Young children’s eye care: a parent survey to explore access and barriers in London UK

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ABSTRACT

Aim

A questionnaire was designed to investigate the attitudes of parents living in London, England towards eye care for their young children (4-6 year olds only) and whether there are any barriers to accessing eye care for this age group. We attempted to explore whether these beliefs and barriers are influenced by certain demographic factors such as ethnicity, level of parental income, level of parental education, confidence with speaking English and a reported family history of eye problems.

Method

1317 questionnaires (hard copies) were distributed to parents of children in primary school reception and year one (ages 4-6) from 14 schools across 5 London boroughs. 90 online surveys were sent to parents at 2 further London schools. All questionnaires were anonymous.

Results

A total of 384 completed questionnaires were analysed (27% response rate). 338 parents (24%) completed the ‘parental knowledge’ section of the questionnaire.

65% (n=249) of responses were from parents whose children attended a school where a programme of school entry vision screening took place. Of these, 15% (n=36) of parents reported that they were aware of it.

Barriers to accessing eye care for their children were reported by 38% (n=153) of parents/carers who responded. 12% (n= 47) reported not knowing how to access an eye test for their child and 12% (n=47) reported that they were concerned their child would be given glasses that weren’t needed. When compared to parents from white ethnic groups, parents from African ethnic groups were more likely to report not knowing how to access an age appropriate eye test for their child (p=0.001). Parents of African ethnic origins were statistically more likely to report barriers to eye care (p=0.001).

Discussion

The study provides evidence of some parental misconceptions around eye care for young children and some barriers to access.

INTRODUCTION

Large population based studies indicate that the majority of cases of significant visual disorder in childhood are those of refractive error or strabismus both of which often result in amblyopia.1,2,3,4,5 These studies show the incidence of clinically significant early childhood refractive error to be between 5% and 8% and strabismus between 2% and 5% depending on study definitions and age group. These studies also show a close association between refractive error and prevalence of strabismus.

The United Kingdom National Screening Committee recommends all children undergo vision screening at school entry (age 4-5 years) as part of an orthoptic-led programme5 to detect amblyopia. The resposibility for commissioning vision screening lies with local authorities and it is not mandated. There is evidence from a number of freedom of information requests to local authorities and from orthoptic department audit reports that school entry vision screening is not commissioned in some areas 6The NHS choices website states 7 ‘*In most parts of England, children are offered a screening test to look for reduced vision in one or both eyes during their first year at school’* and eye/ vision screening at birth, 6 weeks and school entry is also referenced. In addition to this the healthy child programme 8 advises a newborn and 6 week eye check. The ‘red book’ given as part of the programme makes no reference to General Ophthalmic Service sight tests provided by UK optometrists, how they can be accessed and for what age of child. There is some debate as to the need to treat amblyopia,9 however it has been argued that it may impact on a child’s education and behaviour and have long term negative visual consequences.10 There is some evidence that uncorrected childhood vision defects almost double the risk of lifetime bilateral visual impairment11. Recent research 12 suggests that children from the most deprived backgrounds are more likely to fail preschool vision screening and Williams et al 3 evidenced an increased incidence of some childhood eye problems (hypermetropia, esotropia and amblyopia) in lower parental socio-economic groups. It is worth noting that visual problems other than amblyopia may also impact on a child’s development and that where vision screening is limited to only testing distance visual acuity, visual disorders including hypermetropia and poor convergence may be missed 13.

Additionally in the United Kingdom all children up to the age of 16 (or 19 in full time education) are entitled to a free National Health Service eye examination by a community optometrist under the General Ophthalmic Service14.  The Royal College of Ophthalmologists recommend that *‘parents should be aware that their child is entitled to a free NHS eye examination up to the age of 16’*.15

To date there is little published information regarding access to eye care in young children in the UK. However, in one study, Majeed et al 16 report families in the UK with low incomes accessed children’s eye care less frequently. Studies in the United States 17,18,19  report overall low incidence of follow up following failed vision screening Su et al 17 reported only 47% of children who failed screening accessed further eye care with the most common reason for not doing so being parents not being aware of screening results. Cost was also a common reported barrier in the United States studies. A recent focus group study in India20 identified potential factors that facilitated parents seeking eye care for their children. These included ocular complaints from the child, remarks from the child’s teacher, school vision screening notification, observation of symptoms by parents themselves, and positive ocular family history. Lack of money, lack of time, difficulty in arranging or obtaining appointments, language barriers, and lack of cooperation from family members were the reported barriers to seeking eye care.

As children usually rely upon a parent or carer to gain access to care, UK adult studies and the barriers they report may perhaps also be considered relevant.21,22 These have shown that eye care knowledge in young adults is poor in general. Optometrists were seen differently to other healthcare professionals, with the retail aspect of optometry being reported as dominant. Young adults also reported a lack of information from the NHS on eye health with attendance for eye care tending to be symptom led.

The UK General Ophthalmic Service Terms of Contract14  states that ‘...*the ophthalmic services contractor.... shall provide mandatory services under [their] contract to any eligible person if a request is made for such services*’. However, Shah et al 23 carried out a ‘mystery shopper’ survey and reported in 2007 that 50% of 200 UK optometrists surveyed would not examine a one-year-old child.

Because of the lack of information and inconsistencies discussed above, the present study wanted to evaluate if parents know how to access eye care for their young children, what may prompt them to do so and what barriers might exist to prevent them from doing so.

METHODS

A questionnaire was designed for parents of children aged 4-6 years old (in reception and year 1 of primary school) (See Appendix 1 for a blank copy of the final questionnaire). The study was intended to gather data on the experiences of eye care for young children and aimed to analyse this in the context of the demographic mix of respondents.

A pilot study was carried out in 2013 by the authors in two schools in the London Borough of Greenwich. The results of the pilot study were used to refine the questionnaire- they were not included in the final data. In the pilot study, open questions with free text responses were used to identify possible reasons to seek an eye test (For what reason may you consider seeking eye care for your child?) and possible barriers (What may prevent you from seeking an eye test for your child?). The most frequently cited responses to these questions in the pilot study were used to develop the lists used in the final questionnaire and facilitated analysis of responses. Following poor response rates to the pilot (of 97 questionnaires distributed 8%, n=12, were returned completed), the questionnaire was also shortened and anonymised. Anonymity was also considered important to encourage honesty. A control question was added to help identify inaccurate responses.

The questionnaire asked parents /carers to indicate what may prompt them to seek an eye test for their child. The option ‘stepfather has a squint’ was used as a control, where this option was selected, results were discounted (selecting this ‘nonsense’ option was used as an indicator that the respondent was making random/inaccurate selections). Parents/carers were asked what factors may prevent them from seeking eye care for their child. Parents/carers knowledge was investigated by asking them to agree/disagree with 5 statements about children’s eye care. We also investigated whether certain factors affected either knowledge regarding eye care or barriers to eye care. The factors investigated were family history of glasses/ amblyopia, socio-economic status (eligibility for free school meals and postcode deprivation quintiles21 were used as indicators), ethnicity, level of parental education and confidence in speaking English.

Ethical approval for the study was obtained from City, University of London’s School of Health Sciences Research Ethics Committee.

The British and Irish Orthoptic Society, London Clinical Commissioning Groups (CCGs) and school nursing teams were contacted to investigate protocols regarding school vision screening across London (at March/April 2014). Using this information, two areas were identified where school entry/reception age vision screening was reported to be in place during the 2013/14 academic year (Southwark and Barking-Dagenham) and 3 areas where we were informed no school screening was taking place (Camden, Enfield and Havering). Head teachers of all infant and junior schools in each borough (159 schools in total) were contacted to ascertain if they would be willing to distribute hard copies of the questionnaire to all parents of children in reception and year 1.

. The study aimed to receive at least 360 completed questionnaires in order to give a margin of error under 5% and hence a confidence level of 95% (as there are approximately 66,000 children in each year group in the UK22).The head teacher of 17 schools in total agreed to take part. Hard copies of the questionnaires were distributed to and collected from a total of 14 schools (questionnaires were distributed to a further 3 schools but we were unable to collect completed copies as the schools had not distributed them to parents). A further 2 schools distributed a link to the online survey only, this was at the request of the schools to reduce administrative burden. Between March and November 2014, hard copies of 1317 parent questionnaires were distributed (including 45 which were translated into Turkish at the request of one school with a large number of parents who only speak Turkish).

RESULTS

A total of 387 completed questionnaires were collected, of these 3 were excluded on the basis of the control being chosen, thus a total of 384 completed questionnaires were analysed (27% response rate). 10 parents/carers completed the online survey (11% response rate). 338 parents (24%) completed the ‘parental knowledge’ section of the questionnaire. Table 1 shows the ethnic distribution of respondents. Subjects who participated in our survey identified themselves either as of White (British or other), African (African, Afro-Caribbean), Asian (Pakistani, Bangladeshi, Indian and other), Mixed or Other (Turkish, Moroccan, Algerian, Arab and South American) ethnic origin and these ethnic groups have been used in the analysis. Because of the uneven and broad distribution across different ethnicities all the African, Asian and White origin ethnicities were grouped together. This left us with 5 different ethnicity categories: White, Asian, African, Mixed and Other.

Table 1: Distribution of ethnicities amongst respondents

|  |  |  |  |
| --- | --- | --- | --- |
| Ethnicity | Frequency (n=384) | Percentage | London (2011 census data23) ethic distribution by % |
| White British | 91 | 23.7 | 44.9 |
| White other | 64 | 16.7 | 12.6 |
| Bangladeshi | 15 | 3.9 | 2.7 |
| Indian | 9 | 2.3 | 6.6 |
| Pakistani | 5 | 1.3 | 2.7 |
| Black African | 111 | 28.9 | 7.0 |
| Black other | 21 | 5.5 | 6.3 |
| Mixed | 18 | 4.7 |  |
| Other | 24 | 6.2 |  |
| Not stated | 7 | 1.8 |  |
| **TOTAL** | 384 | 100% |  |

Table 2 shows the reported highest level of education amongst those who responded.

Table 2: Distribution of level of parental education

|  |  |  |
| --- | --- | --- |
|  | Frequency (n=384) | Percentage |
| Up to 18 | 152 | 40 |
| Post 18/ further | 188 | 49 |
| Not stated | 44 | 11 |

65% (n=249) of responses were from parents whose children attended a school where a programme of school entry vision screening took place. Of these only 15% (n=36) of the parents reported that they were aware of the screening programme. 21.4% (n=82) of parents/carers reported not knowing how to access an eye test appropriate for their child’s age. A chi-square test was used to investigate which factors, if any, influence whether parents report that they know how to access an eye test appropriate for their child. The factors investigated were parental ethnicity, level of parental education, socio economic status (using postcode deprivation quintiles) and presence of an existing screening programme in a child’s school. After adjusting for multiple corrections via Bonferroni (0.05/4=0.013), a significant relationship was found between ethnicity and how to access eye care X2 (4,n=374)=54.98, p<0.001. 48% of African parents compared to 24% of white parents reported not knowing where to access eye care. All other factors did not reach statistical significance.

Parents were asked to select from a list any possible reasons that might lead to seeking an eye test for their child and the responses are detailed in Table 3.

Table 3: Parental responses to the question ‘’ *For what reasons would you consider seeking an eye test for your child?’’*

|  |  |  |
| --- | --- | --- |
| **Reason to seek eye care** | **Responses (N)** | **Percentage of total responses (n/384)** |
| Concerns about poor vision | 258 | 67 |
| Advised by healthcare provider or teacher | 245 | 64 |
| Routine check up | 202 | 53 |
| Complaints of double vision | 200 | 52 |
| Headaches | 183 | 47 |
| Concerns eyes not straight/ have a turn | 166 | 43 |
| Family history | 154 | 40 |
| Poor concentration/short attention span | 85 | 22 |
| Poor school achievement and/or difficulties with literacy | 70 | 18 |
| No reasons selected | 25 | 7 |
| Stepfather has a squint | 10 |  |

**Barriers to Accessing Eye Care**

We asked parents to identify possible barriers to accessing eye care. 38% (n=146) of parents/carers reported one or more barrier. Responses are outlined in Table 4.

Table 4: Parental responses to the question *‘’ What reasons may prevent you from taking your child for an eye test?’’*

|  |  |  |
| --- | --- | --- |
| **Barrier reported** | **Number of responses** | **Percentage of total responses n/384** |
| No barriers reported | 238 | 62 |
| I don't know how or where to arrange | 47 | 12 |
| I am worried may be given glasses he/she doesn’t need | 47 | 12 |
| I think my child is too young to have an eye test | 33 | 9 |
| I am worried if my child is given glasses it will make his/her eyes weaker | 33 | 9 |
| I am worried about the cost of glasses | 29 | 8 |
| I am worried about the cost of an eye test | 25 | 7 |
| I am worried my child doesn’t yet know all the letters | 24 | 6 |
| I don’t want my child to wear glasses | 21 | 5 |
| I have been told that my child is too young for an eye test | 18 | 5 |
| Other | 10 | 3 |

Respondents were assigned a ‘barrier score’ with no reported barriers assigned a score of 0 to a maximum of 10 reported barriers. The data was tested for normality via Shapio Wilks which revealed that the data was not normally distributed. A non-parametric Kruskal Wallis was therefore carried out to investigate any possible relationship between barrier score and either ethnicity, level of parental education or socio economic status. After adjusting for multiple comparisons via Bonferroni, the only factor found to have a statistically significant relationship with barriers to eye care was ethnicity, Kruskal Wallis X2(4, n=377)=32.48, p<0.001. The mean rank revealed that those of African ethnicity had the largest barrier score following by Asian ethnicity and White ethnicity. All other factors did not reach statistical significance.

**Knowledge of Eye Care**

Table 5 details parents/carers responses to the statements that we asked them to consider, relying on existing knowledge. A total of 338 parents/carers completed this section of the questionnaire (89% of all respondents i.e. 24% response rate for this section).

Table 5: Responses to Eye Knowledge Statements

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Response:  (total n=338) | Agree | Disagree | Not Sure | No response |
| *‘Children can only have an eye test when they know the names of the letters’* | 18% | 66% | 16% | 1% |
| *’Eye checks at an opticians/optometrists are free on the NHS for children under 16’* | 85% | 2% | 13% | 1% |
| *‘Wearing glasses if you need them when under age 7 will make your eyes and vision stronger’* | 48% | 14% | 35% | 3% |
| *‘It is normal for a child aged 1-7 to occasionally have an eye turn’* | 33% | 15% | 50% | 2% |
| *‘School vision screening tests for all eye problems’* | 33% | 15% | 50% | 2% |

Each respondent was assigned a ‘children’s eye care knowledge score’ - this was calculated by giving a score of 0 for an incorrect or ‘not sure’ response to the eye care knowledge questions and a score of 1 for each correct answer. The maximum knowledge score was 5 and the minimum 0. The knowledge score was tested for normality via Shapio Wilks which revealed that the data was not normally distributed. A non-parametric Kruskal Wallis was therefore carried out to investigate any possible relationship between barrier scores and ethnicity, level of parental education and socio economic status.. No statistically significant effect was found for any of these factors on the parents’ knowledge score. However it is worth noting that a relationship between knowledge score and ethnicity had a value approaching significance before Bonferoni correction Kruskal Wallis X2(4, n=376)=9.29, p=0.054). Mean rank revealed that those of African ethnicity had the lowest Knowledge score following by Asian, Other, White and Mixed. All other factors did not reach statistical significance.

**DISCUSSION**

Only 15 (n=36) of the families whose children attended a school with a screening programme in place knew of its existence. This appears to correlate with the findings of Su et al14  in the US who found the most common reason for not seeking secondary care following failed screening was lack of knowledge of the outcome of primary screening. Improved communication with parents regarding the purpose and outcome of screening is clearly needed. Only 51% of parents reported that their child had received ‘any kind of eye or vision check’ . In fact, 65% of parents who completed the questionnaire were parents of children who attended a school where vision screening took place. The survey took place in the summer term, so all year 1 and a significant percentage of the reception age children would have had their vision screened when their parent completed the survey. Our findings indicate, at least in the areas where we surveyed, improved communication with parents regarding the purpose and outcome of screening in clearly needed. It is hoped that new Public Health England Guidelines issued in Jan 2018 (14a) which came into place after the survey was completed should, if implemented, help to improve parental knowledge around screening, as they include sample information letters for parents following screening as well as suggested screening service specifications and pathways for onward management. Previous to these guidelines, no national guidelines were in place to suggest pathways following failed screening; Public Health England now recommends ‘referral to diagnostic pathway’. These pathways will most likely vary depending on local arrangements but our findings suggest proactive referral combined with provision of information is necessary to improve uptake of further investigations..

Our results highlight significant reported barriers to accessing eye care with 38% of all respondents citing at least one barrier. There is also evidence of some significant misconceptions regarding children’s eye care which may further reduce parent’s likelihood of actively seeking care.

Ethnicity was found to be statistically significant in affecting the barrier and knowledge score of parents/ carers, with parents from African and Asian ethnic groups being more likely to report barriers. Other studies have reported under- accessing of health care by minority ethnic groups.13,14,15,16  A weaker link was also found between parental knowledge score and ethnicity with parents of African ethnicity scoring lowest.

These barriers need to be addressed by improving accessibility of services, particularly in light of the evidence that the incidence of eye conditions is higher in minority ethnic groups. 13 Studies have also reported under-accessing of health care where language is a barrier23. Although no statistically significant association was found between barriers and difficulties with English, the study was limited by a small sample size of parents who were not confident in speaking English (n=31, 8%).

When compared to the 2011 census data for London the study sample had a higher percentage from black African ethnicities and a lower percentage representation of White British ethnicity. A limitation of the study is that we were unable to obtain overall ethnicity data for the schools surveyed so we cannot be sure if the ethnicities of the respondents accurately represent the demographic breakdown of the total school population.

Of the 89% of respondents who answered the eye care knowledge questions, less than half (48%) agreed with the statement that 'wearing glasses if you need them when under age 7 will make your eyes and vision stronger'. 33% agreed with the false statement that ‘it is normal for a child aged 1-7 to occasionally have an eye turn.’ Only 15% of parents disagreed with this false statement. These responses highlight the need for better parent education regarding the importance of timely detection and intervention of childhood eye conditions. 33% of parents stated they don’t know how or where to access an eye test for their child. It is worth remembering that this survey is for school age children so it may be hypothesised that this figure will be higher for younger children. This is supported by the finding that 9% of parents stated their child is too young to have an eye test and 6% believe their child cannot be tested because they don't know the letters. 12% of parents express concerns that their child will be given glasses they don’t need. This suggests a degree of mistrust in high street optometry practice which correlates with the ‘retail’ associations of optometry reported by young adults in England 19. No evidence can be found in the literature to discredit or substantiate such concerns which suggests an audit of UK prescribing practice may be needed.

There has been no national public health messaging in England around the importance of timely eye care for young children which may help to address some of these issues. In view of the significant barriers reported and inequality between ethnic groups, signposting of parents and carers to appropriate eye care is suggested. One possible solution is signposting to General Ophthalmic Service sight tests as part of the healthy child programme to better embed it into the NHS provision for yound cgildren. .Shah et al 20 documented that 50% of optometric practices refused to examine a 1 year old child so it should be considered that there may be real barriers for young children to access the General Ophthalmic Service. A possible solution would be making lists of optometrists with a paediatric special interest and/or relevant specialist accreditation available to the public from national professional registers and health teams. In the UK the College of Optometrists offers a Professional Certificate in paediatrics but currently there is no means by which holders of this additional training can be identified by the general public. The inclusion of paediatrics as a speciality on the General Optical Council register wouls make this possible. Routine signposting to these clinicians nationally could also be considered as an alternative to the current piecemeal screening services. Previous studies 14,15 report poor attendance for secondary assessment following failed primary vision screening and the barriers and lack of knowledge this study identified can be assumed to contribute to this. If parents don’t understand the need for early intervention and have perceived barriers they are less likely to seek eye care for their children. In light of these findings and also to improve equality of care across different ethnic and geographic groups, it is suggested that referral for further care should be initiated by the primary screener, rather than initiation being requested of the parent. Primary screening can only be effective if the children it identifies go on to receive further care.

Only 14.5% of the families in schools with a screening programme in place were aware of it. Giving parents further information at the time of and after screening is suggested to improve attendance and compliance for future eye care needs. Referral directly to services from primary screeners would reduce the impact of parent knowledge of how to access eye care and also barriers. This would give greater equality to all children accessing services from different backgrounds. It is also recommended that online and leaflet resources be given to parents at the time of screening as per the Public Health England guidelines (14a).

1. .

85% of the parents surveyed believe that school vision screening tests for all eye problems. If a parent is aware that their child has had vision screening this may prevent them seeking a full eye examination. Children can pass a vision screening with significant hyperopia, squints, poor convergence or ocular pathology 10.

Studies have shown that visual problems can lead to poor academic performance 26,27,. Only 23.55% of parents stated that they would consider seeking an eye test if their child had poor concentration in school and only 19.39% would consider seeking an eye test if their child was achieving poorly in school. The authors would suggest that links between ocular problems and poor concentration or school performance need to be better related to parents. Again, possible means to do so would be using leaflets to include links to online information at the time of screening to all children. It is also suggested that parents are advised that vision screening is not a full eye examination and that certain conditions can be missed.

The study provides evidence of barriers to accessing eye care for young children as well as some parental misconceptions around eye care and vision for young children. Our findings suggest a need for improved parent education and communication around the importance of how to access eye care for young children and of existing screening programmes. Defined referral protocols following failed school vision screening are suggested as recommended by Public Health England (14a).

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Appendix 1: Parent Questionnaire.

***Dear Parents***

We are a research team from City University London carrying out a survey to investigate access to eye care for families with children under 7 in conjunction with the College of Optometrists. All responses will be treated as confidential and anonymous. Your participation in this research survey is voluntary. The survey should take less than 5 minutes to complete and all completed surveys will be entered into a draw to win £100. **PLEASE RETURN FORMS ASAP TO BE ENTERED INTO THE DRAW**.

If you have any questions regarding the survey/ research please contact Lisa Donaldson on 07899975143 or email: lisa.donaldson.2@city.ac.uk

***Please answer these questions about your child currently in reception/ year 1 (if you have more than one child in reception/year 1 please complete a separate form for each child)***

1. Is there a routine vision screening in your child’s school?

***Yes/No/Not sure***

2. Have you ever had any concerns about your child’s eyes or vision?

***Yes/No/Not sure***

1. Would you know how to access an eye test appropriate for your child’s age if you had any concerns?

***Yes/ No /Not sure***

1. Do you or any of your child’s close family i.e. parents, brothers or sisters have glasses, a lazy eye (amblyopia) or an eye turn?

***Yes/No/Not sure***

5. Has your child ever had any kind of eye or vision test?

***Yes /No/Not sure***

1. Has your child ever been refused an eye test? ***Yes/No/Not sure***
2. What reason was given when you child was refused an eye test?

8. For what reasons would you consider seeking an eye examination for your child (**please tick all that apply**):

* Advised by healthcare provider or teacher
* Concerns about poor vision
* Concerns eyes not straight/ had a turn
* Headaches
* Poor concentration/ short attention span
* Poor school achievement and/or difficulties with literacy
* Complaints of double vision
* Routine check-up
* Family history
* Step father has a squint
* Other –please state

1. Please state any possible reasons that may prevent you from taking your child for an eye test (**please tick all that apply**):
   * I don’t know how and/or where to arrange an appointment for an eye test
   * I am worried about the cost of an eye test
   * I am worried about the cost of glasses
   * I think my child is too young to have an eye test
   * I am worried my child doesn’t yet know all the letters
   * I have been told that my child is too young for an eye test
   * I don’t want my child to wear glasses
   * I am worried my child may be given glasses he/she doesn’t need
   * I am worried if my child is given glasses it will make his/her eyes weaker
   * Other (please state)

***Please read and respond (circle) with your existing knowledge to the following statements:***

10. Children can only have an eye test when they know the names of the letters

***Agree Disagree Not Sure***

11. Eye checks at an optician’s/optometrist’s are free on the NHS for children under 16

***Agree Disagree Not Sure***

12. Wearing glasses if you need them when under age 7 will make your eyes and vision stronger

***Agree Disagree Not Sure***

13. It is normal for a child aged 1-7 years to occasionally have an eye turn

***Agree Disagree Not Sure***

14. School vision screening tests for all eye problems

***Agree Disagree Not Sure***

***Finally Please Answer the following about yourself:***

*15*. Please state your FULL postcode\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(This information will only be used to map services)

16. Please circle the ethnic origin you identify with:

Asian-Bangladeshi Asian-Indian

Asian-Pakistani Other Asian (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Black-African Black-Caribbean

Black Other (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Chinese (specify\_\_\_\_\_\_\_\_\_\_)

White British White Other (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Mixed (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) Other (specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

17***.*** Do you feel comfortable speaking English?  ***Yes/No/Not Sure***

18. Does your child receive free school meals? ***Yes/No/Not Sure***

19. What is the highest level of formal education for either parent?

* Left school before any formal exams/age 16
* GCSEs/ O levels or equivalent age 16 exams
* AS level
* A level /IB or age 18 equivalent exams
* First Degree
* Masters Degree
* PhD/Doctoral degree
* Other? Please specify

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We would like to contact some parents again to repeat the survey in a few months. If you are happy for us to contact you again please provide us with your contact details:

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Please write any other comments below (continue over the page if necessary):***

***Many thanks for your help in completing this survey***