100 YEARS
Protecting Irish Eyes
1918 – 2018
Irish College of Ophthalmologists

Newsletter

ISSUE 21 SUMMER 2018

Message from the President

Dear Colleagues,

After a long wait, summer arrived in Kilkenny at our Centenary Conference. With the good weather came a celebratory atmosphere which permeated the lectures, workshops and exhibition.

The standard of presentations was superb, from our international speakers through to our interns. We are grateful for the attendance of the American and British Ophthalmology Presidents who thoroughly enjoyed their time in Ireland and contributed greatly to the celebratory mood. The Conference has never been so well attended. Thank you all for your support.

We plan a questionnaire to acquire feedback and generate novel ideas for the Conference so please complete it on arrival.

The Royal College of Ophthalmologists held their Annual Dinner in London recently and President Mike Burdon was most complimentary about our anniversary and our conference in his speech to Council and guests.

UEMS Section of Ophthalmology met in Rungsted, Denmark and a report is contained elsewhere in this newsletter.

The World Ophthalmology Congress was held in Barcelona, Spain recently and the College was asked to partake in a joint Society session with the Sociedad Portuguesa Ophtalmologia. Yvonne Delaney and David Keegan joined three Portuguese speakers in a lively session which I chaired on population studies and education.

The commemoration of our founding Society's 100th Anniversary will continue this year. We ask you to save the date of the 16th November 2018 as an important occasion when after the RAMI and Montgomery Lecture by Dr. Micheal Brennan, we will join together in the RCSI to mark this important milestone for Irish Ophthalmology.

Dr Alison Blake

ICO Annual Conference 2018

The ancient city of Kilkenny was a fitting destination for the Irish College of Ophthalmologists Annual Conference this year, as we marked our own historical occasion of the 100th Anniversary of the first Irish ophthalmic society, the IOS in 1918.

The three day meeting was held at the Kilkenny Convention Centre at the Lyrath Hotel from Wednesday 16th to the 18th May, with over 200 members in attendance for discussions on the latest clinical and scientific updates and developments in the specialty.

The programme of symposia, workshops and papers at the 2018 Conference covered a broad range of topics pertinent to Ophthalmology in 2018. The College were delighted to welcome colleagues from the USA and the UK to present at this years' meeting, and wish to extend our thanks and appreciation to all our guest speakers for their invaluable participation in what resulted in a most invigorating and highly educational meeting.

Alison Blake, President of the Irish College of Ophthalmologists is pictured with Dr. Cynthia Bradford, Professor of Ophthalmology at the Dean McGee Eye Institute, University of Oklahoma Health Sciences Center. Dr. Bradford delivered the 2018 Annual Mooney Lecture on "The Challenge of Cataract Surgery – Hard Work to Make it Look Easy" at the ICO Annual Conference 2018

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If you would like to make any suggestions for future issues of the College Newsletter please contact **Siobhan on siobhan.kelly@eyedoctors.ie**

Annual Mooney Lecture 2018

Dr. Cynthia Bradford, immediate Past President of the American Academy of Ophthalmology and Professor of Ophthalmology at the Dean McGee Eye Institute at the University of Oklahoma Health Sciences Center presented the 2018 Annual Mooney Lecture on *The Challenge of Cataract Surgery – Hard Work to Make it Look Easy.*

In her lecture, Dr. Bradford addressed how cataract surgery is often positioned as a straight forward and 'simple' procedure, when in truth what makes cataract surgery so successful is the extensive training by surgeons, experience and teamwork. Dr. Bradford discussed the common expectation that every cataract surgery must be a win but in order to achieve this high level of success rate, the surgeon must understand the patient's needs, what is possible to achieve and offer the spectrum of options available to achieve their goals. Dr. Bradford looked at the surgeon's ability to anticipate possible complicating features of each individual patient and managing unanticipated intraoperative complication that can make surgery more difficult. It was highlighted how there are a multitude of possible complicating factors with some patients having several complex problems.

Neuro-ophthalmology Symposium

The ICO was delighted to welcome Mr. Michael Burdon, Consultant Ophthalmologist at Queen Elizabeth Hospital, Birmingham and current President of the Royal College of Ophthalmologists, and Professor Patrick Lavin, Professor of Neurology and Neurosciences, and Ophthalmology and Visual Sciences and Director for The Vanderbilt Headache Clinic, Nashville, Tennessee as keynote speakers at the Neuro-ophthalmology Symposium at the this year's annual conference.

The session entitled *"Unexplained Visual Symptoms; to Believe or Not to Believe, that is the Question?"* was chaired by Pat Logan, Consultant Ophthalmic Surgeon at Beaumont Hospital.

Following an interactive neuro-ophthalmology workshop with a number of useful video case studies, Prof. Lavin's first talk, *"Psychogenic Disorders in Neuro-Ophthalmology – Beware the Pitfalls"* discussed common presentations of a non-organic (functional) illnesses in neuro-ophthalmology, how to detect them, and the pitfalls when patients really have organic disease that may be overlooked. Prof. Lavin focused on patients who may be overlooked because of the rarity or subtlety of the disorders, complicated by behavioural characteristics that might be misinterpreted as simulating real disease or exaggeration of minor problems for pecuniary gain.

Prof. Lavin's second talk on *'Unusual visual symptoms, Hallucinations, Illusions, Entopic Phenomena, Visual Snow, Ghosts, etc. When are they of concern?* provided a fascinating look at unusual visual symptoms, how to distinguish them from serious neurological and ocular diseases, and how to manage them. These included entopic phenomenon such as benign floaters, more serious floaters, and migraine aura, which can be present in 25 per cent of migraines and is not harmful.

Pat Logan, Chair of the Neuro-ophthalmology Symposium at the ICO Annual Conference 2018 is pictured with keynote international speakers Prof. Patrick Lavin (left), Professor of Neurology and Neurosciences, and Ophthalmology and Visual Sciences; Director for The Vanderbilt Headache Clinic, Nashville, Tennessee and Mr. Michael Burdon (right), Consultant Ophthalmologist, Queen Elizabeth Hospital, Birmingham President, Royal College of Ophthalmologists.

Prof. Lavin discussed visual conditions, including palinopsia, the persistent recurrence of a visual image after the stimulus has been removed which can be brought on by certain medications, and synaesthesia, a perceptual phenomenon in which stimulation of one sensory or cognitive pathway leads to automatic, involuntary experiences in a second sensory or cognitive pathway.

He highlighted that while visual hallucinations can be caused by drug and alcohol abuse, some visual symptoms may be the manifestation of various serious health issues like stroke, brain tumours or seizures (epilepsy) or certain psychiatric disorders. He said the key to trying to determine the cause of any unusual visual symptoms is taking a thorough patient history and symptom review.

Also presenting at the session was Mr. Michael Burdon who has extensive experience in the diagnosis and management (including surgical correction) of adult motility disorders. His main research interests are papilloedema and idiopathic intracranial hypertension.

Mr. Burdon discussed cases with unusual visual symptoms which transpired to be Creutzfeldt-Jacob Disease (CJD) and highlighted how cortical blindness, dysmetria and hallucinations are among the visual issues that can signal a potential diagnosis of this very rare disease.

Mr. Burdon also looked at night-vision blindness caused by vitamin A deficiency, which can often occur in patients who have had bariatric surgery.

A neuro ophthalmology short paper presentation which following the symposium included a paper on 'Visual Snow', carried out by Emer Doolin under Pat Logan's supervision at Beaumont Hospital.

Visual snow is syndromically consistent from one case to the next and this phenomenon is reported by young and healthy individuals, with neither ophthalmic nor neurological disease. The study of eight patients confirmed that all had normal ocular examinations, normal neuroimaging, and normal electrophysiological studies.

It concluded that patients could be reassured that the condition, although sometimes disabling, is benign, in the sense that it does not lead to visual loss. Special investigations may still be required for patient reassurance, but in this group of patients did not assist in the diagnosis, which must be made on a clinical basis, the study found.

Uveitis Symposium

Dara Kilmartin chaired a dedicated session on uveitis and gave a comprehensive talk on the latest management approaches to the disease. Dara is immediate past Honorary Secretary of the International Uveitis Study Group, and was joined on the panel by Conor Murphy and guest speaker, Dr. Millicent Stone, Consultant Rheumatologist in the Division of Ophthalmology, Guy's and St Thomas's Hospital, and Moorfields Hospital, London who discussed Biologics and Systemic Disease in Uveitis.

Dr. Stone, a University College Cork graduate, set up a combined Rheumatology Uveitis Clinic with the Department of Ophthalmology at St Michael's Hospital in Toronto and conducted research on the prevalence of inflammatory back pain in a uveitis cohort. She was recruited to her current role at Guys and St Thomas Hospital in 2014 to create a program to support patients with inflammatory eye diseases who require immunosuppressant drugs, the first of its kind in UK. The unique role brings together her expertise in biologic agents, clinical outcomes, rheumatology and her interest in medical ophthalmology. Dr. Stone is aware of only one other consultant internationally to date who is working in the United States as a crossover specialist in rheumatology and ophthalmology, but that already St Thomas's is planning to recruit a consultant dermatologist who will also work at their medical eye unit also.

Dr. Stone spoke about how effective the coming together of specialities is, emphasising that patients benefit from rapid access to services familiar with dealing with complex cases and potentially toxic drugs.

She noted that biologic agents have revolutionised the care of rheumatoloid conditions such as rheumatoid arthritis, ankylosing spondylitis and Behcet's disease since their introduction to clinical care over two decades ago.

Dr. Stone said the treatment paradigm and approach to management of inflammatory eye diseases is now undergoing a revolutionary change because of the recent approval of adalimumab, an anti-TNF for use in adult- and childhood-onset uveitis.

Speaking in an interview with the *Irish Medical Times*, Dr. Stone said, "Together with new drugs, novel technologies and a more effective multi-disciplinary way of working we can all greatly enhance how we manage our uveitis patients with systemic disease and improve their outcomes."

Keynote speakers at the Uveitis Symposium at the ICO Annual Conference 2018, Conor Murphy, Dr Millicent Stone, Consultant Rheumatologist, Division of Ophthalmology, Guy's and St Thomas's Hospital, and Moorfields Hospital, London and Dara Kilmartin

In his presentation, Dara Kilmartin, Consultant Ophthalmic Surgeon at the Royal Victoria Eye and Ear Hospital, discussed *Local Therapies and Isolated Ocular Disease in Uveitis*. Dara highlighted that for the past 60 years oral steroids have been the main way of controlling sight-threatening anterior uveitis and that the use of systemic immunosuppressive therapy (IST) of all classes has been in operation for 30 years. He noted that there has been a move from using cyclosporine to tacrolimus, while intravitreal IST like methotrexate or sirolimus are promising, but there is a fear of alkylating agents due to their DNA-altering effects, and they are used in a stepladder approach to minimise the side-effects.

Dara said as IST can have significant toxic side-effects, it is hoped that the advent of biologic therapies and more targeted treatment will mean less risk for patients, though real-world efficacy and cost are current issues.

Speaking to the *Medical Independent*, Dara highlighted that local intravitreal therapy has many advantages, including rapid and targeted delivery and avoidance of systemic side-effects, but is restricted to uniocular disease or marked asymmetry, which is uncommon, while intraocular implants do not have superior visual outcomes versus systemic treatment and have more adverse side-effects, according to the latest studies.

He also highlighted the value of therapeutic vitrectomy, particular in paediatric patients, for suitable uveitis cases.

Conor Murphy, Professor of Ophthalmology, Royal College of Surgeons in Ireland and Consultant Ophthalmic Surgeon, Royal Victoria Eye and Ear Hospital, gave a presentation at the Uveitis Symposium on *Intraocular Lymphoma Masquerading as Uveitis*. Conor specialises in uveitis and disorders of the cornea and ocular surface, providing a national referral service in these areas. Conor heads the Ocular Immunology Research Group at RCSI, which focuses on research into the immunology of Sjogren's syndrome-related dry eye disease, corneal transplantation and uveitis.

In his presentation, Conor discussed primary intraocular lymphoma, a very rare intraocular malignancy that masquerades as autoimmune uveitis, and outlined a detailed case study, which highlighted the difficulty of diagnosing and treating this disease.

Conor explained that this form of lymphoma represents a significant diagnostic challenge for the ophthalmologist and pathologist, as it requires cytological analysis of ocular fluid samples of limited size and cellularity. He said that a lack of prospective studies to identify optimum therapy adds further complexity to this disease, which frequently spreads to the central nervous system (CNS), giving it a poor long-term prognosis, which is not helped by delays in diagnosis.

Notable symptoms to watch out for include behavioural and cognitive changes and Conor said a contrast MRI should be carried out. Once diagnosed, a key management goal is eradication of the reservoir of malignant cells in the eye that can lead to fatal CNS dissemination and to preserve vision.

The treatment options include orbital and ocular radiotherapy, intravitreal methotrexate or rituximab, and high-dose chemotherapy with autologous stem cell Tx, but efficacy versus toxicity must be carefully considered and multidisciplinary team management is vital, Conor noted.

100 Years of Ophthalmic Societies in Ireland

A special symposium marking the 100th Year Anniversary of Ophthalmic Societies in Ireland reflected on how practice and training both within the specialty and in the wider context of health care delivery has evolved and considered what the direction of travel will be over the coming years. The speakers in the symposium examined challenges we face at present and the future plans for ophthalmology, presenting their views on the areas of best focus in a system of ever increasing demand and complexity.

Mr. Micheal Burdon joined Dr. Cynthia Bradford, Alison Blake, Yvonne Delaney and Micheál O'Rourke for the discussion. Dr Philip Crowley National Director, HSE Quality Improvement Division also participated, presenting on Patient Safety & Quality of Care - the Role of Clinical Leaders in Under - Resourced Environments.

Dr. Cynthia Bradford discussed the reasons and impact of burnout on doctors, highlighting how the most susceptible doctors are dedicated, conscientious, motivated and often idealistic with perfectionist qualities. Factors leading to doctor burnout include lack of control over working conditions and decision making, excessive workload pressures, chaotic and inefficient work environments and onerous administration tasks. Dr. Bradford discussed how a major culture change is required to address the issue and to better support doctors. This was echoed in Yvonne Delaney's presentation *Educating our Doctors for tomorrow – Regulation, Resilience and Reward* where she discussed how training and performance assessments are being improved to be less about box-ticking and made more reflective and thorough in relation to competence assessment.

Dr. Philip Crowley highlighted that Ireland has one of the lowest numbers of ophthalmologists per head of population compared to other western countries and the high waiting list in the specialty, acknowledging that more staffing and resourcing is needed. However he said that health funding is finite and that we must try to also learn from those with fewer resources in how to maximize services and outcomes. Dr. Crowley stressed the need for health care staff to be involved in health service decision making and that roles for clinical leaders are continually developed and supported.

Pictured at the "100 Years of Ophthalmic Societies in Ireland" Symposium at the ICO Annual Conference were; Micheál O'Rourke, Siobhan Kelly, Dr. Philip Crowley, National Director HSE Quality Improvement Division, Alison Blake and William Power.

Responding to the *Medical Independent* when asked about the delay in implementation of the HSE Primary Care Eye Services Review Group Report recommendations and the required funding for roll out, Dr. Crowley said he hoped the plan would be implemented, and there had been some progress but "I will be asking why it is stalling".

Mr. Michael Burdon also spoke during this session and called for increased collaboration between the Ireland and the UK, noting that the UK currently has similar issues regarding ophthalmology waiting lists, staff shortages and a lack of political interest in eye care.

Micheál O'Rourke, SPR at the Royal Victoria Eye and Ear Hospital, concluded the session with an excellent talk on *Ophthalmic Practice in the Next Generation – What Will that Be.* Highlighting the major advances the speciality has experienced in the past two decades and our growing ageing population, Micheál discussed the challenges this has brought with it in terms of increasing patient demand for ophthalmic services. Excessive ophthalmology waiting lists, inadequate staffing, uncertainly over contracts, and the delay in implementation of the Primary Care Eye Services Review Report Recommendations must be addressed, Micheál told delegates, adding the importance of the specialty advocating for its patients. "We must advocate for our patients to improve ophthalmic care in Ireland to ensure patients receive the highest international standards of ophthalmic care."

ICO Medal Winners 2018

Sir William Wilde Medal - Best Poster

2018 "Lamina Cribrosa Cell Bioenergetics in Glaucoma:Role of Glycolysis and Glutaminolysis"
Diamaid Hickey

Barbara Know Medal - Best Paper

2018 "Predisposing Risk factors, Clinical and Microbiological Characteristics of Moraxella Keratits"
Terence McSwiney

British Oculoplastic Surgery Society (BOPSS) Annual Conference, Dublin

Report by Tim Fulcher and Gerry Fahy, Organising Committee, BOPSS Annual Conference 2018

Gerry Fahy and Tim Fulcher

The British Oculoplastic Surgery Society (BOPSS) held its annual scientific conference in Dublin from June 13th – 15th 2018. The society was founded in 2000 to advance the education, research and quality of care in plastic, reconstructive and aesthetic surgery of the eyelids, the surrounding facial areas, orbits and lacrimal system.

The meeting was held in "The Printworks" conference centre in the lower courtyard of Dublin Castle.

The annual meeting included an update and recent advances day. The update section included refresher talks on some more basic aspects to eyelid, lacrimal and orbital surgery. This was largely aimed at trainees and non-oculoplastic surgeons. The recent advances section included talks on corneal neurotisation, modern cyberknife and stereotactic radiotherapy techniques for orbital neural tumours and interventional radiological approaches to carotico-cavernous fistulas and dural shunts.

The meeting was attended by almost 350 delegates from Ireland, UK, Europe, USA, Canada and Australia. The Irish College of Ophthalmologists kindly sponsored a large number of trainees to attend the update day and/or the scientific meeting.

The invited keynote speakers were Professor Tim Sullivan (Brisbane, Australia), who spoke on "Eyelid malignancies and eyelid reconstruction", and Dr. Peter Dolman (Vancouver, Canada) who discussed "Trends and controversies in DCR surgery". Both invited speakers gave a numbers of additional, excellent talks on a range of other topics.

The meeting was supported by a number of non-ophthalmic local speakers including Dr. Clare Faul (Radiation oncologist, Beaumont Hospital), Professor Geraldine McCarthy (Rheumatology, Mater Misericordiae Hospital), Dr. Paul Brennan (Interventional radiologist, Beaumont Hospital) and Dr. Michael Capra (Paediatric oncologist, Crumlin Hospital).

A drinks reception was held in the beautiful atrium of Dublin City Hall after the update day to welcome the delegates. The drinks and canapes were kindly sponsored by TheaPamex. We were delighted to be joined at the reception by Dr. Alison Blake, ICO President and Ms. Siobhan Kelly, ICO CEO.

The Gala dinner was held in The Guinness Storehouse where delegates learnt how to "pull a pint", taste exquisite food and dance until late.

World Ophthalmology Congress 2018

At the invitation of the organisers of the 36th World Ophthalmology Congress (WOC) 2018, the Irish College of Ophthalmologists organised a joint session with the Portuguese Society of Ophthalmology on the topic of "Scientific & Population Based Studies & Residency Education".

The WOC of the International Council of Ophthalmology is the largest international ophthalmic congress, with an attendance of over 10,000 delegates at this year's meeting and took place in Barcelona from the 16-19th June 2018.

This year marks an important milestone for the ICO as we celebrate the centenary of the formation of the first national Ophthalmic Society in Ireland, the IOS in 1918, and was a fitting occasion for the College to ensure our representation at this International gathering of our peers. The three day event provided a wonderful opportunity for the ICO members present to network and to highlight the important advancements in terms of training evolution and developments in the specialty in Ireland.

The session was chaired by Alison Blake and included presentations by David Keegan on *Experiences Learned from the Diabetic Retinopathy Screening Programme – the Irish Experience* and from Yvonne Delaney on *The Use of Online Learning Tools in Ophthalmology Residency Education in Ireland.*

Presentations by our Portuguese co-organisers of the session included *The Role of Adherence to a Mediterranean Diet and Lifestyle Risk Factors in AMD – The Coimbra Eye Study* by João Pereira Figueira, the *Use of Ocular Hypotensive Medications in Portugal: PEM Study: A Cross-sectional Nationwide Analysis* by Carlos Marques Neves and a Talk on Residency Experience/ Education in Portugal by Manuel Monteiro-Grillo.

The WOC, first held in 1857, takes place every two years in a different region of the world and covers an extensive scientific program of over 350 sessions addressing all subspecialties and related interests in ophthalmology.

David Keegan and Yvonne Delaney, keynote speakers at a joint session with the Portuguese Society of Ophthalmology at the World Ophthalmology Congress in Barcelona, pictured with Alison Blake, session Chair and Portuguese speakers João Pereira Figueira, Manuel Monteiro-Grillo and Carlos Marques Neves.

Royal Victoria Eye and Ear Hospital Dedicated Cataract Unit

IMPLEMENTATION OF AN OPHTHALMOLOGY ELECTRONIC PATIENT RECORD – ONE YEAR ON

A cataract only theatre unit opened at the Royal Victoria Eye and Ear Hospital in July 2017. The facility was developed to increase theatre capacity within the Hospital. Capital funding for the unit was provided by the Hospital's Teaching and Development Foundation

The introduction of an Electronic Patient Record (EPR) has been instrumental to the efficient management at the new clinic. Speaking to the ICO, Barry Quill, Consultant Ophthalmic Surgeon at the Unit said the considerable investment by the Hospital into the new system has been a crucial asset, allowing for the accurate and secure digital management of patient information.

The software used at the Cataract Unit is MediSight, the most up to date software by MediSoft and is hosted on a unique server for the Hospital.

The service allows for complete wireless access throughout the Hospital, which has invested in approximately one hundred tablet devices allowing exclusive access to the MediSight server.

Care Pathway using EPR

The cataract patient's medical information is electronically recorded throughout the entire stages of the cataract pathway, from the first visit at the pre assessment clinic with nurses to theatre and post- operative visit.

On the day of surgery, the clinician will refer to the patient's EPR, reviewing the nursing notes from the pre assessment clinic (biometry, medication history, pre assessment questionnaire, the plan for admission to hospital, anaesthetic plans and all the relevant medical information – blood pressure, weight, presences of diabetes etc). All information is recorded on the patient's electronic record for the operating surgeon to review via wireless tablets where operative details can also be inputted in real time and any edits/ additions (e.g. biometry or change to lens) to notes the surgeon may wish to make can all be registered on the electronic medical record. Cross referencing against the patients physical chart and EPR also takes place by the surgeon.

The system has a proforma of a normal routine cataract operation under local anaesthesia set to the clinicians settings but which also gives a number of additional options which can be selected where relevant, for example use of a capsular tension ring, or iris hooks etc. The option to record in free hand notes is also available with the system.

Postoperation and input of data, the system generates the prescription automatically with the patient's new medication and a letter detailing the operation and the patient's old and new ocular medications, is printed and sent to the GP.

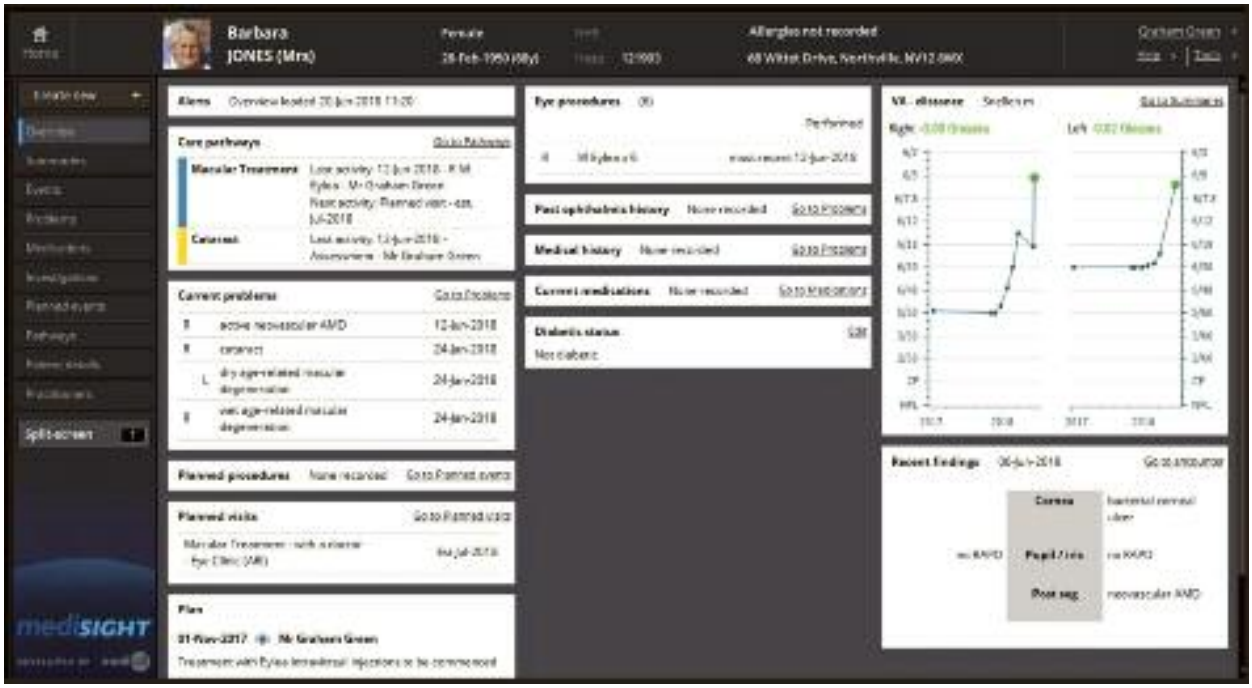
The patient returns to the clinic after four weeks where the post op vision is recorded. All information is shown as a graph of pre and post op vision, which allows for excellent outcome assessment. The EPR also facilitates the surgeon in planning the outpatient appointment, with the patient automatically receiving notification of their appointment. If the patient is listed for a second eye operation, the EPR system will create a new operation and all previous information of the patient's record will be integrated.

The MediSight EPR service is integrated with an image management solution called Forum Zeiss IOL 700, allowing for the integration access to both the imaging and the patient's clinical record through one single logon. The system feeds measurements directly into the system and can be edited in real time.

Audit of Outcomes

A critical function of the EPR is to efficiently record patient outcomes, effectively communicate with the full medical care team, and to provide a tool for clinical audit.

The software provides a very good way of auditing outcomes, enabling the review of complications, intraocular lens and how accurate the biometry and choice of intraocular lens was, comparison of the expected and actual outcomes, visual acuity, the number of cataract surgeries carried out and furtheradditional information and measurement tools for the



The patient names in these graphs/charts (on pages 6 and 7) are fictitious and are only to be viewed as samples.

medical team and hospital to review.

Statistics can be pulled up by operating surgeon or for the whole hospital and will give information such as the number of patients at any one time, how many eyes were operated on, the improvement in the visual acuity, the deviation of the intraocular lens and so on.

The successful implementation of an integrated EPR system for patients gives the following benefits:

- Efficient and dependable access for doctors to real time information through different stages of the cataract patient pathway.
- The EPR increases throughput of patients in theatre by having information instantly available.
- High quality clinical information is recorded in a consistent manner, through a pre-defined electronic datasets – allowing for timely access to patient information, improved security of patient records and elimination of handwritten notes.
- The EPR system has assisted with improved clinical decision making, clinical audit, research and benchmarking. .
- An auditable, secure EPR system – affording easy access to clinical audit information to support service planning needs.
- Reduced risk for the patient as there are no lost notes and imaging equipment sends data directly to the EPR thus reducing any transcription errors.
- Enhanced communication links between the Ophthalmology team provide a more integrated service.

Next Steps for EPR at the Royal Victoria Eye and Ear Hospital

In addition to the introduction of the Electronic Medical Record at the new dedicated cataract unit, the roll out of the MediSight EPR module system for glaucoma and medical retina patients is also now underway at the Royal Victoria Eye and Ear Hospital.

To further increase efficiencies, Barry Quill noted that the goal will also be to link with GP's on the EPR so that the letters can be emailed directly to cut out printing and posting. Currently the relevant staff at RVEEH each has a scanning tag that they scan off the printer which automatically prints out the GP letter.

Barry said the system will be integral to the set-up of satellite clinics and the integrated ophthalmology model of care rollout as per the recommendations contained in the Clinical Programme for Ophthalmology and reflected in the HSE Primary Eye Care Report. MediSight facilitates access to patient's records in the community ophthalmology clinics when patients are under joint care or being referred back to either acute or community services.

In relation to plans for virtual glaucoma clinics, the electronic medical record will allow clinicians to monitor and manage the patient data from various different sites in the future which will be essential.

Barry also noted that if Medical Retina services are delivered in the community healthcare setting in the future, the EPR will be crucial for centralising a hub and spoke system. "We want to integrate with our community eye care team and allow them to feedback to us – once they have seen the patient, and carried out the review, that data is instantaneously available to the acute team to know how the patient has got on and in the audit so the clinician knows if they are achieving the desired outcomes."

ICT and EPR central to successful implementation of a Future, Sustainable Model of Eye Care

In line with Government policy and as per the recommendations outlined in the HSE Primary Care Eye Services Review Group Report, the introduction of ICT and EPR will be central to the successful implementation of the integrated community and acute hospital model of care.

An IT infrastructure will be essential to the 'hub and spoke' model to allow for effective communication channels, allowing access for medical practitioners to efficient and dependable real time information on a patient's medical history and care pathway plans. Each unit must be equipped with the appropriate IT supports so that patients can be easily recalled using an electronic database. This will avoid patients being lost to follow-up, and will allow easy intervention where patients miss appointments.

The development of integrated care pathways will involve sending patient data, including photographs, to multiple locations, and a proven, robust software system will be needed instead of a paper-based system in all locations participating in the pathway.

Fundamental to having a quality model of eye care is procuring a national EPR that enables effective monitoring of performance (coverage, referral rates, outcomes, etc). An EPR will help to underpin the service by allowing all professionals track where the patient is on his or her journey, and will facilitate the collation of metrics for better integration and communication between service providers, and for the conducting of research and audit.

Gala Dinner, ICO Annu

The ICO Gala Dinner at the 2018 Annual Conference was a special occasion for our members this year as we mark the 100th Anniversary of the formation of the forerunner to the ICO, the Irish Ophthalmological Society, in 1918.

Edward Loane, Qistina Pilson, Treasa Murphy, Brendan Cummings, Clare McCloskey and Micheal O'Rourke

Marie Hickey-Dwyer and Gerald Gleeson

John Traynor, Muirin Tempany, David Wallace, Jim O'Reilly and Behrooz Golchin

Emily Hughes and Olya Scannell

Donal Brosnahan, Yvonne Delaney, Stephen Farrell and Mark James

ual Conference 2018

John Ledingham, Alison Blake, Cynthia Bradford and Reagan Bradford

Mike Burdon, President of the Royal College of Ophthalmologists UK and Liz Burdon

Pat Hassett, Gareth Higgins and Maureen Hassett

Mark James and Grace O'Malley

Eamonn Nugent, Sacha Hutchinson and Lisa McAnena

Robert Acheson and Siobhan Kelly

Report on UEMS Section of Ophthalmology Plenary Session

Rungsted, Denmark June 2018 - Alison Blake

Augsto Magalhaes, Klara Marescova, Denise Curtin, Hanne Olsen, Alison Blake, Ivan Heflingeris and Lotte Welinder pictured at the Plenary Session of the UEMS Section of Ophthalmology in Rungsted, Denmark in June.

The 73rd Plenary Session of the UEMS Section of Ophthalmology was held in Rungsted, Denmark 9th-10th June 2018

The Union of European Medical Specialists is an EU wide representative body liaising with the EU Commission divided into sections by specialty. UEMS represents over 1.6 million medical specialists in all the different specialties across 40 countries. It also has strong links and relations with European Institutions (Commission and Parliament), the other independent European Medical Organisations and the European Medical / Scientific Societies. The UEMS has 39 Specialist Sections, which represent independently recognised specialties. They each created a European Board as a subgroup, in conjunction with the relevant European Society, with a view to defining European standards of medical education and training. They also contribute to the work of Multidisciplinary Joint Committees (MJC) which address fields of a multidisciplinary nature. The Section of Ophthalmology encompasses the European Board of Ophthalmology which awards the EBO Diploma. The UEMS sections are grouped and Ophthalmology is in Group 2 Surgery. The current President is Dr. P Magennis from Ireland.

The President of our section of Ophthalmology (4 year term) is Hank Bonnemaijer from The Netherlands, the General Secretary is Denise Curtin (Ireland) and Treasurer Eija Vesti from Finland. Hank Bonnemaijer's term will be completed at year end and Wagih Aclimandos from the United Kingdom will succeed him in 2019.

Accounts are held in Brussels and the annual accounts were accepted by the Section.

EACCME (European Accreditation Council for CME) plays a major part in setting the standards for CME/CPD throughout Europe. This leading role is being increasingly recognised by political organisations (European Commission and Parliament), provider and funding organisations, and doctors. It has mutual recognition with the AMA.

EU European Training Requirement (ETR) – This is likely to be 5 years in future. The UEMS is now 60 years old.

The section is an observer at the European Coalition for Vision.

As Hank Bonnemaijer's Presidential term finishes, we thank him for his fair and safe chairmanship, and for his consistent and generous efforts on behalf of European Ophthalmology.

The plenary session of the Section of Ophthalmology will be held in Valencia, Spain on June 22nd and 23rd, 2019.

The EBO

The European Board of Ophthalmology (EBO) General Assembly was held in Rungsted, Denmark on the 9th June, 2018 and was chaired by the President Gordana Sunaric-Megevand (Switzerland).

The EBO was founded in London in 1992 with Peter Eustace and John Nolan from Ireland and Ophthalmologists from 10 other European countries. The EBO helps to establish common European education standards in ophthalmology by:

1) *Organizing the annual EBO examination*
2) *Residency Review Committee organizing visitations and accreditation of training centers*
3) *Providing grants to residents in their last year of training*
4) *Controlling CME in collaboration with EACCME*

1. Organising the annual EBO examination

Mutual recognition of specialist titles

- It is important to establish common European education standards in ophthalmology

Certificate and FEBO title EBO

- Successful candidates will receive an EBO Certificate
- Anyone who holds both an EBO Certificate and a Title of Specialist in Ophthalmology is permitted to practise ophthalmology independently in any country of the European Union (EU) or in the European Economic Area (EEA) and is eligible to receive the Title of Fellow of the EBO (FEBO)

Examiner requirements

- Language: fluent English and preferably one or two other European languages
- Ophthalmology training completed in a full or associate member state of the EBO (minimum 4 years)
- Specialist title in Ophthalmology
- Minimum 5 years practice after Specialist diploma
- Experience in residence teaching and training

EBO-Subspecialty *Exams were introduced in 2015*

- The goal of the subspeciality exams are to test the knowledge and expertise of specialists who have fulfilled the high standard requirements set by the European Societies and EBO for the subspecialities.

in 2018

- EBO-EGS: Glaucoma since 2015.
- EBO-ESCRS: Cataract and refractive since 2017.
- EPOS-ESA: Paediatrics and Strabismus since 2017

EBO Subspecialty Diploma FEBOS

- To award with formal recognition of knowledge, expertise, high quality and maturity those who have reached the standard set by the European Subspecialty Societies and EBO
- Certificate as a mark of Excellence
- Ascertains quality of care with increased mobility across Europe

Future: will the FEBOS Exam have an Impact on training?

- Setting the bar has an indirect impact on Training
- It empowers Trainees by defining Training expectations

2. Residency Review Committee

- Our purpose is to help the institution and the trainees by providing EBO support with suggestions (if necessary); space, equipment, IT facilities etc.
- A confidential written report within 1 month post-visitation
- EBO Certificate sent those who fulfill all requirements
- RE-certification: after 5 years
  - new application form for re-certification
  - re-visitation only if changes have occurred

Residency Review Committee: Tasks

- Contact and encourage National Delegates to involve more accredited centres per country (at least one center/country)
- Increase collaboration between RRC and REC to ensure that trainees make maximum use of the grants in appropriate training centres

3. Providing Grants to Residents

Residency Exchange Program

- The period of exchange is one month
- EBO provides a grant of €1000 per candidate
- Selected candidate will be expected to cover any additional expenses or to negotiate them with their home chairperson

EBO Diploma awarded to David Dunleavy, RCSI Lecturer in Ophthalmology. Pictured with EBO National Delegate Denise Curtin.

- The Board requests a short written report of the exchange.
- Application form for grants on the EBO website

Who can receive the grant?

- Trainees in the last year of residency
- Who have not received the EBO/SOE grant before
- Recommendation letter from the head of department

4. EACCME (European Accreditation Council for CME)

- An International Accreditation authority recognized in 21 Countries
- Linked with American Medical Association AMA & Royal College of Physicians and Surgeons, Canada RCPSI
- No industry sponsored events are accredited.
- Reviewers are nominated by the EBO Section of Ophthalmology.
- A Committee of 6 represent Ophthalmology

EACCME
Accreditation of Live Educational Events (LEE)

The EACCME® awards ECMEC®s on the following basis:

- One hour of LEE CME activity = 1 ECMEC®
- A participant can claim a maximum of 8 ECMEC®s per day of the LEE

EACCME-EBO collaboration

- Demands for LEE and e-learning sent to the chair of the EBO-CME committee for accreditation
- EBO has an active role in the evaluation of the quality of content of meetings and e-learning as well as potential conflict of interest (industry, speakers etc) in UEMS and associated countries

New developments in 2018

Due to growing popularity, the single location of Paris can no longer accommodate all who apply for the EBO exam and the possibility of a second location in Berlin was discussed at the General Assembly Meeting in Denmark in June. Plans to pilot this are in motion.

The creation of two new committees has taken place in 2018; the MCQ committee and a Viva Voce Committee. Standardisation of questions will be introduced by involving delegates and examiners to create a central question bank.

The EBO now has an advisory committee to take responsibility for the exam. Twenty seven countries were represented at the 2018 exam with 651 sitting the examination, 280 examiners and a 90% success rate.

The Peter Eustace medal was posthumously presented to Prof Constantino Bianchi for long time exceptional contributions to education in Ophthalmology.

The EBO diploma is mandatory for all Irish trainees.

Denise Curtin, Deirdre Townley
National Delegates, June 2018

Scope Ophthalmics Education and Travel Bursary Prize 2018

Garry Treacy, winner of the Scope Ophthalmics Education and Travel Bursary Prize 2018, is pictured with Alison Blake and John Freyne, Scope Ophthalmics at the ICO Annual Conference, Kilkenny Convention Centre (May 16-18th). The Prize was awarded to Garry for the best case submitted for the Medical Ophthalmologists workshop at the ICO's Annual Conference.

GDPR – General Data Protection Regulation

New regulations on data protection came into force across Europe on May 25th 2018.The regulation is aimed at ensuring organisations are transparent in how they collect, use and safeguard personal data. It aims to enhance the current data protection rules, by introducing a number of additional data protection obligations on organisations operating within the EU, and increasing rights for individuals and allowing them more control over their own personal data.

Raising awareness of the new law will be a combined effort of the Data Protection Commission (DPC), the Government, practitioners, and industry and professional representative bodies.

The Commission has stated that many of the main concepts and principles of GDPR are much the same as those in our current Data Protection Acts 1988 and 2003 (the Acts) so if you are compliant under current law, then much of your approach should remain valid under the GDPR.

However GDPR does introduce new elements and enhancements which will require detailed consideration. The GDPR applies to all individuals and organisations (including hospitals, clinics and general practices) that have day-to-day responsibility for data protection.

GDPR and the Medical Sector - The Data Protection Rules in Practice

The confidentiality of patient records forms part of the ancient Hippocratic Oath, and is central to the ethical tradition of medicine and health care. This tradition of confidentiality is in line with the requirements of the Data Protection Acts 1988 & 2003, under which personal data must be obtained for a specified purpose, and must not be disclosed to any third party except in a manner compatible with that purpose.

Given the immense sensitivity of health-related information, it is imperative that professionals in this sector be clear about their use of personal data.

The legal basis for processing of personal data by Medical Practitioners is provided by the following articles in GDPR: Article 6.1(c) and 6.1(d) and Article 9.2(h) and 9.2(i).

Article 6.1(c) in relation to the lawfulness of processing, states: 'processing is necessary for compliance with a legal obligation', for example for accounts and reimbursement claims.

Article 6.1(d) in relation to the lawfulness of processing, states: 'processing is necessary in order to protect the vital interests of the data subject or of another natural person'.

Article 9.2(h) in relation to the processing of special categories of personal data, states: 'processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3'; Paragraph 3 relates to the processing of data concerning health by medical practitioners subject to professional confidentiality under the regulation of the Irish Medical Council.

Article 9.2(i) relates to processing necessary for reasons of public health.

The Irish College of General Practitioners (ICGP) Data Protection Working Group has published Processing of Patient Personal Data: a guideline for general practitioners which members may find helpful. It is available to download on the ICGP website.

Sample Q&A's on the DPC website which ICO members may find informative and helpful:

Should my secretary or office manager be allowed access to my patient records?
Yes, although only to the extent necessary to enable the secretary or manager to perform their functions. Non-medical professionals should have no need to access clinical material or medical notes, as distinct from administrative details (such as patients' names and addresses). The patient is entitled to an assurance that their medical information will be treated on a need-to-know basis.

Can my locum access my patient records?
Yes. The Data Protection Commissioner's view is that making clinical patient records available to a locum doctor, so that the locum may provide medical care to patients, is compatible with the purpose for which the Doctor keeps the patient record.

Do I need to obtain patients' explicit permission before storing their medical details?
As a general rule, no. The Commissioner's view is that the patient's consent for the storage and use of their personal data is implicit in the fact that they come to you, as a medical professional, for help. However, it is good practice to inform people that you will keep their details, and to inform them of what use will be made of their data. Section 2(b)(vii) allows for the processing of sensitive data for medical purposes by health professionals. In addition, you will need to obtain clear consent for some uses of personal data which might not be obvious to the patient (see below), and be for a non-medical purpose.

Can I pass patient details on to another health professional for clinical purposes?
If you are passing patient data on to a person or body acting in an agency capacity for you - such as a clinical laboratory - then this is not a "disclosure" under the Data Protection Act, and the Commissioner does not insist on specific patient consent in such cases. However, you should inform the patient in advance that their data will be used in this way.

If you are passing the patient data to another health professional for guidance and advice on clinical issues, the patient data should be kept anonymous. If you wish to pass on the full patient data, including identifying details, you will need the consent of the patient in advance, except in cases of urgent need.

Can I pass patient data to the HSE or other bodies for administrative purposes?
You can pass on anonymised or aggregate data, from which individual patients cannot be identified. Ideally, you should inform patients in advance of such uses of their personal data.

What if I need to disclose patient data, and I don't have the time to obtain consent?
If patient details are urgently needed to prevent injury or other damage to the health of a person, then you may disclose the details. Section 8(d) of the Acts makes special provision for such disclosures. However, if the reason for the disclosure is not urgent, then you will need to obtain consent in advance.

Can I use patient data for research or statistical purposes?
Ideally you should make patients aware in advance if you intend to use their data for your own research purposes. However, the Acts provide that such uses of personal data are permitted, even where the patient was not informed in advance, provided that no damage or distress is likely to be caused to the individual.

More detailed guidance is available on the DPC website at this link www.dataprotection.ie/documents/guidance/Health_research.pdf

Can I disclose patient data to others for research or statistical purposes?
You may pass on anonymised or aggregate data, from which individual patients cannot be identified. Ideally, you should inform patients in advance of such uses of their personal data. If you wish to pass on personal data, including identifying details, you will need to obtain patient consent in advance.

Cancer research and screening is an exception to this rule. Under the Health (Provision of Information) Act, 1997, any person may provide any personal information to the National Cancer Registry Board for the purpose of any of its functions; or to the Minister for Health or any Body or Agency for the purpose of compiling a list of people who may be invited to participate in a cancer screening programme which is authorised by the Minister.

If I may only disclose anonymised data for research purposes, how can the researchers avoid duplication of data in respect of the same individual?
Researchers who obtain anonymised patient data are sometimes faced with the problem that they may be dealing with two or more data-sets from the same individual, received from different sources. To address this problem, it may be permissible for a data controller (such as a doctor) to make available anonymous data together with a unique coding, which falls short of actually identifying the individual to the researcher. For example, a data controller might "code" a unique data-set using a patient's initials and date-of-birth. The essential point is that the researcher should not be in a position to associate the data-set with an identifiable individual.

Do I need to register with the Data Protection Commissioner?
If you keep personal details on your computer system relating to people's health or medical care, then yes, you do need to register. Registration is a straightforward process, intended to make your data-handling practices transparent.

Do my patients have a right to see their medical records?
Yes they do. An individual is entitled to see a copy of any records which you keep relating to him or her on computer or on paper.

This right of access, outlined fully on the DPC website at www.dataprotection.ie /docs/Data-Protection-Rule-8/m/32.htm is subject to a limited exemption in the case of health and medical records, and in the case of social worker records, where allowing access would be likely to damage the physical, mental or emotional well-being of the individual.

It is essential to be able to facilitate requests from service-users wishing to exercise their rights under the GDPR, including rights of access, rectification, erasure, withdrawal of consent, data portability and the right to object to automated processing (Articles 12 to 22).

General Guidance on GDPR from the Data Protection Commissioner

The Data Protection Commissioner (DPC) has published *The GDPR and You. General Data Protection Regulation. Preparing for 2018.*

The DPC has launched a GDPR-specific website www.GDPRandYou.ie that includes a helpful 12 step general guide for organisations on GDPR.

The introductory document "The GDPR and You" aims to help organisations as they transition to GDPR. These checklists are available online to download and edit according to your own organisation's information. "The GDPR and You". (Insert infographic if space allows).

The DPC also has a helpful checklist for organisations to assess their readiness for the GDPR.

Key considerations include ensuring that key personnel in your practice are aware of the change in Data Protection law, and factor this into future planning. Organisations need to start to identify areas that could cause compliance problems under the GDPR.

The Medical Council and GDPR

The Medical Council has stated that it will be publishing information on their website about GDPR and how as a data controller, the Medical Council is handling the change in legislation. The Council has advised that it is not within its remit to provide advice on data protection, and that Medical Practitioners may wish to contact their professional indemnifier bodies for guidance and assistance on any specific queries they may have.

Medical Protection Society (MPS) Guidance on GDPR

The MPS has published a factsheet on GDPR which is available on the MPS website to download. www.medicalprotection.org/ireland/resources/factsheets/factsheets/data-protection-the-general-data-protection-regulation-(gdpr)

The MPS Factsheet outlines the key changes as a result of the GDPR implementation, a comparison of GDPR with the Data Protection Act 1988 & 2003, accountability, lawful basis for processing (covering Consent), transparency and fair processing, subject access request (SAR), data breach notifications and security considerations. The MPS has stated that the factsheet cannot be a full summary of either the GDPR or the Data Protection Bill 2018 (which is currently subject to discussion in the Houses of Oireachtas) and does not constitute legal advice. The MPS advise that if Medical Practitioners have specific questions regarding the legislation, they should contact the Data Protection Commissioner (DPC) and/or a data protection specialist.

Key GDPR definitions

GDPR: The General Data Protection Regulation (2016/679) is the new EU Regulation on Data Protection, which will come into force on the 25th May 2018.

Personal Data: Information relating to a living individual who is, or can be, identified by that information, including data that can be combined with other information to identify an individual. This can be a very wide definition, depending on the circumstances, and can include

Continued overleaf ➥

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data which relates to the identity, characteristics or behaviour of an individual or influences the way in which that individual is treated or evaluated.

Processing: means performing any operation or set of operations on personal data, including:

a. obtaining, recording or keeping data;
b. organising or altering the data;
c. retrieving, consulting or using the data;
d. disclosing the data to a third party (including publication); and
e. erasing or destroying the data.

Data Controller: A Data Controller is the person or organisation who decides the purposes for which, and the means by which, personal data is processed. The purpose of processing data involves 'why' the personal data is being processed and the 'means' of the processing involves 'how' the data is processed.

Medical Practitioners are controllers of the data concerning health that they utilise to manage patient care. They process the information using their Clinic software system, and they share the patient's personal data and data concerning health with healthcare recipients such as GP's, hospitals, consultants, and primary care teams. The medical professionals with whom patient data concerning health are shared with are data controllers in their own right.

Data Processor: A person or organisation that processes personal data on the behalf of a data controller.

Data subject: A Data subject is the individual the personal data relates to.

Data Protection Impact Assessment (DPIA): A Data Protection Impact Assessment (DPIA) describes a process designed to identify risks arising out of the processing of personal data and minimisation of these risks as far and as early as possible. DPIAs are important tools for negating risk, and for demonstrating compliance, including ongoing compliance, with the GDPR. (More guidance about conducting DPIAs can be found on www.GDPRandYou.ie)

Lawful basis for processing personal data: In order to process personal data you must have a lawful basis to do so. The lawful grounds for processing personal data are set out in Article 6 of the GDPR. These are: the consent of the individual; performance of a contract; compliance with a legal obligation; necessary to protect the vital interests of a person; necessary for the performance of a task carried out in the public interest; or in the legitimate interests of company/organisation (except where those interests are overridden by the interests or rights and freedoms of the data subject).

Retention Policy: How long will your organisation hold an individual's personal data? This will be influenced by a number of factors. There may be legal requirements on your organisation, depending on your business type (e.g. medical council rules). Keep the data for the least amount of time that you can in accordance with the requirements of your business, store it securely while it is in your possession and make sure to delete it fully and safely at the appointed time.

Special Categories (sensitive) of personal data: This is defined in Article 9(1) of the GDPR as data 'which reveals racial or ethnic origin, political opinions, religious or philosophical beliefs, or trade union membership, and the processing of genetic data, biometric data for the purpose of uniquely identifying a natural person, data concerning health or data concerning a natural person's sex life or sexual orientation'.

Consent: Article 7 of the GDPR has altered the conditions needed for consent as a legal basis for data processing to be valid. It is now necessary to consider whether consent was freely given and the data subject must have the opportunity to withdraw consent for processing at any time. Consent should not be assumed and must be obtained before data processing begins (e.g. through Privacy Notices).

The key steps to take to ensure compliance with the GDPR

- Identify what personal data you hold (this can be achieved by setting out the information listed in Article 30 of the GDPR)
- Conduct a risk assessment of the personal data you hold and your data processing activities (Article 24, Recital 75 and section titled "Risk based approach to being GDPR compliant").
- Implement appropriate technical and organisational measures to ensure data (on digital and paper files) is stored securely. The security measures your business should put in place will depend on the type of personal data you hold and the risk to your customers and employees should your security measures be compromised (Article 32).
- Know the legal basis you rely on (consent? contract? legitimate interest? legal obligation?) to justify your processing of personal data (Articles 6 to 8).
- Ensure that you are only collecting the minimum amount of personal data necessary to conduct your area of service, that the data is accurate and kept no longer than is needed for the purpose for which it was collected (Article 5).
- Be transparent with your customers about the reasons for collecting their personal data, the specific uses it will be put to, and how long you need to keep their data on file (e.g. notices on your website or signs at points of sale) (Articles 12, 13 and 14).
- Establish whether or not the personal data you process falls under the category of special categories (sensitive) of personal data and, if it does, know what additional precautions you need to take (Article 9).
- Be able to facilitate requests from service-uses wishing to exercise their rights under the GDPR, including rights of access, rectification, erasure, withdrawal of consent, data portability and the right to object to automated processing (Articles 12 to 22).
- Where appropriate, have up-to-date policy/procedure documents that detail how your organisation is meeting its data protection obligations.

While there is a quite a volume of information to read through, being well informed is important. Use the templates and guidelines to assess whether there are changes you need to make to the way you currently organise your practice. Formulate a plan and a policy and ensure all staff are aware of obligations and the importance of collecting, managing and storing patient's data in the correct manner.

The ICO wish to advise our members that time spent reading the information and preparing for compliance can reasonably be recorded as internal CME points.

The information contained in this article is general guidance only and cannot be relied upon as legal advice.

Further information and advice can be obtained from the Data Protection Commissioner who can be contacted at info@dataprotection.ie / (0761) 104 800 www.dataprotection.ie or www.GDPRandYOU.ie

European Society of Ophthalmology (SOE) Board Meeting, Dublin

The European Society of Ophthalmology (SOE) annual board meeting was held in Dublin on 9th June, hosted by Pat Logan.

The meeting was chaired by SOE President Jan Tjeerd de Faber. Amongst topics discussed were SOE educational grants, Young Ophthalmologists (YO), European public health survey and SOE lectures.

The board dinner was held in Royal College of Surgeons in Ireland that evening and attended by Patricia Quinlan, President Elect of ICO and Siobhan Kelly, ICO CEO.

The next board meeting will be in Nice, France on the 13th June 2019 in conjunction with the SOE biannual academic meeting.

Hannah Duncan, Gabriel van Rij, Jo Gordon and Siobhan Kelly

SOE President Jan Tjeerd de Faber with Cris de Faber.

Annelies van Rij and Gabriel van Rij and Bente Haughom

Lena Uusitalo, Mannu Uusitalo, Thomas Fenech, Pat Logan and Bo Philipson

Patricia Quinlan and Pavel Rozsival

Children First Act 2015

Lisa McAnena

Under the Children First Act of 2015, registered medical practitioners are listed along with numerous other professionals as Mandated Persons, for whom there is a legal obligation to report child protection concerns to the Child and Family agency, Tusla.

The document, "Children First: National Guidance for the Protection and Welfare of Children", published in 2017, outlines guidance for the recognition of the types of abuse (neglect, emotional, physical and sexual) and actions to take if you have any knowledge, belief or reasonable suspicion that a child has been harmed, is being harmed, or is at risk of being harmed.

"Children First" defines thresholds of harm for each category of abuse at which mandated persons have a legal obligation to report concerns. If you are unsure if the concern reaches the legal definition of harm for making a mandated report, you can discuss the concern with a Tusla social worker.

In practical terms, mandated persons have a supportive, rather than an investigative role in the reporting of suspected harm to children; i.e. we must report our concerns to Tusla who then proceed to verify and/or take action on the matter. Reports must be made on the designated mandated report form "as soon as practicable" to your local social worker and may be done so jointly with another involved person. It is best practice to inform the parents that a report is being made unless there is a concern that in doing so, you may be putting the child at further risk of harm.

There is an e-learning programme on the Children First website which covers the topics such as recognition of child abuse, responsibilities of mandated persons and the responsibilities of organisations working with children to safeguard children. The course takes approximately 1.5 hours and is a very informative tool. The completion of the course is now mandatory in many hospitals.

For further information, see:

Children First: National Guidance for the Protection and Welfare of Children;
http://www.tusla.ie/children-first/publications-and-forms/
Information for Mandated Persons;
http://www.tusla.ie/children-first/mandated-persons/
Children First e-learning programme;
http://www.tusla.ie/children-first/children-first-e-learning-programme/

Dr Richard Steeven's Fellowship

The ICO wish to extend our congratulations to Dr Sarah Moran on being awarded a Dr. Richard Steeven's Scholarship in 2018. The award is presented annually to Specialist Registrars with strong track records in achievement. Sarah was one of four outstanding candidates to be awarded the Scholarship this year.

Sarah will undertake a clinical fellowship in Anterior Segment & Corneal Surgery at the Fondation Adolphe de Rothschild in Paris, France, a state of the art, tertiary referral university hospital, which specializes in the fields of ophthalmology, ENT, neurology, neurosurgery and interventional neuroradiology. The post will provide Sarah with an opportunity to train in a high-volume specialist centre, offering outstanding clinical and surgical exposure to a wide range of anterior segment disorders, with particular emphasis on the use of lamellar corneal transplantation techniques.

The department at Fondation Adolphe de Rothschild in Paris was the first centre in Paris, and among the first in Europe to adopt the DMEK (Descemet membrane endothelial keratoplasty) procedure. DMEK is the latest refinement and innovative technique for endothelial keratoplasty, and allows the selective replacement of the patient's diseased Descemet membrane including its endothelium. Apart from unprecedented visual outcomes, DMEK provides additional advantages such as a near perfect restoration of the corneal anatomy, low complication rates and promising graft survival rates. The skills that that Dr. Moran will obtain in this rapidly developing field will be of invaluable benefit to Irish patients.

Ophthalmology has been extremely well represented in this Scholarship over recent years, a testament to the highest standards of applicants entering the Awards from the specialty, and the exceptional Fellowship opportunities secured.

Stephen Farrell was awarded the Scholarship in 2017 and has completed a year Fellowship in Paediatric Ophthalmology and Strabismus in the British Columbia Children's Hospital, University of British Columbia, Canada. The department of Paediatric Ophthalmology in B.C. Children's Hospital manages the entire spectrum of paediatric ophthalmic conditions as the only tertiary referral centre for British Columbia, serving a population of over 4.7 million.

Elizabeth McElnea received a Dr Richard Steeven's Bursary in 2017 and commenced a 12 month Fellowship from last July in Ophthalmic Plastic, Orbit and Reconstructive Surgery in Macclesfield District General Hospital, Cheshire and Royal Liverpool Hospital NHS Trust and the Christie Hospital, Cheshire.

Caitriona Kirwan was a recipient of the Award in 2010 and completed a Fellowship in Paediatric Ophthalmology at the Hospital for Sick Children, Toronto.

We congratulate all past recipients and wish Sarah every success on her Fellowship programme in Paris.

HSE launches new 'WorkWell' website

In response to feedback received through various staff engagement channels, the HSE has identified a need to ensure services and supports are clearly signposted to enable enhanced online accessibility for all staff, irrespective of location.

As a result the HSE has developed a designated website www.workwell.ie for all health care workers to access dedicated information and resources related to health and wellbeing.

The HSE said the aim is of the Workplace Health and Wellbeing Unit is to ensure staff can continue to be physically and emotionally well throughout their working life. It was established to support all employees, making it easier to find resources and the supports available. Resources include information, advice and training; counselling, occupational health; organisational health; rehabilitation; staff health and promotion.