

greatest barrier appears to be financial – cost of treatment limits uptake and sometimes affects ECPs motivation to promote myopia management, while practices are lacking a financial incentive to provide the service. Many reported barriers were indicative of systemic problems within UK eyecare delivery, such as commercial pressures, inadequate NHS funding, and poor public awareness of paediatric eyecare.

**Conclusion** Improving accessibility and uptake of myopia management will require change at various levels, from individual ECPs through to wider stakeholders in UK eyecare provision.

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#### OP-04 CLINICAL USE OF COMFORTABLE PRINT SIZE (CFPS)

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**Introduction** Assessment of reading function is key to providing solutions to difficulties with reading for people with sight loss, with reading performance at print sizes larger than acuity threshold particularly important to understand. Critical print size (CPS), reflecting the smallest size supporting maximum reading speed, is valuable but time consuming to measure. Applying a 'reserve' to acuity threshold (often 2:1) is quicker but does not reflect individual variation. Is there a clinically efficient way of identifying print size allowing maximum reading speed on an individual basis?

**Aims** To introduce comfortable print size (CfPS), compare it to existing alternatives, and consider its utility in visual assessment.

**Methods** Results are presented from two cohorts with self-reported visual loss affecting daily life. All reading assessments were conducted using the MNREAD. CfPS was assessed by asking 'What is the smallest print size that you would find comfortable using?' CPS and reading acuity were established for MNREAD chart and app.

**Results** There is little clinical difference between CPS and CfPS, with a maximum mean difference of 0.1logMAR between CfPS and different assessments of CPS.

Repeatability of CfPS within a session is  $\pm 0.09\log\text{MAR}$ . CfPS is quicker to assess (median 131sec) than CPS with the app (284sec) or chart (185sec excluding graph plotting).

**Conclusion** CfPS is similar to CPS, repeatable (within session), quick to assess, and provides an individualised measure. Its clinical use will be discussed.

#### OP-05 BARRIERS AND FACILITATORS FOR ENGAGING UNDERREPRESENTED ETHNIC MINORITY POPULATIONS IN RESEARCH: A NARRATIVE REVIEW

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**Introduction** Research highlights that participation of ethnic minority individuals in research is low at national level when compared to white counterparts. This poses issues for healthcare, as lack of representativeness in research means that research findings cannot be generalised, and do not provide us with a full picture of how minority populations are affected. This leads to health inequality as these populations are underserved.

**Aims** This narrative review explores the barriers and facilitators of engaging minority individuals in research in order to understand and facilitate better engagement of different communities in research.

**Methods** This was a narrative review. Three databases were searched (MEDLINE, CINAHL, PsycINFO) using the EBSCO platform, resulting in 1316 articles, of which 29 met the inclusion criteria.

**Results** The main barriers for research participation were: mistrust of healthcare professionals, logistical challenges, language and cultural barriers, and the topic being explored. Various facilitators that may support better research participation included: ensuring transparency around the aims and objectives of the research with participants, building rapport, employing culturally competent researchers, personalised approaches, respecting cultural values, offer of incentives, and the use of community facilitators.

**Conclusion** To enable wider participation, it is important to understand not only the barriers but also to employ culturally appropriate facilitators and make more effort to use patient and public involvement (PPI) groups across the whole research pathway, offer cultural training for researchers, and adopt a more collaborative way of working. This review highlights the work that needs to be done to make research accessible and inclusive for ethnic minority groups.

#### OP-06 VIDEO-CONSULTING WITH DIGIVIS TESTING: A REAL-WORLD EVALUATION

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**Introduction** DigiVis is a validated CE marked web-app enabling self-testing of distance visual acuity (VA).

**Aims** To describe the implementation of the DigiVis test in remote consultation in the Orthoptic service.

**Methods** Families of children due a follow-up Orthoptic appointment were invited to have a video consultation with synchronous DigiVis VA testing. Inclusion criteria included an age of 4 years or older, a requirement primarily for VA assessment and parental agreement to participate.

**Results** 71 families agreed to undertake a remote consultation with DigiVis. The median age was 6 years (range 4–10). 53 (74.6%) children were having amblyopia therapy, the remainder were under observation for refractive error or intermittent tropias. 63 (88.7%) were able to complete the test over Attend Anywhere. Compared to the VA assessment at the subsequent face-to-face consultation the mean bias was 0.01 logMAR with upper and lower Limits of Agreement of +0.12logMAR and -0.10logMAR respectively. DigiVis had 100% sensitivity and specificity in identifying an intra-ocular VA difference (IOD) of 0.05logMAR or more. 47 out of 52 (90.4%) families asked said they could and would like to do asynchronous DigiVis testing in the future.

**Conclusion** Synchronous DigiVis testing during video-consultation can support remote consultation in selected orthoptic patients and is well accepted by most parents. It is accurate at detecting IOD and comparable to standard testing in clinic. Remote consultation with DigiVis testing may reduce time off work and school for families, reducing carbon emissions and releasing clinic space.