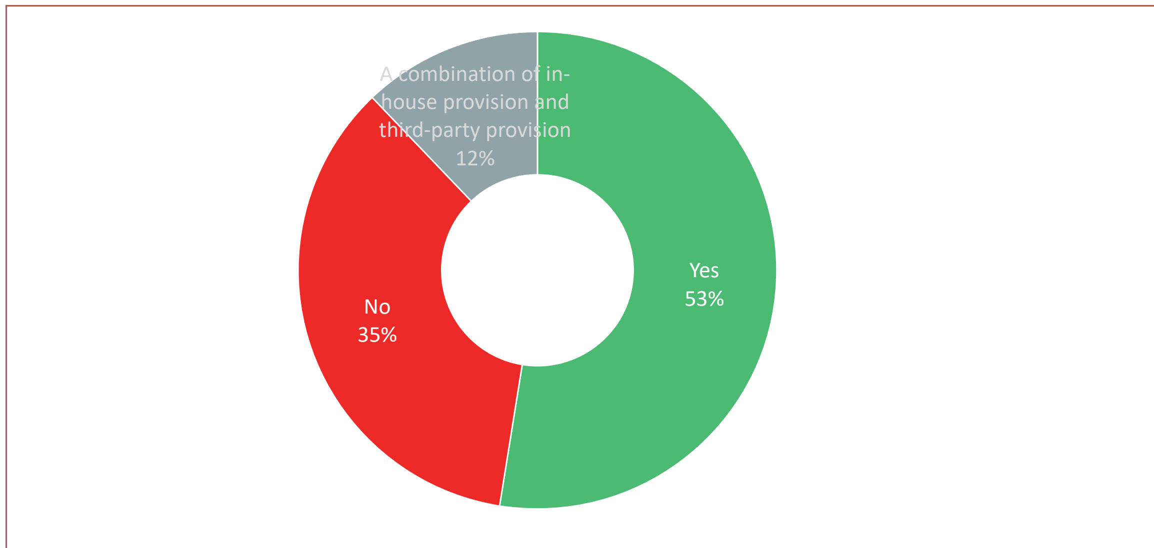
B.6. Whether practice provides its own 24/7 emergency cover

Over half the respondents (53%) reported that their practice provided its own 24/7 emergency cover, 12% reported offering a combination of in-house provision and third-party provision, and 35% did not offer 24/7 emergency cover. See Figure 26.

Figure 26: Whether practice provides its own 24/7 emergency cover



Base: Total 5,544

24/7 emergency cover was significantly[32] more prevalent in large practices than in smaller practices (84% compared with 49% medium-sized and 27% small). 24/7 emergency cover was also significantly more prevalent in remote rural practices than in mixed or urban practices (82% compared with 60% mixed rural and urban and 36% urban). See Table 5.

[32] At the 95% confidence level.

Table 5: Whether practice provides its own 24/7 emergency cover by practice size (surgeons), rurality and country

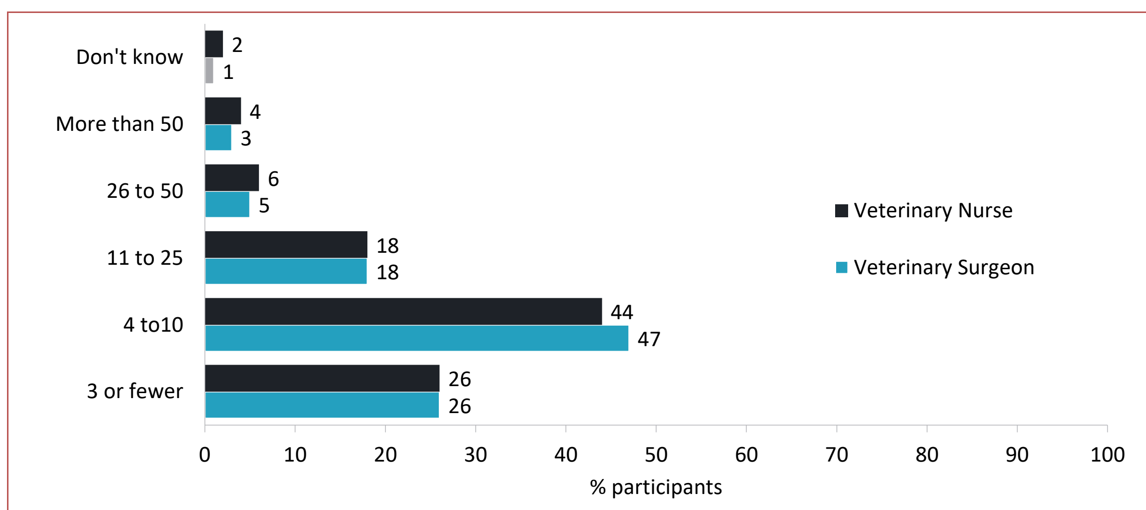
	Practice size			Rurality			Country			
	Small (<3 vets)	Medium-sized (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban	England	Scotland	Wales	Northern Ireland
	%	%	%	%	%	%	%	%	%	%
Yes	27	49	84	82	60	36	51	61	55	66
No	61	36	8	12	27	50	36	30	38	21
A combination of in-house provision and third-party provision	12	15	8	5	13	14	13	9	8	13
Base	1,462	2,588	1,447	458	2,916	2,170	4,590	565	269	120

B.7. Practice size

Practice size was determined by asking for the number full-time-equivalent veterinary surgeons and full-time-equivalent veterinary nurses in the practice where they currently work. If they no were no longer practising they were asked to select the response that best fits the time when they were most recently in practice.

Figure 27 shows the numbers of veterinary surgeons and veterinary nurses by bands and clearly indicates similar numbers for both.

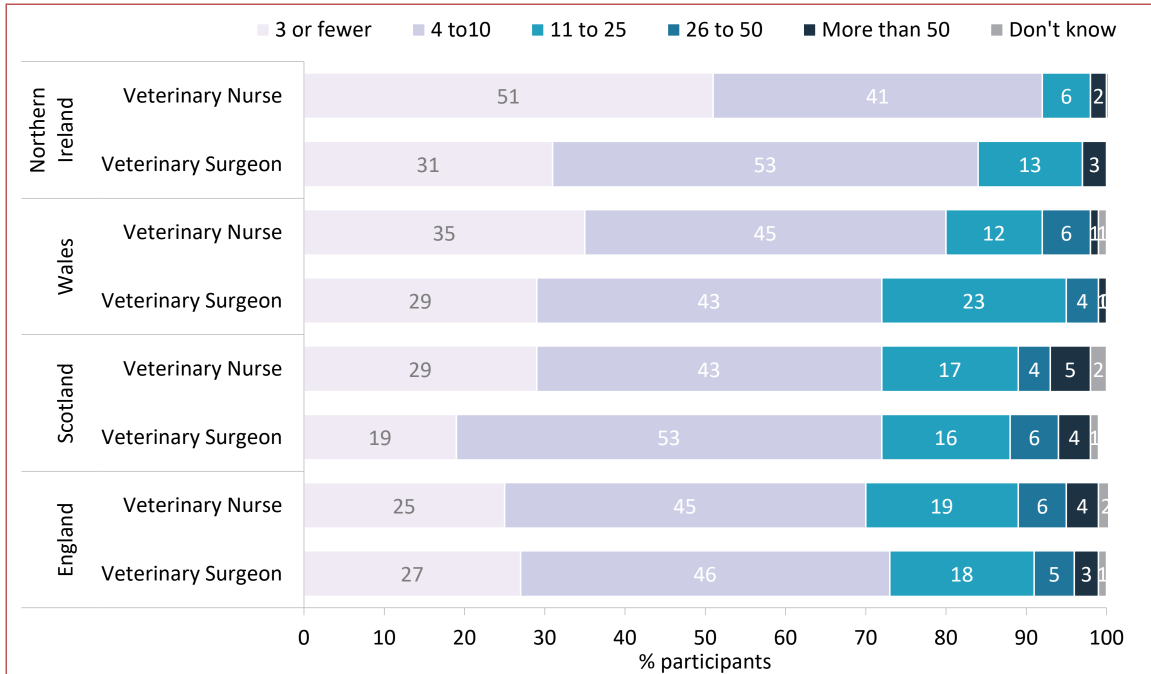
Figure 27: Practice size by role of respondents



Base: Veterinary Surgeon 4,545, Veterinary Nurse 999

Practice size by country shows that practices tend to be smaller in Northern Ireland than in England and Scotland. See Figure 28.

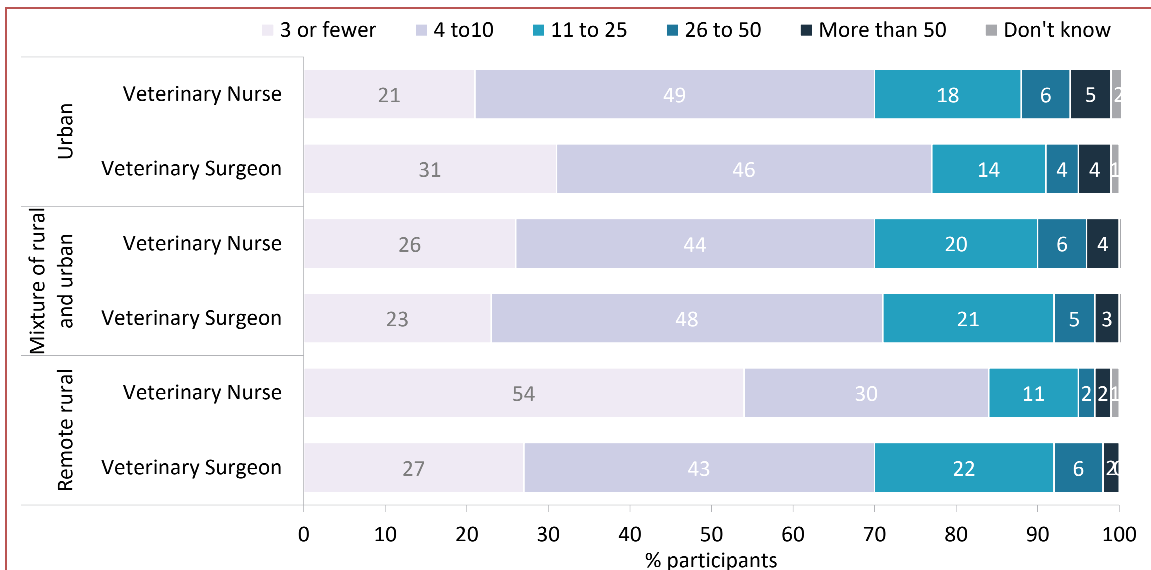
Figure 28: Practice size by country



Base: England 4,590, Scotland 565, Wales 269, Northern Ireland 120

There were similar number of surgeons and nurses by rurality of setting except for remote rural settings, where there were fewer nurses (54% of practices had three or fewer nurses in remote rural, compared with 26% in mixed rural and urban and 21% in urban settings). See Figure 28.

Figure 29: Practice size by rurality

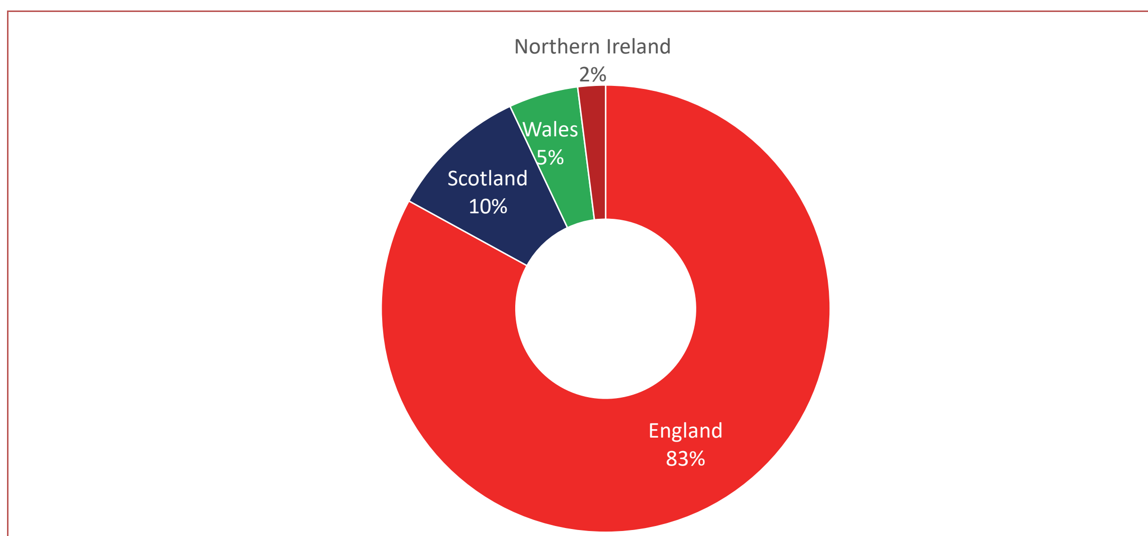


Base: Urban vs rural: Remote rural 458, Mixture of rural and urban 2,916, Urban 2,170

B.8. Country based in

Over four fifths (83%) of the sample were based in England, 10% were in Scotland, 5% in Wales and 2% in Northern Ireland.

Figure 30: Country



Base: Total 5,544

Nearly nine in ten (87%) of urban practices were in England, compared with 69% of remote rural. A much larger proportion of practices were remote rural rather than urban settings in Scotland, Wales and Northern Ireland. See Table 6.

Table 6: Country by practice size and rurality of practice setting

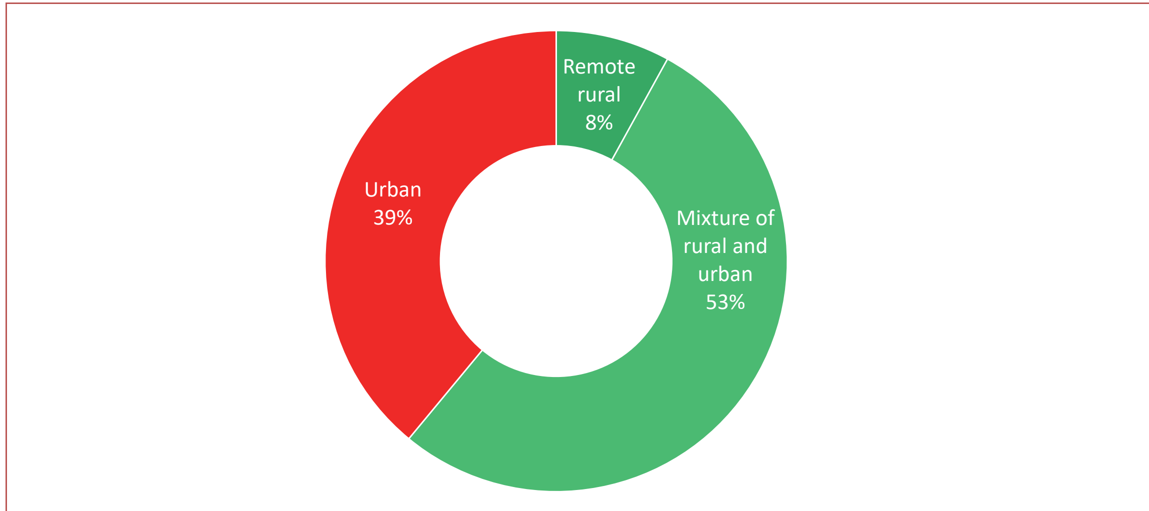
	Practice size			Rurality		
	Small (<3 vets) %	Medium-sized (4-10 vets) %	Large (11+ vets) %	Remote rural %	Mixture of rural and urban %	Urban %
England	85	81	83	69	82	87
Scotland	7	12	10	17	10	9
Wales	5	4	5	9	6	3
Northern Ireland	3	2	1	4	2	2
Base	1,462	2,588	1,447	458	2,916	2,170

** = less than 0.5%*

B.9. Whether respondents work in remote or urban area

Over half the sample (53%) were practising in a mixed rural and urban setting, 39% in an urban setting and 8% in a remote rural setting.

Figure 31: Whether practice setting is urban, rural or a mix



Base: Total 5,544

See Table 7 for analysis of practice setting by size and country. Key differences are:

- Respondents from small practices were significantly more likely to be from urban settings than those from medium-sized or large practices: 46%, compared with 39% medium-sized and 33% large.
- Respondents from large practices were significantly more likely to be based in a mix of rural and urban than those from medium-sized or small practices: 58%, compared with 54% medium-sized and 46% small.
- Respondents from practices in England were significantly less likely to be from remote rural (7%) areas than those in Scotland (14%), Wales (16%) and Northern Ireland (14%).
- Respondents from practices in England were significantly more likely to be from urban (41%) areas than those in Scotland (35%), Wales (21%) and Northern Ireland (28%).

Table 7: Whether practice setting is urban or rural by practice size and country

	Practice size			Country			
	Small (<3 vets) %	Medium-sized (4-10 vets) %	Large (11+ vets) %	England %	Scotland %	Wales %	Northern Ireland %
Remote rural	9	8	9	7	14	16	14
Mixture of rural and urban	46	54	58	52	51	63	58
Urban	46	39	33	41	35	21	28
Base	1,462	2,588	1,447	4,590	565	269	120

Annex C. Survey sub-group analysis

C.1. Good regulation statements: Sub-group analysis

Figure 32: Good regulation statements, mean scores by whether surgeon or nurse

Base: 4,545 veterinary surgeons, 999 veterinary nurses

Table 8: Good regulation statements, mean scores by practice size and rurality (the scores which are significantly[33] higher than the other score(s) within the category are shaded darker)

	Practice size			Rurality		
	Small (<3 vets)	Medium-sized (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban
An animal being under my care means I am responsible for the advice I give in relation to it.	4.47	4.57	4.54	4.61	4.54	4.50
An animal being under my care means I am responsible for all POM-V medications I prescribe to an animal I am treating (and for how long, at what dose and in what combination).	4.40	4.40	4.44	4.40	4.46	4.35
I would only accept an animal as being under my care if my knowledge of the situation and the condition of the animal is good enough to make the best and most competent decision possible regarding its well-being.	4.35	4.32	4.30	4.28	4.34	4.30
Regulations should require veterinary professionals to ensure that provision of 24/7 emergency cover for the relief of pain and suffering is available – either through their practice or via a specialist out-of-hours provider irrespective of the nature of the services / treatments given.	4.05	4.26	4.40	4.24	4.27	4.19
Regulations should restrict certain business models where it can be shown to lead to inadequate or insufficient veterinary provision and so negative impact on animal welfare and/or public health (e.g. leading to under-provision of accessible 24/7 emergency cover for animals in some parts of the country).	3.87	4.04	4.15	4.11	4.06	3.95
Regulations should allow space for professional judgement when interpreting and applying them.	4.07	4.00	4.01	3.97	3.99	4.06
There should be an upper limit defined in regulations on the time between seeing any animal and prescribing POM-Vs	3.94	4.03	4.01	3.89	3.98	4.05
For an animal to be under a vet's care in a way that is real and not just nominal, a recent physical examination is essential.	3.89	3.91	3.92	3.69	3.92	3.93
Regulations should take into account how different prescribed medications carry more or less risk for the well-being of the animal.	3.86	3.88	3.82	3.70	3.83	3.94
Regulations should take into account the pre-existing physical condition of the animal (e.g. if it already has a chronic condition).	3.81	3.83	3.80	3.79	3.79	3.86
Regulations should provide for any adverse impact resulting from a veterinary product or intervention to be addressed by the provider, regardless of the business model or the competitive environment.	3.74	3.74	3.80	3.80	3.75	3.75
Regulations should be more prescriptive, so there is no variation in how they are interpreted across the profession.	3.47	3.63	3.59	3.52	3.58	3.58
There should be an upper limit defined in regulations on the time between seeing an animal and prescribing POM-Vs, but the upper limit should differ depending on animal species.	3.20	3.38	3.35	3.51	3.31	3.29

[33] At the 95% confidence level.

	Practice size			Rurality		
	Small (<3 vets)	Medium-sized (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban
If information were provided from a client when I knew I could rely on the information they provide, I would be comfortable recommending treatment / prescribing POM-Vs, even if I hadn't recently seen the animal.	3.03	3.06	2.98	3.21	3.04	2.99
Having information from sources other than a physical examination (for example, wearable devices, videos, pictures) may be sufficient for an animal to be brought under	3.02	3.03	3.01	2.95	2.97	3.11
If information were provided from a client I knew to be knowledgeable about the species and condition, I would be comfortable recommending treatment / prescribing POM-Vs, even if I hadn't recently seen the animal.	2.88	2.92	2.82	3.06	2.91	2.81
Regulations should take into account the age of the animal.	2.80	2.72	2.60	2.59	2.66	2.81
If information were provided from a client I had never been in contact with before, I would be comfortable recommending treatment / prescribing POM-Vs.	1.70	1.71	1.69	1.63	1.66	1.78
Base	1,462	2,588	1,447	458	2,916	2,170

C.2. Applying principles statements: Sub-group analysis tables

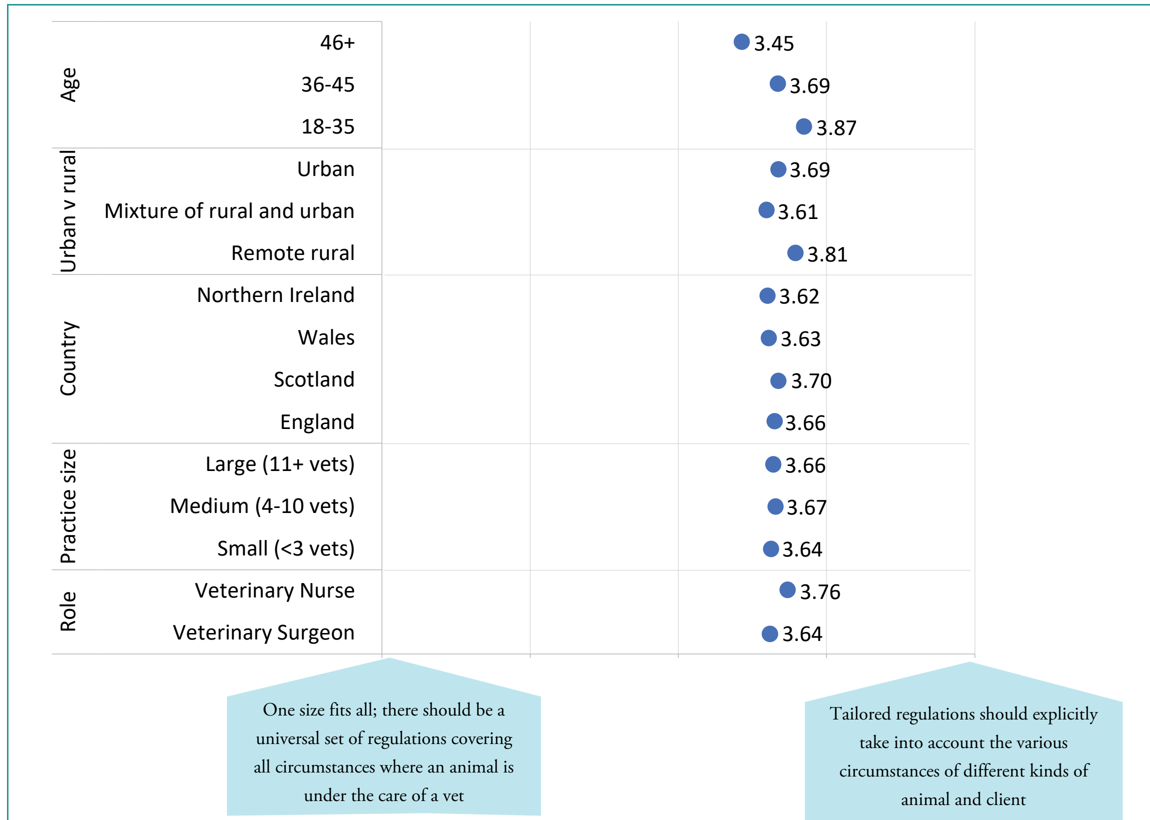
Table 9: Good Regulation Statements, mean scores by practice size and rurality

Statement	Practice size			Rurality		
	Small (<3 vets)	Medium-sized (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban
If an animal is registered with more than one primary care practice, the practices should be required to share clinical records.	4.15	4.24	4.19	4.13	4.22	4.2
Regulations regarding 24/7 emergency cover and 'under care' should recognise the unique advantage of physical examinations over information that is solely obtained remotely (such as photographs, phone calls, biometrics, videos).	4.12	4.2	4.21	4.14	4.21	4.15
Regulation of 24/7 emergency cover and 'under care' should involve a formal agreement between vets and clients that establishes the obligations and responsibilities of each.	3.82	3.94	4.00	3.84	3.93	3.92
Regulations regarding 24/7 emergency cover and 'under care' should explicitly take into account that vets will refer cases to specialists with whom they should have shared accountability.	3.80	3.88	3.93	3.84	3.90	3.84
Regulations and guidance regarding 'under care' and 24/7 emergency cover should specifically recognise that a vet could reasonably treat an animal that is part of a herd or flock differently from one that is a companion animal, where this is in line with a client's preferences.	3.75	3.88	3.86	4.08	3.85	3.78
Regulation of 24/7 emergency cover and 'under care' should focus on establishing the standards below which veterinary care should never fall, rather than seeking to enforce anything beyond this.	3.82	3.75	3.71	3.69	3.74	3.80
Regulations regarding 24/7 emergency cover and 'under care' should specifically require vets to establish a formal and written agreement regarding their mutual responsibilities, and vets can discontinue their obligations if clients do not meet their obligations.	3.70	3.73	3.80	3.69	3.7	3.80
Regulations regarding 24/7 emergency cover and 'under care' should explicitly take into account that vets from the same premises work as a team and should have shared accountability.	3.58	3.72	3.76	3.95	3.73	3.59
Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks common to different geographic locations. For example, regulations for vets working in remote locations should take this into account.	3.72	3.63	3.59	3.57	3.62	3.70
Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks common to different species. For example, regulations for vets working with cattle should be different from regulations for vets working with domestic cats.	3.48	3.61	3.57	3.63	3.5	3.65

Statement	Practice size			Rurality		
	Small (<3 vets)	Medium-sized (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban
Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated with where the animal habitually lives. For example, regulations for vets working with farm animals should be different from regulations for vets working with small animals.	3.56	3.56	3.59	3.63	3.51	3.64
Regulations should allow vets to use remotely provided digital photographs of (for example) a skin condition to prescribe POM-Vs for an animal when that vet has recently physically examined the animal for another condition.	3.35	3.46	3.37	3.40	3.36	3.48
Regulations should allow vets to use remotely provided videos of (for example) a skin condition to prescribe POM-Vs for an animal when that vet has recently physically examined the animal for another condition.	3.41	3.42	3.35	3.32	3.36	3.48
A limited service provider (i.e. a vet/practice that only provides services in a specific area of care, such as vaccinations or neutering) should only be required to provide 24/7 emergency cover for the relief of pain and suffering arising out of the service they delivered and can do this by providing this care themselves or having a formal arrangement in place with another veterinary practice.	3.48	3.31	3.30	3.18	3.31	3.46
Regulations should allow vets to use remotely provided digital photographs of (for example) a skin condition to prescribe POM-Vs for an animal using clinical notes from another vet who has recently physically examined that animal.	3.18	3.2	3.24	3.18	3.16	3.27
Regulations should allow vets to use remotely provided videos of (for example) lameness to prescribe POM-Vs for an animal using clinical notes from another vet who has recently physically examined that animal.	3.17	3.19	3.24	3.17	3.18	3.23
Regulations regarding 24/7 emergency cover and 'under care' should be concerned only with the quality (i.e. reliability, recency and completeness) of the information used to inform clinical judgements and not its source.	3.20	3.12	3.13	3.04	3.14	3.17
Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated common to charities /shelters. For example, regulations for vets working with charities/shelters should be different from regulations for vets working in practice.	2.79	2.82	2.76	2.85	2.75	2.86
Regulations should allow vets to use remotely provided digital photographs of (for example) a skin condition to prescribe POM-Vs for an animal that the vet has never physically examined (i.e. there is no existing patient–client–vet relationship).	1.83	1.76	1.70	1.73	1.71	1.85
Regulations should allow vets to use remotely provided videos of (for example) lameness to prescribe POM-Vs for an animal that the vet has never physically examined (i.e. there is no existing patient–client–vet relationship).	1.86	1.75	1.70	1.76	1.72	1.85
Base	1,462	2,588	1,447	458	2,916	2,170

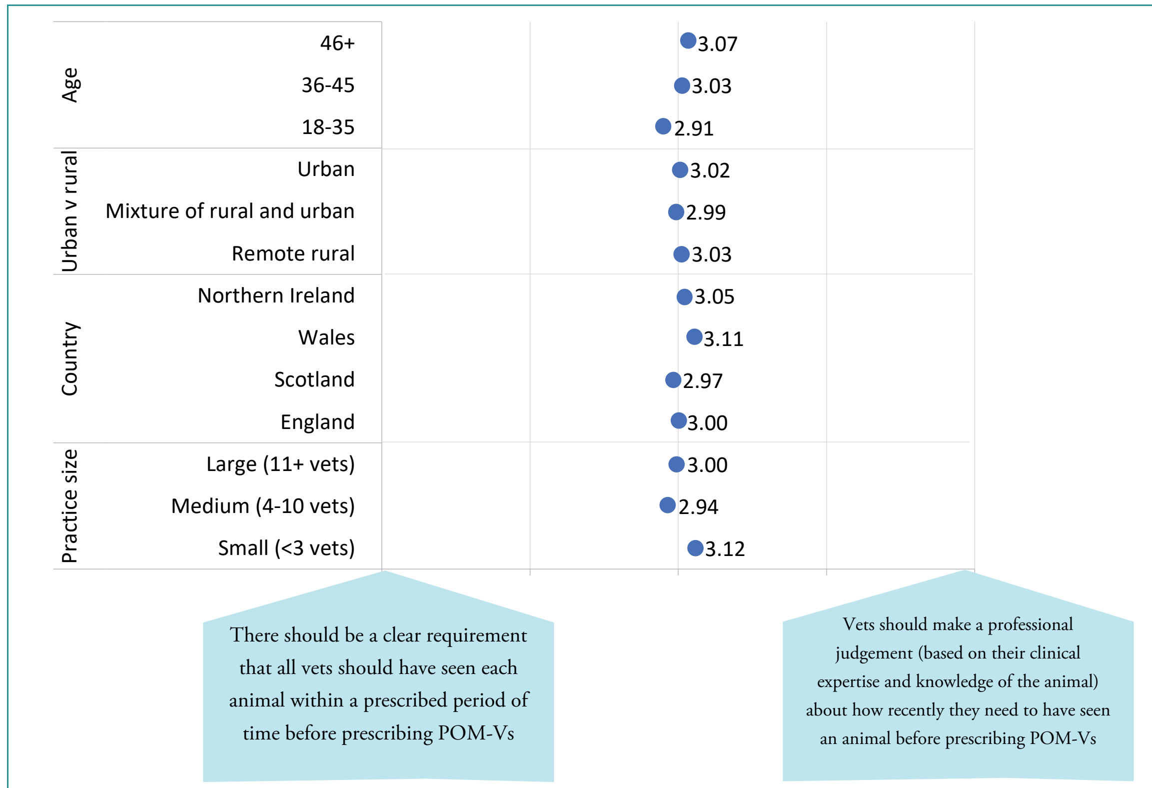
C.3. When principles are in tension: Sub-group analysis

Figure 33: One size fits all vs Tailored regulations – mean scores by age, rurality, country, practice size and role



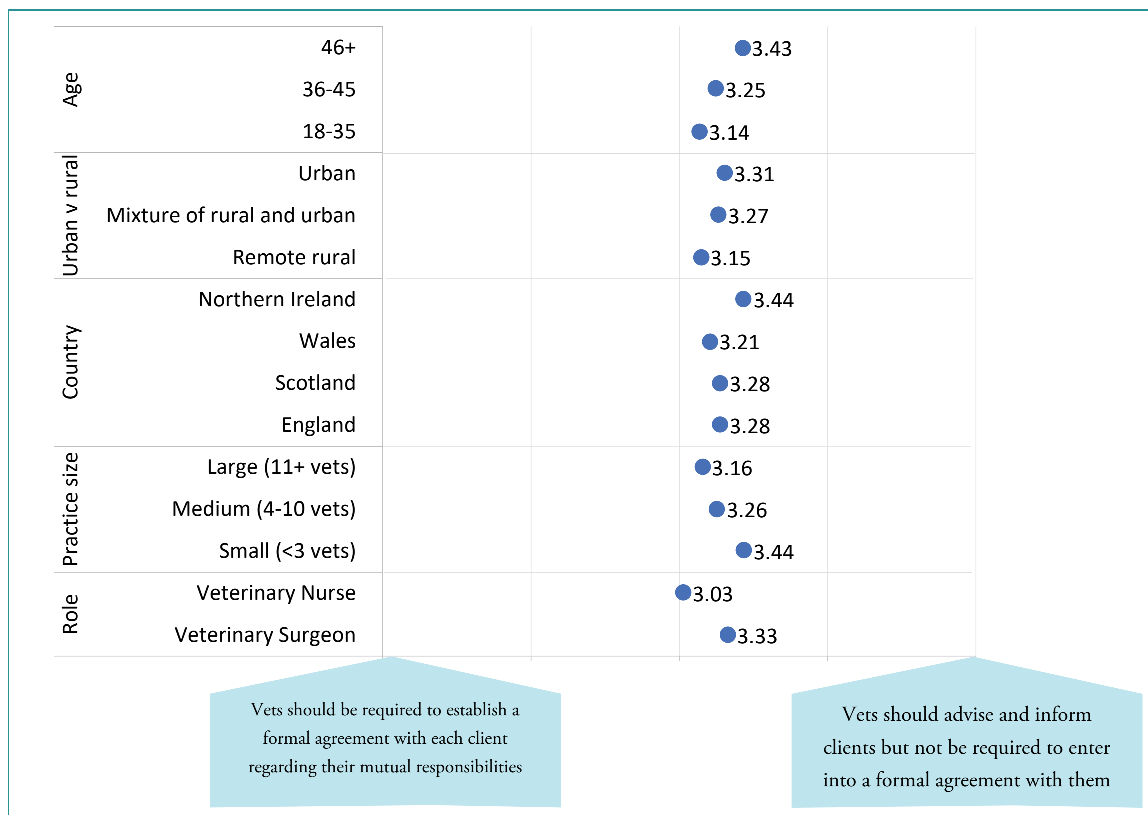
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 34: Before prescribing POM-Vs each animal should be seen within a prescribed period of time vs Vets should make a professional judgement – mean scores by age, rurality of setting, country and practice size: surgeons only



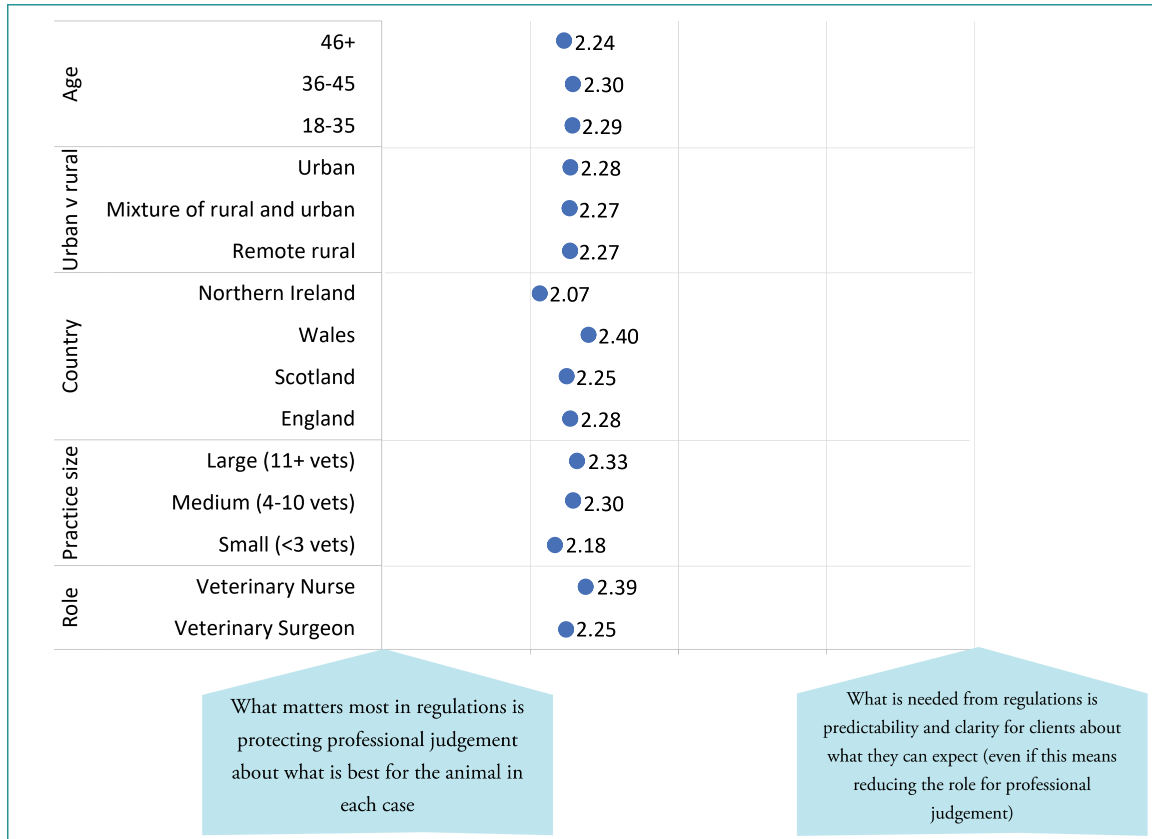
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445

Figure 35: A formal agreement with each client should be required vs Vets should advise and inform clients about agreement – mean scores by age, rurality of setting, country, practice size and role



Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 36: Protecting professional judgement about what is best in each case vs Predictability and clarity for clients about what they can expect – mean scores by age, rurality of setting, country, practice size and role

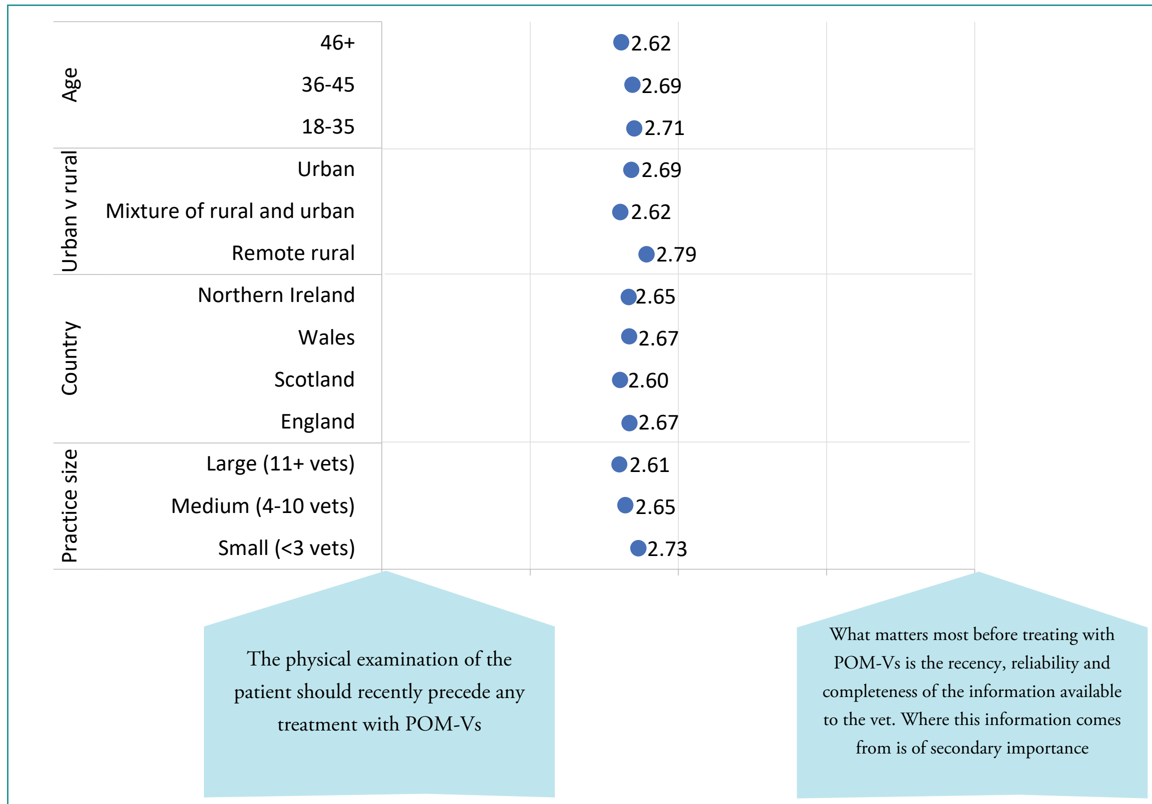


Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 37: Regulations should establish only minimum standards vs Regulations should aim to set the highest possible standards – mean scores by age, rurality of setting, country, practice size and role

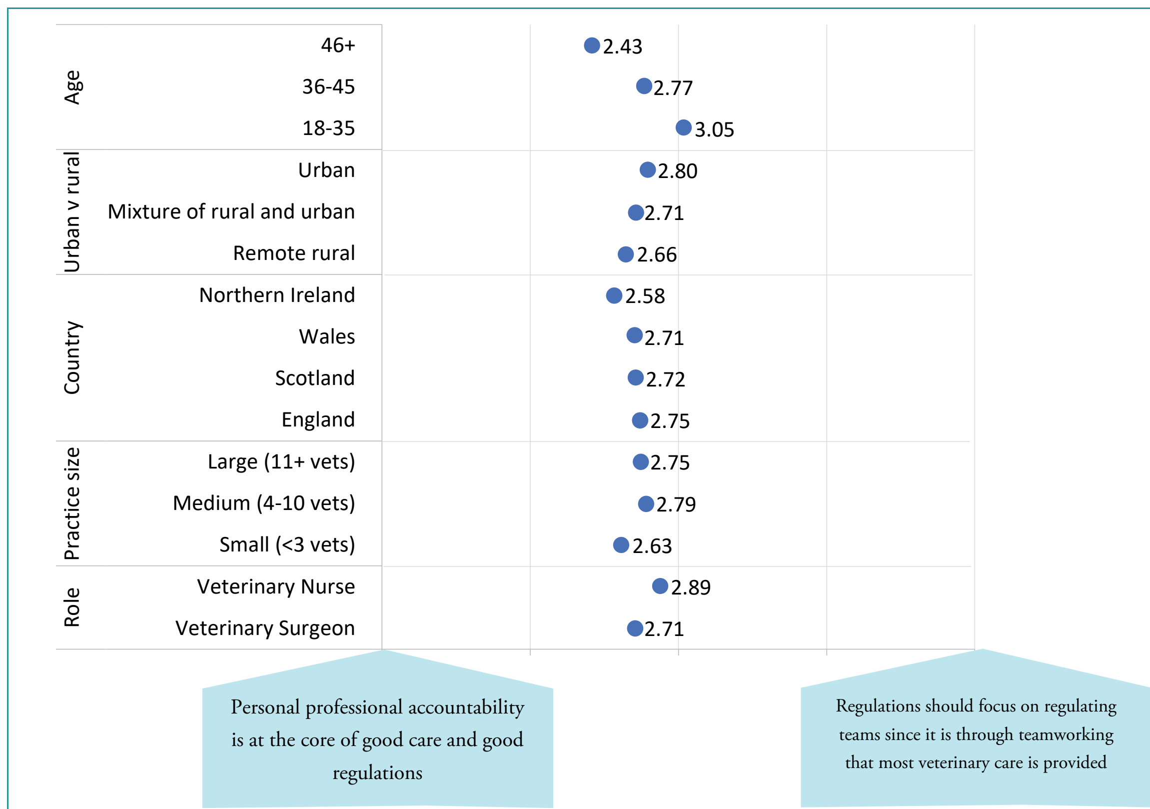
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 38: Physical examination should precede any treatment with POM-Vs vs Recency, reliability and completeness of the information available – mean scores by age, urban vs rural, country and practice size: Surgeons only



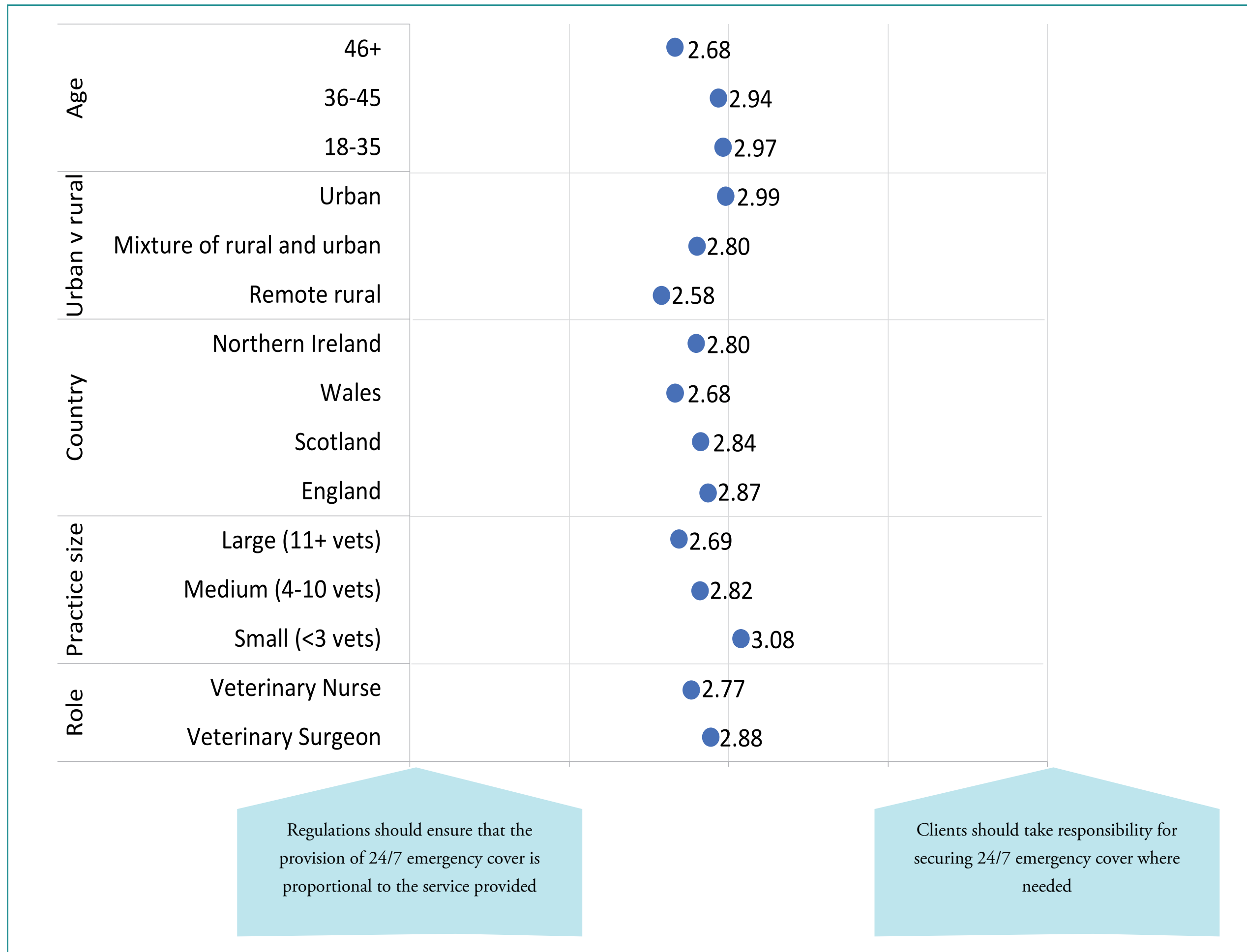
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445

Figure 39: Personal professional accountability is at the core of good care and regulations vs Regulations should focus on regulating teams – mean scores by age, urban vs rural, country, practice size and role



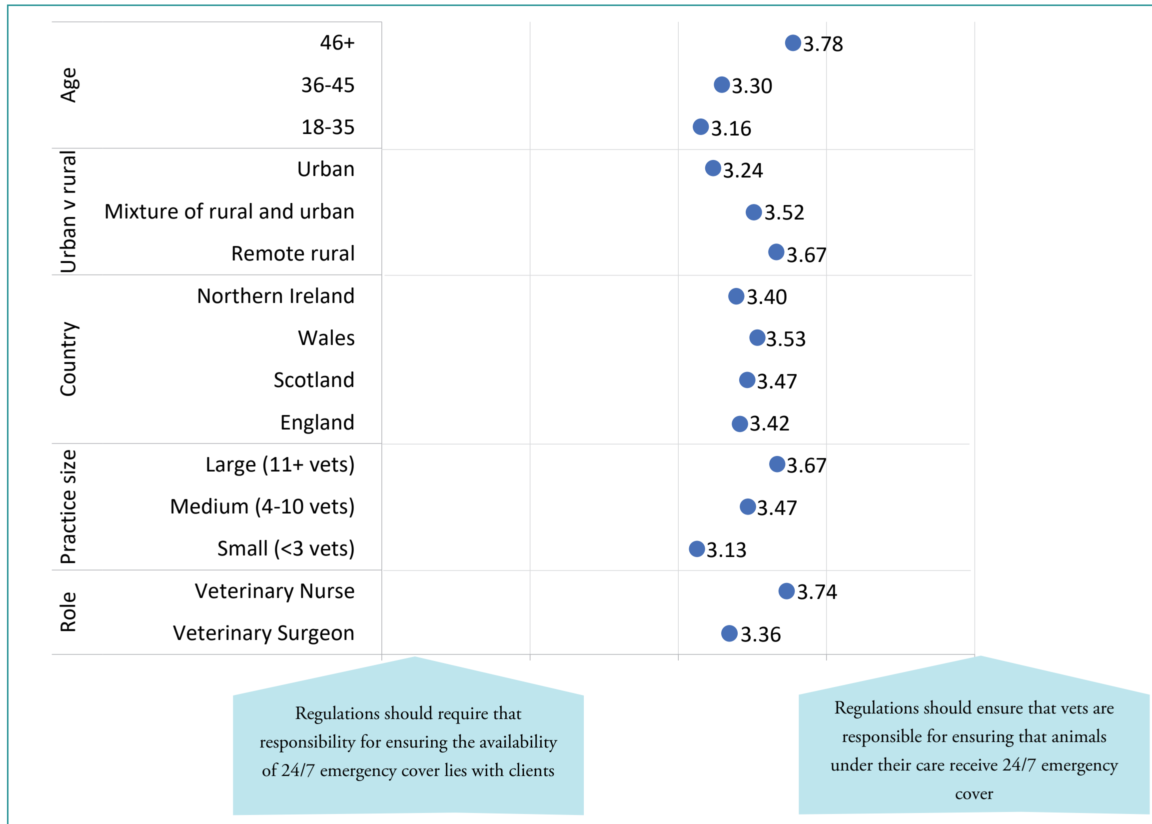
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 40: Provision of 24/7 emergency cover should be proportional to the service being provided vs Clients should take responsibility for securing 24/7 emergency cover where needed – mean scores by age, urban vs rural, country, practice size and role



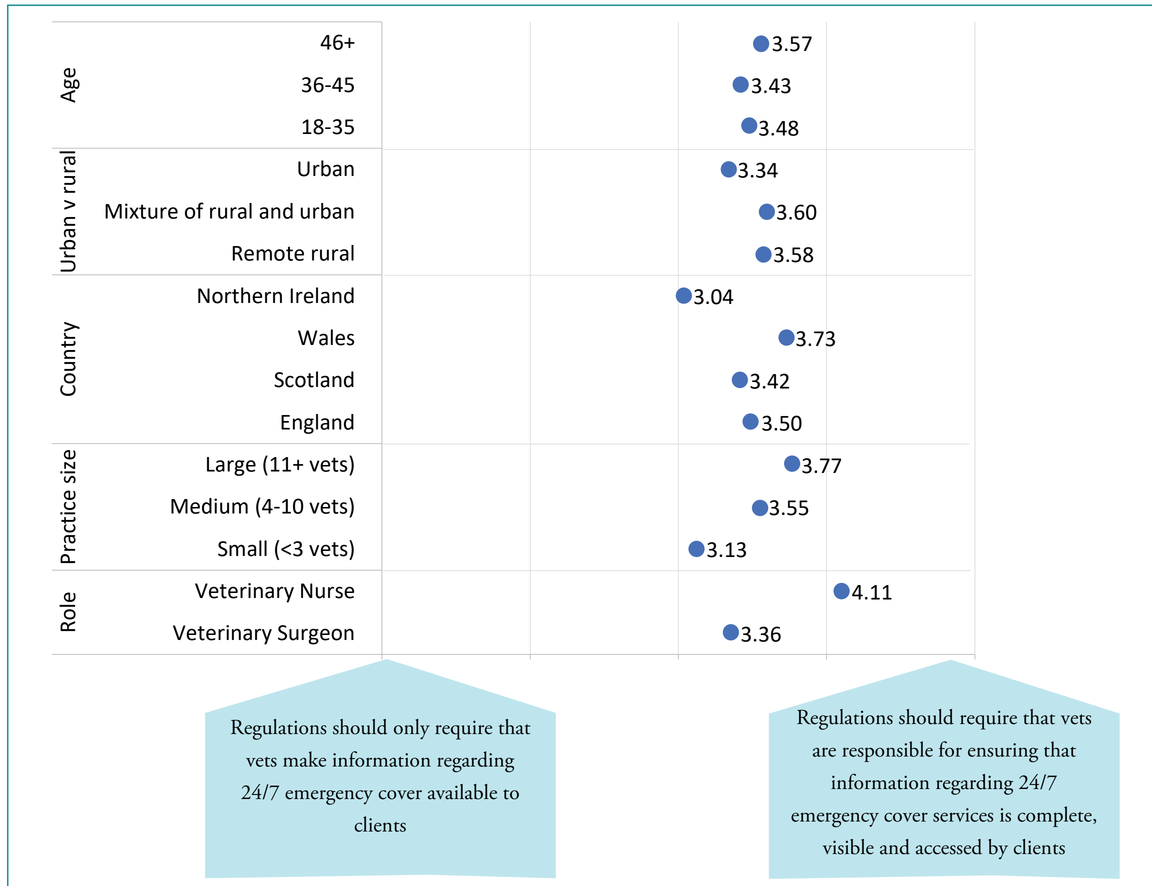
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Setting: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 41: Availability of 24/7 emergency cover lies with clients vs 24/7 emergency cover lies with vets – mean scores by age, urban vs rural, country, practice size and role



Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 42: Information regarding 24/7 emergency cover being available to clients vs Information regarding 24/7 emergency cover being complete, visible and accessed by client – mean scores by age, urban vs rural, country, practice size and role



Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium-sized (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Annex D. Factor analysis theme descriptions

Outlined below are the nine themes used for the factor analysis, and the statements from the 'applying principles' section of the survey that were included in each theme. Statements in red are negatively correlated, meaning that those agreeing with other statements in this theme would most likely disagree with the statement in question.

D.1. Theme 1: Regulation around the source of examination data

Statements which fall under the theme 'source of examination data' discuss whether a physical examination is necessary, or whether a diagnosis can be made or treatment can be prescribed through virtual or non-tangible mediums, such as videos, pictures or information provided by clients who are knowledgeable or otherwise reliable. A high score on this factor indicates agreement that veterinary professionals should be able to use remotely provided information for diagnosis and treatment.

- *Regulations should allow vets to* ***use remotely provided videos of (for example) lameness to prescribe POM-Vs*** *for an animal that the vet has* ***never physically examined*** *(i.e. there is no existing patient–client–vet relationship).*
- *Regulations should allow vets to* ***use remotely provided digital photographs of (for example) a skin condition to prescribe POM-Vs*** *for an animal that the vet has* ***never physically examined*** *(i.e. there is no existing patient–client–vet relationship).*
- *If information were provided from a* ***client I had never been in contact with before, I would be comfortable recommending treatment*** */ prescribing POM-Vs.*
- *For an animal to be under a vet's care in a way that is real and not just nominal,* ***a recent physical examination is essential*** *(negative relationship).*
- *If information were provided from a* ***client I knew to be knowledgeable about the species and condition, I would be comfortable recommending treatment / prescribing POM-Vs****, even if I* ***hadn't recently seen the animal.***
- *If information were provided from a* ***client when I knew I could rely on the information they provide, I would be comfortable recommending treatment / prescribing POM-Vs****, even if* ***I hadn't recently seen the animal.***
- *Having* ***information from sources other than a physical examination (for example wearable devices, videos, pictures) may be sufficient for an animal to be brought under a vet's care*** *in a way that is real and not just nominal.*

- *Regulations regarding 24/7 emergency cover and 'under care' should* ***recognise the unique advantage of physical examinations*** *over information that is solely obtained remotely (such as photographs, phone calls, biometrics, videos) (negative relationship).*

D.2. Theme 2: Regulation around remote prescriptions for animals who have been physically examined

Statements which fall under the theme 'remote prescriptions for animals who have been physically examined' discuss whether a veterinary surgeon should be able to prescribe digitally if the animal has been seen before physically by themselves or another vet. A high score on this factor indicates agreement with remote prescriptions for animals that have been physically examined.

- *Regulations should allow vets to* ***use remotely provided videos*** *of (for example) a skin condition to* ***prescribe POM-Vs for an animal when that vet has recently physically examined*** *the animal for another condition.*
- *Regulations should allow vets to use* ***remotely provided digital photographs*** *of (for example) a skin condition to prescribe POM-Vs for an animal when that* ***vet has recently physically examined*** *the animal for another condition.*
- *Regulations should allow vets to use* ***remotely provided digital photographs*** *of (for example) a skin condition to prescribe POM-Vs for an animal* ***using clinical notes from another vet*** *who has recently physically examined that animal.*
- *Regulations should allow vets to use* ***remotely provided videos*** *of (for example) lameness to prescribe POM-Vs for an animal* ***using clinical notes from another vet*** *who has recently physically examined that animal.*

D.3. Theme 3: Tailored 'under care' regulations

Statements which fall under the theme 'tailored 'under care' regulations' discuss whether the regulations surrounding an animal being 'under care' should be tailored and adapted depending on what and where the animal is. A high score on this factor indicates agreement that the regulations should be tailored.

- *Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated with* ***where the animal habitually lives.*** *For example, regulations for vets working with farm animals should be different from regulations for vets working with small animals.*
- *Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks common to* ***different species****. For example, regulations for vets working with cattle should be different from regulations for vets working with domestic cats.*
- *Regulations and guidance regarding 'under care' and 24/7 emergency cover should specifically recognise that a vet could reasonably treat an animal that is part of a* ***herd or flock differently from one that is a companion animal****, where this is in line with a client's preferences.*

- *Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated common to **charities/shelters**. For example, regulations for vets working with charities/ shelters should be different from regulations for vets working in practice.*
- *Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks common to different **geographic locations**. For example, regulations for vets working in remote locations should take this into account.*

D.4. Theme 4: Structure and stringency around regulations

The statements which fall under the theme 'structure and stringency around regulations' discuss the 'strictness' and 'prescriptiveness' of regulations. A high score on this factor would indicate a vet wanted rigidity and clear definition in the regulations, whereas a low score would indicate a vet would prefer room for judgement.

- *Regulations should be **more prescriptive,** so there is no variation in how they are interpreted across the profession.*
- *There should be an **upper limit defined** in regulations on the time between seeing any animal and prescribing POM-Vs.*
- *Regulations should **allow space for professional judgement** when interpreting and applying them (negatively correlated).*
- *There should be an **upper limit defined** in the regulations on the time between seeing an animal and prescribing POM-Vs, but the upper limit **should differ depending on animal species.***

D.5. Theme 5: Individualisation

The statements which fall under the theme 'individualisation' discuss the need for regulations to take into consideration the individual characteristics of the animal. A high score on this factor indicates agreement that individual characteristics of the animal need to be taken into consideration in the regulations.

- *Regulations should take into account the **pre-existing physical condition** of the animal (e.g. if it already has a chronic condition).*
- *Regulations should take into account the **age** of the animal.*
- *Regulations should take into account how **different prescribed medications** carry more or less risk for the well-being of the animal.*

D.6. Theme 6: Formality of 'under care' agreement

The statements which fall under the theme 'formality of 'under care' agreement' discuss the need for regulations to ensure a written or formal agreement is drawn up to decide responsibilities of all parties. Agreement on this factor would indicate a vet agreed with a formal 'under care' agreement.

- *The regulations regarding 24/7 emergency cover and 'under care' should specifically require vets to **establish a formal and written agreement** regarding their mutual responsibilities, **and vets can discontinue their obligations** if clients do not meet their obligations.*
- *The regulation of 24/7 emergency cover and 'under care' should involve a **formal agreement between vets and clients** that establishes the obligations and responsibilities of each.*

D.7. Theme 7: Veterinary provision

The statements which fall under the theme 'veterinary provision' discuss the provision of regulations around 24/7 care for the relief of pain and suffering. Agreement on this factor would indicate a vet agreed that the provision for 24/7 care for pain and suffering should be required irrespective of the business model.

- *Regulations should require **veterinary professionals to ensure that provision of 24/7 emergency service for the relief of pain and suffering is available** – either through their practice or via a specialist 24/7 provider irrespective of the nature of services/ treatments given.*
- *Regulations should **restrict certain business models where it can be shown to lead to inadequate or insufficient veterinary provision** and so negative impact on animal welfare and/or public health (e.g. leading to under-provision of accessible out-of-hours emergency cover for animals in some parts of the country).*
- ***A limited service provider** (i.e. a vet/practice that only provides services in a specific area of care, such as vaccinations or neutering) should only be required to **provide 24/7 emergency cover for the relief of pain and suffering arising out of the service they delivered** and can do this by providing this care themselves or having a formal arrangement in place with another veterinary practice (negative association).*

D.8. Theme 8: Animal responsibility

The statements which fall under the theme 'animal responsibility' discuss the vet's responsibility for the animal under care. Agreement on this factor would indicate a vet agreed that the responsibility for advice, POM-V and knowledge lies with the vet who takes the animal under their care.

- *An animal being under my care means **I am responsible for the advice** I give in relation to it.*
- *An animal being under my care means **I am responsible for all POM-V medications I prescribe** to an animal I am treating (and for how long, at what dose and in what combination).*
- *I would only accept an animal as being under my care if my **knowledge of the situation and the condition of the animal is good enough** to make the best and most competent decision possible regarding its well-being.*

D.9. Theme 9: Regulatory standards

The statements which fall under the theme 'regulatory standards' discuss the standards for which the regulations should take into consideration. This refers to minimum standards, standards to avert adverse impacts, quality and accountability. Agreement on this factor would indicate a vet agreed that the regulatory

standards should take into consideration the need for minimum standards, for establishing accountability and for standards of care.

- *The regulations for of 24/7 emergency cover and 'under care' should focus on* ***establishing the standards below which veterinary care should never fall,*** *rather than seeking to enforce anything beyond this.*
- *Regulations regarding 24/7 emergency cover and 'under care' should explicitly take into account that* ***vets from the same premises work*** *as a team and should have* ***shared accountability****.*
- *Regulations regarding 24/7 emergency cover and 'under care' should explicitly take into account that* ***vets will refer cases to specialists*** *with whom they should have* ***shared accountability.***
- *Regulations regarding 24/7 emergency cover and 'under care' should be* ***concerned only with the quality (i.e. reliability, recency and completeness) of the information*** *used to inform clinical judgements and not its source.*
- *Regulations should be framed to* ***mitigate any adverse impact resulting from a veterinary product or intervention****, regardless of the business model or the competitive environment in which the product or intervention is delivered.*

Exploring telemedicine / remote consultations using electronic health data

A report by the Small Animal Veterinary Surveillance Network for the Royal College of Veterinary Surgeons
October 2021

Beth Brant, Marisol Collins, Ivo Finns, PJ Noble and Alan Radford

Contents

Summary. **3**

Outline **4**

Module 1: a descriptive study of remote consultations (performed during lockdown) as compared with conventional face-to-face consultations (pre-lockdown) 5

Module 2: a focus on diseases to assess clinical outcome 8

Descriptive data analysis 9

Results part 1. **9**

Consultation date 9

Species 10

Age of consultations 10

Main presenting complaint 11

Immediate outcome 11

SAVSNET category 12

SAVSNET subcategories 13

Prescription products sold in teleconsultations (Tele) and face to face (F2F) controls at the level of *item family.* 15

Results part 2. **19**

Number of follow up visits in a 6-month period 20

Number of follow up visits in a 6-month period relating to the condition. 20

Outcome as recorded over six months 21

Treatments in the following six months. 21

Summary.

Based on reading some 1000 telemedicine consultations and 1000 controls face-to-face consultations (study part 1).

- Consultations with dogs were twice as frequent in this dataset as those with cats. Rabbits made up less than 2% of the final dataset (table 3).
- The age distribution of cats appeared broadly similar between cat cases and controls. However, for dogs, there was a trend towards dogs in older life making up a greater proportion of telemedicine cases (figure 3).
- In both dogs and cats, there was an increased tendency in telemedicine cases to either recommend a follow up teleconsultation or to see in practice if no improvement compared with face-to-face consultations, where "no further action" was the most common immediate outcome (figure 5).
- Considering teleconsultations with dogs, behaviour, digestive and musculoskeletal categories were somewhat over-represented compared to control consultations; whereas dental, integument and weight appeared to be under-recorded. For cats, behaviour and urinary categories appeared highest in teleconsultations, whereas dental disease and weight were clearly under-reported (figure 8).
- At the subcategory level, several conditions were less reported in telemedicine consultations including dental disease (gingivitis, plaque, stomatitis, fractured teeth), internal disease (otitis, tumours, murmurs, retained testicles), weight issues, corneal ulcers and deafness (table 4).
- In contrast, enteric signs (diarrhoea and vomiting), lameness including osteoarthritis, skin disease (pruritus, abscess, dermatitis), external masses, epilepsy, anxiety, cystitis, and urinary incontinence were recorded more frequently. Some of these may represent owner's increased time spent observing their pets during lockdown (table 4).
- With regard to prescriptions, there appeared to be an increased use of antimicrobials and anti-inflammatories in both cats and dogs during teleconsultations. In both species, changes in anti-inflammatory prescription were associated with the increased use of NSAIDs. Antimicrobial changes in cats were associated with a switch from cefovecin (n=13 face-to-face controls, n=2 telemedicine cases) to potentiated amoxycillin (n=5 controls, n=34 cases). An increase in neurological prescriptions in teleconsultations was associated in dogs with prescription of diazepam (n=0 controls, n=3 cases), anti-convulsants (n=0 controls, n=6 cases), and analgesics (n=17 controls, n=33) cases including gabapentin, paracetamol, tramadol and codeine.

Based on reading follow-on health records recorded in SAVSNET for 50 telemedicine consultations and 50 control face-to-face consultations for each of five conditions (upper respiratory, vomiting and/or diarrhoea, pruritus, lameness and ocular; study part 2).

- there appeared to be a slight tendency for telemedicine cases to have no related additional follow-up consultations over the subsequent six months (lameness, ocular, respiratory and vomiting and/or diarrhoea) (figure 12).
- In ~60% of the cases for these five selected conditions, it was unclear from subsequent records whether an individual case was resolved or not; this seemed consistent across the

five clinical categories (figure 13). Less frequently, a range of outcomes were explicitly recorded in the six-month follow-up period including ongoing disease, euthanasia and resolution. The pattern of these also appeared to be broadly similar between telemedicine cases and their controls.

Outline

During the COVID-19 pandemic, RCVS issued guidance on how veterinary practices should respond to UK government enhanced social distancing measures (commonly referred to as 'lockdown') to allow ongoing service provision at the national and devolved nation level.

Among guidance measures has been a temporary dispensation permitting the use of telemedicine and remote prescribing regulations to safeguard animal health and welfare and public health. At the time of writing, The RCVS standards committee has decided to end this dispensation on Sunday 21st November 2021, with scope to review in response to future changes in Government advice and policy[1].

In a series of six SAVSNET reports detailing the impact of the COVID-19 pandemic on companion animal practice in the UK in 2020, summary quantitative data from consultations between March 2020 and November 2020 showed an expected rise in remote consulting during the early national lockdown phase, with a gradual reduction in the latter phases of this timeframe, in line with the Government's COVID-19 recovery strategy and allied RCVS guidance[2].

While reported trends may have been affected by significant changes in practice workflow, and much has happened since, these changes may also reflect the gradual return to face-to-face consultations as the profession responded to regulations guiding the phased return towards near-normal operations.

This project was designed to better understand quantitatively and qualitatively how telemedicine consultations were carried out during periods of COVID-19 lockdown, and to explore in a descriptive way, how these might be different to consultations undertaken face-to-face. It made use of electronic health records collected by SAVSNET (the Small Animal Veterinary Surveillance Network), that collects consultation data in real time from a network of over 200 practices across the UK. Each consultation records includes information on the animals age, sex, species, breed, neuter status, treatments, and any free text written during the consultation. Each record is supplemented with a practitioner-derived syndrome label – we call this the Main Presenting Complaint (MPC), which identifies both sick animals (gastrointestinal, respiratory, tumour, trauma, other unwell), and vaccine consultations. In addition, a unique animal ID allows us to track individual animal consultations over time.

These data were used to support two modules of analysis. This report complements the Module 1 and Module 2 spreadsheet databases in Excel created as project outputs for further analysis. The approach to data-gathering through SAVSNET and salient descriptive findings are summarised.

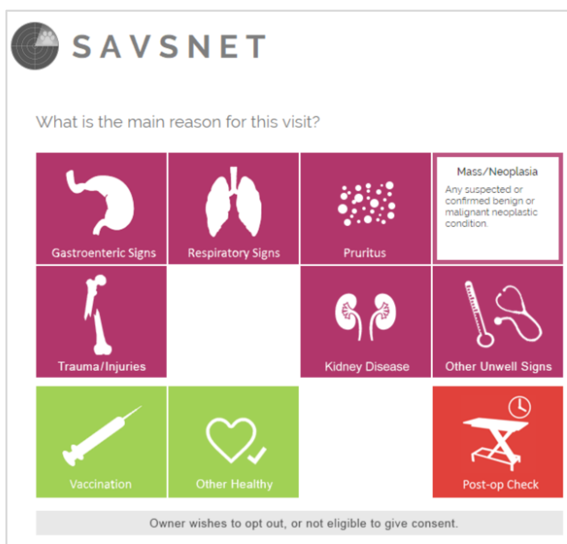
[1] https://www.rcvs.org.uk/news-and-views/news/standards-committee-agrees-to-end-remote-prescribing/

[2] https://www.liverpool.ac.uk/savsnet/covid-19-veterinary-practice-uk/

Module 1: a descriptive study of remote consultations (performed during lockdown) as compared with conventional face-to-face consultations (pre-lockdown)

SAVSNET consultations were first screened by text mining to identify those consultations where words like 'telemedicine' were mentioned. These were then read by a vet or vet nurse to identify a random sample that were true telemedicine consultations (this was necessary to avoid those consultations that, for example, talk about remote consultations happening in the past or the future). One thousand of these consultations, and 1000 random "control" consultations that were performed in 2019 before COVID-19 were read by a vet or vet nurse and categorised as follows

- Date of the consultation
- Patient signalment (age, sex, breed, neuter, microchip and insurance status)
- The SAVSNET MPC as chosen by the veterinary practitioner (as shown below).



- Treatments prescribed will be described at the level of pharmaceutical family such as antimicrobial (systemic and topical) and anti-inflammatory, and the classification of these treatments (POM-V, POM-VPS, CD).

Each consultation was additionally coded by the domain expert based on the clinical free text, to identify the main **categories** of conditions present. The categories used were adapted from those of the World Health Organisation ICD10[3], and based on a similar approach to that used for the RCVS vaccine project as follows: Euthanased, Auditory, Behaviour, Cardiopulmonary, Dental, Digestive, Endocrine, Immunological, Integumentary, Microchip, Musculoskeletal, Neoplasia, Neurological, Ocular, Parasites, Reproductive, Travel, Urinary, Weight, No Features Found, Other.

Table 1: World health organisation (WHO) category and adapted SAVSNET Category used to classify consultations.

WHO ICD10 CATEGORY		SAVSNET 19 ** CATEGORY	Definition
I	Certain infectious and parasitic diseases	PARASITES	Parasites seen or discussed
II	Neoplasms	TUMOUR / NEOPLASIA	n/a
III	blood and blood-forming organs and certain disorders involving the immune mechanism	IMMUNOLOGICAL	n/a
IV	Endocrine, nutritional and metabolic diseases	ENDOCRINE	eg diabetes, cushings, hyperT et
V	Mental and behavioural disorders	BEHAVIOUR	n/a
VI	nervous system	NERVOUS SYSTEM	Including knuckling
VII	eye and adnexa	OCULAR	Includes periocular skin eg entropion
VIII	ear and mastoid process	AUDITORY	Middle or inner
IX	circulatory system	CARSIORESPIRATORY	Coughing, sneezing, murmur, oedema
X	respiratory system		
XI	digestive system	DIGESTIVE	Excluding teeth and anal glands including from lips and tongue to anus
XII	skin and subcutaneous tissue	INTEGUMENT	Including otitis externa, nails and anal glands
XIII	musculoskeletal system and connective tissue	MUSCULOSKELETAL	eg OA, lameness
XIV	genitourinary system	URINARY	Infection, PU, incontinence
XV	Pregnancy, childbirth and the puerperium	REPRODUCTIVE	include discussions about neutering
XVI	Certain conditions originating in the perinatal period	OTHER	n/a
XVII	Congenital malformations, deformations and chromosomal abnormalities		
XVIII	Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified		
XIX	Injury, poisoning and certain other consequences of external causes		
XX	External causes of morbidity and mortality		
XXI	Factors influencing health status and contact with health services		
XXII	Codes for special purposes		
		WEIGHT	discussed
		TRAVEL	n/a
		MICROCHIP	checked or given
		DENTAL	n/a

[3] https://en.wikipedia.org/wiki/ICD-10

- The main subcategories of conditions present; these were built iteratively, and rather than basing them on pre-defined lists, were informed by the language of the practitioners recorded in the health narrative. This method ensures these subcategories best fit the data (see example in table 2).
- Whether the client was new or existing based on their visit history and clinical narrative
- Immediate outcomes based on what was written in the consultation, to include medication prescribed, advised to be seen in practice or no further action

Table 2; Clinician's text fragment and assigned subcategories for those consultations in the neurological category (**please note:** the text is as written in the health record and therefore includes abbreviations and spelling mistakes).

Text from clinical narrative	Case *	Subcategory
anisocoria	0	Anisocoria
noticed L pupil was more dilated than R this morning. Been fine in herself, a bit noiser than usual but has been like that since other cat passed away in March.	0	Anisocoria
Also worried may have had a (unwitnessed) seizure this morning as seemed wobbly	0	Ataxia / wobbly
still slightly wobbly/lower hindlimbs but otherwise fine	0	Ataxia / wobbly
Marked ataxia on back legs in consult, knuckling and obcious	0	Ataxia / wobbly
could be senile dementia type changes	1	Cognitive disfunction
canine dementia	1	Cognitive disfunction
hen collapsed on her side, seemed a bit stiff and ''kicked'' a bit her back legs.	1	Collapse
highly suspicous of CDRM givne breed and presentaiton	1	Degenerative myelopathy
epiphen	1	Epilepsy (monitor)
medication health check for epilepsy.	1	Epilepsy (monitor)
telecon to confirm zonisamide is within range,	1	Epilepsy (monitor)
Telephone consult to discuss Epilepsy meds.	1	Epilepsy (monitor)
telecon to explain epilepsy,	1	Epilepsy / seizures
fitting	1	Epilepsy / seizures
had a seizure this morning. legs thrashing. chomping on blanket. lasted about a minute	1	Epilepsy / seizures
SEIZURES	1	Epilepsy / seizures
seizures. 5 fits in last 36hours.	1	Epilepsy / seizures
all episodes last 30secs-1mins. adv not full tonic clonic seizure, ?partial seizure.	1	Epilepsy / seizures
Came back, vomited then showed involuntary neuro signs as before believed to be seizures.	1	Epilepsy / seizures
no seizure since Jul 2018, good QoL	1	Epilepsy / seizures
couple of minor seizures	1	Epilepsy / seizures
telecon with owner. no seizures overnight, <<identifier>> is brigth an dhappy this mroning.	1	Epilepsy / seizures
having daily partial seizures and monthly tonic clonic seizures.	1	Epilepsy / seizures
Possible seizure.	1	Epilepsy / seizures
Not had a cluster seizure since October	1	Epilepsy / seizures

owner reports fitting occasionally either once every 4-5 months	1	Epilepsy / seizures
Seizure	0	Epilepsy / seizures
had 2 seizures this am but nothing else since started meds reiterate possible brain lesion	0	Epilepsy / seizures
seizures appear under control but is due for another blood test but has not been fasted today as	0	Epilepsy / seizures (controlled)
face dropping	0	Facial paralysis
funny episodes	1	Funny episodes
Very weak in consult, head tilt to LHS, not holding weight well, doesn't correct limbs from abnormal placement.	0	Head tilt; knuckling
Head tilted to right - also dribbling from the right hand side.	1	Head tilt; ptyalism
flare-ups of presumed IVDD.	1	Intervertebral Disc Disease
This morning O also noticed him standing with L HL knuckled under him and he was just swaying w/o placing leg properly for abt 5 min-	0	Knuckling
lumbosacral dsicomfrot on palp. tail nad. ddx: msuculoskeletal discomfort, neurological.	0	Lumbosacral pain
Tremor.	1	Tremor / twitch
hard to completely Ddx recurrent mild ear prob from a neuro condition with twitching	1	Tremor / twitch
Will need physical exam to determine if issues is orthopaedic or neurological,	1	UNCLEAR
meds check - telephone consult	1	UNCLEAR
rpt presc phone consult	1	UNCLEAR
Re-check. He is better but this morning he had another episode of VS.	0	Vestibular syndrome
suspect Idiopathic old dog vestibular syndrome. Horizontal nystagmus.	0	Vestibular syndrome
loosing his balance -when jumps not as steady.	1	Ataxia / wobbly

** Case 1 = telemedicine consultation. Case 0 = telemedicine control.*

Identified remote consultations were partitioned into two time periods based on the date when RCVS remote prescribing guidance changed to look for changing patterns in remote consultations over time as follows. Time period 1 (1st April 2020 – 28th September 2020) Emergency work only - remote prescribe in the first instance. Time period 2 (29th September 2020 – 22nd March 2021); Wales lockdown easing starts. Essential work for public health and animal health and welfare; see animal under your care in the first instance.

Module 2: a focus on diseases to assess clinical outcome

Based on the findings of Module 1, and following discussion with the RCVS, five subcategories were identified to explore in more detail. Using the consultation records received by SAVSNET, for each of these five subcategories, 50 random cases (remote consultation) and 50 random controls (face-to-face consultation) were read and annotated by domain experts to identify, based on the six-month period following the selected consultation, the

- Number of visits in the six-month period
- Treatments prescribed
- Clinical outcome as recorded in the six-month period

- Time to resolution if resolution occurred in the six-month period

Descriptive data analysis

Descriptive data analyses were carried out using functions in EXCEL and are presented here. In addition, anonymised excel spreadsheets were supplied to RCVS to allow for additional further in-house analyses. Due to the low number of consults relating to other species, descriptive results here focus primarily on cats and dogs.

Results part 1.

On reading the selected 2000 consultations, a small number were removed from the final study data set that did not fit the inclusion criteria; for example, some of the 2019 control consultations were shown to be phone consultations, or the 2020 case consultations took place face-to-face: Accordingly, a final data set of 983 telemedicine cases and 904 controls were available for further analyses.

Consultation date.

All control consultations were selected randomly from 2019, before any COVID-19 restrictions, and case consultations selected randomly within the RCVS-stipulated time periods (figure 1). Case consultations were split into Time Period 1 (1st April 2020 – 28th September 2020) and Time Period 2 (29th September 2020 – 22nd March 2021) (figure 2).

Figure 1; Distribution of cases and controls over time.

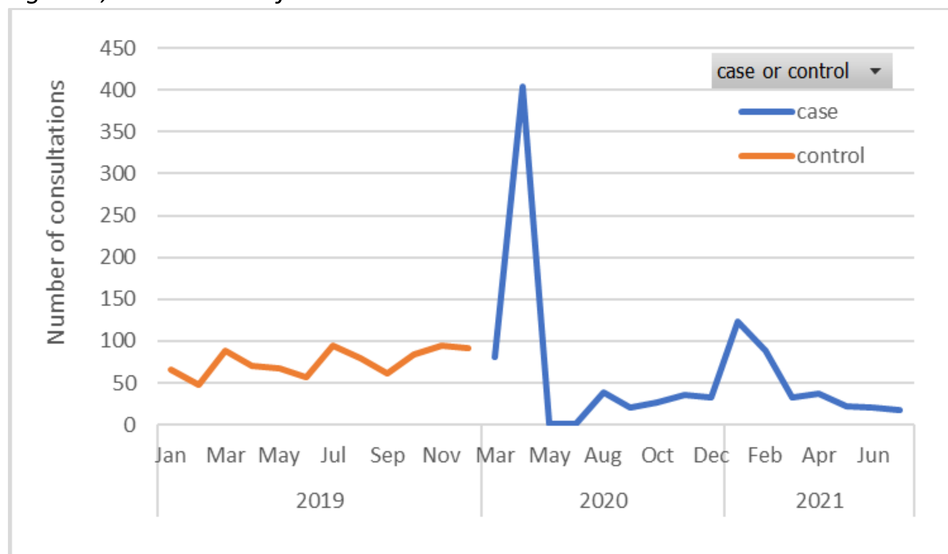
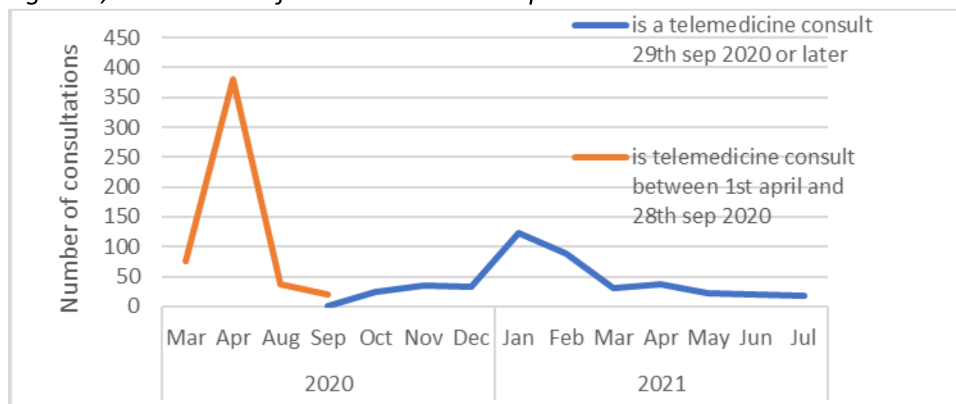


Figure 2; Distribution of cases into two time periods



Species.

As is typical of SAVSNET data, most data were from dogs, and cats, with a smaller number from other species (Table 3).

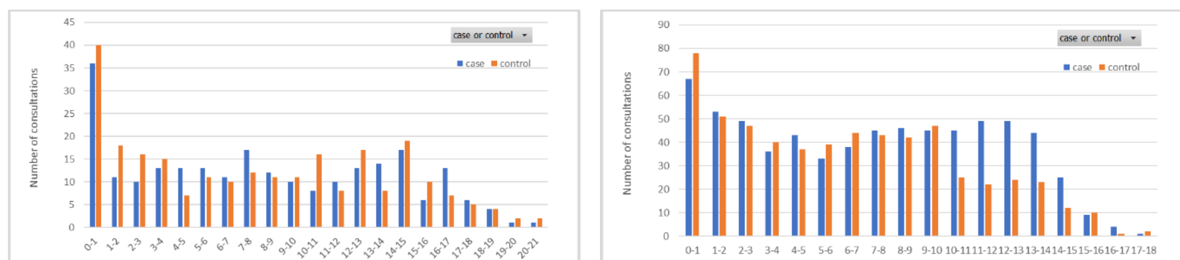
Table 3; species breakdown of telemedicine cases and face-to-face controls.

Species	**Telemedicine *cases***	**Face-to-face *controls***
dog	*681*	*587*
cat	*239*	*249*
Other species		
unknown	*42*	*40*
rabbit	*10*	*17*
hamster	*3*	*1*
guinea pig	*3*	*6*
rat	*2*	*2*
budgerigar	*1*	*1*
mouse	*1*	
duck	*1*	
bearded dragon		*1*
Grand Total	***983***	***904***

Age of consultations.

The age distribution of cats appeared broadly similar between cat cases and controls. However, for dogs, there was a trend towards dogs in older life making up a greater proportion of telemedicine cases (Fig.3)

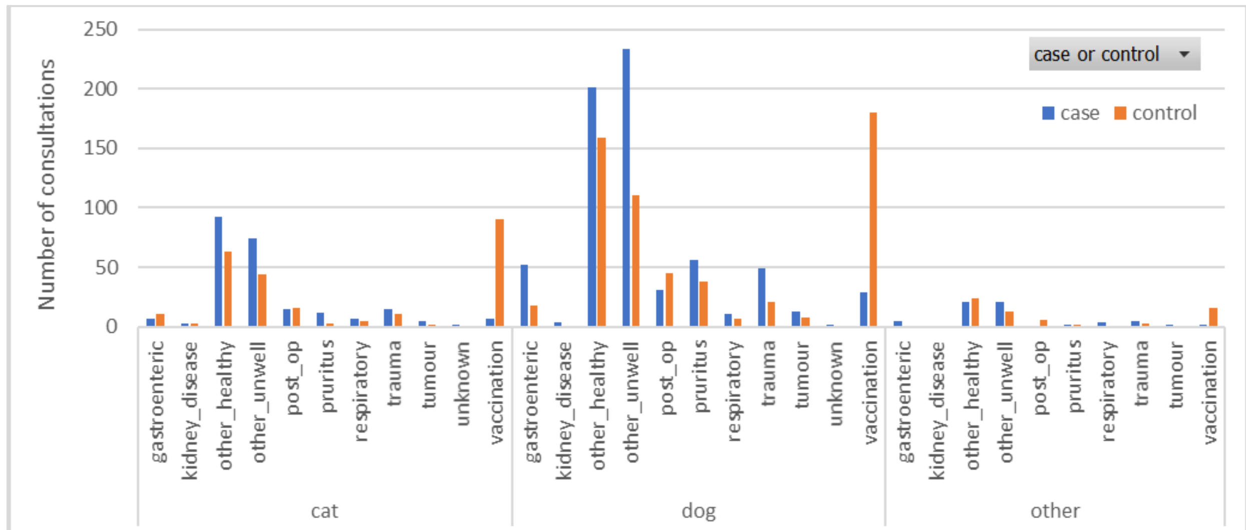
Figure 3; age distribution of cases and controls for cats (left) and dogs (right).



Main presenting complaint

Perhaps not surprisingly there appeared to be some difference between the practitioner recorded main presenting complaint (MPC) for cases (1) and controls (0). Vaccinations were more common in control consultations for both cats and dogs. NOTE: these vaccine consultations would be expected to reduce the proportion of the other MPCs in control consultation (Fig.4).

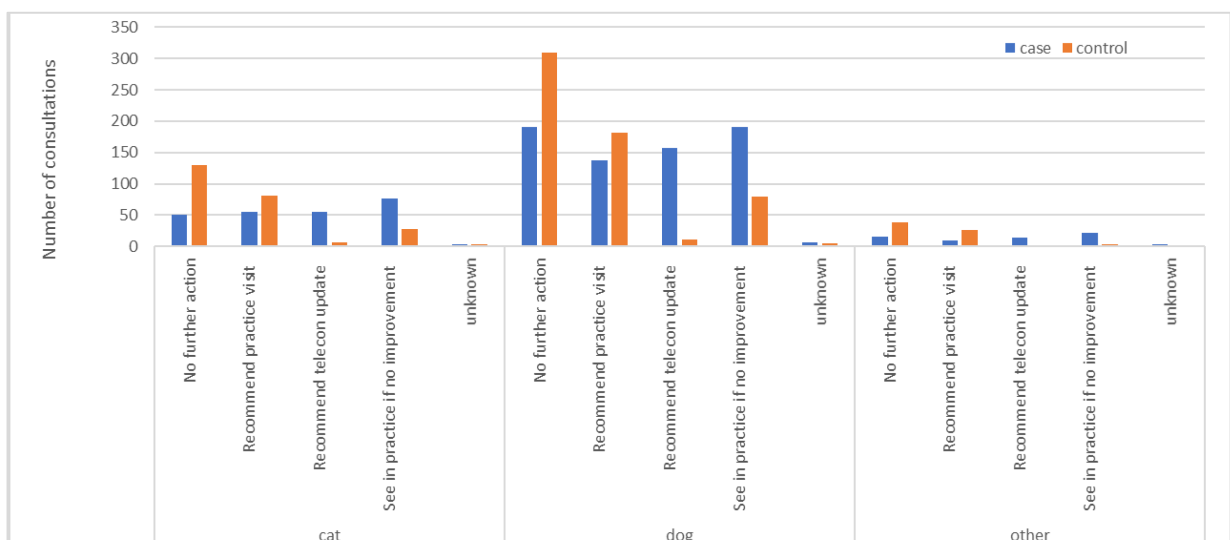
Figure 4; practitioner derived main presenting complaint (MPC) for cats, dogs and other species. Note – "other unwell" are consultations with those animals that don't fit into the specific sick animal categories (gastroenteric, kidney, pruritus, respiratory, trauma, tumour). "other healthy" consultations are those consultations with well animals apart from those involving vaccines.



Immediate outcome

Across all species there was an increased tendency in telemedicine cases (1) to either recommend a follow up teleconsultation or to see in practice if no improvement. For controls (0), "no further action" was the most common immediate outcome (Fig.5).

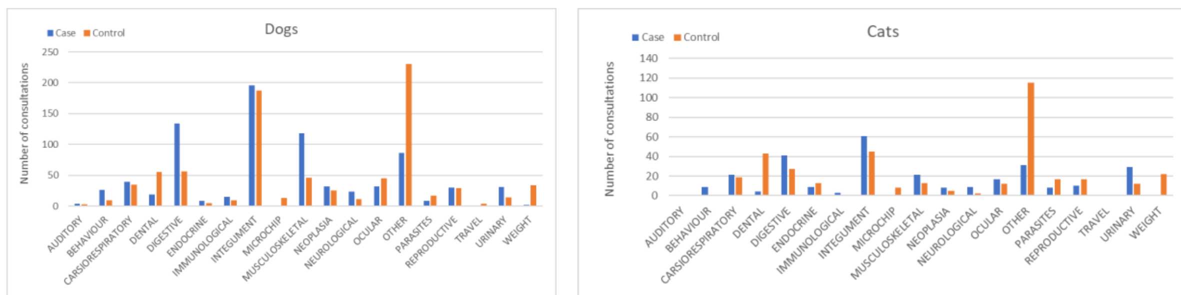
Figure 5; Number of consultations associated with immediate outcome categories on all species.



SAVSNET category

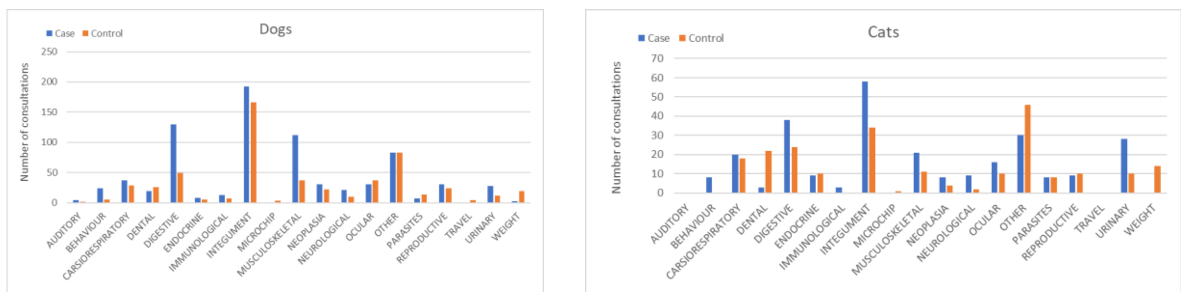
When considering all consultations, the largest SAVSNET category in both species was 'Other', largely because of those subcategories associated with vaccines (Fig.6). These included a wide range of sub-categories including euthanasia, post-op check and general health checks.

Figure 6; Number of SAVSNET categories for teleconsultation cases and face-to-face controls in cats and dogs ***(including the vaccine MPC).***



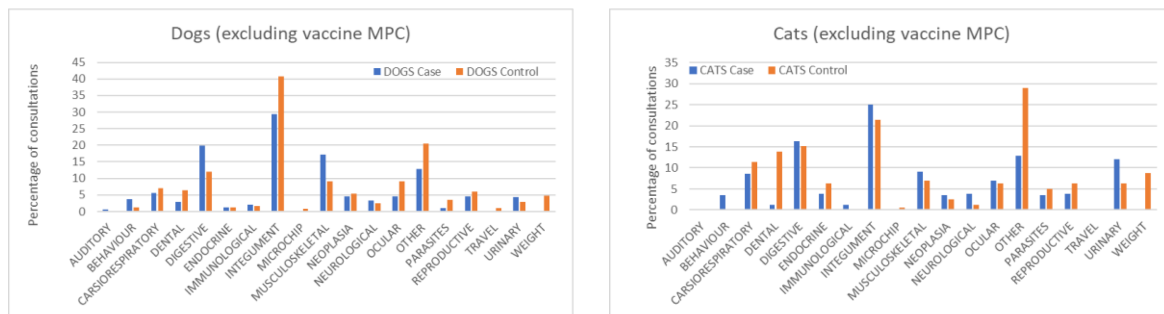
If those consultations categorised as the vaccine MPC are excluded, then for teleconsultations with dogs, behaviour, digestive, musculoskeletal and to a lesser extent urinary subcategories seem somewhat over-represented, whereas weight is under-recorded. For cats, behaviour, digestive, integument, musculoskeletal, urinary are somewhat over-represented in cases, whereas dental disease and weight are largely under-recorded (Fig.7).

Figure 7; Number of SAVSNET categories for teleconsultation cases and face-to-face controls in cats and dogs ***(excluding the vaccine MPC).***



These differences in categories for each species are perhaps clearest when the vaccine MPC is excluded, and they are expressed as percentages of consultations (figure 8). For dogs, behaviour, digestive and musculoskeletal categories are still high in cases, whereas dental, ocular, integument and weight are under-recorded compared to controls. For cats, behaviour and urinary categories are higher in cases, whereas dental disease and weight issues are clearly under-reported compared to controls. One might speculate that these behavioural and urinary categories (as a proxy for FLUTD) seen more in cat cases than controls, may reflect a lockdown-linked rise in stress responses from a change in routine as has been reported in the media.

Figure 8; Percentage of SAVSNET categories for teleconsultation cases and face-to-face controls in cats and dogs ***(excluding the vaccine MPC).***



SAVSNET subcategories

The subcategories making up each category can be seen in the accompanying Excel spreadsheet by navigating through the relevant red worksheet tabs seen at the bottom of the workbook.

In summary at the subcategory level, several conditions were less reported in telemedicine consultations including dental disease (gingivitis, plaque, stomatitis, fractured teeth), internal disease (otitis, tumours, murmurs, retained testicles), weight issues, corneal ulcers and deafness (table 4). In contrast, enteric signs (diarrhoea and vomiting), lameness (including osteoarthritis), skin disease (pruritus, abscess, dermatitis), external masses, epilepsy, anxiety, cystitis and urinary incontinence were recorded more frequently. Some of these may result from owners increased time spent observing their pets during lockdown (table 4).

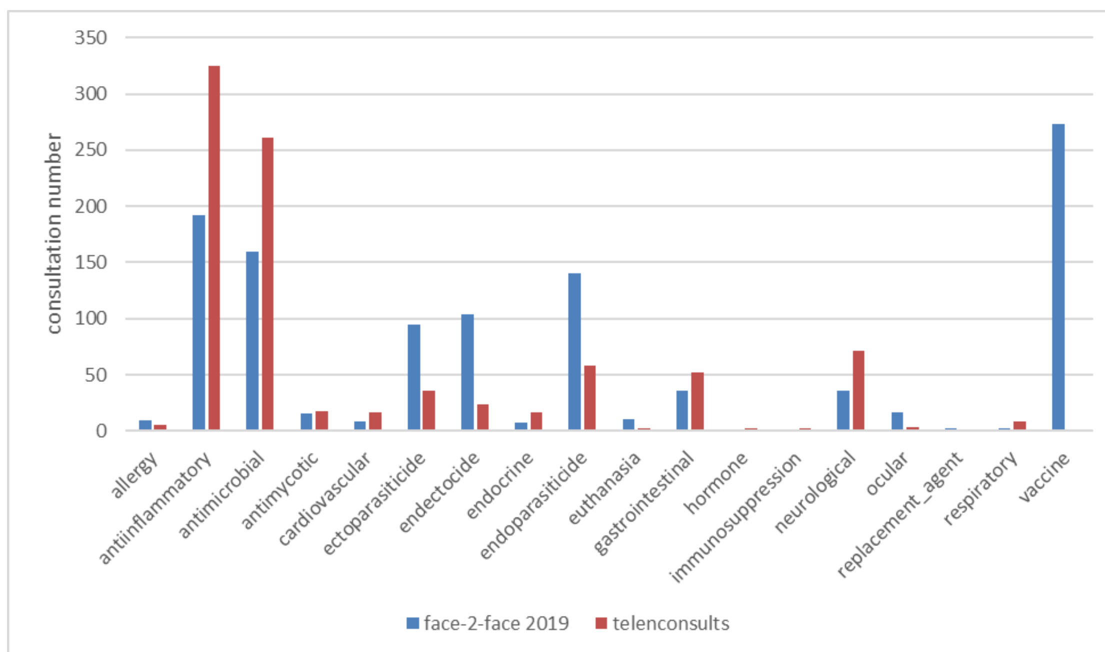
Table 4; A summary of some subcategories with apparent imbalances between teleconsultations and controls are shown below. NOTE- these are not meant to be all inclusive. All analysis is descriptive; inclusion here should not be taken to indicate statistical significance.

Sub-category	category	Tele-consult-ations	controls	bias
tartar / calculus	dental	1	32	decreased in teleconsultations
gingivitis and tartar / calculus	dental	0	11	decreased in teleconsultations
gingivitis	dental	4	15	decreased in teleconsultations
dental disease	dental	3	13	decreased in teleconsultations
tooth; fractured / chipped	dental	0	4	decreased in teleconsultations
Overweight	weight	0	19	decreased in teleconsultations
Anal gland (express)	integument	0	17	decreased in teleconsultations
Anal gland disease	integument	1	9	decreased in teleconsultations
Murmur	cardiopulmonary	0	15	decreased in teleconsultations
Nail (clipped)	integument	0	15	decreased in teleconsultations
Microchip placed	microchip	0	5	decreased in teleconsultations
Checked	microchip	0	15	decreased in teleconsultations
Fleas	parasites	2	12	decreased in teleconsultations
Corneal ulcer	ocular	0	7	decreased in teleconsultations
Epiphora	ocular	0	6	decreased in teleconsultations
Ears dirty	integument	0	6	decreased in teleconsultations
Mass (internal)	neoplasia	0	6	decreased in teleconsultations
Testicle(s) retained	reproductive	0	5	decreased in teleconsultations
Deaf (going)	auditory	0	2	decreased in teleconsultations
Patella luxation	musculoskeletal	0	4	decreased in teleconsultations
Cough	cardiopulmonary	24	15	increased in teleconsultations
diarrhoea	digestive	35	14	increased in teleconsultations
vomit and diarrhoea	digestive	15	6	increased in teleconsultations
diarrhoea (hematochezia)	digestive	14	0	increased in teleconsultations
Mass (external)	neoplasia	24	7	increased in teleconsultations
Osteoarthritis	musculoskeletal	17	7	increased in teleconsultations
Lameness	musculoskeletal	52	6	increased in teleconsultations
Urinary incontinence	urinary	10	4	increased in teleconsultations
Cystitis	urinary	8	2	increased in teleconsultations
Pruritus (ears)	integument	24	4	increased in teleconsultations
Skin disease	integument	13	3	increased in teleconsultations
Dermatitis (trunk)	integument	12	0	increased in teleconsultations
Pruritus (skin)	integument	18	0	increased in teleconsultations
Immune mediated skin disease	immunological	5	0	increased in teleconsultations
Abscess	integument	5	1	increased in teleconsultations
Abscess (cat bite)	integument	6	1	increased in teleconsultations
Epilepsy / seizures	neurological	13	2	increased in teleconsultations
Anxiety	behaviour	8	1	increased in teleconsultations
Lethargy	behaviour	5	0	increased in teleconsultations
Pseudopregnancy; suspect	reproductive	3	0	increased in teleconsultations

Prescription products sold in teleconsultations (Tele) and face to face (F2F) controls at the level of *item family.*

Clearly a large proportion of the face-to-face consultations analysed were associated with vaccines (figure 9). Parasiticide treatment was prescribed more commonly in face-to-face consultations. There appeared to be an increased use of antimicrobials and anti-inflammatories in both cats and dogs during teleconsultations. Note however, some of this effect is likely to be associated with the reduction in sick animals in face-to-face consultations because of the large number of vaccine consultations.

Figure 9; Number (y-axis) of prescriptions for each prescription family (x-axis) – all species.

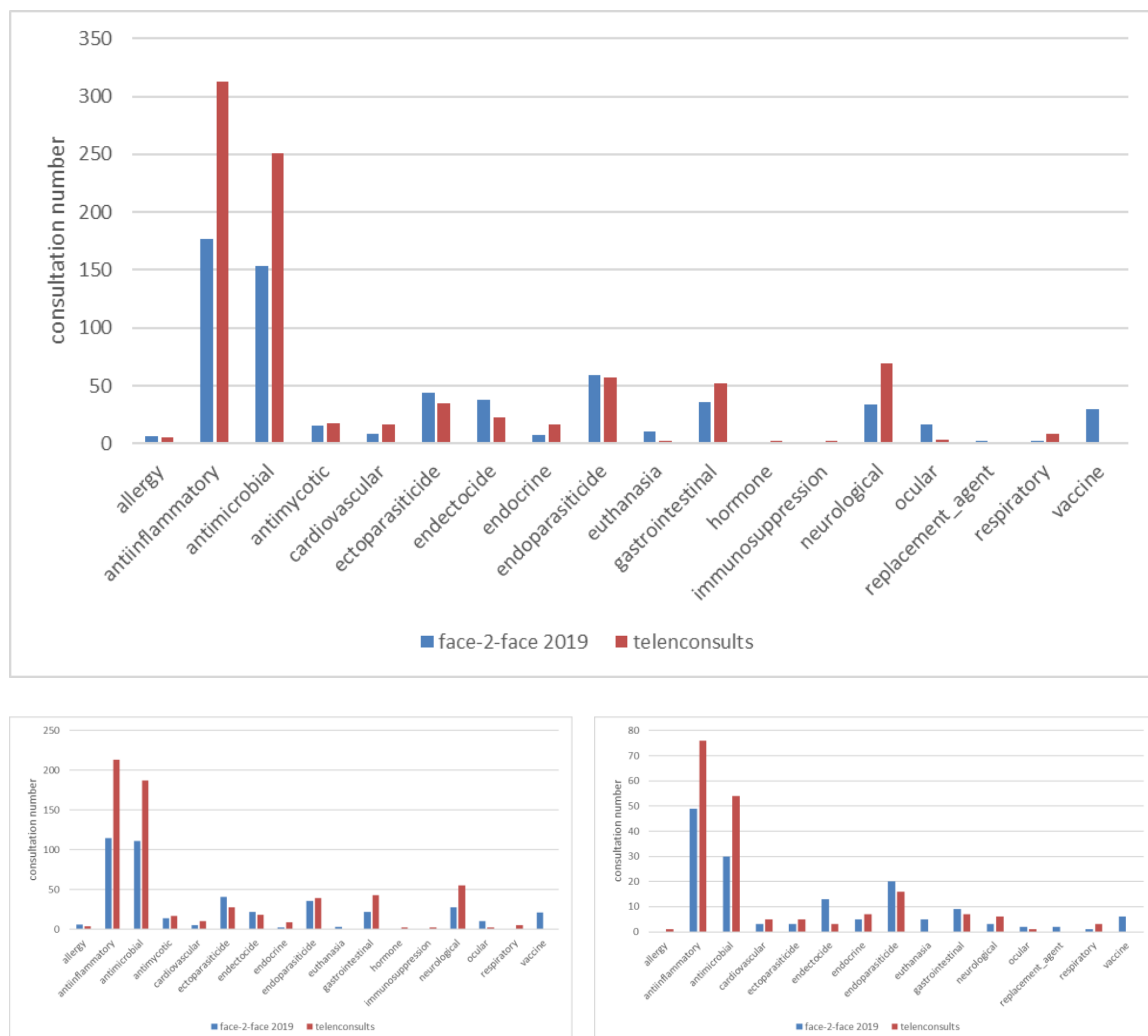


We therefore explored whether these observed differences in therapeutic use remained when vaccine consultations were excluded (figure 10).

The increase of parasiticides previously observed in face-2-face consultations was removed, suggesting their use was primarily associated with vaccine consultations.

However, there still appears to be an increased use of antimicrobials and anti-inflammatories in both cats and dogs during teleconsultations. In both species, anti-inflammatory changes were associated with the increased use of NSAIDs. Notable differences in the use of antimicrobials in cats were with cefovecin (n=13 controls, n=2 teleconsults) and potentiated amoxycillin (n=5 controls, n=34 teleconsults).

*Figure 10; Number (y-axis) of prescriptions for each prescription family (x-axis). The charts below **exclude vaccine MPC consultations**. Top – all species, Bottom left dog only, bottom right cat only.*



Differences noted in the prescription of products for neurological conditions between cases and controls relate to diazepam (n=0 controls, n=3 teleconsults), anti-convulsants (n=0 controls, n=6 teleconsults) and analgesics (n=17 controls, n=33 teleconsults), the latter including gabapentin, paracetamol, tramadol and codeine.

Table 5; Prescription products sold in teleconsultations (Tele) and face to face (F2F) controls at the level of item family. All species. Column 2 and 3 includes all consultation regardless of main presenting complaint (MPC). Columns 3 and 4 excludes vaccine MPC consultations.

Prescription Family and Class	All main presenting complaints (MPC)		Excluding vaccine main presenting complaint	
	F2F	Tele	F2F	Tele
allergy	9	5	6	5
antihistamine	6	5	4	5
immunotherapy	3		2	
antiinflammatory	192	325	177	313
disease_modifying_osteoarthritis_drug	4		3	
glucocorticoid	67	92	64	92
janus1_selective_inhibitor	9	38	8	37
nsaid	107	195	97	184
ocular	5		5	
antimicrobial	160	261	154	251
aminoglycoside	9	8	9	8
amphenicol	19	5	17	5
antim_other	22	33	22	32
beta_lactam	70	127	66	122
fluoroquinolone	6	6	6	6
fusidic_acid	20	45	20	42
lincosamide	5	9	5	8
nitroimidazole	8	20	8	20
nitroimidazole_macrolide		2		2
sulphonamide		1		1
tetracycline	1	5	1	5
antimycotic	15	18	15	18
azole	13	18	13	18
polyene	2		2	
cardiovascular	8	16	8	16
anti_coagulant		1		1
anti_hypertensive	4	6	4	6
cardiovascular		2		2
diuretic	2	4	2	4
positive_inotrope	2	3	2	3
ectoparasiticide	95	36	44	35
ecto_other		1		1
insect_growth_regulator	1	2	1	2
isoxazoline	32	10	19	10
neonicotinoid	61	21	23	20
phenylpyrazole	1	2	1	2
endectocide	104	24	38	23
macrocyclic_lactone	104	24	38	23
endocrine	7	17	7	17
adrenal	1		1	
diabetes_melitus	1		1	
pituitary_adrenal		3		3
thyroid	5	14	5	14
endoparasiticide	140	58	59	57
anthelmintic	16	11	8	11
antiplatyhelminthic	122	43	49	42
antiprotozoal	2	4	2	4

euthanasia	10	2	10	2
euthanasia	10	2	10	2
gastrointestinal	36	52	36	52
anti_emetic	36	50	36	50
poison		1		1
pro_kinetic		1		1
hormone	1	2	1	2
urinary_incontinence	1	2	1	2
immunosuppression	1	2		2
intracellular	1	2		2
neurological	36	71	34	69
anaesthesia	4	3	4	3
analgesic	22	47	20	46
anti_convulsant		7		6
anti_spasmodic	2	2	2	2
anxiolytic	1		1	
behavioural	1	2	1	2
local_anaesthetic	3	1	3	1
muscle_relaxant		4		4
reversal_agent	1		1	
sedative	2		2	
urinary_incontinence		5		5
ocular	17	3	16	3
fluorescein	16	3	15	3
lubricant	1		1	
replacement_agent	2		2	
vitamin_b	2		2	
respiratory	2	8	2	8
bronchodilator		1		1
methylxanthine	1	2	1	2
mucolytic	1	5	1	5
vaccine	273	1	30	
Grand Total	1108	901	639	873

Results part 2.

Five broad clinical categories were selected by the RCVS based on the results of part 1 of this study (upper respiratory; vomiting and/or diarrhoea; pruritus; lameness and ocular) to take forward into an outcome analysis, to explore to what extent outcomes based on SAVSNET measures varied between telemedicine cases and face-to-face controls.

For each of the five broad clinical categories, 50 cases and 50 controls were selected on the basis of matching a subset of relevant subcategories (table 6). Where numbers were sufficient, these were obtained from a random selection of those consultations classified in part 1 of this study. For those conditions that were more common in telemedicine cases, where there were insufficient controls in part 1 of the study (pruritus and lameness), these were supplemented from the same time period (2019). These additional controls were identified by a simple regular expression, and verified by a domain expert (table 6, bottom row).

Table 6; Origin of consultations (50 cases and 50 controls), for use in part 2 of this study.

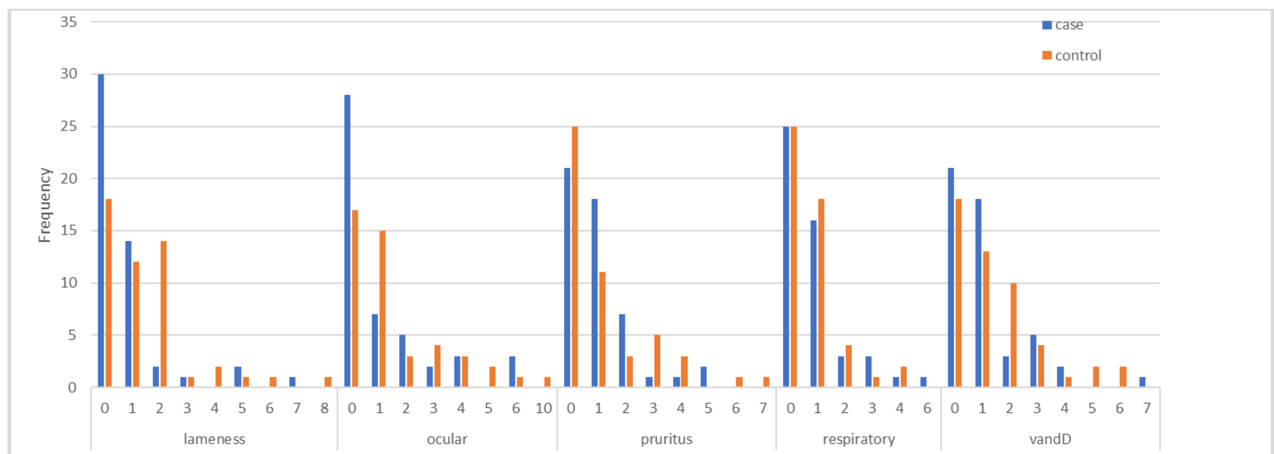
	Upper respiratory	Vomiting and / or diarrhoea	Pruritus	Lameness	Ocular
Subset of existing sub-categories used for part 2 of the study	• Bronchitis • Cough • Cough; collapsing trachea • Cough; nasal discharge • Cough; panting • Cough; sneezing • Feline Respiratory Disease Complex • Nasal discharge • Respiratory crackles • Respiratory disease (non-specific) • Respiratory infection • Sneezing • Sneezing; nasal discharge • Snuffles	• diarrhoea • diarrhoea (?giardia) • diarrhoea (hematochezia) • diarrhoea (iatrogenic) • diarrhoea (improved) • diarrhoea (intermittent) • diarrhoea with blood • diarrhoea; hyporexia • diarrhoea; rectal bleed • hematochezia • vomit • vomit (hematemesis) • vomit (improved) • vomit and diarrhoea • vomit and diarrhoea (hematochezia) • vomit; lethargy • vomit; melaena (suspected) • vomit; retching • vomit; tenesmus • vomiting (improved) • vomiting; anorexia	• Pruritus • Pruritus (anal sac; pedal) • Pruritus (controlled) • Pruritus (ears) • Pruritus (head) • Pruritus (imroved) • Pruritus (leg) • Pruritus (limb) • Pruritus (pedal) • Pruritus (perianal) • Pruritus (skin) • Pruritus (skin/ears) • Pruritus (skin;pedal) • Pruritus (trunk) • Pruritus (trunk;ears)	• Lameness • Lameness (improved) • Lameness (resolved) • Lameness, soft tissue injury • Lameness, stiffness	Random set of all cases and controls from part 1
Regex used to supplement controls	Not necessary – sufficient controls available from part 1	Not necessary – sufficient controls available from part 1	(?<!not\s)(?<!non\s)(?<!non-)(?<!aren't\s)(?<!no longer\s)pruritic	(?<!no\s)(?<!not\s)(?<!inf)(?<!c)(?<!was\s)lame	Not necessary – sufficient controls available from part 1

For each case and control, patients were followed through the SAVSNET database to determine the number of follow up visits in a 6-month period, the number of visits relating to the condition, the outcome as recorded over six months, the time to resolution (where specified in the narrative), and treatments prescribed. It should be noted that SAVSNET only collects data from booked consultations where owners do not opt out – it is therefore likely that for some patients, the number of visits may be an underestimate of the actual total number of visits. That said, a comparison between cases and controls still seems valid.

Number of follow up visits in a 6-month period

There seemed to be a slight skew for lameness and ocular telemedicine cases to have no further consultations compared to controls (figure 11).

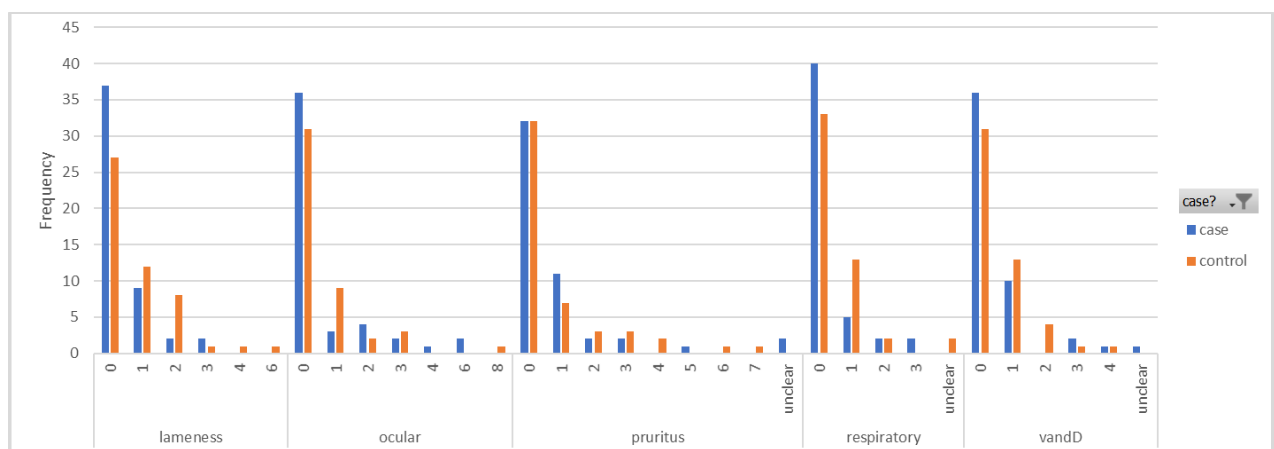
Figure 11; number of consultations occurring over the following six months for teleconference consultations and face-to-face controls.



Number of follow up visits in a 6-month period relating to the condition.

When only consultations relating to the selected case were counted in the proceeding six months, there remained a similar albeit less obvious tendency for telemedicine cases to have no additional follow up (lameness, ocular, respiratory and vomiting and / or diarrhoea) (figure 12).

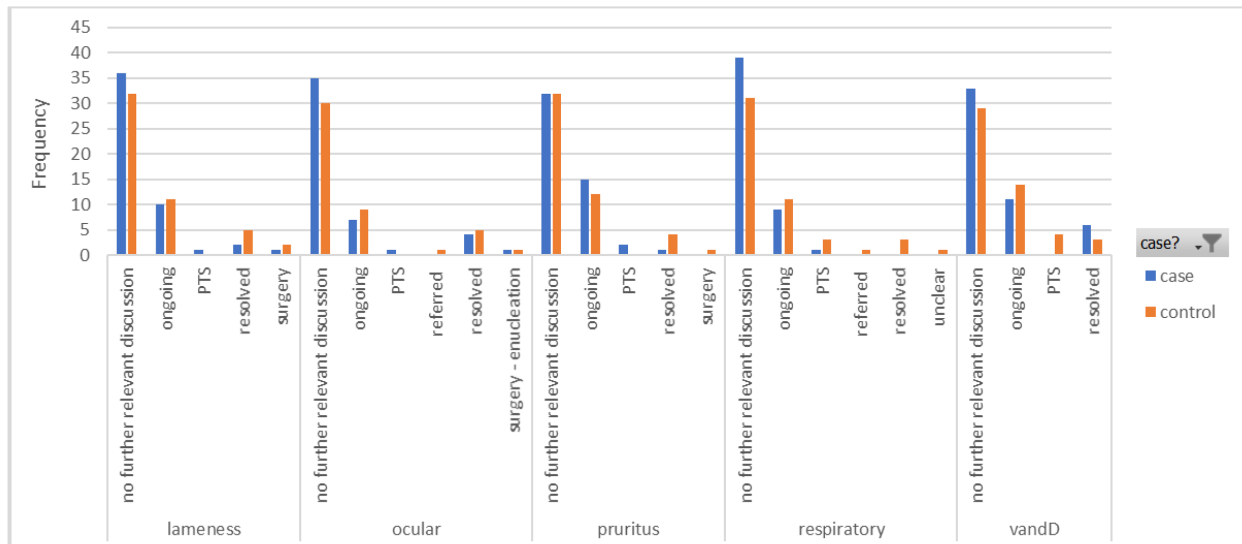
Figure 12; number of related consultations occurring over the following six months.



Outcome as recorded over six months

In the majority of cases (~60% of those read), it was not clear over the proceeding records whether the an individual case was resolved or not (based on no further relevant discussion of the condition of interest); this seemed consistent across the five clinical categories (figure 13). Less frequently, a range of outcomes were explicitly recorded in the six-month follow-up period including ongoing disease, PTS, resolution. The pattern of these also appeared to be broadly similar between telemedicine cases and their controls.

Figure 13; Frequency of outcomes recorded in the following six-month narratives.



Treatments in the following six months.

Treatments most commonly prescribed in the six months following the initial consultation of interest are described in table 6 for species and clinical categories.

It is important to note that not all the treatments prescribed to an animal during consultations in this period may relate to the condition central to the consultation of interest. For example, concurrent treatments for co-morbidities or for subsequent new and unrelated conditions. This is likely to be particular true where the initial presentation was for a more acute and self-limiting disease.

Still, it is interesting to note differences, such as the preference towards injectable treatments (methylprednisolone and cefovecin) in cats attending face-to-face control consultations for pruritus and upper respiratory complaints compared to telemedicine consults for the same conditions. The frequent use of meloxicam in the respiratory category in both species may subjectively suggest a suspicion of Kennel Cough / cat flu, where it might be used to reduce upper respiratory inflammation.

Table 7; most frequent treatments used in the following six months (n in brackets).

Condition	Case or control	Cat	Dog
lameness	case	meloxicam (5)	meloxicam (25)
	control	meloxicam (9)	meloxicam (25)
ocular	case	fusidic acid (7)	fusidic acid (15)
	control	selamectin / robenacoxib / meloxicam / vaccine / praziquantel / clindamycin (2 each)	fluorescein sodium (14)
pruritus	case	prednisolone (5)	oclacitinib (16)
	control	methylprednisolone (5)	prednisolone (19)
respiratory	case	meloxicam (11)	meloxicam (8)
	control	cefovecin (7)	meloxicam (16)
V and/or D	case	meloxicam (4)	omeprazole / praziquantel (10 each)
	control	praziquantel (7)	vaccine / maropitant (10 each)

This work would not have been possible without the data submitted by participating veterinary practices. We are grateful for their involvment in SAVSNET.

We hope this report is a useful aid to your discussions Should you have any questions, please contact us and we would be happy to help.

SAVSNET
Tel: 0151 795 6080
Email: savsnet@liverpool.ac.uk
Social media: @savsnet

RCVS VETCOMPASS EQUINE PANDEMIC PROJECT

DR S ALLEN, DR D O'NEILL, DR J CARDWELL, PROF K VERHEYEN, PROF D BRODBELT
VETERINARY EPIDEMIOLOGY, ECONOMICS AND PUBLIC HEALTH GROUP
DEPARTMENT OF PATHOBIOLOGY AND POPULATION SCIENCES
ROYAL VETERINARY COLLEGE

EXECUTIVE SUMMARY **June 2022**

The COVID-19 pandemic posed considerable challenges for the profession. Changes to normal working practices were needed to provide essential services, whilst safeguarding human health. This study explores the impact of the pandemic on equine veterinary care in the UK. The study describes equine veterinary activity in the 12-months immediately prior to and following the introduction of the first lockdown and reviews care in two periods during maximal COVID-19 restrictions and the same periods pre-pandemic. The specific objectives were to:

- Describe 12 months of equine veterinary activity during (23/03/2020–22/03/2021) and before (23/03/2019–22/03/2020) the pandemic for the entire study population.
- Review in detail, in a random sample, equine veterinary care for two two-month periods when maximum COVID-19 restrictions were enforced (23/03/2020–22/05/2020 and 05/11/20-04/01/2021) and the corresponding periods in the pre-pandemic year.

The study population included equids under the active care of 20 UK mixed and equine veterinary practices participating within VetCompass. The total number of equids and care episodes were reported per month. Proportional measures of activity and face-to-face activity were calculated. Wilcoxon signed rank tests were used to compare activity in the pre-pandemic and pandemic year. Details of all care episodes provided to random samples of 1,000 equids in four, two-month periods of interest were extracted. Nature of care (face-to-face or non-face-to-face), episode type (routine or problem) and clinical indications were described by number and expressed as a proportion of corresponding episodes or indications, with 95% confidence intervals.

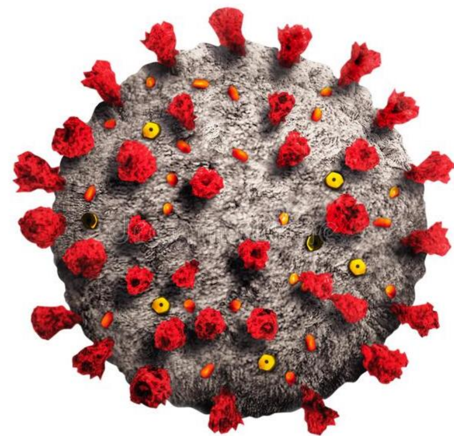
During the two-year study period, 236,997 care episodes were provided to 46,095 equids. The greatest disruption to veterinary activity was observed in the early pandemic. In the month following the introduction of the first national lockdown, compared to pre-pandemic, there was a 39% and 43% decrease in the numbers of equids under active care and episodes of care, respectively. In the first pandemic period, proportional activity fell by a median of 10.7% and proportional face-to-face activity by a median of 20.2% per practice compared to the corresponding pre-pandemic period. Consistent with professional guidance, there was a decrease in the proportion of care episodes attributable to vaccination and routine dental work. Whilst there was no difference in systemic antimicrobial prescription, there was an increase in the proportion of clinical care episodes where non-steroidal anti-inflammatory drugs were prescribed in the early pandemic compared to the early pre-pandemic period. By June 2020, absolute and proportional measures of veterinary activity had returned towards near normal levels. Subsequent tightening of COVID-19 restrictions had little effect on equine veterinary care.

Throughout the pandemic, veterinary professionals have acted in a manner that not only protected human health but ensured animal health or welfare were not compromised. In addition to the measures described above, within the EPRs there was evidence of veterinarians conducting COVID-19 risk assessments prior to attendance and recommending non-urgent work be delayed. In addition, the clinical narrative often stated that social distancing was maintained, and personal protective equipment worn during physical examinations.

Equine veterinary care was adversely affected in the early pandemic, however, disruption to services was short-lived. Throughout this challenging time, the profession demonstrated their ability to implement COVID-19 risk-mitigating working practices and maintain vital veterinary services.

Royal Veterinary College
University of London

Impact of COVID-19 on Equine Veterinary Care in the UK



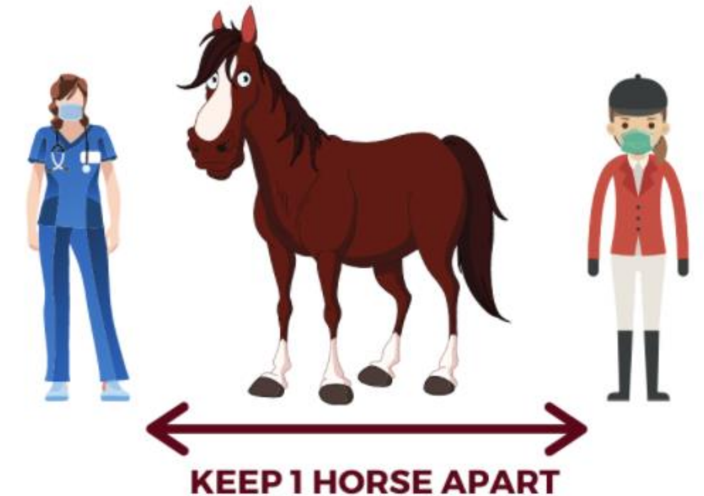
Sarah Allen, Dan O'Neill, Jackie Cardwell, Kristien Verheyen & Dave Brodbelt

Project Summary June 2022

Project Summary

Background

- COVID-19 pandemic poses an unprecedented challenge
- Changes to normal working practices
  - Social distancing, illness, self-isolation, furlough
- Potential for negative impact on animal health
  - Reduced health-seeking behaviour
  - Delays in diagnosis and treatment



Objectives

- Describe the nature of equine veterinary activity before (23 March 2019 to 22 March 2020) and during the pandemic (23 March 2020 to 22 March 2021)
  - Equid and care episode numbers
  - Estimation of face-to-face activity
- Detailed review of equine veterinary activity in periods of interest

RVC

VetCompass
Your Knowledge Hub

Materials and Methods: Objective 1

- **Study Population**
  - All equids under the active care of 20 UK mixed and equine veterinary practice, participating in VetCompass, during the two-year study period
- **Care Episodes**
  - Uniquely dated entries identified
  - Semi-automated classification of nature of care
- **Descriptive Statistics**
  - Number of equids and care episodes per month
  - Monthly and period
    - Activity
    - Proportional face-to-face activity
  - Wilcoxon signed rank tests

RVC

VetCompass
Your Knowledge Hub

Materials and Methods: Objective 2

- **Sample populations**
  - Simple random sample of 1,000 equids under active care
    - Early and late pre-pandemic (23 Mar to 22 May 2019, 5 Nov 2019 to 4 Jan 2020)
    - Early and late pandemic (23 Mar to 22 May 2020, 5 Nov 2020 to 4 Jan 2021)

- **Description**
  - Demography
  - Care episodes
    - Nature (face-to-face v non-face-to-face) and type (routine or problem)
  - Immediate management and treatments
  - Nature of subsequent care episodes
  - Indications
    - Nature and type
    - Problem by indications by top-level disorder group and diagnosis

Illustration/Jarom Vogel

Collaborating Practices

Practice Type

Equine only = 5
Mixed with dedicated equine department = 5
Mixed without dedicated equine department = 10

RCVS Accreditation Status

Equine hospital = 4
General equine practice = 5
Core standards = 5
None = 6

Practice Size (Equid Numbers)

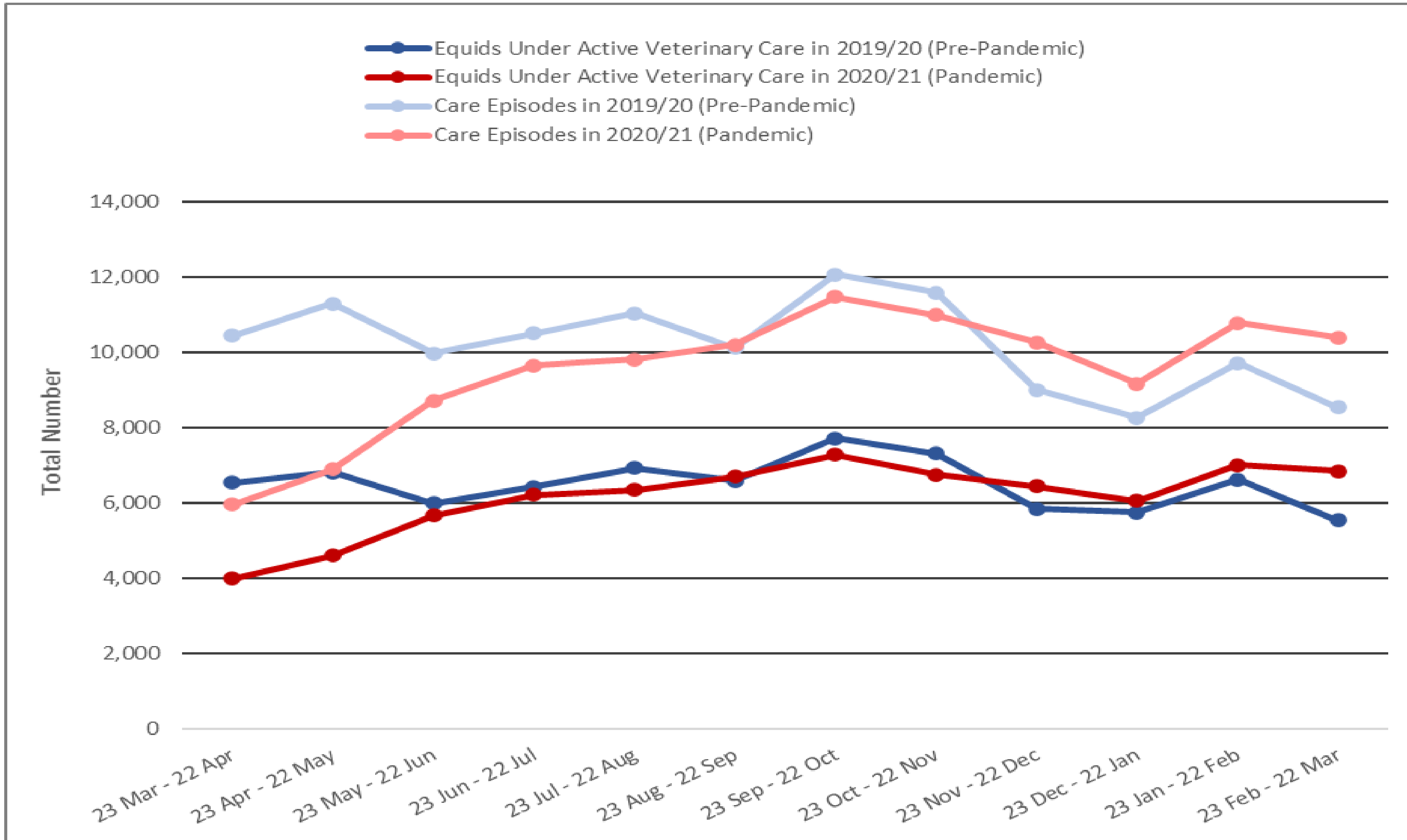
Median = 1,794
IQR: 512-3,744, range 202-8,203

Location

RVC

VetCompass
Your Knowledge Hub

Equid and Care Episode Numbers



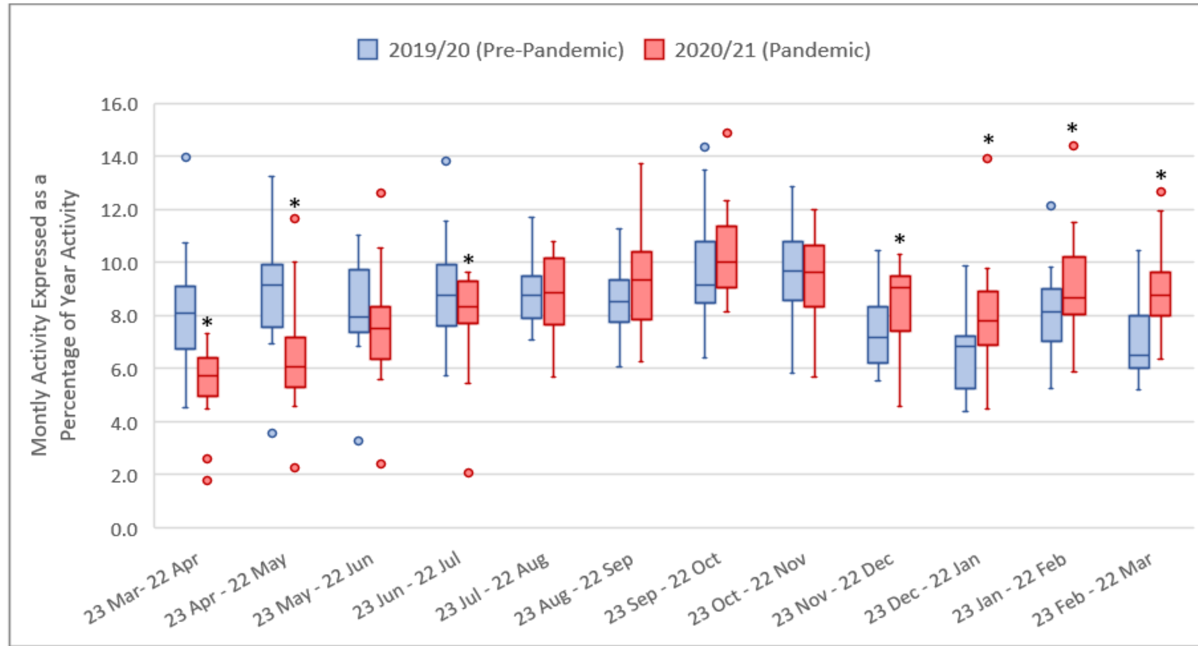
Study Population
46,095

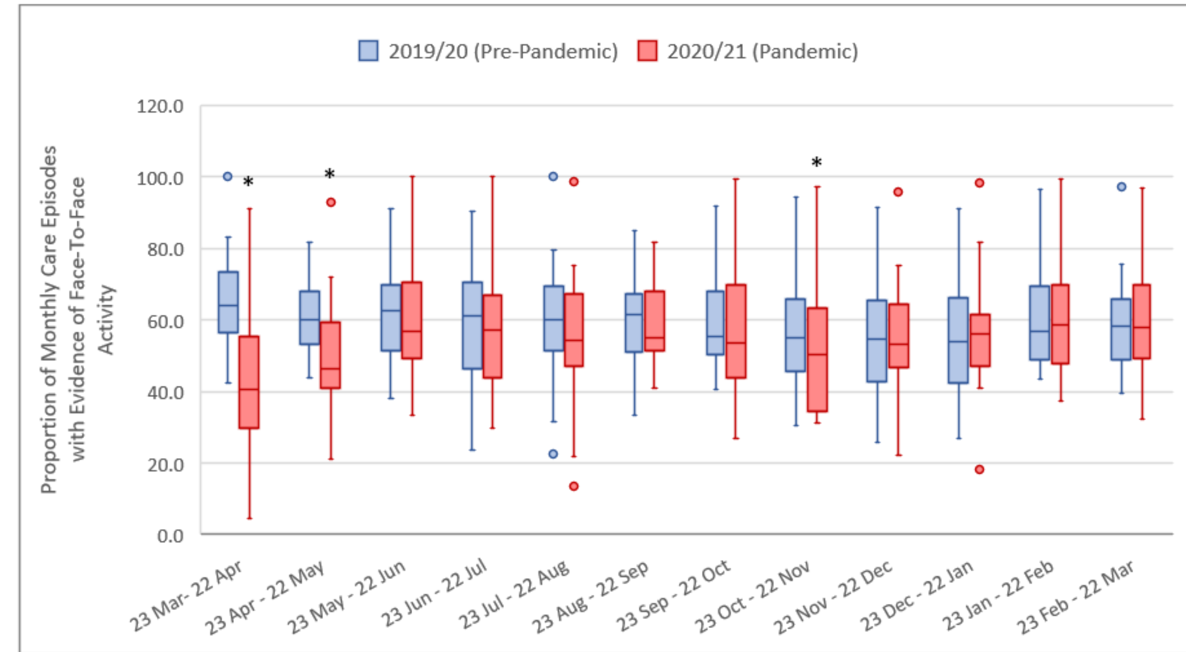
Total Care Episodes
236,997

RVC

VetCompass
Your Knowledge Hub

Monthly Activity





Decreased activity

- 23 Mar to 22 Apr
- 23 Apr to 22 May
- 23 Jun to 22 Jul

Increased activity

- 23 Nov to 22 Mar

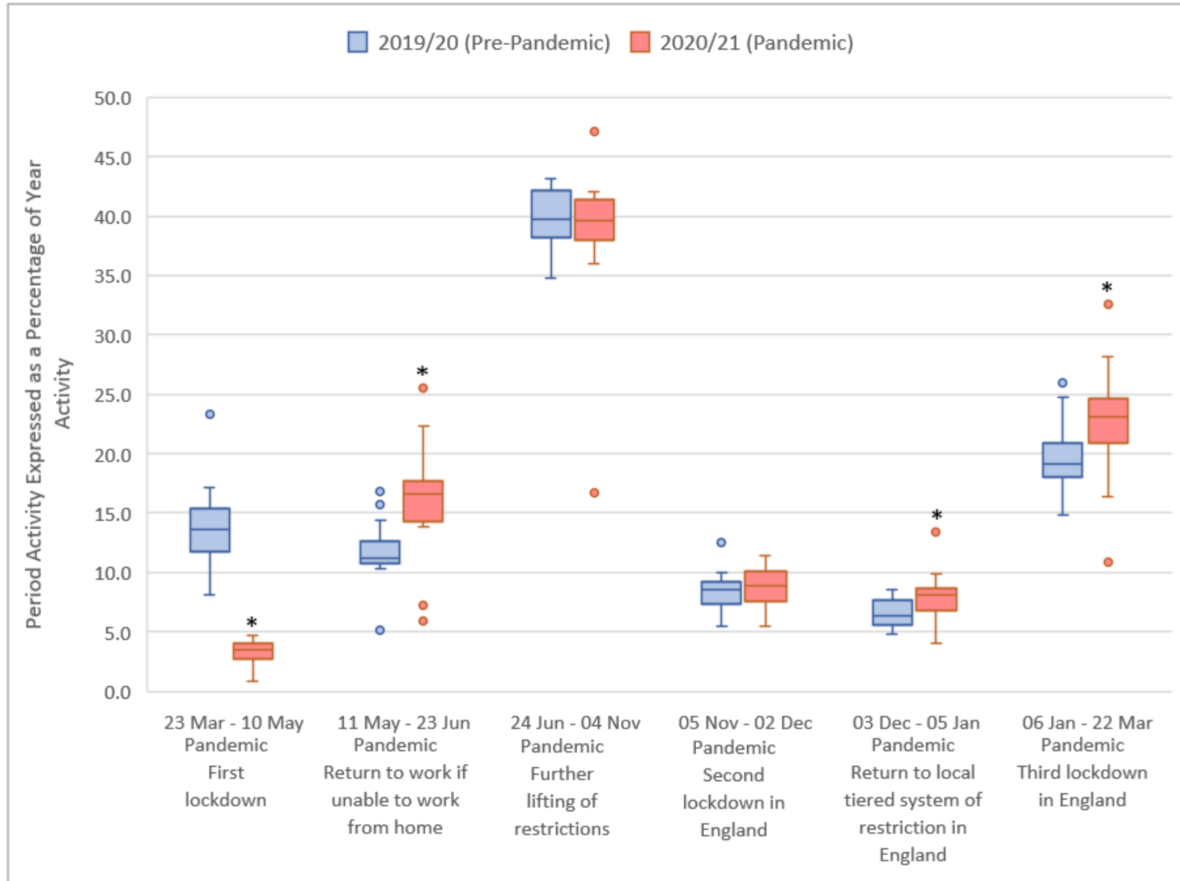
Decreased face-to-face activity

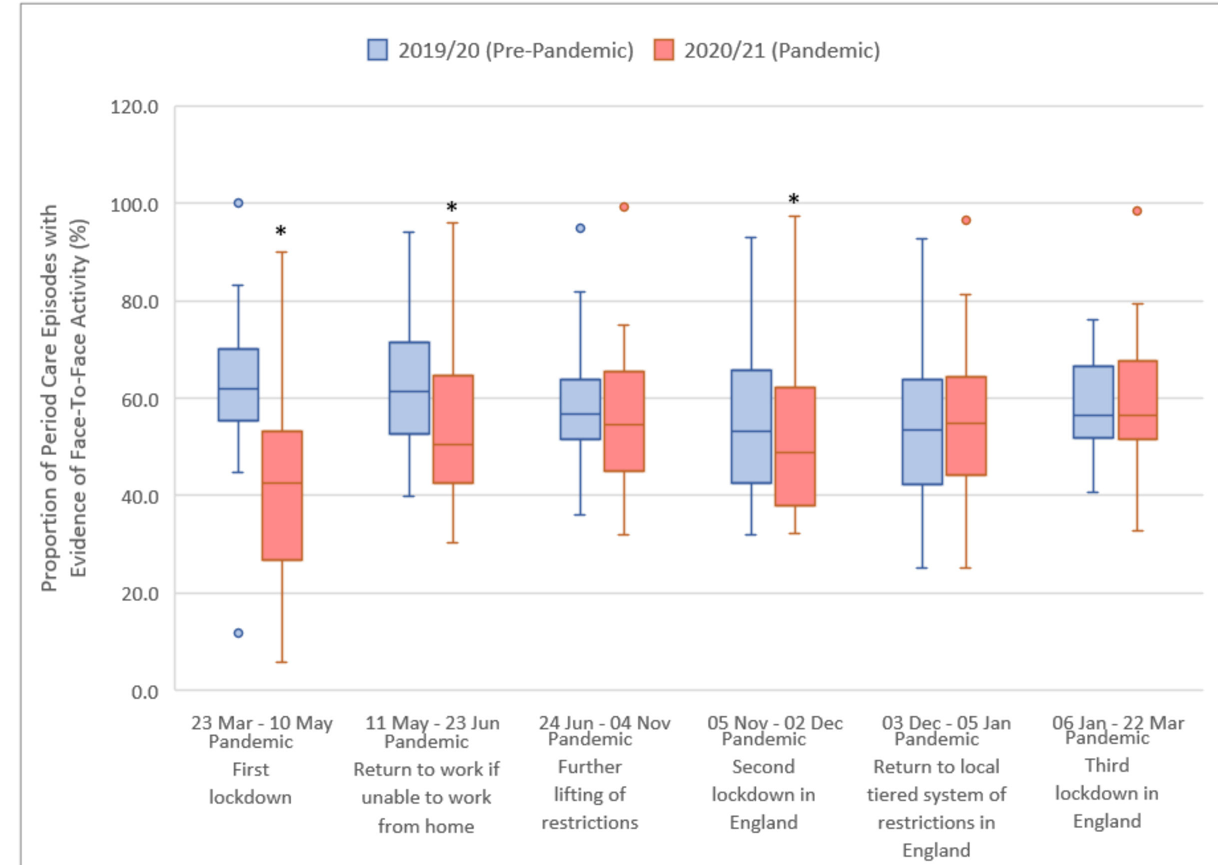
- 23 Mar to 22 Apr
- 23 Apr to 22 May
- 23 Oct to 22 Nov

RVC

VetCompass
Your Knowledge Hub

Period Activity





Decreased activity

- 23 Mar to 10 May

Increased activity

- 11 May to 23 Jun
- 03 Dec to 05 Jan
- 06 Jan to 22 Mar

Decreased face-to-face activity

- 23 Mar to 10 May
- 11 May to 23 Jun
- 05 Nov to 02 Dec

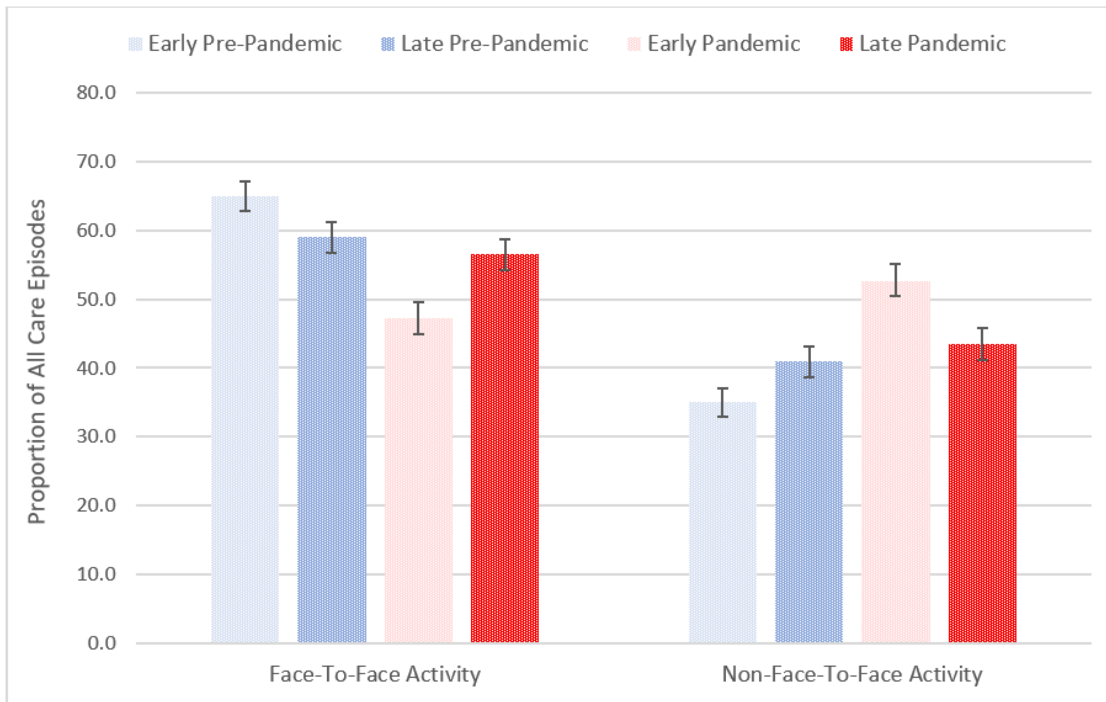
RVC

VetCompass
Your Knowledge Hub

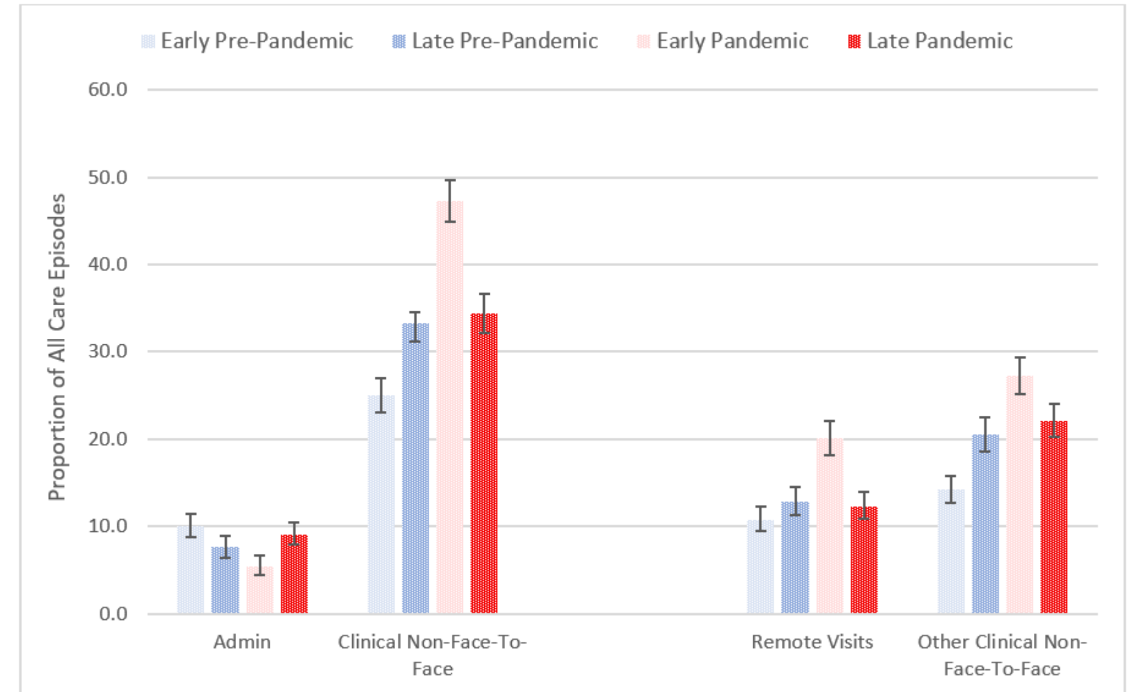
Nature of All Care Episodes

Total number of care episodes

Early pre-pandemic =1,979
Late pre-pandemic =1,837
Early pandemic =1,779
Late pandemic =1,869



Decreased face-to-face activity in early pandemic period



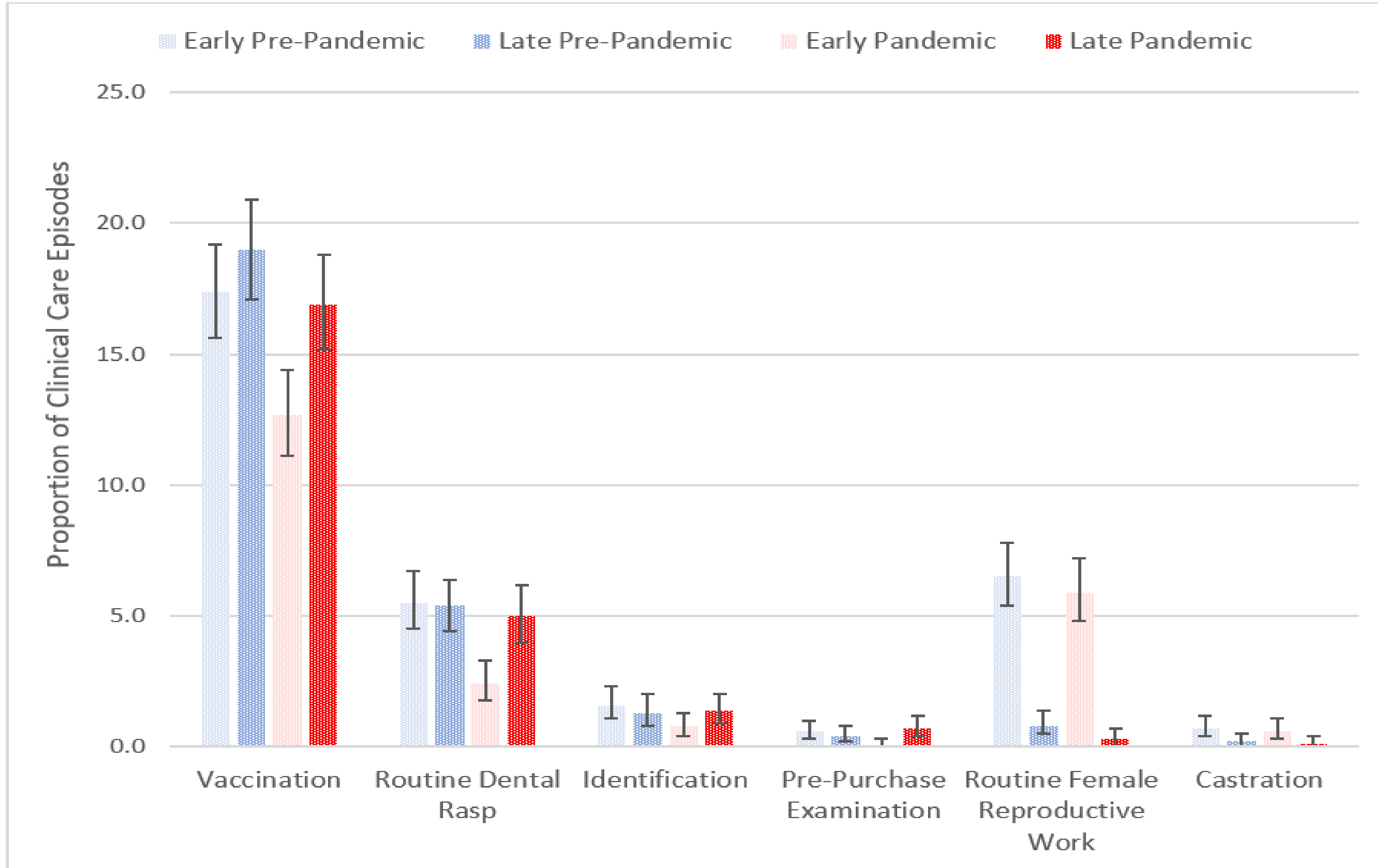
Decreased admin in early pandemic compared to early pre-pandemic

Increased remote visits + other clinical non-face-to-face activity

RVC

VetCompass
Your Knowledge Hub

Routine Procedures

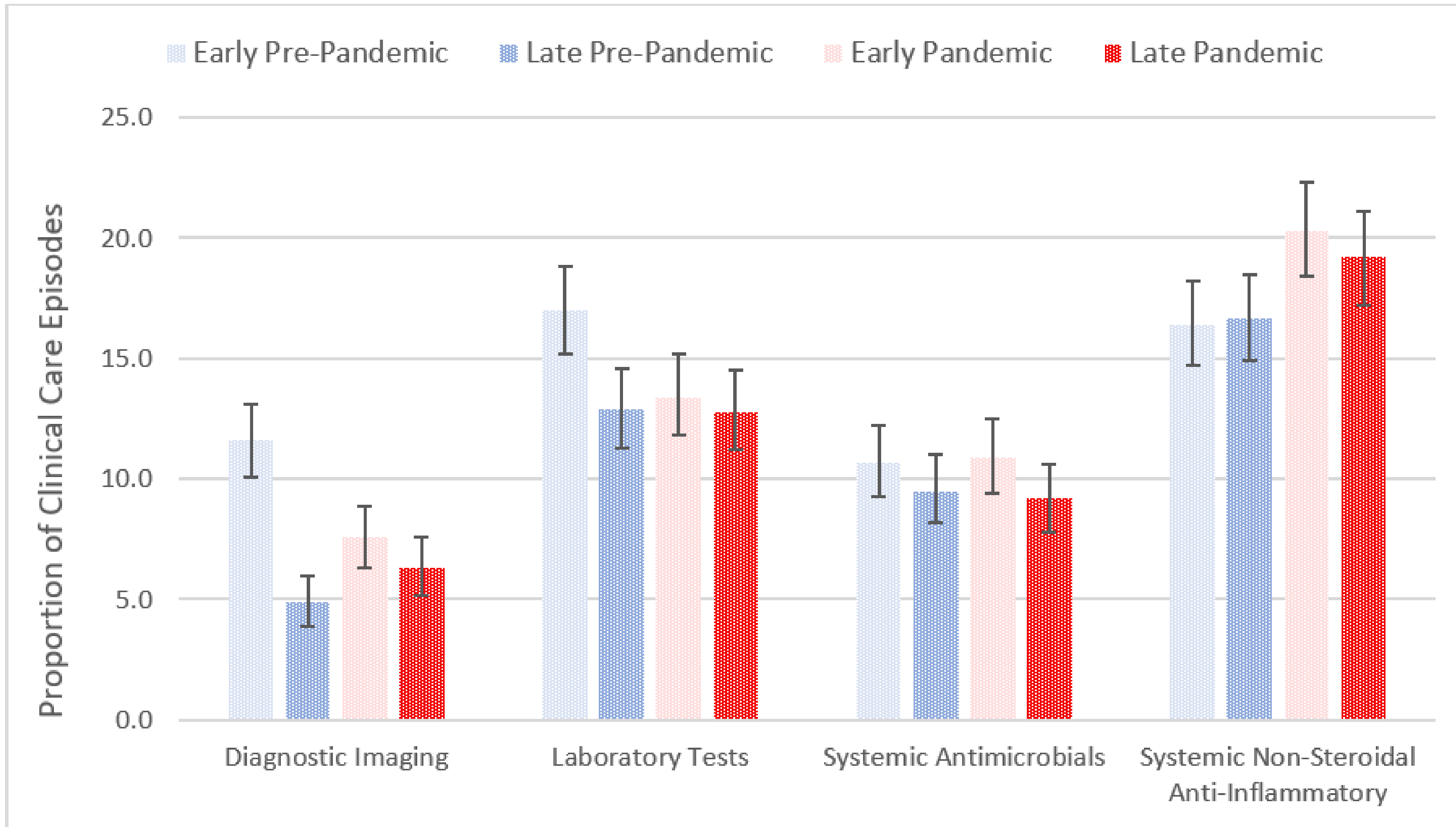


Decrease in the proportion of clinical care episodes attributable to **vaccination** & **routine dental treatment**

RVC

VetCompass
Your Knowledge Hub

Common Procedures & Prescriptions



Decreased proportion for **diagnostic imaging** in early pandemic compared to early pre-pandemic

Increased proportion for prescription of **systemic NSAIDs** in early pandemic compared to early pre-pandemic

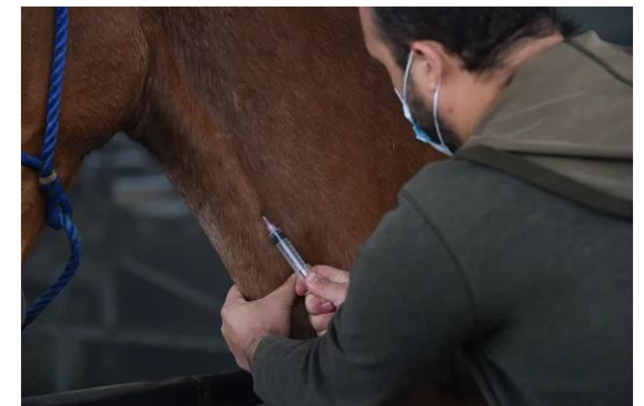
VetCompass Your Knowledge Hub

Limitations

- **Semi-automated classification** reliant on appropriate invoicing
- **Lockdown phases** correspond to England and may not accurately reflect restrictions in a practice's local area
- **Quality** of clinical recording variable
  - Demography & clinical indications
- **Convenience sample** of veterinary practices

Conclusions

- **Greatest disruption in early pandemic period**
- Working practices **adapted** to maintain veterinary services
  - COVID-19 risk assessment forms
  - Social distancing + personal protective equipment
  - Extra staff taken on visits
  - Non-urgent care delayed during tightest restrictions
  - Increased use of remote visits + prescribing
  - Non-certified vaccination
- Veterinary professionals acted to **maintain animal health and welfare**



RVC

VetCompass
Your Knowledge Hub

ROYAL COLLEGE OF VETERINARY SURGEONS

ADVICE ON INTERPRETATION OF VETERINARY MEDICINES REGULATIONS 2013

---

1. I have been asked to advise on the interpretation of sub-paragraph 4(1) of Schedule 3 of the Veterinary Medicines Regulations 2013. The paragraph provides as follows:

   A veterinary surgeon who prescribes a veterinary medicinal product classified as POM-V must first carry out a clinical assessment of the animal, and the animal must be under that veterinary surgeon's care.

2. Having considered the language of the provision and of the surrounding legislation, and the purpose of the legislation, it is my view that the words *"clinical assessment"* should be interpreted so as to include both in-person and remote clinical assessment.

3. The question of what *"clinical assessment"* must be carried out before the prescription of a POM-V depends upon the circumstances of the case i.e. it is the clinical assessment which is necessary for a veterinary surgeon to be satisfied that the prescription he makes is appropriate. This will be a matter of clinical judgment in each case. Some cases will require an in-person physical examination by the veterinary surgeon of the animal for the necessary clinical assessment to have been carried out, but not all.

4. Furthermore, it is my view that the words *"under that veterinary surgeon's care"* do not change the interpretation of the words *"clinical assessment"*. An animal may be under a veterinary surgeon's care within the meaning of the Regulations in circumstances that include both in-person and remote care. The question of whether the veterinary surgeon's contact with the animal is sufficient to render it under his care within the meaning of the Regulations will depend upon the circumstances of each case. Answering the question will involve consideration of whether the veterinary surgeon is taking professional responsibility for the animal to which he is prescribing the POM-V in relation to its prescription.

Fenella Morris QC

39 Essex Chambers

30 March 2022

RCVS | SETTING VETERINARY STANDARDS

Review of ‘under care’ and 24/7 emergency cover

A consultation on proposed guidance

July 2022

UNDER CARE **REVIEW**

Contents

A. Foreword 3

B. Background 5

C. The current position 6

D. The review 7

E. Proposed ‘under care’ guidance 9

F. Recommendations regarding 24-hour emergency cover 11

G. How to respond 12

A. Foreword

A long journey

The journey of reviewing ‘under care’ and provision of 24-hour emergency first-aid and pain relief has been a long one, its origins dating back to the Vet Futures initiative in 2016.

Relating as it does to a fundamental aspect of veterinary practice, this review has generated considerable discussion and debate in recent years, with strongly held views presented on all sides during all stages, including evidence-gathering, analysis and feedback.

As ever, it is the College’s responsibility, through the work of our Standards Committee and Council, to consider in detail the views and experience of all our stakeholders along with, in this case, formal legal advice and commissioned independent research, and to propose a way forward.

The pandemic effect

A significant contributor to the length of this journey, of course, has been the Covid-19 pandemic, which has delayed the review’s progress by around two years. Nevertheless, numerous lockdowns have afforded us the chance to explore our long-held understanding of what ‘under care’ means in principle, and to learn how new guidance could best work in practice, across all species types.

> ***“The proposed guidance seeks to protect animal health and welfare and maintain public trust by ensuring that decision-making remains firmly in the hands of individual veterinary surgeons.”***

Along with many things, the past two years have demonstrated that the veterinary professions are highly capable of adapting to changing societal needs. As veterinary professionals, we cannot, and should not, expect established ways of practice to go unchallenged and remain unchanged, particularly in the face of shifting public expectations and advancements in technology. However, it is our collective responsibility to ensure that any

changes continue to allow us to provide safe and effective care for our patients, and meet the appropriate expectations of our clients.

The need for change

Whilst therefore recognising and reflecting this need for change, the proposed guidance seeks to protect animal health and welfare and maintain public trust by ensuring that decision-making remains firmly in the hands of individual veterinary surgeons, as to what they, in their professional judgement, consider appropriate in a specific situation.

This consultation, then, whilst not a referendum on whether RCVS guidance on 'under care' and 24-hour emergency first-aid and pain relief should change – that decision having been made by Standards Committee and approved by Council based on the evidence gathered, including the views of the profession and objective evidence, and legal advice – is a crucial opportunity for you to tell us whether we have got the draft guidance right, or if there is anything we might have missed.

Animal health and welfare

In the online survey you can provide feedback on each individual element of the proposed guidance. We are particularly keen to know if there are any factors we may have overlooked that could impact on animal health and welfare, and/or public trust.

Before answering the questions, however, I would urge you to read the background and detail of the proposal set out on the following pages. This will help to explain the journey to this point and the challenges we have met along the way.

Full details on how to respond are set out on page 22, but please make sure to send us your feedback by 5pm on Monday, 12 September 2022.

Thank you in advance for your time and consideration.

Dr Melissa Donald BVMS MRCVS
RCVS President, Former Chair of Standards Committee

B. Background

1) The Royal College of Veterinary Surgeons (RCVS) is both the Royal College and regulatory body for veterinary surgeons and veterinary nurses in the UK. As a regulator, we set, uphold and advance veterinary standards and, as a Royal College, we promote, encourage and advance the study and practice of the art and science of veterinary surgery and medicine. We do all these things in the interests of animal health and welfare, and in the wider public interest.

2) Our review of telemedicine, ‘under care’ and 24/7 first-aid and pain relief began in 2016 with the Vet Futures initiative. This then led to the ambition in the RCVS Strategic Plan 2017-2019 to ‘review the regulatory framework for veterinary businesses to ensure a level playing field, enable a range of business models to coexist, ensure professionalism in commercial settings, and explore the implications for regulation of new technologies (eg telemedicine)’. This led to consideration of ‘telemedicine’ in its narrowest sense, ie in relation to remote prescribing, including the possibility of ‘trialling’ remote prescribing.

> ***“As this review hinges on the legal interpretation of the terms ‘clinical assessment’ and ‘under care’, we sought legal advice to ensure that the basis of the guidance that governs the profession is correct and reliable.”***

3) A key theme that emerged through these discussions was that remote prescribing and out-of-hours care were closely linked. The reason being that if a medicine is prescribed without a physical examination, consideration needs to be given to where owners go to seek help or their animals in the event of an adverse reaction or deterioration.

4) All the of the above ultimately resulted in the current, broad-ranging review of under care and out-of-hours guidance that began in 2019, conducted by the RCVS Standards Committee. As this review hinges on the legal interpretation of the terms ‘clinical assessment’ and ‘under care’, we sought legal advice to ensure that the basis of the guidance that governs the profession is correct and reliable. That legal advice is discussed further below and underpins the recommendations made.

5) The Standards Committee presented its findings to Council in spring 2022, and we now wish to consult on the changes proposed as a result.

C. The current position

Under care

6) Before a veterinary surgeon can prescribe prescription-only veterinary medicines (POM-Vs), according to **Schedule 3, paragraph 4 of the Veterinary Medicines Regulations 2013 (VMRs)** they must first carry out a 'clinical assessment' and have the animal 'under their care'. These terms are not defined by the VMRs and so it is left to the RCVS to interpret what they mean.

7) It is important to note that, under the VMRs, the requirements to carry out a clinical assessment and have the animal under one's care only apply to the prescription of POM-Vs. This means that when prescribing other classes of medicines or treatment not involving the prescription of POM-Vs, veterinary surgeons do not need to satisfy these requirements (although there are more general obligations relating to the provision of veterinary care, 24-hour emergency first-aid and pain relief, and responsible prescribing that must be met).

> ***"The terms 'under care' and 'clinical assessment' are not defined by legislation, so it is left to the RCVS to interpret what they mean."***

8) Our **current guidance on prescribing POM-Vs** effectively requires a physical examination to be carried out before **a** veterinary surgeon can establish that **an** animal is under their care. The guidance states that animals should be 'seen' immediately prior to prescribing or 'recently or often enough for the veterinary surgeon to have personal knowledge' of the animal or herd. It goes on to say that a veterinary surgeon cannot usually have an animal under their care if there has been no physical examination and that they should not prescribe POM-Vs via the internet alone. Remote prescribing is therefore allowed under our current guidance, but only where the animal is already under the veterinary surgeon's care.

9) We recognise, however, that there are some situations where the precise requirements of the VMRs are not practical, for example, when prescribing for herds, shoals and flocks, or issuing repeat prescriptions as a locum. In addition, the current guidance was written at a time before good quality video calls were widely accessible and physiological data could, in some cases, be gathered at a distance.

24-hour emergency first aid and pain relief

10) The *RCVS Code of Professional Conduct* requires all veterinary surgeons in practice to 'take steps to provide 24-hour emergency first aid and pain relief to all animals according to their skills and the specific situation'. Veterinary surgeons are not obliged to provide the service personally or expected to remain constantly on duty. They are, however, required to ensure clients are directed to another appropriate service when they are off duty or otherwise unable to provide the service. The current guidance is set out in full in **Chapter 3: 24-hour emergency first aid and pain relief**.

11) The out-of-hours obligations for veterinary surgeons working for limited service providers (LSPs), or based in referral practices, are slightly different to the general position described above and this is discussed more below.

D. The review

12) The current review began in 2019 to find out whether the current rules are fit for purpose, or whether change is required. As with all RCVS guidance, the aim is to protect animal health and welfare, maintain and uphold veterinary standards and ensure public confidence in the profession.

13) To assist with data gathering, the Standards Committee engaged the services of RAND Europe (an independent consultancy). The review comprised focus group discussions with members of the professions, the outcomes of which informed a survey which went out in May 2021 and had 5,544 responses. RAND analysed the survey responses and produced a report, which can be found via **www.rcvs.org.uk/undercare**.

> ***"The issue of whether a physical examination is necessary [in order to make a clinical assessment] should be a matter of judgement for the veterinary surgeon in each individual case."***

14) As a result of the difficulties arising from the Covid-19 pandemic, it was necessary to suspend the normal guidance and introduce temporary guidance allowing veterinary surgeons to establish 'under care' remotely in certain situations. The purpose of this was to ensure that veterinary surgeons could continue to care for animals without breaching government guidelines and restrictions, and in a way that was safe for them, their teams and their clients.

15) The operation of this temporary guidance presented us with a unique opportunity to carry out research and gather evidence based on real experiences. We therefore commissioned two independent pieces of research from SAVSnet and VetCompass to find out how veterinary surgeons applied the temporary guidance, and to compare treatment

before and after the pandemic to see whether there were any negative implications for animal health and welfare. The findings showed that veterinary surgeons behaved responsibly and, where issues were identified, these have been factored into the proposals (see section B of the online survey). In the words of VetCompass: *'Throughout the pandemic, veterinary professionals have acted in a manner that not only protected human health but ensured animal health or welfare were not compromised'*. The research report from SAVSnet and executive and project summaries from VetCompass can also be found via **www.rcvs.org.uk/undercare**.

16) As explained above, this review hinges on the interpretation of legislation and, in particular, the terms 'clinical assessment' and 'under care'. Therefore, we sought legal advice to ensure the basis of the guidance that governs the profession is correct and reliable. Interpreting legislation requires an assessment of intention at the time it was enacted, as well as applying the context of today's world.

17) In the case of 'clinical assessment', we have been advised that this should be interpreted as including both in-person and remote clinical assessments. The issue of whether a physical examination is necessary should be a matter of judgement for the veterinary surgeon in each, individual case. We were further advised that 'under care' does not change the interpretation of 'clinical assessment' and involves consideration of whether the veterinary surgeon has taken professional responsibility for the animal. This legal advice can be found via **www.rcvs.org.uk/undercare**.

18) The proposals in this consultation therefore reflect the findings of the review, the results of the independent research projects, and legal advice we have received.

Why are we consulting?

19) With all the above in mind, we would like your views on our proposed guidance on 'under care', in particular, on whether there are adequate safeguards built in to protect animal health and welfare and to maintain public confidence in the veterinary profession. As regards out-of-hours care, we would like to know whether you agree with the approach taken, together with some specific questions about what level of 24-hour emergency cover is appropriate for limited service providers and referral practices.

20) We believe that the proposed guidance set out in Section E will continue to protect animal health and welfare and ensure veterinary surgeons prescribe POM-Vs safely. The proposed guidance is intended to uphold public trust in the profession and give clarity, as well as providing a degree of future proofing so that the profession is prepared for the inevitable development of technology.

21) We also intend to consult with members of the public to better understand their views and how the proposals might affect access to veterinary care.

E. Proposed ‘under care’ guidance

22) We propose that the current guidance on ‘under care’ be removed and replaced with the following.

Prescribing POM-Vs

1. *According to the Veterinary Medicines Regulations 2013 (VMRs), to prescribe prescription-only veterinary medicines (POM-Vs), a veterinary surgeon must carry out a clinical assessment of the animal and the animal must be under their care. The terms ‘clinical assessment’ and ‘under…care’ are not defined by the VMRs, however the RCVS has interpreted them in the following way.*

2. *An animal is under a veterinary surgeon’s care when the veterinary surgeon is given, and accepts, responsibility for the health of an animal (or a herd, flock or group of animals) whether generally, or by undertaking a specific procedure or test, or prescribing a course of treatment. Responsibility for an animal may be given by the owner/client, statute or other authority.*

3. *A clinical assessment is any assessment which provides the veterinary surgeon with enough information to diagnose and prescribe safely and effectively. A clinical assessment may include a physical examination, however, this may not be necessary in every case.*

4. *Whether or not a physical examination is necessary is a matter for the veterinary surgeon’s judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:*

    a. *The health condition, or potential health conditions, being treated and any associated risks (see further guidance below at paragraph 5 and 6).*

b. The nature of the medication being prescribed, including any possible side effects (see further guidance below at paragraphs 7 and 8).

c. When the animal (or premises in the case of agricultural animals) was last physically examined by a veterinary surgeon.

d. Whether there is access to the animal's previous clinical history.

e. The experience and reliability of the animal owner.

f. Whether the animal is known to the veterinary surgeon and/or whether there is an existing relationship with the client or animal owner.

g. The practicality of a physical examination for individual animals, particularly when dealing with herds, flocks or groups of animals.

h. The health status of the herd, flock or group of animals.

i. The overall state of the animal's health.

j. The impact of any prescription made without physical examination on the ability to gather subsequent diagnostic information.

5. *The more complex or unusual the health needs of the animal, or where a differential diagnosis includes serious conditions not yet ruled out, the more likely a physical examination will be necessary.*

6. *In respect of paragraph 4(a) above, a physical examination is required where a notifiable disease is suspected or part of a differential diagnosis.*

7. *In respect of paragraph 4(b) above, and given the importance of minimising the development of antimicrobial resistance:*

    a. *A physical examination is required in all but exceptional circumstances where a veterinary surgeon prescribes antimicrobials for an individual animal or group of animals that are not agricultural animals. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without a physical examination and record this justification in the clinical notes.*

    b. *When prescribing antimicrobials for agricultural animals, veterinary surgeons should ensure they have an in-depth knowledge of the premises, including its production systems, the environment, disease challenges and the general health status of the herd or flock. Veterinary surgeons should have attended the premises and physically examined at least one animal immediately prior to prescribing or, where this is not possible, recently enough to ensure they have adequate information and knowledge to prescribe responsibly. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without conducting a physical examination and record this justification in the clinical notes.*

Note: *For more information about responsible prescribing to minimise antimicrobial resistance, please see* ***Chapter 4: Medicines, paragraphs 4.23 and 4.24****.*

8. *In respect of 4(b) above, when prescribing controlled drugs to an animal in the first instance, veterinary surgeons should carry out a physical examination in all but exceptional circumstances and be prepared to justify their decision where no physical examination has taken place. This justification should be recorded in the clinical notes. It is acceptable to issue a repeat prescription for controlled drugs without a physical examination, however, veterinary surgeons should carry out a further clinical assessment to ensure they have enough information to do so safely and effectively.*

9. *Where a physical examination is not carried out immediately prior to prescribing POM-Vs, veterinary surgeons should ensure that a 24/7 follow-up service involving physical examination and any other necessary investigation if required is immediately available in the event that the animal does not improve, suffers an adverse reaction or deteriorates. Where a veterinary surgeon is not able to provide this service themselves, they should arrange for another veterinary service provider to do so. This arrangement should be made before veterinary services are offered and confirmed in writing as part of the conditions of service agreed by the client.*

10. *Veterinary surgeons must maintain clinical records of animals, herds, flocks or other groups of animals under their care.*

F. Recommendations regarding 24-hour emergency cover

23) We do not propose any substantive change to our **current guidance on 24-hour emergency first aid and pain relief**, except for the proposed guidance for limited service providers (LSPs) set out below. We believe that, in the absence of an animal equivalent to a local accident and emergency department, animal welfare is best served by the current requirement that veterinary surgeons in practice take steps to provide 24-hour emergency first-aid and pain relief.

24) Our current supporting guidance only recognises two kinds of LSP, namely, vaccination clinics and neutering clinics. Veterinary surgeons who work in vaccinations clinics are required to make provision for 24-hour emergency cover for the period in which adverse reactions may arise. Those working in neutering clinics must make provision for the entire post-operative period during which complications arising from the surgery may develop.

> ***"The issue of "Animal welfare is best served by the current requirement that veterinary surgeons in practice take steps to provide 24-hour emergency first-aid and pain relief."in each individual case."***

25) We recognise that there are many other types of LSP not currently provided for, and that fairness requires that providers should be treated the same unless there is good reason not to. We therefore propose that the current guidance on LSPs (see paragraphs 3.49-3.41 of **Chapter 3: 24-hour emergency first aid and pain relief**) be removed and replaced with that set out below, which provides a broader definition of the type of practice that can be considered an LSP and imposes a general obligation to provide out-of-hours emergency care that is proportionate to the service offered.

26) We believe that the proposed guidance will protect animal health and welfare whilst providing clarity and ensuring fairness.

Limited service providers

1. A limited service provider is a practice that offers no more than ***one*** *service to its clients and includes, but is not limited to, vaccination clinics, equine reproductive clinics and neutering clinics. For these purposes, a 'practice' is a Registered Veterinary Practice Premises (RVPP) as entered into the register held by the RCVS.*

2. Limited service providers should provide 24-hour emergency cover that is proportionate to the service they offer. This means that veterinary surgeons working for limited service providers should ensure that the 24-hour emergency cover provision covers any adverse reaction or complication that could be related to procedures or examinations carried out, or medicines prescribed or used.

G. How to respond

27) This consultation is for veterinary professionals and those working alongside them, vet and vet nurse students, and representatives of stakeholder organisations.

28) Details of a separate consultation exercise for the animal-owning/-keeping public will be published in due course.

29) Before you respond to this consultation, we would urge you to view the additional reports, research papers and legal advice information provided at **www.rcvs.org.uk/undercare**.

"This is your opportunity to tell us whether the proposed guidance contains adequate safeguards to protect animal health and welfare, and maintain public confidence in the veterinary professions."

30) This is your opportunity to tell us whether our proposed new guidance on 'under care' and 24-hour emergency first-aid and pain relief contains adequate safeguards to protect animal health and welfare, and to maintain public confidence in the veterinary professions.

31) We would like to know how much you either agree or disagree with each element of the guidance, and whether you have any specific comments or suggestions to make in each case.

32) To submit your views, please visit our online survey available via 'How to respond' at **www.rcvs.org.uk/undercare**. You will first be prompted to answer a few demographic questions, for example, whether you are responding as an individual or on behalf of an organisation, before answering questions on the guidance itself.

33) The deadline for responses is 5pm on Monday, 12 September 2022.

34) Thank you for taking the time to send us your views. Responses from individuals will be treated as confidential and anonymised. With permission, we may quote from individual responses in any subsequent report, however these quotes will be anonymised. Where comments from organisations are quoted in any report, the organisation may be identified.

Royal College of Veterinary Surgeons
The Cursitor, 38 Chancery Lane,
London WC2A 1EN
T 020 7222 2001 F 020 7222 2004
E info@rcvs.org.uk @theRCVS
www.rcvs.org.uk

RCVS | SETTING VETERINARY STANDARDS

Review of ‘under care’ and 24/7 emergency cover

Consultation report

January 2023

UNDER CARE **REVIEW**

RCVS review of ‘under care’ and 24/7 emergency cover

Consultation report

Background to the consultation

This consultation follows a lengthy review conducted by the RCVS Standards Committee on its guidance on the interpretation of ‘under care’ in respect of prescribing prescription-only veterinary medicines (POM-Vs) and the current rules on 24-hour emergency first aid and pain relief.

The history of this review starts as far back as 2016 with thoughts from the Vet Futures initiative, leading to the ambition in the RCVS Strategic Plan to ‘review the regulatory framework for veterinary businesses to ensure a level playing field, enable a range of business models to coexist, ensure professionalism in commercial settings, and explore the implications for regulation of new technologies (e.g. telemedicine)’. This led to consideration of ‘telemedicine’ in its narrowest sense i.e. in relation to remote prescribing, including the possibility of having a trial. This in turn led to a broad-ranging review of under care and out of hours, to the present when recommendations of the Standards Committee on changes to the supporting guidance are presented for consideration in order to go out to a formal public consultation.

It is a topic that has generated much discussion and debate. Views are strongly held on all sides, understandably so as it relates to a fundamental aspect of veterinary practice and goes to the heart of what the RCVS is about: the protection of animal health and welfare and public trust.

The review comprised a significant number of meetings by the Standards Committee in order to discuss the evidence and information gathered throughout the process. This information and evidence included surveys, reports from independent researchers, views expressed by organisations and individuals and legal advice. Through these discussions, the Standards Committee developed proposals as to how the guidance should be amended and a

consultation with the professions about the proposals was launched in July 2022. That consultation has now closed and this report analyses the responses that were received.

Further information about the review itself, including the evidence and information reviewed by the Standards Committee, is set out in a paper presented to RCVS Council in January 2022.

Consultation process and methodology

In total, 2,748 responses to the survey were received and the completion rate was 75%. The vast majority of responses (99%) were from individuals, the rest were on behalf of organisations. Of those who provided individual responses, 84% were veterinary surgeons and 12% were veterinary nurses, the remaining respondents included practice managers, veterinary and veterinary nurse students and other roles within veterinary practice. Of the veterinary surgeons, the majority were on the UK Practising register and in clinical practice.

The consultation included a mixture of closed and open-ended questions and, as such, both quantitative and qualitative data have been gathered. The analysis of the qualitative data has involved careful assessment of each individual response in order to identify the key themes arising in response to the open-ended questions. The qualitative responses included a mixture of arguments for and against the proposed changes, queries and requests for further information and suggestions as to how the guidance could be improved or amended.

Summary of responses

This report should be read together with the consultation document (see Annex), which sets out the proposed guidance in full, together with the context for the questions.
The purpose of this consultation report is to set out the data in terms of the responses received to the consultation. It is presented in conjunction with a paper to RCVS Council dated 19 January 2023, which sets out the conclusions reached by the Standards Committee following the review of ‘under care’, together with the other information and evidence that has been considered during that process.

1. Questions on proposed 'under care' guidance

A) Factors that might determine whether a physical examination is required.

Q1 To what extent do you agree that this should be included in the list?

4. Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:

a. The health condition, or potential health conditions, being treated and any associated risks

Responses

For guidance paragraph 4a, the overwhelming majority agreed with this guidance statement with 89% agreeing or strongly agreeing with this approach. 18% (398) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Physical examination of the animal necessary in most/all cases (43%)	• Many respondents felt that without a physical examination there is a possibility of misdiagnosis or missing unsuspected conditions, therefore compromising animal welfare, and therefore regular check-ups should still be necessary. Some were concerned that information about the health condition relayed by the animal owners is not always reliable, and would not match what a vet would deem to be the issue in a physical examination. A few respondents thought that it is difficult to decide whether a physical examination is necessary, and remote consultants should be linked to a practice that can perform a physical exam if necessary. • Many stipulated that POM-V medications should always require physical examination. • There were also concerns that remote consulting through video or phone triage may not be sufficient in accurately depicting conditions as well as determining factors vital for prescribing correct doses such as bodyweight.

Needs greater clarification/lacks clarity (15%)	• Many responses indicated respondents were worried about the guidance being ambiguous and open to interpretation, especially in terms of which conditions should require a physical examination and what is meant by associated risks. • Some responses worried the ambiguity of the statement would be open to abuse by some vets who would prefer to prescribe remotely, as well as clients who may put pressure on vets to prescribe remotely.
Responsibility of vets to make the judgement (17%)	• Many respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely. • Some responses stipulated that this judgement should be aided by other diagnostic tools such as clinical history, and risk assessments should be recorded. Some noted that the Vet-Client-Patient Relationship (VCPR) is vital to making this judgement, and that new clients should always require a physical examination. • Some believed that other factors should be considered when making this judgement such as species and welfare impacts.
Some conditions may require a physical examination while others may not (19%)	• Respondents felt that some conditions may not be suitable for remote examination and prescribing, particularly conditions that are new, more serious and complex, or those that may need additional diagnostics (i.e. urine samples, ocular examinations etc.) should require a physical examination. • Responses indicated that some conditions should be able to be assessed remotely, such as parasitic infections, skin conditions and milder conditions that require low risk treatments. Some also indicated that repeat prescriptions can be prescribed remotely. If remote consultations were conducted it was considered important to that clients were informed of the risks of remote consultation and consented to this. • Some responses agreed that the health condition being treated is relevant in making the decision about whether a physical examination is necessary, and important to protect animal welfare.

Remote consultations can be helpful for vets/clients (5%)	• Several respondents felt that this statement was an unnecessary addition to the guidance, as notifiable disease could be included in differential diagnosis. • Some responses believed that it is difficult to know when there is a notifiable disease, and that notifiable diseases could be added to many differential lists, and therefore when making the judgment the needs to take into account likelihood of notifiable disease

Q2 To what extent do you agree that this should be included in the list?

b. The nature of the medication being prescribed, including any possible side effects

Responses

For guidance paragraph 4b, the overwhelming majority agreed with this guidance statement with 90% agreeing or strongly agreeing with this approach. 15% (329) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Different medications carry different risks (35%)	• Many responses discussed how different medications carry different risks. Anti-parasitic drugs, NSAIDs, topical treatments and medications with a wide therapeutic index were considered medications that were safer to prescribe remotely, whereas controlled drugs, ear and eye drops and cardiac drugs were noted as examples of drugs that should require a physical examination. • Many responses stipulated that prescribing POM-V medications, particularly antimicrobials and antibiotics, should be prescribed after physical examination.

Physical examination is necessary for prescribing medicine (25%)	• Respondents indicated that they believed a physical examination was vital for prescribing medications due to the possibility of misdiagnosis and therefore mistreatment, or the possibility of missing potential comorbidities. Some raised concerns that any medication can have adverse effects, while others were worried that remote prescribing could be abused by less scrupulous vets or difficult clients. • A few responses also were concerned about the potential for incorrect dosing because they may not have an accurate bodyweight of the animal without performing a physical examination. • Some responses indicated that access to the full medical history may is also necessary to consider when treating an animal, and it will aid prescribing where physical examination may not be possible.
Nature of medication being prescribed is relevant in making the decision about whether a physical examination is necessary (12%)	• Respondents believed that the nature of the medication being prescribed was an important factor to be considered when determining whether a physical examination was necessary. • Some respondents felt that the more potential adverse effects that a medication may cause, the greater the likelihood that a physical examination should take place to prescribe that medicine. • Additionally, some responses suggested that vets may not need to carry out a physical examination when prescribing lower risk medications, and that prescribing these medications remotely may have benefits to the animal such as preventing deterioration in the early course of the disease. • Respondents believed that it is important for the prescribing vet to explain these potential side effects to client, regardless of whether a physical examination has taken place.

Needs greater clarification/lacks clarity (7%)	• A few responses indicated that they would like more guidance on what medications should and should not be prescribed remotely. • Some responses suggested that this guidance should also include other factors such as the potential risk to other animals, public health and the environment, as well as the potential safety risks of medication for the owner, although others noted it would not be practical to list all side effects.
Responsibility of vets to make the judgement (8%)	• Many respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, however some believed that an existing VPCR is vital for making the decision to prescribe remotely. • Some responses indicated that allowing the vet to make the judgement of whether to prescribe remotely may benefit both clients and vets, by helping clients in situations where a physical exam may not be feasible as giving vets more flexibility. • A few respondents thought that medication being prescribed, and its potential side effects are not relevant in making this judgement as it is not possible to predict potential side effects even if a physical examination is conducted.

Q3 To what extent do you agree that this should be included in the list?

c. When the animal (or premises in the case of agricultural animals) was last physically examined by a veterinary surgeon

Responses

For guidance paragraph 4c, the overwhelming majority agreed with this guidance statement with 86% agreeing or strongly agreeing with this approach. 18% (388) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Prescribing most/all medications require recent physical examination (34%)	• Responses revealed that respondents believed a recent physical examination was important for treatment and prescribing medications, to allow vets to be up to date with the health status of the animal and identify any comorbidities. • Some respondents suggested 12 or 6 months as a timeframe guideline for a recent examination, but a few responses suggested a more stringent timeframe guideline of 3 months. • Some also stipulated that a post mortem examination should be considered as a physical examination for farm and flock animals for the purpose of deciding whether a remote examination was possible.
Different medications/conditions need different time frame (8%)	• Some were of the view that the timeframe for when a physical examination should have taken place is dependent on the condition being treated or medication being prescribed. Medications that were considered safer to prescribe remotely were thought to require a less stringent time frame, whereas those that were considered to need to be seen physically such as antibiotics, needed a more recent examination. Acute more serious conditions or conditions in older animals were deemed to require a more recent examination compared to chronic or less serious conditions or conditions in younger animals which were thought to be able to be monitored remotely.

When animal is last seen in irrelevant (in some situations) (12%)	• Some respondents believed that when the animal was last physically examined was irrelevant, especially in certain situations such as a medical emergency or if the vet has access to the animal's full clinical history.
Needs greater clarification/lacks clarity (29%)	• Many respondents felt that this statement was too vague, particularly asking for more guidance on the timeframe that constitutes a recent examination, as well as whether the vet prescribing has to be the person who performed the most recent examination or whether it can be another vet in their practice. • Some respondents worried that the vagueness of the statement opens up the possibility of exploitation of telemedicine vets, or fraud from clients inappropriately trying to obtain medications. • Some wished this guidance would also include other groups of animals and not just agricultural animals, for example laboratory animals and zoo animals.
Responsibility of vets to make the judgement (15%)	• Many respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely. • Some noted that when the animal was last seen, or when the premises was last inspected, as well and an existing relationship between the vet and client are both important factors in in this consideration. • Some also expressed that remote consultations can be helpful for both clients and vets.

Q4 To what extent do you agree that this should be included in the list?

d. Whether there is access to the animal's previous clinical history

Responses

For guidance paragraph 4d, the overwhelming majority agreed with this guidance statement with 82% agreeing or strongly agreeing with this approach. 21% (453) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Full medical history is not always available (in out-of-hours (OOH)/ emergency situations) (15%)	• Many responses raised concerns that the animal's previous clinical history is not always available, especially in out of hours care or emergency situations. The clinical history may also not be available as clients may use multiple different practices. • Some respondents also thought that this access would be ideal, and therefore there needs to be a better system in place to make the previous clinical history of the animal available to the client and vets who may not primarily care for that animal.
Medical history is useful but not always necessary (17%)	• Many respondents felt that although having access to the previous clinical history is useful, it is not always necessary to make a diagnosis or dictate whether a physical examination is necessary. Some felt that this clinical history may not be relevant at all in some cases as the current condition of the animal may be unrelated to any previous conditions. • Some respondents felt that the necessity of the clinical history of the animal is dependent on the condition, as well as the chronicity of that condition being treated. Clinical history was thought to be more helpful for treating chronic conditions. • Others believed that reading and obtaining clinical histories can be impractical as it can take too much time, thereby delaying treatment and risking animal welfare.

Prescribing most/all medications require recent physical examination (14%)	• Responses revealed that respondents believed a recent physical examination was important for prescribing medications, with a few respondents believing that a physical examination is more important than access to previous clinical history. Physical examination was seen as especially important in cases where animals which had never been examined before by the prescribing vet surgeon or colleagues of the same practice, as well as where there is no access to the clinical history of the animal.
Responsibility of vets to make the judgement (2%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely. • Others believed that an existing VPCR is vital for making the decision to prescribe remotely.
Vets having access to previous medical history is important prescribing medications (46%)	• Many respondents felt that it is important or essential for vets to have access to the previous clinical history when prescribing treatments, as the welfare of the animal could be compromised due to previous illness or adverse reactions to certain medications, and therefore is a relevant factor in deciding whether a physical examination is necessary. • Some respondents felt that access to clinical history from a veterinary professional was especially important for remote prescribing where no physical examination took place, as they believe animal owners are not always reliable sources of the animal's medical history.
Needs greater clarification (1%)	• Some believed this guidance needs greater clarification, especially in terms of where previous history would come from and what it would entail.

Q5 To what extent do you agree that this should be included in the list?

e. The experience and reliability of the animal owner

Responses

For guidance paragraph 4e, the majority agreed with this guidance statement with 60% agreeing or strongly agreeing with this approach. 26% (571) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Client experience is irrelevant (22%)	• Some respondents believed the experience of the client is irrelevant as it cannot be substituted for a veterinary degree, and others felt that it is not the responsibility of vets to judge their clients by determining their reliability and experience. • Some responses raised concerns that having to judge clients puts them in a difficult position if they have to use this guidance statement as justification for requiring an in-person examination. • Others felt that is unfair to judge their clients and treat them differently based on this judgement and it could lead to vets being pressured by clients to prescribe remotely if they do not agree with the vet's judgement.
Difficult to determine if an owner is experienced (30%)	• Many felt that it is difficult for a vet to be able to determine whether a client is reliable or experienced, especially if this judgement was to be made remotely or if they had never met the client in person. • Some mentioned that judgements about reliability and experience can only be built by knowing the client over time. • Several were also concerned that making judgements about clients could lead to claims of discrimination or opens them up to intimidation by clients.

Reliability/experience of clients differs (15%)	• Some felt that some clients have more experience with managing certain conditions and were more reliable than other clients, and thereby they could trust them when prescribing remotely. • Many also raised the point clients are not always reliable sources of their animal's clinical history and that even clients that are perceived to be experienced can be wrong.
Needs greater clarification (10%)	• Some felt that the guidance would benefit from more clarity, especially regarding what is considered ownership, with some suggesting to expand this statement to say 'owner or caretaker'. • Several responses indicated that this statement was too subjective and would be interpreted differently by different vets.
Prescribing most/all medications require recent physical examination (6%)	• Some respondents believed a physical examination is necessary in most or all cases, regardless of the client's experience or knowledge.
Responsibility of vets to make the judgement (17%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, with the VCPR playing a critical role in this decision making. • Some responses suggested that the experience and knowledge of the owner is important and should be acknowledged, with some noting that this is especially the case when determining an owner's ability to administer medications as well as being more relevant for agricultural animal owners than companion animals. • Others stipulated that although information from the owner is helpful, it is not a priority for making a judgement on necessity of physical exam and other factors should also be taken into consideration like financial considerations.

Q6 To what extent do you agree that this should be included in the list?

f. Whether the animal is known to the veterinary surgeon and/or whether there is an existing relationship with the client or animal owner

Responses

For guidance paragraph 4f, the overwhelming majority agreed with this guidance statement with 77% agreeing or strongly agreeing with this approach. 19% (413) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Prescribing most/all medications require recent physical examination (15%)	• Responses revealed that respondents believed a recent physical examination was important for diagnosis and prescribing medications, especially if the animal had never been seen by the prescribing vet before. • Some noted that physical examination should be the standard, with remote prescribing only happening in rare circumstances.
Vet/client relationship is important (43%)	• Many respondents felt that a strong relationship between the vet and their client/animal is important for maintaining animal welfare, and that building trust between the client and the vet aids both the diagnosis as well as determining whether a physical exam is necessary. • Some noted that animals being prescribed to should be registered with the practice, or at the very least heave been examined before by that practice. • Some respondents deemed the vet-client relationship to be notably important in ongoing chronic cases. • Some respondents felt like other aspects of the Under Care guidance are contingent on the vet-client relationship, particularly statement 4e, although the 4f guidance statement was noticeably less controversial than 4e. • A few responses stipulated that whether the animal is known part of the guidance is more important than the relationship with the client.

Vet/client relationship is irrelevant (14%)	• Some felt that the relationship between the client and vet was an irrelevant factor in making the decision of whether to prescribe remotely, and ta close relationship could lead the vet to make a biased decision. • A few respondents believed that if there is access to clinical history then a vet-client relationship is not necessary, especially in cases where animal welfare will be at risk if they are not treated.
Difficult to have existing relationship with client in certain cases (OOH, locum, etc.) (4%)	• Some respondents brought up that it is unlikely that vets working in certain roles such as locums or in out of hours care will have a relationship with their client.
Needs greater clarification/lacks clarity (15%)	• Some respondents expressed that the term relationship was too vague and open to interpretation and needed more of a definition of what this would entail. • Some respondents suggested that the relationship should not just be limited to the prescribing vet and should instead be broadened to cover the whole veterinary practice. • A few responses raised concerns that emphasising a strong relationship between the vet and client is open to abuse in terms of the potential for the vet to be put under pressure to prescribe by both clients and their employers.
Responsibility of vets to make the judgement (1%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely.

Q7 To what extent do you agree that this should be included in the list?

g. The practicality of a physical examination for individual animals, particularly when dealing with herds, flocks or groups of animals

Responses

For guidance paragraph 4g, the majority agreed with this guidance statement with 73% agreeing or strongly agreeing with this approach. 17% (365) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Physical examination is vital (19%)	• Responses revealed that respondents believed a recent physical examination was important in most or all cases, with some noting that for groups of animals, a representative proportion of the group should be examined and others believing they should still be treated and examined as individual animals. • Some responses stipulated that a physical examination is important for making sure infectious diseases are not missed. • A few respondents suggested that if physical examination is not possible reasons should be documented.
Practicality of a physical examination is irrelevant (10%)	• Some believed that the practicality of a physical examination is irrelevant as inconvenience should not be an excuse for not performing a physical examination. • Several respondents believed that a physical examination of an individual animal is unrepresentative of the group, and that other documentation including herd documents, site inspections and post-mortem examinations are better at aiding diagnosis.

<table>
<tr><td>Responsibility of vets to make the judgement (42%)</td><td>Some respondents believed that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, and that the practicality of an examination was a relevant factor to consider when making this judgement. This was thought to be especially important when animal welfare is at risk if not treated, but it should not override the need for a physical exam if necessary. Respondents felt that this distinction was important as it may not be possible to physically examine every individual animal in large groups of animals.
Many responses indicated that this guidance statement is especially relevant for distressed or aggressive animals who are difficult to carry out examinations on, protecting the safety of veterinary staff and reducing the stress on the animal.
Some mentioned that other factors such as a good relationship with the client and medications being prescribed will also need to be considered when making this judgement.</td></tr>
<tr><td>Needs greater clarification/lacks clarity (21%)</td><td>Some respondents were concerned that this guidance was too vague, they particularly wanted more clarification on what is meant by the term practicality, as well as including other groups of animals such as lab, zoo, and wild animals.
Some believed that practicality for the client in terms of costs and distance should be considered, while others thought it should not.
Some thought that this guidance was more relevant for groups of animals than individual animals, with some stipulating that individual animals need a physical examination.
Some were worried that this clause could be exploited and used as an excuse to not perform physical examinations.</td></tr>
</table>

Q8 To what extent do you agree that this should be included in the list?

h. The health status of the herd, flock or group of animals

Responses

For guidance paragraph 4h, the majority agreed with this guidance statement with 72% agreeing or strongly agreeing with this approach. 9% (201) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Physical examination is vital (28%)	• Some expressed that they believed a recent physical examination of a sample of the group was vital regardless of the health status of the group, with some believing that physical examination was necessary to determine the health status. Without a physical examination or site inspection problems will be missed including issues of biosecurity, husbandry and infectious diseases.
Important to know the health status of the group (32%)	• Many felt that it is important to consider the health status of the group when deciding whether a physical examination is necessary, although some noted that this should be derived from the clinical history as well as a good relationship with the client. • Some felt that this has already been covered by the individual animal health status in guidance 4a.
Needs greater clarification/lacks clarity (11%)	• Some responses indicated that this guidance was too vague and wanted greater clarification on what is meant by the health status of the group. • A few respondents thought that the necessity of the health status of the group depended on other factors such as the medication being prescribed, whether the prescribing vet is treating an individual animal or the whole group, quality of record keeping and whether the animals are domestic or commercial. • A few respondents noted that group animals should be treated the same as individual animals.

Health status is irrelevant (7%)	• Some believed that health status of the group is irrelevant when deciding on whether a physical examination is necessary as health status doesn't necessarily mean that animals are not unwell, and that other information such as her documents, lab diagnostics and site inspections are more helpful for making this judgement.

Q9 To what extent do you agree that this should be included in the list?

i. The overall state of the animal's health

Responses

For guidance paragraph 4i, the overwhelming majority agreed with this guidance statement with 83% agreeing or strongly agreeing with this approach. 12% (273) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Physical examination is vital (56%)	• Some expressed that they believed a recent physical examination was vital regardless of the overall state of the animal's health, with many noting that you would need a physical examination to be able to assess this. • Others stipulated that a physical examination would be necessary if the animal was affected by factors such as poorer health, comorbidities, or older age, while others may benefit from remote consultations such as palliative care.
Clause 4i is relevant (14%)	• Several respondents believed that the overall state of health was a relevant factor to consider when deciding whether a physical examination is necessary, although some noted that knowledge about this should come from the animal's clinical history.

Needs greater clarification (10%)	• Responses indicated that this guidance would benefit from greater clarity especially in terms of who would be judging the state of health (noting that it should not be clients) as well as how this would be assessed. • Some felt that the statement was too vague in terms of whether the information would come from (whether it be from the animal owner or clinical history), as well as wanting more guidance on the severity of the disease that should require a physical examination.
Responsibility of vets to make the judgement (7%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, and that a good relationship between the vet and client is necessary to know the overall state of the animal's health. • Some stipulated that animal welfare must take precedence when making this judgement even if clients may not agree with the judgement made.
Overall health status is irrelevant (9%)	• Some responses indicated that the overall state of the animals health is irrelevant, as it is not necessarily an accurate predictor of the current condition and can change rapidly, and this should already be considered in guidance 4a.

Q10 To what extent do you agree that this should be included in the list?

j. The impact of any prescription made without physical exam on the ability to gather subsequent diagnostic information

Responses

For guidance paragraph 4j, the overwhelming majority agreed with this guidance statement with 77% agreeing or strongly agreeing with this approach. 12% (259) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Prescribing most/all medications require recent physical examination (28%)	• Responses revealed that respondents believed a recent physical examination was important for prescribing medications.
The impact of any prescription made without physical exam needs to be discussed with the client (11%)	• Respondents felt that an important aspect of remote prescribing is discussing the potential issues of prescribing medication without a physical examination to clients. • A few highlighted that the responsibility for making the decision to continue would lie with the client.
4j is important (38%)	• Several respondents believed this clause was an essential consideration as remote prescriptions risk the ability to run subsequent testing therefore impacting the chances of future diagnosis. • Some noted that this should be considered in both in person and remote consultations. • Many respondents discussed how certain medications have a greater impact on later diagnostic testing, with steroid and antibiotics being examples of these types of medications. • Some felt that diagnosis should be made before treating to ensure animal welfare, and if a diagnosis cannot be made the animal should be seen face-to-face. • Some believed there needs to be provisions for if medication prescribed remotely doesn't work and therefore the responsibility for inappropriate prescribing lies with the remote vet.

4j is unnecessary/not relevant (13%)	• Some felt that this statement was unnecessary for the guidance because any medication could have an impact on future diagnostics. • A few respondents worried that this clause would be open to abuse particularly vets facing intimidation from clients to prescribe medications or abuse by telemedicine companies making GP vets harder if the first line treatment fails. • Some believed this guidance was irrelevant as a vet wouldn't necessarily need a diagnosis to treat an unwell animal, and they may not be known at the time that subsequent testing is needed.
Responsibility of vets to make the judgement (6%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, and they should make a risk benefit analysis to make this decision. • A few responses raised the point that a good relationship between the vet and client would aid this decision making, although animal welfare should take precedence when considering whether to physically examine the animal.

Q11 Are there any additional factors that should be added to the list?

Responses

23% of respondents thought there were additional factors that should be added to the list, and 23% (452) of respondents who answered this question left additional comments explaining what factors should be added.

Themes:

Factors related to owner

- Ability of owner to administer medication to the animal/compliance
- Proximity to the client and animal/ability of client to get animal to the practice
- VCPR
- Risks of telemedicine diagnostics and treatment explained and consented to by owner
- Financial costs should not be a reason to avoid physical examination

- Financial situation of client should be considered
- The client's role in responsibility
- Owner abusing telemedicine to obtain drugs
- Quality of information from the owner
- Ability of owner to monitor deterioration
- Reasons for switching practices
- If difficulties communicating with client (e.g. language barriers, visual/hearing impairments, etc.)

Factors related to medicine

- Prescribing most/all medications require recent physical examination
- Certain medications should not be prescribed without a physical examination (e.g. antibiotics, POM-Vs)
- Repeat prescriptions
- Use of cascade medications
- If prescription given without physical examination doesn't work, physical examination is necessary
- Protection of public health
- Concurrent medications/drug interactions/contraindications
- Treatments or prophylaxis
- Amount of medication being prescribed
- Specific list of medications that can be prescribed remotely

Factors related to consultation

- Extent of consultation i.e. video versus audio only
- Guidance on time frames for physical examinations
- Supersession of factors to be considered in this guidance
- Diagnostic tests
- If condition is newly presenting or ongoing
- Urgency of treatment
- Ability to examine in case of emergency
- When the animal was last examined
- Second opinions

Local knowledge of disease

- Clinical reasoning for not performing an exam
- Whether or not a diagnosis is confirmed
- Emergency scenarios (e.g. war, pandemic, etc.)
- Biosecurity
- Likelihood a physical exam will affect treatment choices
- Follow up consultations
- Subsequent provision of evidence for legal cases
- Treatment means the animal is under the care of prescribing vet care
- Declining services

Factors related to vet surgeon or practice

- Level of experience of veterinary surgeons
- Passing on updated clinical histories to relevant parties
- Ability of vet or practice to provide veterinary care
- RVNs role in this guidance
- Safety of vet and team
- Which vet surgeon has performed the most recent examination
- If the animal is registered with the practice
- Abuse of telemedicine businesses
- Where the practice is based
- Corporate company policies influencing vet's judgement
- If telemedicine provider is linked with a practice
- Conflicts of interest
- Reference to individual veterinary surgeon versus practice team
- Consequences if lack of physical examination leads to poor animal welfare

Factors Related to animal

- Behavioural factors (e.g. aggressive or distressed animals)
- Reliability of clinical history
- Species of the animal
- Impact on animal welfare if not treated
- Other groups of animals should be included with agricultural animals i.e. lab animals

- Accurate bodyweight
- Growth periods
- Proof of animal existence/identity
- Age of animal
- Suspected abuse or neglect
- If animal is under the care of another vet
- Animal's environment

Q12 To what extent do you agree with this?

5. The more complex or unusual the health needs of the animal, or where a differential diagnosis includes serious conditions not yet ruled out, the more likely a physical examination will be necessary.

Responses

For guidance paragraph 5, the overwhelming majority agreed with this guidance statement with 89% agreeing or strongly agreeing with this approach. 12% (271) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Prescribing most/all medications require recent physical examination (49%)	• Responses revealed that respondents believed a recent physical examination was important in most or all cases, as it is difficult to know how complex a case is without having performed a physical examination. • Others thought that if the initial course of treatment from a remote consultation was not successful, then an in person examination would be necessary before prescribing further medication. • Some believed that wording of this statement needs to be made stronger, emphasising that physical examination should be mandatory in serious or complex cases.

Responsibility of vets to make the judgement (10%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe remotely, and access to the animal's clinical history and a good relationship with the client will aid this judgement.
This statement is unnecessary/ has been covered in earlier statements (6%)	• Some respondents thought that clause 5 was unnecessary as it should be common sense, with a few respondents believing this was covered by other statements in the guidance, particularly statement 4a. • Some respondents were concerned that many conditions would fall into the category of differential diagnosis and therefore this guidance wasn't particularly helpful.
Needs greater clarification (12.5%)	• Some thought this statement was too vague and subjective, with some suggesting that they would like more guidance on which conditions would be considered serious. • Others however felt that this guidance was too complicated. • Some respondents were concerned that this guidance would be open to abuse from telemedicine provides and leave vets open to intimidation from clients.
Clause 5 is relevant (19%)	• Many believed that clause 5 is a relevant factor when deciding whether a physical examination is necessary, with some believing this should be obvious. • Some thought that the potential risks of remote consultations in this situation needs to be discussed and consented to by the owner. • A few responses indicated that remote consultations can be helpful in these circumstances, especially is specialists are required.

B. Exceptions to the rule

Q13 To what extent do you agree with this?

6. A physical examination is required where a notifiable disease is suspected or part of a differential diagnosis.

Responses

For guidance paragraph 6, the overwhelming majority agreed with this guidance statement with 93% agreeing or strongly agreeing with this approach. 8% (178) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Clause 6 is essential (51%)	• Some believed that investigating the suspicion of notifiable disease is essential for public health protection and disease prevention. • Several respondents said that any suspicion of notifiable disease need to be immediately referred to a state veterinary service, specifically APHA or DEFRA.
Physical examination of the animal necessary in most/all cases (17%)	• Responses revealed that respondents believed a recent physical examination was important in most or all cases.
Remote exam be helpful for notifiable disease – protects vet/ other animals (8%)	• Some responded thought that being able to examine the animal remotely (or home visit with appropriate PPE) is helpful in cases of notifiable disease, as it can protect both the vet and other animals from the spread of the disease. A physical examination may not be necessary if lab samples can be obtained to test for notifiable diseases.

Needs greater clarification/lacks clarity (4%)	• Some respondents wanted more clarification for this statement and particularly wanted an addition about the probability of notifiable disease concerned. • A few respondents suggested that zoonotic diseases should also be included in this statement. The need for a physical examination depend on other factors such as the urgency of an examination and the risk to public health.
Unnecessary addition/notifiable disease could be included in differential diagnosis (2%)	• Several respondents felt that this statement was an unnecessary addition to the guidance, as notifiable disease could be included in differential diagnosis. • Some responses believed that it is difficult to know when there is a notifiable disease, and that notifiable diseases could be added to many differential lists, and therefore when making the judgment the needs to take into account likelihood of notifiable disease

Q14 To what extent do you agree with this?

7. [Also] given the importance of minimising the development of antimicrobial resistance:

a. physical examination is required in all but exceptional circumstances where a veterinary surgeon prescribes antimicrobials for an individual animal or group of animals that are not agricultural animals. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without a physical examination and record this justification in the clinical notes.

Responses

For guidance paragraph 7a, the overwhelming majority agreed with this guidance statement with 78% agreeing or strongly agreeing with this approach. 20% (423) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Needs greater clarification (24.5%)	• Some respondents felt that different aspects of this statement needed greater clarification, especially about which groups of animals would be considered agricultural animals. • Some believed that the terminology “in all but exceptional circumstances is to subjective and open to interpretation and could be subject to abuse. Some believed that some examples of exceptional circumstances and more guidance on which antibiotics classes would be helpful. • Several believed that this statement should also apply to agricultural animals and lab animals. • A few respondents thought that anti-parasite treatments should also be included because of issues of resistance. • Some felt that the ambiguity of the statement would leave this guidance open to abuse.

Physical examination is not always necessary for prescribing antimicrobials (30%)	• Some respondents indicated that a physical examination is not always necessary for prescribing antimicrobials, especially in cases where there is a strong relationship between the client and vet or if their judgement can be supported by lab testing and diagnostics. • Many felt that exceptions for the need of a physical examination should be made in cases of repeat prescriptions or where it is obvious from the remote consultation that there is infection.
Physical examination is necessary for prescribing antimicrobials (38%)	• Responses revealed that respondents believed a recent physical examination was important for prescribing antimicrobials to prevent inappropriate use of antibiotics and to combat antimicrobial resistance. • Some felt that agricultural animals should not be treated differently than individual animals, as they face the same risks regarding AMR. • Some believed that exceptions for the necessity of a physical examination should be made for repeat prescriptions.
Responsibility of vets to make the judgement (10%)	• Some respondents felt that the vet was most qualified to make the judgement of whether a physical examination would be necessary to safely prescribe antimicrobials remotely, given the information that they have, although they should be able to document the justification of the use of antimicrobials. • A few respondents thought this judgement should depend on other factors such as when the animal was last seen or access to clinical history.

Q15 To what extent do you agree with this?

b. When prescribing antimicrobials for agricultural animals, veterinary surgeons should ensure they have an in-depth knowledge of the farm, including its production systems, the environment, disease challenges and the general health status of the herd or flock. Veterinary surgeons should have attended the premises and physically examined at least one animal immediately prior to prescribing or, where this is not possible, recently enough to ensure they have adequate information and knowledge to prescribe responsibly. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without conducting a physical examination and record this justification in the clinical notes

Responses

For guidance paragraph 7b, the overwhelming majority agreed with this guidance statement with 80% agreeing or strongly agreeing with this approach. 11% (238) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Needs greater clarification (29%)	• Some felt that this guidance needed greater clarity, particularly bout where groups of animals who are not agricultural animals, including lab animals and equines, fit into this guidance. • Some respondents believed that the terminology of "recently enough" in the statement is too vague, and there should be some guidance on the timeframe necessary to prescribe antimicrobials. • Some clarified that they believed agricultural animals should be treated the same as companion animals and should be required to have a physical exam to prescribe antimicrobials. • Others noted that the guidance should be broadened to include the whole vet team of the practice and should not just apply to the individual veterinary surgeon. • Some were concerned that the ambiguity of the guidance would leave it open to abuse.

Physical examination is not always necessary for prescribing antimicrobials (20%)	• Some believed that a physical examination is not always necessary for prescribing antimicrobials. • Some were concerned that this would not be practical farmers or clinics for a multitude of reasons including financial reasons. Some worried that they don't have time for the additional requirements of documentation, while other were concerned that this would not be possible with the shortage of veterinary staff. • A few responses indicated that a physical examination of one animal contributes very little information about the overall health status of the herd, and that other farm record and diagnostics are more helpful when deciding to prescribe antimicrobials in agricultural animals.
Physical examination is necessary for prescribing antimicrobials (16%)	• Responses revealed that respondents believed a recent physical examination was important for prescribing antimicrobials to prevent inappropriate use of antibiotics and to combat antimicrobial resistance. • Some thought that a physical exam of a representative proportion of the group was necessary. • Others believed all affected animals should be examined.
Clause 5b is relevant (15%)	• Some felt that this statement was a relevant addition to the guidance for public health and animal welfare. • Some respondents thought vets should be able to justify and document the use of antimicrobials. • Others believed that a relationship between the client and vet would aid the ability of the vet to prescribe antimicrobial remotely.

Q16 To what extent do you agree with this?

8. When prescribing controlled drugs to an animal in the first instance, veterinary surgeons should carry out a physical examination in all but exceptional circumstances and be prepared to justify their decision where no physical examination has taken place. This justification should be recorded in the clinical notes. It is acceptable to issue a repeat prescription for controlled drugs without a physical examination, however veterinary surgeons should carry out a further clinical assessment to ensure they have enough information to do so safely.

Responses

For guidance paragraph 8, the overwhelming majority agreed with this guidance statement with 85% agreeing or strongly agreeing with this approach. 15% (327) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Needs greater clarification (19%)	• Some respondents felt this statement needed further clarification and wanted more guidance on what the terms "exceptional circumstances" and "further clinical assessment" would entail, as well as more clarification on what time frame would be suitable between re-examinations for repeat prescriptions. • Some believed that the guidance needs to be made stronger as so indicated that the ambiguity could leave this guidance open to abuse.
Physical examination not always necessary for prescribing controlled drugs (20%)	• Some felt that physical examination is not always necessary for prescribing controlled drugs and that exceptional circumstances for this guidance should include situations involving palliative care and in circumstances where the safety of the vet is at risk, for example aggressive animals. • Many respondents believed that there are certain controlled drugs that should be able to be prescribed without a physical examination, with phenobarbitone and gabapentin being medications that would benefit from the exemption.

Physical examination is necessary for prescribing controlled drugs (45%)	• Responses revealed that respondents believed a recent physical examination was important for prescribing controlled drugs, with many citing the prevention of misuse of the drugs by animal owners as the primary reason for the need of a physical examination. • Some felt that it makes no difference if it is controlled drugs being prescribed remotely, the welfare of the animal matters more. • Several respondents felt that there should be no exceptional circumstances for controlled drugs, and that a physical examination should always be performed for prescribing them.
This clause is useful (8%)	• A few responses felt that statement was useful and relevant. • Some noted that for remote consultations, vets should limit the amount of controlled drugs prescribed and examine at the nearest availability. • Some also stipulated that repeat prescriptions should also require a physical examination.
Responsibility of vets to make the judgement (7%)	• Some responses indicated that it should be the responsibility of the vets to make the judgement of whether a remote consultation is appropriate, and a relationship between the client and vet would aid the ability of the vet to prescribe controlled drugs remotely. • Some also thought this judgement would depend on other factors especially clinical history.

Q17 Are there any other situations where a physical examination should be required?

Responses

34% of respondents thought there were other situations where a physical examination should be required, and 31% of respondents who answered this question left additional comments explaining what situations should be added. There were 605 responses.

Themes:

Factors related to owner

- No VCPR or ongoing relationship
- Client is new to the practice or hasn't been examined before
- If difficulties communicating with client (e.g. language barriers, intoxication, etc.)
- Where animal owner raises suspicion or is unreliable
- If ownership is unclear
- If owner requests a physical examination

Factors related to medicine

- Prescribing most/all medications require recent physical examination
- Certain medications should not be prescribed without a physical examination (e.g. antibiotics, POM-Vs, controlled drugs)
- Prescription of medication is new
- Previous prescription is not efficacious and client is requesting new treatment
- Use of cascade medications
- Previous adverse reactions/possible adverse reactions
- When vet needs to demonstrate how to use medication (e.g. injectables)
- Chemotherapy drugs
- Sedation medication
- Drugs that could cause abortion
- Repeat prescriptions or change of dose requests
- Medication that has human risks
- Medications with contraindications
- Group treatments for agricultural animals

Factors related to condition

- If condition is new
- Where condition has changed
- For situations where the animal is in pain
- Periparturient animal
- Severe or life-threatening conditions
- Protection of public health (e.g. zoonotic disease)
- Eye or ear disease
- Cardiac diseases
- Accidental drug ingestion
- Where contraindications may be possible
- Dystocia
- Respiratory problems
- If differential diagnosis is potentially serious
- Notifiable diseases
- No improvement in condition
- Neoplasia
- Gastrointestinal conditions
- Seizures or collapsed animal
- Generally unwell animals (e.g. non-specific symptoms)
- Trauma cases
- Hyperthyroidism
- Lameness
- Orthopaedic conditions
- Pyometra
- When animal has other comorbidities

Factors related to consultation

- Where there is any doubt about the certainty of diagnosis a physical examination is required
- Where there is no access to clinical history
- If cannot assess properly remotely (e.g. ocular examinations)
- Before surgery

- If providing a second opinion
- Guidance on time frame for examination
- Repeat prescription health checks
- Export of animals or travel paperwork
- Imported animals
- Euthanasia
- Where litigation is likely
- Before referral to a specialist
- Vet’s clinical experience
- If the practice is a long distance from the client
- Prior to referral
- If there are changes in the veterinary premises (e.g. new staff or ownership)

Factors Related to animal

- If animal is unregistered with the practice
- Where abuse or neglect of the animal is suspected
- Where animal welfare may be compromised
- When an accurate weight of the animal is necessary
- Age of animal – elderly or very young
- Aggressive animals
- Confirmation of the animal’s identity

Other themes:

- Other
- No additions
- Vet’s judgement
- Needs greater clarification
- Concerns about guidance

C. 24/7 follow-up service

Q18 To what extent do you agree with this?

9. Where a physical examination is not carried out immediately prior to prescribing POM-Vs, veterinary surgeons should ensure that a 24/7 follow-up service involving physical examination and any other necessary investigation if required is immediately available in the event the animal does not improve, suffers an adverse reaction or deteriorates. Where a veterinary surgeon is not able to provide this service themselves, they should arrange for another veterinary service provider to do so. This arrangement should be made before veterinary services are offered and confirmed in writing as part of the conditions of service agreed by the client

Responses

For guidance paragraph 9, the overwhelming majority agreed with this guidance statement with 79% agreeing or strongly agreeing with this approach. 24% (509) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Needs greater clarification (11%)	• Some felt they needed greater clarification about this guidance, especially regarding what confirmation in writing would look like and how the term “immediately available” would be quantified. • Others felt suggested that the 14/7 follow up service needs to a suitable proximity to clients, and this statement would benefit from more guidance on what a suitable proximity would entail. • Some believed that the phrase ‘arrangement should be made before services are offered’ should be highlighted in this guidance and needs to clear to clients before they consent to treatment, while others wanted the wording of the guidance to be stronger, replacing the word ‘should’ with the word ‘must’. • Some felt that the world “immediately” is too restrictive.

Concerns about this guidance (23%)	• One concern that was mentioned by some respondents was that will increase the number of out of hours calls practices receive. • Many felt that it is impractical and unnecessary to confirm the arrangement of follow up services in writing, as this will greatly increase their workload. • A few respondents believed that this provision would not be possible in some rural areas where there may not be an out of hours clinic locally and is impractical for other areas who are struggling with staff shortages and overburdened clinics. • Others felt this guidance was impractical for clients for other reasons including costs, the welfare of the animal being compromised if not treated, and issues of transport, and impractical for vets as it closes down telemedicine to only those who have a network OOH, thereby penalising small independent businesses. • Several respondents were also concerned that this policy would be open to abuse by insurance companies and telemedicine by pushing this requirement onto other practices. • There were some respondents who also noted that owners may not comply with the ongoing care provided.
Physical examination of the animal necessary in most/all cases (15%)	• Many felt that the provision of 24/7 follow up care is important and necessary to protect animal welfare, although some noted that this should always be the case regardless of whether an examination has taken place and needs to be made clear to clients.

Follow up care access is important (44%)	• Many felt that the provision of 24/7 follow up care is important and necessary to protect animal welfare, although some noted that this should always be the case regardless of whether an examination has taken place and needs to be made clear to clients. • Some however felt that the responsibility for ongoing care after treatment should lie with the prescribing vets practice, so not to pass off cases to other practices. • Others felt the client should be responsible for finding ongoing care for their own animal or it should be the responsibility of their registered practice. If a secondary provider was to perform OOH care for a remote prescribing vet, many stipulated that this should be agreed upon with the secondary provider as well to ensure that there is availability for them to handle the case. • Some responses indicated that clinical histories should be passed to any relevant parties, whether that be a secondary OOH care provider, or back to the original practice. • Some noted that the 24/7 follow up care has not been happening in practice, and that these rules must be enforced by RCVS. • Some noted that 24/7 care services should only be used for emergencies only and clients need to be made more aware of this.
Unnecessary – this is covered by other RCVS 24-hour guidance (4%)	• Several respondents believed that this statement was unnecessary as it is covered by other RCVS 24-hour care guidance. • Others felt that 24/7 cover responsibilities should not apply to all vets, with mobile vets being an example of a vet who would not need 24/7 cover.

2. Questions on 24-hour emergency first-aid and pain relief

D. General obligations

Q19 To what extent do you agree with this approach?

23. We do not propose any substantive change to our current guidance on 24-hour emergency first aid and pain relief, except for the proposed guidance for limited service providers (LSPs).

We believe that, in the absence of an animal-equivalent to a local accident and emergency department, animal welfare is best served by the current requirement that veterinary surgeons in practice take steps to provide 24-hour emergency first aid and pain relief.

(Please note that this section of the survey relates to a veterinary surgeon's general obligations in respect of 24-hour emergency care, as distinct from the proposal that a 24/7 follow-up service should be provided where a POM-V is prescribed without a physical examination.

Responses

The overwhelming majority agreed with this statement with 75% agreeing or strongly agreeing with this approach. 18% (368) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
There needs to be a review of 24-hour guidance (35%)	• Some believed that there needs to be a review of the current 24-hour guidance because it isn't sustainable, with some attributing issues of shortages in the workforce to this provision. • Some brought up that current staff shortages meant clinics were already struggling to get out of hours care and were worried this requirement would make the situation worse. • Some were concerned that this requirement penalises small, independent, and rural businesses by putting undue stress on them to be available 24/7. • Many suggested a move towards and A&E type system for emergencies would be more beneficial than having this provision, and this would be created if the requirement of 24-hour emergency care would be removed.
24-hour emergency care is necessary (30%)	• Some felt that 24-hour emergency care is necessary to protect animal welfare, although several noted vets should only have to provide 24-hour cover or registered clients. If this OOH care is outsourced, this would need to be agreed upon, and then the responsibility for ongoing care would then be transferred to them. A few respondents felt that the wording needs to be made stronger with the phrase "takes steps to" being replaces with the word must. Some believed that every practice should be subject to the same rules, including LSPs and telemedicine providers who should at least provide emergency pain relief or euthanasia. Respondents believed that OOH care needs to be made clear to clients and clinical histories for the animal needs to be passed along to the relevant parties.

Where does responsibility lie for ongoing care? (17%)	• Some indicated that the responsibility for ongoing care lies primarily with the client, some believed it was the responsibility of the registered practice, and others thought that it was the responsibility of the person prescribing otherwise the burden will fall on other practices. • Some stipulated if that the responsibility should fall with the practice and not individual veterinary surgeons.
Needs greater clarification (10%)	• Some felt that this guidance needed more clarity, especially in terms of time limits and distances that locality entails, with some noting that OOH care should be a reasonable distance. • Some felt that it needs to be made clearer to clients that OOH visits are for emergencies only.
LSPs (3%)	• Some felt that LSPs should not exist while others wanted a clearer definition of LSPs.

E. Limited Service Providers (LSPs)

Q20 To what extent do you agree with this definition of LSPs?

1. A limited service provider is a practice that offers no more than one service to its clients and includes, but is not limited to, vaccination clinics, equine reproductive clinics and neutering clinics. For these purposes, a ‘practice’ is a Registered Veterinary Practice Premises (RVPP) as entered into the register held by the RCVS.

Responses

In respect of this, the majority agreed with this guidance statement with 67% agreeing or strongly agreeing with this approach. 14% (284) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
LSPs can perform more than one service (19%)	• Many felt that this definition of limited-service providers was too limited as they believed that LSPs can perform more than one service. A typical example given would be vaccination clinics being considered LSPs despite offering other services such as neutering or treating fleas and worms.
LSPs should be responsible for OOH where necessary	• Several respondents thought that limited service providers should be responsible for the out of hours care and 24-hour cover by themselves, or at least outsourcing this to a OOH provider.
LSPs should not be allowed	• Some respondents believed that limited service providers should not be allowed, with concerns that they take business away from practices as well as encourage the formation of inappropriate breeding clinics. • Some believed that LSPs were open to abuse by cherry picking cheap and easy to provide services without having to provide full cover for their services.

Needs more clarification/specific list of LSPs included	• Some respondents felt that this statement needed greater clarification, with some wanting more guidance on which types of services would be considered LSPs and whether you can be an LSP and perform more than one service. • Some of the services that were noted that should be considered as LSPs were fertility clinics and mobile or telemedicine practices. • Some believed that if a practice is performing veterinary surgery, they should not be considered an LSP.
Clause E 1 is relevant	• Some felt that this was a relevant cause to include and were happy that LSPs were clarified as only performing one service, although some believed that it is important to inform clients of the limitations of LSPs.
LSPs should not be responsible for OOH care	• Some respondents thought that LSPs should not be responsible for OOH care, with some noting that this would be the responsibility of their registered practice.

Q21 To what extent do you agree with the proposed 24-hour emergency obligations for LSPs?

2. Limited service providers should provide 24-hour emergency cover that is proportionate to the service they offer. This means that veterinary surgeons working for limited service providers should ensure that the 24-hour emergency cover provision covers any adverse reaction or complication that could be related to procedures or examinations carried out, or medicines prescribed or used.

Responses

In respect of this, the overwhelming majority agreed with this guidance statement with 80% agreeing or strongly agreeing with this approach. 15% (311) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
LSPs should provide 24-hour coverage (59%)	• Many respondents believed that limited-service providers should have to provide 24-hour coverage like any other veterinary practice otherwise it puts unfair burden on other practices. This 24-hour coverage could be performing care themselves, outsourcing to an emergency care provider via arrangement, or simply signposting clients to OOH care. • Some responses noted that this should not be proportionate to treatment but should instead cover any condition that arises, as it can be difficult to determine if this adverse reaction is from treatment. • Some noted that it is important for clients to be informed of the limitations of LSPs and their OOH care responsibilities.
LSPs should not be required to provide 24-hour care (12%)	• Some respondents felt that LSPs should not be obligated to provide 24-hour coverage as this requirement is unviable for them as they may not have the facilities to provide appropriate care. While some felt this was a good thing as it would facilitate the comeback of local smaller practices, others felt that this requirement is unfair and acts as a barrier for independent workers. • Responses indicated that LSPs don't provide emergency care in practice. • Some noted that certain LSPs like home euthanasia services should not be required to provide 24-hour care.
Responsibility of ongoing care (7%)	• Some respondents suggested that the primary care practice should be responsible for providing out of hours care as they are better equipped to provide this level of care. • Others believed that it is the animal owner's responsibility to find out of hours care for their animal.
LSPs should not exist (4%)	• A few respondents felt that LSPs should not exist, with some being concerned that they would be open to abuse by cherry picking profitable services and abdicating responsibility for ongoing care.

Need greater clarification (15%)	• Some respondents believed that the guidance needed greater clarification, especially about who will be enforcing or regulating these rules. • Some noted that responsibility for ongoing care should be longer for neutering procedures. • Some responses indicated that the guidance here is too vague. Particularly, they wished for more guidance on the time period that 24-hour care should be available as well as which services that would be considered LSPs, as well as what is meant by the term 'proportionate'.

F. Advice-only services

Q22 To what extent do you agree with this approach?

At present, veterinary surgeons offering advice-only services are not obliged to provide 24-hour emergency first aid and pain relief.

We believe this approach is proportionate and do not propose any changes to this position.

Responses

The majority of respondents agreed with this statement, with 54% agreeing or strongly agreeing with this approach. 22% (451) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Advice only services should provide OOH care (40%)	• Many respondents believed that advice-only services have the responsibility to provide 24-hour emergency coverage or at least sign post clients to emergency care. • Respondents felt this was important for maintaining continuity of care. Some respondents believed that all veterinary surgeons should be responsible for 24-hour emergency care regardless of the type of veterinary services they provide while others believed that this would depend on the advice being given.

Suggestions for guidance (23%)	• Some felt that advice-only services should not be able to prescribe treatments, particularly POM-Vs. • Many noted that advice-only services should be held responsible for any wrong advice given. • Some thought that advice-only services should make it clear to clients that they need to be registered with a practice as a way of ensuring that they have access to emergency care. • Some believed that advice only services should not charge clients, and if they do, they should be responsible for any ongoing care. • Several responses suggested that advice-only services should be in communication with veterinary practices they refer clients. • Others felt that advice-only service should be linked to a brick-and-mortar practice, where they can direct clients to that would be able to carry out an examination if necessary.
Advice only services should not exist (15%)	• Some respondents believed that advice-only services should not exist with some saying that they cause confusion for clients if advice given differs from that given by the practice and they undermine local veterinary business. • Some believed that if they give wrong advice, it could be detrimental to animal welfare and puts extra burden on general practices.
Advice only services can be useful (3%)	• Some respondents believed that advice-only services can be useful for triaging and giving clients access to good quality information, thereby reducing strain on emergency providers. • Some noted that any access to veterinary care is better than nothing if getting a physical appointment is not possible. • Some noted that it is important to make sure clients are aware of the limitations of these services.

Needs greater clarification (9%)	• Respondents felt that this guidance would need more clarification, especially in terms of who would be responsible if wrong advice was given. • Some respondents did not understand what advice-only services are or didn't know that they existed and wanted a clearer definition of what being an advice-only service entails.
Advice only services should not have to provide OOH care (4%)	• Some responses indicated that advice-only services should not have to provide emergency cover as they cannot provide meaningful cover remotely without access to the facilities or medicines required to perform an appropriate service. • A few respondents believed that the responsibility for ongoing care lies with the client's registered practice.

G. Referral practices

Q23 To what extent do you agree with this approach?

The current out-of-hours obligation for veterinary surgeons working in referral practices is that they 'should provide 24-hour availability in all their disciplines, or they should, by prior arrangement, direct referring veterinary surgeons to an alternative source of appropriate assistance'.

The guidance also requires referral practices to make arrangements to provide advice to the referring veterinary surgeon on a 24-hour basis and that appropriate post-operative or inpatient care should be provided by the veterinary surgeon to whom the case is referred, or by another veterinary surgeon with appropriate expertise and at a practice with appropriate facilities.

We believe this approach protects animal health and welfare and as such, we do not propose any changes to this position.

Responses

The overwhelming majority agreed with this statement, with 88% agreeing or strongly agreeing with this approach. 10% (204) of respondents left additional comments explaining their reasoning for their answer, and the themes that were most prevalent are as follows:

Theme	Brief description of responses
Referral vets should not have 24-hour obligations (55%)	• Some believed that referral vets should not have 24-hour obligations with many feeling that these requirements for referral practices were impractical because of the increasing caseload and shortage of staff, and because of this many referral services do not provide this coverage in practice. • Some believed that requirements to have 24-hour emergency care for all disciplines is too expansive and impractical, especially due to low numbers of specialist vets. • A few respondents also noted that this guidance would reduce clients access to excellent care.
Vet surgeons should offer OOH care/24-hour emergency care (26%)	• Some respondents believed that referral vet surgeons should offer 24-hour emergency care. • Some agreed that vets working in referral practices should provide 24-hour availability to the referring vet, however some specified that being available for advice to the referring vet is fine, but they should not have to provide cover. • A few respondents believed whether referral vets should be responsible for ongoing care depends on other factors such as the type of practice, the specific service being performed or the location of the practice. • A few respondents believed that requirements for referral practices should match those of GP practices and be responsible for 24-hour care.
Needs greater clarification (16%)	• Some respondents indicated that this guidance needs greater clarification as the guidance was overly complicated, with some noting that there should be a distinction in the guidance regarding care for existing clients and prospective clients. • Others were concerned that this guidance would be open to abuse by allowing referral centres delegating the OOH responsibilities to other practices. • Respondents also emphasise that this guidance needs to be enforced in practice.

Review of ‘under care’ and 24/7 emergency cover

Annex

RCVS | SETTING VETERINARY STANDARDS

Review of ‘under care’ and 24/7 emergency cover

A consultation on proposed guidance

July 2022

UNDER CARE **REVIEW**

Contents

A. Foreword 3

B. Background 5

C. The current position 6

D. The review 7

E. Proposed 'under care' guidance 9

F. Recommendations regarding 24-hour emergency cover 11

G. How to respond 12

A. Foreword

A long journey

The journey of reviewing 'under care' and provision of 24-hour emergency first-aid and pain relief has been a long one, its origins dating back to the Vet Futures initiative in 2016.

Relating as it does to a fundamental aspect of veterinary practice, this review has generated considerable discussion and debate in recent years, with strongly held views presented on all sides during all stages, including evidence-gathering, analysis and feedback.

As ever, it is the College's responsibility, through the work of our Standards Committee and Council, to consider in detail the views and experience of all our stakeholders along with, in this case, formal legal advice and commissioned independent research, and to propose a way forward.

The pandemic effect

A significant contributor to the length of this journey, of course, has been the Covid-19 pandemic, which has delayed the review's progress by around two years. Nevertheless, numerous lockdowns have afforded us the chance to explore our long-held understanding of what 'under care' means in principle, and to learn how new guidance could best work in practice, across all species types.

"The proposed guidance seeks to protect animal health and welfare and maintain public trust by ensuring that decision-making remains firmly in the hands of individual veterinary surgeons."

Along with many things, the past two years have demonstrated that the veterinary professions are highly capable of adapting to changing societal needs. As veterinary professionals, we cannot, and should not, expect established ways of practice to go unchallenged and remain unchanged, particularly in the face of shifting public expectations and advancements in technology. However, it is our collective responsibility to ensure that any

changes continue to allow us to provide safe and effective care for our patients, and meet the appropriate expectations of our clients.

The need for change

Whilst therefore recognising and reflecting this need for change, the proposed guidance seeks to protect animal health and welfare and maintain public trust by ensuring that decision-making remains firmly in the hands of individual veterinary surgeons, as to what they, in their professional judgement, consider appropriate in a specific situation.

This consultation, then, whilst not a referendum on whether RCVS guidance on 'under care' and 24-hour emergency first-aid and pain relief should change – that decision having been made by Standards Committee and approved by Council based on the evidence gathered, including the views of the profession and objective evidence, and legal advice – is a crucial opportunity for you to tell us whether we have got the draft guidance right, or if there is anything we might have missed.

Animal health and welfare

In the online survey you can provide feedback on each individual element of the proposed guidance. We are particularly keen to know if there are any factors we may have overlooked that could impact on animal health and welfare, and/or public trust.

Before answering the questions, however, I would urge you to read the background and detail of the proposal set out on the following pages. This will help to explain the journey to this point and the challenges we have met along the way.

Full details on how to respond are set out on page 22, but please make sure to send us your feedback by 5pm on Monday, 12 September 2022.

Thank you in advance for your time and consideration.

Dr Melissa Donald BVMS MRCVS
RCVS President, Former Chair of Standards Committee

B. Background

1) The Royal College of Veterinary Surgeons (RCVS) is both the Royal College and regulatory body for veterinary surgeons and veterinary nurses in the UK. As a regulator, we set, uphold and advance veterinary standards and, as a Royal College, we promote, encourage and advance the study and practice of the art and science of veterinary surgery and medicine. We do all these things in the interests of animal health and welfare, and in the wider public interest.

2) Our review of telemedicine, ‘under care’ and 24/7 first-aid and pain relief began in 2016 with the Vet Futures initiative. This then led to the ambition in the RCVS Strategic Plan 2017-2019 to ‘review the regulatory framework for veterinary businesses to ensure a level playing field, enable a range of business models to coexist, ensure professionalism in commercial settings, and explore the implications for regulation of new technologies (eg telemedicine)’. This led to consideration of ‘telemedicine’ in its narrowest sense, ie in relation to remote prescribing, including the possibility of ‘trialling’ remote prescribing.

> ***“As this review hinges on the legal interpretation of the terms ‘clinical assessment’ and ‘under care’, we sought legal advice to ensure that the basis of the guidance that governs the profession is correct and reliable.”***

3) A key theme that emerged through these discussions was that remote prescribing and out-of-hours care were closely linked. The reason being that if a medicine is prescribed without a physical examination, consideration needs to be given to where owners go to seek help or their animals in the event of an adverse reaction or deterioration.

4) All the of the above ultimately resulted in the current, broad-ranging review of under care and out-of-hours guidance that began in 2019, conducted by the RCVS Standards Committee. As this review hinges on the legal interpretation of the terms ‘clinical assessment’ and ‘under care’, we sought legal advice to ensure that the basis of the guidance that governs the profession is correct and reliable. That legal advice is discussed further below and underpins the recommendations made.

5) The Standards Committee presented its findings to Council in spring 2022, and we now wish to consult on the changes proposed as a result.

C. The current position

Under care

6) Before a veterinary surgeon can prescribe prescription-only veterinary medicines (POM-Vs), according to **Schedule 3, paragraph 4 of the Veterinary Medicines Regulations 2013 (VMRs)** they must first carry out a 'clinical assessment' and have the animal 'under their care'. These terms are not defined by the VMRs and so it is left to the RCVS to interpret what they mean.

7) It is important to note that, under the VMRs, the requirements to carry out a clinical assessment and have the animal under one's care only apply to the prescription of POM-Vs. This means that when prescribing other classes of medicines or treatment not involving the prescription of POM-Vs, veterinary surgeons do not need to satisfy these requirements (although there are more general obligations relating to the provision of veterinary care, 24-hour emergency first-aid and pain relief, and responsible prescribing that must be met).

> ***"The terms 'under care' and 'clinical assessment' are not defined by legislation, so it is left to the RCVS to interpret what they mean."***

8) Our **current guidance on prescribing POM-Vs** effectively requires a physical examination to be carried out before **a** veterinary surgeon can establish that **an** animal is under their care. The guidance states that animals should be 'seen' immediately prior to prescribing or 'recently or often enough for the veterinary surgeon to have personal knowledge' of the animal or herd. It goes on to say that a veterinary surgeon cannot usually have an animal under their care if there has been no physical examination and that they should not prescribe POM-Vs via the internet alone. Remote prescribing is therefore allowed under our current guidance, but only where the animal is already under the veterinary surgeon's care.

9) We recognise, however, that there are some situations where the precise requirements of the VMRs are not practical, for example, when prescribing for herds, shoals and flocks, or issuing repeat prescriptions as a locum. In addition, the current guidance was written at a time before good quality video calls were widely accessible and physiological data could, in some cases, be gathered at a distance.

24-hour emergency first aid and pain relief

10) The *RCVS Code of Professional Conduct* requires all veterinary surgeons in practice to 'take steps to provide 24-hour emergency first aid and pain relief to all animals according to their skills and the specific situation'. Veterinary surgeons are not obliged to provide the service personally or expected to remain constantly on duty. They are, however, required to ensure clients are directed to another appropriate service when they are off duty or otherwise unable to provide the service. The current guidance is set out in full in **Chapter 3: 24-hour emergency first aid and pain relief**.

11) The out-of-hours obligations for veterinary surgeons working for limited service providers (LSPs), or based in referral practices, are slightly different to the general position described above and this is discussed more below.

D. The review

12) The current review began in 2019 to find out whether the current rules are fit for purpose, or whether change is required. As with all RCVS guidance, the aim is to protect animal health and welfare, maintain and uphold veterinary standards and ensure public confidence in the profession.

13) To assist with data gathering, the Standards Committee engaged the services of RAND Europe (an independent consultancy). The review comprised focus group discussions with members of the professions, the outcomes of which informed a survey which went out in May 2021 and had 5,544 responses. RAND analysed the survey responses and produced a report, which can be found via **www.rcvs.org.uk/undercare**.

"The issue of whether a physical examination is necessary [in order to make a clinical assessment] should be a matter of judgement for the veterinary surgeon in each individual case."

14) As a result of the difficulties arising from the Covid-19 pandemic, it was necessary to suspend the normal guidance and introduce temporary guidance allowing veterinary surgeons to establish 'under care' remotely in certain situations. The purpose of this was to ensure that veterinary surgeons could continue to care for animals without breaching government guidelines and restrictions, and in a way that was safe for them, their teams and their clients.

15) The operation of this temporary guidance presented us with a unique opportunity to carry out research and gather evidence based on real experiences. We therefore commissioned two independent pieces of research from SAVSnet and VetCompass to find out how veterinary surgeons applied the temporary guidance, and to compare treatment

before and after the pandemic to see whether there were any negative implications for animal health and welfare. The findings showed that veterinary surgeons behaved responsibly and, where issues were identified, these have been factored into the proposals (see section B of the online survey). In the words of VetCompass: *'Throughout the pandemic, veterinary professionals have acted in a manner that not only protected human health but ensured animal health or welfare were not compromised'*. The research report from SAVSnet and executive and project summaries from VetCompass can also be found via **www.rcvs.org.uk/undercare**.

16) As explained above, this review hinges on the interpretation of legislation and, in particular, the terms 'clinical assessment' and 'under care'. Therefore, we sought legal advice to ensure the basis of the guidance that governs the profession is correct and reliable. Interpreting legislation requires an assessment of intention at the time it was enacted, as well as applying the context of today's world.

17) In the case of 'clinical assessment', we have been advised that this should be interpreted as including both in-person and remote clinical assessments. The issue of whether a physical examination is necessary should be a matter of judgement for the veterinary surgeon in each, individual case. We were further advised that 'under care' does not change the interpretation of 'clinical assessment' and involves consideration of whether the veterinary surgeon has taken professional responsibility for the animal. This legal advice can be found via **www.rcvs.org.uk/undercare**.

18) The proposals in this consultation therefore reflect the findings of the review, the results of the independent research projects, and legal advice we have received.

Why are we consulting?

19) With all the above in mind, we would like your views on our proposed guidance on 'under care', in particular, on whether there are adequate safeguards built in to protect animal health and welfare and to maintain public confidence in the veterinary profession. As regards out-of-hours care, we would like to know whether you agree with the approach taken, together with some specific questions about what level of 24-hour emergency cover is appropriate for limited service providers and referral practices.

20) We believe that the proposed guidance set out in Section E will continue to protect animal health and welfare and ensure veterinary surgeons prescribe POM-Vs safely. The proposed guidance is intended to uphold public trust in the profession and give clarity, as well as providing a degree of future proofing so that the profession is prepared for the inevitable development of technology.

21) We also intend to consult with members of the public to better understand their views and how the proposals might affect access to veterinary care.

E. Proposed 'under care' guidance

22) We propose that the current guidance on 'under care' be removed and replaced with the following.

Prescribing POM-Vs

1. *According to the Veterinary Medicines Regulations 2013 (VMRs), to prescribe prescription-only veterinary medicines (POM-Vs), a veterinary surgeon must carry out a clinical assessment of the animal and the animal must be under their care. The terms 'clinical assessment' and 'under…care' are not defined by the VMRs, however the RCVS has interpreted them in the following way.*

2. *An animal is under a veterinary surgeon's care when the veterinary surgeon is given, and accepts, responsibility for the health of an animal (or a herd, flock or group of animals) whether generally, or by undertaking a specific procedure or test, or prescribing a course of treatment. Responsibility for an animal may be given by the owner/client, statute or other authority.*

3. *A clinical assessment is any assessment which provides the veterinary surgeon with enough information to diagnose and prescribe safely and effectively. A clinical assessment may include a physical examination, however, this may not be necessary in every case.*

4. *Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:*

   a. *The health condition, or potential health conditions, being treated and any associated risks (see further guidance below at paragraph 5 and 6).*

b. The nature of the medication being prescribed, including any possible side effects (see further guidance below at paragraphs 7 and 8).

c. When the animal (or premises in the case of agricultural animals) was last physically examined by a veterinary surgeon.

d. Whether there is access to the animal's previous clinical history.

e. The experience and reliability of the animal owner.

f. Whether the animal is known to the veterinary surgeon and/or whether there is an existing relationship with the client or animal owner.

g. The practicality of a physical examination for individual animals, particularly when dealing with herds, flocks or groups of animals.

h. The health status of the herd, flock or group of animals.

i. The overall state of the animal's health.

j. The impact of any prescription made without physical examination on the ability to gather subsequent diagnostic information.

5. *The more complex or unusual the health needs of the animal, or where a differential diagnosis includes serious conditions not yet ruled out, the more likely a physical examination will be necessary.*

6. *In respect of paragraph 4(a) above, a physical examination is required where a notifiable disease is suspected or part of a differential diagnosis.*

7. *In respect of paragraph 4(b) above, and given the importance of minimising the development of antimicrobial resistance:*

   a. *A physical examination is required in all but exceptional circumstances where a veterinary surgeon prescribes antimicrobials for an individual animal or group of animals that are not agricultural animals. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without a physical examination and record this justification in the clinical notes.*

   b. *When prescribing antimicrobials for agricultural animals, veterinary surgeons should ensure they have an in-depth knowledge of the premises, including its production systems, the environment, disease challenges and the general health status of the herd or flock. Veterinary surgeons should have attended the premises and physically examined at least one animal immediately prior to prescribing or, where this is not possible, recently enough to ensure they have adequate information and knowledge to prescribe responsibly. Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without conducting a physical examination and record this justification in the clinical notes.*

Note: *For more information about responsible prescribing to minimise antimicrobial resistance, please see* ***Chapter 4: Medicines, paragraphs 4.23 and 4.24***.

8. *In respect of 4(b) above, when prescribing controlled drugs to an animal in the first instance, veterinary surgeons should carry out a physical examination in all but exceptional circumstances and be prepared to justify their decision where no physical examination has taken place. This justification should be recorded in the clinical notes. It is acceptable to issue a repeat prescription for controlled drugs without a physical examination, however, veterinary surgeons should carry out a further clinical assessment to ensure they have enough information to do so safely and effectively.*

9. *Where a physical examination is not carried out immediately prior to prescribing POM-Vs, veterinary surgeons should ensure that a 24/7 follow-up service involving physical examination and any other necessary investigation if required is immediately available in the event that the animal does not improve, suffers an adverse reaction or deteriorates. Where a veterinary surgeon is not able to provide this service themselves, they should arrange for another veterinary service provider to do so. This arrangement should be made before veterinary services are offered and confirmed in writing as part of the conditions of service agreed by the client.*

10. *Veterinary surgeons must maintain clinical records of animals, herds, flocks or other groups of animals under their care.*

F. Recommendations regarding 24-hour emergency cover

23) We do not propose any substantive change to our **current guidance on 24-hour emergency first aid and pain relief**, except for the proposed guidance for limited service providers (LSPs) set out below. We believe that, in the absence of an animal equivalent to a local accident and emergency department, animal welfare is best served by the current requirement that veterinary surgeons in practice take steps to provide 24-hour emergency first-aid and pain relief.

24) Our current supporting guidance only recognises two kinds of LSP, namely, vaccination clinics and neutering clinics. Veterinary surgeons who work in vaccinations clinics are required to make provision for 24-hour emergency cover for the period in which adverse reactions may arise. Those working in neutering clinics must make provision for the entire post-operative period during which complications arising from the surgery may develop.

> ***"The issue of "Animal welfare is best served by the current requirement that veterinary surgeons in practice take steps to provide 24-hour emergency first-aid and pain relief."in each individual case."***

25) We recognise that there are many other types of LSP not currently provided for, and that fairness requires that providers should be treated the same unless there is good reason not to. We therefore propose that the current guidance on LSPs (see paragraphs 3.49-3.41 of **Chapter 3: 24-hour emergency first aid and pain relief**) be removed and replaced with that set out below, which provides a broader definition of the type of practice that can be considered an LSP and imposes a general obligation to provide out-of-hours emergency care that is proportionate to the service offered.

26) We believe that the proposed guidance will protect animal health and welfare whilst providing clarity and ensuring fairness.

Limited service providers

1. *A limited service provider is a practice that offers no more than* ***one*** *service to its clients and includes, but is not limited to, vaccination clinics, equine reproductive clinics and neutering clinics. For these purposes, a 'practice' is a Registered Veterinary Practice Premises (RVPP) as entered into the register held by the RCVS.*

2. *Limited service providers should provide 24-hour emergency cover that is proportionate to the service they offer. This means that veterinary surgeons working for limited service providers should ensure that the 24-hour emergency cover provision covers any adverse reaction or complication that could be related to procedures or examinations carried out, or medicines prescribed or used.*

G. How to respond

27) This consultation is for veterinary professionals and those working alongside them, vet and vet nurse students, and representatives of stakeholder organisations.

28) Details of a separate consultation exercise for the animal-owning/-keeping public will be published in due course.

29) Before you respond to this consultation, we would urge you to view the additional reports, research papers and legal advice information provided at **www.rcvs.org.uk/undercare**.

> ***"This is your opportunity to tell us whether the proposed guidance contains adequate safeguards to protect animal health and welfare, and maintain public confidence in the veterinary professions."***

30) This is your opportunity to tell us whether our proposed new guidance on 'under care' and 24-hour emergency first-aid and pain relief contains adequate safeguards to protect animal health and welfare, and to maintain public confidence in the veterinary professions.

31) We would like to know how much you either agree or disagree with each element of the guidance, and whether you have any specific comments or suggestions to make in each case.

32) To submit your views, please visit our online survey available via 'How to respond' at **www.rcvs.org.uk/undercare**. You will first be prompted to answer a few demographic questions, for example, whether you are responding as an individual or on behalf of an organisation, before answering questions on the guidance itself.

33) The deadline for responses is 5pm on Monday, 12 September 2022.

34) Thank you for taking the time to send us your views. Responses from individuals will be treated as confidential and anonymised. With permission, we may quote from individual responses in any subsequent report, however these quotes will be anonymised. Where comments from organisations are quoted in any report, the organisation may be identified.

Royal College of Veterinary Surgeons
The Cursitor, 38 Chancery Lane,
London WC2A 1EN
T 020 7222 2001 F 020 7222 2004
E info@rcvs.org.uk @theRCVS
www.rcvs.org.uk

Under Care Review – Additional comments from organisations[1]

Q1. To what extent do you agree that paragraph (4a*) should be included in the list?
If you would like to, please give reasons for your answer

**4. Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:*

a. The health condition, or potential health conditions, being treated and any associated risks (see further guidance below at paragraph 5 and 6).

Organisation type		Reasons
Government and public bodies		
1.	Veterinary Medicines Directorate	[We] suggest the text is tweaked to: "The health condition(s), or potential health condition(s), being treated and any associated risks." It might be useful to expand on what 'associated risks' means in terms of risk to the animal and/or risk to the user/owner.
Industry		
2.	Salmon Scotland Prescribing Vet Group	Nature of fish farming makes physical examination less feasible and practical in some cases, noting the number of individuals in production units and the aquatic environment.
3.		Factors such as zoonotic risks, welfare impacts and differential diagnoses are important to consider.
Practices/Practice groups		
4.		When considering population medicine in poultry practice multiple histories (site, region, flock) are used in this decision making process. Other diagnostic and production information is also relevant.
5.	IVC Evidensia	We strongly agree that a veterinary surgeon is best placed to make the assessment as to whether a physical examination is required in any specific individual case or group of animals and that the reported health condition is a key factor in making this decision. Experience throughout the pandemic and in other jurisdictions strongly suggest veterinary surgeons recommend physical examinations in a very high proportion of patients (particularly if healthy patients requiring preventative health care medications are excluded) where prescriptions are required. This professionalism and overall attitude to risk suggests that should the consultation be implemented, animal welfare will be maintained whilst veterinary surgeons will have the ability to make a nuanced judgement and not to perform a physical examination if they judge on balance that the welfare to the patient is better met this way
Professional bodies		

[1] Where consent has been obtained, the responses in this document have been attributed to the organisations that provided them. Where consent has not been provided and the organisation is identifiable due to the nature of the responses given, these have been removed completely. RCVS Council has been provided with all responses in full on a confidential basis.

6.	British Cattle Veterinary Association	Require individual assessment taking into account complexity of case, notifiable or zoonotic disease risk or risk to other animals and may need a physical examination
7.	British Veterinary Poultry Association	A physical examination is part of a tool set that the vets have and is not the only tool that we can use when dealing with large flocks or herds, other information is appropriate to be used.

Q2. To what extent do you agree that paragraph (4b*) should be included in the list?
If you would like to, please give reasons for your answer

**4. Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:*

b. The nature of the medication being prescribed, including any possible side effects (see further guidance below at paragraphs 7 and 8).

Organisation type		Reasons
Government and public bodies		
1.	Veterinary Medicines Directorate	[We] recommend broadening this out to include '…possible risks and side effects'
Industry		
2.	Salmon Scotland Prescribing Vet Group	Nature of fish farming makes physical examination less feasible and practical in some cases, noting the number of individuals in production units and the aquatic environment.
3.		Longer term effects, eg environmental, development of resistance issues, should also be considered.
Practices/Practice groups		
4.		Variation is seen between using anthelmintics compared to any case that may require HPCIA
5.	IVC Evidensia	We strongly agree the nature of the medication and the risk of adverse events is an important consideration, particularly noting any non-preventative medication will likely carry a higher risk. In addition, we believe the maintenance of the 247 requirement associated with any prescription is a crucially important factor in maintaining animal welfare and public confidence.
Professional bodies		
6.	British Cattle Veterinary Association	Consider any contraindications or side effects and impact on food chain safety. Use of antimicrobials and controlled drugs
7.	British Veterinary Poultry Association	Medication dependent e.g. HPCIA antibiotics compared to an POM-VPS wormer.

Q3. To what extent do you agree paragraph (4c*) should be included in the list?
If you would like to, please give reasons for your answer

**4. Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive:*

c. When the animal (or premises in the case of agricultural animals) was last physically examined by a veterinary surgeon.

Organisation type		Reasons
Government and public bodies		
1.	Veterinary Medicines Directorate	Is it clear what is meant by "agricultural animals"? Are gamebirds and alpacas included in this term? Is "food-producing animals" more reflective of the intention here? [We] question the inclusion of physically examining premises in the case of agricultural animals. Is the intention of this phrase a) that the veterinary surgeon attends the premises in person and b) the herd/flock is examined? If so, it should be clarified that attending the premises includes some assessment of one or more of the animals under care (even if physical exam in not practicable). Also we consider that premises are inspected rather than "physically examined" and that a premises inspection is just as important in some small animal/equine cases. E.g. Stable yards, breeding kennels, hunting kennels etc. This shouldn't be restricted just to agricultural animals. Suggested text: "When the animal was last physically examined by a veterinary surgeon (and/or premises and herd/flock last inspected in person).". Should this be qualified, e.g. focusing on the prescribing veterinary surgeon/ practice, since a recent physical exam conducted by a different veterinary surgeon or practice, without the prescribing VS having knowledge of the findings, is considered insufficient to influence the need for a physical examination.
Industry		
2.	Salmon Scotland Prescribing Vet Group	Nature of fish farming makes physical examination less feasible and practical in some cases, noting the number of individuals in production units and the aquatic environment.
3.		For some remote and rural premises there is a challenge around regular visits so a degree of flexibility in these cases is vital. However, there is also a risk of opening loopholes which lead to inappropriate prescribing here so caution in required.
Practices/Practice groups		
4.		Post mortem and other diagnostic tools can be used in this decision process.
5.	IVCEvidensia	We strongly agree with this statement. We would suggest further qualifying this with some examples particularly noting that the timeframe would be variable based on the disease conditions and patient involved. We note that there has been a common assumption of a 6 month timeframe for physical examination/site visit across the profession; we would suggest emphasising this is appropriate in the majority of cases with more frequent examination appropriate in some (e.g. newly diagnosed

		animals with serious disease) and less frequent than this only with good justification (e.g a hyperthyroid cat who is very stressed by transport).
Professional bodies		
6.	British Cattle Veterinary Association	Need current awareness of on farm situation and seasonality changes, may need more recent visit or detailed review
7.	British Veterinary Poultry Association	Agree assuming a post mortem examination is classified under a physical examination. This needs to be clarified by the RCVS, as a physical examination of a live bird will not provide as much information as a PME. Strongly disagree if PME is not covered by a physical examination as other methods are more appropriate.
8.	British Equine Veterinary Association	This is important but is sometimes not relevant