 June 2011

Auditor's remuneration:

The auditors of the Society for the year ended 30 June 2011 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 2010.

	2011 $	2010 $
4. Cash and cash equivalents		
Cash on hand	300	300
Cash at bank	363,693	660,642
Cash on short term deposit	1,337,902	607,479
	1,701,895	1,268,421
5. Trade and other receivables		
Trade receivables	188,734	147,494
Other receivables	27,275	6,630
	216,008	154,124
6. Other current assets		
Prepayments – general	72,850	35,881
Prepayments and deposits - ASM	30,267	10,267
	103,117	46,148
7. Financial assets		
Held to maturity financial assets	15,724	16,000
- comprises NZ Debentures (Balanced Fund)		

Notes to the Financial Statements

for the year ended 30 June 2011

	2011 $	2010 $
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	(82,425)	(54,950)
	1,016,575	1,044,050
Total land and buildings	2,226,575	2,254,050
Plant and equipment		
Plant and equipment - at cost	205,359	208,718
Less accumulated depreciation	(164,088)	(147,930)
Total plant and equipment	41,271	60,788
Total property, plant and equipment	2,267,846	2,314,838

Revaluation of property

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

Subsequent to the end of the financial year, the Society engaged an independent valuer to conduct an assessment of the property at 10 levers Terrace, Carlton. The external expert's valuation report as at 23 August 2011 indicated an increment in the fair value of the building. As the valuation was commissioned subsequent to 30 June 2011, all fair value adjustments will be brought to account in the financial year ending 30 June 2012.

Notes to the Financial Statements

for the year ended 30 June 2011

Movements in carrying amounts

	Freehold land and buildings $	Plant and equipment $	Total $
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
2011			
Balance at 1 July 2010	2,254,050	60,788	2,314,838
Additions	-	6,603	6,603
Disposals/write-offs	-	(839)	(839)
Depreciation for the year	(27,475)	(25,281)	(52,756)
Balance at 30 June 2011	2,226,575	41,271	2,267,846

	2011 $	2010 $
9. Income Fund		
Australians Donate Education Fund	95,434	92,342

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. $76,375 has been invested in a 6 month term deposit with ANZ at 6.0% p.a.. The balance is held in the ANZICS bank account.

Notes to the Financial Statements

for the year ended 30 June 2011

	2011 $	2010 $

10. Trade and other payables

Sundry creditors and accruals	156,925	114,891
Grants received in advance	173,678	56,900
Subscriptions received in advance	309,332	215,635
Sponsorship & registrations received in advance	78,959	65,497
Employee entitlements - current	77,246	67,889
	796,140	520,812

11. Employee benefits

Non-current

Provision for long service leave	34,854	27,162
Opening balance at 1 July 2010	27,162	
Increase in provision during the year	7,692	
Balance at 30 June 2011	34,854	

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.

	2011 $	2010 $

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 $13,640 (2010: $12,480) being 682 (2010: 624) members with a liability limited to $20 each.

Notes to the Financial Statements

for the year ended 30 June 2011

	2011 $	2010 $

14. Notes to the Statement of Cash Flows

Reconciliation of cash flow from operations with profit after income tax

Profit from ordinary activities	222,039	69,235
Add/(less) non-cash items:		
Depreciation	52,756	55,611
Loss on disposal of non-current assets	840	1,008
Change in assets and liabilities		
(Increase)/decrease in trade and other receivables	(61,885)	376,051
(Increase)/decrease in other current assets	(56,693)	121,683
(Increase)/decrease in financial assets	-	(642)
Increase/(decrease) in trade and other payables	265,971	(120,615)
Increase/(decrease) in provisions	17,049	12,038
Net cash provided by operating activities	440,077	514,369

15. Related Parties

Directors

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

Dr Michael O'Leary, Dr Mary G White, Dr Andrew J Turner, Dr Marc Ziegenfuss, Dr Satyadeepak Bhonagiri, Dr David Durham, Dr Simon Erickson, Dr Anthony Holley, Dr Ian Jenkins, Dr Janet Liang, Dr David Pilcher, Dr David Rigg, Dr Stephen Warrillow, Dr Steven Webb, Dr Graeme Hart and Dr Peter Hicks

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

16. Key management personnel compensation

	Short-term benefits $	Post employment benefits $	Total $
2011			
Total compensation	243,676	21,667	365,343
2010			
Total compensation	283,619	23,663	307,282

Notes to the Financial Statements

for the year ended 30 June 2011

17. Events subsequent to reporting date

Subsequent to the end of the financial year, the Society engaged an independent valuer to conduct an assessment of the property at 10 levers Terrace, Carlton. The external expert's valuation report as at 23 August 2011 indicated an increment in the fair value of the building. As the valuation was commissioned subsequent to 30 June 2011, all fair value adjustments will be brought to account in the financial year ending 30 June 2012.

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:

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

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

Notes to the Financial Statements

for the year ended 30 June 2011

(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

	2011 Carrying amount $	2011 Fair value $	2010 Carrying amount $	2010 Fair value $
Cash and cash equivalents	1,701,895	1,701,895	1,268,421	1,268,421
Trade and other receivables	216,008	216,008	154,124	154,124
Other current assets	103,117	103,117	46,148	46,148
Trade and other payables	718,894	718,894	452,923	452,923

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

(c) Interest Rate Risk

	Carrying amount 2011 $	2010 $
Floating rate instruments		
Cash and cash equivalents	1,701,895	1,268,421

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.

Notes to the Financial Statements

for the year ended 30 June 2011

(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	
	2011 $	2010 $
Loans and receivables	216,008	154,124
Cash and cash equivalents	1,701,895	1,268,421
	1,917,903	1,422,545

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

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

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

	Gross amount $	Past due and impaired $	Past due but not impaired (days overdue)				Within initial trade terms $
			<30 $	31-60 $	61-90 $	>90 $	
2011							
Trade receivables	188,734	-	108,056	7,370	8,800	64,508	108,055
Other receivables	27,275	-	27,275	-	-	-	27,275
Total	216,008	-	135,331	7,370	8,800	64,508	135,330
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

Notes to the Financial Statements

for the year ended 30 June 2011

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 2011 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 2011							
Payables	718,894	718,894	564,228	154,666	–	–	–
30 June 2010							
Payables	452,923	452,923	452,923	–	–	–	–

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 34-50, 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 2011 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 Marc Ziegenfuss
Director

Dated this 2nd day of September 2011.

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

Report on the financial report

We have audited the financial report of Australian and New Zealand Intensive Care Society (the Society) which comprises the statement of financial position as at 30 June 2011, the statement of comprehensive income, statement of changes in equity and statement of cash flows for the year then ended, notes 1 to 20 comprising a summary of significant accounting policies and other explanatory information, and the directors' declaration.

Directors' responsibility for the financial report

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

Auditor's responsibility

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

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

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

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

Independence

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

Auditor's opinion

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

a) the *Corporations Act 2001*, including:

(i) giving a true and fair view of the Society's financial position as at 30 June 2011 and of its performance for the ended on that date; and

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

KPMG

Mitch Craig
Partner

Melbourne

2 September 2011

Appendix One

Annual General Meeting

5.15pm Friday 15th October, 2010

Room 220
Melbourne Convention and Exhibition Centre

Draft Minutes

1. Welcome, Present & Apologies

Michael O'Leary welcomed attendees to the meeting and noted the apologies received.

Present

Michael O'Leary (President)
Peter Hicks (Immediate Past President)
Andrew Turner (Honorary Treasurer)
Allan Beswick
Troy Browne
Anthony Burrell
Peter Cameron
David Charlesworth
Andrew Davies
Geoffrey Dobb
Graeme Duke
Simon Erickson
David Fraenkel
Elizabeth Fugaccia
David Gattas
Con Giannellis
Graeme Hart
Ian Jenkins
Michael Kalkoff
John Lambert
Anne Leditschke
Paul McGinn
Helen Opdam
Ranald Pascoe
Mathew Piercy
David Pilcher
Sam Radford
Michael Reade
David Rigg
John Santamaria
Phil Sargent
Simon Scothern
Ian Seppelt
Yahya Shehabi
Anthony Slater
Liz Steel
Richard Totaro
Stephen Warrillow
Ravindranath Tiruvoipati
Ann Whitfield
Marc Ziegenfuss

In Attendance

Erin O'Sullivan (ANZICS GM)
Chris Nash (Minutes)

Apologies

Amjed Aziz
Louise Cole
Theresa Jacques
Ronald Lo
John Myburgh
Kui-Hian Sim
Wally Thompson
Mary White (Honorary Secretary)

2. Minutes of the Previous Meeting

Motion: The minutes be accepted as a true and accurate record of the meeting.
Proposed: S. Erickson
Seconded: T. Burrell
Motion Carried

3. President's Report

Michael O'Leary (MOL) presented the President's report and provided a summary of the activities undertaken during the year.

MOL advised that the Board has embarked on a strategic planning process and noted that responses from the membership had been discussed and considered.

MOL declared that he sits on the Council of the European Society of Intensive Care Medicine (ESICM – EU). MOL noted that ANZICS members have a reciprocal membership arrangement whereby they can join the ESICM for 100 Euros, which entitles them to a number of benefits, including access to their online journal Intensive Care Medicine.

MOL advised that following a teleconference in August, 2010 between ANZICS and the Society of Critical Care Medicine (SCCM – US) he remained hopeful that an MOU would be drafted between the

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two Societies, with the aim of running joint events in the future.

MOL advised that he attended the 16th Congress of Asia Pacific Association of Critical Care Medicine (APACCM) in Manila as the ANZICS representative. MOL noted that ANZICS had sponsored Sandy Peake, who delivered three presentations, to attend.

MOL confirmed that Ian Jenkins (IJ) had facilitated an agreement with the Society of Intensive Care Medicine (Singapore) to run the inaugural Singapore-ANZICS Intensive Care Forum 2011 in April 2011, in Singapore.

MOL reported that the ANZICS Board had agreed that a taskforce should be formed between the PricE Committee and CORE to address workforce planning, separate to the CICM initiative, and to provide guidelines on how specialist groups may be balanced within hospitals.

MOL confirmed that ANZICS was a supporting member of the Global Sepsis Alliance (GSA) and declared that, at the request of the GSA, he now sits on their Board of Directors.

4. Treasurer's Report

Andrew Turner (AT) presented the Treasurer's report. AT reported that $943,000 had been received in CORE grants; the 2009 ASM produced a profit of $193,000 with an additional $530,000 received from other sources. AT noted that expenses were stable compared to the 2008/2009 period, with improvement noted in a number of operational areas. Current equity was reported at $3.25M, with $2.3M of this being in ANZICS House.

AT reported that the Board had approved the 2010/11 budget, with a deficit of $156,000 based on conservative ASM profit distribution. AT noted that the seasonalised accounts as of 30 September 2010 reflect the Society being ahead of budget by $328,000. AT noted that in 2000 the Society's equity stood at $1.04M compared to approximately $3.3M currently, which reflects a reasonable rate of growth.

4.1 Auditor's Report for 2009/2010

Motion: That the Honorary Treasurer's report be accepted.
Proposed: R. Pascoe
Seconded: D. Charlesworth
Motion Carried

Motion: That KPMG be appointed as auditors for the financial year ended 30 June 2011.
Proposed: G. Dobb
Seconded: S. Warrillow
Motion Carried

4.2 Member Subscriptions for 2009/10

AT reported that $275,000 had been received in subscriptions for the 2009/ 2010 financial year.

Motion: That membership subscription remain the same for the financial year ended 30 June 2011.
Proposed: J. Santamaria
Seconded: G. Hart
Motion Carried

5. ANZICS Strategic Plan

MOL noted that the strategic planning process comes on the 35th anniversary of the Society. MOL reported that a total of 30 responses were received to the discussion paper that was disseminated to the membership in July. It was noted that most were uniform in their view, presenting strong beliefs and arguments for the Society to remain separate from CICM. MOL reported that as a result of an extraordinary meeting of the Board in August, it was decided that ANZICS should have a focus on education, CME and professional development, necessitating the formation of an Education Committee. MOL reported that preliminary discussions have been initiated between CICM and ANZICS regarding how resources may be shared to ensure the most cost effective operations for members. MOL reported that the service ANZICS provides to its members in terms of industrial support has been discussed. It was noted that while PricE has always worked for the benefit of members, it will be focusing on ways to broaden its scope beyond private practice. It was noted that the Board and its structure will be scrutinised, as will the regulations of the Society, to determine whether or not they are still relevant and beneficial for the Society and its members.

6. CICM

6.1 CICM Report

Phillip Hart (PHart) presented the CICM report on behalf of John Myburgh.

PHart noted that there is currently strong financial support of the College, due to foundation subscriptions. It was noted that the College is based in a leased

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property at 1 Greville Street, Prahran, to which the College welcomes Fellows to visit. It was noted that there is no future plans to move from these premises.

PHart reported that there is an average of 50 new Fellows per year. The first Annual Scientific Meeting (ASM) of the College was held in June in Sydney, with their Annual General Meeting (AGM) running alongside this. It was noted that their next ASM will be held in Canberra in June, 2011.

PHart advised that the Australian Medical Council accreditation process is underway and the submission process is expected to be finalised and approved by the end of the 2010 calendar year.

PHart noted the ongoing support and recognition of ANZICS on behalf of CICM.

7. Membership

7.1 Report on Membership Numbers

MOL presented the membership report on behalf of Mary White. It was noted that the Society's membership remains stable. The importance of retaining trainee members was noted.

8. Professional Practice

8.1 ANZICS Clinical Trials Group

Ian Seppelt (IS) presented the CTG report. IS reported that the CTG currently has 66 ICUs as full members. IS advised that in January, 2011 units will receive a six month invoice, and then another six month invoice in July in order to bring accounts in line with the financial year.

IS noted that the CTG currently hold three major meeting per year and noted the addition of the Winter Research Forum in August 2010. IS reported that Jeffrey Drazen, Editor of the New England Journal of Medicine, and Kathy Rowan, Director of Intensive Care National Audit Research Centre (ICNARC - UK), will be attending the Noosa 2011 meeting as invited overseas speakers.

IS noted that there are five major working groups running within the CTG currently:

- Capacity Working Group
- Point Prevalence Programme Management Committee
- Standardised Study Tool Working Group
- Translational Research Working Group
- Translation of Research Into Practice (TRIPS) Working Groups

IS noted the CTG Executive Committee's gratitude for the CTG office staff members Rhiannon Tate, Simone Rickerby and Jean Walton, as well as all member units, research coordinators and participants.

IS advised that the CTG Annual Report would be distributed within the coming weeks.

8.2 ANZICS Centre for Outcome and Resource Evaluation

Peter Hicks (PH) presented the CORE report. PH noted that Graeme Hart had stepped down as Chair of CORE, having been replaced by David Pilcher.

It was reported that a governance restructure had been implemented following the report from ICNARC. PH explained that two committees would now govern CORE: an Advisory Committee and a Management Committee. PH advised that the Management Committee has been formed and is meeting regularly and that the Advisory Committee would be formed and convened in the 2011 calendar year. It was noted that the Advisory Committee will consist of a broad membership and key stakeholders. PH noted that Gail Adams had been appointed to the position of CORE manager and welcomed her to ANZICS.

PH made note that all key deliverables had been met during the 2009 – 2010 financial year. PH advised that 85 – 90 percent of admissions to ICUs in Australia and New Zealand had been submitted to the Adult Patient Database (APD). PH also advised that the CCR Survey has been published as has the H1N1 study. The SQAO meeting was noted as having run well.

PH reported that the CORE Management Committee is currently working towards securing the next triennium of funding. PH noted that it is hoped that CORE will receive an increase on previous funding to undertake important IT infrastructure upgrades.

PH noted that a greater collaboration with the MONASH Registries is also on the CORE agenda.

Motion: That thanks be offered to Graeme Hart for his work with CORE
Proposed: J. Santamaria
Seconded: P. Hicks
Motion Carried

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8.3 ANZICS Practice and Economics Committee

MOL presented the PricE report. MOL noted that he has been interim Chair following Yahya Shehabi (YS) stepping down and offered thanks on behalf of ANZICS to YS for his work with the Committee. He advised that at the next meeting of the Committee, a new Chair will be elected.

MOL reported that negotiations with DoHA are ongoing in regards to the fees submission, however, there has been no further development to report. A formal letter from the PricE Committee expressing frustration with progress has only been met with acknowledgement of its receipt. MOL reported that the MBS Quality Framework Review requested nominations for a specialist to sit on the review panel, for which YS was nominated, however, no response has been received to date. It was noted that one of the items under review is pulmonary artery catheterisation. It was noted by MOL that representatives from CICM, ANZICS, Australian Medical Council, cardiac surgery, anaesthesia, and cardiology were part of the review for this item. While some members have resigned in protest to the process, MOL advised that ANZICS will stay involved in this process in an effort to remain influential in the process. It was further noted that a government taskforce on workforce requirements had approached PricE earlier in the year; however there has been no further contact to date.

8.4 ANZICS Safety and Quality Committee

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

TB reported that SQAO 2010, Creswick Victoria, ran successfully with 90 delegates in attendance, and that the collocation of the conference with the CTG Winter Research Forum was beneficial to both groups. It was advised that SQAO 2011 will be held in the first week of August in the Blue Mountains.

TB noted that the Percutaneous Dilatational Tracheostomy Consensus Statement has been finalised and would be circulated to the membership shortly. TB noted that the statement reflects the results of the survey conducted of the ANZICS membership. TB advised that the next project for the Committee will be the development of a Ventilator Associated Pneumonia Consensus Statement.

The Australian Council on Healthcare Standards has received input from the Committee on the Intensive Care Clinical Indicator Set. TB also noted that the Central Line Acquired Bacteraemia project is progressing well.

TB reported that Baxter has granted ANZICS with funds to appoint a Safety and Quality Executive Officer, in addition to approximately $20,000 to be used for seed funding for projects in the area of safety and quality.

8.5 ANZICS Death and Organ Donation Committee

Geoff Dobb (GD) presented the Death and Organ Donation Committee report. GD reported that the ANZICS Statement on Death and Organ Donation version 3.1 has been distributed, with the most up-to-date version available for download from the ANZICS website.

GD reported that the next agenda item for the Committee is a review of the Statement on Withholding and Withdrawing Treatment.

GD reported that a review of the ADAPT course has been conducted by a sub-group formed within the Committee.

9. Intensive Care Foundation

YS presented the Intensive Care Foundation report.

YS reported that the Foundation has undergone a series of changes in the past year. It was reported that a new Executive Officer, Malina Triantafylidis has been appointed.

YS reported that the Foundation Board structure has been reviewed and the Board is now in the process of co-opting a clinical representative and a nursing representative independent of the Society and the Australian College of Critical Care Nursing. YS reported that the Board has commenced a strategic planning process, the aim of which is to increase revenue through co-ops and sponsorship.

10. Future Meetings

10.1 2011 ANZICS/ACCCN 36th ASM – Brisbane, Queensland

MOL noted that Marc Ziegenfuss (MZ) is the convenor for the 2011 ASM.

Appendix One

10.2 2011 Singapore-ANZICS Meeting

MOL reported that Society of Intensive Care Medicine (SICM - SG) has agreed to run the Singapore ANZICS Intensive Care Forum 2011, in Singapore in April 2011.

10.3 2011 6th World Congress of Paediatric Intensive Care (WFPICCS) – Sydney

No discussion noted.

10.4 2012 ANZICS/ACCCN 37th ASM – South Australia

No discussion noted.

11. Election Of Office Bearers

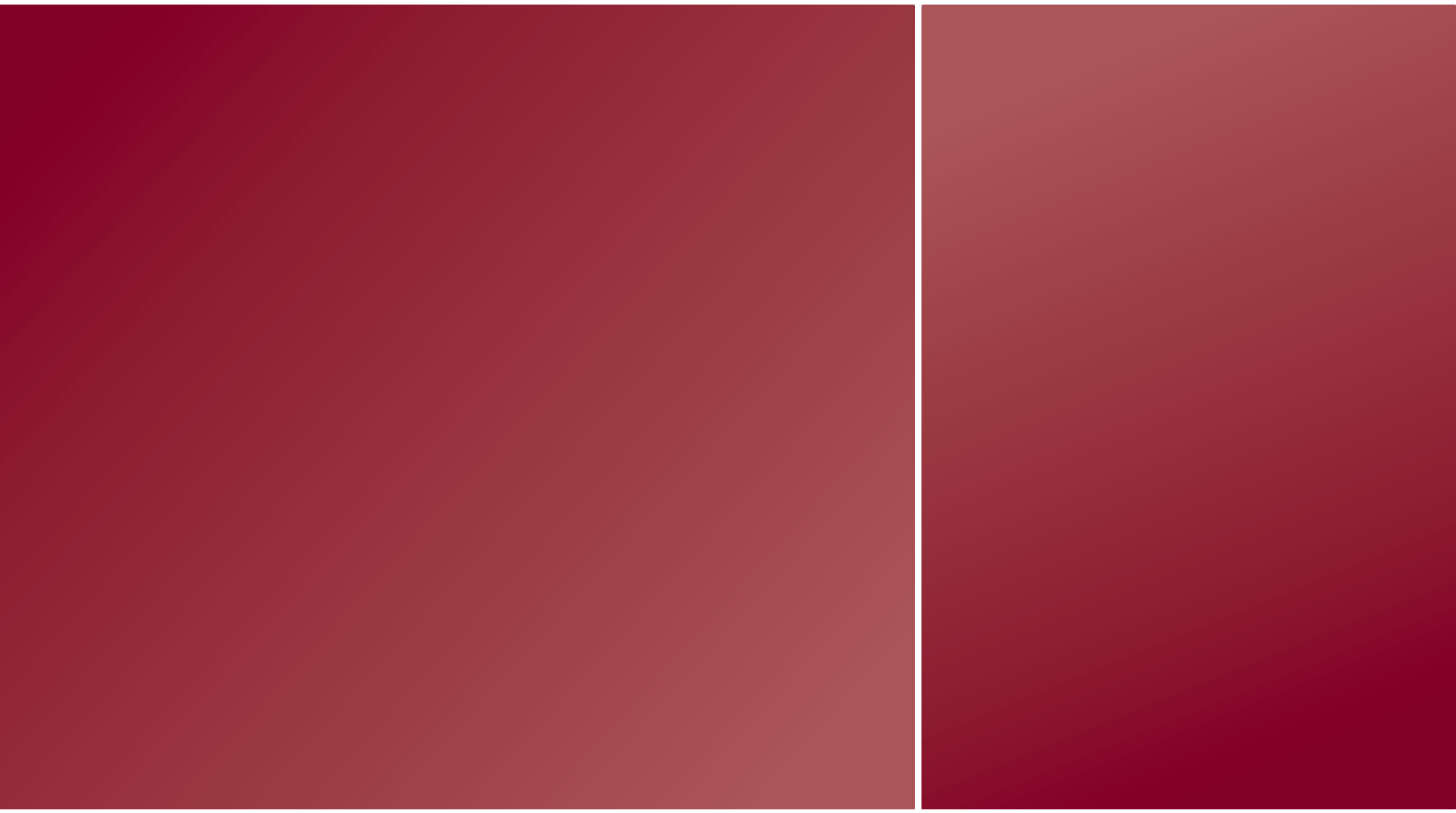
MOL noted that PH is stepping down from the position of Immediate Past President. MOL offered his thanks to PH for his service to the Board. MOL advised that MZ has been nominated unopposed as Honorary Treasurer, AT appointed unopposed to the position of Honorary Secretary, and Mary White (MW) appointed unopposed as Vice-President.

12. Other Business

None noted.

13. Date Of Next Meeting:

Friday 14th October 2011, Brisbane.



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