Council Meeting

Remote meeting to be held on Wednesday, 6 July 2022 at 4:00 pm by Zoom

Agenda	Classification[1]	Rationale[2]
1. **President's introduction**	Oral report Unclassified	n/a
2. **Apologies for absence**	Oral report Unclassified	n/a
3. **Declaration of interests**	Oral report Unclassified	n/a
4. **Matter for decision by Council (unclassified items)**		
a. Under Care / Out of Hours Review	Unclassified	n/a
5. **Notices of motion**	Oral report Unclassified	n/a
6. **Questions**	Oral report Unclassified	n/a
7. **Any other College business (unclassified items)**	Oral report Unclassified	n/a
8. **Risk Register, equality and diversity (unclassified items)**	Oral report Unclassified	n/a
9. **Dates of next meetings** Friday, 8 July 2022 (AGM) Thursday, 8 September 2022 at 10:00 am (reconvening in the afternoon) in person at Glasgow University Veterinary School.	Oral report Unclassified	n/a
Dawn Wiggins Secretary, RCVS Council 020 7202 0737 / d.wiggins@rcvs.org.uk		

[1]Classifications explained	
Unclassified	Papers will be published on the internet and recipients may share them and discuss them freely with anyone. This may include papers marked 'Draft'.
Confidential	Temporarily available only to Council Members, non-Council members of the relevant committee, sub-committee, working party or Board and not for dissemination outside that group unless and until the relevant committee or Council has given approval for public discussion, consultation or publication.
Private	The paper includes personal data which should not be disclosed at any time or for any reason, unless the data subject has agreed otherwise. The Chair may, however, indicate after discussion that there are general issues which can be disclosed, for example in reports to committees and Council.

[2]Classification rationales	
Confidential	1. To allow the Committee or Council to come to a view itself, before presenting to and/or consulting with others 2. To maintain the confidence of another organisation 3. To protect commercially sensitive information 4. To maintain public confidence in and/or uphold the reputation of the veterinary professions and/or the RCVS
Private	5. To protect information which may contain personal data, special category data, and/or criminal offence data, as listed under the General Data Protection Regulation

Terms of Reference (derived from the Royal Charter)

RCVS Council

1. RCVS Council exists to enable the College to fulfil its objects, as laid down in the Supplemental Charter granted on 17 February 2015 to the Royal Charter of 1844, ie:

   a) To set, uphold and advance veterinary standards, and to promote, encourage and advance the study and practice of the art and science of veterinary surgery and medicine, in the interests of the health and welfare of animals and in the wider public interest.

   b) The Charter also recognises those functions provided for in the Veterinary Surgeons Act 1966, in terms of the regulation of the profession, and also recognises other activities not conferred upon the College by the Veterinary Surgeons Act or any other Act, which may be carried out in order to meet its objects, including but not limited to:

      i. Accrediting veterinary education, training and qualifications, other than as provided for in the Act in relation to veterinary surgeons;
      ii. Working with others to develop, update and ensure co-ordination of international standards of veterinary education;
      iii. Administering examinations for the purpose of registration, awarding qualifications and recognising expertise other than as provided for in the Act;
      iv. Promulgating guidance on post-registration veterinary education and training for those admitted as members and associates of the College;
      v. Encouraging the continued development and evaluation of new knowledge and skills;
      vi. Awarding fellowships, honorary fellowships, honorary associateships or other designations to suitable individuals;
      vii. Keeping lists or registers of veterinary nurses and other classes of associate;
      viii. Promulgating guidance on professional conduct;
      ix. Setting standards for and accrediting veterinary practices and other suppliers of veterinary services;
      x. Facilitating the resolution of disputes between registered persons and their clients;
      xi. Providing information services and information about the historical development of the veterinary professions;
      xii. Monitoring developments in the veterinary professions and in the provision of veterinary services;
      xiii. Providing information about, and promoting fair access to, careers in the veterinary professions.

2. It is laid down in the Charter that the affairs of the College shall be managed by the Council as constituted under the Act. The Council shall have the entire management of and superintendence over the affairs, concerns and property of the College (save those powers of directing removal from, suspension from or restoration to the register of veterinary surgeons and supplementary veterinary register reserved to the disciplinary committee established under the Act) and shall have power to act by committees, subcommittees or boards and to delegate such functions as it thinks fit from time to time to such committees, subcommittees or boards and to any of its own

number and to the employees and agents of the College. The Council is also responsible for the appointment of the CEO and Registrar, and the ratification of the Assistant Registrars. Appointment of all other staff members is the responsibility of the CEO and relevant members of the Senior Team.

3. A strategic plan is normally developed and agreed by Council to facilitate the delivery of these activities and to ensure ongoing development and quality improvement.

4. This scheme outlines how Council's functions are currently delegated.

Summary	
Meeting	Council
Date	6 July 2022
Title	Review of under care and 24-hour emergency cover
Summary	This paper builds on the Council's previous discussion in April and attaches a draft consultation paper for consideration.
Decisions required	Council is asked to: a. Confirm that there should be separate consultations for the public and the professions; b. Confirm that the terms of the public consultation are circulated to Standards Committee for its approval prior to launch; c. Approve the draft consultation to the professions attached at **Annex A**; d. Agree the timeline set out.
Attachments	Annex A – Draft consultation paper Annex B – Draft guidance Annex C – Survey analysis report from RAND Europe Annex D – SAVSnet research report Annex E – VetCompass research executive summary and presentation Annex F – Legal Advice from Fenella Morris QC
Author	Eleanor Ferguson Registrar/Director of Legal Services e.ferguson@rcvs.org.uk Gemma Kingswell Head of Legal Services (Standards) g.kingswell@rcvs.org.uk / 020 7965 1100

Classifications

Document	Classification[1]	Rationales[2]
Paper	Unclassified	n/a
Annexes A – F	Unclassified	n/a

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Introduction

1. Although the College's review of 'under care' and 24-hour emergency cover has been exercising the minds of Standards Committee and Council for some time, this paper and, in particular, its annexes, represents the first real opportunity for veterinary surgeons, veterinary nurses and all our stakeholders to explore and understand for themselves the complex issues in question, and the detail of what now is being proposed for full public consultation.

2. As such, although the main purpose of this paper is to seek Council's approval for a draft consultation paper (as agreed at its meeting in April 2022), we recognise that many will be reading this with a view to understanding how the RCVS has reached the position that is has. The draft consultation paper (attached at **Annex A**) therefore sets out the current position, the multi-stage review process and timeline, the animal health and welfare implications and rationale for consulting, the legal advice and independent research considered, the recommendations and the proposed guidance itself.

Background

3. At its meeting in April 2022, Council was presented with recommendations from the Standards Committee flowing from the review of 'under care' and 24-hour emergency cover and decided that a consultation paper be drafted for consideration. Following further consideration (discussed more below), the Standards Committee recommends that there should a separate consultation with the public and as such, the draft consultation attached to this paper at **Annex A** is aimed at the professions.

4. At the same meeting of Council, there was a great deal of discussion around the recommendations themselves. Standards Committee considered all matters discussed and the draft guidance can be found separately at **Annex B** for ease of reference.

Public consultation

5. Due to the clinical and complex nature of the subject matter, some of the questions the Standards Committee wish to ask about the proposed guidance are very technical and unlikely to be appropriate for members of the public. As such, the Committee recommends that a separate consultation be devised for members of the public.

6. The Standards Committee is keen to ensure that public-facing questions are aimed at all kinds of animal owners/keepers, including farmers and relevant organisations such as those representing owners and keepers (for example the National Farmers Union), and that relevant groups have the opportunity to respond.

7. The Standards Committee agreed that for the consultation with the public to have adequate reach and engagement (e.g. remote areas/those with disabilities), it would be appropriate to use the services of an external agency such as YouGov for delivery. As regards questions to ask, the Committee was keen to understand how the proposed changes might affect animal owners' access to veterinary care, in respect of both benefits and risks, as well as seeking views on specific topics such as limited-service providers. In terms of timing, the intention is for the public consultation to run in parallel with that for the professions. Once Council has agreed the terms of

the consultation to the professions it is suggested that the terms of the public consultation are finalised and circulated to Standards Committee for its approval prior to launch.

Consultation with the professions

8. The intention is that the consultation with the professions (see **Annex A**) will comprise a consultation document setting out the background, context and recommendations, followed by an online survey asking questions about the proposals. The consultation document will also signpost to a number of supplementary materials including:

    a. Survey analysis report from RAND Europe (**Annex C**)

    b. SAVSnet research report (**Annex D**)

    c. VetCompass research executive summary and presentation (**Annex E**)

    d. Legal Advice from Fenella Morris QC (**Annex F**)

9. It should be noted that the RAND survey analysis report attached at **Annex C** is an interim report that was not originally intended for publication. It is currently being copy edited/quality assured. It is not anticipated that there will be any significant changes to the findings, conclusions or recommendations of the interim report in the final version that will accompany the consultation.

Timeline

10. The proposed timeframe for the consultation phase of the review is set out below:

    - 6 July – Council to consider proposed consultation document
    - by end of w/c 11 July – open consultation to the professions
    - by w/c 12 September – close consultation to the professions (allowing extra time because consultation will be open over August)
    - by w/c 24 October – produce report on consultation responses (allowing 6 weeks from closing consultation for analysis and report writing) and Standards Committee to consider
    - 10 November – Council to consider recommendations from Standards Committee following the consultation

11. This timeline could enable the updated guidance to come into effect before the end of the year, although additional Standards Committee meeting(s) may be required. However, if the consultation results in substantive changes to the proposed guidance, it could take longer.

Decisions required

12. Council is asked to:

    a. Confirm that there should be separate consultations for the public and the professions;

    b. Confirm that the terms of the public consultation are circulated to Standards Committee for its approval prior to launch;

c. Approve the draft consultation attached at **Annex A**;

d. Agree the timeline set out above.

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

A consultation

[XXX Date 2022]

Contents

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 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"

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.

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 below, together with a timeline of what will happen next, but please make sure to send us your feedback by [deadline].

Thank you in advance for your time and consideration

Dr Melissa Donald BVMS MRCVS
Chair, RCVS 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.

"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."

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.

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 for 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 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.

"The terms 'under care' and 'clinical assessment' are not defined by legislation, 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).

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. The detail of the current legislation and guidance is set out [XXX signpost XXX].

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 [XXX signpost XXX].

"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 summary with presentation from VetCompass can be found [XXX signpost XXX].

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 here [XXXsignpostXXX].

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.

"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."

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 are available at: [XXX LINK XXX].

29) Before you respond to this consultation, we would urge you to read the explanatory information set out at www.rcvs.org.uk/undercare, along with the additional reports, research papers and legal advice information provided.

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.

"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."

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 at [XXX survey link XXX]. 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 [XXX deadline date XXX].

34) Thank you for taking the time to send us your views. Responses from individuals will be treated as confidential. We may use extracts from any comments in any report produced following this consultation however, these comments will be reported anonymously. Where comments from organisations are used as part of any report, the organisation will be identified.

[Content for online survey]

Before responding to these questions, we would urge you to read the explanatory information set out at www.rcvs.org.uk/undercare, along with the additional reports, research papers and legal advice provided.

1. Questions on 'under care'

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

Under the proposed guidance, whether or not to carry out a physical examination is a matter of for the veterinary surgeon's judgement (save for some notable exceptions - see Section E of the consultation document, paragraphs 6-8 of the proposed guidance).

In order to assist veterinary surgeons, paragraph 4 and 5 of the proposed guidance set out a number of factors that might be relevant in deciding whether a physical examination is required as part of a clinical assessment in a particular 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)*

Q1 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q2 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q3 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

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

[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

e. The experience and reliability of the animal owner

Q5 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q6 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q7 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q8 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

i. The overall state of the animal's health

Q9 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

Q10 To what extent do you agree that this should be included in the list?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

[Yes/No/Don't know]

If yes, please tell us what they are

[Free text]

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.*

Q12 To what extent do you agree with this?

[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer

[Free text box]

B. Exceptions to the rule

The proposed guidance does not require veterinary surgeons to carry out a physical examination in every case. However, we believe that there are some situations where a physical examination is required in all but exceptional circumstances to protect animal health and welfare and public health, including to prevent drug misuse in the case of controlled drugs.

The exceptions relating to antimicrobials are intended to encourage responsible prescribing due to the growing threat of antimicrobial resistance, as well as addressing the fact that the SAVSnet study saw an increase in the prescription of antimicrobials during the operation of the temporary guidance in the pandemic.

The guidance addresses these exceptions to the rule in the following way:

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.*

Q13 To what extent do you agree with this?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

7. *In respect of paragraph 4(b) above, and 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.*

Q14 To what extent do you agree with this?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

   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.*

Q15 To what extent do you agree with this?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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.*

Q16 To what extent do you agree with this?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

Q17 Are there any other situations where a physical examination should be required?
[Yes/No/Don't know]

If yes, please tell us what they are
[Free text]

C. 24/7 follow-up service

In order to protect animal health and welfare, the proposed guidance requires veterinary surgeons to ensure that, where POM-Vs are prescribed without a physical examination, a 24/7 follow-up service is available:

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.*

Q18 To what extent do you agree with this?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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

D. General obligations

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) (see Section F of the consultation document). 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.

Q19 To what extent do you agree with this approach?

[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

E. Limited Service Providers

Our current supporting guidance only recognises two kinds of Limited Service Provider (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.

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 the following, which provides a broader definition of the type of practice that can be considered LSPs and imposes a general obligation to provide out-of-hours emergency care that is proportionate to the service offered.

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.*

Q20 To what extent do you agree with definition of LSPs?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

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.*

Q21 To what extent do you agree with the proposed 24-hour emergency obligations for LSPs?
[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

F. Advice-only services

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.

Q22 To what extent do you agree with this approach?

[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

G. Referral practices

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 in-patient 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.

Q23 To what extent do you agree with this approach?

[Strongly agree/agree/neutral/disagree/strongly disagree]

If you would like to, please give reasons for your answer
[Free text box]

The views of the professions are important in helping us to shape the guidance on prescribing POM-Vs and out-of-hours care. Thank you for taking the time to let us know what you think.

Under care

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.

Limited Service Providers

11. 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.

12. 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.

Interim report

RCVS Under Care and 24/7 Emergency Care Review

Survey results and analysis

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RAND Europe

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Summary

Introduction

Changes in technology, organisational structures and practices, patterns of animal ownership, and the expectations of animal owners and the wider public, have all contributed to an increasingly complex environment for veterinary practice, offering new opportunities as well as new challenges. These developments raise questions concerning core aspects of the existing regulations and guidelines, including what it means for an animal to be 'under care' of a veterinary surgeon, and how far, and in what circumstances, professional obligations should extend to providing out-of-hours care. Consequently the Royal College of Veterinary Surgeons (RCVS) held a consultation in 2017 that provides part of the context for the work described here. The consultation and the wider debate revealed strongly held and often divergent views within the profession and among stakeholders.

The aim of this study is to collect evidence to support the review of the regulations and guidance RCVS should offer in relation to 'under care' and 'out of hours' care. The overall research programme gathered information from members across the veterinary profession, using focus group discussions and a survey and in-depth interviews with key veterinary stakeholder organisations, and from a large-scale quantitative survey. The data from the focus groups and stakeholder engagement was presented in an earlier report to RCVS. This report details and analyses the results of this large-scale quantitative survey.

Methodology

The research method was a large scale online survey administered to RCVS members (surgeons and nurses). The survey was designed based on the data collected from the focus groups and engagement with key veterinary organisations, and in consultation with RCVS. The survey was structured as follows:

- Demographics
- Good Regulation Statements: agreement/disagreement with 18 statements about the approach towards the regulation of 'under care' and 24/7 emergency cover
- Applying Principles: agreement/disagreement with 20 statements about what regulations should require or permit in particular contexts
- When Principles Are in Tension: level of agreement between 10 pairs of statements.

The survey was piloted to ensure clarity of questions and flow, and the RCVS member database was used to disseminate the survey. The survey was open from 11 May 2021 to 16 June 2021. In total, 5,544 completed the survey (10% response rate overall, 13% for veterinary surgeons and 5% for veterinary nurses).

The overall responses to each of the questions were analysed individually, with further analysis conducted by demographics (role, age, practice size, rurality and country). In addition, nine themes were generated from the statements in the 'good regulation and 'applying principles' sections which involved grouping statements that had been agreed to in a consistent way. Factor analysis was conducted on these themes to explore the differences across demographic groups in further detail.

Findings

Here, we will briefly summarise the key takeaway messages from the survey, and then provide a short overview of the responses to each survey question.

Summary of overall key findings

The result of the survey provides clear guidance regarding the attitudes and expectations of veterinary professionals towards the regulation of 'under care' and out of hours care. It identifies a shared common core of vets' attitudes towards 'under care' and out of hours care, along with an expectation that regulations should reflect these values.

However, when asked to apply these values to specific cases, and when asked how they might handle tensions between them, there are nuances and differences that appear that are relevant to any consideration of future regulations. The report shows how these differences reflect the professional background and experience of vets with age, size of practice, type of practice and geographical location all being relevant.

When prompted to provide open text comments on why they hold their (differing) views, the responses are often related to practicalities (rather than principles); for example, the reasons offered for preferring that regulation should require physical examination prior to any diagnosis or treatment rather than allow other sources of evidence in addition show that all vets agree on the need for complete, recent and relevant evidence but differ about how in practice to best ensure this is available. We believe that this suggests that some differences are more apparent than real and reflect a different understanding of how regulations might work in practice. This came through particularly strongly when comparing the quantitative survey responses to the free-text answers. In some cases, the free-text answers indicated that respondents at opposite ends of the quantitative scale actually held the same core values but rather differed in the practical ways in which these values should be implemented.

In using this report as part of the review of future regulations and guidelines we suggest there are at least 5 things to consider:

1. The Report suggests that an approach to improving regulation which starts with a focus on the core activities of veterinary practice – the immediate care of patients – should gain wide agreement
2. Many important differences concerning how the business of providing care should be regulated come down to the practicalities and consequences of implementing regulations (for example would less explicit regulation lead to 'free riders' or more explicit regulation ignore the differences between caring for sheep, cats and fish). Greater attention might need to be given to explaining not only what is 'right' but also what is practicable (including unintended consequences). It is not possible to defend regulations that do not deliver the intended benefits or that cause unintended harm.
3. However, there remain differences that are not linked to practicalities (for example, should regulation aim to set minimum standards or aim to drive up overall standards) where (based on our focus groups and the open text responses in particular) the discussion within the profession appears to be 'unanchored' and where leadership from the profession may be needed to establish what 'good regulation' looks like (these might include, for example, no unreasonable restriction on innovation and entrepreneurship, as least burdensome as possible, minimum standards based on best evidence)
4. The report identifies a small number of instances where the profession appears to hold inconsistent views. For example, the survey shows a sizable agreement with the importance of vets taking personal professional responsibility, but also shows that a sizable minority is comfortable using information provided by a trusted animal owner, and shows that still others would like to see a more formal agreement with owners regarding co-responsibility for the care of their animals. This may be another area where more propositional leadership within the

profession could help build consensus. In the short run, however, regulators may need to take an approach which is not based on a consistent and fixed view from the profession.

5. This report also identifies ways in which communications with the profession on these issues might be targeted – showing what are common concerns, but also revealing how different groups of professionals have different attitudes towards (for example) team working, treatment of groups of animals, or the use of digital information. In particular, the report highlights how opinions diverge in relation to key themes.

Good regulation statements

Overall, the analysis shows broad agreement among respondents for the statements concerning what good regulations should involve. In particular, there was agreement regarding:

- The vet is responsible for both advice regarding care and the prescription of POM-Vs for an animal under their care.
- A vet can accept an animal into their care if their knowledge of the situation and the condition of the animal is good enough to make competent care decisions.
- All vets should provide 24/7 emergency cover for the relief of pain and suffering (either themselves or via a third party).
- Professional judgement should be allowed when interpreting and applying regulations.
- Vets would not feel comfortable recommending/prescribing treatment for a client they never seen before.

There was a lack of consensus as to whether the regulations should specifically take into account the age of the animal; whether a vet should recommend/prescribe treatment they have not recently seen if the client is knowledgeable and/or reliable; and whether a vet can have an animal under their care based on information from sources other than a physical exam.

These findings suggest that the highest levels of consensus (either collectively agreeing or disagreeing) were registered in response to statements that are most close to the identity and activities of being a veterinary surgeon or nurse. There was much less consensus on questions about what regulations should cover, which are at one stage removed from the direct role of caring for animals.

There were also some important differences among sub-groups. Nurses showed a significant tendency to have greater confidence in regulations to deliver benefits than was the case for surgeons. In addition, there were differences in responses by the size of the practice the respondent worked at, as well as rurality. These could be explained in the context of different business models and ways of working, e.g. rural vets were less likely to agree that a recent physical exam is needed to provide real and not nominal care.

Applying principles

For the statements on applying principles, there was agreement around the following statements:

- Practices should share clinical records where they provide care for the same animal.
- Regulations should recognise the advantage physical exams have over information obtained remotely.
- A formal agreement should be set up between the client and vet to outline the obligations and responsibilities of each party (although responses differed when a similar questions was asked in a later question in the 'principles in tension' section)
- There should be shared accountability recognised in the regulations in cases where a vet refers an animal to a specialist for care.

- There should be recognition that animals that are part of a herd or flock are treated differently to companion animals (where this aligns with client preferences).
- Regulations should not allow the prescription of POM-Vs based on the use of photos or videos where the vet has never physically examined the animal.

There was disagreement among respondents as to whether regulations should differ for shelters/charities compared to other practices, and whether regulations should be only about quality of information (rather than source).

The differences in responses were explored across different demographics. Overall, of the 20 statements, only 5 produced significantly different responses from respondents based on their practice size or rurality, suggesting a basis for agreement within the profession (although important differences were picked up in factor analysis).

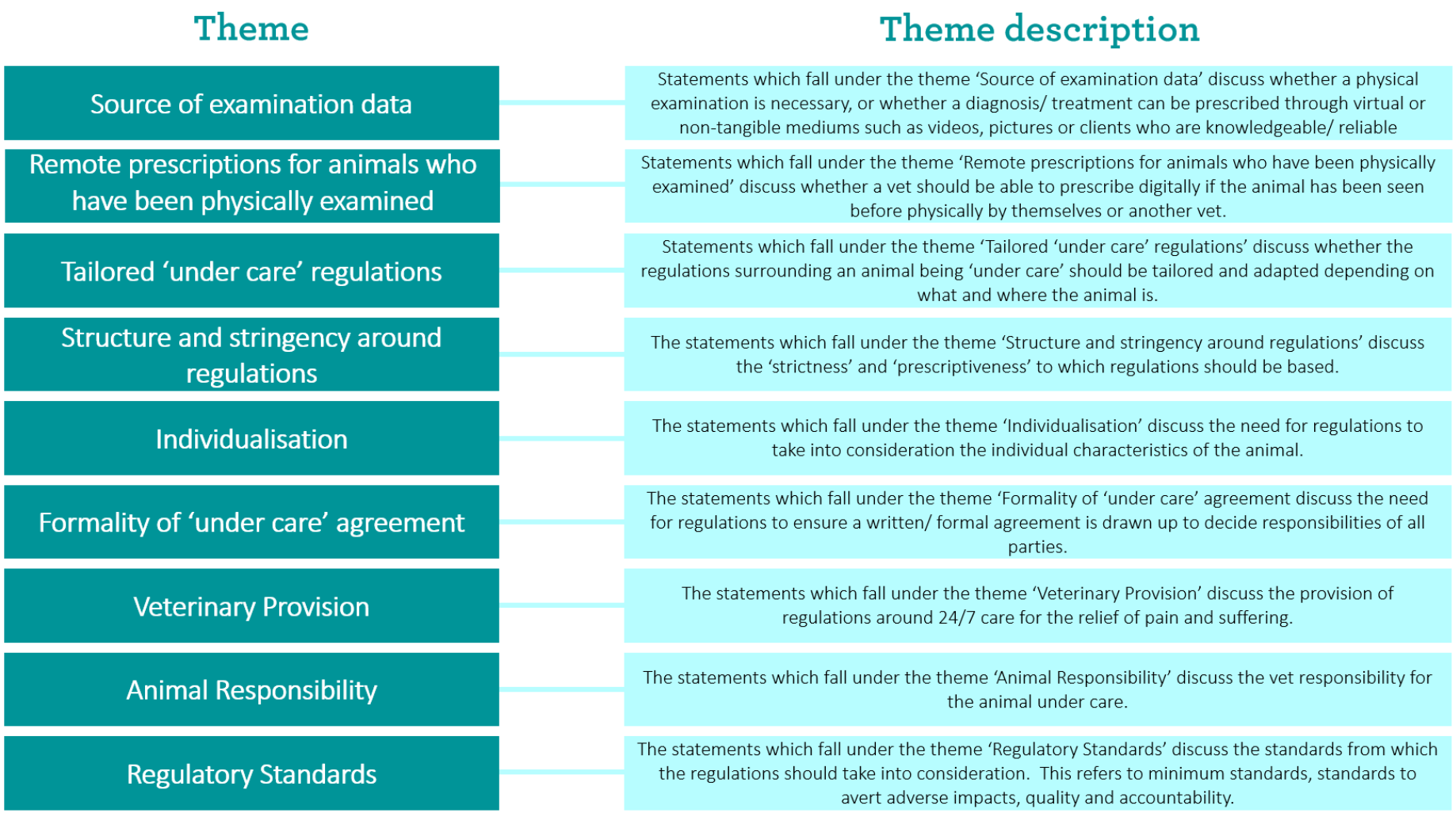
Factor analysis

Factor analysis aims to simplify a large number of observed survey responses by identifying underlying (unobserved, or latent) variables. We applied this technique by looking for patterns in the way participants of the study have agreed or disagreed to the statements around regulation.[1] It looks for groups of statements which have been agreed to in a consistent way. The groups of statements that result are therefore data driven, and because they tend to talk about a 'theme' they can be given a subjective heading.

Through this technique, we identified nine key themes revealed through the responses (set out below). It is highly likely that these are themes that concern vets in relation to 24/7 emergency provision and 'under care'. Statements within each theme have been grouped because they are highly correlated with each other meaning that each participant is likely to rate each of the statements in the theme in a similar way. The 9 themes can therefore be considered a 'summary' of a large number of statements, and they reveal the key areas that surgeons consider on this topic overall.

[1] NB: Only surgeons were included in this analysis as nurses were not asked to complete all questions.

Figure 1: The nine themes identified from the factor analysis



The factor analysis demonstrates that surgeons from smaller practices were less likely to agree than those from larger practices on:

- The strictness of the regulations
- The need for a written agreement for 'under care'
- Veterinary provision for 24/7 care for pain and suffering

Surgeons from more remote rural locations were more likely than average to agree with regulations around:

- The source of examination data – agreeing that this source could be virtual
- Tailored 'under-care' regulations – agreeing that this could be based on the type of animal and location
- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care

Surgeons from urban practices were less likely to agree with the regulated requirement for 'veterinary provision'.

Of all segments analysed for differences in agreement on the nine themes, opinion varied the most by age group. Older surgeons (aged 55+) were more likely to agree with the following:

- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care
- Animal responsibility – agreeing that the veterinary surgeon has full responsibility for the animal in their care
- Regulatory standards – agreeing that the standards that under-pin the term 'under-care' for 24/7 emergency cover should include accountability for all parties involved

Older surgeons were also generally more likely to agree that there should be room for judgement and some flexibility around the regulations. Younger veterinary surgeons (aged 18-35) were more likely to agree with a more 'virtual' approach to care. Despite agreeing that there needs to be provision for individual cases and 'tailored' under-care agreements, they generally agree that having the structure and security of regulations is more favourable.

When principles are in tension

In this final part of the survey, we were concerned with the preferred balance between principles which might be equally desirable but might also be in tension with one another such that more of one might result in less of the other. Respondents were presented with 10 pairs of statements and were asked to state (using a sliding scale) which statement they agreed with the most. The results for each of the 10 statements was the following:

- One size fits all v tailored regulations: Overall, there was a strong preference for tailored regulations over one size fits all. Nurses and younger respondents were more likely to want regulations to be tailored (than surgeons and older respondents).
- Before prescribing POM-Vs each animal should be seen within a prescribed period of time versus vets should make a professional judgement[2]: Overall, responses to this statement were split. However, respondents from smaller practices and those aged 46+ were more likely to agree that

[2] Surgeons only.

vets should make a professional judgement about how recently they need to have seen an animal before prescribing POM-Vs (than those from larger practices and of younger ages).

- Protecting professional judgement about what is best in each case versus predictability and clarity for clients about what they can expect: Overall, there was a very strong preference for regulations protecting professional judgement about what is best for the animal rather regulations providing predictability and clarity for clients about what they can expect. Surgeons and respondents from smaller practices were significantly more likely to agree that protecting professional judgement is more important (compared to nurses and those from larger practices).
- A formal agreement with each client should be required versus vets should advise and inform clients about agreement: A larger proportion of respondents thought that vets should advise and inform clients rather than be required to establish a formal agreement (which is contrary to the similar question asked in the 'applying principles' section). Surgeons and respondents aged 46+ were more likely to feel that a formal agreement should not be required. However in open text responses, very few respondents shared objections to such agreements.
- Regulations should establish only minimum standards versus should aim to set the highest standards possible standards: There was a slight preference for minimum standards being set by regulations rather than the highest possible standards. Nurses were more likely to agree that regulations should set high standards than surgeons. Smaller practices more likely to agree that regulations should set minimum standards than larger ones.
- Physical examination should precede any treatment with POM-Vs versus recency, reliability and completeness of the information available:[3] The balance of opinion was that the physical examination of the patient should precede any treatment with POM-Vs rather than assessing the recency, reliability and completeness of the information available. There were no statistically significant differences by demographic groups.
- Personal professional accountability is at the core of good care and regulations versus regulations should focus on regulating teams: The balance of opinion was in favour of personal professional accountability in regulations being more important than the regulation of teams. Surgeons and those aged 46+ were more likely to agree that personal accountability is most important (compared to nurses and younger respondents).
- Provision of 24/7 emergency cover should be proportional to the service being provided versus clients should take responsibility for securing 24/7 emergency cover where needed: There was a slight balance in favour of regulations ensuring that the provision of 24/7 emergency cover is proportional to the service being provided, as opposed to clients taking responsibility for securing 24/7 emergency cover where needed. Nurses were more likely to agree that regulations should ensure 24/7 emergency care is proportional to service being provided than surgeons. Urban vets and those from smaller practices were more likely to feel that clients should take responsibility for securing 24/7 cover (compared to vets from rural/mixed areas and those from larger practices).
- Availability of 24/7 emergency cover lies with clients versus 24/7 emergency cover lies with vets: There was a strong preference for regulations ensuring that vets are responsible for ensuring that animals under their care receive 24/7 emergency cover rather than asking clients to ensure that cover. Nurses, respondents from large practices, respondents aged 46+ and rural/mixed rurality vets were more likely to agree that vets should be responsible for ensuring 24/7 emergency care (rather than clients).

[3] Surgeons only

- Information regarding 24/7 emergency cover available to clients versus it being complete, visible and accessed by clients: There was a strong preference for regulations requiring vets to be responsible for ensuring that information regarding 24/7 emergency cover services is complete, visible and accessed by clients rather than just making that information available to clients. Nurses, respondents from larger practices and those aged 46+ were more likely to agree that vets should ensure the information is complete, visible and accessed (rather than just available).

Conclusions

Overall, there is broad agreement on how vets want to be regulated in relation to their core purpose of caring for individual animals. However, there appeared to be less consensus on the regulation of their wider activities which were focused more on the management of veterinary practice as opposed to direct care of patients. Dissensus became more apparent on specific topics when respondents were asked about how to apply regulations in practice.

Understanding how vets handle tensions revealed some fundamental differences depending on role, age and rurality. However, differences may be less than they appear on exploring the open-text responses to the questions on tensions. The table below summarises the conclusions and areas for RCVS to consider for the consultation, drawing on the findings from both the focus groups and survey.

Table 1: Conclusions and areas for RCVS to consider for the consultation (from the focus groups and survey)

Issue	Implications
Strongly held core values	• The well-being of the animal 'under care' is considered to be paramount and ensuring emergency provision is available for animals 'under care' is a 24/7 professional responsibility (rather than the clients) • Good veterinary practice is believed to be under-pinned by vets having personal responsibility and accountability for their decisions and prescription of medication, rather than the regulation of teams • There must be room for professional judgement in interpreting the regulations to balance different types of evidence, circumstance of the animal and when it was last examined and clinical uncertainty. Regulations should be tailored to different situations and circumstances rather than having a one size fits all approach. However, the practical difficulties of extending the reach and complexity of regulations were highlighted. • Vets should be responsible for ensuring 24/7 emergency cover is in place to deal with pain and suffering (either providing this service themselves or via a third party), not the client. Vets should ensure that information on 24/7 emergency care should be complete, visible and accessed by the client. • To recommend and prescribe POM-Vs, the vet needs to have had some previous (physical) contact with the client and animal. • Relevant, timely, complete and accurate knowledge and information is at the heart of good veterinary practice (therefore physical examination is often the 'gold standard') but reliable information can also be obtained from clinical notes and records, digital images, videos and specialist guidance). However, alternative forms of information (non-physical exam) should not be used alone in instances where the vet has not physically seen the animal. • In cases of multiple vets providing care to an animal, the practices should share clinical records. There should also be shared accountability for both the primary care vet and the specialist/referral vet. To support this, all veterinary professionals involved in an animal's care should be aware of what treatment/care is being provided by other professionals. This can be declared by a client in any formal agreement made between them and the vet (although as mentioned below, there was divergence as to whether an agreement such as this is necessary). • There should be a recognition in the regulations that herd/flock animals (primarily for commercial purposes) are treated differently to companion animals, according to the clients' preferences.
Areas of divergence and lack of consensus	• What is regulation for – to minimise harm or maximise excellence. Although there was a slight preference in the survey for minimum standards over maximum. • Agreement that a physical examination is centrally important (particularly for new clients) – but disagree on how far other sources of information should be depended upon • The role of clients' expertise and reliability in shaping vets treatment decisions. • To what extent regulations should take into account specific aspects of the animal, such as age, and be tailored to different practice situations (particularly whether shelters/charities should be treated differently to other practices). • Whether the quality (recency and reliability) of the information on the animal is more important than where the information came from.

Issue	Implications
	• While there was general agreement that professional judgement should be protected - there was disagreement as to whether regulations should prescribe a period of time in which a physical exam needs to have been conducted to prescribe POM-Vs, or whether this can be left to professional judgement. • In the survey, two questions were asked on whether a formal agreement should be put in place between a vet and client to outline the obligations and responsibilities of each party. The responses to the first question indicated good consensus that a formal agreement should be in place, however responses to the second question on this indicated a preference for vets to advise and inform clients rather than be required to establish a formal agreement.
Recommended areas for RCVS to explore in the consultation	• In the survey and in the focus groups, there was a relatively comfortable agreement around the role of regulation in relation to the core, caring functions of the vet. Once wider questions were explored, such as working across organisational boundaries, team responsibilities, and relationships with clients, there was less agreement. In their responses (as our thematic analysis suggests) vets drew upon their experiences (varying according to length of service, size of practice etc.) but not upon a clear sense of what regulations are for in principle. This, in our view, leaves the debate unanchored and therefore difficult to progress. RCVS could be propositional. This might include (among other things) reinforcing the importance of simplifying the regulatory environment, supporting (or at least not inhibiting) innovation, and improving the interface between veterinary medicine and public health. It might also include communicating to the public the benefits of a well-regulated profession for both their animals and for an effective 'One health' approach. • Even with such a propositional approach there will remain significant tensions. RCVS should take a view on which of these tensions are in principle resolvable through discussion and which are more fundamental. We were impressed by the many open text responses suggest that some problems were seen to be practical rather than a fundamental point of principle. In such areas of disagreement (formal agreements with clients, 24/7 arrangements, and sources of information to inform decisions) it may be that guidelines based on clear principles would be acceptable and effective. • The focus groups highlighted a tension between a blanket commitment to the responsibility of vets for animals under their care and a recognition that the delivery of care is co-produced with owners who provide very variable environments for their animals. The preference indicated in the survey is for personal professional responsibility. However, at the same time, 38% of respondents agreed that they would also be comfortable acting on information provided by trusted clients. This apparent tension may be easily resolved should it be clear that personal professional responsibility and competence includes responsibility for building relationships with the clients (as well as the animal). Similarly, personal professional responsibility should include contributing to team working and information-sharing. • The personal responsibility of vets to the well-being of the animal 'under care' is strong and often fits comfortably with the practices, such as team working, emergency out of hours providers, and specialist advice. However, it fits less well with the role of limited service providers and the lack of oversight of the animal where owners elect to 'pick and mix' among providers. Further attention to this was seen to be a priority in the focus groups. • To future proof regulations, and to accommodate the views of younger professionals, it might be better to focus on the responsibilities of vets to ensure that the information they use is timely and relevant, and for veterinary practices to ensure an information architecture that can support this, rather than focussing on how this information was obtained (e.g. physical examination or digital image).

Issue	Implications
	• The survey highlighted key differences across different groups of the veterinary profession in what they thought the regulations should cover and look like. Irrespective of other decisions, RCVS could use the analysis of these differences when designing their engagement and communications strategies for their members. In particular it should take into the account the particular responses of veterinary nurses and younger professionals.

Table of contents

1. Introduction

The Royal College of Veterinary Surgeons (RCVS) aims to deliver public benefits through improved animal health and welfare through setting, upholding and advancing educational, ethical and clinical standards of veterinary surgeons and veterinary nurses. It is a statutory regulator under the terms of the Veterinary Surgeons Act 1966. Veterinary nursing is also regulated by the RCVS. It also validates academic qualifications in universities that offer courses that lead to becoming a qualified veterinarian.

Changes in technology, organisational structures and practices, patterns of animal ownership, and the expectations of animal owners and the wider public, have all contributed to an increasingly complex environment for veterinary practice, offering new opportunities as well as new challenges. These developments raise questions concerning core aspects of the existing regulations and guidelines, including what it means for an animal to be 'under care' of a veterinary surgeon, and how far, and in what circumstances, professional obligations should extend to providing out-of-hours care.

Consequently, as the statutory regulator, RCVS held a wide-ranging consultation in February to March 2017 that provides part of the context for the work described here. Predating the 2017 consultation was a set of discussions following the publication of the Vet Futures Report *Taking charge of our future: a vision for the veterinary profession for 2030*[4] and a commitment in the *RCVS Strategic Plan 2017-19*[5] to review the regulatory framework in this regard. The consultation and the wider debate revealed strongly held and often divergent views within the profession and among stakeholders.

The aim of this study is to collect evidence to support the review of the regulations and guidance RCVS should offer in relation to 'under care' and 'out of hours' care. The overall research programme gathered information from members across the veterinary profession, using focus group discussions and a survey and in-depth interviews with key veterinary stakeholder organisations, and from a large-scale quantitative survey. During the focus groups and stakeholder engagement, the meaning and practice of an animal being 'under care' and vets providing out of hours care were discussed. RCVS regulations and guidance relating to these topics were discussed in detail, and focus group participants were asked to describe how satisfactory they found current regulation and guidance and what, if any, changes might be made. The survey questions were designed based on data collected from these focus groups and stakeholder organisation engagement. The data from the focus groups and stakeholder engagement was presented in an earlier report to RCVS. This report details and analyses the results of this large-scale quantitative survey before arriving at key conclusions and recommended areas for RCVS to explore in the consultation phase.

The following section will provide a brief overview of the survey methodology, as well as a reflection on the steps taken to ensure that the survey was impartial, relevant and meaningful to participants.

1.1. Methodology

The research method was a large scale online survey administered to RCVS members (surgeons and nurses). As mentioned, the survey was designed based on the data collected from the focus groups and engagement

[4] RCVS. (2020). *Strategic Plan 2020-2024.*

[5] Vet Futures. (2015). *Taking charge of our future: A vision for the veterinary profession for 2030.*

with key veterinary organisations, and in consultation with RCVS. The full survey can be found in Annex A. The survey was structured as follows:

- Demographics
- Good Regulation Statements: agreement/disagreement with 18 statements about the approach towards the regulation of 'under care' and 24/7 emergency cover
- Applying Principles: agreement/disagreement with 20 statements about what regulations should require or permit in particular contexts
- When Principles Are in Tension: level of agreement between 10 pairs of statements.

Given the nature of some of the questions, nurses were not shown all questions (e.g. in relation to prescribing medications).

The survey was subject to a number of pilot stages. Firstly, the research team reviewed the survey to ensure there were no errors, e.g. with skip logic or question wording. The second stage was piloting of the survey by a small number of the RCVS team and three veterinary professionals to ensure the questions were accurate and clear, and to identify any issues. Finally, the survey was sent to an initial set of 450 members of the profession to ensure there were no issues (content or technical) before disseminating the survey to all members.

The RCVS member database was used to disseminate the survey, which comprised a sample of 54,021 individuals (34,787 surgeons and 19,234 nurses). There were 390 undeliverable emails (for example the email address was not recognised). Thus, 53,181 emails were sent in total. There was no incentive offered for participants. The survey was open from 11 May 2021 to 16 June 2021. To strengthen response rates, three reminders were sent to the profession while the survey was open. To keep response rates as high as possible, we kept the time to complete the questionnaire to a minimum compatible with the aims of the survey; the average time to complete the questionnaire was 23 minutes.

In total, 5,544 completed the survey (10% response rate overall, 13% for veterinary surgeons and 5% for veterinary nurses). 13% is around the middle of the range of responses for this kind of survey while 5% is at the bottom end.

The overall responses to each of the questions were analysed individually, with further analysis conducted by demographics (role, age, practice size, rurality and country). In addition, nine themes were generated from the statements in the 'good regulation and 'applying principles' sections which involved grouping statements that had been agreed to in a consistent way (further detail on the generation of these themes is provided in section 2.3). Factor analysis was conducted on these themes to explore the differences across demographic groups in further detail.

1.2. Ensuring the survey questions were impartial, relevant, and meaningful to professionals

The survey explored questions at the heart of the professional lives of veterinary surgeons and nurses. It was therefore important that the survey questions reflected the language used by professionals to describe their work. These questions also explored some areas where there had been a history of disagreement. The research team used language to explore these disagreements that reflected how professionals discussed these issues but at the same time avoided 'leading' questions. The focus groups and stakeholder engagement was a valuable first stage that shaped the language we used in the survey questions and ensured their relevance to the experiences of veterinary surgeons and nurses. In addition, we piloted the questionnaire in three separate stages. The order the questions appeared in within the different sections was also randomised

to avoid the possibility that results might be systematically influenced by how participants had responded to earlier statements (or fatigue). Finally, we ensured that open-ended questions created opportunities for respondents to reflect in their own words across all sections of the survey.

However, there are a small number of limitations of the survey to highlight. The survey required participants to self-select, which may mean the views obtained are from those more interested in the topic or who have stronger opinions. The participants were weighted more heavily towards small animal professionals compared to equine, farm and other. While this is a general reflection of the demographics of the veterinary profession, it may mean that the results are skewed towards the views of those dealing with small animal.

1.3. Developing a survey design to explore complex issues

We were made aware through the focus groups and stakeholder engagement that many of the issues regarding under care and 24/7 emergency cover were neither simple nor binary. Some provoked shades of opinion ranging from strong agreement to strong disagreement. Others suggested that there were trade-offs to be made between equally desirable things which could not simultaneously be achieved. For these reasons we developed a survey design which could explore progressively add layers of complexity. To this end, following demographic questions including the background and experience of participants, we set out 18 'good regulation statements' (derived from the focus groups) and invited respondents to state their strength of agreement or disagreement with each of these. This helped establish what the profession agreed with, and where veterinary surgeons and nurses were divided in their responses. From this we have established how far, and on what issues, respondents agreed about what 'good regulation' looks like in relation to under care and emergency cover. We went on to ask respondents to agree or disagree with 20 statements on how these principles might be applied in specific circumstances. This reflected findings from the focus groups which suggested that views that might be held 'in principle' might be applied in more nuanced ways in practice. By structuring findings from these first two sets of questions into broad factors (see section 2.3) we have been able to contribute new understanding of how the professions might align or fragment in relation to the key themes. Finally, we asked respondents to respond to ten pairs of circumstances where principles might be in tension (for example, wanting both professional independence and adherence to certain practices). In these questions, respondents could use a slider to indicate how they might balance these tensions.

1.4. A reflection of the key findings from the focus groups

To understand the context in which this survey was developed, and to ensure findings across the study are integrated together, we will briefly reflect on the conclusions from the focus groups here.

1.4.1. Core values are clear and strongly held

Any development of the regulations and guidelines would be building on a relatively firm foundation in which certain core values are clear. Vets should be responsible for their professional decisions and although patient care may be shared and may pass from one vet to another, once an animal is under the care of a vet, they take personal responsibility for the wellbeing of that animal. Likewise, the focus groups revealed that the primacy of the wellbeing of the animal is agreed, as is the importance of having sufficient reliable, timely and relevant information, alongside the recognition that such information is most likely to require a physical examination of the animal. It is also agreed that vets' decisions should take into account the contextual factors and constraints facing the animal, the owner and the vet themselves. Finally, it was agreed that, while specificity in regulations may be desirable for certain elements (e.g. the maximum time to elapse

between a physical examination and prescribing) in general there must be room for professional judgement in the light of the very varied contexts within which vets are required to act.

1.4.2. However, there are significant complicating factors

Complicating factors may be clustered in areas:

- Developments in veterinary practice:
    - New or growing organisational and commercial entities including limited service providers, emergency out of hours providers, and corporates are changing the organisational setting within which animals 'under care' are managed and care is provided. This is complicating transitions (or hand-offs) between providers.
    - Some medical and clinical developments are increasing specialisation of care and shared responsibilities but increasing the risk of fragmenting responsibility and reducing continuity of care.
    - New communications technologies have opened up new ways for vets to interact with animals, their owners, and each other making some new business models involving remote care more viable but raising questions around when and how remote provision results in better care.
- The context in which animals are cared for:
    - Animal owners cannot be assumed to have technical skills in caring for animals (but some are highly skilled) and have different priorities for the care of their animals. These differences should be taken into account if the duty of care is to be discharged but understanding these differences may be a matter of judgement and experience.
    - Differences among owners very often coincide with differences among farm animals, small animals, equine and so forth who face differing commercial pressures and priorities.
    - Herds and flocks face additional risks for animal (and human) wellbeing that individual animals do not face. Threats to other animals (and public health) may require vets to treat animals in herds or flocks differently and the well-being of the individual animal will not, in this situation, be paramount.
- The owner-professional relationship:
    - Owners (and the general public) have rising expectations about what vets can do technically and are able to afford commercially adding to the pressures facing veterinary practices.
    - Farm managers may be increasingly prepared to pick and choose among providers. making continuity of care and safe management of each animal's care harder to oversee.
    - Companion animal owners are believed to be using online search engines to identify sources of information that may be unreliable. This combines with a more consumerist approach to bring additional pressures on vets.

1.4.3. Areas of dispute and divergence

In the space of a two-hour focus group, there are limitations to what can be covered but some issues seemed to be both addressed and unresolved, including:

- Among those who expressed an opinion, there was a tendency to see regulation as a way to minimise harm (non-maleficence) rather than to deliver excellence (helping more recently qualified vets, helping to push back against unreasonable clients). However, there was not a clear consensus around what 'good' regulations would be like.
- While every participant saw a significant role for physical examinations, many different opinions were expressed ranging from insisting that only physical examinations should be used, through to identifying special cases where remote working was sensible, through to a small minority seeing a greater role for remote working. The experiences of changed working in response to Covid-19 have not changed this viewpoint substantially.
- The role and responsibilities of owners came up often as a concern but few if any solutions were put forward (beyond encouraging RCVS to launch an information campaign to encourage more realistic expectations). For example, facilitators did not raise the idea of a North American style Veterinarian-Client-Patient Relationship (VCPR) which is designed to address this issue but neither did this arise spontaneously.
- While there was a general view that regulation should not lead to a loss of entrepreneurship and competition, there was also anxiety that without regulations around remote providers and limited providers there would be risks to animal wellbeing (including less continuity of care, less oversight of an animal's prescriptions, and loss of accessible OOHs providers in some parts of the country). It was not resolved how to balance these differing benefits of entrepreneurship with potential risks to animal well-being.

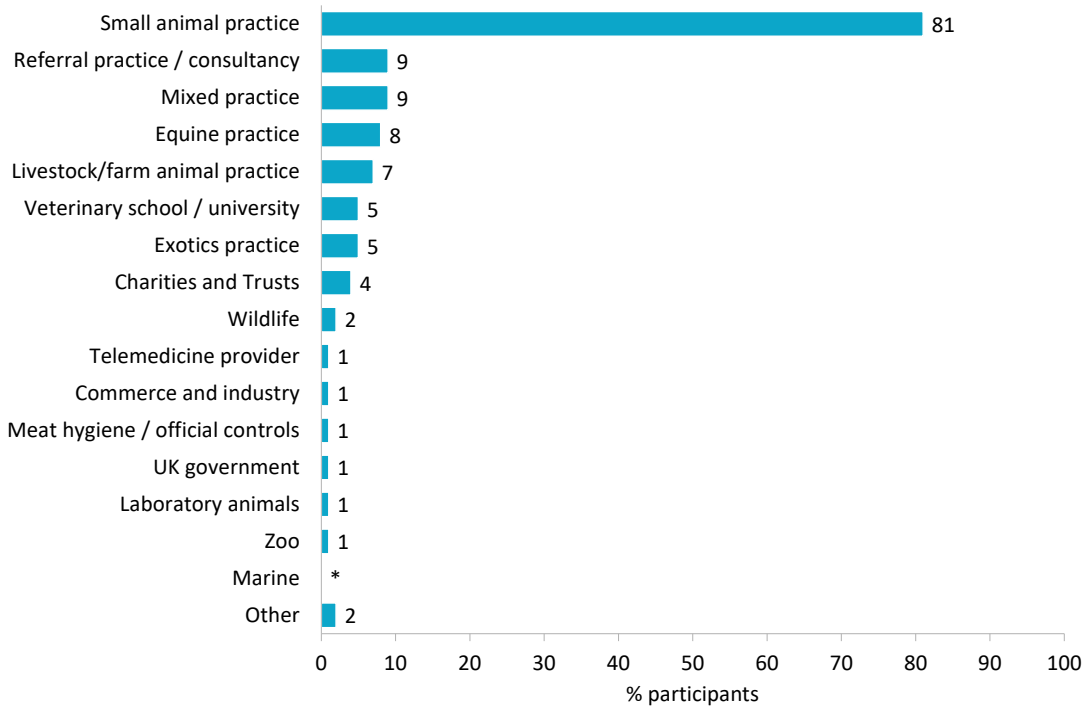
1.5. Survey sample characteristics

Granular detail on sample characteristics may be found in Annex B. In summary, 18% of the sample were veterinary nurses and 82% were veterinary surgeons. The demographic of RCVS members is 36% nurses and 64% surgeons so there was a much higher response from surgeons than nurses to the survey.

Nurses tended to be younger than surgeons: 47% were aged under 35 years old compared to 31% for surgeons. There was a fairly even spread by registration years with between 10-20% in each five-year period between 1995-1999 and 2015-2019. Participating surgeons tended to have registered earlier than nurses, with 38% registering before 2000 compared to half that amount for nurses. Age and number of year's experiences correlated closely in the sample (so those of older age were very likely to also have a higher number of years' experience). Therefore, the analysis by age group presented in this report can also be applied to years' experience.

For just over four fifths (81%) the main area of work was small animal practice. No other area attracted more than 9%. However, referral practice, mixed practice, equine, livestock were all well represented with over 7% in each category. These details are in Figure 2.

Figure 2: Main area of work (n=5,544)[6]



Overall, a large majority were either part of a corporate group (40%) or an independent, stand-alone practice (37%). Over half the practices (53%) provide their own 24/7 emergency cover. Another 12% offer a combination of in-house provision and third-party 24/7 emergency cover provision and 35% did not offer 24/7 emergency cover.

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

[6] Respondents could indicate more than one area of work, hence the totals exceed 100%

2. Findings

Following the demographic questions, as outlined in the previous chapter, we asked three sets of questions:

- **Good Regulation Statements:** agreement/disagreement with 18 statements about the approach towards the regulation of 'under care' and 24/7 emergency cover
- **Applying Principles:** agreement/disagreement with 20 statements about what regulations should require or permit in particular contexts
- **When Principles Are in Tension:** balance between 10 pairs of statements.

The key results for each of these are discussed below.

2.1. Good Regulation Statements

Respondents were shown 18 statements regarding regulation. Each statement was shown in turn with a slider scale from strongly disagree to strongly agree. The responses were converted to a five-point numerical scale where 1 = strongly disagree and 5 = strongly agree.

2.1.1. Overall analysis

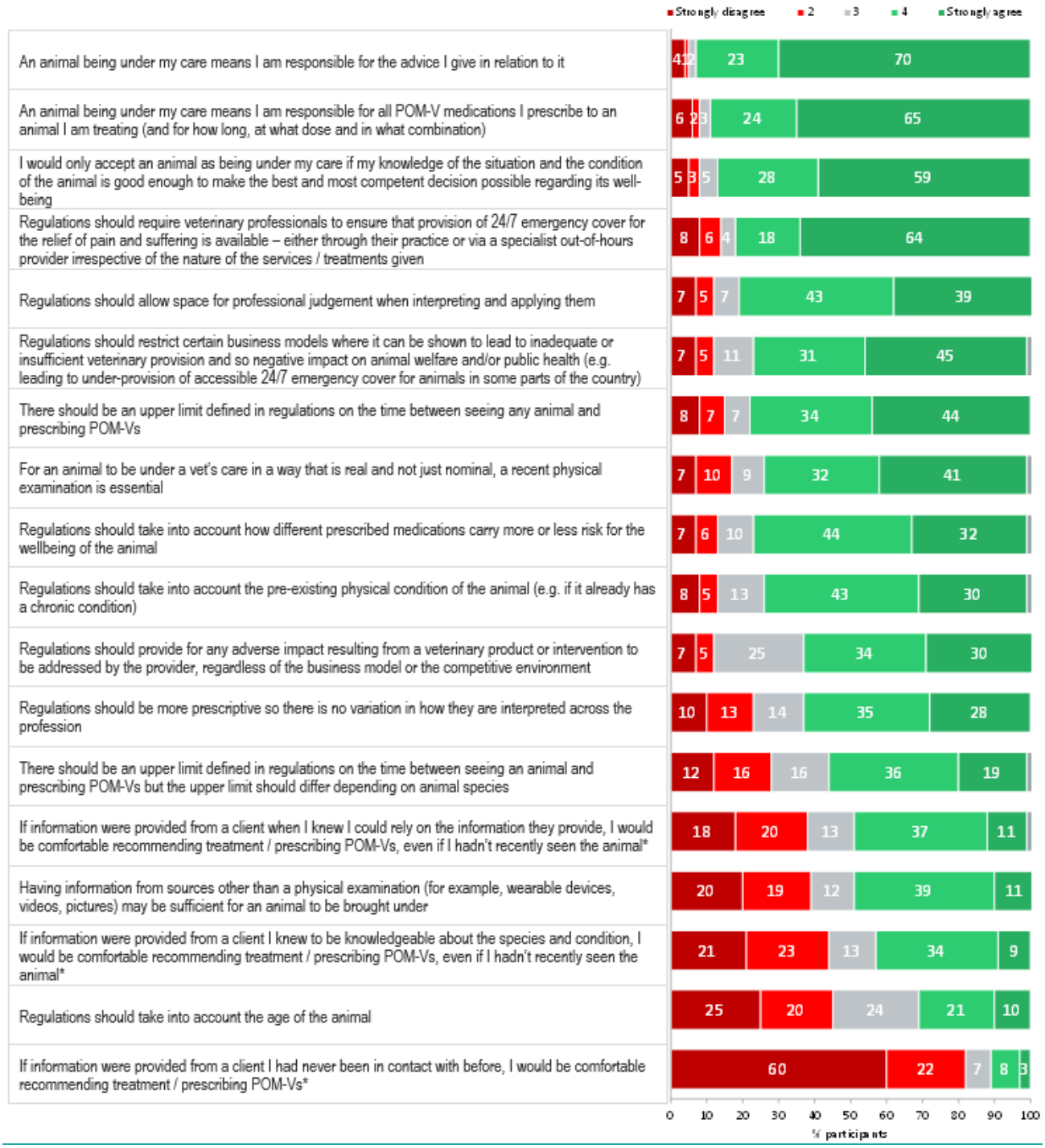
The analysis shows that the veterinary profession was able to broadly concur with the statements arising from our focus groups concerning what good regulations should involve. The highest levels of consensus (either collectively agreeing or disagreeing) were registered in response to statements that are most close to the identity and activities of being a veterinary surgeon or nurse. Statements with higher levels of consensus were:

- *An animal being under my care means I am responsible for the advice I give in relation to it* – 93% agree, 5% disagree
- *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)* – 89% agree, 8% disagree
- *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* – 87% agree, 8% disagree
- *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* – 82% agree, 14% disagree
- *Regulations should allow space for professional judgement when interpreting and applying them* – 82% agree, 12% disagree
- *'If information were provided from a client I had never been in contact with before, I would be comfortable recommending treatment / prescribing POM-Vs'*, 82% disagree, 11% agree.

However, there is much less consensus on questions about what regulations should cover, which are at one stage removed from the direct role of caring for animals. For example, in response to the statement *'Regulations should take into account the age of the animal'* – 45% disagreed and 31% agreed.

The overall analysis of all statements is provided in the figure below.

Figure 3: Good Regulation Statements overall analysis



*Base: 5,544 except for statements marked with * which were only shown to 4,545 veterinary surgeons*

2.1.2. Sub-group analysis

This section will highlight some of the key differences between sub-populations when responding to the questions on good regulation. The graphs for the sub-group analysis can be found in Annex C.

Nurses showed a (statistically significant) tendency to have more confidence in regulations to deliver benefits than was the case for surgeons. The only exceptions were the following three statements:

- *An animal being under my care means I am responsible for the advice I give in relation to it.*
- *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).*
- *Regulations should allow space for professional judgement when interpreting and applying them.*

We analysed differences by practice size and by rural versus urban and again found relatively few differences at a statistically significant level. Significant differences included respondents from **small practices** giving lower levels of agreement to each of the following statements:

- *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.*
- *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).*
- *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 an animal and prescribing POM-Vs but the upper limit should differ depending on animal species.*

It might be supposed that these preferences reflect that these have a better fit with business models and ways of working for small practices.

Respondents from **rural practices** were statistically significantly more likely to agree with the statements:

- *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.*
- *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.*
- *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.*

In addition, respondents from **rural practices** would be less likely to agree with the statements:

- *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.*
- *Regulations should take into account how different prescribed medications carry more or less risk for the wellbeing of the animal.*

It might also be supposed that rural practices, often with close working relationships with animal owners, and varied needs of livestock, would express these preferences.

These nuanced differences seem intuitively plausible and can be explained in the context of different practice size and location. This gives us confidence that we are identifying meaningful responses to the survey as a whole, but overall this is initially a picture of a profession which, when asked what good care

looks like - and what regulation should do to support this - can arrive at a degree of consensus. However, as we discuss in Section 2.3, when we explore the themes underlying these responses, a more complex picture emerges.

2.1.3. Whether any features of good regulations were missing from the statements

After the set of 18 statements regarding regulation, respondents were invited to provide open feedback in two areas relating to 'under care' and 24/7 emergency out of hours care. This focused on asking respondents to highlight any features of good regulation that they thought was important, but was not reflected in the previous statements.

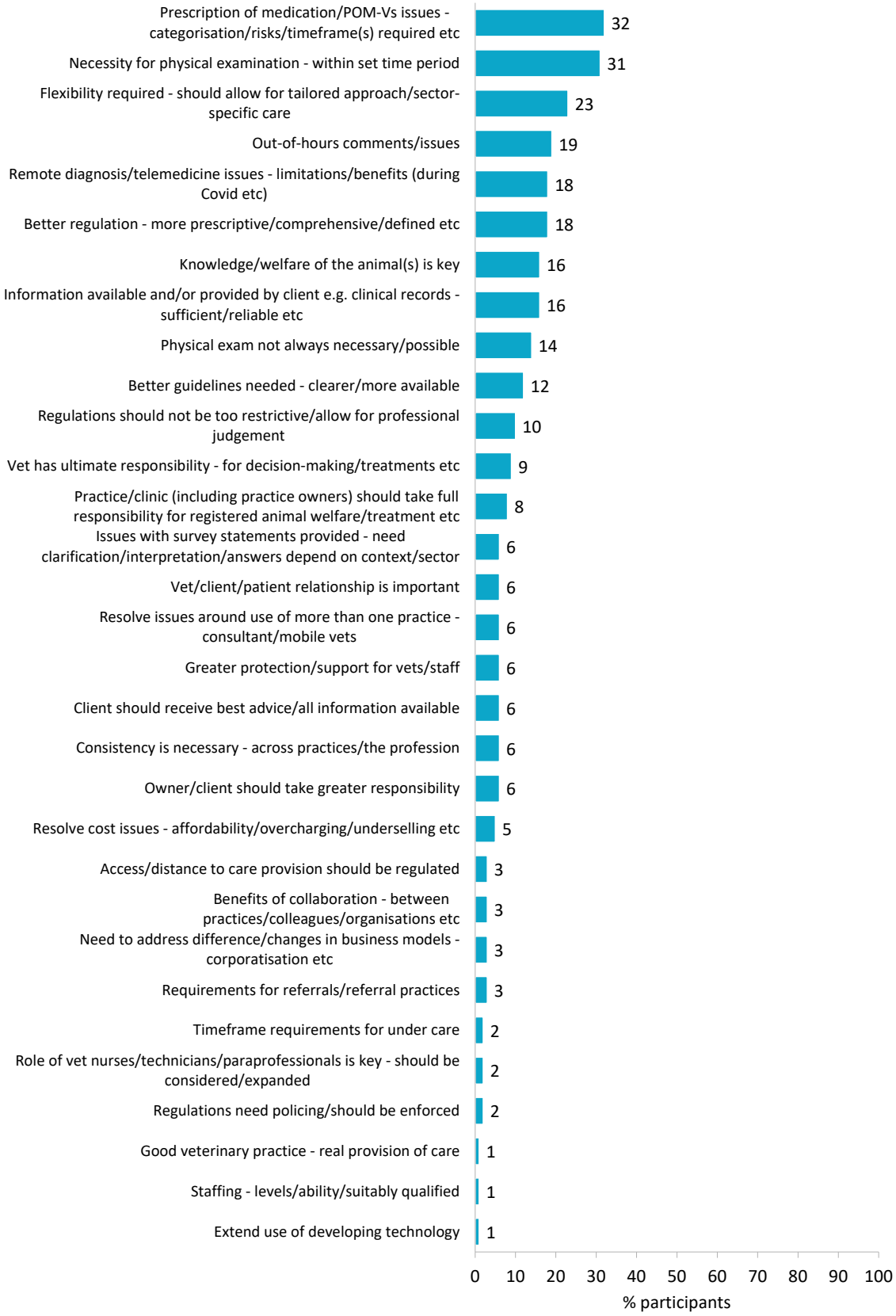
Under Care

Overall, 25% of the sample provided additional comments. The comments have been analysed and coded to a code frame. The main areas which were felt to be missing from the statements on good regulation for 'under care' were:

- Prescription of medication/POM-Vs issues, e.g. categorisation/risks/timeframe(s) required etc. (32% of comments)
- Necessity for physical examination within a set time period (31% of comments)
- Flexibility required in terms of allowing for tailored approach/sector-specific care (23% of comments)

A full listing of the responses is shown in Figure 4.

Figure 4: Missing features for 'under care'



Base: 1,363

24/7 emergency out of Hours

Overall, 27% of the sample provided additional comments relating to 24/7 emergency out of hours care. The comments have been analysed and coded to a code frame. The main areas which were felt to be missing from the statements on good regulation for 24/7 emergency out of hours care were:

- Access/distance to out of hours care provision, e.g. what is reasonable (23% of comments)
- Practice/clinic (veterinary service) should be responsible for providing (access to) an out of hours service to registered animals under their care (22% of comments)
- Outsourcing of out of hours care, specifically, what the requirements are for this (18% of comments)

A full listing of the responses is shown in Figure 5.

Figure 5: Missing features for 'out of hours'

Base: 1,476

2.2. Applying principles

Respondents were shown 20 statements in relation to applying principles. Each statement was shown in turn with a slider scale from strongly disagree to strongly agree. The responses were converted to a five-point numerical scale where 1 = strongly disagree and 5 = strongly agree.

2.2.1. Overall analysis

The statements that gained most consensus for agreement were:

- *If an animal is registered with more than one primary care practice, the practices should be required to share clinical records* – 82% agree, 11% disagree
- *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)* – 82% agree, 9% disagree
- *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* – 75% agree, 13% disagree
- *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* – 74% agree, 12% disagree
- *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* – 72% agree, 11% disagree

The following statements suggest that there is a consensus to disagree:

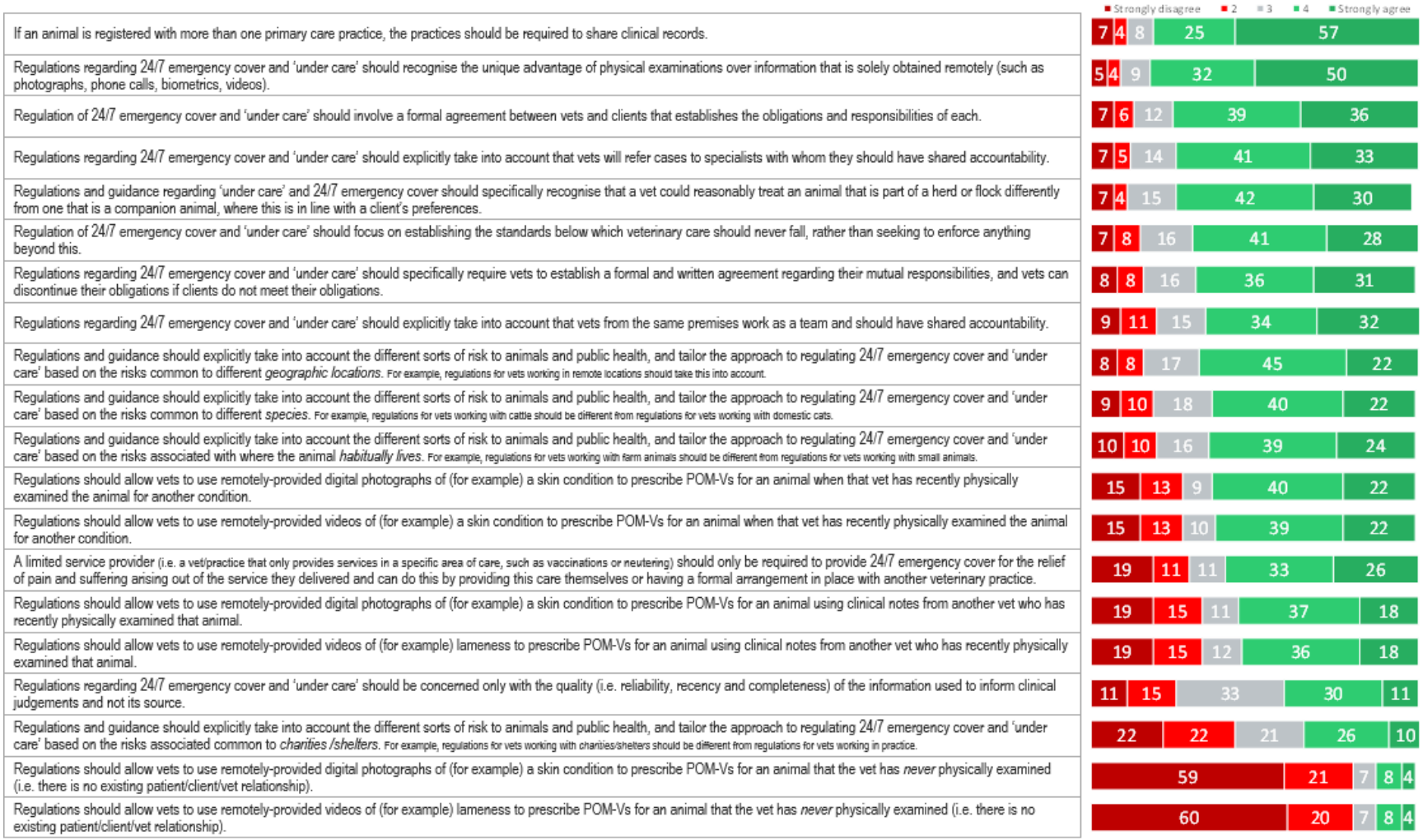
- *Regulations should allow vets to use remotely-provided videos of (for example) lameness to prescribe POM-Vs for an animal that the vet has never physically examined (i.e. there is no existing patient/client/vet relationship)* – 82% disagree, 12% agree
- *Regulations should allow vets to use remotely-provided 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)* – 81% disagree, 12% agree

Statements where there is dissensus were:

- *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* – 44% disagree, 36% agree.
- *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* - 26% disagree, 41% agree.

The overall responses to all the statements are presented in the figure below.

Figure 6: Applying Principles Statements



Base: 4,545 veterinary surgeons, 999 veterinary nurses

2.2.2. Sub-group analysis

There was some variation in responses statistically associated with the size of practice and its location. Respondents from **small practices** were significantly **less** likely than those from medium and larger practices to agree with the following three statements:

- *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 compared to 3.94 for medium and 4.00 for large
- *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 compared to 3.88 for medium and 3.86 for large
- *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 compared to 3.72 for medium and 3.76 for large.

In addition, respondents from **small practices** were significantly **more** likely than those from medium and larger practices to agree with the following two statements

- *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 compared to 3.31 for medium and 3.30 for large
- *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 compared to 1.75 for medium and 1.70 for large.

Remote **rural respondents** were significantly **more** likely than mixed and urban vets to agree that regulations 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 (4.08 compared to 3.85 mixed and 3.78 urban).

Urban respondents were significantly **less** likely than mixed and remote rural vets to agree that regulations should explicitly take into account that vets from the same premises work as a team and should have shared accountability (3.58 compared to 3.73 mixed and 3.95 remote rural). Urban respondents were also significantly **less** likely than mixed and remote rural vets to agree that a limited service provider should only be required to provide 24/7 emergency cover for the relief of pain and suffering arising out of the service they delivered (either by providing this care themselves or having a formal arrangement in place with another veterinary practice) (3.46 compared to 3.31 mixed and 3.18 remote rural).

Annex C provides a table summarising the differences across practice sizes and rurality for the applying principles statements.

Overall, of the 20 statements, only 5 produced significantly different responses from respondents based on their practice size or location, suggesting a basis for agreement within the profession. However, in the following section we show how these apparent areas of agreement reward closer investigation, suggesting some important differences within the profession.

2.3. Factor analysis

Factor analysis aims to simplify a large number of observed survey responses by identifying underlying (unobserved, or latent) variables. We applied this technique by looking for patterns in the way participants of the study have agreed or disagreed to the statements around regulation. By using factor analysis, the data

becomes much easier to interpret – rather than analysing responses to 38 statements, the statements can be grouped into themes and an overall score for each theme can be analysed by a number of groups (such as practice size).

Factor analysis is therefore based on the principle of correlation. The technique looks for groups of statements which have been agreed to in a consistent way. The groups of statements that result are data driven, then grouped into 'themes' which have been given a subjective heading. The naming of each theme is therefore not derived from the data.

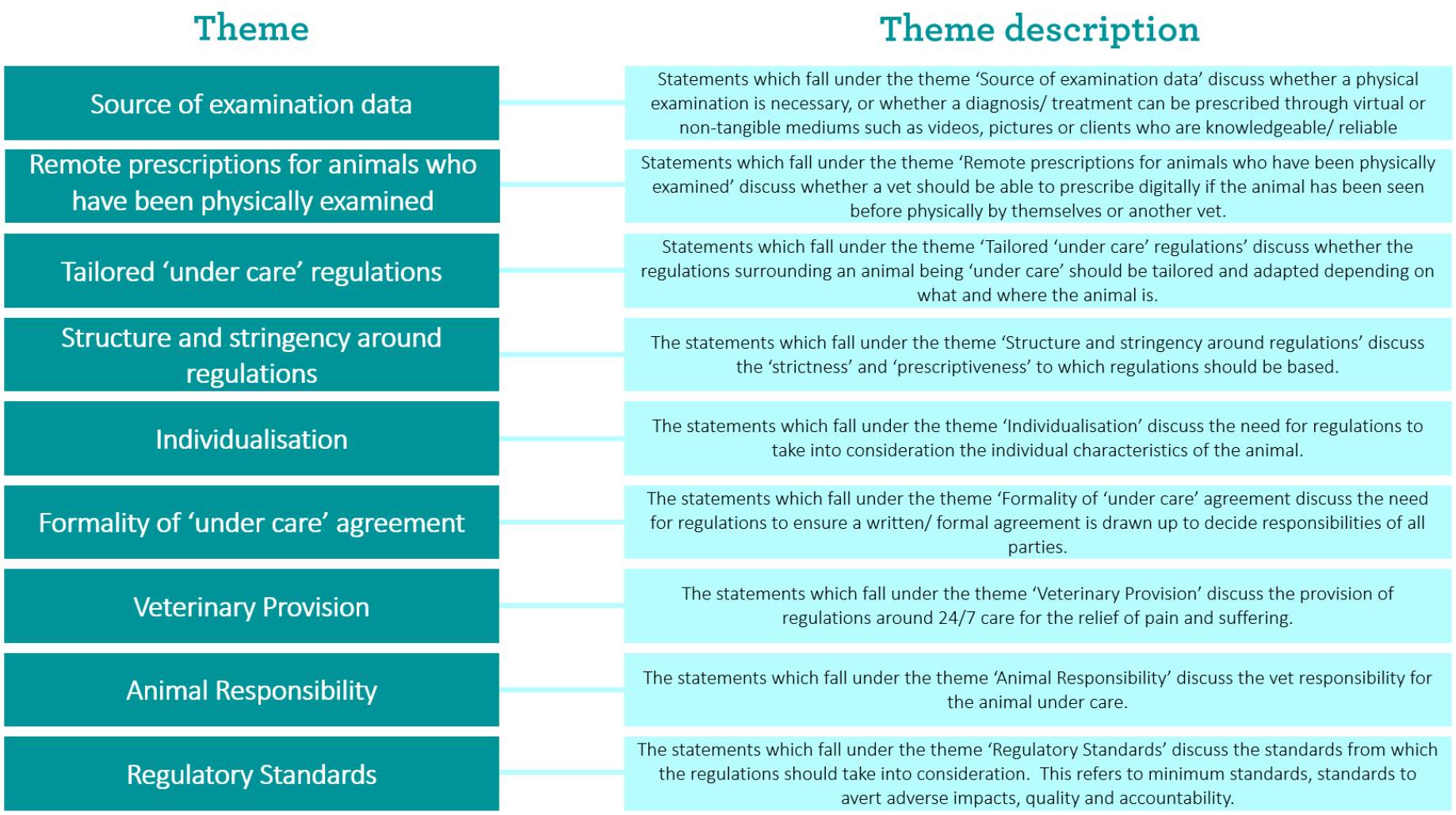
Through this technique, we identified nine key themes revealed through the responses. It is highly likely that these are themes that concern vets in relation to 24/7 emergency provision and 'under care'. Statements within each theme have been grouped because they are highly correlated with each other. Statements that are highly correlated mean that each participant is likely to rate each of the statements in the theme in a similar way. For example, if a participant agrees with one statement in the theme, they are likely to agree with all in that theme. In a similar way, if a participant disagrees with one statement, they are likely to disagree with all in that theme. The 9 themes can therefore be considered a 'summary' of a large number of statements, and they reveal the key areas that surgeons consider on this topic overall.

Benefit of a factor analysis for this study

First, the factor analysis makes visible the themes that appear to lie behind responses from the profession, helping to structure the issues to be considered in an under care review. It therefore helps structure the discussion. Second, they allow us to interrogate how different groups varied in their approach to these themes. It therefore helps analyse the issues.

There were nine factors derived from analysis of the two sets of statements (good regulation and applying principles statements). These are set out below, and the statements included in each theme are outlined in Annex D. It should be noted that factors can only be derived for surgeons, who were required to respond to all questions.

Figure 7: The nine themes identified from the factor analysis



2.3.1. Factor analysis of the nine themes

Using the themes outlined in the previous section, it is possible to look at the differences that occur between different sub-groups (for example, different practice size). Each participant is scored on each theme, using their original agreement scores for each of the statements and an algorithm that underpins the mathematical factors. Using this score, it is possible to look at differences between key groups.

The centre-point line shows the average, bars to the left indicate that the segment is less likely to agree with the statements which form the theme. Bars to the right indicate that the segment is more likely to agree with the statements in the theme *than the average*. The average line for each chart is therefore a representation of the sample size for each group. Note that bars to the left do not necessarily indicate disagreement with the statement but only that the segment is less likely to agree with the statement than the average response. So, for example, all respondents might agree with the theme but segments on the left agree less strongly.

As the theme scores are all 'standardised' to have a mean of zero and a standard deviation of 1, the scale for all charts is identical and therefore groups can be compared within the chart itself, as well as across charts. These analyses are based on responses from surgeons only.

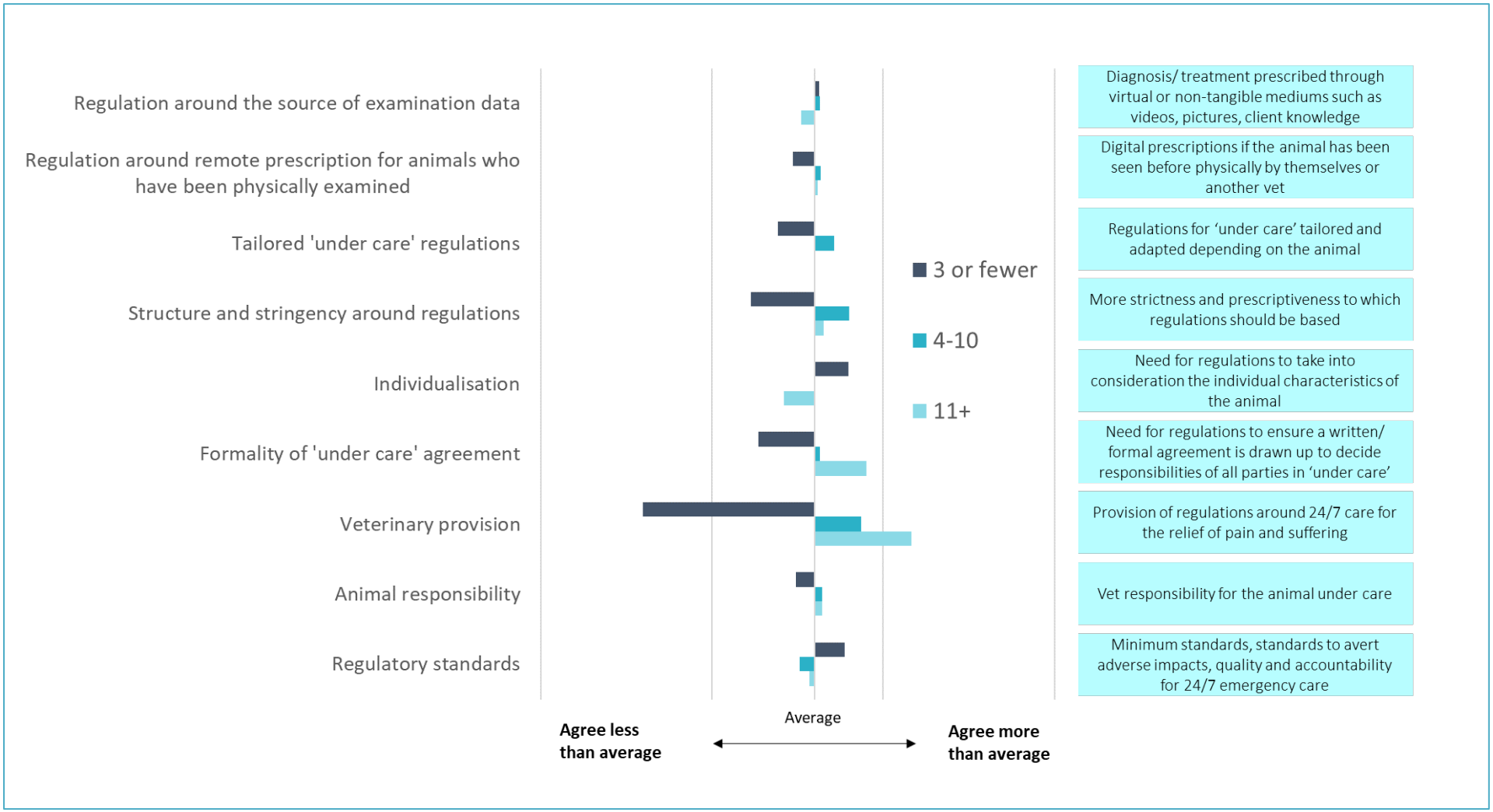
Differences in practice size

The differences in agreement between larger practices (11+ full time equivalent surgeons) and smaller practices (fewer than 3 surgeons) are most contrasting on the following areas (Figure 8):

- The strictness of the regulations
- The need for a written agreement for 'under care'
- Veterinary provision for 24/7 care for pain and suffering

Surgeons from smaller practices were less likely to agree on each of the bulleted areas above than those from larger practices. Possible reasons for this include that it may indicate a lack of resourcing or ability to be able to meet more stringent regulations in these areas.

Figure 8: Differences by practice size (surgeons only)



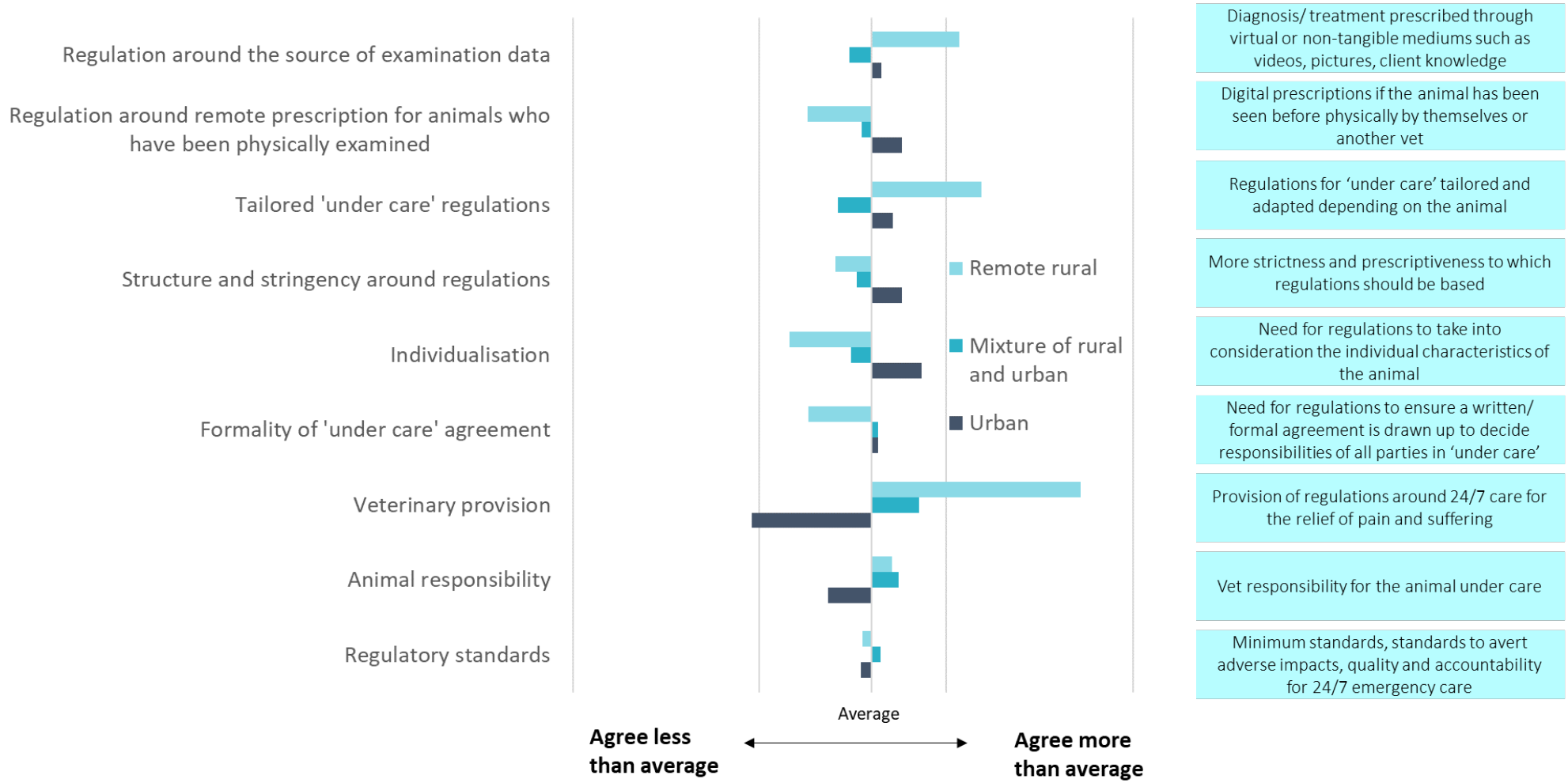
Differences between geographical areas

As might be expected, the differences in agreement between 'remote rural' and 'urban' are the most variable (Figure 9). Surgeons from more remote rural locations were more likely than average to agree with regulations around:

- The source of examination data – agreeing that this source could be virtual
- Tailored 'under-care' regulations – agreeing that this could be based on the type of animal and location
- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care

By way of contrast, surgeons from urban practices were less likely to agree with the regulated requirement for 'veterinary provision'.

Figure 9: Differences by whether urban or remote (surgeons only)



Differences between age groups

Of all segments analysed for differences in agreement on the nine themes, opinion varied the most by age group. This intuitively plausible difference has not previously been quantified, we believe, and as Figure 17 shows, differences are striking. As mentioned earlier, there was very close correlation between age and years' experience in the sample, so these findings from the age group analysis can also be applied to years' experience.

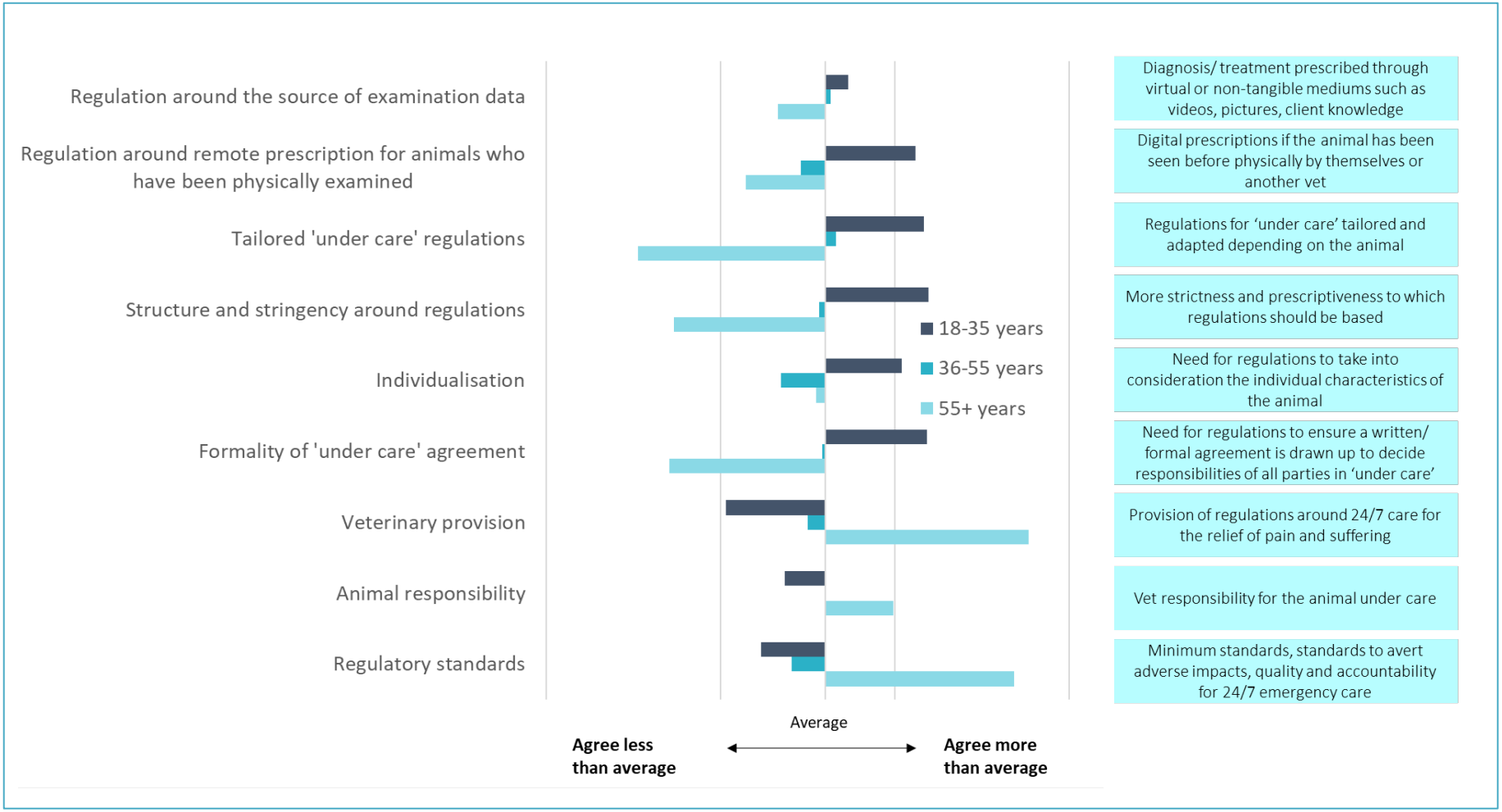
Older surgeons (aged 55+) were more likely to agree with the following:

- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care
- Animal responsibility – agreeing with full veterinary surgeon responsibility for the animal in care
- Regulatory standards – agreeing that the standards that under-pin the term 'under-care' for 24/7 emergency cover should include accountability for all parties involved

However, surgeons aged 55+ were also generally more likely to agree that there should be room for judgement and some flexibility around the regulations.

Younger veterinary surgeons (aged 18-35) were more likely to agree with a more 'virtual' approach, favouring digital diagnosis, examination and prescribing. Despite agreeing that there needs to be provision for individual cases and 'tailored' under-care agreements, the younger age group generally agree that having the structure and security of regulations is more favourable. This includes having the formality of a written agreement for 'under care' and less 'room for judgement' in prescribing and treating animals in their care.

Figure 10: Differences by age group



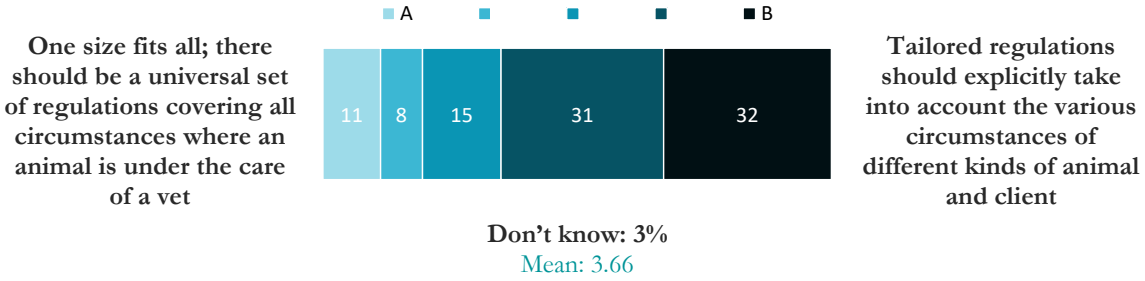
2.4. When principles are in tension

In this final part of the survey, we were concerned with the preferred balance between principles which might be equally desirable but might also be in tension with one another such that more of one might result in less of the other. These are not intended to be points on a spectrum but reflect some of the tensions and dilemmas identified in the focus groups. Regulations often have to work in the context of such tensions, meaning that they may not please all professionals equally and may sometimes have to reflect a compromise. The results presented below show, on average, the profession responds to such tensions but also identifies important variations in a range of responses.

The slider could be moved from the extreme left to the extreme right. The responses have been grouped into a five-point scale between 1 and 5 indicating support for the left hand statement 'A' to support for the right hand statement 'B'. A mean score of 3 is ambivalent between the statements, a score of less than 3 indicates support for the left-hand statement and a score of more than 3 indicates support for the right hand statement. We present each pair of statements in turn.

2.4.1. One size fits all v tailored regulations

Overall, there was **a strong preference for tailored regulations** over a one size fits all approach to regulations with a mean score of 3.66 (where 1 = A and 5 = B).



Nurses were significantly[7] more likely than surgeons to agree with the second statement. Also, even more markedly, younger participants (aged 18-35) were significantly more likely than older participants (aged 46+) to agree with the second statement. This suggests that younger surgeons and nurses would prefer regulations that were more tailored to the specific needs of each animal type, while older vets would prefer regulations that were more universal. However, the nursing respondents tended to be younger than the surgeons which may have contributed to the difference in roles.

There were no statistically significant differences by practice size, whether urban or rural and country. The graph summarising sub-group analysis for this question is in Annex C.

In the open text responses following this question a range of views were articulated. Some regarded equal care (possibly based on general principles) for all animals as a fundamental goal of regulation. Others saw general regulations as a good way to prevent abuse or undue pressure being placed on vets. More opinions emphasised that there is no 'one-size-fits-all' in medicine and the need for professional discretion. Still others emphasised the need for regulations to accommodate the specific and different circumstances of different animals. These opinions are report in Figure 11 below.

[7] At the 95% confidence level

Figure 11: Open text responses to 'one size fits all versus tailored regulations'

One size fits all; there should be a universal set of regulations covering all circumstances where an animal is under the care of a vet

Don't know not shown

Tailored regulations should explicitly take into account the various circumstances of different kinds of animal and client

Basic/universal set of regulations required

- *Core basic standards with species specific amendments.*
- *It is impossible to cover all possible circumstances so would prefer regulations based on good principles.*
- *I think all animals should be treated with same care. Farm, pets, strays, wildlife, I hate the situation where pigeon is put to sleep even without checking what is wrong with it because it is just pigeon.*

Clear/simple regulations required – not open to interpretation/abuse

- *One size allows for clear interpretation and everyone working to the same regulations, but in reality this might not be as simple as that. Maybe a standardised approach with caveats?*
- *While it would be lovely to tailor regulations to each precise situation, there are so many possible permutations of circumstances that this would result in a regulatory minefield where, for example, an on-call vet in mixed general practice would be governed by one set of regulations for equine patients, another for companion animals, another for farm animals and yet another for exotic species. The potential for confusion and mistakes would be huge.*

There isn't a one-size-fit-all in medicine

- *There is not a 'one size fits all' scenario in veterinary medicine.*
- *There are no two identical situations in clinical practice.*
- *Tailored regs would be good but you cannot account for every situation.*

Should allow for professional judgement

- *Professional clinical discretion.*
- *Will depend on the vets confidence in the clients ability to judge the situation + communicate it to them-if a vet has a longstanding relationship with a client they may be able to judge this + other factors may have to be taken into account such as the ability of the client to get the animal in to be examined if for example client is unwell vets should be able to use their own judgement up to a point.*
- *Regulations should allow professional judgement and professional responsibility. I don't think a field as diverse as ours would do well with universal regulations (farm animals and companion animals require a completely different approach for example).*

Different regulations required – should allow for tailored approach

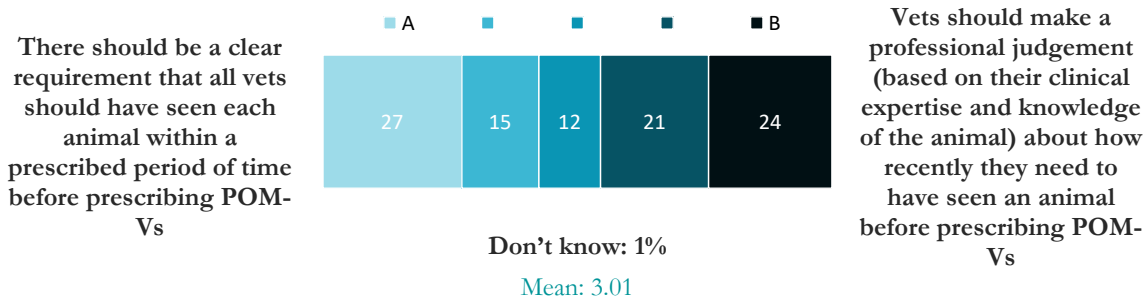
- *Nuance and holistically assessing a situation will be removed in a one size fits all system*
- *I feel it is important to recognise that circumstances differ in different situations and regulations should take this variation into account.*
- *One size categorically does not fit all and medicine is NOT and exact science as anybody who has noticed that we are in the midst of a pandemic must now realize.*

Depends on Sector/ Species / Context / Treatment requirement

- *The specific conditions of my current sector (farmed fish) are very different to other sectors in which I have worked (eg companion animal practice); I want to see regulations fit for my sector and do not believe this is possible under 'one size fits all' regulation.*
- *Farm animal, equine, small animal, and exotic practice will all have very different requirements and the regulations should have enough flexibility to account for that.*
- *Geographic, financial, access, staffing and practical issues should be taken in to account when setting regulations because strict regulations may be impractical or unrealistic in remote areas.*

2.4.2. Before prescribing POM-Vs each animal should be seen within a prescribed period of time versus vets should make a professional judgement

This pair of statements was shown to surgeons only. There was an even split for this pair of statements with a mean score of 3.01.



Small sized practices were significantly[8] more likely than medium sized practices to agree with the second statement. Also, participants aged 46 and older were significantly more likely than participants aged 18-35 to agree with the second statement. Possibly, this reflects the greater confidence in one's professional judgement that comes with experience. It also appears from the previous theme that younger vets would prefer more tailored regulations and a greater level of prescription regarding time lapses between seeing an animal and prescribing POM-Vs. There were no statistically significant differences by whether urban or rural and country. The graph summarising sub-group analysis for this question is in Annex C.

The open text responses suggest that, for some (as in the previous set of responses), there was a concern that complexity would create a lack of clarity which would lead to inconsistent practices and complaints from animal owners. There was also a concern that those with power over those below them in the professional hierarchy might use a lack of clarity to bring undue pressure on more junior professionals. But there was also a concern that animals would suffer if they lacked regular physical examinations between prescriptions of POM-Vs. On the other side of this argument, it was suggested that the well-being of animals depended crucially on the freedom to exercise independent professional judgement. For example, fewer visits to the vet might reduce stress experienced by some animals. Between these two positions was an emphasis on having different levels of regulation for different drug categories and using guidance plus flexibility rather than regulation. The range of responses can be seen in Figure 12 below.

[8] At the 95% confidence level

Figure 12: Open text responses to the question on 'Before prescribing POM-Vs each animal should be seen within a prescribed period of time versus vets should make a professional judgement'

There should be a clear requirement that all vets should have seen each animal within a prescribed period of time before prescribing POM-Vs

Vets should make a professional judgement (based on their clinical expertise and knowledge of the animal) about how recently they need to have seen an animal before prescribing POM-Vs

Clear guidelines required – not open to interpretation

- *It is easier to have a clear recommendation so that the public can be given consistent advice.*
- *This is easier if there is a simple rule, otherwise it's open to misinterpretation and is going to lead to inconsistencies between different vets within a practice and between different practices. If it's complex it will inevitably lead to complaints.*

Physical examination required for diagnosis/prescription of POM-Vs

- *We've all known instances where 'the boss' has pandered to their favourite/most important client and prescribed POMs without examining the animal. The animal must come first.*
- *There is a huge amount of pressure already on vets by owners to prescribe without examination. Having explained to clients for years why we won't do this , with very good reason for their animals welfare, the RCVS would be handing owners the right to demand this way of treating animals even though it is not in the animals best interest.*
- *Through lockdown I saw several patients that deteriorated due to the remote prescribing of POM-Vs without a physical exam.*

Depends on drug category

- *POM-Vs are not all the same. Some, like many internal and external parasiticides do not need such close supervision as, for instance, cardiac medicines. The only way of working a prescribed period would be to specify such a period for each class of drug, possibly further broken down into it's specific use.*
- *Impossible to be prescriptive on this. For good antimicrobial use an animal should always be examined before antimicrobials are prescribed.*

Flexibility required

- *I believe that more guidance needs to be given as regards prescribing periods but the flexibility should be there to allow vets to be able to step outside of these periods where they can show evidence of the need as regards animal welfare.*
- *I think it would be helpful to have guidance rather than regulation on this topic as it can be quite variable but should not allow prolonged prescribing without appropriate assessment.*

Should allow for professional judgement

- *Everything depends on the problem and the medication and the animal. Central regulations cannot reliably make those distinctions, the vet who knows the animal can.*
- *Individual professional judgement can be the only factor vet takes responsibility for.*

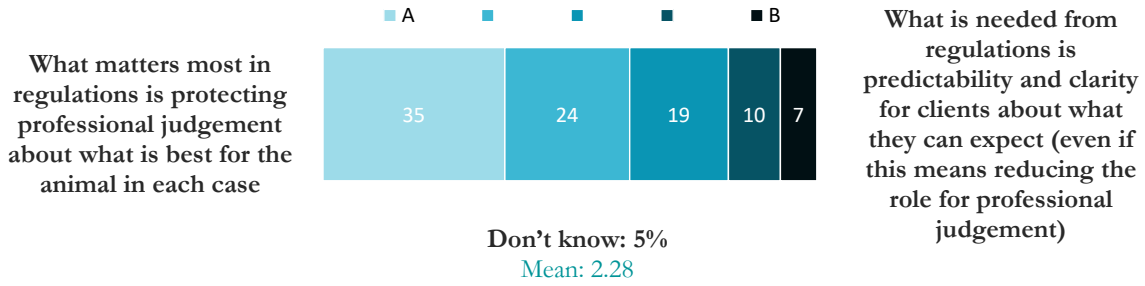
Physical examination not always possible/necessary/advantageous – use of remote diagnosis

- *Antibiotics (topicals included) should not be used remotely. Data sheets should contain the recommendation and risks. Risks should be discussed openly for remote prescribing. It is not for us to chose, but for the keeper of the animal.*
- *For animal welfare a remote examination and recent clinical notes (from a registered practice) allow a patient client relationship to be formed. This can allow for remote prescribing to ensure the highest level of animal welfare in our profession rather than clients resorting to buying inadequate products from pet shops or amazon with no professional advice.*
- *Stress of visit to vet can conflict with welfare needs.*

2.4.3. Protecting professional judgement about what is best in each case versus predictability and clarity for clients about what they can expect

This is a question of the balance between having a formal and clear structure for engaging with clients versus the need for a vet to be able to act in the best interests of the animal rather than be constrained by a prior formal agreement with the client.

Overall, there was a very strong preference for regulations protecting professional judgement about what is best for the animal in each case as opposed to regulations providing predictability and clarity for clients about what they can expect with a mean score of 2.28.



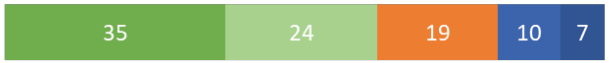
Surgeons were significantly[9] more likely than nurses to agree with the first statement. Also, respondents from small practices were significantly more likely than medium and large practices to agree with the first statement. These two differences may reflect variation in levels of professional responsibility, with surgeons running smaller practices potentially having more responsibility for the reputation and financial performance of the practice than those working in larger practices. There were no statistically significant differences by age, whether urban or rural and country. The graph summarising sub-group analysis for this question is in Annex C.

The question of achieving clarity for both vets and owners was touched on in the responses to the previous questions and it was reinforced in the open text responses that clarity and predictability was 'vital' for the wellbeing of vets and owners alike. It was also believed that clear and predictable regulations help vets manage clients' expectations. On the other hand, knowledge of the animal was said to be key to its welfare and there was anxiety that regulations might be overly prescriptive and miss the nuances of good care. It was also questioned whether clients would ever be influenced by regulations. In an important comment, it was questioned why predictability and clarity should necessarily reduce the role for professional judgement. The range of open text responses to this question can be seen in Figure 13

[9] At the 95% confidence level

Figure 13: Open text responses to 'Protecting professional judgement about what is best in each case versus predictability and clarity for clients about what they can expect'

What matters most in regulations is protecting professional judgement about what is best for the animal in each case



What is needed from regulations is predictability and clarity for clients about what they can expect (even if this means reducing the role for professional judgement)

Professional judgement is essential/the practitioner's responsibility

- *Almost no clients will ever read the regulations, the RCVS certainly won't meaningfully advertise or distribute them. But that said there has to be some room for professional judgement in the application of the regulations; but not too much, otherwise there's no point in having them.*
- *I'm not clear about how these represent opposite ends of a spectrum - professional judgement must play a role in how regulation is interpreted and clients need predictability and clarity. I don't see it that one rules out the other.*

Knowledge/welfare of animal is key

- *Knowing the particular client + animal does have an impact on your decision.*
- *The clients should only have the right to expect that the vet is doing his best. The best for an individual animal will vary with the confidence and experience of the vet at the time.*
- *The RCVS oath taken by veterinary surgeons states that first and foremost their duty is to uphold the welfare of the animal in their care (not first and foremost they will provide predictability for clients).*

A balance is required – both statements are valid

- *Regulations should seek to ensure the best balance here. Allowing professional judgement is important as long as there is still accountability.*
- *I think there needs to be a balance for this. Some things should be explicitly regulated for client clarity (eg 6 months between repeat exams for medications). But some areas should be left open for professional judgement. I think this should be made clear in the regulations.*
- *Both important but I don't see why predictability and clarity for clients should reduce the role for professional judgement.*
- *What's best for animals is a client-vet partnership. I think I agree with both statements and don't find the mutually exclusive.*

Regulations should provide clarity/predictability – for clients/vets

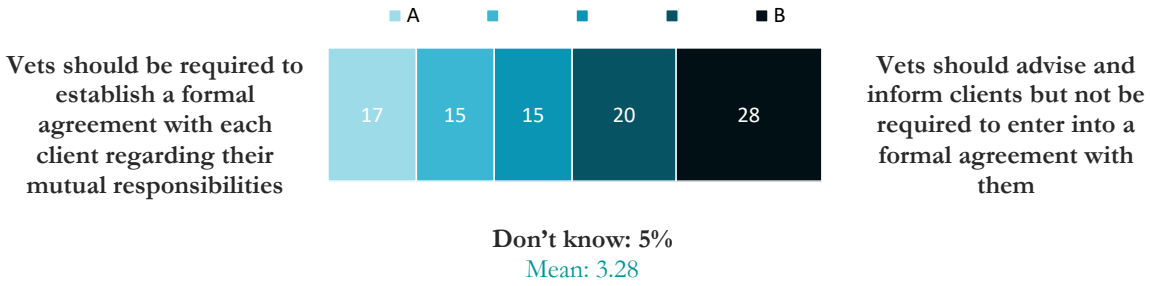
- *Because vague guidelines (as seen with COVID flow chart) is easily abused to make profits.*
- *Predictability and clarity is vital for clients and for the mental health of vets. Professional judgement is extremely important but young vets often face pressure and intimidation to retract their judgement - regulations backing them up are much better.*
- *The wider the interpretation of regulation is, the less supportive it is for vets and will allow clients to complain which has a huge effect on mental health. Schedule 3, under our care, 24/7 have always been unclear and lead to stress. If protecting the public is the aim, the RCVS should give clear regulation that can be used to explain decisions.*

Need to manage client expectations – communication/provision of information

- *Increasingly clients challenge the profession as to why they 'have to have an appointment'. Grey and loose legislation tends to make it more difficult to discuss as another practice may behave differently. If there was some clear underlying red lines then clients would be able to see and understand these.*

2.4.4. A formal agreement with each client should be required versus vets should advise and inform clients about agreement

The previous question explored the balance between the role of professional judgement and the role of more formal agreements with the client. This question explores the balance between vets being responsible for ensuring that clients enter into a formal agreement regarding mutual responsibilities vets providing advice and information to clients as and when deemed necessary. A larger proportion thought that vets should advise and inform clients rather than be required to establish a formal agreement with each client with a mean score of 3.28.



Don't know: 5%
Mean: 3.28

Surgeons were significantly[10] more likely than nurses to agree with the second statement. It is possible that surgeons might feel disempowered by a formal agreement whereas nurses might feel empowered. Respondents from small practices were significantly more likely than those from medium and large practices to agree with the second statement. Also, participants aged 46 and older were significantly more likely than participants aged under 45 to agree with the second statement. There were no statistically significant differences by whether urban or rural and country. It is possible that vets in rural practices and younger vets both showed a leaning towards more formal arrangements but for different reasons. The graph summarising sub-group analysis for this question is in Annex C.

There was a clear preference against formal agreements but it is worth noting that for some in the free-text responses, this was regarded as a 'nice' idea but very difficult to achieve in practice. This might explain the preference against formal agreements, but others added that neither do clients like formal agreements and nor is it a vet's job to produce these. Others worried about the bureaucracy and threat of litigation involved. Very few objected in principle to such agreements. Those in favour suggested it would ease relationships with clients and strengthen professional accountability. These views from the free-text responses are summarised in Figure 14.

[10] At the 95% confidence level

Figure 14: Open text responses to the 'A formal agreement with each client should be required versus vets should advise and inform clients about agreement'

Vets should be required to establish a formal agreement with each client regarding their mutual responsibilities

Vets should advise and inform clients but not be required to enter into a formal agreement with them

In favour of formal agreement – beneficial etc

- *I think it would make clear the responsibilities of both the client and vet if a formal agreement was established which could be referred to if there was a dispute later on.*
- *I believe formal agreement, in form of traditional paper consent form, short text message with Y/N reply, electronic survey or electronic document gives veterinary practice protection from client saying 'Nobody told me that' even if did or told it to his wife who is named owner of their pet in the system.*
- *We need accountability.*

Client should take/share responsibility

- *Vets and owners should recognise their equal responsibility for an animal's welfare.*
- *Then clients can have an expectation of what we look for and what we expect of them and at the same time we have a responsibility to them that they can see as well what they can expect from us.*

Formal agreement is good, but not easy to get right / enforced

- *I'm struggling to see the benefit of ensuring a formal agreement is in place but I suspect its to mitigate some accountability in the event of a poor outcome to treatment or such.*
- *It's a nice idea, but would be an absolute minefield to define everything that owner or vet is responsible for*
- *A formal agreement might be a good idea however I am worried it would put many clients off from seeking treatment for their pet.*
- *It would be very difficult to enforce with all owners.*
- *Whilst I would actually like a formal agreement with clients I am uncertain how this would be practically put into place.*

Against formal agreement

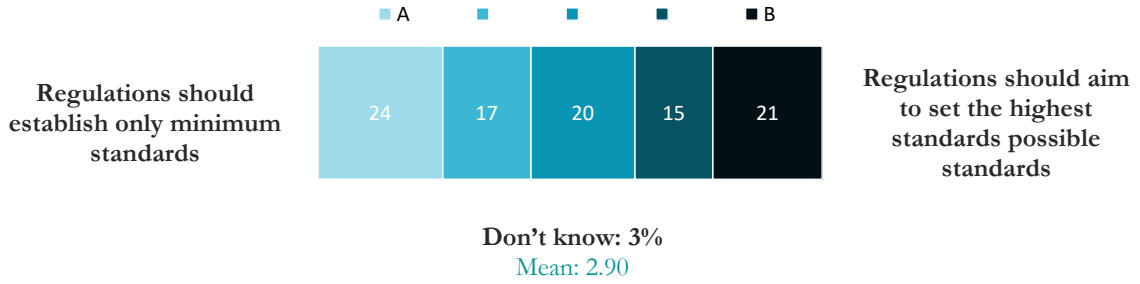
- *Clients don't like formal agreements. They enjoy the privilege of moving between practices and between individual preferred veterinary surgeons for the care of different animals in their household. Exotics to one practice, dogs & cats to a cheaper general practice, horses to an equine practice.*
- *It's not a vets job to have a formal agreement - each party has their responsibilities already in law.*
- *Formal agreement can lead to litigation.*
- *I don't see how it could be formalised in a sensible way - clients will always want to have a certain amount of freedom/choice.*

Too onerous – too much bureaucracy/admin/time-consuming

- *More paperwork is not the answer, it rarely is. An explicit agreement per client will present yet another barrier to care and another drain on practices time. Each new regulation or paperwork exercise adds cost to care provision. We should focus on making care maximally available, rather than maximally regulated.*
- *Enough paperwork. Inform, write in clinical notes (can be done by reception), sorted.*
- *Who has time for that? Seriously.*

2.4.5. Regulations should establish only minimum standards versus should aim to set the highest standards possible standards

Regulations may seek to establish minimum requirements (a floor) or to move the profession towards highest standards of practice (a ceiling). There was a slight preference on balance for minimum standards being set by regulations rather than the highest possible standards with a mean score of 2.90.



Don't know: 3%
Mean: 2.90

Nurses were significantly[11] much more likely than surgeons to agree with the second statement. Also, respondents from small practices were significantly more likely than those from medium and large practices to agree with the first statement. There were no statistically significant differences by age, or whether practices were urban or rural and country. The graph summarising sub-group analysis for this question is in Annex C.

Open text responses suggest at least two reasons for supporting minimum standards; reducing the room for interpretation and leaving room for other approaches to quality improvement (for example accreditation schemes). Reasons given for wanting the highest standards possible were less to do with regulation and more to do with the professional obligation to meet the highest standards possible. Meanwhile others stressed the importance of flexibility and a recognition that specialists and generalists might be held to different standards. The results from the analysis of open text responses to this question are in Figure 15.

[11] At the 95% confidence level

Figure 15: Open text responses to 'Regulations should establish only minimum standards versus should aim to set the highest standards possible standards'

Regulations should establish only minimum standards

24 | 17 | 20 | 15 | 21

Regulations should aim to set the highest standards possible standards

In favour of minimum standards

- *Mandatory regulations should set the minimum standards, accreditation schemes are a more suitable vehicle for encouraging and certifying the very highest standards.*
- *Highest standard regulations may be punitive in certain circumstances, whereas minimum standard ensures that there is a base level of welfare provision that should never be compromised. This can be more easily presented to a client and gives practices scope to go above and beyond the requirements.*

Standards should be reasonable/attainable/workable

- *A middle ground needs to be found where we make sure our standards of care are high, but without reaching gold standard levels of care that are unattainable for most practices.*
- *Regulations should allow the freedom to make judgement based on professional opinion.*
- *Whilst I agree that regulations should aim to have the highest standard, it then leaves things open for interpretation and things can be argued/debating. Therefore I believe regulations should have defined minimum standards, but then state what should be realistically aimed for.*

Flexibility required – should allow for tailored approach

- *Difficult one – I'm sure we all try to provide the highest possible standard of care to our own ability but that must surely vary. For example I have worked in first opinion practice for nearly 40 years and but inevitably, for certain cases, my care will not be as high as a specialist to whom I might refer a case.*
- *Regulation is important, but must never take the place of individual professional judgement and flexibility of approach. Set the bar too high and good service to both client and animals will suffer.*
- *Balance is needed to protect the wellbeing of the professional whilst striving to optimise welfare of the animal.*

Best possible standards required

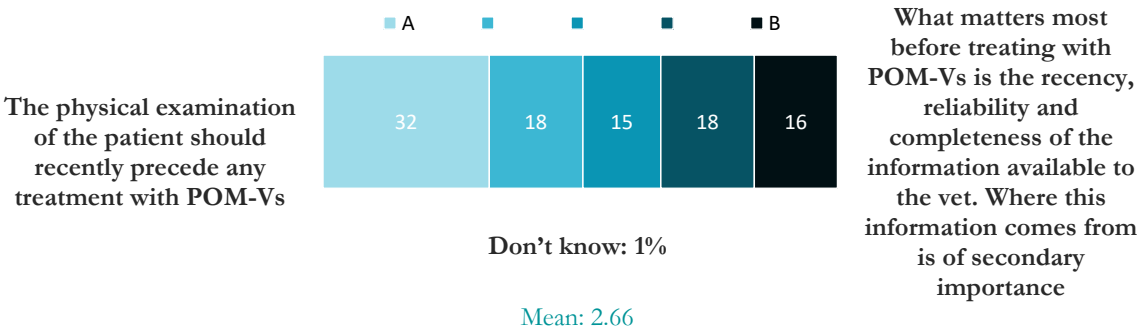
- *Always try reach as highest standard as is feasible.*
- *We must ALWAYs work to the highest standard; We MUST never compromise.*
- *Regulations should set the highest standards, anything decision that led to a situation below this would have to be well reasoned and supported.*

Should aim to improve/raise standards

- *If you set minimum standards then many lazy vets will only adhere to that. You should be trying to get all the profession to be as good as possible.*
- *I appreciate that it is not possible in all circumstances to provide the highest possible care due to finances, remoteness, compliance, client and patient behaviour. However, this should always be our goal.*

2.4.6. Physical examination should precede any treatment with POM-Vs versus recency, reliability and completeness of the information available

This pair of statements was shown to surgeons only. The balance of opinion was that the physical examination of the patient should precede any treatment with POM-Vs rather than assessing the recency, reliability and completeness of the information available with a mean score of 2.66.



There were no statistically significant differences by role, age, whether urban or rural, country or practice size. This sense of consensus is reinforced by the very low 'don't know' return (1%) and the open text responses. The graph summarising sub-group analysis for this question is in Annex C.

Even those supporting the need for a recent physical examination before treating with POM-Vs do not appear to reject alternative sources of information in principle. Rather, their concerns reflect the view that alternative sources of information provide less complete information and could result in harm to the animal. Even those suggesting that physical examination is not always necessary, recognise the value of physical examination but suggest that it may not always be practical and, indeed, a well-managed remote consultation could even be more reliable in some circumstances. There was a strongly articulated view that flexibility and response to circumstances are most important.

Figure 16: Open text responses to 'Physical examination should precede any treatment with POM-Vs versus recency, reliability and completeness of the information available'

The physical examination of the patient should recently precede any treatment with POM-Vs

What matters most before treating with POM-Vs is the recency, reliability and completeness of the information available to the vet. Where this information comes from is of secondary importance

Recent physical examination required for prescription of POM-Vs

- *Physical examination gives the best chance of an accurate diagnosis and allows supplementary tests to be carried out and that is necessary to target treatment.*
- *There can only be a few exceptions to physical examination - the reliability of any information other than this has to be questioned.*
- *A physical exam is required to confirm the suspicions gained by other methods.*

Need complete picture – awareness of all symptoms/pre-existing conditions

- *Can get a lot of information from photos, tele cons etc, often this is enough to decide if a physical consult is needed. A physical cons will always be the gold standard, and allow addition problems to be identified that the client may be unaware of such as dental disease, heart murmur, BCS. Remote consults are useful but clients need to understand their limitations.*
- *The patient needs to have been seen fairly recently - the client may send us a photo of its bad skin, but be completely unaware of serious dental disease, heart disease etc (that a clinical examination would pick up on) and leave the patient suffering unnecessarily.*

Flexibility required – should allow for tailored approach

- *Recent reliable and completeness are not attainable. Physical exam is not usually useful.*
- *There are many conditions that are readily diagnosed from images, spoken information etc, or that have a certain diagnostic approach. Any vet is quite capable of deciding whether a physical examination is required and prescribing appropriately.*
- *Depends on whether it's a patient with stable chronic disease, or something new/ changing. What does 'recent' mean?*
- *It's neither nor. ideally there should be a physical exam, but there should be scope for individual circumstances.*
- *It is a balance, this depends on so many factors and specific situations may require different approaches. I think it should be based on the veterinary surgeon's professional judgement in the specific situation.*

Physical examination not always necessary/possible

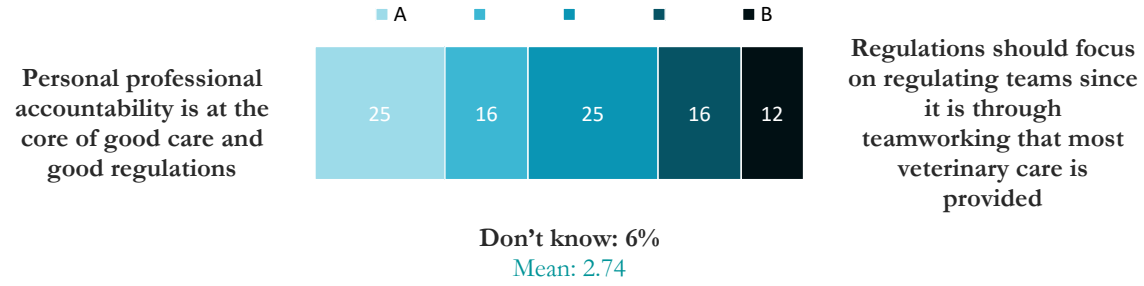
- *Physical examination is a tool, just one part of the completeness of information. However if the attending has not examined the animal themselves, or have good and recent knowledge of it, it must be seen and examined.*
- *Again - it its not possible to physically examine all animals prior to treatment especially in large farmed populations where they cannot be treated as individuals.*

Information available and/or provided by client should be sufficient/reliable

- *Sometimes good remote consult is more reliable than clinical exam and history from the client.*
- *There are absolutely times when a physical exam is necessary, but many times, it is not and we should be allowed to use whatever information we feel comfortable with in order to make treatment decisions.*

2.4.7. Personal professional accountability is at the core of good care and regulations versus regulations should focus on regulating teams

The balance of opinion was in favour of personal professional accountability in regulations being more important than regulation of teams with a mean score of 2.74.



Don't know: 6%
Mean: 2.74

Surgeons were significantly[12] more likely than nurses to agree with the first statement. Participants aged 46 and older were significantly more likely than participants aged under 45 to agree with the first statement. This may reflect nurses and younger people's approach to team working in veterinary medicine. Also, medium practices were significantly less likely than small practices to agree with the first statement. There were no statistically significant differences by whether urban or rural and country. The graph summarising sub-group analysis for this question is in Annex C.

It is interesting to note how infrequently team-working was raised spontaneously in relation to regulation. Here, however, respondents were explicitly invited to comment on this. Those holding the importance of focusing on teams argued that the practice is the organisation responsible for the care of the animal and, indeed, too much emphasis on individualism can make veterinary practices dysfunctional. It was suggested that regulations should cover the entire veterinary team and that very few animals are only seen by a single vet. The counter argument was very much about the accountability of the individual professional and that a team cannot have ultimate responsibility. Others argued for a balanced approach and that good care reflects both team working and individual responsibility.

[12] At the 95% confidence level

Figure 17: Open text responses to 'Personal professional accountability is at the core of good care and regulations versus regulations should focus on regulating teams'

Personal professional accountability is at the core of good care and good regulations

Regulations should focus on regulating teams since it is through teamworking that most veterinary care is provided

Professionalism requires accountability

- *I feel every situation is individual and part of being a professional is taking responsibility for making a professional judgment according to individual circumstances.*
- *We benefit from professional status so must be accountable.*
- *If I am allowed to maintain my personal professional judgement, I am happy to take responsibility for my own actions.*

Responsibility lies with the vet in charge of team

- *Although teamwork is very important, there are still sole practitioners in our profession, and ultimately it is an individual responsibility to maintain standards, and education to be competent and accountable.*
- *Teams fail.*
- *A team cannot have ultimate responsibility.*

Both statements are true

- *Both teams and the individual are accountable.*
- *these are not mutually exclusive to me but equally important.*
- *Both important. Veterinary teams are composed of professional persons, so regulation applies to all through both. Unqualified people (including student nurses, vet students and reception/support staff) should only be acting under direction of qualified persons anyway.*

There should be a balance

- *Vets don't work in a vacuum, but equally should be personally responsible for the work they do.*
- *We do work in teams but not every team is equally accountable as each member.*
- *Good care is a combination of team work and individual responsibility.*

The veterinary practice is a team

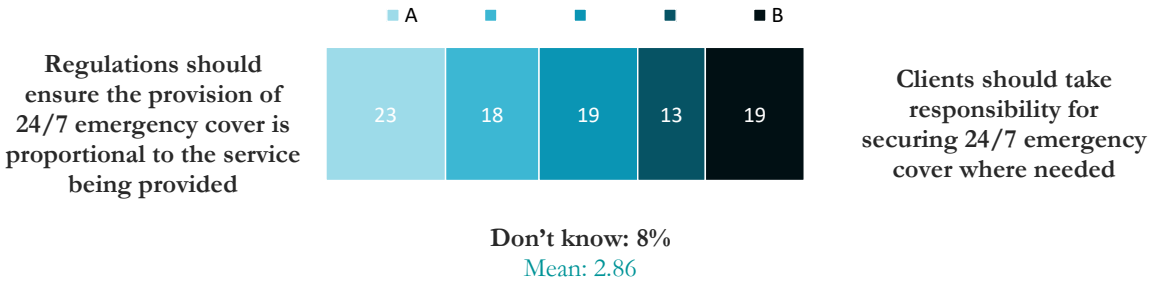
- *A practice is responsible for the care of an animal not an individual.*
- *A crucial change over the past 40 years. Delivery of service is a team effort no matter how big the team. Contemporary regulation must regulate the service delivery not just the individual.*
- *Teams in veterinary practice are dysfunctional as a result of too much focus on the individual.*

All aspects of practice need to be regulated

- *There is a conflict between 'under our care' leading to prosecution of one vet only and the way practice operate. Animal are seen by several surgeon and POM-V prescribed by the team.*
- *I think there should be regulations that govern the entire veterinary team, after all we have a relationship of trust and mutual respect so why shouldn't we all be upheld to the same standard of care for a patient.*
- *Very few cases are dealt with by a single vet - usually there are several people involved and these should all be accountable.*

2.4.8. Provision of 24/7 emergency cover should be proportional to the service being provided versus clients should take responsibility for securing 24/7 emergency cover where needed

There was a slight balance in favour of regulations ensuring that the provision of 24/7 emergency cover is proportional to the service being provided as opposed to clients taking responsibility for securing 24/7 emergency cover where needed. There was a mean score of 2.86.



Don't know: 8%
Mean: 2.86

Nurses were significantly[13] more likely than surgeons to agree with the first statement. Respondents from small practices were significantly more likely than those from medium and large practices to agree with the second statement. Urban vets were significantly more likely than remote rural to agree with the second statement. There were no statistically significant differences by age or country. The graph summarising sub-group analysis for this question is in Annex C.

The open text responses belie any sense that the profession is agreed on this, however, for some, the vet should be responsible and that any vet taking an animal under their care has a 24/7 responsibility to provide care. For others, clients should be responsible and owners need to be prepared to take responsibility. Clients should be provided with clear and accessible information to this effect. Still, others insisted that both statements were true and compatible.

[13] At the 95% confidence level

Figure 18: Open text responses to 'Provision of 24/7 emergency cover should be proportional to the service being provided versus clients should take responsibility for securing 24/7 emergency cover where needed'

Regulations should ensure the provision of 24/7 emergency cover is proportional to the service being provided

Clients should take responsibility for securing 24/7 emergency cover where needed

If a vet provides treatment the vet should be responsible for providing 24 hour care

- *It shouldn't be up to the client to organise emergency provision. If a vet takes an animal under their care - (even for just a vaccine/home visit clinic) - they should provide an option for OOH care.*
- *The vet should be responsible not the client.*
- *Vets should provide 24/7 care it is not the clients job.*

24 hour care should be a requirement of all practices

- *Regulations should ensure that 24/7 cover is always in place - either provided by the vet/practice themselves or outsourced to a provider who commits to a minimum standard of provision.*
- *It is the responsibility of the practice to provide suitable 24/7 care.*
- *Vital we continue to provide emergency care.*

This is a two way street

- *OOH care provision is the joint responsibility of both parties.*
- *Practice should provide client with info where to seek OOH care. It is then up to the client's own responsibility to act on this.*
- *Once again it is a shared responsibility. Clients need to understand vets cannot work days and nights.*

Both statements are true

- *These statements are not in opposition.*
- *The 2 statements hold no relation to each other.*
- *I agree fully with both of these statements and do not see them as being mutually exclusive.*

Clients have ultimate responsibility for their pets welfare, vets only advise

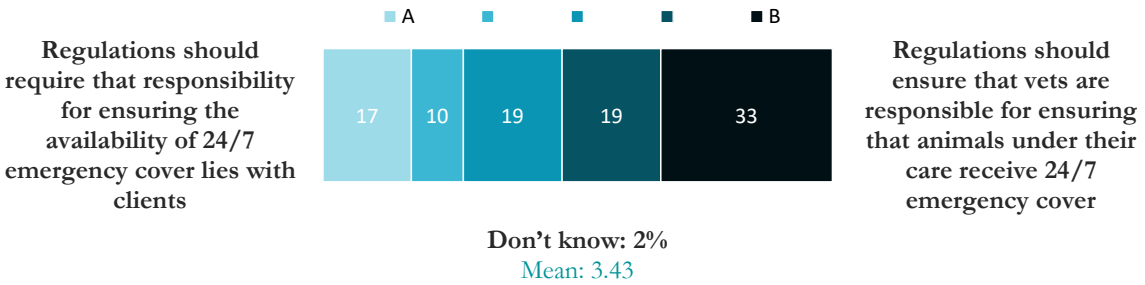
- *Clients should be responsible for ensuring that they are prepared in the event of an emergency to source veterinary care.*
- *Animal owners should accept responsibility for the provision of adequate care and protection of their animals, large or small.*
- *Yes they need to take responsibility for this. Too many wait until they have an 'emergency' to form any relationship with a vet and consequently are unaware of costs, procedures and practicalities.*

Clients need information to understand this

- *Provided all information is available to them so that an informed decision can be made.*
- *Vets should make this readily accessible, but it is the client's responsibility. Clients should however be fully informed of the out of hours care for their primary practice.*
- *As long as appropriate information on where one might access OOH care locally is available then that should be the end of the practice's responsibility.*

2.4.9. Availability of 24/7 emergency cover lies with clients versus 24/7 emergency cover lies with vets

There was a strong preference for regulations ensuring that vets are responsible for ensuring that animals under their care receive 24/7 emergency cover rather than asking clients to ensure that cover with a mean score of 3.43.



Nurses were significantly[14] more likely than surgeons to agree with the second statement. Respondents from large practices were significantly more likely than those from medium and small practices to agree with the second statement. Remote rural and mixed rural and urban vets were significantly more likely than urban vets to agree with the second statement. Participants aged 46 and older were significantly more likely than participants aged under 45 to agree with the second statement. There were no statistically significant differences by country. The graph summarising sub-group analysis for this question is in Annex C.

As with the previous set of responses, the open text responses to this question reveal a trenchant and fundamental disagreement among respondents. Essentially, one view was proposed that clients have obligations as animal owners to take responsibility and cannot and should not pass this on to professionals. An opposite view was also expressed that for vets to take responsibility 24/7 was 'fundamental to the job'. Once again there was a voice in the middle stressing mutual responsibility and the need for balance.

[14] At the 95% confidence level

Figure 19: Open text responses to 'Availability of 24/7 emergency cover lies with clients versus 24/7 emergency cover lies with vets'

Regulations should require that responsibility for ensuring the availability of 24/7 emergency cover lies with clients

17 | 10 | 19 | 19 | 33

Regulations should ensure that vets are responsible for ensuring that animals under their care receive 24/7 emergency cover

Not the vet's responsibility

- *Clients do not have a right to a pet: it is a privilege, and with that comes responsibility.*
- *Not our responsibility to babysit clients' pets 24/7.*
- *As discussed earlier, obliging small practices or teams of staff (sometimes people who work alone) to work 24/7 365 days a year is too burdensome on the veterinary staff.*

Clients should always be responsible of their animals

- *Clients do need to be proactive in anticipating emergency care cover and in obtaining it at the appropriate times.*
- *The onus is on the client. Veterinary services are a tool in the provision of care for their pet.*
- *Clients are responsible for their pet if they choose to have one.*

Mutual responsibility

- *Both parties have responsibility to provide the best care for the pet one as owner and the other as medic.*
- *Both clients and vets carry a responsibility for this as this is a decision of society.*
- *Joint enterprise.*

There should be a balance

- *I do think there should be a balance, to protect the safety of veterinary staff.*
- *It depends - it is on the client to ensure they have access to 24/7 care, but the vet to provide 24/7 care for animals on their premises.*
- *It should really be a collaboration between vets and clients. The client must agree if the vet wishes to send the patient to a 24/7 care facility if they don't have it in-house.*

It is a vet's responsibility to ensure that the animals under their care receive 24/7 care.

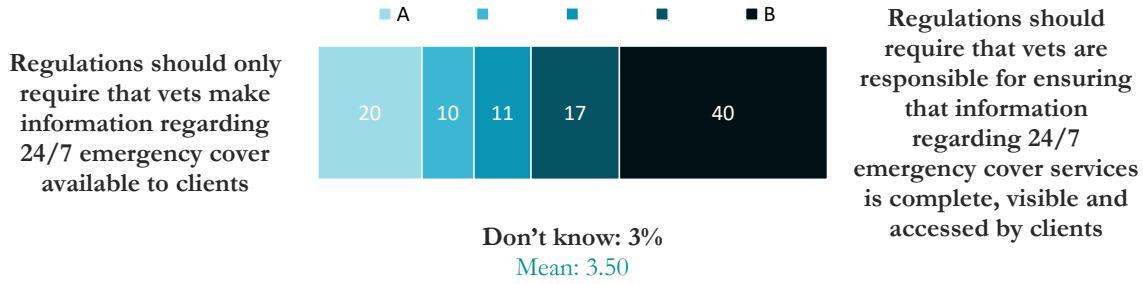
- *Fundamental to the job.*
- *Personally it is very important that vets should ensure their patients have access to 24 hr care.*
- *It is absolutely the vets responsibility to give clients full disclosure on what they offer.*

Imposing this on clients is not realistic

- *How are clients expected to do this in areas where it's not economic to provide local 24/7 cover for veterinary practices.*
- *The buck has to stop somewhere. Clients cannot be expected to have the same level of expertise and judgment as their vet.*
- *Clients are often not in a position to determine the care their animals need.*

2.4.10. Information regarding 24/7 emergency cover available to clients versus it being complete, visible and accessed by clients

There was a strong preference for regulations requiring vets to be responsible for ensuring that information regarding 24/7 emergency cover services is complete, visible and accessed by clients rather than just making that information available to clients with a mean score of 3.50.



Don't know: 3%
Mean: 3.50

Nurses were significantly[15] more likely than surgeons to agree with the second statement. Respondents from large practices were significantly more likely than those from medium and small practices to agree with the second statement. Remote rural and mixed rural and urban vets were significantly more likely than urban vets to agree with the second statement. Participants aged 46 and older were significantly more likely than participants aged 36-45 to agree with the second statement. There were no statistically significant differences by country. The graph summarising sub-group analysis for this question is in Annex C.

Although there was a clear leaning towards the second statement, it is noteworthy that those that held the alternative view were strongly of the opinion that it was not the vet's responsibility to ensure that clients accessed information and nor would they be able to ensure that this was the case. In the free-text responses, those in favour of the second statement believed that it would be practical (for example with newly registering clients) to make this information clear. It was suggested that complete transparency in advance of any emergency was more likely to produce a better outcome for the animal.

[15] At the 95% confidence level

Figure 20: Open text responses to 'Information regarding 24/7 emergency cover available to clients versus it being complete, visible and accessed by clients'

Regulations should only require that vets make information regarding 24/7 emergency cover available to clients

Regulations should require that vets are responsible for ensuring that information regarding 24/7 emergency cover services is complete, visible and accessed by clients

Owners should take responsibility for finding information themselves

- *Clients need to take some responsibility and consider what sort of OOH service they require when registering with a practice*
- *Not our responsibility. Any responsible pet owner should sort this out for themselves.*
- *We can't nor should we be responsible for how well a client pays attention or accesses information. This is on the client!!!*

Vets can only make information accessible to clients, you cannot make them actually access it and be liable for it

- *Vets cannot be responsible for making sure clients access the information.*
- *How do you ensure the clients choose to access the information? - this is perhaps going too far.*
- *How are vets to monitor if clients access the information?*

This is a shared responsibility

- *Practices should ensure that clients know how their services work, but ultimate responsibility for a pet being registered and able to receive care should be with clients.*

The two statements are not clear

- *These essentially say the same thing - The regulations don't need to get involved in ensuring clients who don't need the information getting it - They simply need to ensure that the services are available and accessible when the client needs them.*
- *I do not quite understand the difference but I believe that all available information should be easily accessed.*
- *These two statements are too similar to be able to answer. Poor question writing.*

This information should be made clear / or better / in the vet's interest

- *I believe vets can and should be required to make this knowledge clear to all newly registering clients.*
- *If we expect clients to choose their vet on the level of service it needs to be clearly stated.*
- *It is in the vets interest to be able to confirm that clients fully understand the situation.*

Vet owners are often in distress so info must be easily accessible / they need this important information to be better prepared for an emergency

- *There should be complete transparency in how an owner gets medical help in the event of an emergency. In these situations, they are likely to be panicked and in a hurry and unnecessary delays may be fatal.*
- *The information should be easily available before an emergency to reduce stress for clients.*
- *Clients need to understand the limitations of what the Primary Practice offers with regard to OOH cover and as importantly, what the OOH service offers including sample price list.*

3. Conclusions and recommended considerations for RCVS' regulations

This chapter will bring together the results from the survey to highlight the key conclusions and aspects that RCVS could consider when designing the consultation on updating the regulations, which is planned to take place over the remainder of 2021.

3.1. We are confident in the results of this survey

The responses to this survey are robust and reliable as we completed ten focus groups across sectors and geographies, a survey and interviews with key stakeholder organisations; and various interactions with RCVS which gave us guidance as to the key issues to include in the survey and the language to use. The results of the survey enrich and extend our initial understanding but reinforce the key messages from the focus groups and stakeholder interviews. Where we note that responses differed by age, practice size and so on, these differences were plausible. Equally, the scale of the response – and the demographic spread of respondents reinforces our confidence. In addition, out of a concern to ensure that we had not missed important issues, the survey included multiple open text opportunities for respondents to add further contextual information to their responses. Reviewing these open-text responses, only a small number of issues were identified which were not covered in the survey questions themselves. These included the benefits of collaboration between practices, colleagues and organisations (n=3); the role of vet nurses, technicians and paraprofessionals (n=2); and staffing issues (n=1). Only a very small number of open text responses were concerned about the questions asked.

Although there was a good 'fit' with previous research activities, the survey allowed us to: measure much more precisely than previously where the areas of agreement and difference lay; identify themes and how segments responded differently to these themes and; see how vets respond to tensions and trade-offs.

3.2. There is broad agreement on how vets want to be regulated in relation to their core purpose of caring for individual animals

Respondents were clear that they were comfortable being held to account for taking full personal responsibility for the animal under their care, that they should be accountable for prescribing POM-Vs, and that they should not depend solely on information provided by clients when treating animals under their care. Furthermore, there was agreement on how practices should share clinical notes. Within this consensus there were some variations most likely reflecting the experiences of vets in different locations. Rural vets, for example, were less likely to support regulations requiring every animal to have been recently physically examined. Also, nurses appeared to be more likely to anticipate the benefits of more formal regulation and less likely to rely on professional judgement. However, there was less consensus on how far regulations should reach or how complex they should be. Dissensus became more apparent on specific topics when respondents were asked about how to apply regulations in practice

3.3. Applying regulations in practice

For the applying principles section of the survey, 7 out of 20 questions resulted in more than 70% agreeing or disagreeing with the statements offered. Consensus included areas such as sharing clinical records, having

formal agreements between vets and clients, and recognising that specialists have a shared accountability with the generalist for the animal's well-being. Where there was less consensus was on areas such as whether to have different regulations depending upon the practice context (charities or animal shelters, for example), or concerning the source of information used to inform clinical judgements. In these responses we can also see that some differences where nurses are significantly different than surgeons in their responses. However, of the 20 statements, only 5 produced significantly different responses from vets based on their practice size or location. The responses to the first two sets of questions identify some areas of agreement that might support and inform any changes to current regulations. However, it was when we went on to explore the factor analysis that important segments of opinion began to emerge.

3.4. The factor analysis reveals more significant differences within the profession

To be clear, the thematic analysis does not show a profession incapable of agreeing on questions of regulation. However, based on the key themes we identified we can make more visible the differences between key groups.

Our key segment thematic analysis was based on surgeons only (as nurses had not been asked to respond to some statements). The results of this analysis reveal that different segments differ on important issues. Therefore, the **size of a vet's practice** is associated with very different views on:

- The strictness of the regulations
- The need for a written agreement for 'under care'
- Veterinary provision for 24/7 care for pain and suffering

Rurality is associated with different views on:

- The source of examination data – agreeing that this source could be virtual
- Tailored 'under-care' regulations – agreeing that this could be based on the type of animal and location
- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care

Most strikingly of all, **age** is also associated with different responses and older vet surgeons (aged 55+) are more likely to agree with the following:

- Veterinary provision – agreeing that all types of vet practices should be regulated to provide a high level of care, including providing 24/7 pain and suffering care
- Animal responsibility – full vet responsibility for the animal in care
- Regulatory Standards – the standards that under-pin the term 'under-care' for 24/7 emergency cover should include accountability for all parties involved

By reducing the number of themes to nine, identifying segments and understanding differences amongst these, it is possible for RCVS to manage a more structured engagement and communications approach when designing the consultation phase of the regulation review.

3.5. Understanding how vets handle tensions revealed some fundamental differences…

Veterinary **nurses** emerge as holding distinct views on certain issues such as ensuring full and formal information available to clients regarding 24/7 provisions, and believing that regulations should set the highest possible standards. **Younger** respondents also leaned less firmly towards, for example, not having formal agreements with clients, more strongly supported the regulation of teams, and believed the responsibility for 24/7 emergency provision lies with the client. **Rurality** was not often associated with differences except in cases such as whether vets should physically examine all animals prior to treating with POM-Vs.

3.6. But in some respects differences are perhaps less than appeared

The open text responses are revealing in many respects but in particular in identifying possible reasons behind different responses. For example, for the 'one size fits all' statement, those in favour of a more tailored approach did not emphasise points of principle but, rather focused on the nature of medicine as an inexact science, or the practicalities of managing farmed fish. Equally, those wanting 'one size fits' all emphasised that a tailored approach was not so much wrong as impractical. Similarly, the reasons given for wanting mandatory physical examinations of animals prior to prescribing POM-Vs give almost entirely practical reasons; managing client expectations or pushing back against the unreasonable demands of more senior vets. Equally, those in favour of allowing more professional judgement emphasised the variability of animals needs while others emphasised the differences among different categories of drugs (antimicrobials were also mentioned in this context). Similarly, the reason for promoting individual professional responsibility rather than team accountability were often linked to the impracticality of entrenching team accountability compared with holding individual vets to account.

Where differences are rooted in practicalities rather than principles, it might be easier to present arguments and demonstrations to build a common ground. It would appear that non-binding guidelines showing sensitivity to context would gain support. This appears to be the case in many of the open text responses concerning the reach and complexity of regulations. It is, however, possible that the practical arguments in open text responses are post hoc rationalisations of prior and more deeply held beliefs.

3.7. What might we have expected to see more of?

We anticipated seeing more responses on certain topics. These were all touched on but not given great attention. This may have been a consequence of the survey design (which, as explained, build on the findings from the focus groups) but there were also a number of open text opportunities. From our wider reading and prior engagement with the profession through the focus groups, we expected more comments regarding:

- **Team working.** More collaborative working has become ubiquitous in many areas of veterinary medicine, where it is rare for an animal to see only one professional. There was a specific question on this but it rarely emerged spontaneously.
- **The role of veterinary organisations in regulation**. For example, in the revalidation of professionals in human health, health organisations have an increasingly prominent role. This may

not be an appealing prospect for vets, but strengthening the role of veterinary organisations in reinforcing good regulation is an issue worth considering.

- **Innovation in technology**. New technologies (including information technology, artificial intelligence, remote monitoring) have the capacity to transform how veterinary care is provided. Specialisation is likely to be an independent but reinforcing driver in this respect. However, responses were largely based on existing models of care. Given the context of Covid-19 resulting in many vets working remotely during lockdowns, we anticipated that more attention might be given to this.
- **Consumerism and client expectations.** In the focus groups, the idea that the 'Herriot model' of the professional/client relationships was all but gone and a new, more consumerist relationship was emerging was often discussed but came up less frequently in the survey responses.
- **Public health** and animal-born infections was certainly mentioned and in particular in relation to prescribing POM-Vs. However, given the context of Covid-19, as with technology innovations, we anticipated that more attention might be given to this.
- **Vets awareness of other veterinary professionals treating an animal.** The issue of an animal being cared for by multiple veterinary professionals, potentially without the vets knowing, was discussed multiple times in the focus groups. Despite survey questions asking about aspects such as sharing clinical records and shared accountability, this issue was not mentioned frequently in the free-text responses.

3.8. Implications for the next steps; some reflections on the focus group and survey results

This final section will bring together the key findings and conclusions of both the focus groups and survey, and identify some recommended areas in which RCVS could focus their consultation on in the coming months. The table below outlines the strongly held core values, complicating factors and areas of divergence and lack of consensus that arose from both focus groups and the survey.

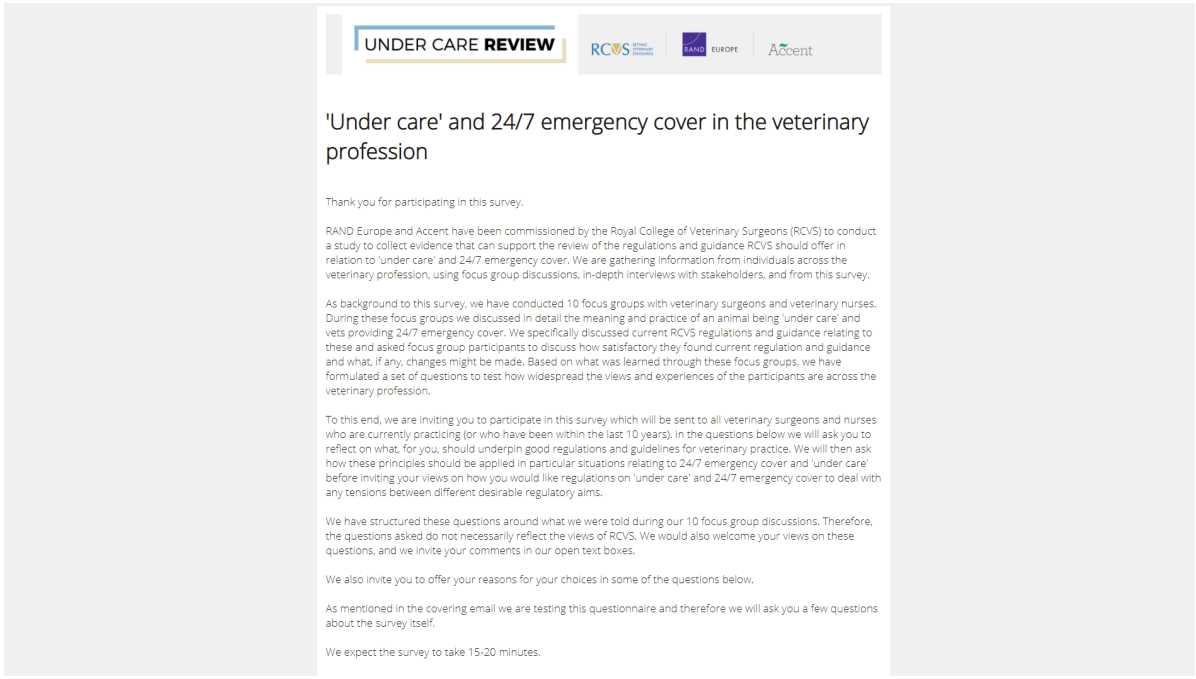
Table 2: Conclusions and areas for RCVS to consider for the consultation (from the focus groups and survey)

Issue	Implications
Strongly held core values	• The well-being of the animal 'under care' is considered to be paramount and ensuring emergency provision is available for animals 'under care' is a 24/7 professional responsibility (rather than the clients) • Good veterinary practice is believed to be under-pinned by vets having personal responsibility and accountability for their decisions and prescription of medication, rather than the regulation of teams • There must be room for professional judgement in interpreting the regulations to balance different types of evidence, circumstance of the animal and when it was last examined and clinical uncertainty. Regulations should be tailored to different situations and circumstances rather than having a one size fits all approach. However, the practical difficulties of extending the reach and complexity of regulations were highlighted. • Vets should be responsible for ensuring 24/7 emergency cover is in place to deal with pain and suffering (either providing this service themselves or via a third party), not the client. Vets should ensure that information on 24/7 emergency care should be complete, visible and accessed by the client. • To recommend and prescribe POM-Vs, the vet needs to have had some previous (physical) contact with the client and animal. • Relevant, timely, complete and accurate knowledge and information is at the heart of good veterinary practice (therefore physical examination is often the 'gold standard') but reliable information can also be obtained from clinical notes and records, digital images, videos and specialist guidance). However, alternative forms of information (non-physical exam) should not be used alone in instances where the vet has not physically seen the animal. • In cases of multiple vets providing care to an animal, the practices should share clinical records. There should also be shared accountability for both the primary care vet and the specialist/referral vet. To support this, all veterinary professionals involved in an animal's care should be aware of what treatment/care is being provided by other professionals. This can be declared by a client in any formal agreement made between them and the vet (although as mentioned below, there was divergence as to whether an agreement such as this is necessary). • There should be a recognition in the regulations that herd/flock animals (primarily for commercial purposes) are treated differently to companion animals, according to the clients preferences.
Areas of divergence and lack of consensus	• What is regulation for – to minimise harm or maximise excellence. Although there was a slight preference in the survey for minimum standards over maximum. • Agreement that a physical examination is centrally important (particularly for new clients) – but disagree on how far other sources of information should be depended upon • The role of clients' expertise and reliability in shaping vet's treatment decisions. • To what extent regulations should take into account specific aspects of the animal, such as age, and be tailored to different practice situations (particularly whether shelters/charities should be treated differently to other practices). • Whether the quality (recency and reliability) of the information on the animal is more important than where the information came from.

Issue	Implications
	• While there was general agreement that professional judgement should be protected - there was disagreement as to whether regulations should prescribe a period of time in which a physical exam needs to have been conducted to prescribe POM-Vs, or whether this can be left to professional judgement. • In the survey, two questions were asked on whether a formal agreement should be put in place between a vet and client to outline the obligations and responsibilities of each party. The responses to the first question indicated good consensus that a formal agreement should be in place, however responses to the second question on this indicated a preference for vets to advise and inform clients rather than be required to establish a formal agreement.
Recommended areas for RCVS to explore in the consultation	• In the survey and in the focus groups, there was a relatively comfortable agreement around the role of regulation in relation to the core, caring functions of the vet. Once wider questions were explored, such as working across organisational boundaries, team responsibilities, and relationships with clients, there was less agreement. In their responses (as our thematic analysis suggests) vets drew upon their experiences (varying according to age, size of practice etc.) but not upon a clear sense of what regulations are for in principle. This, in our view, leaves the debate unanchored and therefore difficult to progress. RCVS could be propositional. This might include (among other things) reinforcing the importance of simplifying the regulatory environment, supporting (or at least not inhibiting) innovation, and improving the interface between veterinary medicine and public health. It might also include communicating to the public the benefits of a well-regulated profession for both their animals and for an effective 'One health' approach. • Even with such a propositional approach there will remain significant tensions. RCVS should take a view on which of these tensions are in principle resolvable through discussion and which are more fundamental. We were impressed by the many open text responses suggest that some problems were seen to be practical rather than a fundamental point of principle. In such areas of disagreement (formal agreements with clients, 24/7 arrangements, and sources of information to inform decisions) it may be that guidelines based on clear principles would be acceptable and effective. • The focus groups highlighted a tension between a blanket commitment to the responsibility of vets for animals under their care and a recognition that the delivery of care is co-produced with owners who provide very variable environments for their animals. The preference indicated in the survey is for personal professional responsibility. However, at the same time, 38% of respondents agreed that they would also be comfortable acting on information provided by trusted clients. This apparent tension may be easily resolved should it be clear that personal professional responsibility and competence includes responsibility for building relationships with the clients (as well as the animal). Similarly, personal professional responsibility should include contributing to team working and information-sharing. • The personal responsibility of vets to the well-being of the animal 'under care' is strong and often fits comfortably with the practices, such as team working, 24/7 emergency out of hours providers, and specialist advice. However, it fits less well with the role of limited service providers and the lack of oversight of the animal where owners elect to 'pick and mix' among providers. Further attention to this was seen to be a priority in the focus groups.

Issue	Implications
	• To future proof regulations, and to accommodate the views of younger professionals, it might be better to focus on the responsibilities of vets to ensure that the information they use is timely and relevant, and for veterinary practices to ensure an information architecture that can support this, rather than focussing on how this information was obtained (e.g. physical examination or digital image). • The survey highlighted key differences across different groups of the veterinary profession in what they thought the regulations should cover and look like. Irrespective of other decisions, RCVS could use the analysis of these differences when designing their engagement and communications strategies for their members. In particular it should take into the account the particular responses of veterinary nurses and younger professionals.

Annex A. Survey questions



UNDER CARE REVIEW

RCVS | RAND EUROPE | Accent

'Under care' and 24/7 emergency cover in the veterinary profession

Thank you for participating in this survey.

RAND Europe and Accent have been commissioned by the Royal College of Veterinary Surgeons (RCVS) to conduct a study to collect evidence that can support the review of the regulations and guidance RCVS should offer in relation to 'under care' and 24/7 emergency cover. We are gathering information from individuals across the veterinary profession, using focus group discussions, in-depth interviews with stakeholders, and from this survey.

As background to this survey, we have conducted 10 focus groups with veterinary surgeons and veterinary nurses. During these focus groups we discussed in detail the meaning and practice of an animal being 'under care' and vets providing 24/7 emergency cover. We specifically discussed current RCVS regulations and guidance relating to these and asked focus group participants to discuss how satisfactory they found current regulation and guidance and what, if any, changes might be made. Based on what was learned through these focus groups, we have formulated a set of questions to test how widespread the views and experiences of the participants are across the veterinary profession.

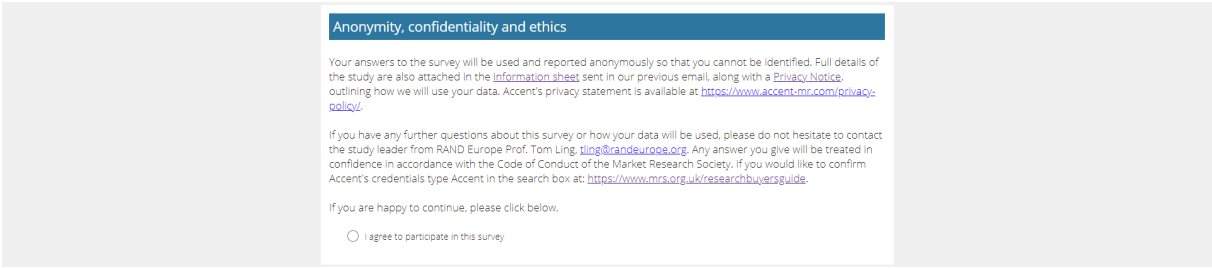
To this end, we are inviting you to participate in this survey which will be sent to all veterinary surgeons and nurses who are currently practicing (or who have been within the last 10 years). In the questions below we will ask you to reflect on what, for you, should underpin good regulations and guidelines for veterinary practice. We will then ask how these principles should be applied in particular situations relating to 24/7 emergency cover and 'under care' before inviting your views on how you would like regulations on 'under care' and 24/7 emergency cover to deal with any tensions between different desirable regulatory aims.

We have structured these questions around what we were told during our 10 focus group discussions. Therefore, the questions asked do not necessarily reflect the views of RCVS. We would also welcome your views on these questions, and we invite your comments in our open text boxes.

We also invite you to offer your reasons for your choices in some of the questions below.

As mentioned in the covering email we are testing this questionnaire and therefore we will ask you a few questions about the survey itself.

We expect the survey to take 15-20 minutes.



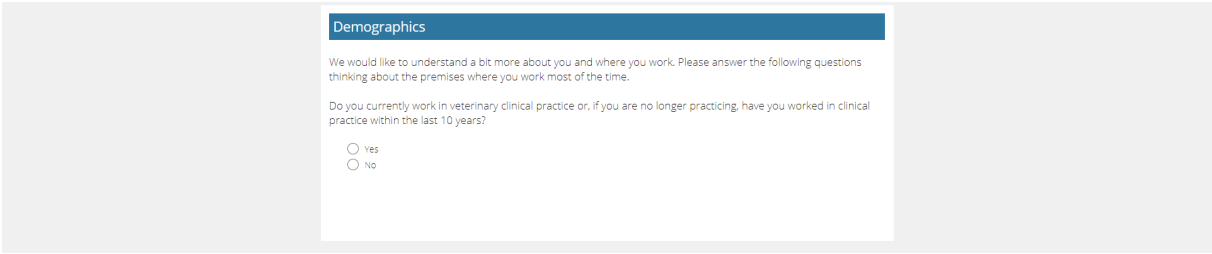
Anonymity, confidentiality and ethics

Your answers to the survey will be used and reported anonymously so that you cannot be identified. Full details of the study are also attached in the information sheet sent in our previous email, along with a Privacy Notice, outlining how we will use your data. Accent's privacy statement is available at https://www.accent-mr.com/privacy-policy/.

If you have any further questions about this survey or how your data will be used, please do not hesitate to contact the study leader from RAND Europe Prof. Tom Ling, tling@randeurope.org. Any answer you give will be treated in confidence in accordance with the Code of Conduct of the Market Research Society. If you would like to confirm Accent's credentials type Accent in the search box at: https://www.mrs.org.uk/researchbuyersguide.

If you are happy to continue, please click below.

- ○ I agree to participate in this survey

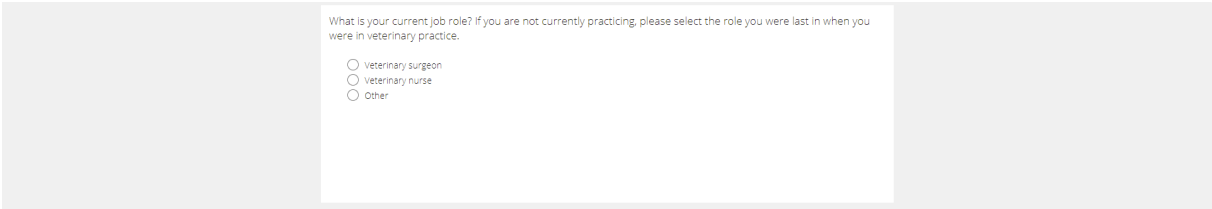


Demographics

We would like to understand a bit more about you and where you work. Please answer the following questions thinking about the premises where you work most of the time.

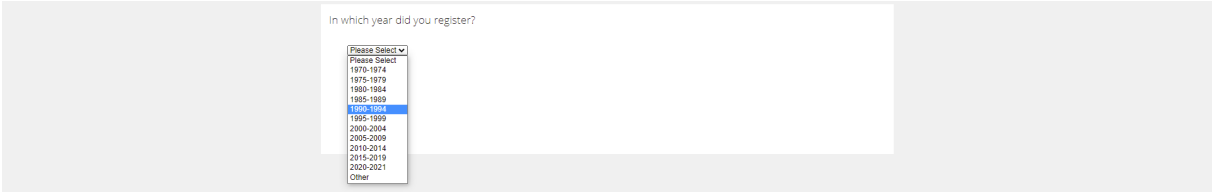
Do you currently work in veterinary clinical practice or, if you are no longer practicing, have you worked in clinical practice within the last 10 years?

- ○ Yes
- ○ No



What is your current job role? If you are not currently practicing, please select the role you were last in when you were in veterinary practice.

- ○ Veterinary surgeon
- ○ Veterinary nurse
- ○ Other



In which year did you register?

Please Select
Please Select
1970-1974
1975-1979
1980-1984
1985-1989
1990-1994
1995-1999
2000-2004
2005-2009
2010-2014
2015-2019
2020-2021
Other

Which is (or was) your main area of work? Please select all those that apply.

- [ ] Small animal practice
- [ ] Exotics practice
- [ ] Livestock/farm animal practice
- [ ] Equine practice
- [ ] Wildlife
- [ ] Zoo
- [ ] Marine
- [ ] Laboratory animals
- [ ] Mixed practice
- [ ] Referral practice / consultancy
- [ ] UK government
- [ ] Meat hygiene / official controls
- [ ] Veterinary school / university
- [ ] Commerce and industry
- [ ] Charities and Trusts
- [ ] Telemedicine provider
- [ ] Other (please specify)

What business model best describes your clinical practice workplace?

- ◯ Independent, stand-alone practice (e.g. a partnership)
- ◯ Independent practice that is part of a larger group (with some shared centralised function)
- ◯ Part of a corporate group
- ◯ Part of a joint venture with a corporate group
- ◯ Veterinary school
- ◯ Charity
- ◯ Out-of-hours-only provider
- ◯ Don't know
- ◯ Other

Does the practice where your work currently provide its own 24/7 emergency cover service? If you are no longer practicing, please select the response that best fits the time when you were most recently in practice.

- ◯ Yes
- ◯ No
- ◯ A combination of in-house provision and third-party provision

How many full time equivalent veterinary surgeons are part of the practice where you currently work? If you are no longer practicing, please select the response that best fits the time when you were most recently in practice.

- ◯ 3 or fewer
- ◯ 4-10
- ◯ 11-25
- ◯ 26-50
- ◯ More than 50
- ◯ Don't know

How many full time equivalent veterinary surgeons are part of the practice where you currently work? If you are no longer practicing, please select the response that best fits the time when you were most recently in practice.

- ◯ 3 or fewer
- ◯ 4-10
- ◯ 11-25
- ◯ 26-50
- ◯ More than 50
- ◯ Don't know

Which country are you based in?

- ◯ England
- ◯ Scotland
- ◯ Wales
- ◯ Northern Ireland
- ◯ Other

Is your work mainly in a remote rural, semi-rural or urban area?

- ◯ Remote rural
- ◯ Mixture of rural and urban
- ◯ Urban

What is your age group?

- ◯ 18-24
- ◯ 25-35
- ◯ 36-45
- ◯ 46-55
- ◯ 56-65
- ◯ 66-70
- ◯ 71+
- ◯ Prefer not to say

1. GOOD REGULATION STATEMENTS

Based on what we heard in the focus groups, we will present a series of statements about what might constitute good regulation and ask the extent to which you agree or disagree with them. These are not direct quotes but reflect closely what was said to us in the focus groups discussions.

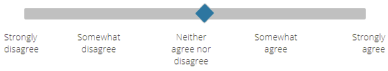
The aim of this is to understand where agreements and disagreements sit around what 'good' looks like for you as a professional. What approach would you like to see towards the regulation of 'under care' and 24/7 emergency cover?

At the end of the series of statements, there will be an option for you to provide further (free-text) detail on your responses.

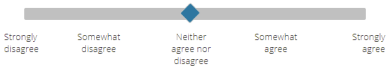
Click the + button to return to a statement you have previously answered

- 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.

- 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).



- Regulations should take into account the pre-existing physical condition of the animal (e.g. if it already has a chronic condition).



- Regulations should be more prescriptive so there is no variation in how they are interpreted across the profession.

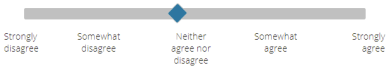
- For an animal to be under a vet's care in a way that is real and not just nominal, a recent physical examination is essential.

- 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.

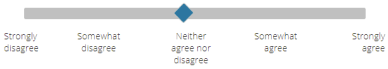
- Regulations should allow space for professional judgement when interpreting and applying them.

- 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.

- 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 the services / treatments given.



- 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



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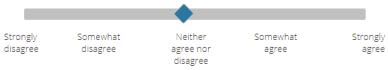
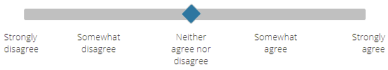
An animal being under my care means I am responsible for the advice I give in relation to it.

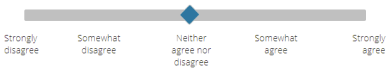


- Regulations should take into account the age of the animal

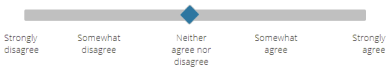


- Regulations should be framed to mitigate any adverse impact resulting from a veterinary product or intervention, regardless of the business model or the competitive environment in which the product or intervention is delivered.

- 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.

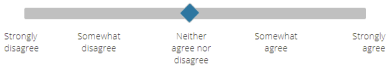


- There should be an upper limit defined in regulations on the time between seeing any animal and prescribing POM-Vs

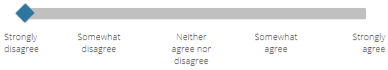


- If information were provided from a client I had never been in contact with before, I would be comfortable recommending treatment / prescribing POM-Vs.

- Regulations should take into account how different prescribed medications carry more or less risk for the wellbeing of the animal.



- 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 care for animals in some parts of the country).



UNDER CARE

We have tried to include all the features of good regulation discussed in our focus groups but if there are any additional features that you feel are missing FOR 'UNDER CARE' please list them here. Please list any additional features that describes the regulatory approach you would like to see. To help with the analysis, please use only positive descriptions of what you would like to see (and avoid stating what you would *not* want).

OUT OF HOURS

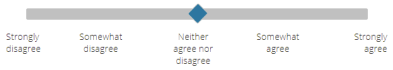
We have tried to include all the features of good regulation discussed in our focus groups but if there are any additional features that you feel are missing FOR EMERGENCY 'OUT OF HOURS CARE' please list them here. Please list any additional features that describes the regulatory approach you would like to see. To help with the analysis, please use only positive descriptions of what you would like to see (and avoid stating what you would *not* want).

2. APPLYING PRINCIPLES

What follows is a series of statements about what regulations should require or permit in particular contexts. These are based on differing views we heard during the focus groups. Please state the extent to which you agree or disagree with each of the statements.

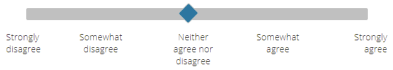
Click the + button to return to a statement you have previously answered

- 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.

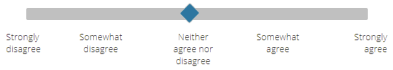


- Regulations regarding 24/7 emergency cover and 'under care' should be concerned only with the quality (i.e. reliability, recency and completeness) of the information used to inform clinical judgements and not its source.

- Regulations should 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.



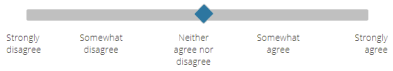
- Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated with where the animal *habitually lives*. For example, regulations for vets working with farm animals should be different from regulations for vets working with small animals.



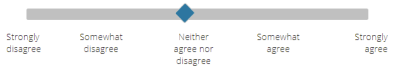
- Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks associated common to *charities/shelters*. For example, regulations for vets working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

- 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

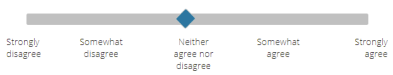


- Regulations and guidance should explicitly take into account the different sorts of risk to animals and public health, and tailor the approach to regulating 24/7 emergency cover and 'under care' based on the risks common to different *geographic locations*. For example, regulations for vets working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



- 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.

- 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).



- 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 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 and guidance regarding 'under care' and out of hours 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.

- 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

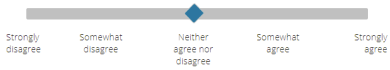
- The regulation of 24/7 emergency cover and 'under care' should involve a formal agreement between vets and clients that establishes the obligations and responsibilities of each.

- 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 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 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)

- If an animal is registered with more than one primary care practice, the practices should be required to share clinical records.



- 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).

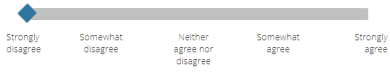
- Regulations should allow vets to use remotely provided digital photographs of (for example) a skin condition to prescribe POM-Vs for an animal using clinical notes from another vet who has recently physically examined that animal.

- 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)

- If an animal is registered with more than one primary care practice, the practices should be required to share clinical records.

- 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 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.



WHEN PRINCIPLES ARE IN TENSION:

Regulations must often balance between different desirable things. In this section we would like you to use the slider to show how far to one side or the other you would prefer when arriving at a balance *regarding the regulation of 24/7 emergency cover and under care*. There will be a 'don't know/don't have a view' option; each pair will have a separate slider

The physical examination of the patient should recently precede any treatment with POM-Vs

What matters most before treating with POM-Vs is the recency, reliability and completeness of the information available to the vet. Where this information comes from is of secondary importance

☐ Don't know

If you would like to, please tell us the key factors responsible for your decision

Personal professional accountability is at the core of good care and good regulations

Regulations should focus on regulating teams since it is through teamworking that most veterinary care is provided

☐ Don't know

If you would like to, please tell us the key factors responsible for your decision

Regulations should require that responsibility for ensuring the availability of 24/7 emergency provision lies with clients

Regulations should ensure that vets are responsible for ensuring that animals under their care receive 24/7 care

☐ Don't know

If you would like to, please tell us the key factors responsible for your decision

Regulations should establish only minimum standards

Regulations should aim to set the highest standards possible

☐ Don't know

If you would like to, please tell us the key factors responsible for your decision

Regulations should ensure the provision of 24/7 emergency service is proportional to the service being provided

Clients should take responsibility for securing 24/7 care where needed

☐ Don't know

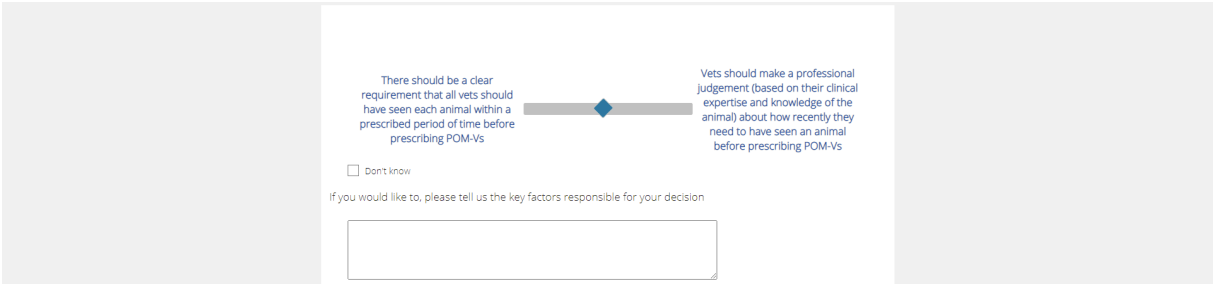
If you would like to, please tell us the key factors responsible for your decision

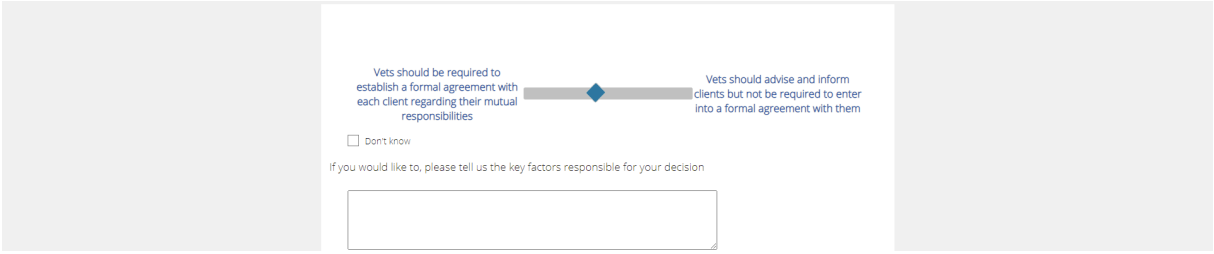
One size fits all; there should be a universal set of regulations covering all circumstances where an animal is under the care of a vet

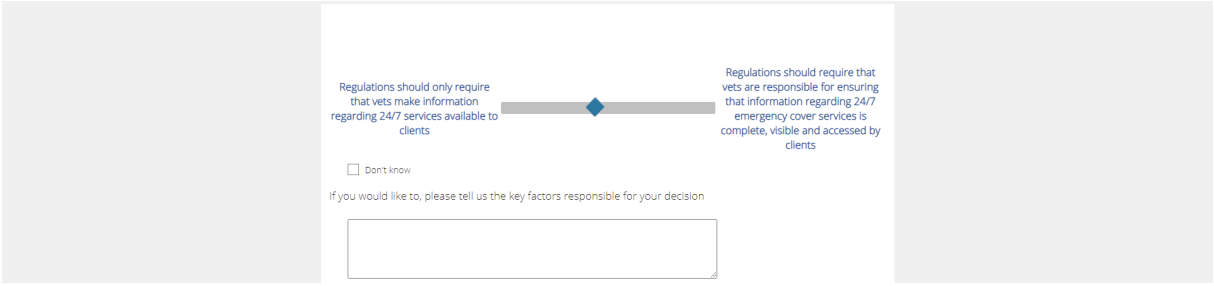
Tailored regulations should explicitly take into account the various circumstances of different kinds of animal and clients

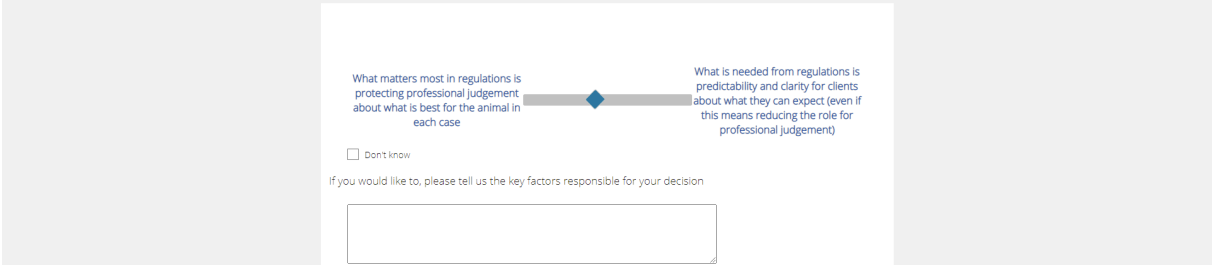
☐ Don't know

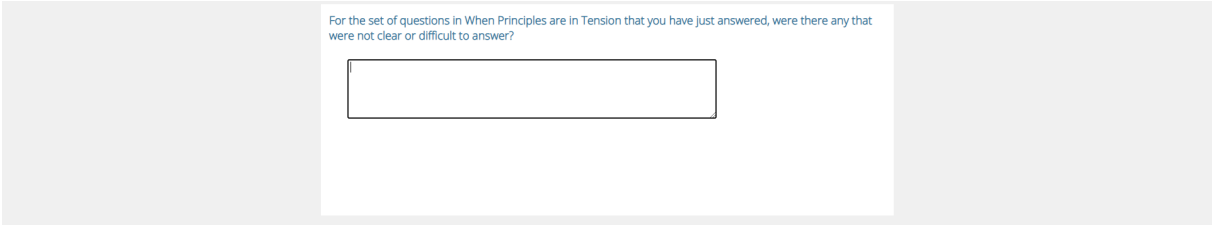
If you would like to, please tell us the key factors responsible for your decision


There should be a clear requirement that all vets should have seen each animal within a prescribed period of time before prescribing POM-Vs
Vets should make a professional judgement (based on their clinical expertise and knowledge of the animal) about how recently they need to have seen an animal before prescribing POM-Vs
Don't know
If you would like to, please tell us the key factors responsible for your decision


Vets should be required to establish a formal agreement with each client regarding their mutual responsibilities
Vets should advise and inform clients but not be required to enter into a formal agreement with them
Don't know
If you would like to, please tell us the key factors responsible for your decision


Regulations should only require that vets make information regarding 24/7 services available to clients
Regulations should require that vets are responsible for ensuring that information regarding 24/7 emergency cover services is complete, visible and accessed by clients
Don't know
If you would like to, please tell us the key factors responsible for your decision


What matters most in regulations is protecting professional judgement about what is best for the animal in each case
What is needed from regulations is predictability and clarity for clients about what they can expect (even if this means reducing the role for professional judgement)
Don't know
If you would like to, please tell us the key factors responsible for your decision


For the set of questions in When Principles are in Tension that you have just answered, were there any that were not clear or difficult to answer?

Annex B. Further detail on the sample characteristics

This Annex provides further detail on the survey sample characteristics, including a breakdown of different sub-populations.

B.1. Profession

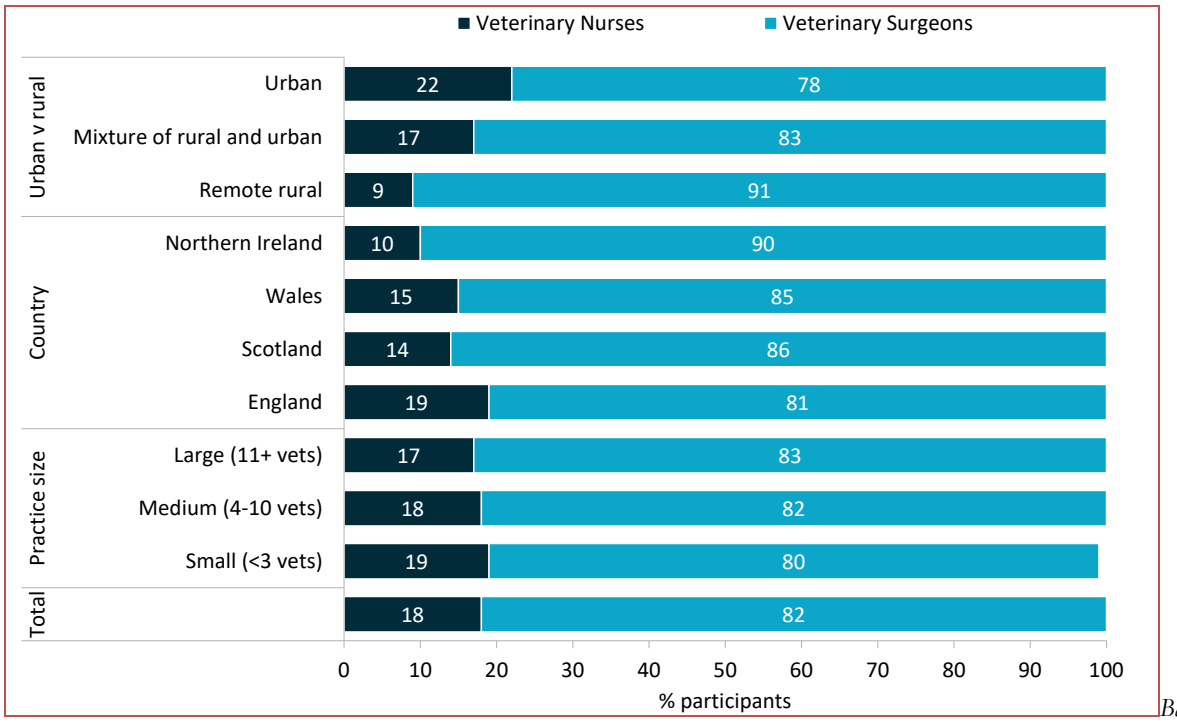
The sample were asked that their current job role was. They were informed that if they were not currently practicing, they should select the role they were last in when they were in veterinary practice.

Overall, 18% of the sample were veterinary nurses and 82% were veterinary surgeons. The make-up of the sample received from RCVS was 36% nurses and 64% surgeons so there was a much higher response from surgeons than nurses.

There was little difference in the proportions of nurses and surgeons by practice size. There was a lower proportion of nurses in remote rural locations (9%) and a higher proportion in urban locations (22%).

Analysis by country shows that there was a lower proportion of nurses in Northern Ireland (10%) and a higher proportion in England (19%). See Figure 21.

Figure 21: Whether nurse or surgeon by practice size (surgeons), country and urban v rural



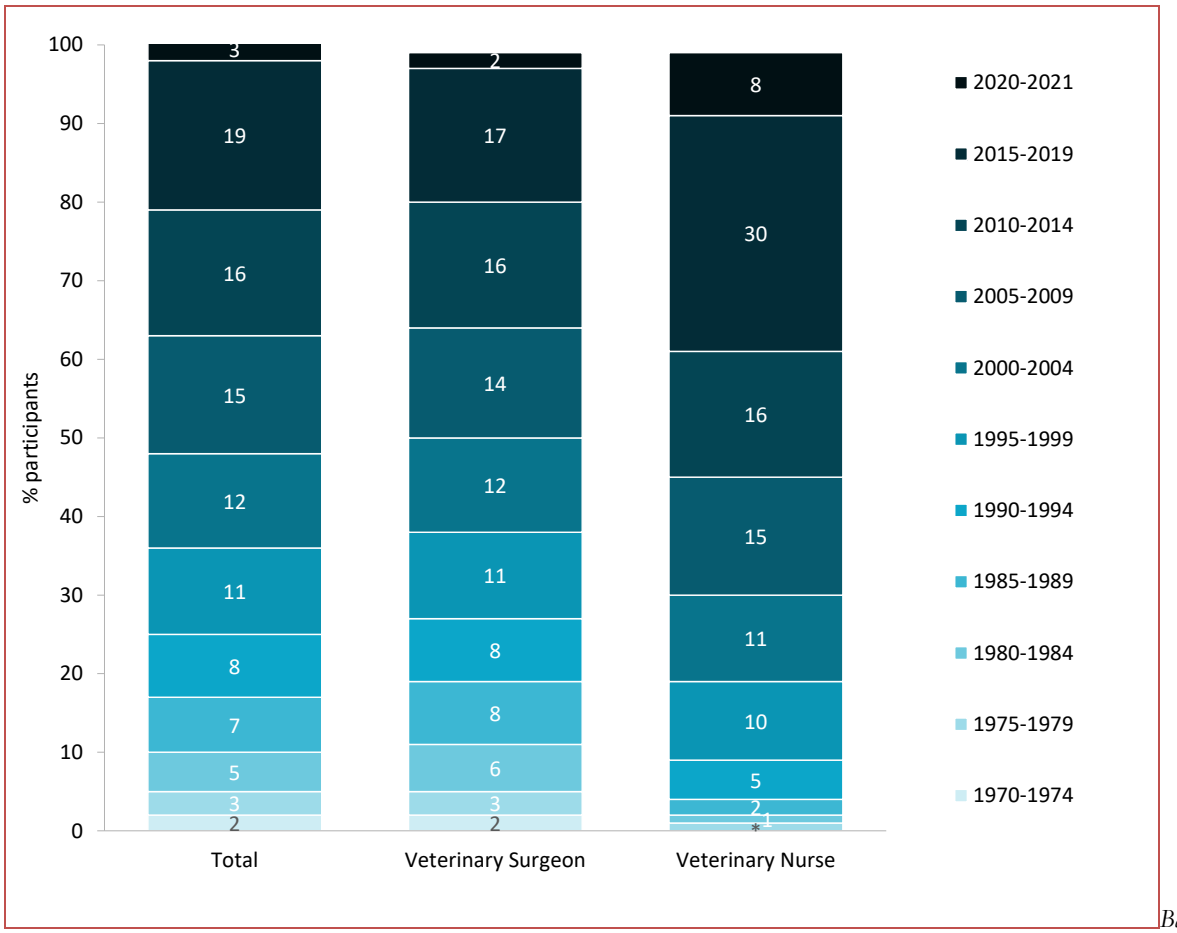
Base: Practice size: Small (<3 vets) 1,462, Medium (4-10 vets) 2,588, Large (11+ vets) 1,447; Country: England 4,590, Scotland 565, Wales 269, Northern Ireland 120; Urban v rural: Remote rural 458, Mixture of rural and urban 2,916, Urban 2,170

B.2. Year registered

Participants were asked in which year they registered and shown a drop-down list with five year age ranges.

There was a fairly even spread of registrations years with between 10-20% in each 5 year period between 1995-1999 and 2015-2019. Surgeons tended to register earlier with 38% registering on the last century compared to half that amount for nurses. See Figure 22.

Figure 22: Year registered by whether nurse or surgeon

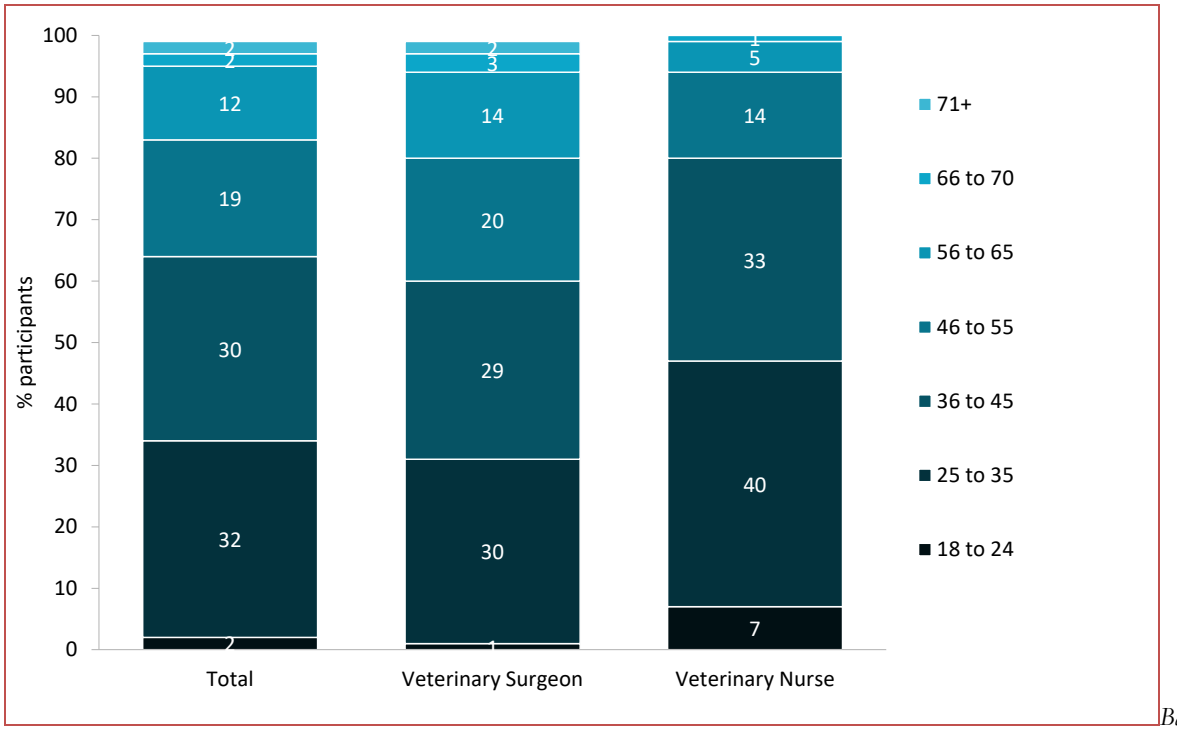


Base: Total 5,544, Veterinary Surgeon 4,545, Veterinary Nurse 999

B.3. Age group

The participant age group was probed. Nurses tended to be younger than surgeons: 47% were aged under 35 years old compared to 31% for surgeons. See Figure 23.

Figure 23: Age group



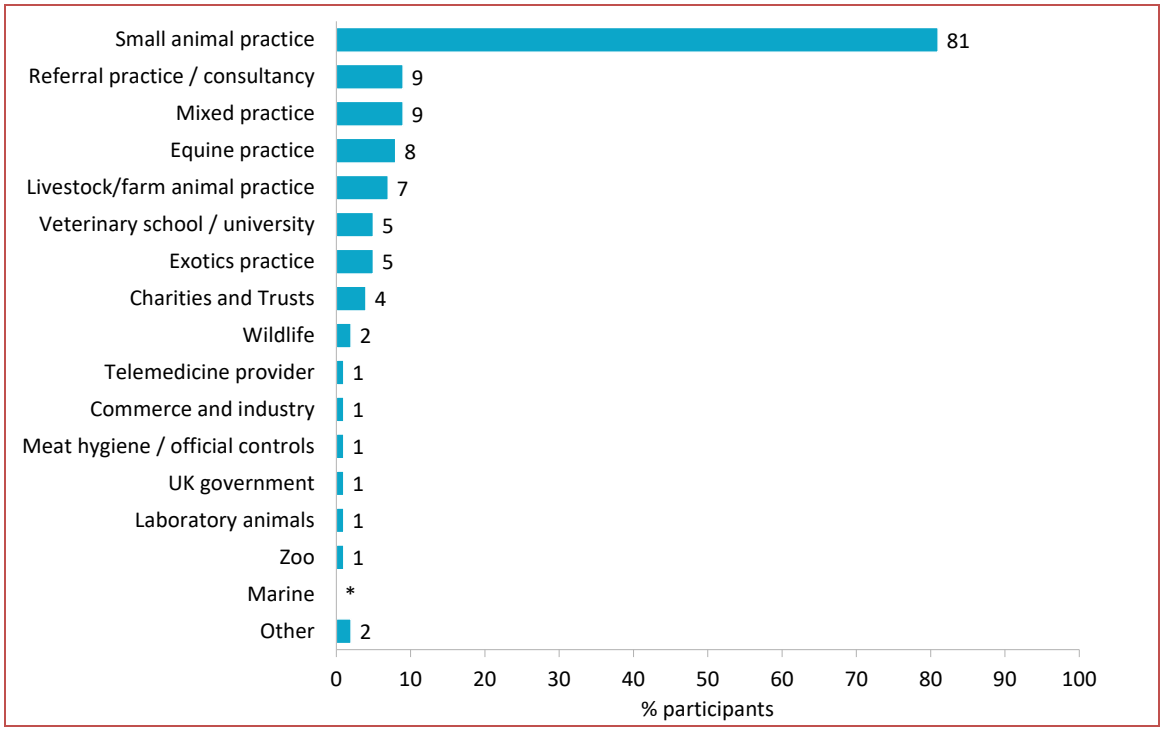
Base: Total 5,544, Veterinary Surgeon 4,545, Veterinary Nurse 999

B.4. Main area of work

For just over four fifths (81%) the main area of work was small animal practice. No other area attracted more than 9%. See Figure 24.

Figure 24: Main area of work[16]

[16] More than one area could be ticked so figures sum to more than 100%.



Base: Total 5,544

Table 3 shows main areas of work by practice size, type of location and country. Analysis by practice size shows that respondents from smaller practices were significantly more likely to concentrate on small animals (87%) than medium (82%) and small practices (72%). Respondents from large practices were significantly more likely to be from referral practices/consultancies (20%), livestock/farm animal practices (10%) and veterinary schools/universities (10%) than medium and small practices.

Analysis by type of location shows large differences in areas of work. For example:

- Respondents from remote rural practices were significantly[17] more likely to be based in livestock/farm animal practices (31%), mixed practice (25%) and equine practices (23%) than mixed rural and urban (8%, 13% and 12% respectively) and particularly urban (1% each).
- Respondents from urban practices were significantly more likely to be based in small animal practices (95%) than mixed rural and urban (77%) and particularly rural (37%).

Analysis by country shows that:

- Respondents from practices in England were significantly18 more likely to be from small animal practices than the other three nations (83% compared to 61% in Northern Ireland, 70% in Scotland and 74% in Wales)
- Respondents from practices in England were significantly less likely to be from mixed practices than the other nations (7% compared to 33% in Northern Ireland, 24% in Scotland and 16% in Wales).

[17] At the 95% confidence level

[18] At the 95% confidence level

- Respondents from practices in England were significantly less likely to be from livestock/farm animal practices than the other nations (6% compared to 27% in Northern Ireland, 13% in Scotland and 10% in Wales).

Table 3: Main area of work by practice size (surgeons), whether urban or rural and country

	Practice size			Urban v rural			Country			
	Small (<3 vets)	Medium (4-10 vets)	Large (11+ vets)	Remote rural	Mixture of rural and urban	Urban	England	Scotland	Wales	Northern Ireland
	%	%	%	%	%	%	%	%	%	%
Small animal practice	87	82	72	37	77	95	83	70	74	61
Exotics practice	5	5	4	3	5	6	5	4	4	3
Livestock/farm animal practice	5	7	10	31	8	1	6	10	13	27
Equine practice	7	9	10	23	12	1	8	10	7	10
Wildlife	2	2	1	2	1	2	2	3	*	1
Zoo	1	1	1	1	1	1	1	1	1	1
Marine	*	*	*	*	*	*	*	*	0	1
Laboratory animals	1	1	1	1	1	1	1	1	0	4
Mixed practice	5	11	10	25	13	1	7	24	16	33
Referral practice / consultancy	7	4	20	7	10	9	10	10	5	8
UK government	1	1	1	2	1	*	1	1	3	4
Meat hygiene / official controls	1	1	1	1	1	*	1	2	1	3
Veterinary school / university	3	3	10	5	5	4	4	12	2	3
Commerce and industry	2	1	1	3	2	1	2	1	*	1
Charities and Trusts	3	5	4	3	2	7	4	4	2	1
Telemedicine provider	2	1	2	*	1	2	1	3	1	3
Other	3	1	1	3	2	1	2	2	3	2
Base	**1,462**	**2,588**	**1,447**	**458**	**2,916**	**2,170**	**4,590**	**565**	**269**	**120**

** = less than 0.5%*

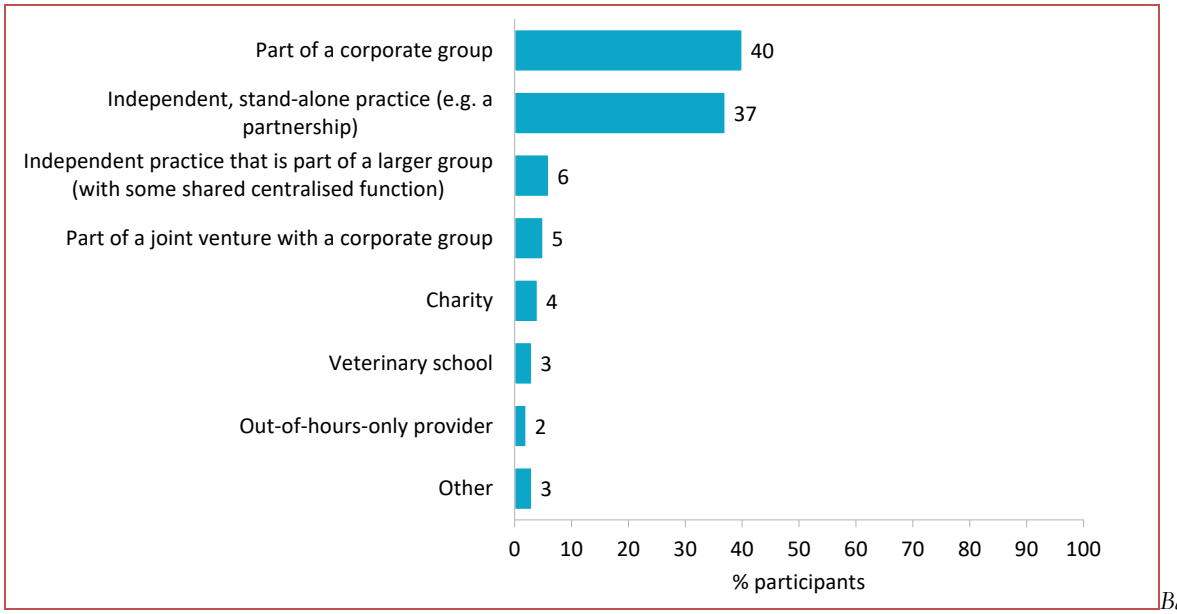
B.5. Practice business model

Participants were asked what business model best described their clinical practice workplace from the following list:

- Independent, stand-alone practice (e.g. a partnership)
- Independent practice that is part of a larger group (with some shared centralised function)
- Part of a corporate group
- Part of a joint venture with a corporate group
- Veterinary school
- Charity
- Out-of-hours-only provider

Overall, a large majority of respondents were either part of a corporate group (40%) or an independent, stand-alone practice (37%). See Figure 25.

Figure 25: Practice business model



Base: Total 5,544

Table 4 shows the practice business model by practice size, type of location and country. Respondents from small practices were significantly[19] more likely to be based in independent, stand-alone practices (45%) than medium (37%) and large (30%) practices. Respondents from small practices were also significantly more likely to be part of a joint venture with a corporate group (11%) than medium (5%) and large (less than 0.5%) practices. Analysis by nation indicates that respondents from Scotland were significantly more likely to be from a veterinary school (10%) than other nations: England (3%), Northern Ireland (1%) and Wales (less than 0.5%).

Analysis by type of location shows the following significant differences in practice business model:

- Respondents from remote rural practices were significantly[20] more likely to be from independent, stand-alone practices (53%) than mixed rural and urban (43%) and urban (53%) practices.
- Respondents from urban practices were significantly more likely to be part of a corporate group (44%) than mixed rural and urban (39%) and rural (30%) practices.
- Respondents from urban practices were significantly more likely to be part of a joint venture with a corporate group (10%) than mixed rural and urban (2%) and rural (1%) practices.
- Respondents from urban practices were significantly more likely to be a charity (8%) than mixed rural and urban (1%) and rural (3%) practices.

Table 4: Practice business model by practice size (surgeons), whether urban or rural and country

	Practice size	Urban v rural	Country

[19] At the 95% confidence level

[20] At the 95% confidence level

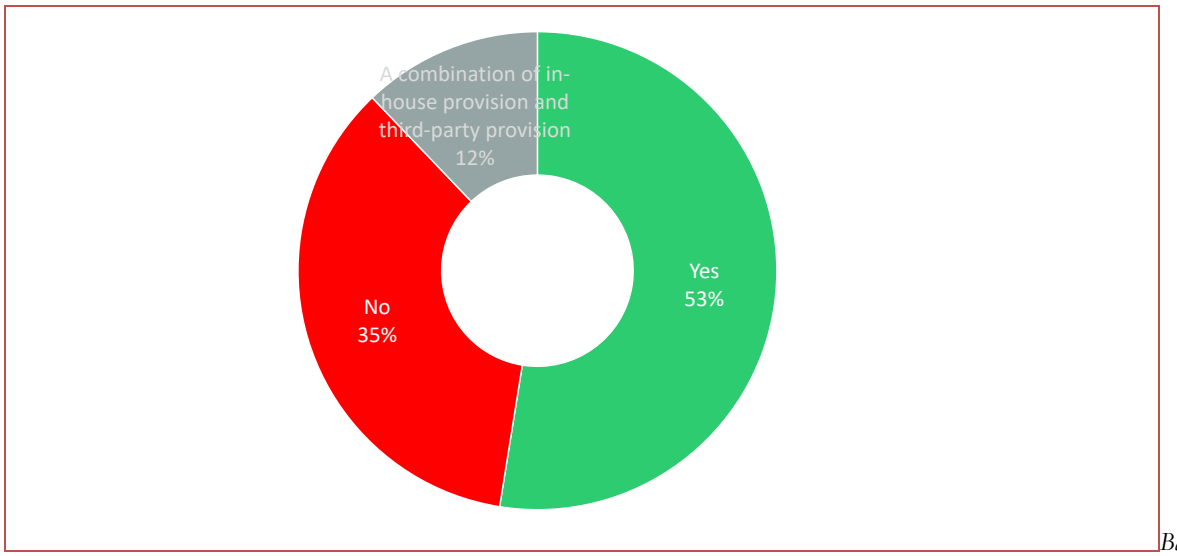
	Small (<3 vets) %	Medium (4-10 vets) %	Large (11+ vets) %	Remote rural %	Mixture of rural and urban %	Urban %	England %	Scotland %	Wales %	Northern Ireland %
Part of a corporate group	29	42	47	30	39	44	41	36	31	33
Independent, stand-alone practice (e.g. a partnership)	45	37	30	53	43	25	36	39	47	50
Independent practice that is part of a larger group (with some shared centralised function)	5	4	9	7	5	6	6	5	6	5
Part of a joint venture with a corporate group	11	5	*	1	2	10	5	3	5	4
Charity	2	6	2	3	1	8	4	3	3	2
Veterinary school	1	2	9	2	4	3	3	10	*	1
Out-of-hours-only provider	3	2	1	1	2	3	2	3	4	2
Other	4	2	2	3	3	2	3	2	3	3
Base	1,462	2,588	1,447	458	2,916	2,170	4,590	565	269	120

** = less than 0.5%*

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

Over half the respondents (53%) reported that their practice provided their 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[21] more prevalent in large practices than smaller practices (84% compared to 49% medium and 27% small). 24/7 emergency cover was also significantly more prevalent in remote rural practices than mixed or urban practices (82% compared to 60% mixed rural and urban and 36% urban). See Table 5.

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

	Practice size			Urban v rural			Country			
	Small (<3 vets)	Medium (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

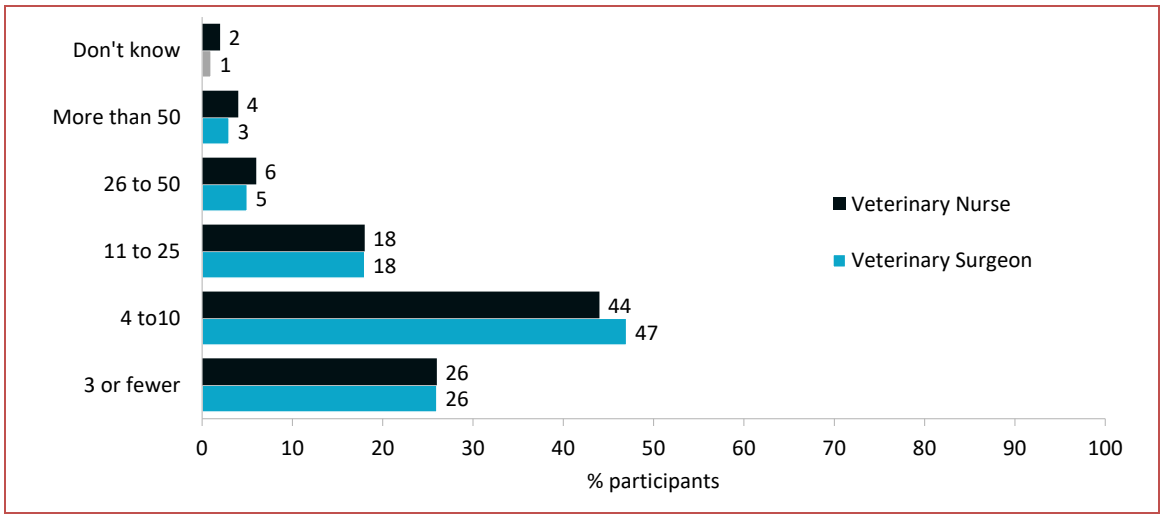
B.7. Practice size

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 practicing 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.

[21] At the 95% confidence level

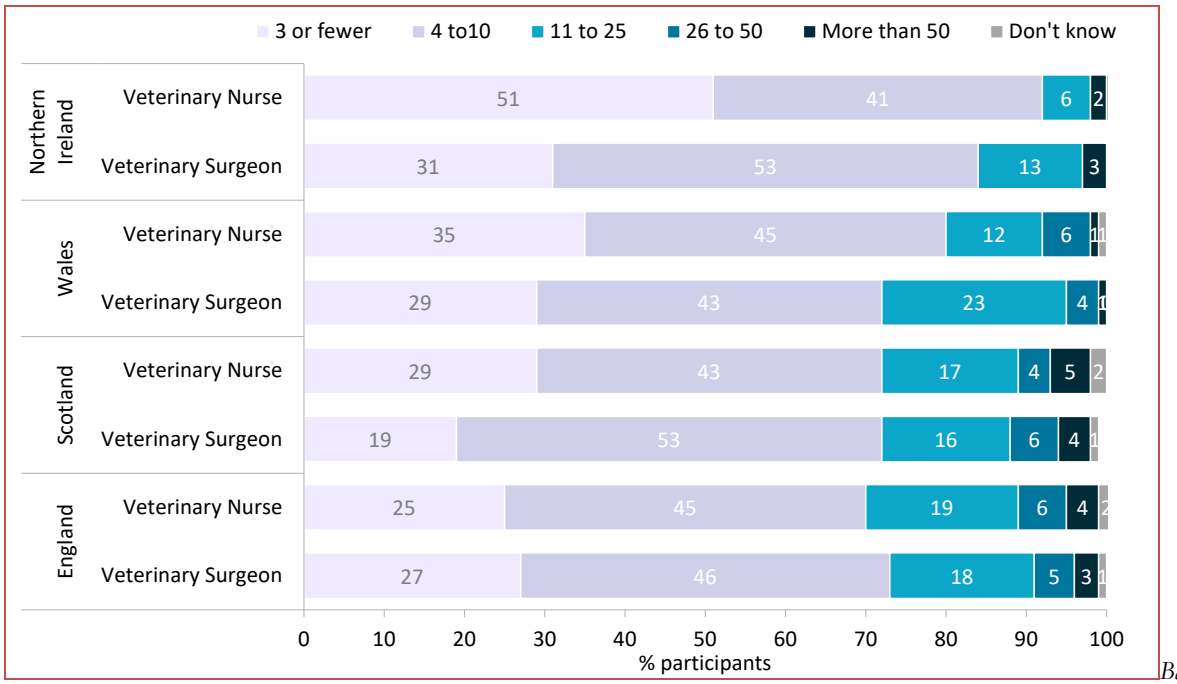
Figure 27: Practice size



Base: Veterinary Surgeon 4,545, Veterinary Nurse 999

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

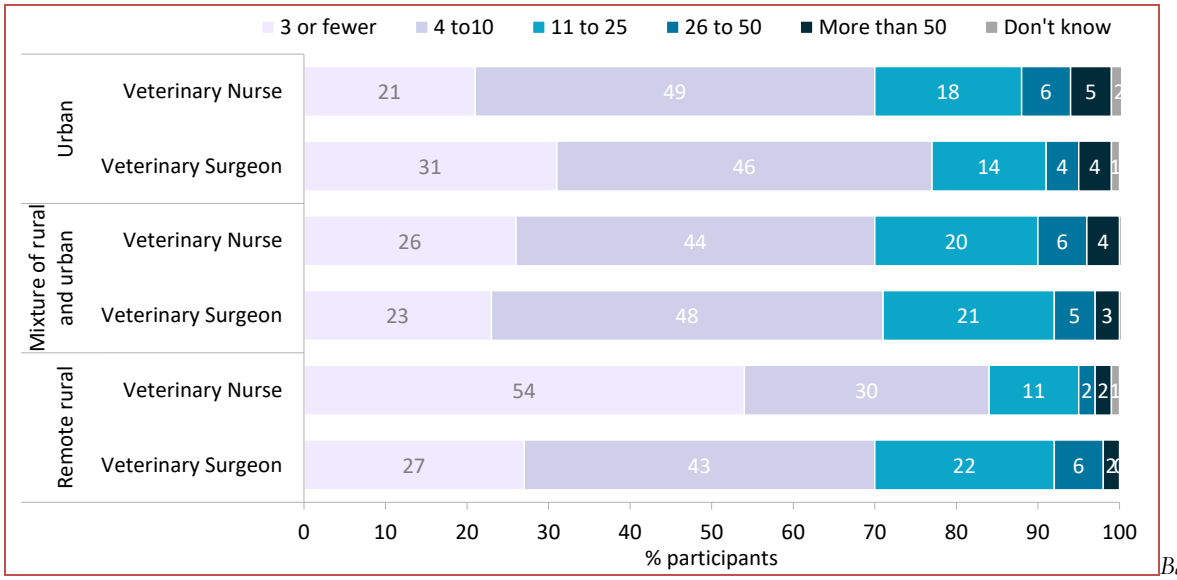
Figure 28: Practice size by country



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

There were similar number of surgeons and nurses by region except remote rural where there were fewer nurses (54% three or fewer nurses in remote rural compared to 26% in mixed rural and urban and 21% urban). See Figure 28.

Figure 29: Practice size by whether urban or remote

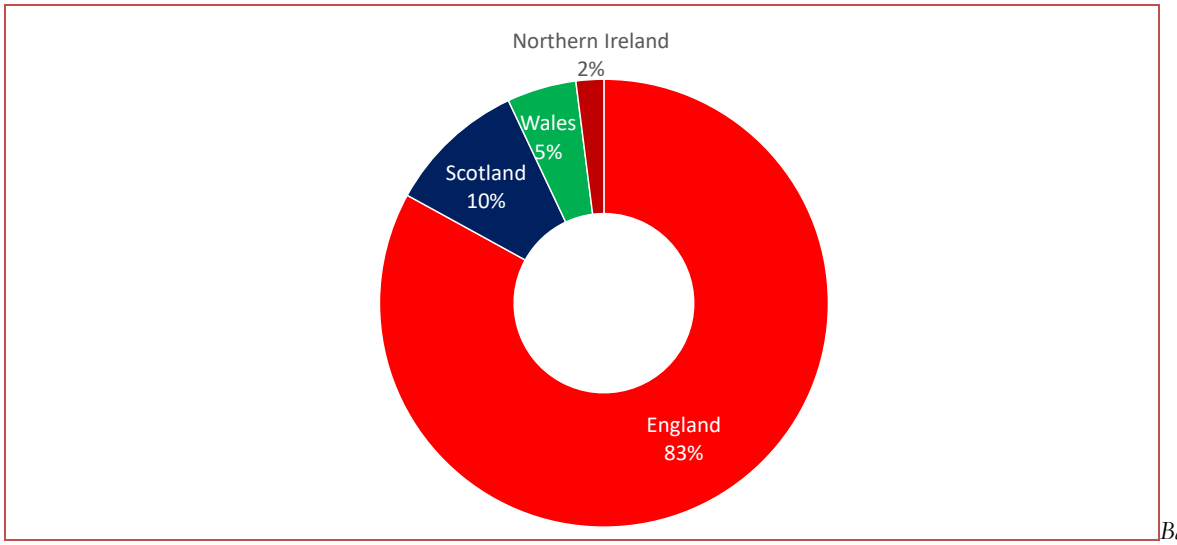


Base: Urban v rural: Remote rural 458, Mixture of rural and urban 2,916, Urban 2,170

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 to 69% remote rural. A much larger proportion of practices were remote rural rather than urban in Scotland, Wales and Northern Ireland. See Table 6.

Table 6: Country by practice size and whether practice location urban or rural

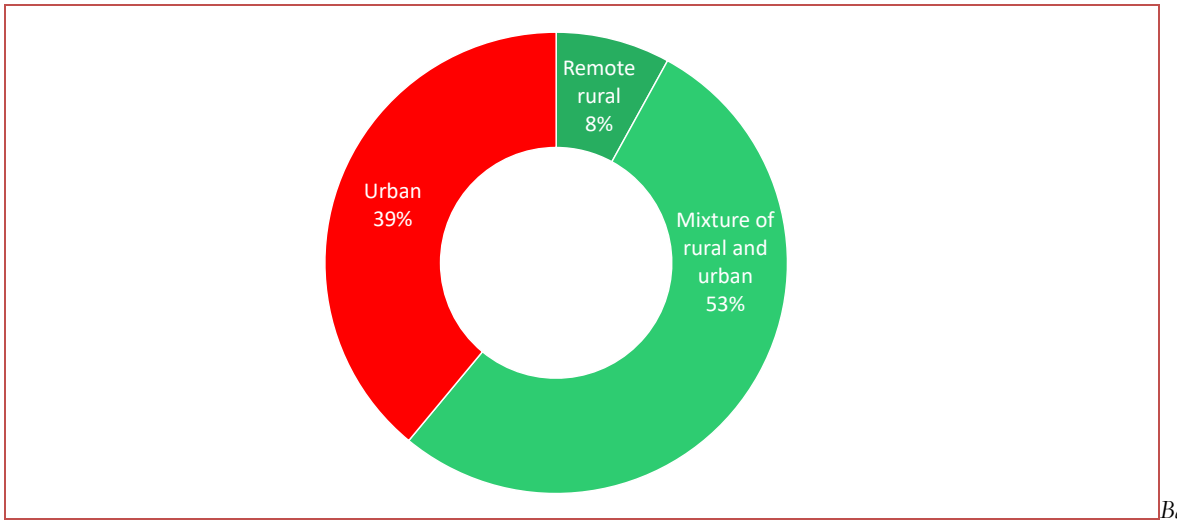
	Practice size			Urban v rural		
	Small (<3 vets) %	Medium (4-10 vets) %	Large (11+ vets) %	Remote rural %	Mixture of rural and urban %	Urban %
England	85	81	83	69	82	87
Scotland	7	12	10	17	10	9
Wales	5	4	5	9	6	3
Northern Ireland	3	2	1	4	2	2
Base	1,462	2,588	1,447	458	2,916	2,170

** = less than 0.5%*

B.9. Whether work in remote or urban area

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

Figure 31: Whether practice location urban or rural



Base: Total 5,544

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

- Respondents from small practices were significantly more likely to be from urban than medium or large practices: 46% compared to 39% medium and 33% large.
- Respondents from large practices were significantly more likely to be based in a mix of rural and urban than medium or small practices: 58% compared to 54% medium 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 location urban or rural by practice size and country

	Practice size			Country			
	Small (<3 vets) %	Medium (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 whether urban or rural (the scores which are significantly[22] higher than the other score(s) within the category are shaded darker)

	Practice size			Urban v rural		
	Small (<3 vets)	Medium (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 wellbeing 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

[22] At the 95% confidence level

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 graphs

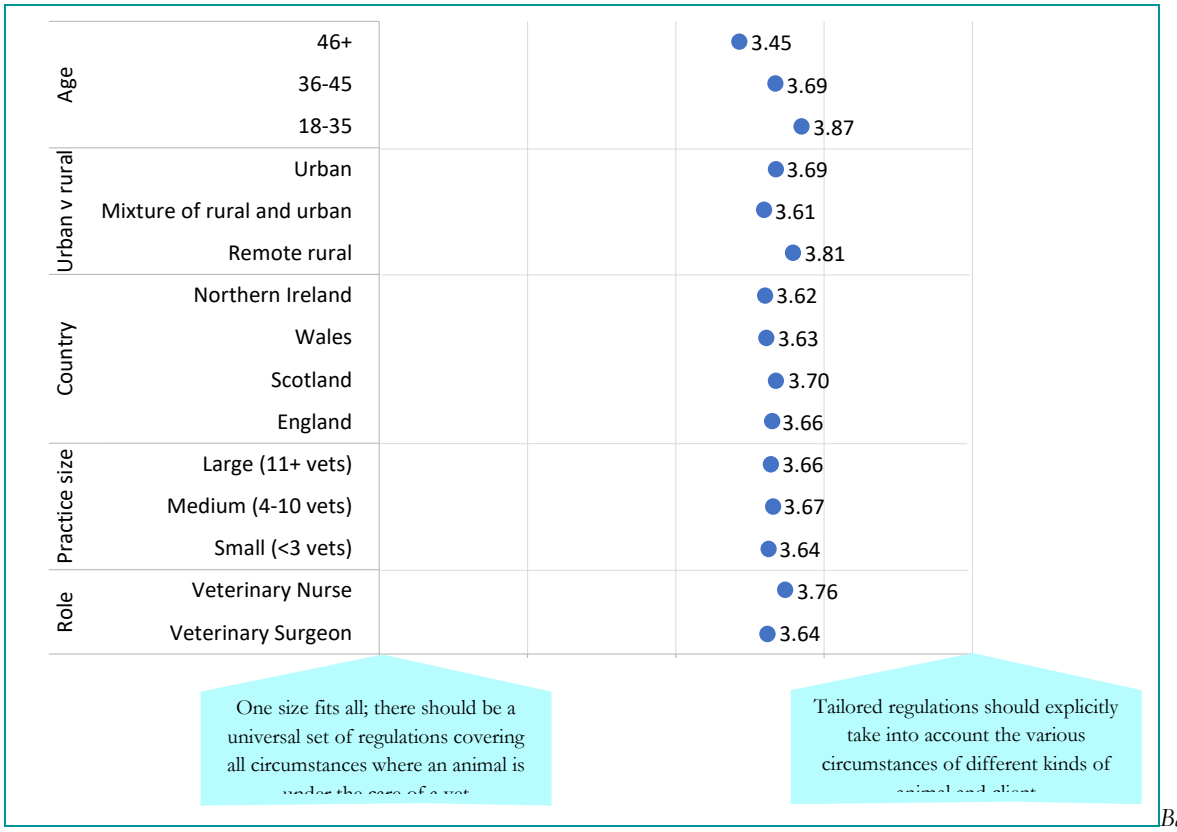
Table 9: Good Regulation Statements, mean scores by practice size and whether urban or rural

Statement	Practice size			Urban v rural		
	Small (<3 vets)	Medium (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			Urban v rural		
	Small (<3 vets)	Medium (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**

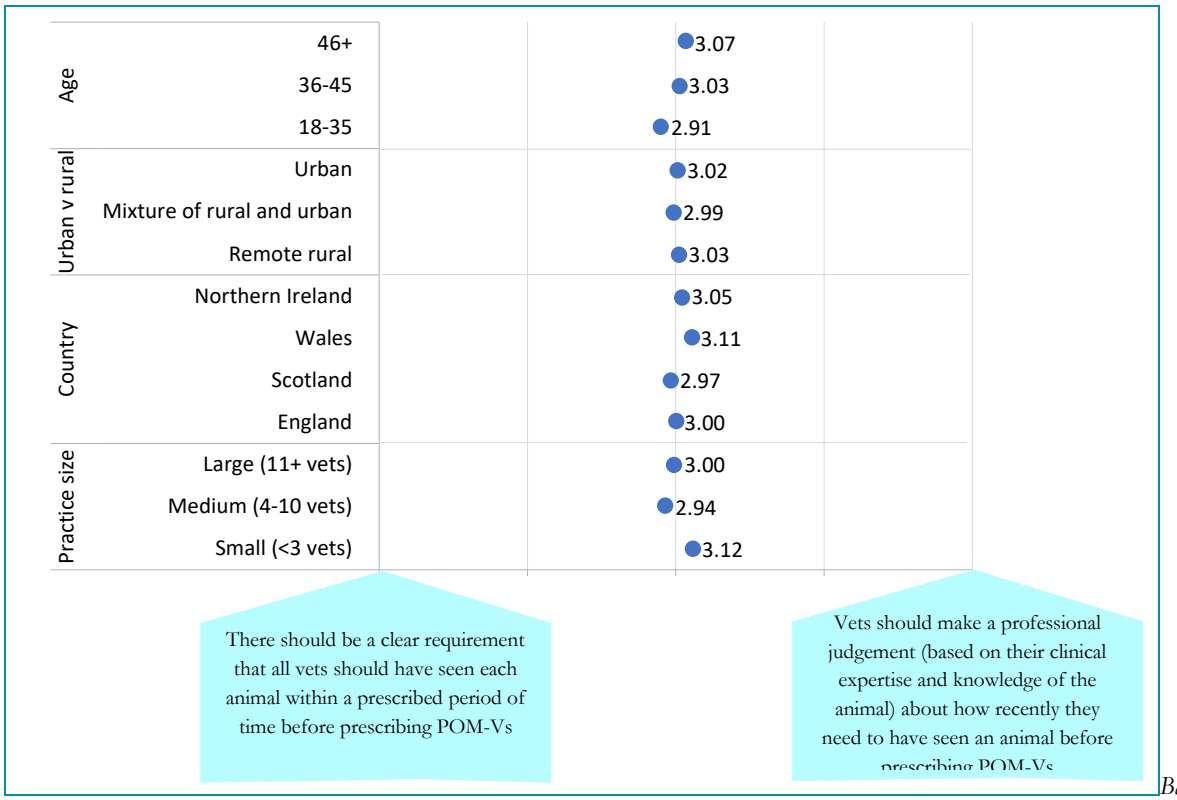
C.3. When principles are in tension sub-group analysis

Figure 33: 3.8.1. One size fits all v tailored regulations- Mean scores by age, urban v rural, country, practice size and role



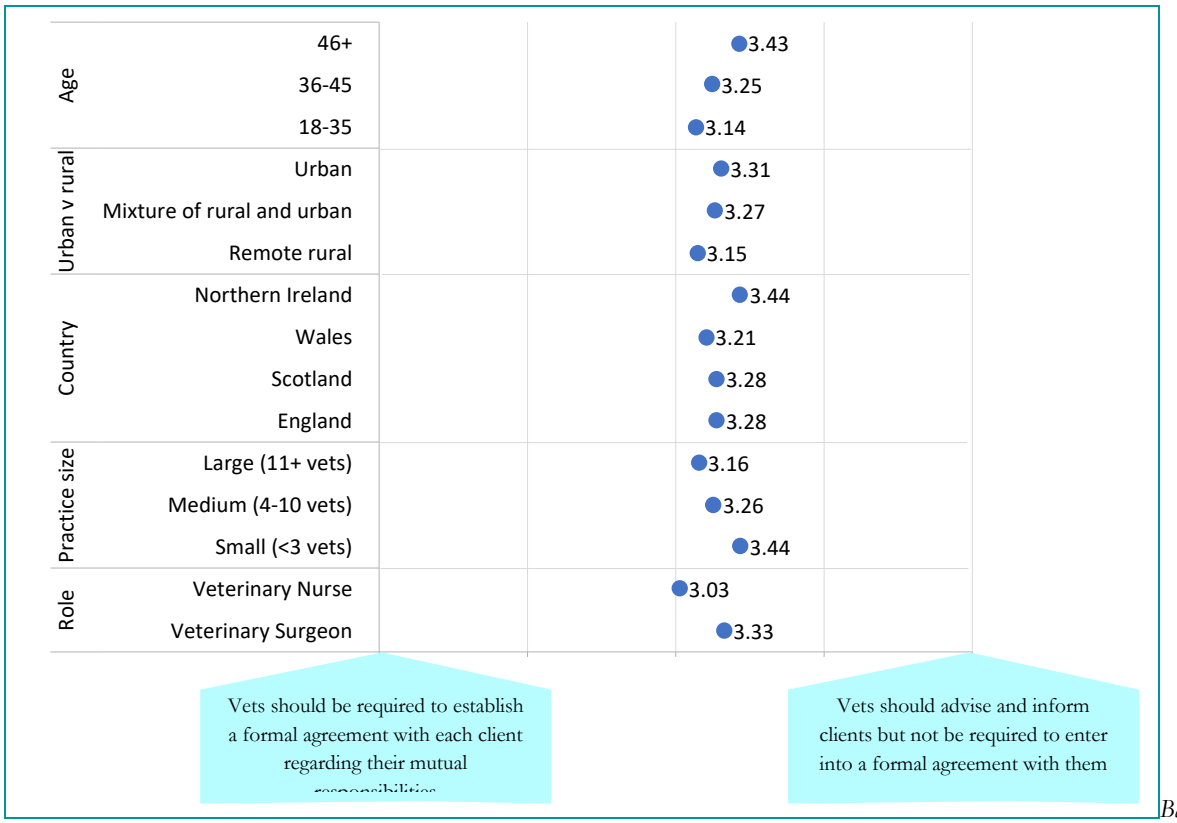
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

Figure 34: Before prescribing POM-Vs each animal should be seen within a prescribed period of time versus vets should make a professional judgement- mean scores by age, urban v rural, country and practice size: Surgeons only



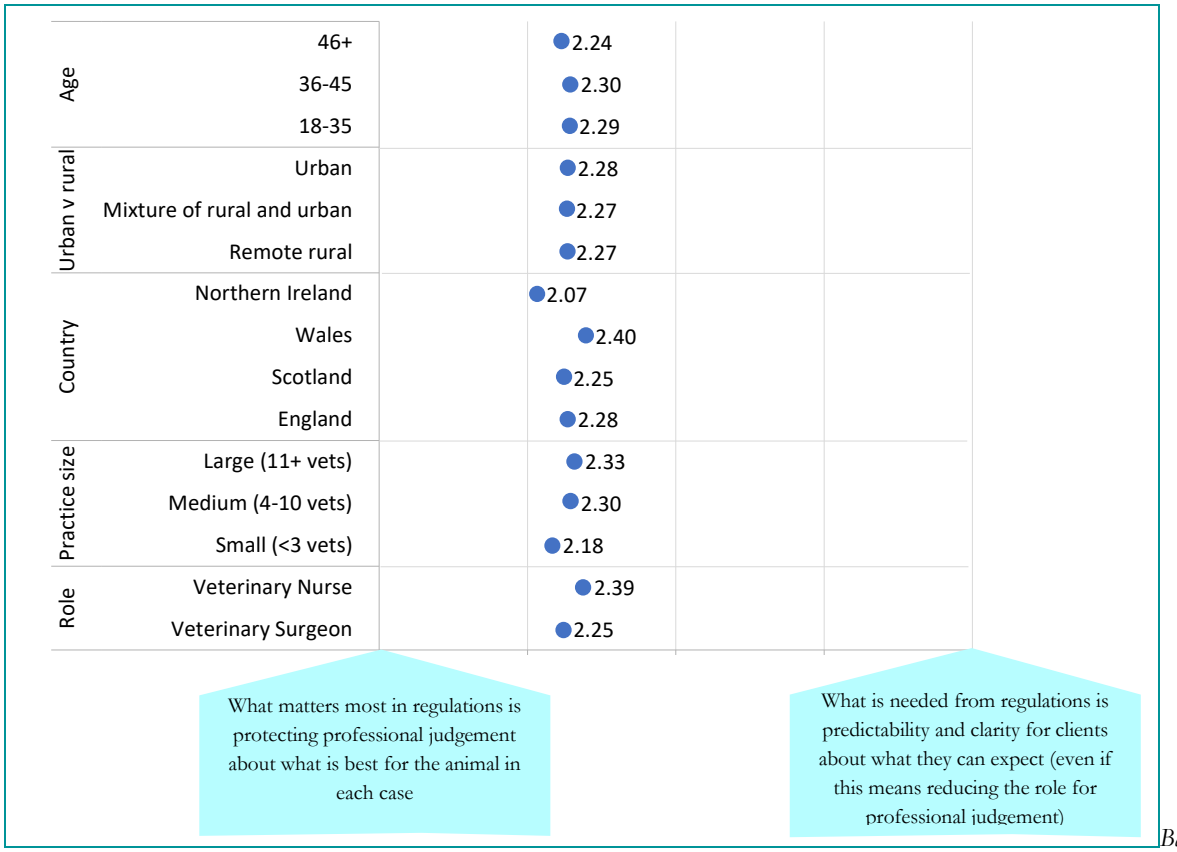
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445

Figure 35: A formal agreement with each client should be required versus vets should advise and inform clients about agreement- mean scores by age, urban v rural, country, practice size and role



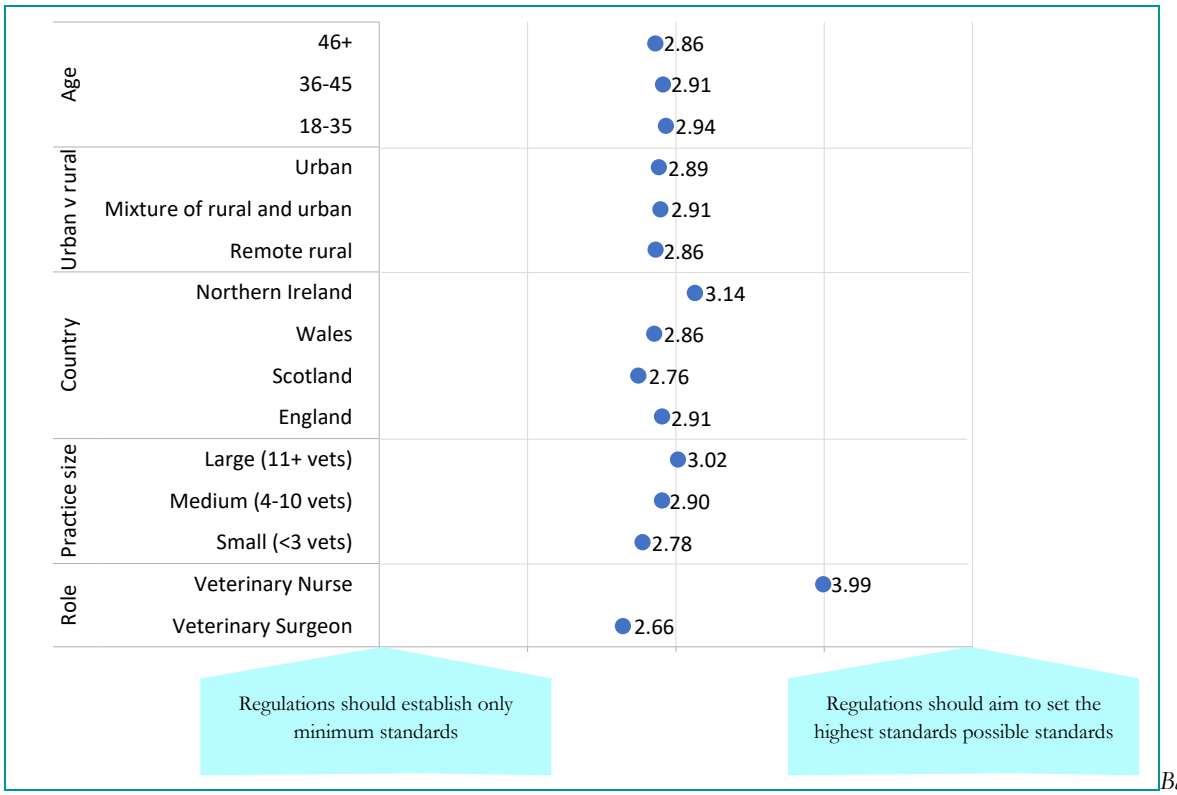
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

Figure 36: Protecting professional judgement about what is best in each case versus predictability and clarity for clients about what they can expect- mean scores by age, urban v rural, country, practice size and role



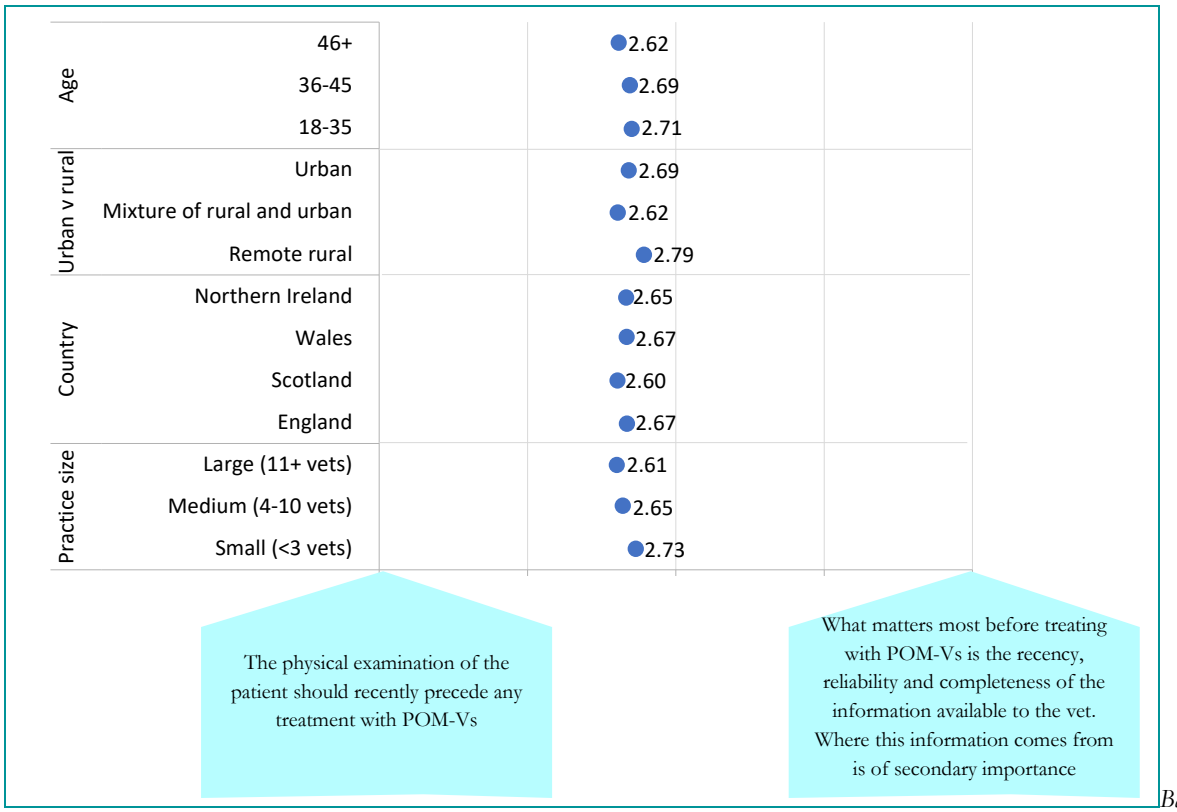
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

Figure 37: 1.1.1. Regulations should establish only minimum standards versus should aim to set the highest standards possible standards- mean scores by age, urban v rural, country, practice size and role



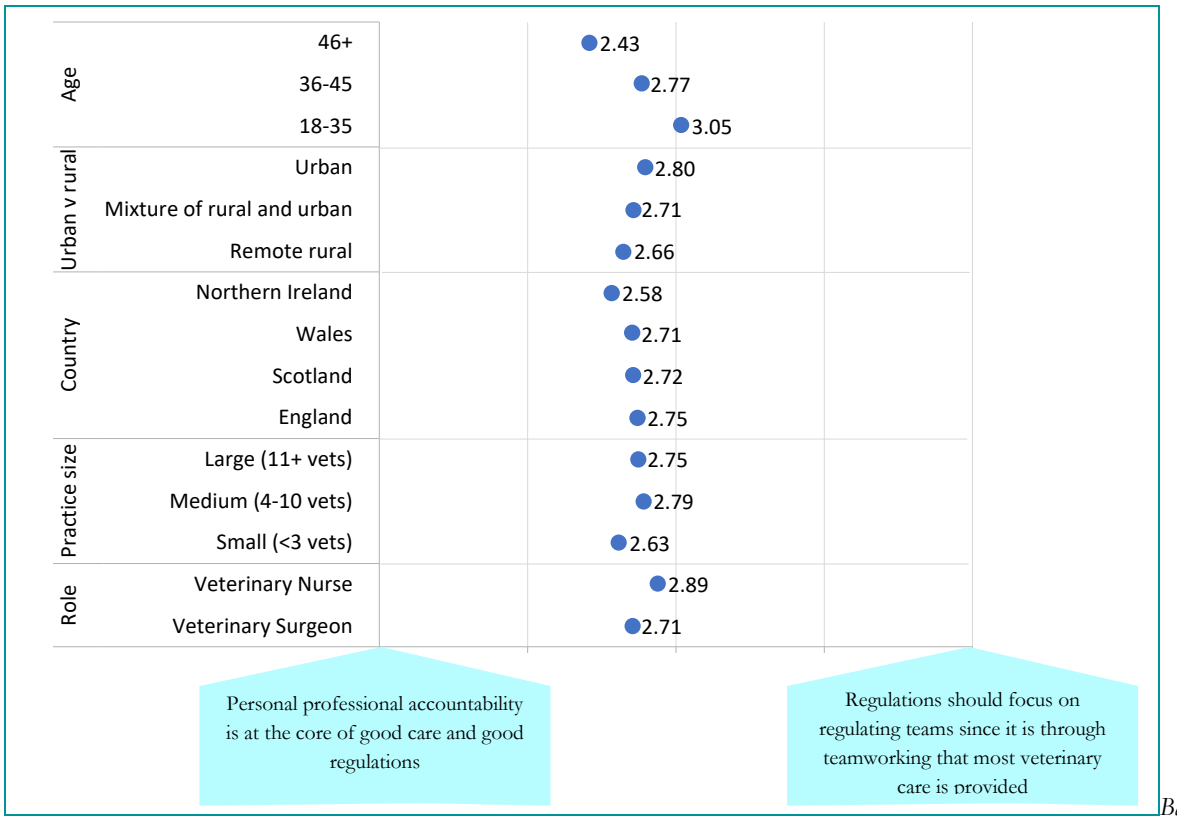
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

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



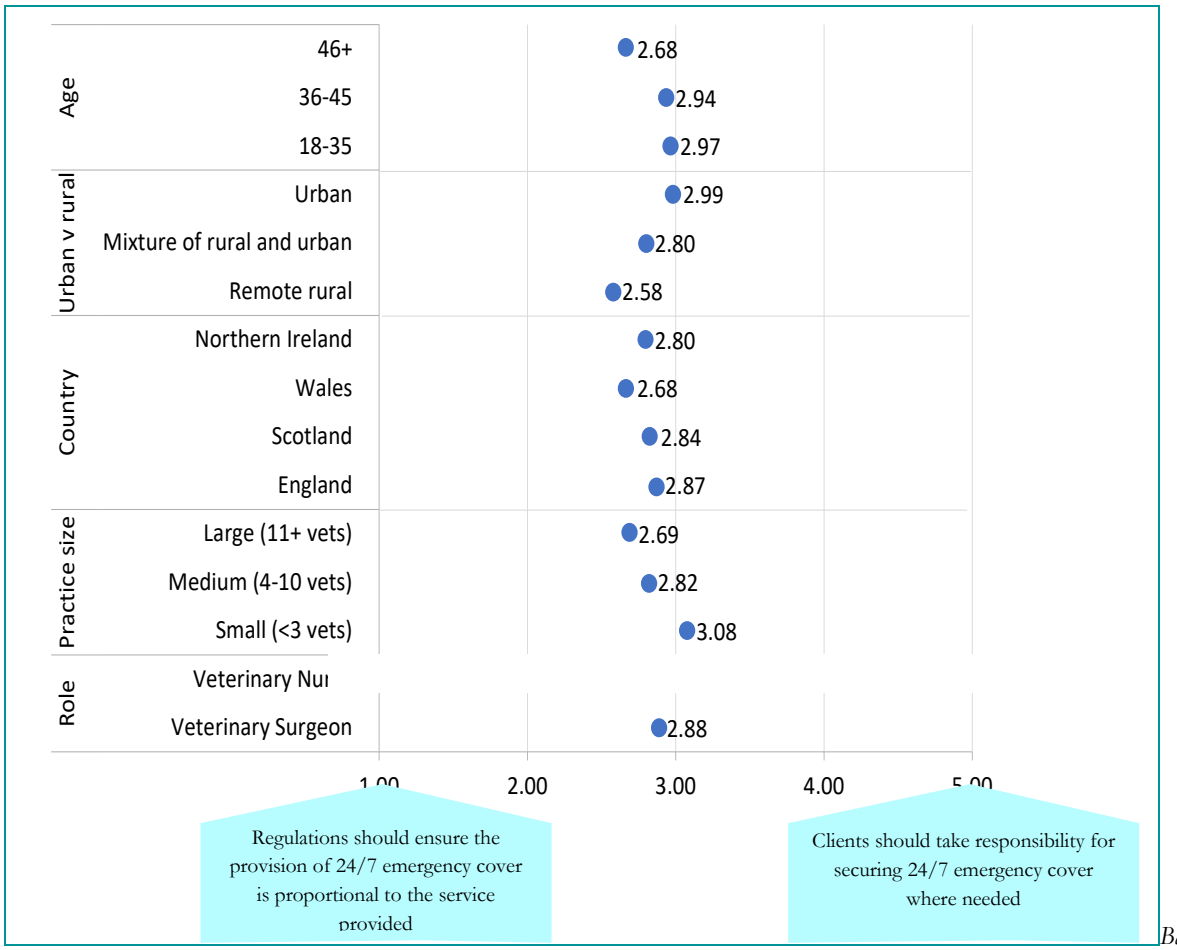
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445

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



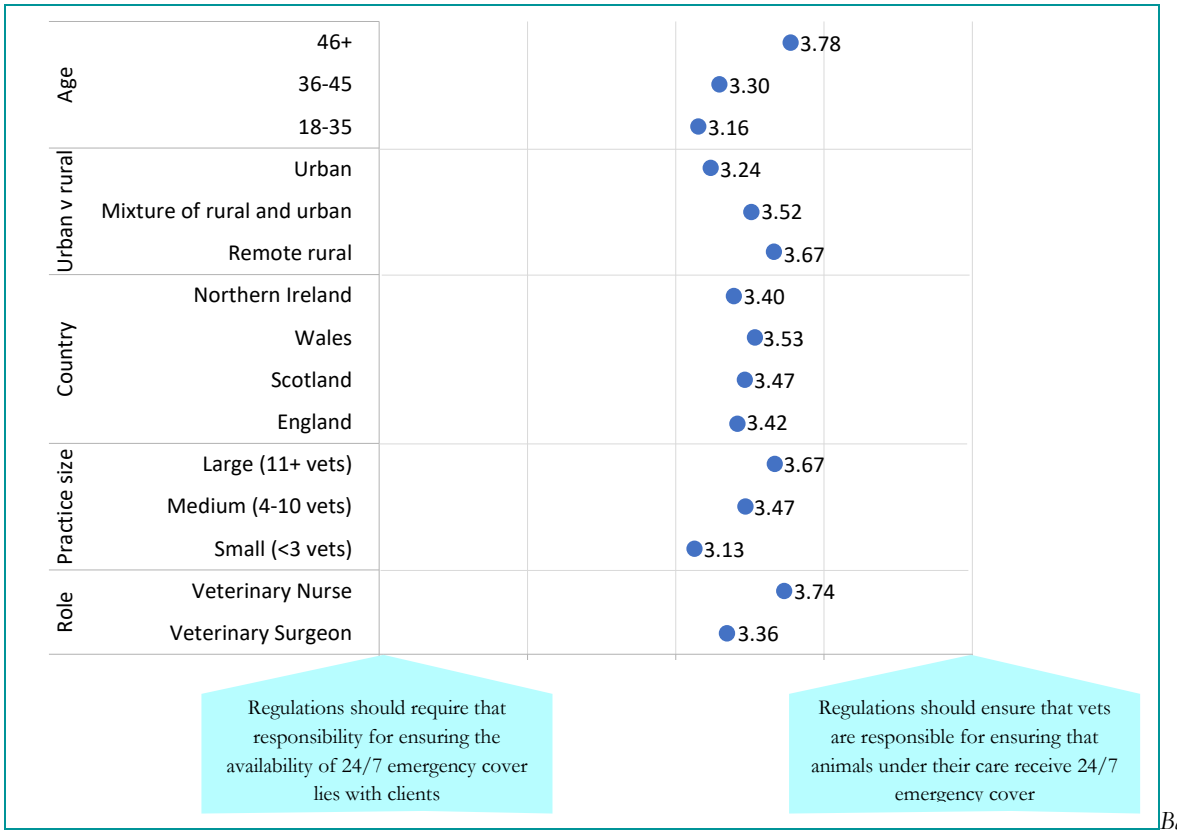
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

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



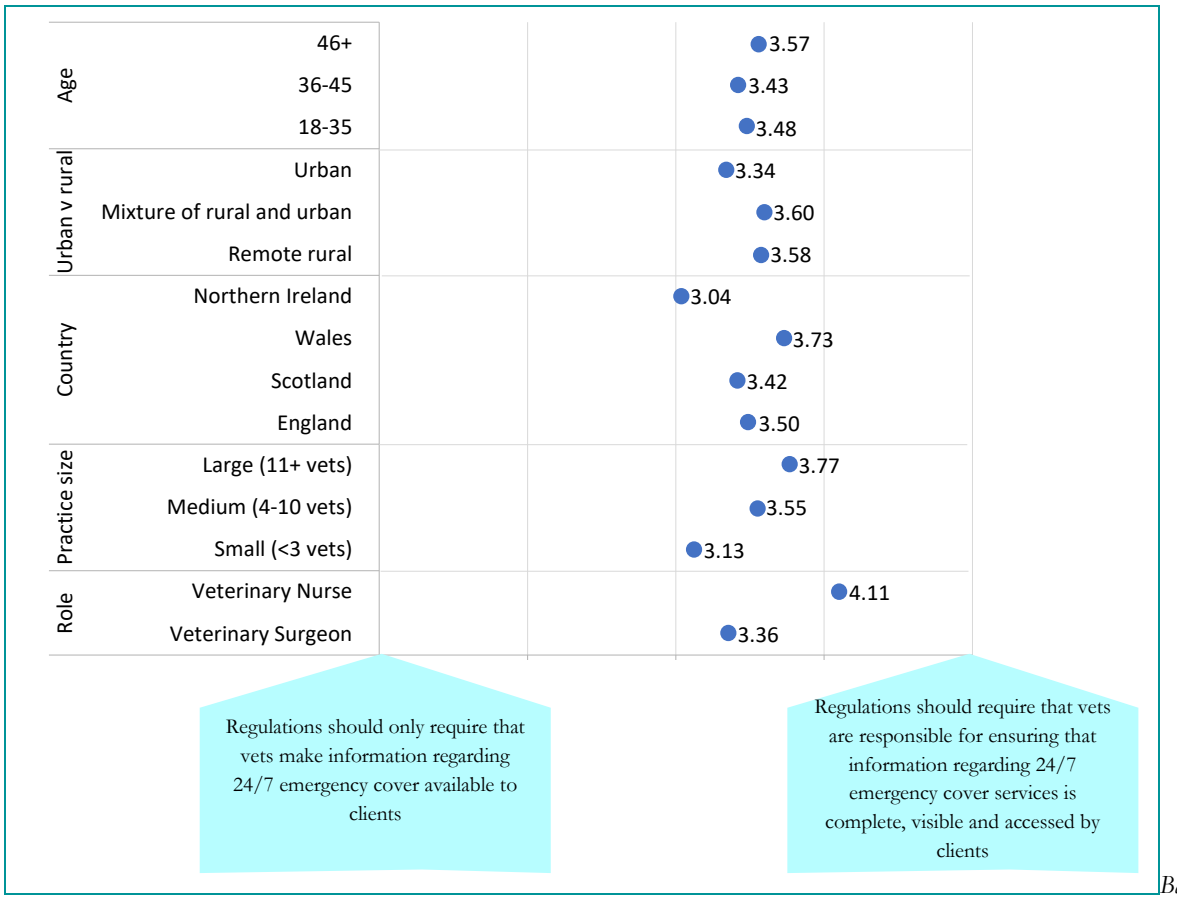
Base: Age: 18-35 1,883, 36-45 1,646, 46+ 1,990; Urban v rural: Remote rural 454, Mixture of rural and urban 2,911, Urban 2,167; Country: England 4,581, Scotland 563, Wales 269, Northern Ireland 119; Practice size: Small (<3 vets) 1,460, Medium (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999,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

Figure 41: Availability of 24/7 emergency cover lies with clients versus 24/7 emergency cover lies with vets- mean scores by age, urban v 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 (4-10 vets) 2,580, Large (11+ vets) 1,445; Role: Nurse 999, surgeon 4,534

Figure 42: Information regarding 24/7 emergency cover available to clients versus it being complete, visible and accessed by client- mean scores by age, urban v 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 (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 or treatment can be prescribed through virtual or non-tangible mediums such as videos, pictures or 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 who 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' to which regulations should be based. A high score on this factor would indicate a vet wanted rigidity and clear definition in the regulations, whereas disagreement 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 wellbeing 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/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

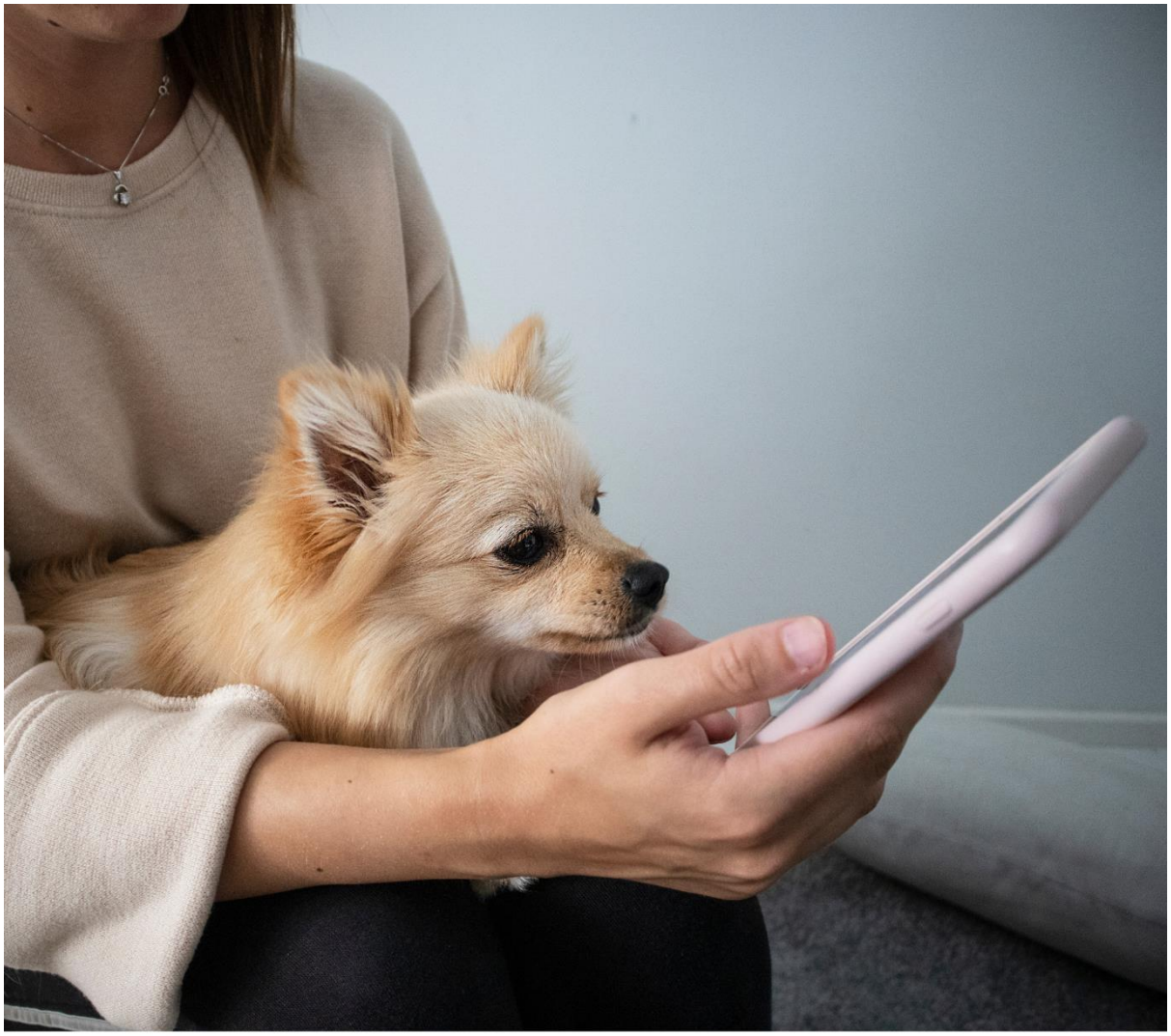
The statements which fall under the theme 'animal responsibility' discuss the vet responsibility for the animal under care. Agreement on this factor would indicate a vet agreed that the responsibility for advice, POM-V and knowledge is with the vet who takes the animal under their care.

- *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 from 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.

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.

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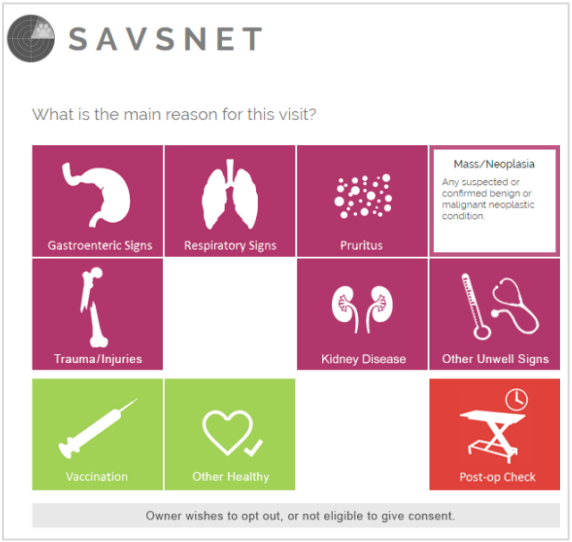
[1] *https://www.rcvs.org.uk/news-and-views/news/standards-committee-agrees-to-end-remote-prescribing/*

[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.

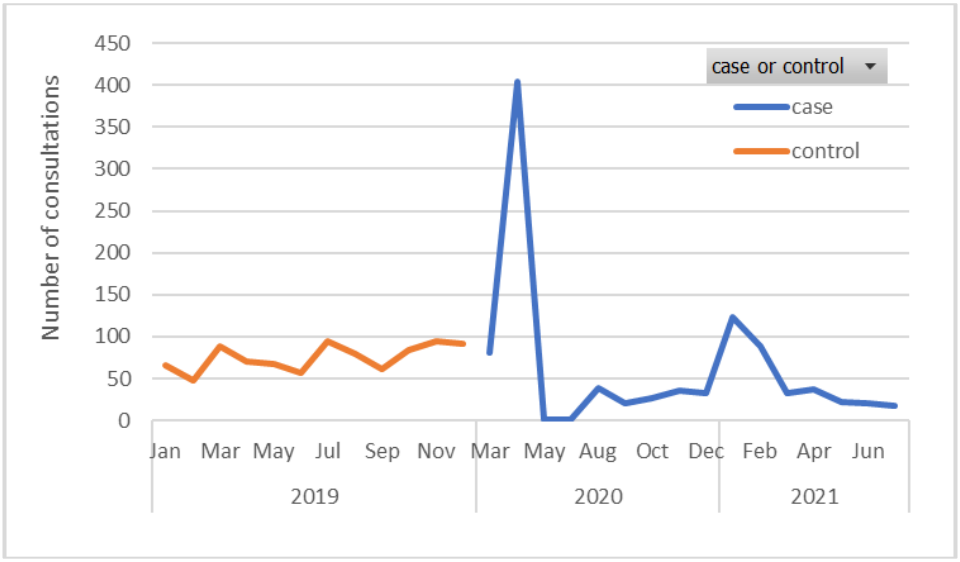
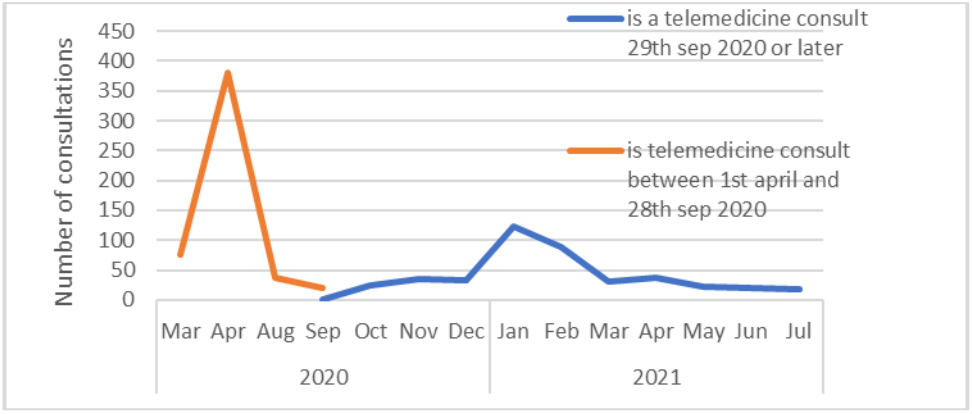


Figure 2; Distribution of cases into two time periods



Species.

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

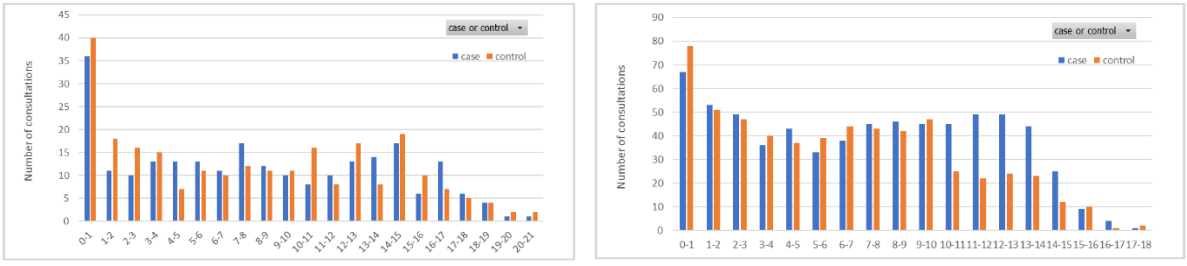
Table 3; species breakdown of telemedicine cases and face-to-face controls.

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)

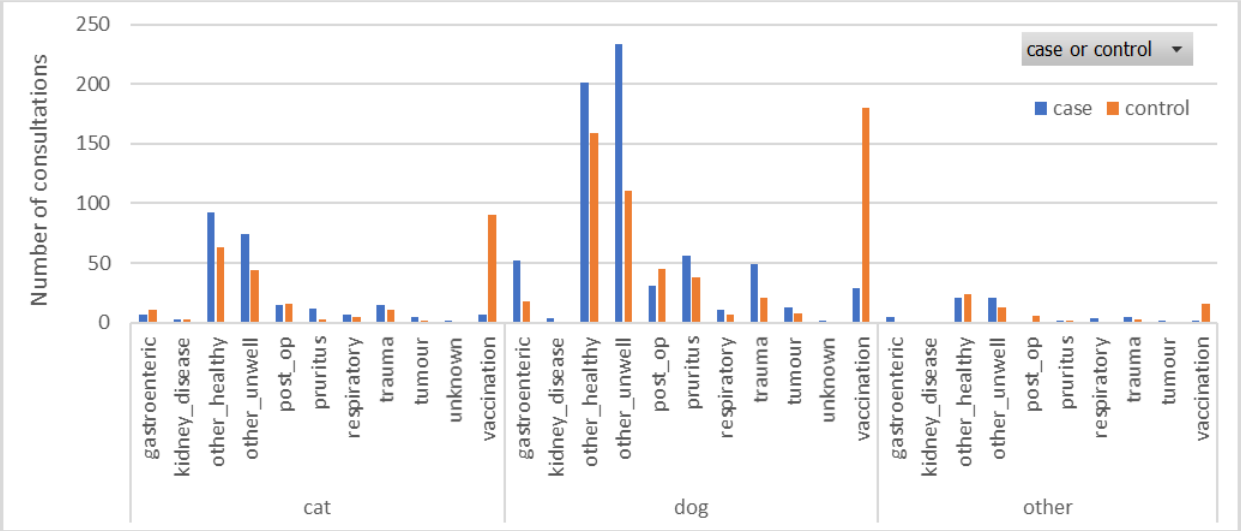
Figure 3; age distribution of cases and controls for cats (left) and dogs (right).



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).

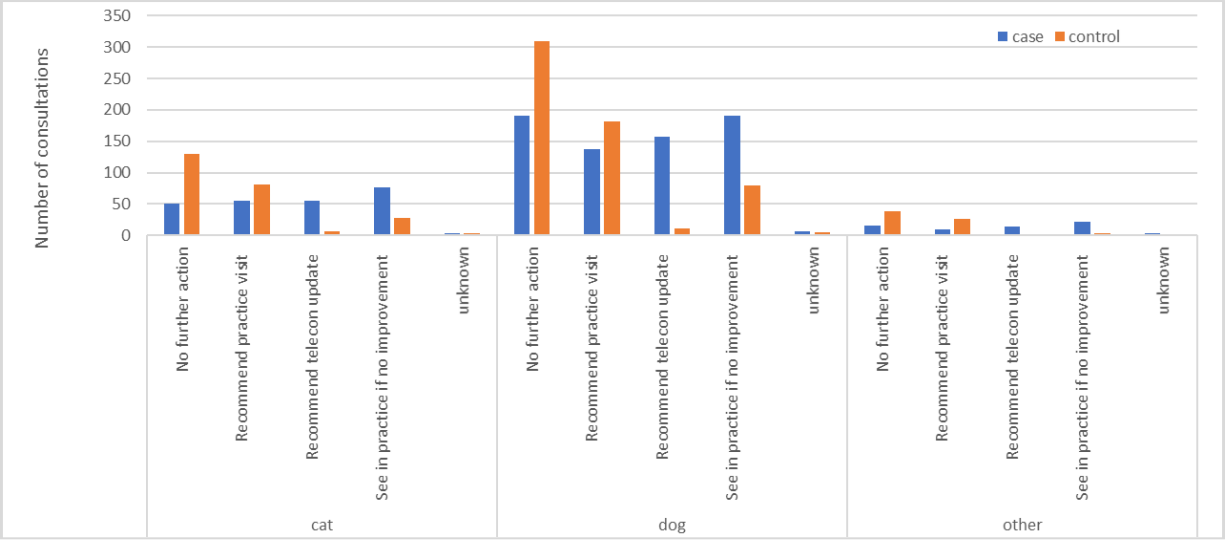
Figure 4; practitioner derived main presenting complaint (MPC) for cats, dogs and other species. Note – "other unwell" are consultations with those animals that don't fit into the specific sick animal categories (gastroenteric, kidney, pruritus, respiratory, trauma, tumour). "other healthy" consultations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

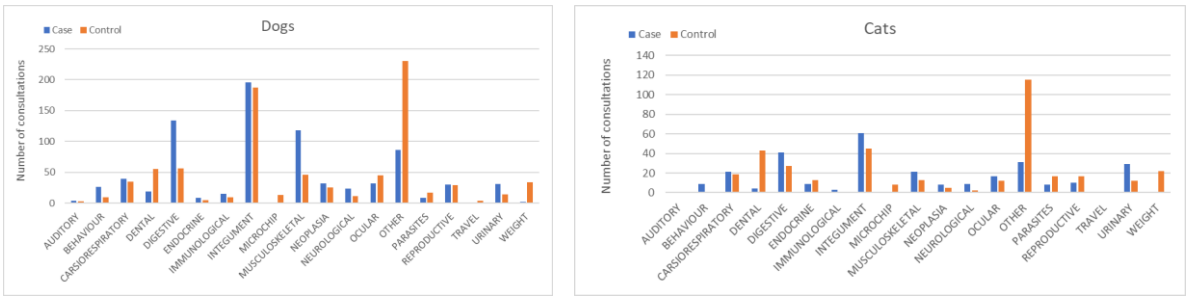
Figure 5; Number of consultations associated with immediate outcome categories on all species.



SAVSNET category

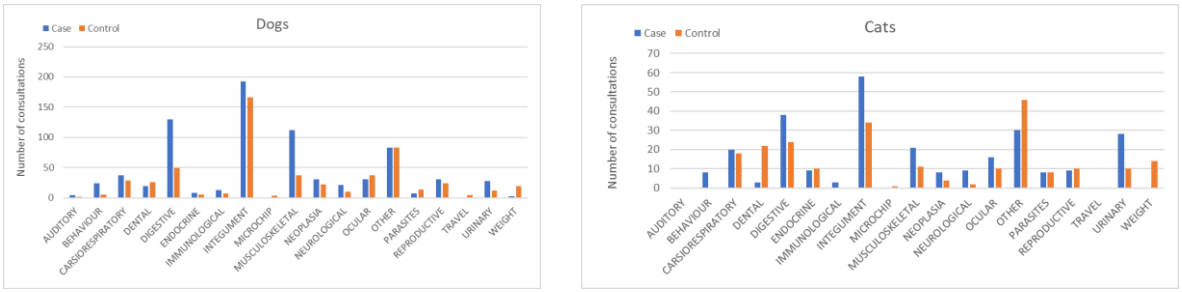
When considering all consultations, the largest SAVSNET category in both species was 'Other', largely because of those subcategories associated with vaccines (Fig.6). These included a wide range of sub-categories including euthanasia, post-op check and general health checks.

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



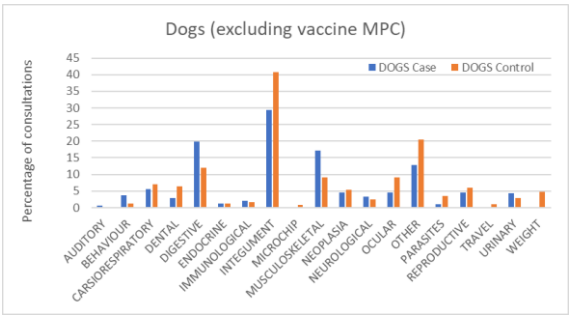
If those consultations categorised as the vaccine MPC are excluded, then for teleconsultations with dogs, behaviour, digestive, musculoskeletal and to a lesser extent urinary subcategories seem somewhat over-represented, whereas weight is under-recorded. For cats, behaviour, digestive, integument, musculoskeletal,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

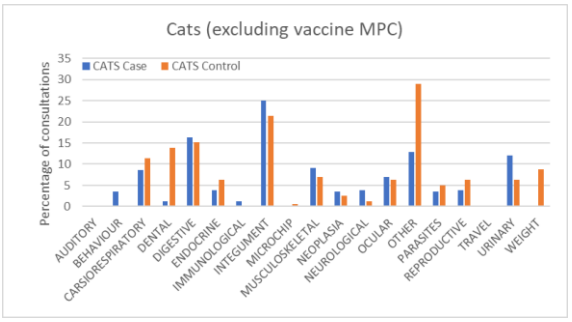
Figure 7; Number of SAVSNET categories for teleconsultation cases and face-to-face controls in cats and dogs ***(excluding the vaccine MPC).***



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).

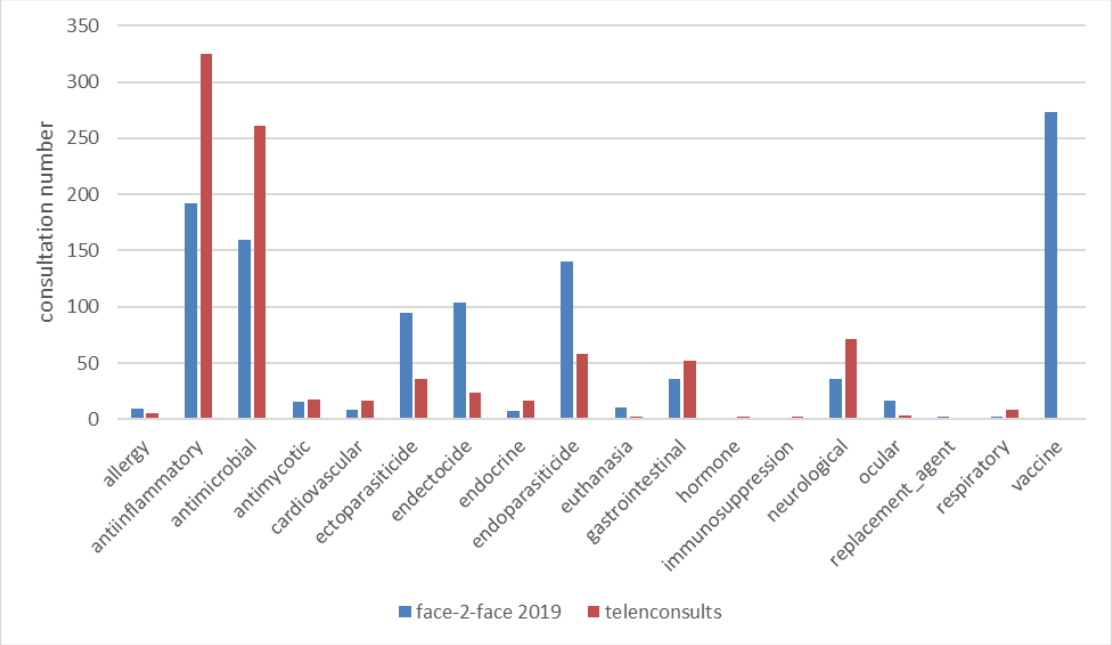
Table 4; A summary of some subcategories with apparent imbalances between teleconsultations and controls are shown below. NOTE- these are not meant to be all inclusive. All analysis is descriptive; inclusion here should not be taken to indicate statistical significance.

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.

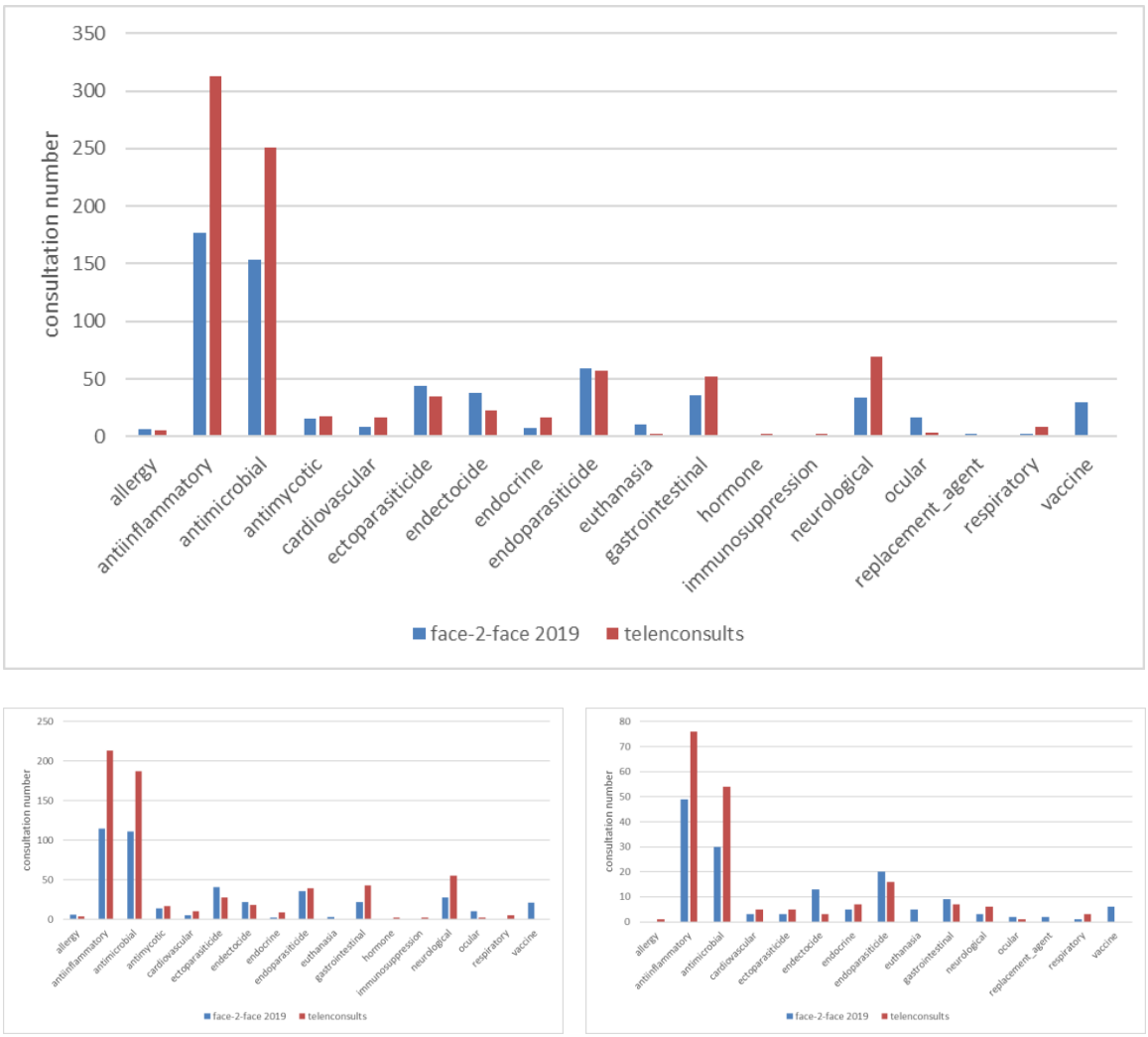


We therefore explored whether these observed differences in therapeutic use remained when vaccine consultations were excluded (figure 10).

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.

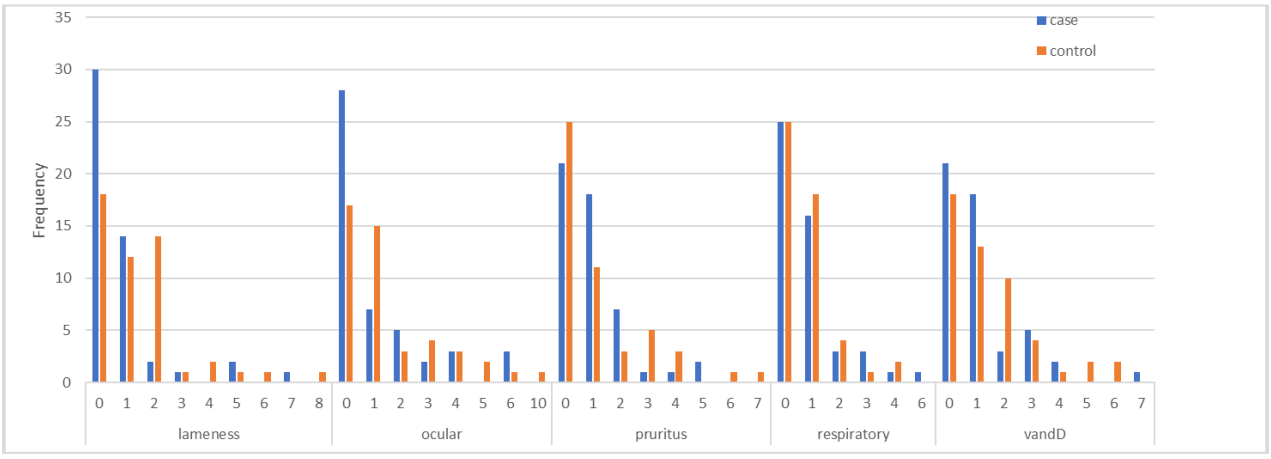
	Upper respiratory	Vomiting and / or diarrhoea	Pruritus	Lameness	Ocular
Subset of existing sub-categories used for part 2 of the study	• Bronchitis • Cough • Cough; collapsing trachea • Cough; nasal discharge • Cough; panting • Cough; sneezing • Feline Respiratory Disease Complex • Nasal discharge • Respiratory 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).

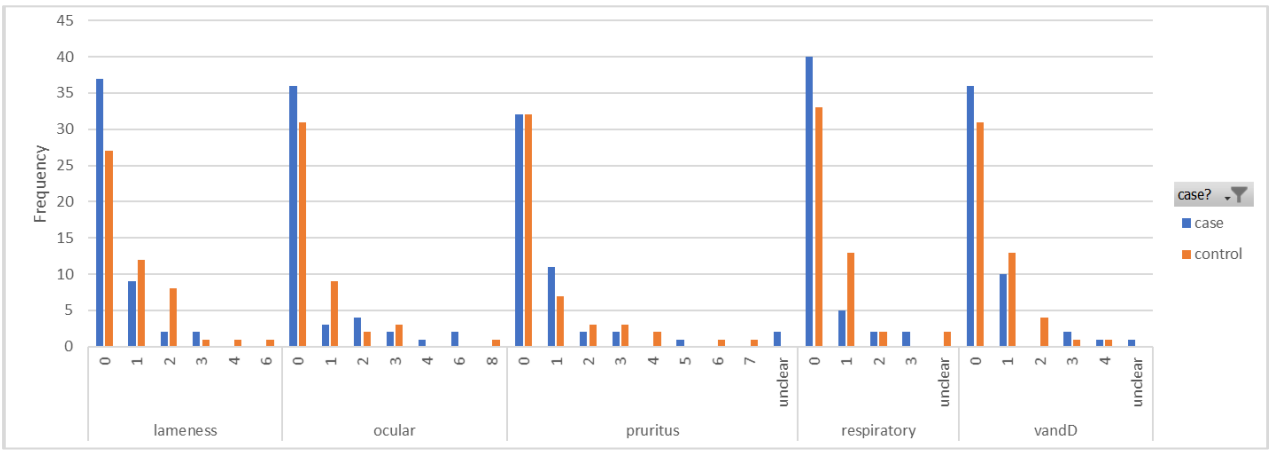
Figure 11; number of consultations occurring over the following six months for teleconference consultations and face-to-face controls.



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).

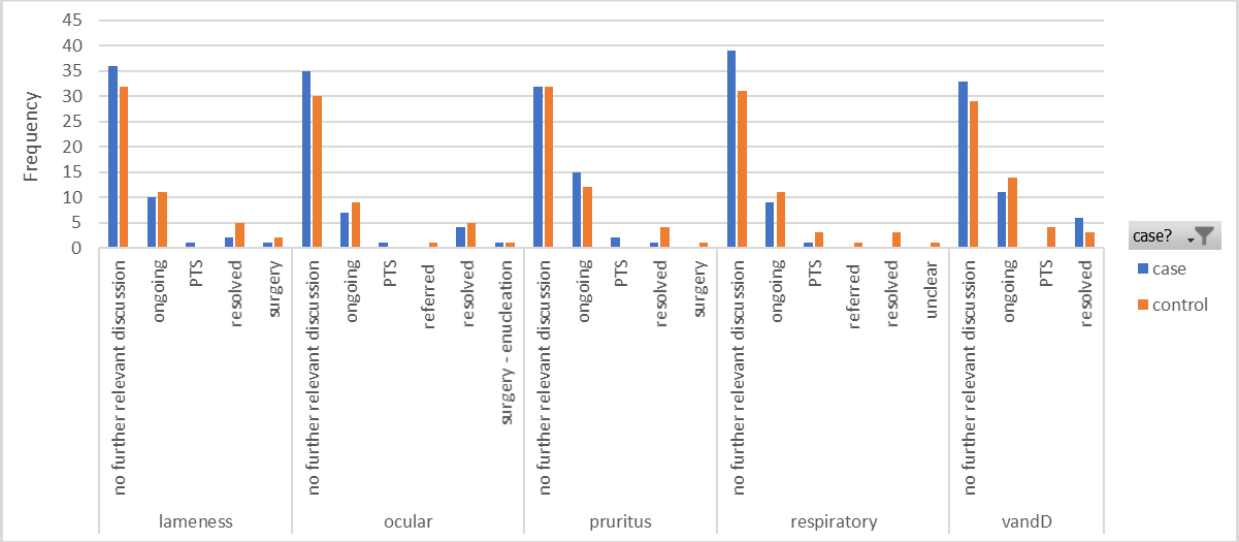
Figure 12; number of related consultations occurring over the following six months.



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.

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RCVS VETCOMPASS EQUINE PANDEMIC PROJECT

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VETERINARY EPIDEMIOLOGY, ECONOMICS AND PUBLIC HEALTH GROUP
DEPARTMENT OF PATHOBIOLOGY AND POPULATION SCIENCES
ROYAL VETERINARY COLLEGE

THIS DOCUMENT REPRESENTS A SUMMARY OF THE WORK UNDERTAKEN BY THE ABOVE AUTHORS. THE FULL PROJECT IS UNDER JOURNAL SUBMISSION AND THE FINAL JOURNAL PUBLICATION OF THE REPORT WILL BE AVAILABLE IN DUE COURSE.

JUNE 2022

RCVS VETCOMPASS EQUINE PANDEMIC PROJECT

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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.

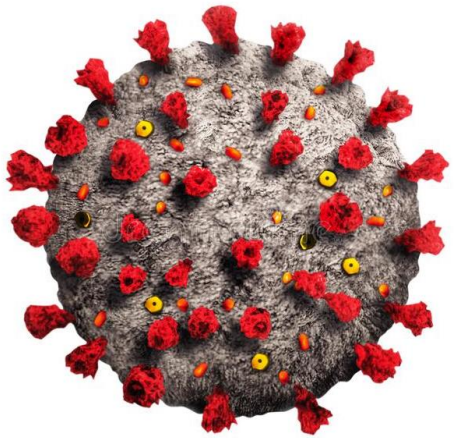
During the two-year study period, 236,997 care episodes were provided to 46,095 equids. The greatest disruption to veterinary activity was observed in the early pandemic. In the month following the introduction of the first national lockdown, compared to pre-pandemic, there was a 39% and 43% decrease 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



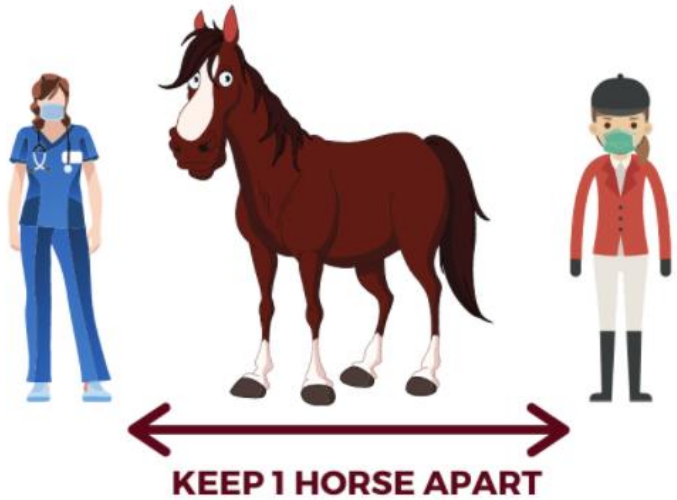
Sarah Allen, Dan O'Neill, Jackie Cardwell, Kristien Verheyen & Dave Brodbelt

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

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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

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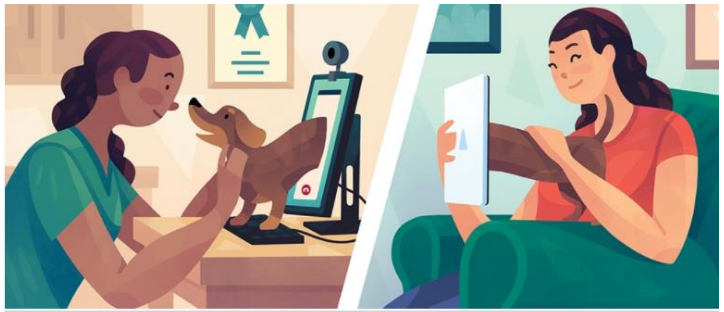
Materials and Methods: Objective 2

- **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

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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

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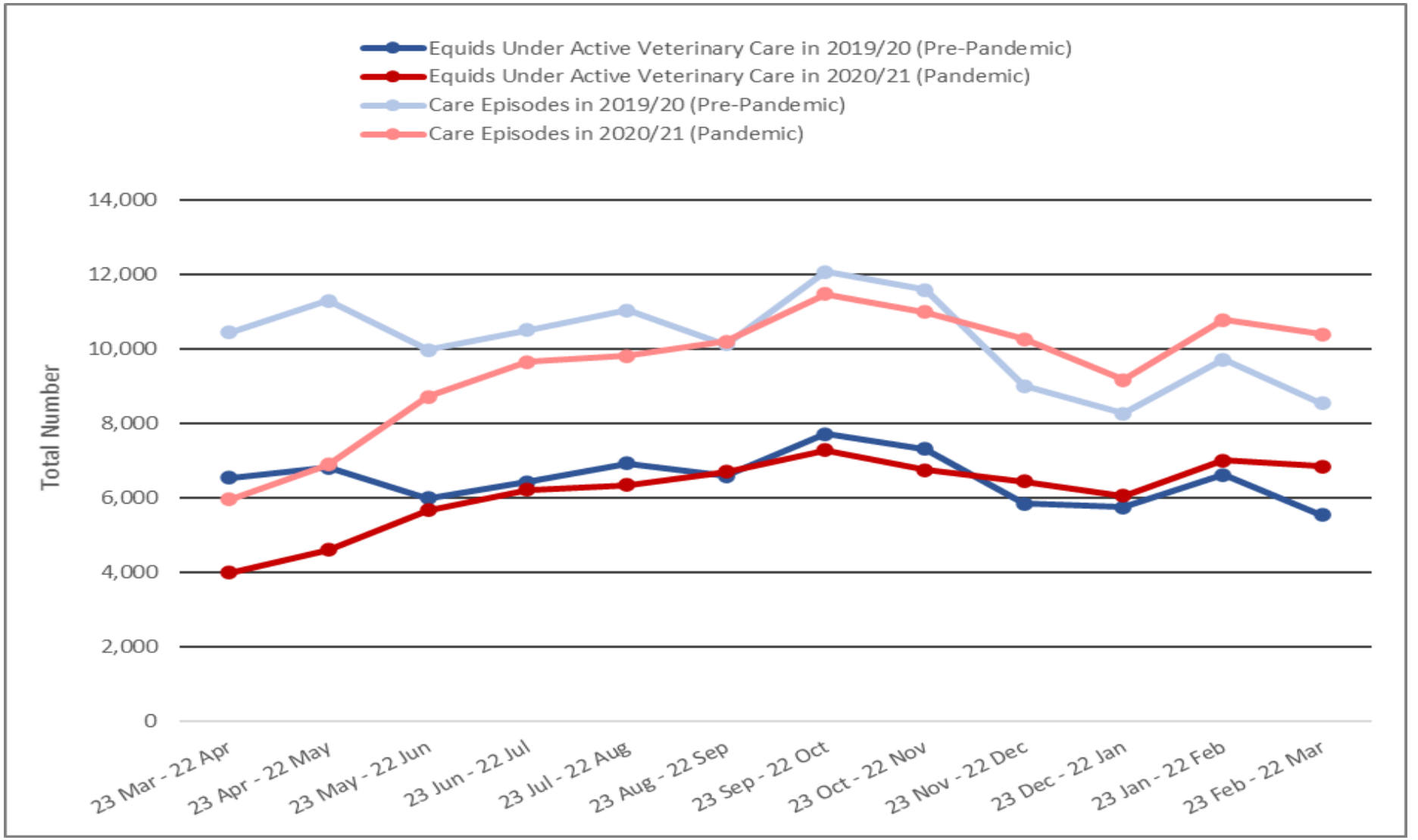
Equid and Care Episode Numbers



Study Population
46,095

Total Care Episodes
236,997

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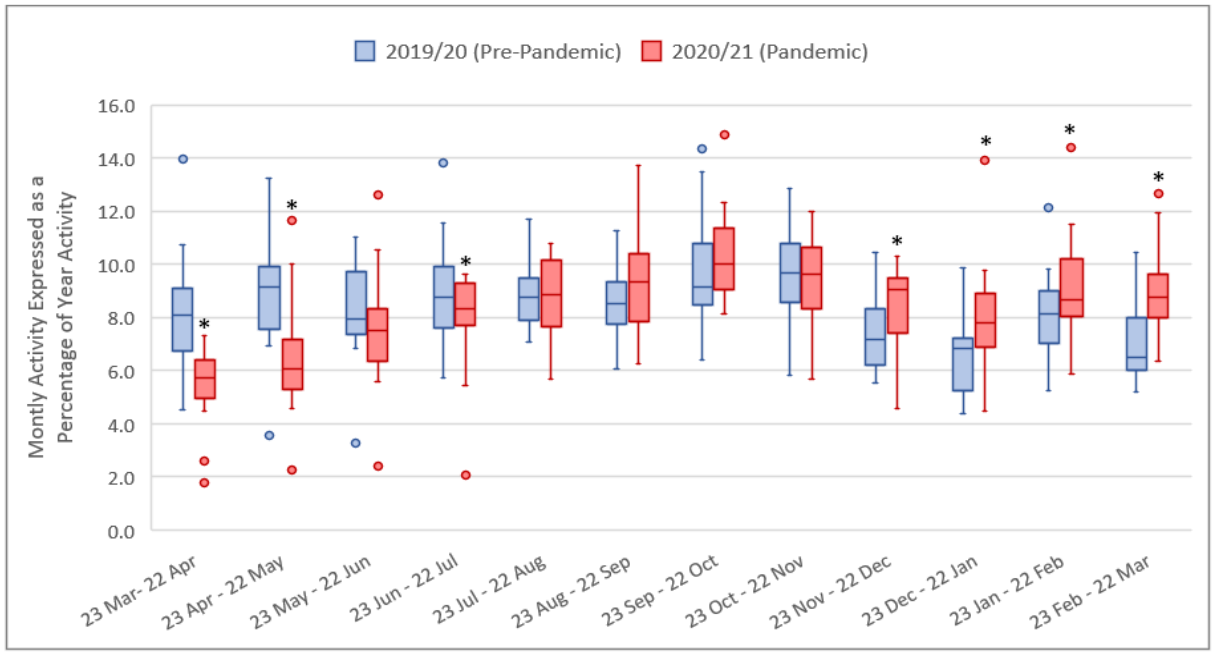
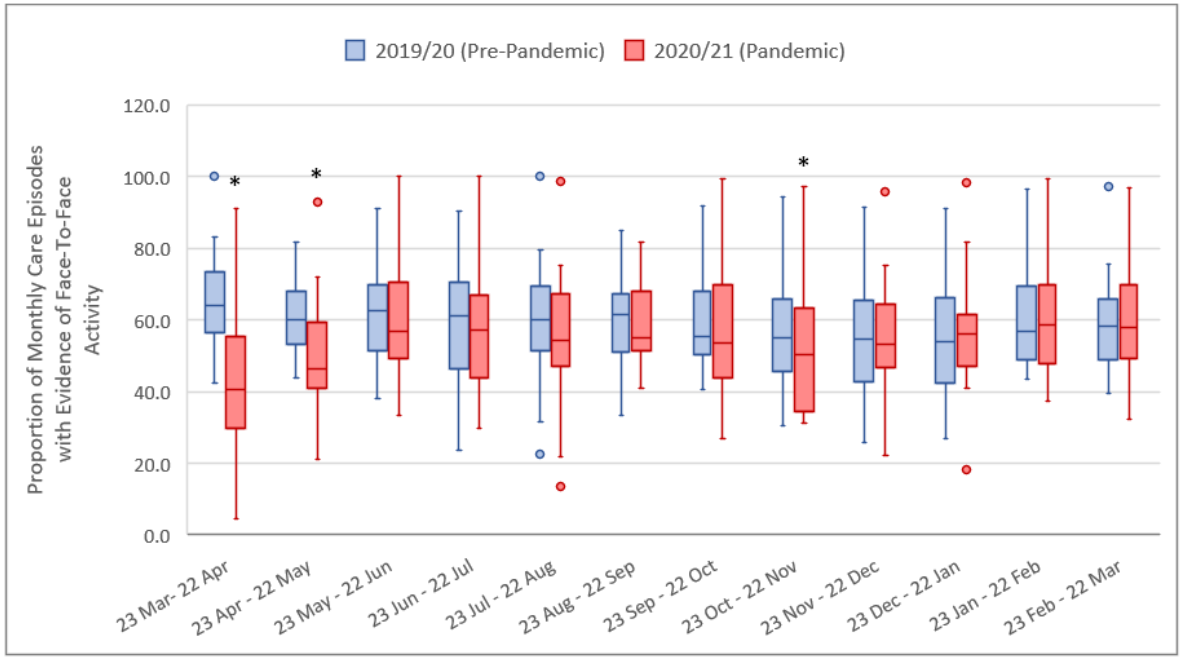
Monthly Activity





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

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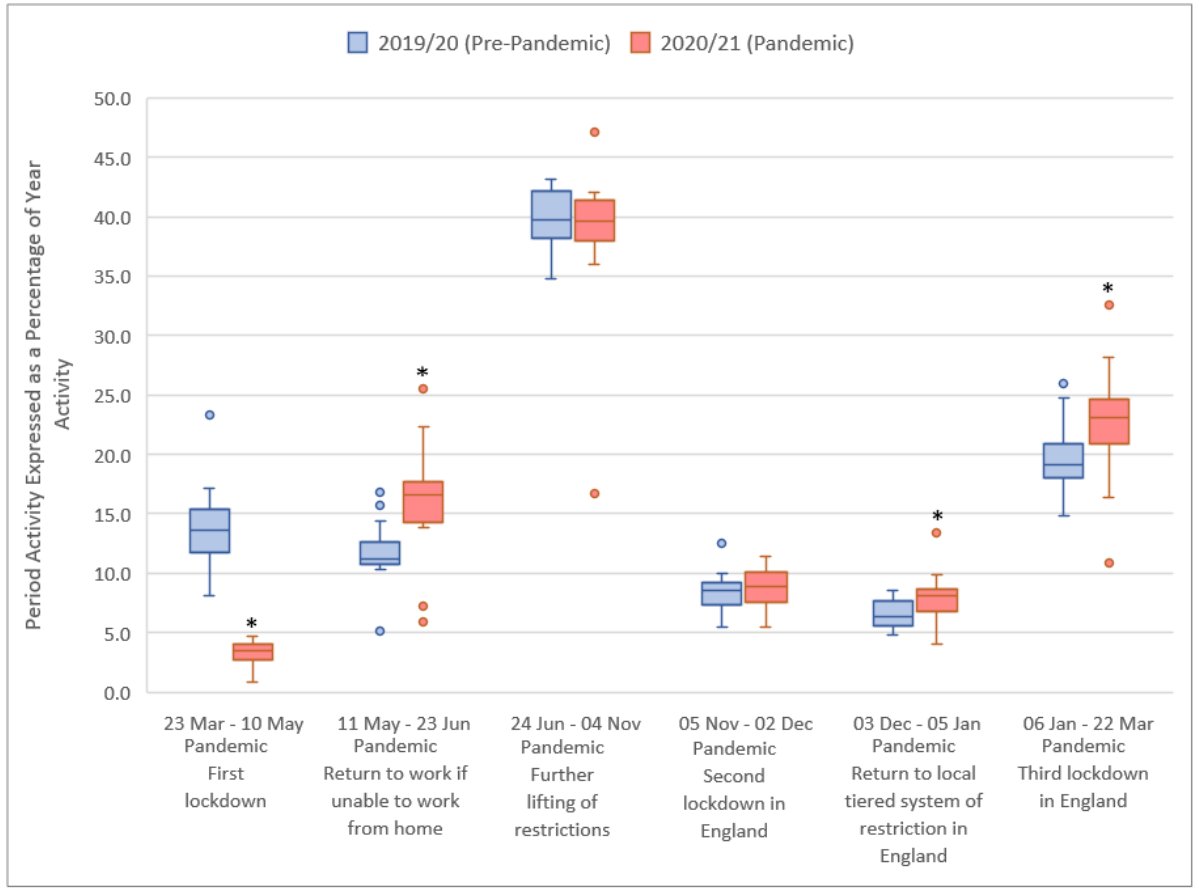
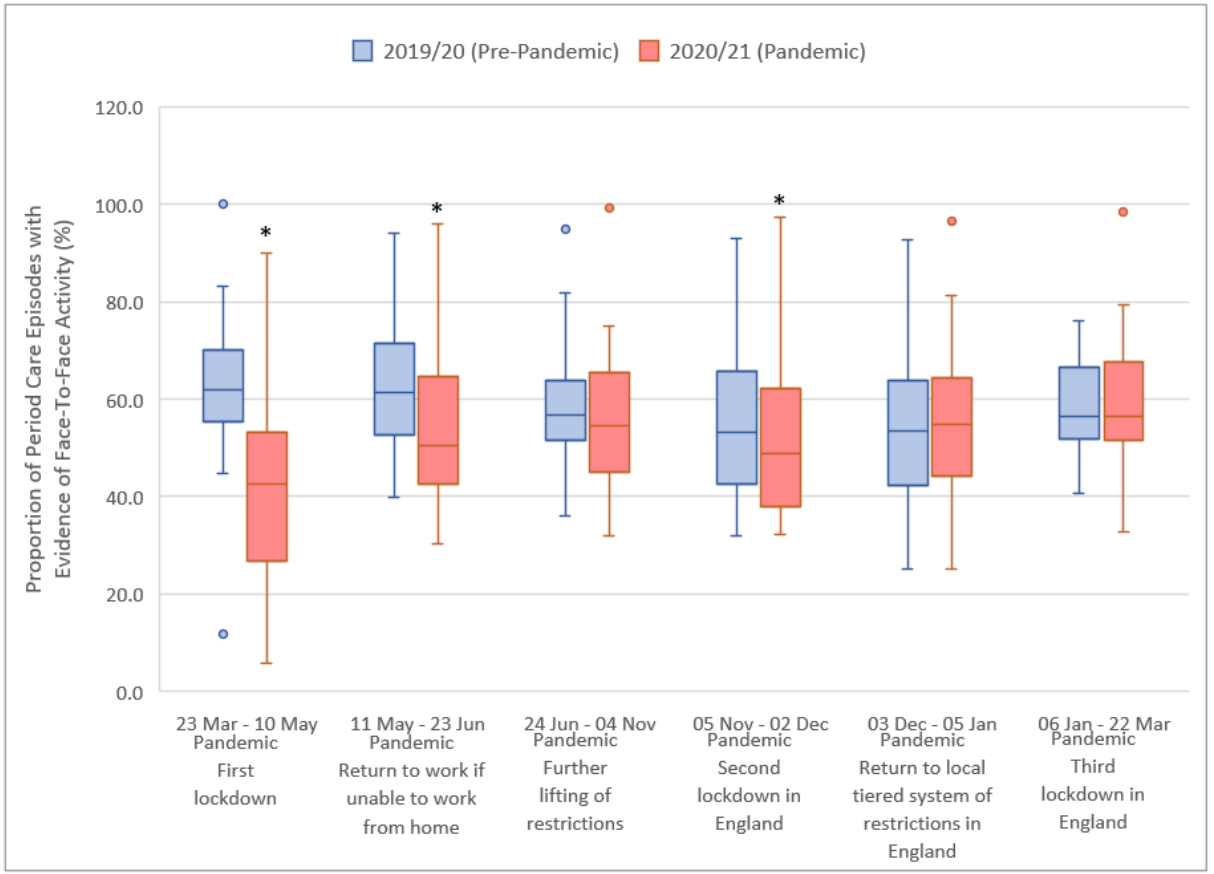
Period Activity





Decreased activity

- 23 Mar to 10 May

Increased activity

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

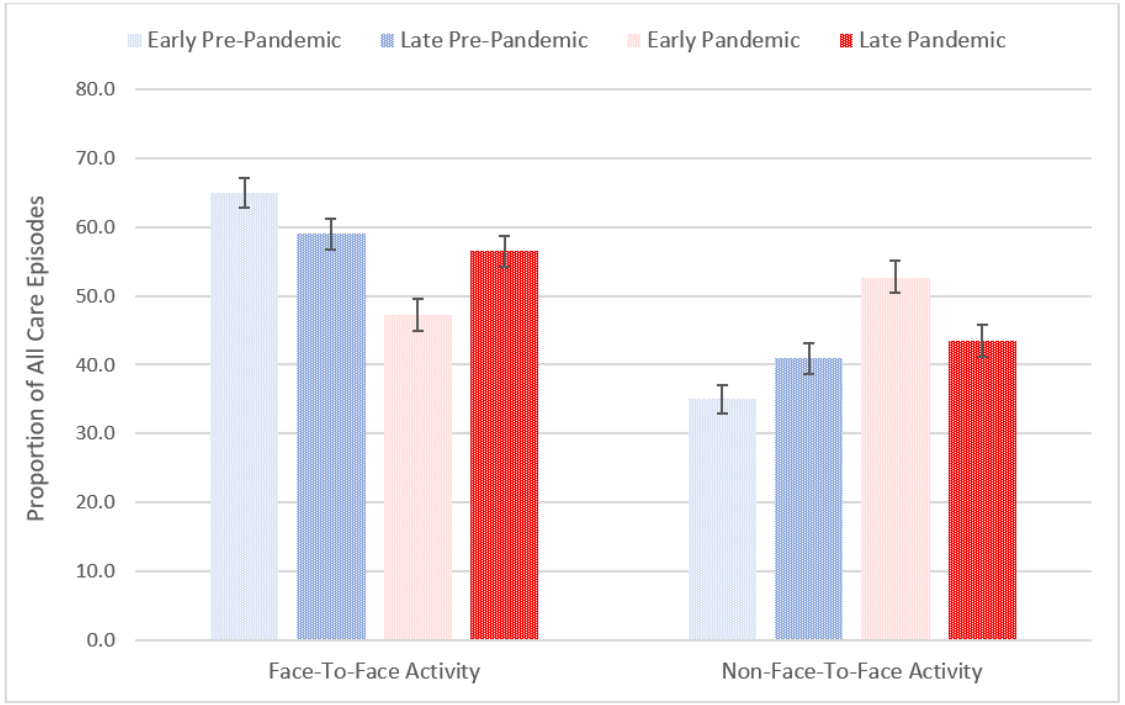
Decreased face-to-face activity

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

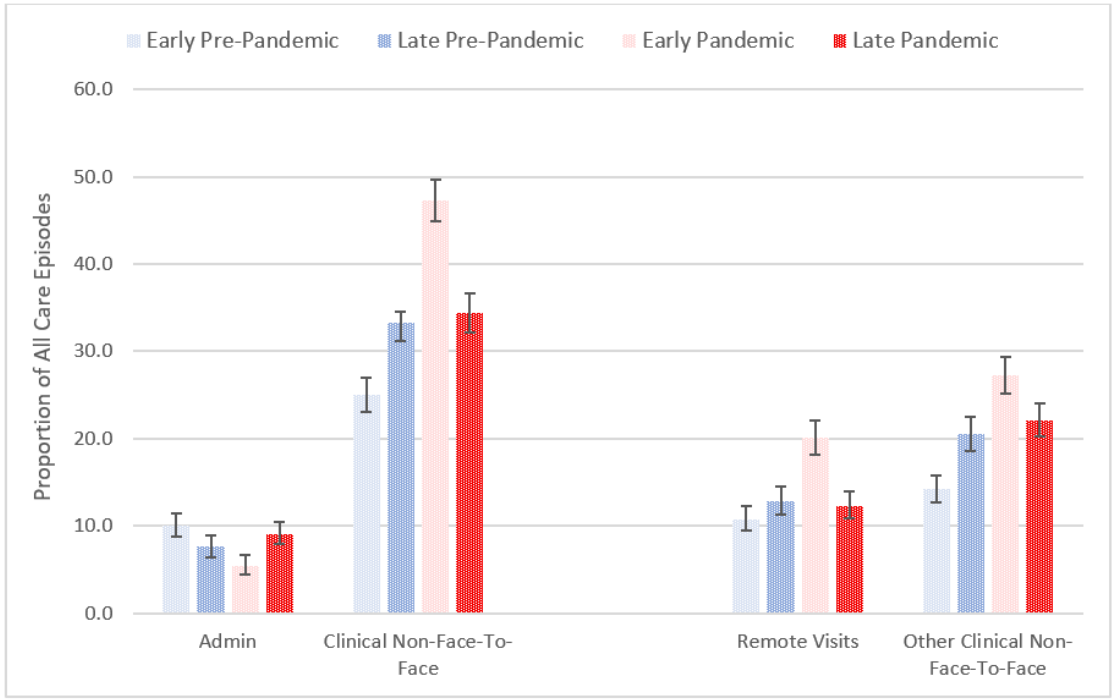
Nature of All Care Episodes

Total number of care episodes

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



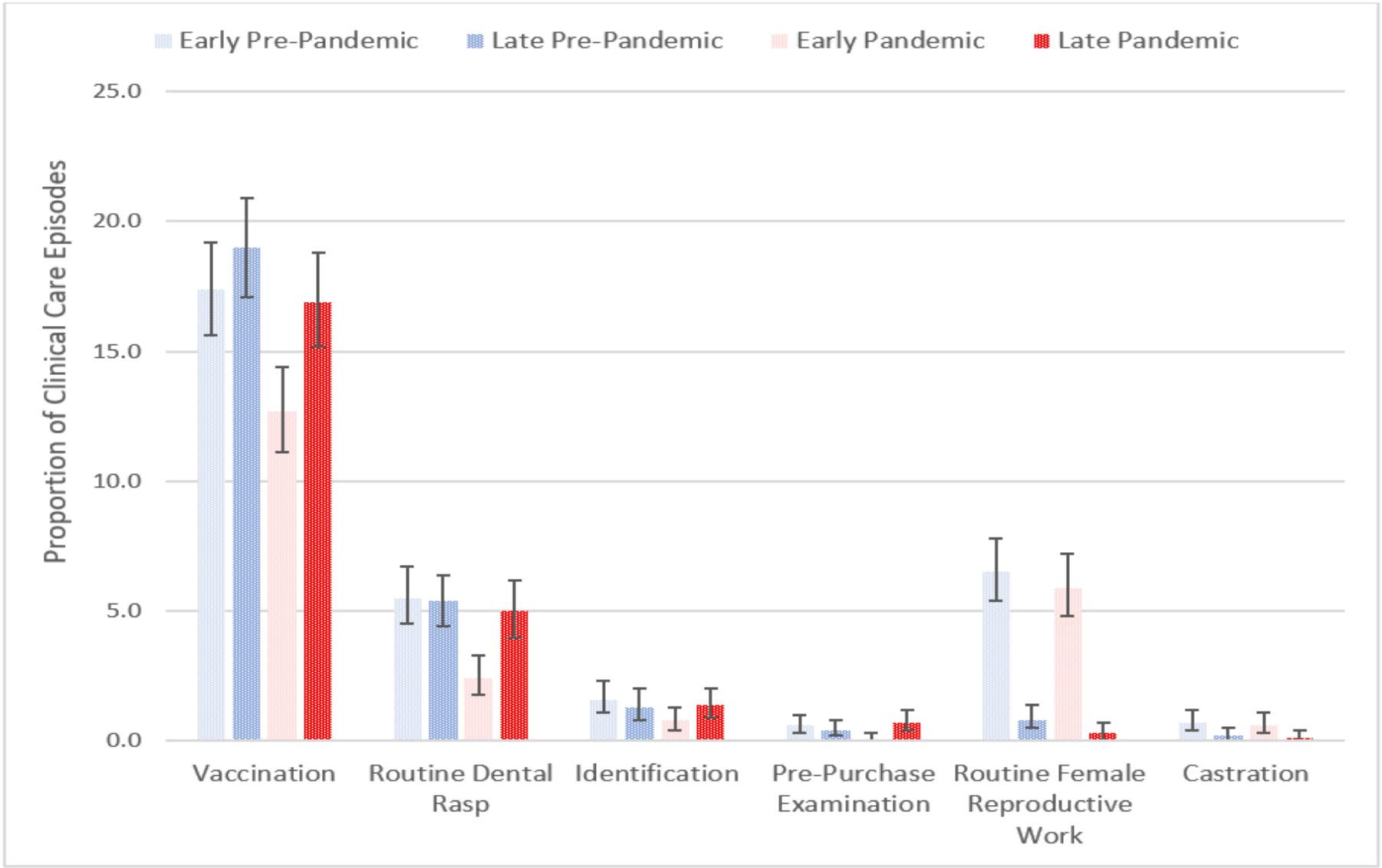
Decreased face-to-face activity in early pandemic period



Decreased admin in early pandemic compared to early pre-pandemic

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

Routine Procedures



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

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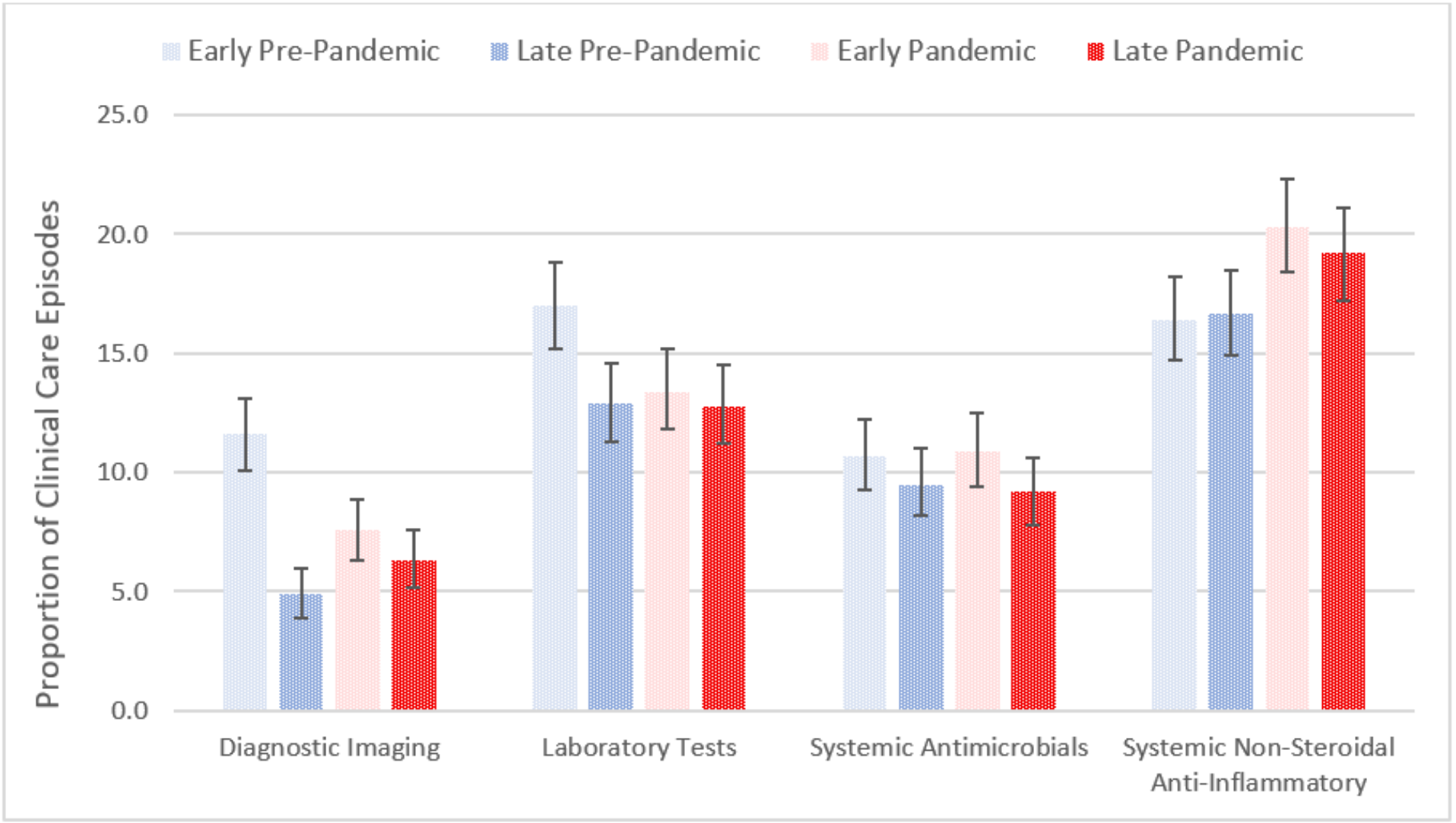
Common Procedures & Prescriptions



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

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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

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RCVS SETTING VETERINARY STANDARDS

Legal Advice

Legal advice was obtained from Fenella Morris QC – which she summarised on 30 March 2022 as follows:

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.