Council Meeting

Thursday, 8 October 2020 at 10:00 am to be held remotely by Microsoft Teams

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. **Minutes**		
a. Meeting held 3 September 2020:		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**1, 3, 4, 5**
b. Meeting held 21 September 2020 – classified appendix	**Confidential**	**1, 2, 3**
5. **Matters arising**		
a. Obituaries	Oral report Unclassified	n/a
b. Council correspondence	Oral report Unclassified	n/a
c. CEO update	Oral report Unclassified	n/a
6. **Matters for decision by Council and for report (unclassified items)**		
a. Under Care/Out of Hours – update	Oral report Unclassified	n/a
b. Remote prescribing	Unclassified	n/a
c. Covid-19 Taskforce	Unclassified	n/a
d. Council culture	Unclassified	n/a
e. Legislation Working Party – draft consultation document	Unclassified	n/a

7. **Reports of standing committees – to note**		
a. Advancement of the Professions Committee		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**1**
b. Audit and Risk Committee		
i. Meeting held 7 May 2020 - Unclassified minutes	Unclassified	n/a
ii. Meeting held 7 May 2020 - Classified appendix	**Confidential**	**1, 2, 3**
iii. (DRAFT) Meeting held 31 July 2020 - Unclassified minutes	**Confidential**	**1, 2, 3**
iv. (DRAFT) Meeting held 31 July 2020 - Classified appendix	**Confidential**	**1, 2, 3**
c. Education Committee		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**1**
d. Finance and Resources Committee		
i. Meeting held 23 July 2020 - Unclassified minutes	Unclassified	n/a
ii. Meeting held 23 July 2020 - Classified appendix	**Confidential**	**1, 2, 3**
iii. (DRAFT) Meeting held 10 September 2020 - Unclassified minutes	**Confidential**	**1, 3, 4**
iv. (DRAFT) Meeting held 10 September 2020 - Classified appendix	**Confidential**	**1, 3, 4**
e. Standards Committee		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**1, 2, 3**
f. Veterinary Nurses Council		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**1, 2, 3, 4**
g. PIC/DC Liaison Committee		
i. Unclassified minutes	Unclassified	n/a
ii. Classified appendix	**Confidential**	**4**
8. **Reports of statutory committees – to note**		
a. Preliminary Investigation Committee	Unclassified	n/a
b. RVN Preliminary Investigation Committee	Unclassified	n/a
c. Disciplinary Committee and RVN Disciplinary Committee	Unclassified	n/a
9. **Notices of motion**	Oral report Unclassified	n/a

10. **Questions**	Oral report Unclassified	n/a
11. **Any other College business (unclassified)**	Oral report Unclassified	n/a
12. **Risk Register, equality and diversity (unclassified)**	Oral report Unclassified	n/a
13. **Date of next meeting** Thursday, 5 November 2020 at 10:00 am (reconvening in the afternoon)	Oral report Unclassified	n/a
14. **Matters for decision by Council and for report (confidential items)**		
a. Certification review	**Confidential**	**1, 2, 3, 4**
b. Estates Strategy - update	Oral report **Confidential**	**1, 2, 3**
c. 2021 Budget	**Confidential**	**1, 2, 3**
15. **Any other College business (confidential)**	Oral report **Confidential**	**# TBC**
16. **Risk Register, equality and diversity (confidential)**	Oral report **Confidential**	**# TBC**
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

Summary

Meeting	Council
Date	3 September 2020
Title	September 2020 Council minutes
Summary	Minutes of the meeting held on Thursday, 3 September 2020
Decisions required	To approve the minutes and classified appendix
Attachments	Classified appendix
Author	Dawn Wiggins Secretary, Council d.wiggins@rcvs.org.uk / 020 7202 0737

Classifications

Document	**Classification[1]**	**Rationales[2]**
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**1, 3, 4, 5**

[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

Council Meeting

Minutes of the meeting held remotely via Microsoft Teams on Thursday, 3 September 2020

Members:

Dr M O Greene (President in the Chair)
Dr C J Allen
Mrs B S Andrews-Jones
Professor D J Argyle
Miss L Belton
Professor D Bray
Mr J M Castle
Dr D S Chambers
Dr N T Connell
Professor S Dawson
Dr M A Donald
Dr J M Dyer
Ms L Ford
Mr D J Leicester
Mrs C-L McLaughlan
Dr S Paterson
Mr M L Peaty
Mr M E Rendle
Dr K A Richards
Dr C L Scudamore
Dr N C Smith
Dr R S Stephenson
Dr C W Tufnell*
Mr T J Walker
Professor J L N Wood
Ms J S M Worthington

*Absent

In attendance:

Ms E C Ferguson	Registrar
Ms L Lockett	CEO
Ms C McCann	Assistant Registrar / Director of Operations (DoO)

Guests:

Ms C Ashcroft	Visionline (mrcvs.co.uk)
Ms E Butler	Chair, Audit and Risk Committee
Ms A Debanks	Visionline (mrcvs.co.uk)
Dr D Dos Santos	President, British Veterinary Association (BVA)
Mr A Guthrie	Vetsurgeon.org
Mr J Loeb	*Veterinary Record*
Mr J Westgate	*Veterinary Times*

RCVS Knowledge Annual General Meeting

1. RCVS Knowledge Trustees had received their papers in August 2020; the minutes would be recorded separately to the RCVS Council minutes herewith.

2. The President thanked Dr Molyneux on behalf of the College for her work with the RCVS Knowledge Team and for being the Knowledge Board Chair since 2014; for her focus on promoting Evidence-Based Veterinary Medicine (EVBM); assistance in increasing the global membership to over 10,000; and for her involvement in the Quality Improvement (QI) project that influences work within the veterinary professions.

President's introduction and welcome to new members

3. The President extended a warm welcome to guests and outlined the order of the meeting.

4. Drs Richards and Stephenson were welcomed back onto RCVS Council as newly-elected members; Mrs Andrews-Jones and Mr Rendle were welcomed as the new Veterinary Nurses Council (VNC) representatives.

Apologies for absence

5. Apologies for absence were received from:

- Miss C H Middlemiss Chief Veterinary Officer, Observer
- Dr C W Tufnell

Declarations of interest

6. New declarations of interest were received from:

- Mr D J Leicester Now Head of the Vets Now Telemedicine service;
- Dr C L Scudamore Now Advisor to Harper & Keele Veterinary School on pathology matters.

Minutes

Minutes and classified appendix of the meeting held on 4 June 2020

7. Council had the opportunity to comment on the minutes and classified appendix electronically.

8. A vote was taken:

For:	24
Against:	0
Abstentions:	1

9. The minutes and classified appendix were accepted as a true record of the meeting by a majority vote.

Classified appendix of 15 – 16 June 2020

10. Council had the opportunity to comment on the classified appendix electronically.

11. A vote was taken:

For:	24
Against:	0
Abstentions:	1

12. The classified appendix was accepted as a true record of the meeting by a majority vote.

Minutes of the meeting held on 10 July 2020 (immediately post-Annual General Meeting (AGM))

13. Council had the opportunity to comment on the unclassified minutes electronically.

14. A vote was taken:

For:	25
Against:	0
Abstentions:	0

15. The minutes were accepted as a true record of the meeting by a unanimous vote.

Matters arising

Obituaries

16. No written obituaries had been received. Council was encouraged to have a moment of quiet reflection following the meeting for all members who had passed since the last meeting, and for the on-going difficulties resulting from the current pandemic.

Council correspondence

17. The President reported:

RCVS Honours and Awards 2020

18. The Honours and Awards part of RCVS Day originally scheduled for July had been moved to the evening of Thursday 10 September 2020 from 7:00 pm; the events page on the RCVS website had details relating to this event and Council was further reminded that as this was a social event expenses were not claimable. The 2021 round of Honours and Awards will open shortly for nominations.

RCVS Day 2021

19. This will be held on Friday, 9 July 2021 at One Great George Street, Westminster, subject to government guidelines on gatherings.

Contacts and Calendar Booklet 2020 – 2021

20. Hard copies of the booklet had been received from the printers and would be sent to Council and VNC that week. An electronic copy had been sent for information in the meantime.

Reminder for Loss of Earnings / expenses claims

21. Per previous Council agreement, Council members were reminded it was their own responsibility to submit claims to the Finance Team with the six-month deadline, after which time the claim was deemed to have lapsed and should not be submitted. In addition, during the prolonged period of remote working and meetings by video link, individual meeting secretaries would indicate the duration of the meeting following guidance circulated by email referring to amounts claimable – if any member needed to see the breakdown again, please contact the Council Secretary.

CEO update

22. The CEO introduced the paper and took the opportunity to thank the Covid-19 Taskforce for its hard work and agile decision making over recent months. The table within the paper related to each area of the Strategic Plan that, whilst work had initially been delayed on due to the pandemic, was now starting to recommence.

23. Furthermore, Council was informed that in the recent meeting with the European Association for Quality Assurance in Higher Education (ENQA) they had been very complimentary and impressed by the speed with which the College had acted on their suggestions. The Education and Veterinary Nursing Departments were thanked for their efforts.

24. Following recent government reports regarding a return to normal working practice, she confirmed that regular surveys had been undertaken with College staff and currently the majority were keen to continue working from home. Senior Team had discussed matters and decided that College offices within Belgravia House would be accessible for c. 20 – 25 staff on a pre-bookable basis from week commencing 21 September 2020. Stress was on 'accessible', rather than fully open; this meant that current practice regarding remote meetings would continue, and the College retained its ability to close the premises again at limited notice. This status would be reviewed again in November and Council kept informed. Regarding the statutory disciplinary function, it was reported that some single-day hearings had been successfully held virtually, and that some full hearings were in the process of being rescheduled for later this year – but instead of being held at Belgravia House, in most cases venues would be hired that were close to the respondent so that those involved in the case would not be required to travel into London, and that were large enough to properly social distance.

25. Comments and questions included but were not limited to:

- what was the current proposed timescale for the Covid-19 Taskforce continuing, particularly as the government and schools were returning to normal practice, and the College was constituted within a particular structure?

    - not all decisions in normal practice were made by Council, however, it was for Council to decide the duration of the Taskforce; but that there was still a need for an ability for speed in decision-making i.e. not wait for the usual route via committees up to Council;

- the website needed updating around temporary remote prescribing guidance as it still stated it would be reviewed on 18 August 2020; and agree that delegation should revert from the Taskforce back to the routine process;

    - there was a news piece that was valid to September, but this would be checked;

- during semester one universities still had to have the ability to make rapid decisions around extra-mural studies (EMS) and teaching; any change to the Taskforce would be strongly resisted;

- things had changed since the start of the pandemic, whilst not the same there was still uncertainty, particularly around the remote prescribing – Standards Committee continued to work on this matter but delegation should be made clear and joined together with the Taskforce;

    - the Taskforce only looked at *temporary* decisions made in line with Covid-19 as it progressed;

- what was the CEO's concern in not having a Taskforce; what did it need to focus on; and what could now go back to committees?

    - having a Taskforce focussed on Covid issues in a broad thematic way, to ensure continuity of decisions across the different parts of the organisation, had been helpful, as had speed of decision-making. The Taskforce was time-limited so delegation could go back to committees but there was still a need for a process to make fast decisions, or a mechanism to bring back the Taskforce if need arose;

- Taskforce meetings had reduced to fortnightly and decisions could be made by email if necessary;

- members of the profession had asked for more explanatory guidance around remote prescribing, in particular why it had been extended each time;

    - there were regular press releases around issues faced and how the decisions had been made;

- some decisions would have a long-term impact e.g. EMS and the practices supporting students, so some delegation could go back to normal but could there also be a hybrid way?

- a particular concern was regarding virtual abattoir training when there was still nine months available for students to complete this unit of their training and there were few UK-graduates going into the public health field;

    - there were no exemptions from completing this unit of training but it had moved into a virtual format to ensure students did not miss out; the Food Standards Agency (FSA) and Food Standards Scotland (FSS) had been consulted on the approach and were content

for the work to be done virtually as no abattoirs were currently allowing student access; the emphasis was therefore the opposite to allow training to continue when otherwise it would not;

- agree that the Taskforce could be stood down but there should be parameters in place to come back into action if needed;

- it was suggested that a paper come back to October Council meeting with an outline of current issues and proposed ways forwards; and was argued that Council members did think about issues carefully prior to meetings and should be able to make a collective decision [today] to disband the Taskforce with the view that it could be re-established in the instance of another lock-down.

26. A vote was taken on whether the decision to disband or keep the Taskforce should be taken at this meeting:

For:	10
Against:	15
Abstentions:	0

27. This was not carried.

28. The CEO agreed to bring a paper back to the October 2020 Council meeting for discussion and decision. The update was noted.

Matters for decision by Council and for report (unclassified items)

Proposal for new Registration Committee

29. The Registrar introduced the paper and stated that the proposal had arisen from the Council decision in 2019 to take forward paraprofessionals in a vet-led team. Discussions had taken place with a number of groups and work could progress with groups where no legislative changes were required, for example, Vet Techs were keen to progress to becoming associates of the College in the same manner as veterinary nurses. The first step would be to set up a working party to report back through normal channels. The issue was that there did not appear an obvious committee via which to channel this work apart from possibly the Register and Registration Sub-committee (RRSC).

30. Additionally, it was noted that registration is a core function historically dealt with as an administration function, but with no over-arching committee with responsibility within the College. In a post-EU exit and post-Covid world registration might become a different process and would therefore require an enhanced governance structure. The current committee calendar was very busy so if Council wished to go ahead with a new committee, it could initially meet on an ad hoc basis; draft Terms of Reference were attached at Annex A to the paper.

31. It was queried if the current work of the RRSC (i.e. around temporary registration) would be absorbed into the new committee, and it was confirmed that was the intention.

32. Council was asked to approve (Part A): the formation of a Registration Committee as per the draft Terms of Reference at Annex A to the paper:

For:	25
Against:	0
Abstain:	0

33. Part A, the formation of a Registration Committee was agreed by a unanimous vote. Therefore, Council was not required to vote on Part B (to approve an extension of the role of the current RRSC as currently constituted, to include the immediate work required around the creation of new categories of Associate members of the RCVS).

Notices of Motion

34. There were no notices of motion received.

Questions

35. There were no questions received.

Any other College business (unclassified)

36. There was no other College business.

Risk Register, equality and diversity (unclassified)

37. There were no items identified in the open session of the meeting.

Date of next meeting

38. The next scheduled meeting is Thursday, 8 October 2020 commencing at 10:00 am (reconvening in the afternoon).

Matters for decision by Council and for report (confidential items)

Estates Strategy – update

39. This information is available in the classified appendix at paragraphs 1 – 9.

Confidential matters

40. This information is available in the classified appendix at paragraphs 10 – 21.

RCVS Council election 2020

41. The President reported that there had been no challenges received following the 2020 RCVS Council election. Paperwork for the 2021 election was being finalised and would be circulated to retiring members and loaded to the website once complete.

Any other College business (confidential items)

42. There was no other College business in the confidential session.

Risk Register, equality and diversity (confidential items)

43. This information is available in the classified appendix at paragraph 22.

Dr Allen, Mr Peaty, and Professor Wood left the meeting

Council Workshop: Unconscious Bias

44. Council undertook an interactive training session on various aspects of Unconscious Bias that was provided by Jasmine Gartner Consulting.

45. The meeting was brought to a close.

Dawn Wiggins
Secretary, Council
020 7202 0737
d.wiggins@rcvs.org.uk

Summary

Meeting	Council
Date	8 October 2020
Title	Covid-19 temporary remote prescribing guidance
Summary	In response to the Covid-19 pandemic, Council agreed in March 2020 to temporarily allow veterinary surgeons to prescribe prescription-only veterinary medicines (POM-Vs) remotely, without first having physically examined the animal. The temporary guidance has been reviewed and extended on several occasions (with a current review date of on or before 31 October) and it is for Council to decide whether it wishes to extend the temporary guidance beyond this date and if so, on what basis.
Decisions required	Council is asked to decide whether or not it wishes to extend the temporary guidance on remote prescribing, and if so, the basis on which it wishes to do so.
Attachments	Annex A – IES Survey Annex B – IES presentation Annex C (i - iii) – PDSA data Annex D – VCMS Q 3 report Annex E (i – ii) – Joii data Annex F – Letter from BVA Annex G (i – ii) – Most recent temporary prescribing guidance (FAQ 2 flow chart and FAQ 4).
Author	Eleanor Ferguson Solicitor / Registrar / Director of Legal Services e.ferguson@rcvs.org.uk Lisa Price Head of Standards l.price@rcvs.org.uk

Classifications

Document	Classification[1]	Rationales[2]
Paper	Unclassified	n/a

Annex A	Unclassified	n/a
Annex B	Unclassified	n/a
Annex C	Unclassified	n/a
Annex D	Unclassified	n/a
Annex E	Unclassified	n/a
Annex F	Unclassified	n/a
Annex G	Unclassified	n/a

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

Background

1. To enable the profession to continue to provide veterinary care during the Covid-19 pandemic, Council agreed in March 2020 to temporarily allow veterinary surgeons to prescribe POM-Vs remotely, without first having physically examined the animal, subject to a number of conditions and safeguards being in place. These included that the practitioner must be satisfied that:

    a. they have enough information to do so safely without physically examining the animal;
    b. there is no suitable alternative, categorised as a POM-VPS, NFA-VPS, or AVM-GS; and
    c. the risk to the animal and/or public health is outweighed by the benefit.

2. The College commissioned the Institute of Employment Studies (IES) to prepare an online questionnaire to capture the experiences of the profession between 1-14 June 2020. An initial 'red flag' report was made available on 16 July and an updated report on 30 July to ascertain if there were any areas of concern in the operation of the temporary guidance that might signal that changes needed to be made to protect animal health and welfare. The main points raised were:

    a. Given the recent local lockdowns, Covid-19 is far from over, and it seemed likely that remote prescribing would be needed for some time to ensure practices can continue to offer some sort of service.
    b. Practitioners felt that remote consulting was a positive addition to their toolkit. It appeared that no serious safety concerns had been identified.

IES report

3. IES has provided a full report (**Annex A**) and accompanying presentation (**Annex B**). The final report does not highlight any new issues. In summary:

    a. Most of the cases seen remotely by the profession related to small animal practice with farm and equine practices appearing to have generally operated as close to 'business as usual' in seeing the majority of animals in person.
    b. The majority of professionals who consulted remotely saw those animals already known to the practitioner who had been seen in the previous 12 months for advice/triage/prescriptions.
    c. In respect of remote prescribing, there appears to have been caution exercised when prescribing for new conditions and a high proportion of new animals were seen in person following an initial remote consultation.

4. It is evident that many of the survey participants were comfortable with using their professional judgment to determine when remote consulting was more or less appropriate than face to face consultations (which may have then resulted in a remote prescription). The results provide some reassurance that the profession appear to have opted to see animals face to face when they feel they need to, whether in the first instance or via a repeat consultation.

Remote consultations and prescription experiences from stakeholders

BEVA and BCVA

5. BEVA confirmed that their Council has recently received some anecdotal practice data and whilst this has not been provided to the RCVS, BEVA has confirmed that the RCVS temporary guidance was welcomed. However, BEVA did not find any evidence that the temporary guidance

significantly increased the number of prescriptions issued in equine practice, barring a small upward bulge at the beginning of lockdown.

6. BCVA approached their professional and board members for views on the RCVS temporary guidance, and whilst they did not receive much feedback, BCVA considers that this reflects that its members are familiar of the concept of remote prescribing under an ongoing relationship with clients. In summary, the main comments provided by BCVA were as follows:

   a. Remote prescribing should only be permitted where those animals or groups of animals are under the care of the veterinary practice, and where that care is as a result of an ongoing relationship.
   b. It is important to ensure that remote prescribing is not associated with undesirable outcomes such as an increase in the use of antimicrobials, or inappropriate or conflicting advice.
   c. Whilst veterinary opinion is key in ensuring the frequency of visits is appropriate to ensure the principle of under the vet's care is adhered to, some more guidance on this from the RCVS would be beneficial.

PDSA

7. PDSA have provided the RCVS with feedback received from the profession on remote prescribing. PDSA has confirmed that the data is management information and designed to provide insight and steer; it has not been scientifically or statistically validated. Council is directed to their comments in full at **Annex C**.

8. PDSA concluded that "after six months overall experience of remote consulting and prescribing there remains no direct evidence that the addition of these new service elements have had a negative impact upon the safety of our patients; and have indeed provided great benefit to the charity, our teams, our clients and our patients."

VCMS

9. VCMS has provided the RCVS with their Q3 report (**Annex D**) which confirms that, unsurprisingly, "In June and July 2020, the VCMS then received a marked increase in referrals, (+51% compared to June 2019, and +92% compared to July 2019)."

10. VMCS report that an analysis of the complaints received in Q3 suggests that Covid19 may have contributed to and exacerbated complaints "in the form of earlier escalation, less opportunity to resolve matters contemporaneously and communication challenges due to Covid-Secure restrictions".

Vet-AI (Joii)

11. Survey data was provided to the RCVS by Vet-AI in July in relation to its remote services platform Joii (**Annex E**).

12. Vet-AI states that "As well as keeping safe social distancing, the use of telemedicine services in the UK shows the industry is working hard to create the opportunity to reduce risks for everyone by ensuring cases being handled via phone-consultation, either verbally or via video and that only the right cases are coming in to the practice for treatment. With risk still in our communities and

staff to needing to best use [of] their time and limited resources, it seems obvious that some new ways of working are going to stay and be needed for a while to come yet."

BVA

13. The BVA has written to the College's President (**Annex F**) requesting further information on the rationale for the extension of the temporary guidance on remote prescribing. BVA state that "Even under local lockdowns veterinary practices have not returned to providing emergency services only and we cannot currently see any reason why a new client would be unable to access in person veterinary care in the first instance."

Temporary guidance on remote prescribing

14. The temporary guidance was reviewed by the Covid Taskforce on 17 September. At that time, according to the RCVS' latest economic survey, 50% of practices were still carrying out remote consulting. It was discussed, however, that many practices were now able to go back to 'normal' and that, where this was possible, it should be encouraged.

15. Against that background, the decision was made to continue to facilitate access to remote prescribing without a physical examination. However, as can be seen from the detail in **Annex G**, there was a fundamental change to the guidance: the default position was altered to revert to the established requirements of "under care", as set out in Chapter 4 of the Supporting Guidance, but *where this was not possible*, still allowed for remote prescribing of POM-V's (albeit with the same caveats and safeguards as before).

16. The reason for maintaining the possibility of remote prescribing where the animal is not already under care of the practitioner by means of a physical examination was that it was recognised that the current situation is unpredictable and while the ability for the public to visit practices in person has improved over the last few months, it was considered that situations might still arise where that would not be possible and where access to remote prescribing would be necessary such as local of local lockdowns, ongoing quarantine arrangements, and the fact that some members of both the veterinary team and the public continue to shield.

17. Since 17 September, the government in England and Wales has introduced new requirements and at the time of writing, new local lockdowns with additional restrictions have been put in place in various locations throughout the UK. It has been made clear that restrictions of varying severity should be anticipated over the next six months. There is therefore the very real possibility of returning to more severe "lockdown" measures during the winter period – whether nationally or locally – and as such, it is unlikely that there will be a return to 'business as usual' overall for some time.

Decision required

18. Council is asked to decide whether or not it wishes to extend the temporary guidance on remote prescribing beyond 31 October, and if so, the basis on which it wishes to do so bearing in mind the commitment previously made to ensure that practices have sufficient notice of changes to allow any adaptions to be made.

ies Report

Institute for Employment Studies

RCVS Covid-19 Survey 2020

Survey report

Dilys Robinson and Julie Vanderleyden

September 2020

Full report

Institute for Employment Studies

IES is an independent, apolitical, international centre of research and consultancy in public employment policy and HR management. It works closely with employers in all sectors, government departments, agencies, professional bodies and associations. IES is a focus of knowledge and practical experience in employment and training policy, the operation of labour markets, and HR planning and development. IES is a not-for-profit organisation.

Acknowledgements

The authors are indebted to the veterinary surgeons and veterinary nurses who responded to the survey and shared their experiences and views of working during the Covid-19 pandemic.

Many thanks to Sara Butcher at IES for setting up and administering the online survey and for formatting and tidying the report.

Institute for Employment Studies
City Gate
185 Dyke Road
Brighton BN3 1TL
UK

Telephone: +44 (0)1273 763400
Email: askIES@employment-studies.co.uk
Website: www.employment-studies.co.uk

IES project code: 00194-5933

Contents

Executive summary

The survey

The Royal College of Veterinary Surgeons (RCVS) commissioned the Institute for Employment Studies (IES) to run a fast-turnaround online survey of UK-practising veterinary surgeons (VSs) and veterinary nurses (VNs) during the Covid-19 pandemic. The aims were firstly to see if there were any immediate safety, quality or efficiency issues to inform decisions about a temporary exemption to RCVS guidance; and secondly to capture data on the experience of VSs and VNs carrying out remote consulting, including remote prescribing, to inform RCVS's wider review. The two-week period from 1 to 14 June 2020 was chosen as the time period on which respondents were asked to focus.

The survey was launched on 26 June and closed on 7 July; in total 3,841 responses were received (2,672 from VSs and 1,169 from VNs), with the response reducing to 3,673 when unusable responses were discarded. The majority of respondents (87%) had worked in clinical practice during the two-week period.

Respondent profile

VS respondents

- Almost two-thirds (65.2%) are female.
- Ages range from 23 to 77, with a mean average of 42.2 (40 for women, 46.4 for men).
- 34.6% have dependent children living with them, and 3.9% provide care to an adult dependant.
- 2.8% have a physical disability or medical condition, and 2.4% a mental health condition, that limits the work they can do.
- Almost all (98.6%) usually work in clinical practice. Of these, their main personal area of practice is: small animal 85.5%, mixed 6.3%, equine 4.6%, farm 2.4% and other 1.1%.

The breakdown of the type of practice in which VS respondents normally work is shown in Table 1.

Table 1 Type of practice in which VS respondents work

	N	%
Small-animal-only practice (including small animal practices that treat exotics)	1,696	77.1
Equine-only practice	89	4.0
Farm-animal-only practice	34	1.5
Mixed practice	240	10.9
Referral practice	95	4.3
Telemedicine provider	21	1.0
Other	25	1.1
Total	2,200	100

Source: RCVS Covid-19 Survey, 2020

- The majority (81.7%) have practice premises based in England: 9.8% are based in Scotland, 5.6% in Wales, 1.9% in Northern Ireland, and 1.0% outside the UK. Of those based in England, almost half (47%) are based in the three southern regions (South East, South West and London).
- 35.1% work in a small practice of fewer than four full time equivalent (FTE) VSs, 47.1% in a medium practice (4 to 10 FTE VSs), and 17.9 per cent in a large practice (more than 10 FTE VSs).

Table 2 shows that the majority of respondents work in either an independently-owned or a corporately-owned practice.

Table 2 Practice ownership structure: VSs

	N	%
An independent, stand-alone practice (e.g. a partnership or sole trader)	823	38.0
An independent, stand-alone practice that is part of a larger group (with some shared centralised support functions)	126	5.8
Total independent	**949**	**43.8**
Part of a corporate group	895	41.3
Part of a joint venture with a corporate group	141	6.5
Total corporate	**1,036**	**47.8**
A charity	99	4.6
Part of a veterinary school	33	1.5
An out-of-hours-only provider	17	0.8
Other type of ownership structure	32	1.5
Total other	**181**	**8.4**

Source: RCVS Covid-19 Survey, 2020

- 49.6% of VS respondents say their practice covers its own out-of-hours work (with or without locum help) or co-operates locally with other practices, while 45.7% say their practice uses a dedicated out-of-hours provider. When broken down by practice type, over half (57.8%) in small-animal-only practices say their out-of-hours work is covered by a dedicated out-of-hours provider; by contrast, in all other practice types, in-house coverage is the norm.

VN respondents

- Almost all (97.3%) are female.
- Ages range from 20 to 69, with a mean average of 36.9.
- 29.4% have dependent children living with them, and 5.2% provide care to an adult dependant.
- 5.4% have a physical disability or medical condition, and 2.0% a mental health condition, that limits the work they can do.
- Almost all (99%) usually work in clinical practice. Of these, the main practice area of the large majority is small animal (93.8%), with 4.7% saying mixed and the rest equine, farm or other.
- The breakdown of the type of practice in which VN respondents normally work is: small-animal-only practice 84.2%, mixed practice 8.6%, referral practice 4.3%, with the rest in equine, farm, telemedicine or other type of practice.
- The large majority (87.7%) work in practice premises based in England; 6.8% are based in Scotland, 4.1% in Wales, 1.1% in Northern Ireland, and 0.7% outside the UK. Of those based in England, half (49.4%) are based in the three southern regions (South East, South West and London).
- 38.4% work in a small practice of fewer than four full time equivalent (FTE) VSs, 44.4% in a medium practice (4 to 10 FTE VSs), and 17.1% in a large practice (more than 10 FTE VSs).
- 36.8% work in an independently-owned practice, while 54% (notably higher than the VS percentage) work in a corporately-owned practice; the remaining 9.2% work in a practice with a different type of ownership structure, such as a charity, veterinary school or out-of-hours provider.
- 44.1% of VN respondents say their practice covers its own out-of-hours work (with or without locum help) or co-operates locally with other practices, while 51.6% say their practice uses a dedicated out-of-hours provider.

Caseload 1 to 14 June 2020

Table 3 gives the ‘in person’ services provided by VS and VN respondents during 1 to 14 June 2020. It is clear that relatively few respondents provided ‘business as usual’, with ‘reduced caseload’ or ‘near normal’ applying to the majority of VSs and VNs.

Table 3 'In-person' services personally provided during 1 to 14 June

	VS N	VS %	VN N	VN %
Business as usual	169	7.8	43	5.0
Near normal	634	29.4	239	27.8
Reduced caseload, including some routine work	1055	48.8	433	50.4
Emergencies only	237	11.0	129	15.0
None	38	1.8	8	0.9
Other	27	1.3	7	0.8

Source: RCVS Covid-19 Survey, 2020

Further analysis shows that equine-only and farm-animal-only practices are notably more likely to have conducted 'business as usual' or a 'near normal' caseload than small-animal-only practices, while small-animal-only and mixed practices are more likely to have experienced a 'reduced caseload'.

When asked if they had personally used remote consulting during 1 to 14 June, the majority (71.7 % of VSs and 62.7% of VNs) said yes. A further 19.8% of VSs and 14.8% of VNs used it before 1 June but not during the fortnight, with the remaining 8.5% of VSs and notably higher 22.4% of VNs saying they had not used it, neither before nor during the two-week period.

- The main reasons VSs had not used remote consulting at all were that they continued to see clients face-to-face, were concerned about accuracy of diagnosis, and were concerned about owners' ability to describe animals' problems. For VNs, practice policy was also an important consideration for not using remote consulting.
- The main reasons VSs stopped using remote consulting before 1 June were lockdown easing, concerns about accuracy of diagnosis, concerns about owners' ability to describe animals' problems, and a preference for face-to-face consultations. For VNs, the main reasons were lockdown easing and practice policy.

When asked about the extent to which Government guidance and social/physical distancing impacted their practice's (rather than their personal) use of remote consulting during the two-week period, 94.4% of VSs, and a lower 87% of VNs, said that their practice used it more than pre-Covid-19.

Experiences of consulting

Animals seen 1 to 14 June

In person

Although the main focus of the survey was to capture experiences of remote consulting and prescribing, the majority of VSs and VNs who worked during 1 to 14 June 2020 did

significant amounts of face-to-face work with animals. Table 4 indicates that just 5.1 per cent of VSs and 10.8 per cent of VNs only saw animals remotely during this period.

Table 4 Types of animals seen in person between 1 to 14 June 2020

	VS N	VS %	VN N	VN %
Small animal	1293	89.5	368	88.7
Equine	132	9.1	7	1.7
Farm animal	127	8.8	5	1.2
Not applicable, I did not attend to any animal in person	74	5.1	45	10.8

Source: RCVS Covid-19 Survey, 2020

The types of small animal cases seen by the greatest number of VS and VN respondents in person during the two-week period (all seen by at least 850 VSs and/or at least 200 VNs) are: diarrhoea and/or vomiting (986 VSs and 241 VNs), ear or eye conditions (986 VSs and 230 VNs), lethargy and/or inappetence (943 VSs and 221 VNs), musculoskeletal disease (856 VSs and 115 VNs), respiratory conditions (853 VSs and 188 VNs), pain (847 VSs and 200 VNs), collapse (834 VSs and 200 VNs), dental conditions (797 VSs and 203 VNs), and minor wounds (778 VSs and 210 VNs). Respondents also gave the number of times they saw each type of case during 1 to 14 June, from which the mean averages have been calculated. The four conditions with the highest mean averages for both VSs and VNs are diarrhoea and/or vomiting, ear or eye conditions, lethargy and/or

The types of equine case seen most frequently by VSs in person during the two-week period are lameness (seen by 83 VSs) and colic (seen by 73 VSs). However, reproductive issues and dental cases, while seen by a lower number of VSs, have high mean averages, indicating that these VSs saw a large number of cases.

The types of farm animal case seen most frequently by VS respondents in person during the two-week period, looking at number of respondents, are individual sick animal (89 VSs) and obstetrical problem (76 VSs); however, fertility and reproduction and assisting/guiding statutory disease control testing, while seen by a lower number of VSs, have high mean averages, indicating that these VSs saw a large number of cases.

Very few VNs saw equine or farm animal cases in person during the two-week period.

Remotely

Table 5 shows the type of cases seen remotely by respondents during 1 to 14 June. A comparison with cases seen in person indicates:

- Although the number of VSs who saw small animals remotely is fairly close to the number who saw cases in person, the number who saw equine and farm animal cases remotely is notably lower than the number who saw cases in person.
- Notably fewer VNs saw animals remotely than face-to-face, and almost all those who saw animals remotely saw only small animals.

Table 5 Types of animals seen remotely by VSs and VNs between 1 to 14 June 2020

	VS N	VS %	VN N	VN %
Small animal	1231	94.3	284	99.3
Equine	88	6.7	6	2.1
Farm animal	74	5.7	4	1.4

Source: RCVS Covid-19 Survey, 2020

Table 6 shows the types of small animal cases seen by the greatest number of VS and VN respondents remotely during the two-week period: these were all seen by at least 500 VSs. Respondents also gave the number of times they saw each type of case during 1 to 14 June, from which the mean averages have been calculated. While VSs and VNs both saw a considerable number of cases of diarrhoea and/or vomiting remotely, it appears VNs were particularly active in seeing cases of fleas and/or worms remotely.

Table 6 Type of small animal cases seen remotely 1 to 14 June 2020 by the greatest number of VSs and VNs

	VS N	VS mean	VN N	VN mean
Diarrhoea and/or vomiting	809	7.18	116	8.24
Skin conditions	799	7.01	81	7.40
Ear or eye conditions	728	6.16	91	6.85
Lumps and bumps	716	5.34	87	6.64
Musculoskeletal disease	711	6.09	48	7.13
Minor wounds	611	3.94	102	4.38
Fleas and/or worms	551	9.80	119	13.92
Pain	516	5.79	78	7.49
Behaviour problems	508	2.73	86	3.49

Source: RCVS Covid-19 Survey, 2020

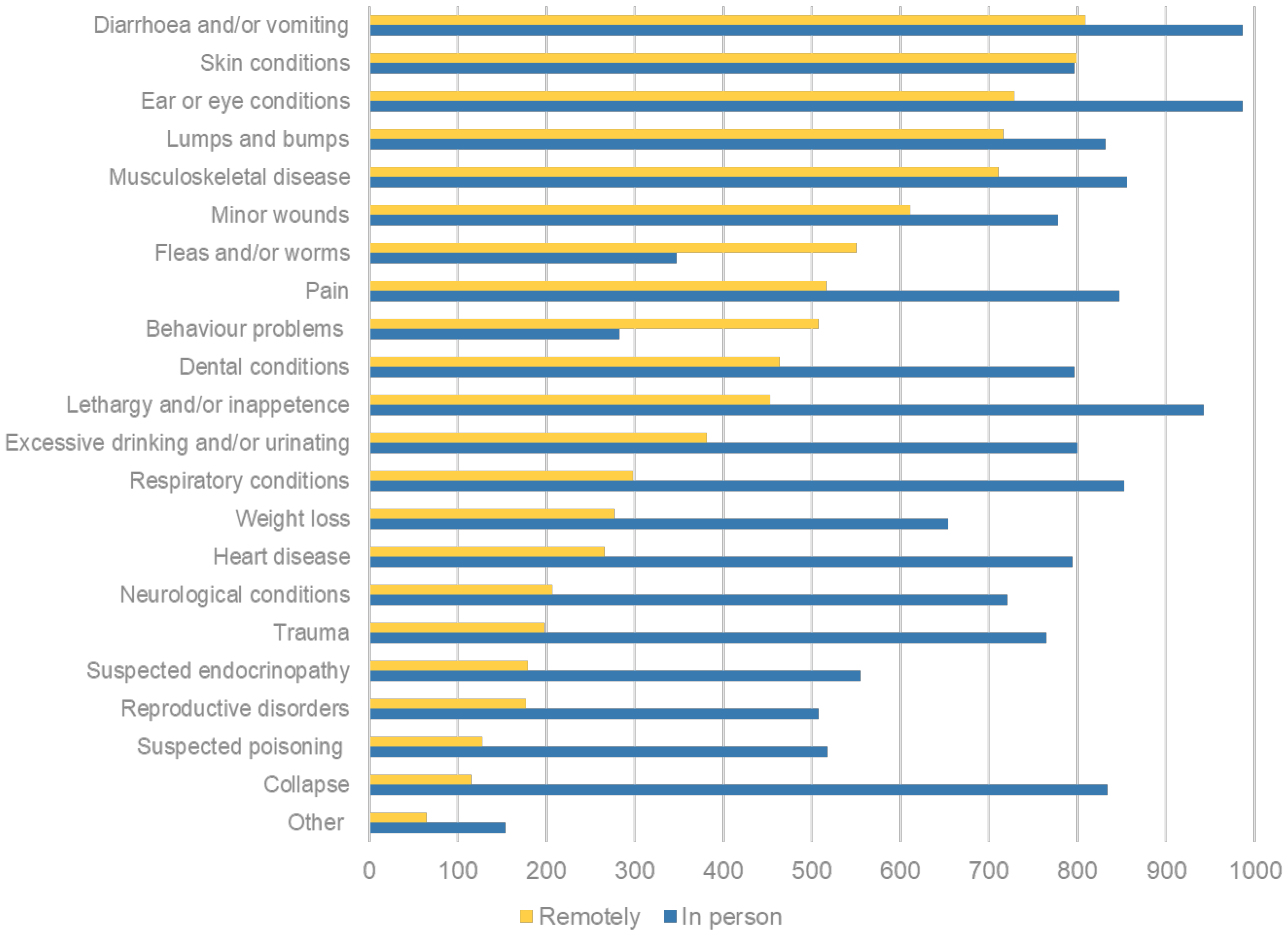
The types of equine case seen most frequently by VS respondents remotely during the two-week period, looking at number of respondents, are lameness (54 VSs) and skin conditions (47 VSs).

The types of farm animal case seen most frequently by VS respondents remotely during the two-week period, looking at number of respondents, are individual sick animal (51 VSs), herd/flock disease outbreak (24 VSs) and herd or flock health plan (24 VSs).

Figure 1 compares, for each type of small animal case, the number of VSs who saw animals with these cases in person and remotely. This illustrates the most frequently-seen types of cases, and the differences (for some types, very considerable differences) between cases seen remotely and in person. It is notable that the number seeing cases remotely clearly exceeded the number seeing cases in person for only two types of case: fleas and/or worms and behaviour problems. Free text comments provided by some

respondents indicate they are more confident about seeing cases remotely that are more routine in nature (e.g. fleas and/or worms) or that present with visual evidence that the client can provide via photographs or videos (e.g. skin conditions); they are less confident when the animal has no obvious visual signs or the signs are hard to diagnose without a physical examination (e.g. respiratory or heart conditions).

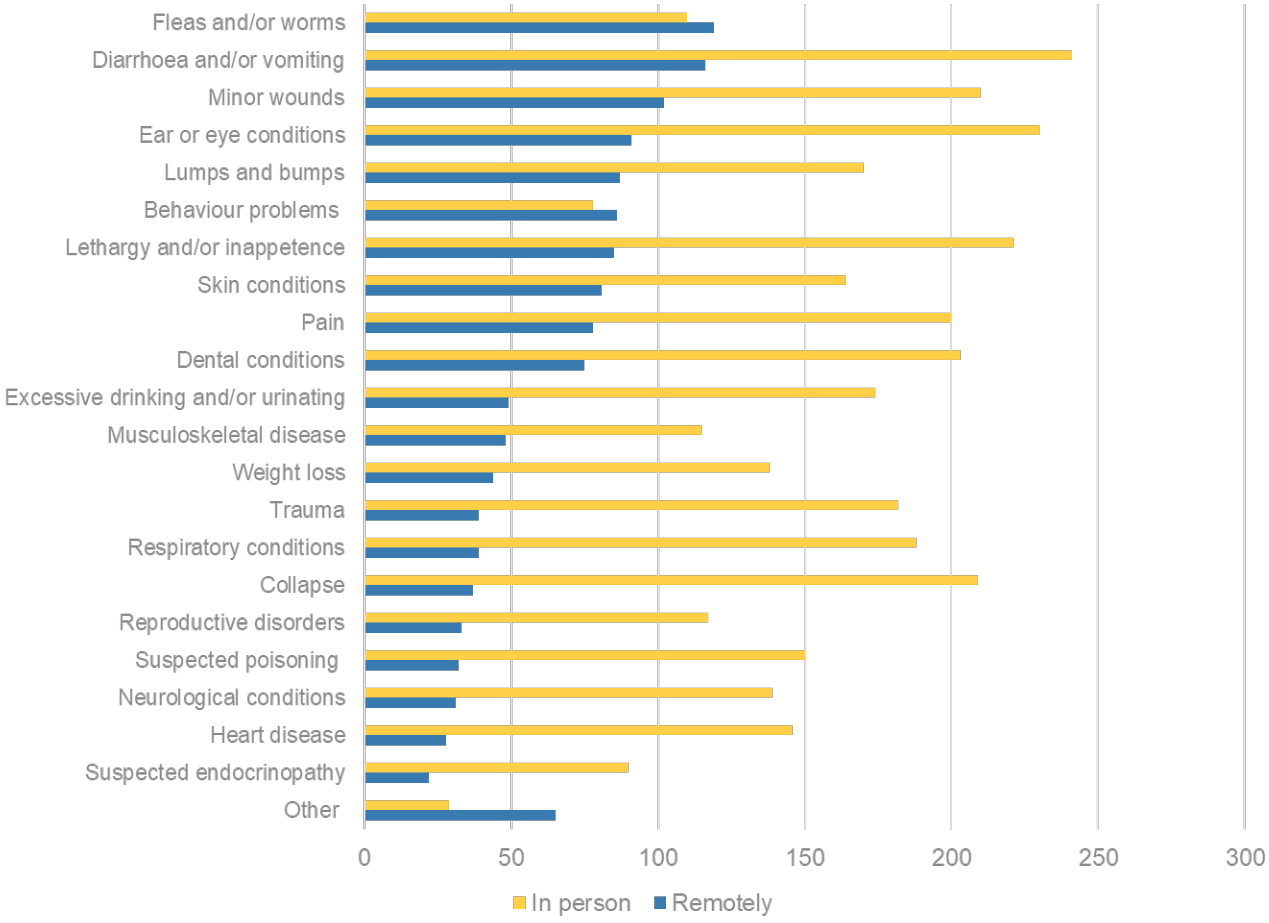
Figure 1 Number of VSs seeing different types of small animal cases seen remotely and in person 1 to 14 June 2020



Source: RCVS Covid-19 Survey, 2020

Figure 2 presents a similar picture for VN respondents; it is clear that VNs were notably more likely to have seen animals in person than remotely during the two-week period. As with VSs, the number seeing cases remotely exceeded the number seeing cases in person for only two types of case: fleas and/or worms and behaviour problems.

Figure 2 Number of VNs seeing different types of small animal cases seen remotely and in person 1 to 14 June 2020



Source: RCVS Covid-19 Survey, 2020

Experiences of remote consulting

Uses

The extent to which the animal and/or client was already known to the practice and the respondent personally seems to have influenced the clients and animals seen remotely. Table 7 shows that the large majority (92.5% of VSs and 90.8% of VNs) saw animals/clients existing to the practice that they had personally seen within the last 12 months, whereas only half (51.6% of VSs and 52.8% of VNs) saw animals/clients new to the practice.

Table 7 Personal use of remote consulting during 1 to 14 June 2020: VS and VN (multiple response)

	VS N	VS %	VN N	VN %
Existing (to the practice) clients and animals you personally have seen within the last 12 months?	1398	92.5	423	90.8
Existing (to the practice) clients and animals that you personally have not seen for more than 12 months?	1078	71.3	313	67.2
Existing (to the practice) clients and animals that you personally have never seen?	1004	66.4	258	55.4
Clients that are new to the practice?	780	51.6	246	52.8

Source: RCVS Covid-19 Survey, 2020

The large majority of VSs and VNs used remote consulting for advice and triage for animals/clients known to the practice. In addition, 87.7 per cent of VSs and 66.5 per cent of VNs used it for repeat prescriptions, and 67.2 per cent of VSs and 26.9 per cent of VNs used it for prescriptions for new conditions. More detail about the medicines prescribed can be found in the 'Experiences of remote prescribing' section below.

However, 21.7 per cent of VSs and 17.3 per cent of VNs did not use remote consulting for new animals/clients. Those who did see new animals/clients remotely did so mainly for triage and to give advice. A relatively low percentage used it to issue repeat prescriptions for a pre-existing condition (22.3% of VSs and 14.1% of VNs) or prescriptions for new conditions (35.8% of VSs and 14.1% of VNs), indicating an understandable caution when dealing with unknown animals and/or clients.

Approaches

The most-frequently-used method of providing remote consultations during 1 to 14 June 2020 was via the telephone – with or without supplementary visual evidence such as photographs and videos – for both existing and new animals/clients. The third most popular method was email consultations with supplementary photographs or videos. Less frequently-mentioned were live video consultations (using either free-to-access options such as Skype or bespoke platforms), and email consultations without supplementary visual material. Free text comments suggest that telephone consultations were preferred by clients due to the ease of use and familiarity.

- When asked if any specific training was provided by their practice in relation to remote consulting, 28.5% of VSs and 29.1% of VNs respondents said yes. Mostly, this was in-house training, although around one-third took part in webinars.
- 51.4% of VSs, and a much higher 66.4% of VNs, said their practice developed written policies or protocols for remote consulting.
- When asked if their practice recorded remote consultations (other than taking written notes) during the two-week period, 68% of VSs and 62.2% of VNs said no; 27.6% of VSs and 32.4% of VNs said this happened routinely, and 4.5% of VSs and 5.4% of VNs in specific situations.

- Although 19.2% of VSs and 11% of VNs said their practice was not actively following up on cases seen remotely during the two-week period, the majority (57% of VSs and 61.4% of VNs) said this happened in specific circumstances, while 23.8% of VSs and 27.6% of VNs said it was routinely done.

Time-efficiency

Tables 8 and 9 indicate that whereas well over half of VSs and VNs find remote consultations less time-efficient compared to pre-Covid-19 face-to-face consultations, VSs' opinions are more divided about the comparison of remote and face-to-face consultations during Covid-19 whereas VNs find them less time-efficient. Free text comments support these findings, with some respondents commenting that remote consultations can take a lot of time due to the VS having to ask a lot more questions and the client not always being able to provide relevant information in an efficient way.

Table 8 Time-efficiency of remote consultations compared to face-to-face consultations pre-Covid-19

	VS N	VS %	VN N	VN %
More efficient	205	16.8	35	14.5
Neither more nor less efficient	305	25.0	54	22.3
Less efficient	711	58.2	153	63.2

Source: RCVS Covid-19 Survey, 2020

Table 9 Time-efficiency of remote consultations compared to face-to-face consultations using regime adopted during Covid-19

	VS N	VS %	VN N	VN %
More efficient	453	37.3	40	16.6
Neither more nor less efficient	287	23.6	54	22.4
Less efficient	426	35.0	126	52.3
Not applicable - I saw no face-to-face cases during Covid-19	50	4.1	21	8.7

Source: RCVS Covid-19 Survey, 2020

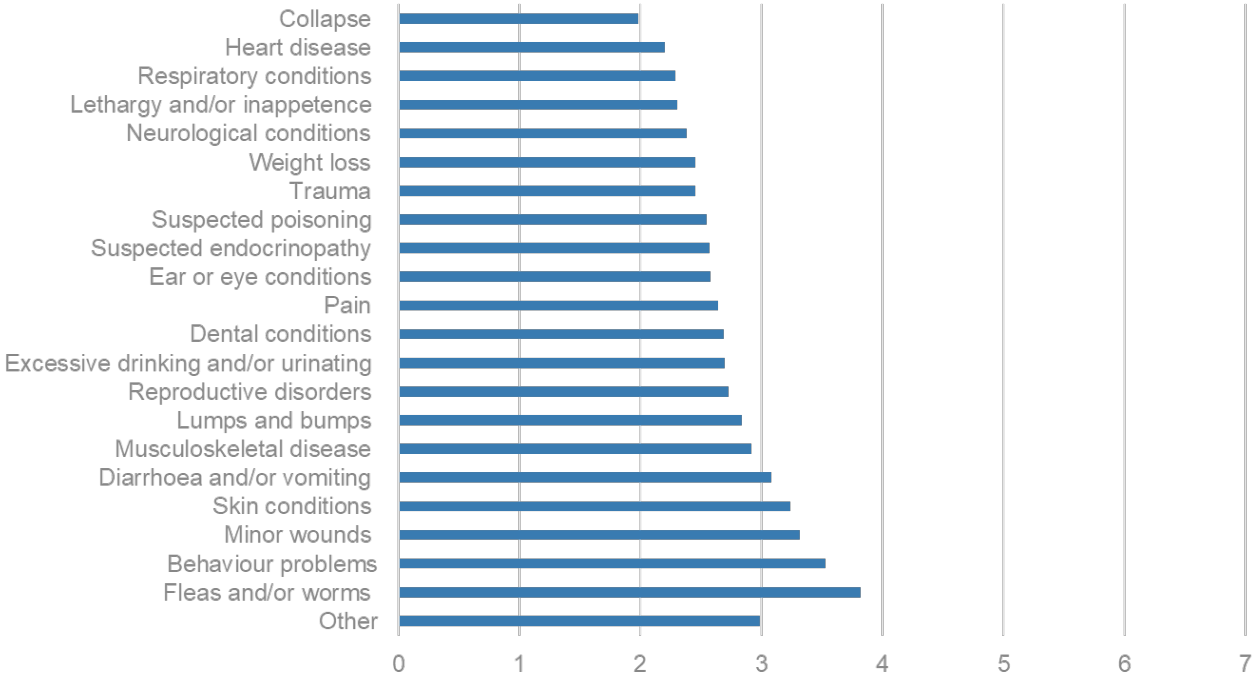
Further analysis by practice type, however, shows that VSs in equine practices are more favourably-disposed to the time-efficiency of remote consultations: 45.9 per cent find them more efficient than pre-Covid-19 face-to-face, and 59.5 per cent find them more efficient than face-to-face using the regime adopted during Covid-19.

Confidence

For each type of case seen remotely, VS respondents were asked to rate their confidence in their remote diagnoses compared to face-to-face diagnoses pre-Covid-19, using a seven-point scale ranging from 'much less confident' (scoring 1) to 'much more confident' (scoring 7), with a mid-point of 'equally as confident' (scoring 4).

Figure 3 shows that, for **small animal** cases, all 22 of the overall mean scores were below the midpoint of four, and for the first seven conditions on the graph (collapse down to trauma) the score was below 2.5; only two conditions, fleas and/or worms and behaviour problems, have scores above 3.5.

Figure 3 Confidence in small animal diagnoses compared to face-to-face diagnoses pre-Covid-19: mean scores, VS



Source: RCVS Covid-19 Survey, 2020

- VSs seeing **equine cases** are a little more confident overall in their remote diagnoses. Although the mean scores for the nine types of case they were asked to rate were all below the midpoint of four, none was below 2.5. The lowest score, indicating the lowest level of confidence, was for dental cases (2.64), while the highest was for reproductive issues (3.70).
- VSs seeing **farm animal cases** also returned scores below the midpoint of four for every type of case they were asked to rate. The two lowest (both below 2.5), indicating the lowest level of confidence, were for assisting/guiding surgery (2.0) and obstetrical problem (2.27), while the highest two were for herd or flock health plan, farm assurance or routine health visit (3.61) and herd/flock disease outbreak (3.5).

- VNs were also asked about their confidence in their remote diagnoses. For **small animal cases**, 21 out of 22 of their mean scores, which ranged from 2.88 to 4.27, were below the midpoint of four, the exception being fleas and/or worms. They are considerably more confident than VSs overall, possibly because, as some point out in various places in free text comments, the responsibility for accurate diagnosis lies with VSs. Their lowest average scores, indicating the lowest level of confidence, are for neurological conditions (2.88) and suspected endocrinopathy (2.98).

Table 10 indicates that VS respondents were generally less confident in their remote diagnoses during 1 to 14 June when the client/animal was new to them, with only a little over one quarter (27.4%) feeling it made no difference to their confidence; VNs, however, were more confident, with 51.9 per cent saying it made no difference.

Table 10 Confidence in remote diagnoses if client/animal not known to respondent

	VS N	VS %	VN N	VN %
Yes, I was much less confident when attending to a new client/animal remotely	190	18.7	13	8.0
Yes, I was less confident when attending to a new client/animal remotely	256	25.2	31	19.1
Yes, I was a little less confident when attending to a new client/animal remotely	291	28.7	34	21.0
No, it made no difference whether the client/animal was known to me or not	278	27.4	84	51.9

Source: RCVS Covid-19 Survey, 2020

Table 11 indicates that VS and VN SQP respondents are fairly cautious in making diagnoses and treating animals via remote consultations: 55.3 per cent of VSs and 74.2 per cent of VN SQPs said that at least half the cases they saw remotely between 1 to 14 June led to their giving advice that the animal needed to be physically seen.

Table 11 Percentage of cases seen remotely resulting in advice that the animal should be physically seen

	VS N	VS %	VN SQP N	VN SQP %
90% or more	90	7.5	4	12.9
75% to 89%	209	17.4	7	22.6
50% to 74%	365	30.4	12	38.7
25% to 49%	323	26.9	6	19.4
Fewer than 25%	212	17.7	2	6.5

Source: RCVS Covid-19 Survey, 2020

The survey asked if respondents were involved in carrying out any face-to face re-checks during 1 to 21 June of animals previously seen remotely, firstly by them or someone else in their practice, and secondly by another practice or provider. More than three-quarters (78.5%) of VSs, and a much lower 29.5 per cent of VNs, were personally involved in carrying out face-to-face re-checks of cases they, or someone else in their practice, had previously seen remotely. Table 12 presents the drivers for these face-to-face re-checks.

Table 12 Drivers of face-to-face re-checks of animals previously seen remotely within the practice (multiple response)

	VS N	VS %	VN N	VN %
Required further investigation that could not be performed remotely	887	92.6	117	87.3
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	749	78.2	69	51.5
Accurate diagnosis was considered essential and that this required physical examination	685	71.5	89	71.5
Diagnostic uncertainty was too great to continue remote management	653	68.2	68	66.4
Patient was deteriorating and required hospitalisation	486	50.7	76	56.7
Other	31	3.2	7	5.2

Source: RCVS Covid-19 Survey, 2020

- VS respondents involved in face-to-face re-checks said this happened between one and 90 times, with a mean of 11.9, a median of eight and a mode of ten. The overall VS mean masks considerable differences when the means in practice types are compared: small animal 12.7, mixed 9.2, referral 7.7, farm 4.4 and equine 2.6. VN respondents involved in face-to-face re-checks said this happened between one and 80 times, with a mean of 18.95 and a median of ten.
- When asked if this number was higher or lower than would have been expected had the initial consultation been face-to-face, 44.7% of VSs and 34.9% of VNs per cent selected ‘about the same’, 42.6% of VSs and 31.7% of VNs ‘higher’ and 12.7% of VSs and 33.3% of VNs ‘lower’.

During 1 to 14 June, 28% of VS and 25.5% of VNs were personally involved in carrying out face-to-face re-checks of cases that had previously been seen remotely by another practice or provider. Table 13 presents the drivers for these face-to-face consultations.

Table 13 Drivers of face-to-face consultations with animals previously seen remotely by another practice or provider (multiple response)

	VS N	VS %	VN N	VN %
Required further investigation that could not be performed remotely	256	75.5	45	76.3
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	202	59.6	24	40.7
Accurate diagnosis was considered essential and that this required physical examination	192	56.6	31	52.5
Diagnostic uncertainty was too great to continue remote management	191	56.3	27	45.7
Another veterinary practice was not able to see or did not feel it needed to see the animal	188	55.5	27	45.8
Patient was deteriorating and required hospitalisation	181	53.4	35	59.3
Other	34	10.0	8	13.6

Source: RCVS Covid-19 Survey, 2020

- The VSs who were involved in such consultations involving animals previously seen remotely elsewhere said that this had occurred between one and 80 times, with a mean average of 7.5, a mode of two and a median of four. The VNs who were involved in such consultations said that this had occurred between one and 50 times, with a mean average of 13.9 and a median of six.

Interactions with clients

- When asked about **clients' willingness to pay for remote consultations**, around two-thirds (63.9% of VSs and 67.4% of VNs) said their clients were willing to pay something, but not as much as a face-to-face consultation; one quarter (26.8% of VSs and 25.5% of VNs) said they were willing to pay the same amount; but 9.3% of VSs and 7.1% of VNs selected 'unwilling to pay anything'.
- **Clients' ability to operate any technology required for remote consultations** during the two-week period is rated as 'adequate' or 'good' by 77.1% of VSs and a much more generous 89.5% of VNs, with 22.9% of VSs but only 10.5% of VNs rating it 'poor'.
- **The technical quality of the remote consultation** on average (in terms of audio and/or visual quality) is rated as 'adequate' or 'good' by 80.3% of VSs and 86.4% of VSs; again, VNs are more generous than VSs in their ratings, in that only 13.6% rated it as 'poor' compared to 19.7% of VSs.
- Most VSs rate their **clients' ability to provide relevant information** such as the animal's history, clinical signs or weight as 'adequate' (51.9%) or 'good' (27.8%); however, 20.3% rate it as 'poor'. VNs have very similar views: 52.6% 'adequate', 28.2% 'good' and 19.2% 'poor'.

Experiences of remote prescribing

The two most frequently-occurring methods of providing prescriptions to the client during 1 to 14 June 2020 were the client collecting medicines from the practice (92.5% of VSs and 96.4% of VNs) and medicines being posted to the client (70.0% of VSs and 75.9% of VNs). In addition, almost half (46.1% of VSs and 48.8% of VNs) said the practice delivered medicines to the client in person.

When asked about methods used to verify client identity when issuing remote prescriptions, the two most-frequently occurring answers were the practice only prescribed to known clients with previously-seen animals (59.3% of VSs and 67.9% of VNs), and the practice sending medicines to the client's address as registered on the system (55.6% of VSs and 62.9% of VNs). The most frequently-cited method for new clients is the verification of the client's address, such as obtaining records from the previous practice (31.0% of VSs and 34.8% of VNs).

Table 14 indicates that for the majority of VS and VN SQP respondents, more than half of the cases they saw remotely resulted in remote prescriptions being given.

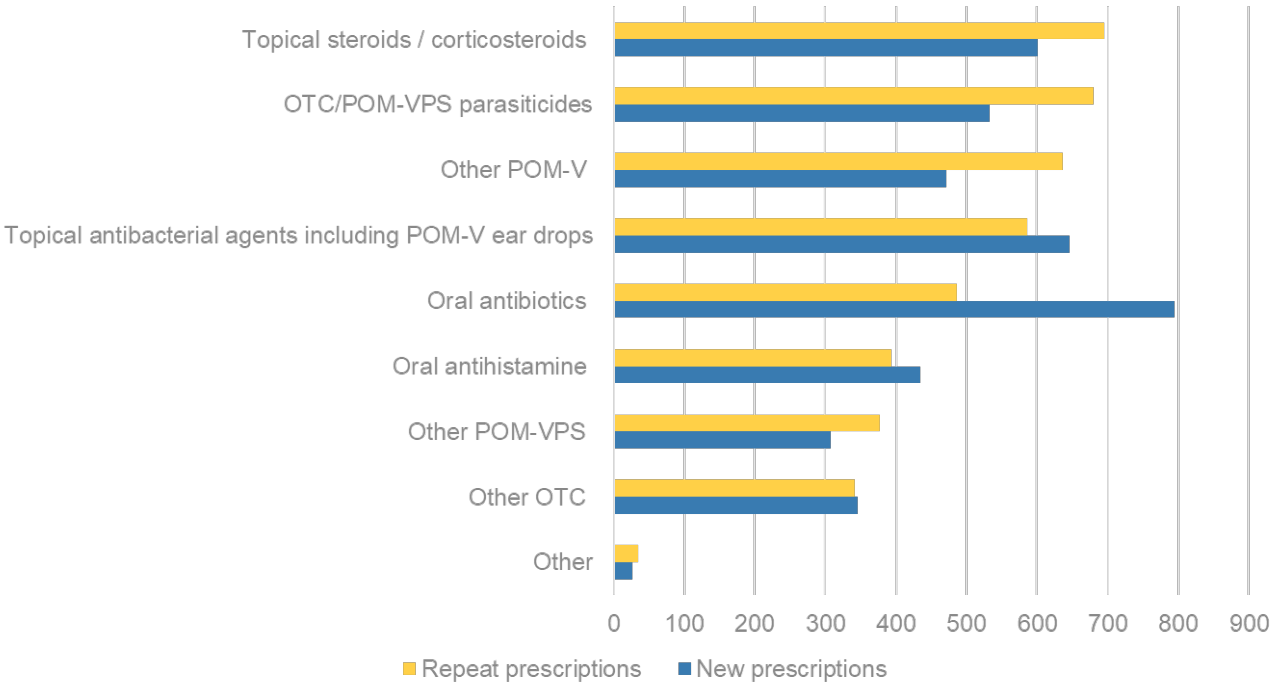
Table 14 Percentage of cases seen remotely 1 to 14 June 2020 resulting in remote prescriptions: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
90% or more	87	7.3	3	11.1
75% to 89%	222	18.6	7	25.9
50% to 74%	330	27.7	7	25.9
25% to 49%	268	22.5	3	11.1
Fewer than 25%	286	24.0	7	25.9

Source: RCVS Covid-19 Survey, 2020

Of the VSs and VN SQPs who issued prescriptions during 1 to 14 June 2020, almost all were for small animals: 94.6% of VSs (N = 1,157) and 92.6% of VN SQPs (N = 25) issued small animal prescriptions. A much lower percentage of VSs issued prescriptions for equine and farm animals (7.4% equine and 6.8% farm animal). Figure 4 shows the number of respondents (VS and VN SQP added together) prescribing different types of small animal medicines, and indicates that topical steroids/corticosteroids were the most frequent repeat prescriptions, and oral antibiotics the most frequent new prescriptions.

Figure 4 Number of respondents prescribing different types of small animal medicines 1 to 14 June 2020: VS and VN SQP



Source: RCVS Covid-19 Survey, 2020

For equine prescribing, pain medication was the medicine prescribed by the greatest number of VSs, both as repeat and new prescriptions, whereas for farm animals,

injectable antibiotics and nonsteroidal anti-inflammatory drugs (NSAIDs) were prescribed by the greatest number of VSs, both as repeat and new prescriptions.

When asked if any animal experienced any suspected adverse drug reaction(s) to medication prescribed remotely by them during the two-week period, resulting in the animal having to be seen urgently, only 20 VSs and no VN SQPs said yes; when asked for further details, the most common response was gastrointestinal issues such as diarrhoea and vomiting, usually as side-effect of NSAIDs.

Table 15 shows that the majority of both VS and VN SQP respondents think that clients expected a prescription to be given on 'about the same' number of occasions when they saw cases remotely, compared with face-to-face consultations pre-Covid-19.

Table 15 Client expectations about prescriptions, comparing remote with pre-Covid-19 face-to-face consultations: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
Less often than face-to-face	172	14.1	4	13.8
More often than face-to-face	196	16.1	8	27.6
About the same as face-to-face	852	69.8	17	58.6

Source: RCVS Covid-19 Survey, 2020

When asked about their confidence in estimating weight for dosage requirements in comparison to face-to-face consultations, it is clear that respondents feel less confident overall (see Table 16), with around one quarter overall feeling notably less confident.

Table 16 Confidence in estimating weight for dosage requirements when seeing cases remotely compared to face-to-face: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
As confident	295	24.4%	6	20.7%
Somewhat less confident	613	50.6%	17	58.6%
Notably less confident	303	25.0%	6	20.7%

Source: RCVS Covid-19 Survey, 2020

Respondents' views

An analysis of the free text comments provided in response to a request to give feedback on firstly the current temporary change to the RCVS Guidance which allows remote prescribing, and secondly remote consulting and prescribing in general, reveals a wide variety of views which could be difficult to reconcile going forward.

- Some respondents say they have found the temporary change useful, not only because it has helped their practice continue working; they believe it has benefits and would like it to continue:

  Temporary remote prescribing has allowed us to function as a business, where we might otherwise have been unable to do so.

  Independently-owned practice VS

  We need to develop this more. It has saved me a lot of miles in the car and has meant I can focus on more technical advice.

  Farm animal VS

  Using nurses to triage and give advice is very helpful, also it is having a benefit that nurses can have more of a discussion around health and welfare … It allows better utilisation of nurse and vet time.

  VN

  This change must be maintained to provide vets with another pathway to provide veterinary care for patients where attendance to practice is not considered essential. This will give more pets access to veterinary care.

  Small animal practice VS

  I think video and telephone consulting has a future in veterinary medicine, especially as we now have such advanced technology for viewing and speaking to our clients.

  Referral practice VS

- Others have disliked the experience and found it unhelpful, at best seeing it as a necessary, but strictly temporary measure; some appear to take this further, being implacably opposed to allowing remote consulting and remote prescribing to continue:

  … time consuming, expensive and unproductive.

  Equine practice VS

  This has been a valuable asset during this crisis but not one I feel I would be in the patient's best interest in the long term.

  Small animal practice VS

  This experience has convinced me that remote consulting should only be allowed in extreme circumstances e.g. Pandemic.

  Corporately-owned practice VS

  USELESS, DANGEROUS. WILL NEVER DO AGAIN … This should be completely stopped and back to original prescribing laws once covid-19 outbreak over. Need a physical consultation, phone or video is doing the animal and client a disservice.

  Corporately-owned practice VS

- However, a more frequently-expressed view is that remote consulting and remote prescribing could be useful, but with rules attached, such as limiting their use to certain conditions, situations and medicines; in addition, VSs would need a greater degree of protection from complaints:

  Remote prescribing should only take place with animals already known to the practice and very recently examined.

  Independently-owned practice VS

  We had a client make a complaint based entirely on the owner's lack of compliance and inability to follow instructions which scared me.

  Independently-owned practice VS

  I firmly believe that all POM-V should only be prescribed for clients with an established relationship with a practice, so that full responsibility is taken for any adverse effects and treatment instigated in a timely manner. Given the potential for error, under normal circumstances no new prescription should be dispensed without a physical/clinical examination.

  Independently-owned practice VS

  Providing a 6 monthly in clinic physical exam can be done I don't see why routine prescribing for ongoing conditions could not continue in this way for the future, including routine flea and worm treatments.

  VN SQP

- Some respondents believe that the change has been beneficial to animals' and their owners' well-being and welfare, and would continue to be useful for certain types of client and animal; an opposing view is that animals have been put at risk, and would continue to be at risk, due to misdiagnoses:

  It has helped us to provide care and alleviate pain and suffering in animals that otherwise could not have been seen.

  Independently-owned practice VS

  It allowed us to help the most vulnerable clients.

  Corporately-owned practice VS

  Helpful specially to people who find coming into practice hard or with animals who find it stressful coming to the vets.

  VN SQP

  … for conditions with minimal external visual markers … there is a huge risk in misdiagnosis of many cases.

  Corporately-owned practice VS

  The skills of a veterinary surgeon which we were trained in are the physical examination of an animal in relation to its history. Clients are not adequately trained

to perform this role without errors being made and animal welfare being compromised.

Mixed practice VS

- If, however, remote consulting and prescribing are to continue, some respondents would like clearer guidance from the RCVS and assurances of protection from client's complaints.

  Would be nice to clarify liability – if we're doing a remote consultation and the owner is bitten/scratched is that still our responsibility?

  Corporately-owned practice VS

  Could the RCVS also take the opportunity to firm up guidance about 'under our care' for repeat prescriptions, the current code of practice is open to too wide interpretation.

  Equine practice VS

  I think it has its place with the correct guidelines.

  VN

  I think vets need a definite RCVS guide on how often is minimum animals should have a physical exam, though, to ensure continuity throughout the profession and to ensure clients are clear as to what can and cannot be done.

  VN

- Although some clients would be very happy to see the change made permanent, there is a worry among respondents that the search for a cheaper service will lead to lowered standards and possibly some unscrupulous business practices:

  Clients have been surprisingly willing to use it and it has opened up new consulting methods.

  Independently-owned practice VS

  I think developing remote consulting for 'normal' time is a bit of a slippery slope to a point eventually where clients will self-diagnose and buy medicines (potentially without prescription) online.

  Independently-owned practice VS

  Clients will want a cheap option but then be ever so quick to go down the RCVS / litigation route when honest mistakes are made.

  Corporately-owned practice VS

  I strongly feel that remote consulting and prescribing undervalues our work as vets. It sends the message to clients that doing a clinical examination is of negligible value, and that owner assessment at home is adequate.

  Small animal practice VS

It is a bad idea. It will allow a small handful of clever people to cream off the easy work and leave large areas of the country (typically the poorer and more remote areas) with a dearth of physical veterinary practices.

Equine practice VS

If it were to continue I think we need to be careful not to devalue the consultation.

Corporately-owned practice VS

Conclusions

The survey has yielded a wide-ranging set of results with regard to the experiences and opinions of VSs and VNs which are not easy to summarise or reconcile, particularly when the RCVS is considering the future of remote consulting and prescribing. Some respondents have enjoyed remote consulting and prescribing, some have found it necessary but less than ideal, and some have hated it and never want to try it again.

There are clear confidence issues, with respondents being less confident about their ability to diagnose accurately via remote consultations, or to estimate weights for medication doses remotely, in comparison to face-to-face consultations allowing the physical examination of animals. This is linked to the finding that a high percentage of remote consultations resulted in VSs advising that the animal needed to be seen face-to-face. Understandably, there are particular concerns around the remote diagnosis and treatment of serious conditions, especially if there are few external visual signs. Respondents reported that their confidence increases when the animal is known to them, indicating greater concern around diagnosis and prescribing for new animals/clients. Both VSs and VNs have found it difficult to obtain accurate information about animals from clients, due partly to technological limitations (quality of visual evidence and client availability/familiarity with equipment) and partly to inability to describe the animal's condition adequately.

Some respondents describe benefits to some clients and animals, especially clients who find it hard to visit the practice, and animals who have chronic or routine conditions and/or are nervous. However, there are also concerns that, post Covid-19, it might be difficult to re-educate clients and manage their expectations; clients may, for example, resent returning to face-to-face consultations and annual health checks, and may expect price reductions. A further concern is that some veterinary providers may start to specialise in certain 'easy' conditions, financially disadvantaging those offering a full service. VNs, often the first point of contact for clients, have had differing experiences of them, with some saying they were appreciative, understanding and co-operative, and others finding them rude, demanding, and unprepared to pay for remote consultations.

If remote consulting and prescribing are to continue, the survey findings indicate that the RCVS will need to provide detailed and clear guidance to VSs and VNs. Issues raised by respondents include: requests for more guidance about the meaning of 'under our care'; rules about the types of medication that can be prescribed remotely, and about the conditions that can be diagnosed remotely without a further physical examination;

suggestions that remote consultations should only be permitted when the animal is known/registered to the practice and has been seen recently; and further suggestions that remote prescribing should only be allowed if the animal's weight is recorded at the practice. The survey findings on the very varied practices around the verification of clients' identities indicate that RCVS guidance may also be required here.

1 Introduction

Chapter summary

- The RCVS Covid-19 online survey was launched on 26 June and closed on 7 July 2020.
- UK-practising veterinary surgeons (VSs) and veterinary nurses (VNs) were invited to participate.
- Respondents answered questions, and provided free text comments, about their experiences of consulting and, if relevant, remote prescribing, from 1 to 14 June 2020.
- 3,841 responses were received: 2,672 from VSs and 1,169 from VNs: 168 responses were rejected due to having no usable content, and a further 167 respondents were asked no further questions because they did not work in clinical practice during 1 to 14 June, and would not normally have done so.
- 314 respondents did not do any clinical practice work during 1 to 14 June, although they would normally have done so: their main reason for not working was being furloughed (208 respondents).

1.1 Background

In May 2020 the Royal College of Veterinary Surgeons (RCVS) commissioned the Institute for Employment Studies (IES) to run a fast-turnaround online survey on its behalf to ask UK-practising veterinary surgeons (VSs) and veterinary nurses (VNs) about their experiences of working during the Covid-19 pandemic. There were two main reasons for the survey:

- To see if there were any immediate safety, quality or efficiency issues to inform a review of a temporary exemption to RCVS guidance that ordinarily means that prescribing of certain categories of medicines is not possible without a hands-on examination of the animal. The exemption was made in the light of social distancing requirements due to the Covid-19 pandemic.
- To capture data on the experience of VSs and VNs carrying out remote consulting, including remote prescribing, to inform a wider review of the topic which is being carried out by the RCVS (currently on pause due to the pandemic).

Due to the timing of the commissioning of the survey, and the requirement to select a time period that would be relatively fresh in the minds of respondents, the two-week period from 1 to 14 June 2020 was chosen as the time period on which respondents were asked to focus. By this fortnight, some lockdown easing was taking place although there were still rules and guidelines in place around social distancing and safe working.

1.2 The survey

1.2.1 Process

The RCVS and IES teams worked together to draw up and agree the survey questions, after which the survey was set up online by the IES team using the Snap survey tool, and tested by IES researchers and the RCVS team. The survey was launched on 26 June 2020 via an invitation email, containing the link to the survey, to all UK-practising VSs and VNs using email addresses provided by the RCVS. The RCVS issued an email to its membership in advance of the launch, to inform VSs and VNs that the survey would shortly be live, and a further blanket email reminder while the survey was in the field. The survey was closed on 7 July 2020.

Two sets of headline results were sent to the RCVS soon after the survey closed: an immediate 'red flag' headlines report on a small number of selected questions one week after survey closure, and a fuller set of headline results for every question, together with a sample of free text comments, two weeks after survey closure. In-depth analysis was then carried out for this full survey report.

A small number of VSs and VNs sent emails to IES, mostly to explain why they did not complete the survey (generally because they had not worked during 1 to 14 June or because they did not work in clinical practice). However, some wanted either to give their views about remote consulting and/ or prescribing without completing the survey, or to expand on their survey answers; these comments were transferred into a short document that was sent to the RCVS after all personal identifiers had been removed.

1.2.2 Response

In total 3,841 responses were received: 2,672 from VSs and 1,169 from VNs. Of these 1,111 were partial responses, in that the participant clicked on the link in the email to open the survey, but did not reach the end of it, or reached the end but did not click on the 'submit' button. The majority of these partial responses contained at least some usable data; however, 168 people had not answered any questions, so were excluded. The final response was therefore 3,673.

1.2.3 The sample: inclusions and exclusions

The first few questions in the survey were designed to ensure that only those respondents who had spent any time working in clinical practice during 1 to 14 June were asked in detail about their experiences. A question asking whether the respondent had spent any time working in clinical practice during the fortnight showed that the large majority (87%, 3,188 respondents) had done so; these respondents were routed to answer the rest of the questions in the survey. However, 167 respondents selected 'No, and I would not normally have done so, regardless of Covid-19'; these were thanked and asked no further questions.

The remining 314 selected ‘No, although I would normally (pre-Covid-19) have done so’ and were asked why, selecting all the reasons that applied to them. The most frequent response was ‘furloughed’ (208 respondents), followed by ‘looking after/home-schooling children’ (35), ‘shielding’ (31), ‘self-isolating’ (19), ‘practice closed’ (14), ‘taking annual leave/holiday time’ (11), and ‘looking after adult dependants’ (9). In addition, 57 respondents selected ‘other’, and some of these provided further details: 26 said they were self-employed or locums, and no work was available; seven had left their jobs, were in between jobs, or were waiting for a new job to start; three were ill or injured; and three had been diverted to management tasks. These 314 respondents were then thanked and asked no further questions.

1.3 This report

This report contains the following chapters:

- Executive summary
- Chapter 1: Introduction
- Chapter 2: Respondent profile
- Chapter 3: Caseload 1 to 14 June 2020
- Chapter 4: Experiences: consultations
- Chapter 5: Experiences: remote prescribing
- Chapter 6: Views
- Chapter 7: Conclusions

Chapters 2, 3 and 4 consider the responses from VSs first, followed by the responses from VNs; this order has been chosen because the majority (70.5%) of respondents working during 1 to 14 June 2020 indicated that they are VSs. Chapter 5 considers the VS and VN responses together, because the majority of questions reported in this chapter were not asked of VNs who do not have the ‘suitably qualified person’ (SQP) title, which enables the prescription and supply certain veterinary medicinal products under the Veterinary Medicines Regulations. Of the 29.6 per cent of survey respondents who are VNs, 15.6 per cent are SQPs.

2 Respondent profile

This chapter describes respondents' personal and job details.

Chapter summary

- 65.2% of VS respondents and 97.3% of VN respondents are female.
- VSs have an average (mean) age of 42.2, while VNs are somewhat younger overall, having an average age of 36.9.
- 34.6% of VSs and 29.4% of VNs have dependent children living with them, while 3.9% of VSs and 5.2% of VNs provide care to an adult dependant.
- 2.8% of VSs and 5.2% of VNs have a physical disability or medical condition that limits the work they can do, while 2.5% of VSs and 4.0% of VNs have a limiting mental health issue.
- The large majority of respondents (85.5% of VSs and 93.8% of VNs) give their main personal practice area as small animal.
- The practice type of VSs breaks down as: small animal 77.1%, mixed 10.9%, referral 4.3%, equine only 4.0%, farm animal only 1.5%, telemedicine 1.0%, other 1.1%.
- In line with their main practice area, VNs are less likely to work in equine or farm animal practices: small animal 84.2%, mixed 8.6%, referral 4.3%, equine only 0.4%, farm animal only 0.1%, telemedicine 0.3%, other 0.2%.
- Most respondents (81.7% of VSs and 87.4% of VNs) are based in England; 9.8% of VSs and 6.8% of VNs are in Scotland, 5.6 % of VSs and 4.1% of VNs in Wales, 1.9% of VSs and 1.1% of VNs in Northern Ireland, and 1.0% of VSs and 0.7% of VNs outside the UK
- Almost half of respondents based in England (47.0% of VSs and 49.4% of VNs) are based in the southern regions (South East, South West and London).
- The geographical area of their main practice location is described as 'a mix of urban and rural' by 42.4% of VSs and 40.9% of VNs, 'urban' by 38.5% of VSs and 42.9% of VNs, and 'rural' by 18.5% of VSs and 15.6% of VNs.
- 35.1% of VSs and 38.4% of VNs work in small practices (i.e. with fewer than 4 full-time-equivalent VSs), 47.1% of VSs and 44.4% of VNs in medium practices (4 to 10 FTE VSs) and 17.9% of VSs and 17.1% of VNs in large practices (more than 10 FTE VSs).
- 43.8% of VSs and 36.8% of VNs work in practices that are independently-owned, 47.8% of VSs and 54.0% of VNs in corporately-owed practices, and 8.4% of VSs and 9.2% of VNs in practices with another type of ownership structure. Small animal and referral practices are, on average, more likely to be corporately-owned.
- 49.6% of VSs and 44.1% of VNs work in practices that cover their own out-of-hours, or co-operate locally to do so, while 45.7% of VSs and 51.6% of VNs say their practice uses a dedicated out-of-hours provider.

2.1 VSs

2.1.1 Personal details

- The majority (65.2%) of VS respondents are female, with one third (33.4%) being male, and 1.5 per cent preferring not to say or preferring to self-describe. The small number who said they prefer to self-describe were asked to give further details: descriptions include ‘demigirl’ and ‘non-binary’.
- The ages given by VS respondents ranged from 23 to 77, with a mean average of 42.2 and a median (middle value) of 41.
  - However, the five modal (most frequently-occurring) ages, each with between 67 to 82 respondents, are all between 28 and 32: in order starting with the highest modal value, these are 29, 31, 28, 32 and 30.
  - To aid further analysis, the ages have been grouped (see table 2.1).

Table 2.1 Age breakdown: VS

	N	%
Under 30	357	17.2
30 to 39	597	28.7
40 to 49	513	24.7
50 to 59	448	21.5
60 and over	166	8.0
Total	2,081	100

Source: RCVS Covid-19 Survey, 2020

  - Women are younger than men, on average, having a mean age of 40 compared to 46.4 for men.
- A little over one third (34.6%) have dependent children living with them.
  - Of these, 33 per cent have children aged 0 to 4, 50 per cent children aged 5 to 11, and 44.6 per cent children aged 12 to 18.
  - Further analysis shows that, of those with dependent children:
    - 17.8 per cent have only children aged 0 to 4
    - 23.2 per cent only children aged 5 to 11
    - 32.1 per cent only children aged 12 to 18
    - 14.5 per cent children aged 0 to 4 and children aged 5 to 11
    - 0.1 per cent children aged 0 to 4 and children aged 12 to 18
    - 11.7 per cent children aged 5 to 11 and children aged 12 to 18
    - 0.7 per cent children in all three age categories.

- A small proportion (3.9%) provide care to an adult dependant.
- For the purpose of further analysis, a new dependants variable was created: child dependants only (33.1% of VS respondents), adult dependants only (2.4%), both child and adult dependants (1.5%) and neither child nor adult dependants (63%).
  - Men are somewhat more likely than women to have child dependants only (37% compared to 31.5%) or both types of dependant (2.3% compared to 1%), while women are more likely than men to have neither type of dependant (65.1% compared to 58.3%).
  - The differences between men and women are, however, linked to men being older than women on average: those with children only have a mean age of 44.2, those with an adult dependant only a mean age of 52.2, those with both a mean age of 49.5, and those with neither a mean age of 40.6.
- When asked about work-limiting physical or mental health conditions, 2.8 per cent consider themselves to have a physical disability or medical condition that limits the work they can do, while 2.4 per cent consider themselves to have a mental health issue that limits the work they can do.
  - Further analysis shows that 2.3 per cent have physical disabilities or conditions only, 1.9 per cent have mental health conditions only, and 0.5 per cent have both.

2.1.2 Job details

Almost all (98.6%) of the VSs who responded to the survey usually work within the profession, in clinical practice; the rest work within the profession, but outside clinical practice (1.2%) or in an 'other' area (0.2%).

Clinical practice area

The main area of clinical practice of the VS respondents who spent time working in clinical practice between 1 and 20 June 2020 is shown in Table 2.2. The VSs who selected 'other' main practice area were asked to specify, and most did so: nine respondents work with exotics only, zoos, animal shelters, or wildlife; five work in commercial poultry, game bird or fish production; five work solely in specialist areas (diagnostic pathology, emergency and critical care, dermatology, anaesthesia and Official Veterinarian); and three work with specific animals only (dogs, feline and laboratory animals).

Table 2.2 Main area of clinical practice: VS

	N	%
Small animal	1,895	85.5
Equine	103	4.6
Farm	53	2.4
Mixed	140	6.3
Other	25	1.1

Total	2,216	100

Source: RCVS Covid-19 Survey, 2020

An analysis by gender shows that women are notably more likely than men to have 'small animal' as their main area of clinical practice: 89.7 per cent of women, compared to 77.3 per cent of men, give this as their main area. In all other areas, there is a higher percentage of men than women: equine 8.4 per cent compared to 2.8 percent, farm 4.6 per cent compared to 1.2 per cent, and mixed 8.3 per cent compared to 5.3 per cent.

Type of practice

Table 2.3 shows the type of practice in which VS respondents normally work. The VSs who selected 'other' type of practice were asked to specify, and most did so. Five work in an exotics only or zoo practice, including peripatetic work; five in commercial food production organisations/laboratories (poultry, game birds or fish); two in a university hospital; and four in mixed practices but not offering services to all types of animal (either equine and farm only, or small animal and equine only).

Table 2.3 Type of practice in which usually work: VS

	N	%
Small-animal-only practice (including small animal practices that treat exotics)	1,696	77.1
Equine-only practice	89	4.0
Farm-animal-only practice	34	1.5
Mixed practice	240	10.9
Referral practice	95	4.3
Telemedicine provider	21	1.0
Other	25	1.1
Total	2,200	100

Source: RCVS Covid-19 Survey, 2020

An analysis by gender shows that women are notably more likely than men to work in a 'small-animal-only' practice: 81 per cent of women, compared to 69.2 per cent of men, give this as their main area. There is also a higher percentage of women than men in 'telemedicine provider' practices, although the numbers are too small for a robust comparison. In all other areas, there is a higher percentage of men than women, with the differences being particularly marked for 'equine only' practices (7.4% of men, compared to 2.5% of women, give this as their practice type) and 'farm-animal-only' practices (3.1% compared to 0.7%).

Some age differences are apparent when comparing the average (mean) ages of VS respondents working in different types of practice. The youngest are those working for a

telemedicine provider (39.2), followed by small-animal-only (41.7), referral (43), mixed (43.5), equine-only (46.1) and farm-animal-only (47.2).

Practice location

For the majority (81.7%) of VS respondents, their main practice premises are based in England; 9.8 per cent are based in Scotland, 5.6 per cent in Wales, 1.9 per cent in Northern Ireland, and 1.0 per cent outside the UK. Those working outside the UK were asked to specify where, and most did so: four are in the Channel Islands, six in EU countries, three in Australia or New Zealand, and three elsewhere.

Table 2.4 shows the region in which the main practice premises of England-based VSs are located, and indicates that almost half (47%) are based in the southern regions (South East, South West and London). The area of their main practice location is described as 'a mix of urban and rural' by 42.4 per cent, 'urban' by 38.5 per cent and 'rural' by 18.5 per cent, with the remaining 0.6 per cent selecting 'not applicable'.

Table 2.4 VSs based in England: region

	N	%
South West	325	18.3
South East	378	21.3
London	131	7.4
East of England	167	9.4
West Midlands	182	10.2
East Midlands	149	8.4
North West	207	11.6
Yorkshire and the Humber	151	8.5
North East	88	4.9
Total	1,778	100

Source: RCVS Covid-19 Survey, 2020

Practice size

Table 2.5 shows the practice sizes in which respondents work, in terms of the full time equivalent (FTE) VSs and registered VNs in their main practice premises.

Table 2.5 Practice size as described by VSs

	VS FTE	VS %	VN FTE	VN %
3 or fewer	759	35.1	749	38.4
4-10	1019	47.1	948	44.4
11-25	291	13.4	286	12.5
26-50	71	3.3	75	2.8

More than 50	25	1.2	39	1.9
Not applicable	-	-	70	3.2

Source: RCVS Covid-19 Survey, 2020

Table 2.5 suggests a very close relationship between the FTE of VSs and that of VNs; additional analysis confirmed this, and also showed the FTE of VNs to be very dependent on the FTE of VSs. For ease of further analysis, therefore, a three-way practice size variable was created: 'small' practices having fewer than four FTE VSs; 'medium' practices having between four and ten FTE VSs; and 'large' practices having more than ten FTE VSs. Using this variable, 35.1 per cent of VS respondents work in a small practice, 47.1 per cent in a medium practice, and 17.9 per cent in a large practice.

The overall small, medium and large percentage breakdown masks some notable differences among types of practice, as Table 2.6 shows; referral practices and telemedicine providers are particularly likely to be large, while small-animal-only practices are predominantly small or medium.

Table 2.6 Practice size by types of practice: VSs

	Small %	Medium %	Large %
Small-animal-only	38.6	49.0	12.4
Equine	40.9	31.8	27.3
Farm	11.8	55.9	32.4
Mixed	18.6	53.4	28.0
Referral practice	15.1	16.1	68.8
Telemedicine provider	15.8	31.6	52.6
Other	45.5	31.8	22.7

Source: RCVS Covid-19 Survey, 2020

Practice ownership structure

Table 2.7 gives the practice ownership structure of the practices in which VS respondents mainly work. As it is clear that the majority of respondents work in either an independent or a corporate practice, a three-way variable was created for the purpose of further analysis: 'independently-owned' (43.8% of respondents), 'corporately-owned' (47.8%) and 'other' (8.4%). The respondents who selected 'Other type of ownership structure' were asked to specify further: six are in telemedicine companies; six in a variety of businesses and companies that are not practices; four in not-for-profit or community interest organisations; three in universities; two in start-up businesses; three in independent practices not fitting the given categories precisely; and five in a variety of referral clinics, charitable concerns and local authorities that the respondent did not feel fitted into any of the given categories.

Table 2.7 Practice ownership structure: VSs

	N	%
An independent, stand-alone practice (e.g. a partnership or sole trader)	823	38.0
An independent, stand-alone practice that is part of a larger group (with some shared centralised support functions)	126	5.8
Total independently-owned	**949**	**43.8**
Part of a corporate group	895	41.3
Part of a joint venture with a corporate group	141	6.5
Total corporately-owned	**1,036**	**47.8**
A charity	99	4.6
Part of a veterinary school	33	1.5
An out-of-hours-only provider	17	0.8
Other type of ownership structure	32	1.5
Total other	**181**	**8.4**

Source: RCVS Covid-19 Survey, 2020

A comparison of ownership structure with practice type reveals some interesting differences (see Table 2.8). Slightly over half of VS respondents working in small animal and referral practices say their practices are owned by corporates; by contrast, slightly over two-thirds of VS respondents working in equine-only and mixed practices say their practices are independently-owned.

Table 2.8 Ownership structure by type of practice: VSs

	Independent %	Corporate %	Other %
Small-animal-only	39.5	52.5	8.0
Equine	68.2	25.0	6.8
Farm	47.1	41.2	11.8
Mixed	71.5	28.1	0.4
Referral practice	28.0	51.6	20.4
Telemedicine provider	40.0	20.0	40.0
Other	45.5	13.6	40.9

Source: RCVS Covid-19 Survey, 2020

Practice approach to 24/7 emergency cover

Finally, Table 2.9 shows the practice's approach to providing 24/7 emergency cover in 'normal', pre-Covid times. The VSs selecting 'We handle 24/7 emergency cover another way' were asked to provide further details. A frequently-mentioned other method (17 mentions) is a combination of the practice's own VSs and an out-of-hours provider, such as the practice's VSs covering weekday evenings and the provider covering nights and

weekends. Another frequently-mentioned other method (17 mentions) is that all the practice's out-of-hours work is covered by another local practice or veterinary hospital. Ten respondents say they are referral or specialist practices so do not offer or need emergency out-of-hours cover. The remaining responses indicate varied ways of providing cover, such as a telephone advice service only, and an out-of-hours service provided by the corporate group to which the practice belongs.

It is apparent that most practices fall into one of two categories: those covering their own out-of-hours work (with or without locum help) or co-operating locally, and those using a dedicated out-of-hours provider.

Table 2.9 Approach to providing 24/7 emergency cover pre-Covid: VSs

	No.	%
Practice covers its own out-of-hours work, using its own veterinary surgeons	946	43.8
Practice covers its own out-of-hours work, with locum help	32	1.5
Practice co-operates with other local practices to share out-of-hours work	92	4.3
Total covering own out-of-hours work or co-operating locally to do so	**1,070**	**49.6**
Practice uses a dedicated out-of-hours service provider	**987**	**45.7**
Practice is primarily or wholly an out-of-hours provider	38	1.8
We handle 24/7 emergency cover another way	65	3.0

Source: RCVS Covid-19 Survey, 2020

Using this two-way division, clear differences are apparent between small-animal-only practices and all other types of practice. Over half (57.8%) of VS respondents in small-animal-only practices say their out-of-hours work is covered by a dedicated out-of-hours provider; by contrast, in all other practice types, in-house coverage is the norm: 97.1 per cent of farm-animal-only practices, 94.3 per cent of equine-only practices, 93.2 per cent of mixed practices, 83.7 per cent of referral practices, and 95.2 per cent of 'other' practices cover their own out-of-hours work, either with their own VSs, or with the help of locums, or working co-operatively with other local practices.

There is also a clear relationship between size of practice in which VS respondents work and provision of 24/7 emergency cover: 84.3 per cent of large practices are able to provide cover in-house, compared to 48.5 per cent of medium-sized practices and 33.2 per cent of small practices.

2.2 VNs

2.2.1 Personal details

- The large majority (97.3%) of VN respondents are female, with 1.9 per cent being male, and 0.8 per cent preferring not to say or preferring to self-describe. Those who prefer to self-describe say they are 'gender neutral, 'genderqueer' and 'non-binary'.
- The ages given by VN respondents range from 20 to 69, with a mean average of 36.9, a median (middle value) of 36 and a somewhat lower modal (most frequently-occurring) age of 28.
  - To aid further analysis, the ages have been grouped (see Table 2.10).

Table 2.10 Age breakdown: VN

	N	%
Under 30	257	29.2
30 to 39	292	33.2
40 to 49	217	24.7
50 to 59	100	11.4
60 and over	13	1.5
Total	879	100

Source: RCVS Covid-19 Survey, 2020

  - Women are a little older than men, on average, having a mean age of 36.9 compared to 34 for men.
- Under one third (29.4%) have dependent children living with them (slightly lower than the VS percentage).
  - Of these, 32.6 per cent have children aged 0 to 4, 48.7 per cent children aged 5 to 11, and 43.6 per cent children aged 12 to 18.
  - Further analysis shows that, of those with dependent children:
    - 22 per cent have only children aged 0 to 4
    - 24.9 per cent only children aged 5 to 11
    - 28.6 per cent only children aged 12 to 18
    - 9.5 per cent children aged 0 to 4 and children aged 5 to 11
    - 0.7 per cent children aged 0 to 4 and children aged 12 to 18
    - 13.9 per cent children aged 5 to 11 and children aged 12 to 18
    - 0.4 per cent children in all three age categories.
- A small proportion (5.2%) provide care to an adult dependant (slightly higher than the VS percentage).

- For the purpose of further analysis, a new dependants variable was created: child dependants only (28.6% of VN respondents), adult dependants only (4%), both child and adult dependants (1%) and neither child nor adult dependants (66.5%).
  - Those with children only have a mean age of 39.9, those with an adult dependant only a mean age of 46.3, those with both a mean age of 44.1, and those with neither a mean age of 34.9.
- When asked about work-limiting physical or mental health conditions, 5.2 per cent consider themselves to have a physical disability or medical condition that limits the work they can do, while 4.0 per cent consider themselves to have a mental health issues that limits the work they can do.
- Further analysis shows that 4.3 per cent have physical disabilities or conditions only, 3.1 per cent have mental health conditions only, and 0.9 per cent have both.

2.2.2 Job details

Almost all (99%) of the VNs who responded to the survey usually work within the profession, in clinical practice; the remining one per cent work within the profession, but outside clinical practice.

Clinical practice area

The main personal area of clinical practice of the VN respondents who spent time working in clinical practice between 1 and 20 June 2020 is shown in Table 2.11, which very clearly shows that the large majority work in the small animal area. ‘Other’ areas include exotics and emergency/critical care.

Table 2.11 Main area of clinical practice: VN

	N	%
Small animal	870	93.8
Equine	8	0.9
Farm	3	0.3
Mixed	44	4.7
Other	3	0.3
Total	928	100

Source: RCVS Covid-19 Survey, 2020

An analysis by gender shows that all the VNs working in equine, farm and mixed areas of practice are female; the small number of male VNs work in small animal or ‘other’ practice areas.

Type of practice

Table 2.12 shows the type of practice in which VN respondents normally work. 'Other' descriptions both relate to working for a charity.

Table 2.12 Type of practice in which usually work: VN

	N	%
Small-animal-only practice (including small animal practices that treat exotics)	768	84.2
Equine-only practice	4	0.4
Farm-animal-only practice	1	0.1
Mixed practice	78	8.6
Referral practice	6.1	4.3
Telemedicine provider	3	0.3
Other	2	0.2
Total	912	100

Source: RCVS Covid-19 Survey, 2020

An analysis by gender shows that 88.2 per cent of men, and 83.9 per cent of women, work in a small-animal-only practice. The remaining men work in a referral practice, while 8.8 per cent of women work in a mixed practice, 6.1 per cent in a referral practice, and the remaining 1.2 per cent in small numbers across equine, farm, telemedicine and other practice types.

The average (mean) ages of VN respondents working in different types of practice are fairly similar: small-animal-only 36.9, referral 35.1, and mixed 37. Those in equine-only practices are slightly younger, and those in farm, telemedicine and 'other' practices older, but the numbers in these areas are too small for robust comparisons.

Practice location

For the majority of VN respondents, their main practice premises are based in England; at 87.4 per cent, this is notably higher than the VS percentage. For other UK countries, 6.8 per cent are based in Scotland, 4.1 per cent in Wales, 1.1 per cent in Northern Ireland, and 0.7 per cent outside the UK. Locations outside the Uk include the Isle of Man, the Channel Islands, Australia and Bermuda.

Table 2.13 shows the region in which the main practice premises of England-based VNs are located, and indicates that, as for VSs, almost half (49.4%) are based in the southern regions (South East, South West and London). The area of their main practice location is described as 'a mix of urban and rural' by 40.9 per cent of VNs, 'urban' by 42.9 per cent and 'rural' by 15.6 per cent, with the remaining 0.7 per cent selecting 'not applicable'; this breakdown suggests that VNs, on average, tend to be located in slightly less rural, more urban, areas than VSs.

Table 2.13 VNs based in England: region

	N	%
South West	135	17.1
South East	206	26.0
London	50	6.3
East of England	62	7.8
West Midlands	82	10.4
East Midlands	53	6.7
North West	90	11.4
Yorkshire and the Humber	65	8.2
North East	48	6.1
Total	791	100

Source: RCVS Covid-19 Survey, 2020

Practice size

Table 2.14 shows the practice sizes in which respondents work, in terms of the full time equivalent (FTE) VSs and registered VNs in their main practice premises.

Table 2.14 Practice size as described by VNs

	VS FTE	VS %	VN FTE	VN %
3 or fewer	338	38.4	313	35.3
4-10	391	44.4	400	45.1
11-25	110	12.5	120	13.5
26-50	25	2.8	31	3.5
More than 50	16	1.8	22	2.5

Source: RCVS Covid-19 Survey, 2020

This breakdown is very similar to that provided by VS respondents (see Table 2.5). Using the three-way practice size variable with ‘small’ practices having fewer than four FTE VSs ‘medium’ practices having between four and ten FTE VSs and ‘large’ practices having more than ten FTE VSs, 38.4 per cent of VN respondents work in a small practice, 44.4 per cent in a medium practice, and 17.1 per cent in a large practice.

In a similar pattern to that of VS respondents, the overall small, medium and large percentage breakdown masks some notable differences among types of practice. The percentages in Table 2.15 for equine, farm, telemedicine and ‘other’ types of practice should be treated with caution, due to the small numbers of VNs working in these types of

practice; however, it is apparent that referral practices are more likely to be large, while small-animal-only practices are predominantly small or medium.

Table 2.15 Practice size by types of practice: VNs

	Small %	Medium %	Large %
Small-animal-only	42.9	45.3	11.9
Equine	-	75.0	25.0
Farm	-	-	100.0
Mixed	14.7	58.7	28.0
Referral practice	9.4	15.1	75.5
Telemedicine provider	-	50.0	50.0
Other	50.0	50.0	-

Source: RCVS Covid-19 Survey, 2020

Practice ownership structure

Table 2.16 gives the practice ownership structure of the practices in which VN respondents mainly work. Using the new three-way variable, the percentages of VNs working in each type are: 'independently-owned' (36.8% of respondents, notably lower than the VS percentage), 'corporately-owned' (54%, notably higher than the VS percentage) and 'other' (9.2%). The respondents who selected 'Other type of ownership structure' were asked to specify further; responses included a not-for-profit organisation and an employee-owned independent.

Table 2.16 Practice ownership structure: VNs

	N	%
An independent, stand-alone practice (e.g. a partnership or sole trader)	263	29.7
An independent, stand-alone practice that is part of a larger group (with some shared centralised support functions)	63	7.1
Total independent	**326**	**36.8**
Part of a corporate group	394	44.4
Part of a joint venture with a corporate group	85	9.6
Total corporate	**479**	**54.0**
A charity	44	5.0
Part of a veterinary school	17	1.9
An out-of-hours-only provider	16	1.8
Other type of ownership structure	5	0.6
Total other	**82**	**9.2**

Source: RCVS Covid-19 Survey, 2020

A comparison of ownership structure with practice type (including only those practice types with ten or more respondents) reveals that corporate ownership is more prevalent in small animal and referral practices than in mixed practices; this is in line with the findings for VS respondents (see Table 2.17).

Table 2.17 Ownership structure by type of practice: VNs

	Independent %	Corporate %	Other %
Small-animal-only	35.3	55.9	8.9
Mixed	59.2	39.5	1.3
Referral practice	22.2	55.6	22.2

Source: RCVS Covid-19 Survey, 2020

Practice approach to 24/7 emergency cover

Finally, Table 2.18 shows the practice's approach to providing 24/7 emergency cover in 'normal', pre-Covid times. The VNs selecting 'We handle 24/7 emergency cover another way' were asked to provide further details. The most frequently-mentioned methods are a combination of cover by the practice VSs and an out-of-hours provider (6 mentions), and cover provided by a local hospital (3 mentions). Additional responses are: the practice is a referral practice that does not provide emergency cover; another branch provides cover; the corporate group has a centre that provides cover; and clients are referred to a telemedicine provider.

Table 2.18 Approach to providing 24/7 emergency cover pre-Covid: VNs

	No.	%
Practice covers its own out-of-hours work, using its own veterinary surgeons	351	39.7
Practice covers its own out-of-hours work, with locum help	9	1.0
Practice co-operates with other local practices to share out-of-hours work	30	3.4
Total covering own out-of-hours work or co-operating locally to do so	**390**	**44.1**
Practice uses a dedicated out-of-hours service provider	**456**	**51.6**
Practice is primarily or wholly an out-of-hours provider	21	2.4
We handle 24/7 emergency cover another way	17	1.9

Source: RCVS Covid-19 Survey, 2020

Using the two-way division applying to most VN respondents' practices of broadly in-house coverage compared to using a dedicated provider, clear differences are apparent between small-animal-only practices and all other types of practice. Over half (59.7%) of VN respondents in small-animal-only practices say their out-of-hours work is covered by a dedicated out-of-hours provider; by contrast, in all other practice types, in-house coverage is the norm: 89.5 per cent of mixed practices and 77.8 per cent of referral practices cover their own out-of-hours work, either with their own VSs, or with the help of locums, or working co-operatively with other local practices.

There is also a clear relationship between size of practice in which VN respondents work and provision of 24/7 emergency cover: 78.8 per cent of large practices are able to provide cover in-house, compared to 47.1 per cent of medium-sized practices and 24.8 per cent of small practices.

3 Caseload 1 to 14 June 2020

This chapter gives an overview of respondents' caseloads during 1 to 14 June, including why some individuals and practices stopped using remote consulting before this fortnight. The following chapters 4 and 5 then describe in detail respondents' experiences of consulting and prescribing during 1 to 14 June.

Chapter summary

- During 1 to 14 June 2020, 48.8% VSs and 50.4% of VNs personally provided a reduced caseload of 'in person' services, while 29.4% of VSs and 27.8% of VNs personally provided a near normal service.
- VSs in equine only and farm animal only practices mostly reported, for 'in person' services, working business as usual or near normal (72.7% and 88.3% respectively) whereas 52.5% of VSs in small animal practices reported a reduced caseload.
- 71.7% of VSs and 62.7% of VNs used remote consulting during 1 to 14 June.
- 8.5% of VSs and a much higher 22.4% of VNs did not use remote consulting at all, either before or during 1 to 14 June, while 19.8% of VSs and 14.8% of VNs used it before 1 June but stopped using it.
- The main reasons for not using remote consulting, or stopping its use, were concerns about the accuracy of diagnosis, continuing to see animals face-to-face or being able to see them face-to-face more easily due to lockdown easing, and concerns about owners' ability to describe their animals' problems. For VNs, practice policy was also an important consideration.
- 94.4% of VSs and 87.0% of VNs say their practices used remote consulting more during 1 to 14 June than pre-Covid-19, while 3.6% of VSs and 6.1% of VNs say their practices used it the same amount.
- 427 respondents have been able to continue working during the Covid-19 pandemic, whereas otherwise this would not have been possible. A comparison of the personal and job characteristics of these 427 respondents with respondents as a whole shows they are more likely to be VSs than VNs, to be male, to have dependent children, and to work in a practice with an ownership structure that is neither independently-owned or corporately-owned; and less likely to be aged under 30 and to work in a corporately-owned practice. However, these differences are not marked.

3.1 VSs

3.1.1 'In-person' services

Table 3.1 'In-person' services personally provided during 1 to 14 June: VSs

	N	%
Business as usual	169	7.8
Near normal	634	29.4
Reduced caseload, including some routine work	1055	48.8
Emergencies only	237	11.0
None	38	1.8
Other	27	1.3

Source: RCVS Covid-19 Survey, 2020

Table 3.1 indicates that a relatively small proportion (7.8%) of VS respondents personally provided business as usual during the two-week period; the majority had a reduced caseload (48.8%) or provided a near normal service (29.4%). However, 11 per cent dealt with emergencies only, and a small number (38 people, 1.8%) provided no services.

Respondents who selected 'other' were asked to give further details. Almost all of these fall into one of three categories. Ten reported they were doing some form of telemedicine either entirely or mainly, such as telephone consults only, telemedicine from home, or video consults. Eight respondents gave responses suggesting they were actually busier than usual, for example 'busier than ever', 'increased caseload', 'very busy', 'more busy than before Covid-19', 'catch-up clinic on a Sunday when not normally open'. Seven said that certain aspects of their services changed, such as some specialist activities no longer happening or being greatly reduced, seeing fewer re-checks, not doing routine surgery, dealing with emergencies and in-patient care only, having a reduced caseload plus emergency cases, and providing a referral service for cases that needed a physical examination.

Table 3.2 shows that there are considerable differences when the overall figures are broken down by practice type. Telemedicine providers and 'other' practice types are not included in table 3.2 because of the small number of respondents belonging to these categories, and some caution is needed due to the relatively low numbers for farm, equine and referral practices. Nevertheless, it is apparent that equine-only and farm-animal-only practices are notably more likely to have conducted business as usual or a near normal caseload than small-animal-only practices, while small-animal-only and mixed practices are more likely to have experienced a reduced caseload.

Table 3.2 'In-person' services personally provided during 1 to 14 June, by practice type: VSs

	Small-animal-only %	Equine-only %	Farm-animal-only %	Mixed %	Referral %
Business as usual	5.2	35.2	47.1	6.4	13.2
Near normal	27.3	37.5	41.2	39.8	31.9
Reduced caseload, including some routine work	52.6	21.6	11.8	47.9	35.2
Emergencies only	12.4	2.3	-	3.8	14.3
None	1.4	3.4	-	0.4	2.2
Other	1.1	-	-	1.7	3.3

Source: RCVS Covid-19 Survey, 2020

Practice size appears to have some impact on the services provided during the two-week period, although not a dramatic one: Taken together, small and medium sized practices are somewhat more likely to report a reduced caseload than large practices (50.5% compared to 41.1%) and somewhat less likely to report business as usual (7.2% compared to 10.4%).

Practice ownership structure appears to have only a very slight impact on the services provided. When independent and corporate practices are compared, independents are a little more likely to report business as usual (9.1% compared to 7% of corporates) and a little less likely to report emergencies only (5.9% compared to 8.7% of corporates).

3.1.2 Remote consulting

When asked if they had personally used remote consulting during 1 to 14 June, the majority of VSs (71.7 per cent) said yes. A further 19.8 per cent used it before 1 June but not during the fortnight, with the remaining 8.5 per cent saying they had not used it, neither before nor during the two-week period.

Analysing this by practice type yields some differences:

- For the use of remote consulting during 1 to 14 June, respondents in small-animal-only and mixed practices are notably more likely to say yes (73.9% and 69.9% respectively) than those in equine-only and farm-animal-only practices (51.1% and 47.1% respectively).
- Respondents in equine-only practices are notably more likely than average to say they used it before 1 June but not during 1 to 14 June: 34.1% compared to 19.8% overall.
- Respondents in farm-only practices are notably more likely to have not used remote consulting during or before the two-week period: 38.2% compared to 8.5% overall.

Practice size makes some difference, although not marked:

- Those in medium practices are a little more likely to have used remote consulting during the two-week period (73.4%) than those in small or large practices (70.2% and 70% respectively).
- Those in large practices are more likely than average to have used remote consulting before 1 June but to have stopped doing so: 16.1% compared to 19.8% overall.
- Those in large practices are also more likely than average to have not used remote consulting at all (14% compared to 8.5% overall).

Looking at personal characteristics:

- Respondents who did not use remote consulting before or during 1 to 14 June are a little older (average age 45.6) than those who used it during the two-week period (42.1) and those who used it before 1 June but not during the two week period (41.5).
- Those with responsibility for dependants (child and/or adult) are a little more likely to have used remote consulting during the two-week period than those without dependants: 73.7% compared to 70.4%. They are also less likely to have used it before 1 June but to have stopped doing so (17.7% compared to 21.1% of those with no dependants).

Factors influencing personal decision not to use remote consulting

Those who had not used remote consulting at all (N = 184) were asked why. Table 3.3 shows that almost one-third (31.1%) continued to see clients face-to-face; for others, issues around IT equipment and skills were much less influential to their decision than concerns around accuracy of diagnosis and owners' ability to describe animals' problems.

Table 3.3 Why remote consulting not used (multiple response): VSs

Reasons	N	%
Concerns about accuracy of diagnosis if animal not seen face-to-face	80	43.7
Continued to see clients face-to-face	79	43.2
Concerns about ability of owners to describe animals' problem(s)	57	31.1
Practice policy	34	18.6
Opposed in principle to remote consulting	30	16.4
Concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome	26	14.2
Lack of IT equipment/software	17	9.3
Lack of confidence in IT skills	11	6.0
Other	63	34.4

Source: RCVS Covid-19 Survey, 2020

Some respondents gave further details relating to their selection of 'other' reasons. These are very varied, and include: inability to do the job remotely (anaesthesia, radiology/ultrasound, TB testing, treating rescue animals, diagnosing equine lameness, emergencies only, dairy veterinary work only) without being physically present (12

responses); being in a role that does not require any interaction with clients, such as planning, logistics or management (six responses); remote work being undertaken by other colleagues in the practice, sometimes those who were shielding or in isolation (six responses), seeing animals face-to-face but with owners elsewhere, e.g. the car park (three responses); and clients not taking up the offer of remote consulting (two responses).

The age of respondents has some bearing on some of the reasons they gave. When the average (mean) age of those giving the reason is compared to that of those who did not use remote consulting before or during the two-week period, but who did not select the reason:

- Those citing 'lack of confidence in IT skills' are older: 48.4 compared to 45.4
- Those citing 'concerns about accuracy of diagnosis if animal not seen face to face' are older: 46.9 compared to 44.5
- Those citing 'concerns about ability of owners to describe animals' problems' are older: 47.1 compared to 44.9
- Those who are 'opposed in principle to remote consulting' are notably older: 48.7 compared to 44.9
- However, those with 'concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome' are younger: 42.9 compared to 45.9
- Finally, those who gave 'practice policy' as a reason are much younger: 38.1 compared to 47.3.

For all reasons given apart from 'practice policy', the average age of those giving the reason is higher than the average age of VS respondents overall (42.2).

After giving their reasons for not using remote consulting either during or before the two-week period, these 184 respondents were thanked and exited from the survey.

Reasons why remote consultation stopped before 1 June

Those who had used remote consulting before 1 June, but stopped using it (N = 428), were asked for their reasons for stopping. Table 3.4 presents the reasons, and shows that over half (57.4%) took advantage of lockdown easing to stop the use of remote consulting, with concerns around accuracy of diagnosis and owners' ability to describe animals' problems also being very important; in addition, 42.6 per cent state a preference for face-to-face consultations.

Table 3.4 Reasons for stopping the use of remote consulting (multiple response): VSs

	N	%
Concerns about accuracy of diagnosis if animal not seen face-to-face	250	58.1
Lockdown easing made face-to-face consultations possible	247	57.4
Concerns about ability of owners to describe animals' problem(s) remotely	214	49.8

Preference for face-to-face consultations	183	42.6
Concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome	112	26.0
Practice policy	95	22.1
Problems with IT equipment/software	36	8.4
Lack of confidence in IT skills	11	2.6
Other	63	14.7

Source: RCVS Covid-19 Survey, 2020

The 'other' reasons described by respondents are very varied: the most frequently mentioned are practical explanations, such as no longer needing to work remotely because colleagues took on this role, demand decreasing, clients wanting to bring in their animals instead, staff returning from furlough making face-to-face consultations possible again, or being sent to a different practice to fill a gap (17 responses); some explanations relate to previous difficulty in diagnosing remotely, or having emergencies during the two weeks which required face-to-face consultation (four responses); and two respondents say they followed company policy or practice.

The age of respondents has some bearing on the reasons given for stopping remote consulting before 1 June, although it is much less influential than for not using remote consulting before or during the two-week period. When the average (mean) age of those giving the reason is compared to that of those who stopped using remote consulting before the two-week period, but who did not select the reason:

- Those citing 'problems with IT equipment/software' are a little older: 43.8 compared to 41.2
- Those with a 'preference for face-to-face consultations' are older: 43.1 compared to 40.3.
- Those with 'concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome' are notably younger: 39.0 compared to 42.3
- Those giving 'practice policy' as a reason are also notably younger: 37.1 compared to 42.7.

After giving their reasons for stopping the use of remote consultations before the two-week period, these 428 respondents were routed to the two questions asking for free-text responses at the end of the survey.

3.1.3 Impact of Government guidance

Finally, respondents were asked about the extent to which Government guidance and social/physical distancing impacted their practice's (rather than their personal) use of remote consulting during the two-week period. Unsurprisingly, the very large majority (94.4%) said that their practice used it more than pre-Covid-19, with 3.6 per cent saying they used it the same amount, and just 1.9 per cent (N = 30) saying they used it less than pre-Covid-19.

Practice ownership structure makes a small difference to responses, in that those who work in an independently-owned practice are a little less likely to say they used remote consulting more than pre-Covid-19 (93.2% compared to 96% of those in corporately-owned practices) and more likely to say they used it the same amount (5% compared to 1.8%). Practice size, however, makes no significant difference.

3.2 VNs

3.2.1 'In-person' services

Table 3.5 'In-person' services personally provided during 1 to 14 June: VNs

	N	%
Business as usual	43	5.0
Near normal	239	27.8
Reduced caseload, including some routine work	433	50.4
Emergencies only	129	15.0
None	8	0.9
Other	7	0.8

Source: RCVS Covid-19 Survey, 2020

Table 3.5 indicates that a relatively small proportion of VN respondents (5%, somewhat lower than that of VSs) personally provided business as usual during the two-week period; in a similar pattern to that of VSs, the majority had a reduced caseload (48.8%) or provided a near normal service (29.4%). However, 15 per cent (somewhat higher than VSs) dealt with emergencies only, and a very small number (38 respondents, 1.8%) provided no services. Further detail given by respondents who selected 'other' include caseload being above average, and dealing with emergencies only.

3.2.2 Remote consulting

When asked if they had personally used remote consulting during 1 to 14 June, the majority of VNs (62.7%, notably lower than the VS percentage) said yes. A further 14.8 per cent had used it before 1 June but not during the fortnight, with the remaining 22.4 per cent (much higher than the VS percentage) saying that had not used it, neither before nor during the two-week period.

Factors influencing personal decision not to use remote consulting

Those who had not used remote consulting at all (N = 166) were asked why. Table 3.6 gives a very different response pattern than that of VSs, in that VNs selected far fewer options and, as might be expected, tend to select practical aspects rather than things that are largely not their responsibility, such as concerns about the accuracy of diagnoses.

Table 3.6 Why remote consulting not used (multiple response): VNs

Reasons	N	%
Continued to see clients face-to-face	48	16.8
Practice policy	41	14.4
Concerns about accuracy of diagnosis if animal not seen face-to-face	35	12.3
Concerns about ability of owners to describe animals' problem(s)	30	10.5
Concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome	21	7.4
Lack of IT equipment/software	15	5.3
Lack of confidence in IT skills	8	2.8
Opposed in principle to remote consulting	4	1.4
Other	83	29.1

Source: RCVS Covid-19 Survey, 2020

The large majority of those who gave explanations for selecting 'other' reasons say that, as a VN, they are not required to do consultations, and/or that consultations are done by VSs (49 respondents). Other reasons are: carrying out other duties, such as reception, management, theatre, night duty, emergencies or looking after in-patients (nine respondents); nurse clinics/consultations not taking place during the two-week period (five respondents); and being involved in remote work, such as triage, but not doing the actual consultations (two respondents).

After giving their reasons for not using remote consulting either during or before the two-week period, these 166 respondents were thanked and exited from the survey.

Reasons why remote consultation stopped before 1 June

Those who had used remote consulting before 1 June, but stopped using it (N = 100), were asked for their reasons for stopping. Table 3.7 presents the reasons, and again shows that VNs selected far fewer reasons than VSs and were more likely to give practical reasons such as lockdown easing and practice policy.

Table 3.7 Reasons for stopping the use of remote consulting (multiple response): VNs

	N	%
Lockdown easing made face-to-face consultations possible	52	24.4
Practice policy	37	17.4
Concerns about accuracy of diagnosis if animal not seen face-to-face	31	14.6
Concerns about ability of owners to describe animal's problem(s) remotely	30	14.1
Concerns about complaints if owners feel remote consulting/prescribing has led to an unsatisfactory outcome	17	8.0
Preference for face-to-face consultations	16	7.5
Problems with IT equipment/software	6	2.8
Lack of confidence in IT skills	2	0.9

Other	22	10.3

Source: RCVS Covid-19 Survey, 2020

Explanations for selecting 'other' include: remote consultations no longer being possible due to time and/or workload pressure (five respondents); arrangements put in place to see animals at the practice, with owners being elsewhere on the telephone (four respondents); and remote consultation continuing but the individual no longer required to do so, because others had returned from furlough (two respondents).

After giving their reasons for stopping the use of remote consultations before the two-week period, these 100 respondents were routed to the two questions asking for free-text responses at the end of the survey.

3.2.3 Impact of Government guidance

Respondents were asked about the extent to which Government guidance and social/physical distancing impacted their practice's (rather than their personal) use of remote consulting during the two-week period. Although the large majority (87%) say that their practice used it more than pre-Covid-19, this percentage is somewhat lower than that of VSs; in addition, a relatively high 6.9 per cent (N = 37) say they used it less than pre-Covid-19, with 6.1 per cent saying they used it the same amount.

3.3 Ability to work during Covid-19 pandemic

Towards the end of the survey, all respondents were asked if remote consulting had enabled them to continue to work during the Covid-19 pandemic, whereas having to physically be at work would not have been possible (due to factors such as shielding, providing childcare and looking after vulnerable relatives). The personal and job characteristics of the 427 respondents who said yes are summarised below; for each point, there is a comparison in brackets with the overall survey sample.

- 77.5% are VSs and 22.5% are VNs; 10.4% of the VNs have SQP status (whole sample: 70.4% VS, 29.5% VN; 15.6% of VNs have SQP status).
- 68.6% are female and 31.4% are male (whole sample: 75.6% female, 24.4% male).
- 38.9% have dependent children living with them (whole sample: 33%).
- 4.7% have physical conditions that limit the work they can do and 1.9% have limiting mental health conditions (whole sample: 3.5% and 2.9%).
- 15.2% are aged under 30, 33.6% are in their 30s, 24.6% in their 40s, 18.7% in their 50s, and 7.9% are 60 and over (whole sample: 20.8%, 30%, 24.6%, 18.5% and 6.1%).
- 78.2% work in small animal practices, 3% in equine practices, 1.2% in farm practices, 7.5% in mixed practices, 5.2% in referral practices, 2.8% in telemedicine practices, and 1.6% in other types of practice (whole sample: 79.2%, 3%, 1.1%, 10.2%, 4.9%, 0.8% and 0.9%).

- 43.6% work in independently-owned practices, 43.3% in corporately-owned practices, and 13% in practices with other ownership structures (whole sample: 41.8%, 49.6% and 8.6%).
- 36.6% work in small practices, 47.2% in medium practices, and 16.3% in large practices (whole sample: 36%, 46.4% and 17.6%).

The above statistics suggest that, in comparison to the overall sample, those who have been enabled to work due to remote consulting are somewhat more likely than average to be VSs rather than VNs; a little more likely to be male and to have dependent children; less likely to be aged under 30; and somewhat less likely to work in a corporately-owned practice, and more likely to work in a practice with other ownership structures. However, these differences are not marked.

4 Experiences: consultations

This chapter describes the experiences of VSs and VNs who were involved in consultations, including remote consultations, during 1 to 14 June.

Chapter summary

- 92.5% of VSs and 90.8% of VNs personally used remote consulting during 1 to 14 June for animals known to the practice and seen by them during the previous 12 months; however, a much lower percentage (51.6% of VSs and 52.8% of VNs) saw animals remotely that were new to the practice.
- For both existing and new animals, the most frequently-cited use of remote consulting by VSs and VNs was to give advice.
- VSs and VNs both say that the most common approach to remote consulting was via the telephone, with or without supplementary visual information such as photographs or videos, although emails supplemented by visual information were also cited frequently.
- 28.5% of VSs and 29.1% of VNs received training in remote consulting, usually in house or via webinars.
- 51.4% of VSs and a notably higher 66.4% of VNs say their practice developed written policies or protocols for remote consulting, before or during the two-week period.
- 68% of VSs and 62.2% of VNs say their practice did not record remote consultations; for 27.6% of VSs and 32.4% of VNs, however, this happened routinely.
- 57% of VSs and 61.4% of VNs say their practice follows up cases seen remotely in specific circumstances, while for 26.3% of VSs and 27.6% of VNs this happened routinely.
- The majority of respondents saw animals in person as well as remotely during 1 to 14 June; just 5.1% of VSs and 10.8% of VNs say they only saw animals remotely during the two weeks.
- The types of small animal cases seen by the highest number of VSs in person during 1 to 14 June are diarrhoea and/or vomiting, ear or eye conditions, lethargy and/or inappetence, and musculoskeletal disease. For VNs, it was similar picture: diarrhoea and/or vomiting, ear or eye conditions, and lethargy and/or inappetence.
- The equine conditions seen most frequently by VSs in person are lameness and colic, while the farm animal conditions seen most frequently by VSs in person are individual sick animal and obstetrical problem.
- Although the number of VSs who saw small animals remotely is close to the number who saw cases in person, the number who saw equine and farm animal cases remotely is notably lower than the number who saw cases in person.
- The types of small animal case that the highest numbers of VSs report that they saw remotely during 1 to 14 June are diarrhoea and/or vomiting, skin conditions and ear or eye conditions. For VNs, it is a somewhat different picture: fleas and worms, diarrhoea and/or vomiting, and minor wounds.

- The equine conditions seen by the highest numbers of VSs remotely are lameness and skin conditions, while the farm animal condition seen by the highest numbers of VSs remotely is individual sick animal.
- For VSs, the only small animal conditions seen by more respondents remotely than in person are fleas and/or worms and behaviour problems; skin conditions were seen by equal numbers remotely and in person; and for all other 19 conditions, notably more VSs saw animals in person than remotely. For VNs, the only small animal conditions seen by more respondents remotely than in person are the same as for VSs, fleas and/or worms and behaviour problems; for all other 20 conditions, notably more VNs saw animals in person than remotely.
- No equine or farm animal conditions were seen by more VSs remotely than in person.
- When asked about the time-efficiency of remote consultations, 58.2% of VSs and 63.2% of VNs say they are less time-efficient than pre-Covid-19 face-to-face consultations.
- The comparison of remote consultations with face-to-face consultations using the regime adopted during Covid-19 is more favourably perceived by VSs, however, with a lower 35% finding remote consultations less time-efficient; VNs are less positive, with a much higher 52.3% finding them less time-efficient.
- VSs dealing with equine cases are notably more positive about the time-efficiency of remote consultations, with around half rating them as more time-efficient than face-to-face consultations pre- or during Covid-19.
- For all 22 types of small animal case seen remotely from 1 to 14 June, VSs say they are less confident about their diagnoses compared to face-to-face. Confidence levels are lowest for collapse, heart disease, respiratory conditions lethargy and/or inappetence, and neurological conditions, and highest for fleas and/or worms and behaviour problems.
- VNs, although somewhat more confident overall than VSs, report they are less confident about remote than face-to-face diagnoses for every type of small animal case except fleas and/or worms.
- VSs are also less confident about remote diagnoses every type of equine and farm animal case, with confidence lowest for dental cases (equine) and assisting/guiding surgery (farm).
- Confidence is further affected when the client/animal is new to the respondent: 72.6% of VSs and 47.1% of VNs are less confident about their diagnoses when the client/animal is new to them (although for 51.9% of VNs, this made no difference).
- 55.3% of VSs and 74.2% of VN SQPs say that, when they saw animals remotely during 1 to 14 June, they advised the animal needed to be seen physically in at least 50% of cases.
- 78.5% of VSs and 25.9% of VNs were personally involved in re-checks during 1 to 14 June of animals they, or someone else in the practice, had previously seen remotely; the most important driver for the re-check was the requirement for further investigation that could not be performed remotely. However, less than half (42.6% of VSs and 31.7% of VNs) said the number of times this happened was higher than would have been expected had the initial consultation occurred face-to-face.
- 28% of VSs and 25.5% of VNs were personally involved in re-checks during 1 to 14 June of animals previously seen remotely by another practice or provider; the most important driver for the re-check, as above, was the requirement for further investigation that could not be performed remotely.
- 63.9% of VSs and 67.4% of VNs say that clients are willing to pay something for a remote consultation, but not as much as face-to-face; however, 9.3% of VSs and 7.1% of VNs say

clients are unwilling to pay anything (increasing to 13.8% of VSs in independently-owned practices).

- 77.1% of VSs and a notably higher 89.1% of VNs rate clients' ability to operate any equipment required for remote consultations as 'adequate' or 'good'.
- 80.4% of VSs and a somewhat higher 86.4% of VNs rate the technical quality of remote consultations as 'adequate' or 'good'.
- 79.7% of VSs and 80.8% of VNs rate clients' ability to provide relevant information about their animal as 'adequate' or 'good'.

4.1 VSs

4.1.1 Use of remote consulting

When asked about the animals they saw remotely during the two-week period, it is clear that the extent to which the animal and/or client was already known to the practice and the VS personally was an influencing factor (see Table 4.1). In particular, the large majority (92.5%) saw animals/clients existing to the practice that the VS had personally seen within the last 12 months, whereas only half (51.6%) saw animals/clients new to the practice.

Table 4.1 Personal use of remote consulting during 1 to 14 June 2020: VS (multiple response)

	N	%
Existing (to the practice) clients and animals you personally have seen within the last 12 months	1398	92.5
Existing (to the practice) clients and animals that you personally have not seen for more than 12 months	1078	71.3
Existing (to the practice) clients and animals that you personally have never seen	1004	66.4
Clients that are new to the practice	780	51.6

Source: RCVS Covid-19 Survey, 2020

Existing animals

VSs used remote consulting for existing (to the practice) animals/clients in different ways, as Table 4.2 shows. The large majority used it for advice, repeat prescriptions and triage, although a lower two-thirds (67.2%) used it to give prescriptions for new conditions.

Table 4.2 Personal use of remote consulting for existing (to the practice) clients/animals: VS (multiple response)

	N	%
Advice	1432	94.9
Repeat prescriptions	1323	87.7
Triage	1295	85.8

Prescriptions for new conditions	1014	67.2
Not applicable - I only used remote consulting for new animals and/or clients	11	0.7
Other	43	2.8

Source: RCVS Covid-19 Survey, 2020

'Other' uses mentioned by more than one respondent are post-operative checks/follow-ups (ten mentions), consultations on specific, non-emergency conditions only (five mentions), flea and worm treatment (three mentions), monitoring of progress after treatment (three mentions), and out-of-hours work (three mentions).

New animals

Respondents were asked about the ways in which they used remote consulting for new animals. The number of people responding to this question (1,480) suggests that many respondents interpreted this question as relating to animals/clients existing to the practice, but not seen before by them, in addition to animals/clients new to the practice.

Table 4.3 shows that, although around one-fifth (21.7%) did not use remote consulting for new animals/clients, the majority of VS respondents used it to give advice (72%) or for triage (67.3%). Less common is the use of remote consulting to issue repeat prescriptions (22.3%) or prescriptions for new conditions (35.8%), indicating that VSs are understandably notably more cautious if the client and/or animal is not known to them.

Table 4.3 Personal use of remote consulting for new clients/animals: VS (multiple response)

	N	%
Triage	996	67.3
Advice	1065	72.0
Repeat prescriptions for a pre-existing condition	330	22.3
Prescriptions for new conditions	529	35.8
Not applicable – I did not use remote consulting for new animals and/or clients	321	21.7
Other	39	2.6

Source: RCVS Covid-19 Survey, 2020

'Other' uses mentioned by more than one respondent are flea/worm/parasite treatment (12 mentions), initial consultations regarding animals of new clients or new puppies/kittens (eight mentions), referral consultations (four mentions), consultations on specific conditions (two mentions), and post-operative checks (two mentions).

4.1.2 Approach to remote consulting

Table 4.4 shows the ways in which VSs provided remote consultations during 1 to 14 June; for each method, the number of respondents using it for existing clients/animals is

given first, followed by the number using it for new clients/animals. It is clear that telephone consultations – with or without supplementary visual evidence such as photographs and videos – was the most frequently-used method, while relatively few respondents used a bespoke platform.

Table 4.4 Approaches to providing remote consulting: VSs (multiple response, number providing each method)

	N
Phone consultations supplemented with photographs or videos from the client - existing clients/animals	1412
Phone consultations supplemented with photographs or videos from the client - new clients/animals	936
Phone consultations (no additional visual information) - existing clients/animals	1228
Phone consultations (no additional visual information) - new clients/animals	701
Email consultations supplemented with photographs or videos from the client - existing clients/animals	622
Email consultations supplemented with photographs or videos from the client - new clients/animals	288
Live video consultations using free-to-access options (e.g. Skype, FaceTime, WhatsApp, Zoom) - existing clients/animals	346
Live video consultations using free-to-access options (e.g. Skype, FaceTime, WhatsApp, Zoom) - new clients/animals	241
Email consultations (no additional visual information) - existing clients/animals	313
Email consultations (no additional visual information) - new clients/animals	130
Live video consultations using a bespoke video consult platform - existing clients/animals	227
Live video consultations using a bespoke video consult platform - new clients/animals	174
Other (please specify) - existing clients/animals	17
Other (please specify) - new clients/animals	8

Source: RCVS Covid-19 Survey, 2020

'Other' methods given by two or more respondents are using specific applications or messaging applications not mentioned in the options provided for the question (nine mentions), and text chat supplemented by photographs and/or videos (four mentions).

- When asked if any specific training was provided by their practice in relation to remote consulting, before or during the two-week period, 28.5 per cent of VS respondents said yes. Of those who received training, for most (74.6%), it took the form of in-house training. However, 30.5 per cent took part in external webinars open to all involved and 5.5 per cent in external webinars for managers, while 7.9 per cent received 'other' training. Respondents were asked to select all the options that applied, so these results indicate that some respondents received more than one type of training.

  - 'Other' types of training mentioned by more than one respondent are a written document/guide (14 mentions), email advice (ten mentions), other forms of remote training (three mentions), and a PowerPoint presentation (two mentions).
- Further analysis shows:
  - VS respondents in small animal practices are more likely than average to have received training (30.5% said yes), while those in equine and farm practices are the least likely to say yes (11.4% and 12.5% respectively). Unsurprisingly, almost all VSs working for a telemedicine practice say that have received training in remote consulting (88.9%).
  - VSs in medium sized practices are more likely than average, while those in small practices are less likely than average, to have received training (32.3% and 23.3% respectively).
  - Those in corporately-owned practices are notably more likely to say yes, they received training, than those in independent practices (20% compared to 35.3%).
- Just over half (51.4%) of VS respondents said their practice developed written policies or protocols for remote consulting, before or during the two-week period.
  - There is a big difference when the responses of VSs in independent and corporate practices are compared, in that 60.2 per cent of those in corporate practices say their practice developed written practices/protocols compared to 38.8 per cent of those in independents.
- When asked if their practice recorded remote consultations (other than taking written notes) during the two-week period, the majority (68%) said no, while 27.6 per cent said this happened routinely and 4.5 per cent in specific situations.
  - Practice type and ownership structure makes no significant difference to recording practices, apart from the unsurprising finding that 88 per cent of VS respondents working in telemedicine practices say calls are recorded routinely.
- Although 19.2 per cent of VS respondents said their practice was not actively following up on cases seen remotely during the two-week period, the majority (57%) said this happened in specific circumstances and 23.8 per cent said it was routinely done.
  - VSs in referral and telemedicine practice are notably more likely than average to say that cases seen remotely were followed up routinely: 47.9 per cent and 50 per cent respectively.
  - Those in independent practices are more likely than those in corporate practices to say that cases seen remotely were followed up routinely: 26.3 per cent compared to 19.4 per cent.

4.1.3 Animals seen in person

Before asking in more detail about respondents' experiences of remote consulting, they were asked about cases they saw in person during 1 to 14 June. Table 4.5 indicates that the majority of VS respondents were fairly active in seeing animals in person; just 5.1 per cent said they only saw animals remotely during this period.

Table 4.5 Types of animals seen in person between 1 to 14 June 2020: VS

	N	%
Small animal	1293	89.5
Equine	132	9.1
Farm animal	127	8.8
Not applicable, I did not attend to any animal in person	74	5.1

Source: RCVS Covid-19 Survey, 2020

Respondents were then asked about the number of different types of small animal case they saw in person between 1 and 14 June. Tables 4.6 to 4.8 below show, separately for small animal, equine, and farm animal: the number of VS respondents who saw at least one case; the minimum and maximum number of cases (with very high outliers removed); and the mean average, the mode (most commonly-occurring value) and the median (middle value). None of these measures of average are ideal, due to the wide variety in the number of cases seen, even with outliers removed; however, taken together they give some indication of the number of cases of different types seen in person.

Small animal cases seen in person

Table 4.6 indicates that the four types of small animal cases seen by the highest number of VS respondents in person during the two-week period are diarrhoea and/or vomiting, ear or eye conditions, lethargy and/or inappetence, and musculoskeletal disease. These types of case are all selected by more than 850 respondents and also all have a mean, mode and median of five or greater.

Table 4.6 Types of small animal case seen in person 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Behaviour problems	283	1	20	2.38	1	2
Collapse	834	1	30	3.21	2	2
Dental conditions	797	1	53	4.49	2	3
Diarrhoea and/or vomiting	986	1	60	10.62	10	8
Ear or eye conditions	986	1	60	8.67	10	6
Excessive drinking and/or urinating	800	1	50	3.91	2	2
Fleas and/or worms	347	1	70	6.57	1	3
Heart disease	794	1	50	3.20	2	2
Lethargy and/or inappetence	943	1	50	7.12	10	5
Lumps and bumps	832	1	50	4.97	2	4
Minor wounds	778	1	25	3.81	2	3
Musculoskeletal disease	856	1	50	6.24	5	5
Neurological conditions	721	1	50	2.65	1	2

Pain	847	1	80	6.70	2	5
Reproductive disorders	508	1	40	2.80	1	2
Respiratory conditions	853	1	50	3.83	2	3
Skin conditions	796	1	50	6.84	2	5
Suspected endocrinopathy	555	1	30	2.89	1	2
Suspected poisoning	517	1	30	2.56	1	2
Trauma	765	1	40	3.95	2	3
Weight loss	654	1	50	3.61	2	2
Other	154	1	80	15.47	10	10

Source: RCVS Covid-19 Survey, 2020

'Other' conditions seen are many and very varied, and many respondents gave types of cases but without numbers, or said they were unable to recall the numbers; indeed, one respondent with no time to look through practice records said 'Suffice it to say that this June has been the busiest month on record in the practice and I'm exhausted'. The most frequent response was first and/or booster vaccinations (65 mentions, with some giving high numbers or saying these were administered several times a day, or very frequently). Other types of case mentioned by more than one respondent are euthanasia (21 mentions), anal gland issues (17 mentions), neutering (nine mentions), bladder or intestinal blockages (eight mentions), urinary tract infections (five mentions), ear tests/infections/problems (five mentions), nail/claw issues (five mentions), abscesses other than anal (two mentions), parasites (two mentions), and treating wildlife/strays (two mentions).

Equine cases

Table 4.7 indicates that the types of equine case seen by the highest number of VS respondents in person during the two-week period are lameness, colic and wounds; however, reproductive issues, lameness and dental have the highest means, and lameness and dental have the highest medians. These findings should be treated with caution as the overall number who saw equine cases is fairly small, and there is a lot of variation among respondents.

Table 4.7 Type of equine cases seen in person 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Colic	73	1	18	2.81	1	2
Dental	45	1	20	4.76	1	3
Eye problems	46	1	5	1.74	1	1
Lameness	83	1	50	5.19	1	3
Reproductive issues	37	1	90	6.62	1	2
Respiratory conditions	54	1	50	3.56	1	2
Skin conditions	44	1	10	2.66	1	2
Wounds	61	1	12	2.79	1	2

Other	44	1	42	8.86	1	5

Source: RCVS Covid-19 Survey, 2020

'Other' conditions seen are very varied, although the most frequently-mentioned (19 times) is vaccinations. Other conditions mentioned more than once are euthanasia (three mentions), emergencies (collapse, recumbent horse, surgical) (three mentions), pre-purchase examinations (two mentions), examinations for export papers (two mentions), pyrexia (two mentions), strangles (two mentions),

Farm animal cases

Table 4.8 indicates that the types of farm animal case seen most frequently by VS respondents in person during the two-week period, looking at number of respondents, are individual sick animal, obstetrical problem, and fertility and reproduction; however, fertility and reproduction, individual sick animal, and assisting/guiding statutory disease control testing have the highest means, while fertility and reproduction, individual sick animal, and herd or flock health plan, farm assurance or routine health visit have the highest medians. These findings should be treated with considerable caution as the overall number who saw farm animal cases is fairly small, and there is a lot of variation among respondents; several respondents give very high numbers of cases for fertility and reproduction in particular, which skews the mean average even when the biggest outlier is removed.

Table 4.8 Type of farm animal case seen in person 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Fertility and reproduction	69	1	400	39.99	1	5
Individual sick animal	89	1	50	6.55	1	4
Obstetrical problem	76	1	20	3.55	1	2
Assisting/Guiding surgery	29	1	15	3.07	1	2
Herd or flock health plan, farm assurance or routine health visit	29	1	24	4.45	1 and 4	4
Herd/flock disease outbreak	26	1	12	2.54	2	2
Assisting/Guiding statutory disease control testing	41	1	30	5.22	2	3
Herd or flock screening	21	1	10	2.71	2	2
Other	11	1	20	14.36	1	2

Source: RCVS Covid-19 Survey, 2020

The small number of respondents providing details about 'other' cases gave varied description, with only castration (two mentions) and euthanasia (two mentions) occurring more than once.

4.1.4 Animals seen remotely

Table 4.9 shows the type of cases seen remotely by VS respondents during 1 to 14 June. A comparison with Table 4.5 indicates that, although the number of VSs who saw small animals remotely is fairly close to the number who saw cases in person, the number who saw equine and farm animal cases remotely is notably lower than the number who saw cases in person.

Table 4.9 Types of animals seen remotely between 1 to 14 June 2020: VSs

	N	%
Small animal	1231	94.3
Equine	88	6.7
Farm animal	74	5.7

Source: RCVS Covid-19 Survey, 2020

Tables 4.10 to 4.12 below show, separately for small animal, equine, and farm animal: the number of VS respondents who saw at least one case; the minimum and maximum number of cases (with very high outliers removed); and the mean average, the mode (most commonly-occurring value) and the median (middle value). As previously stated, none of these measures of average are ideal, due to the wide variety in the number of cases seen, even with outliers removed; however, taken together they give some indication of the number of cases of different types seen remotely.

Small animal cases

Table 4.10 indicates that the five types of small animal case that the highest numbers of VSs report that they saw remotely during the two-week period are diarrhoea and/or vomiting, skin conditions, ear or eye conditions, lumps and bumps, and musculoskeletal disease. These types of case are all selected by more than 700 respondents. However, the highest means give a slightly different picture, in that fleas and/or worms, diarrhoea and vomiting, and skin conditions all have a mean of seven or greater. Finally, the following conditions all have a mode higher than one combined with a mode of five: diarrhoea and vomiting, fleas and/or worms, and skin conditions.

Table 4.10 Types of small animal case seen remotely 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Behaviour problems	508	1	29	2.73	1	2
Collapse	116	1	20	3.23	1	2
Dental conditions	464	1	39	3.82	2	2
Diarrhoea and/or vomiting	809	1	50	7.18	2	5
Ear or eye conditions	728	1	96	6.16	1	4
Excessive drinking and/or urinating	381	1	32	3.44	1	2

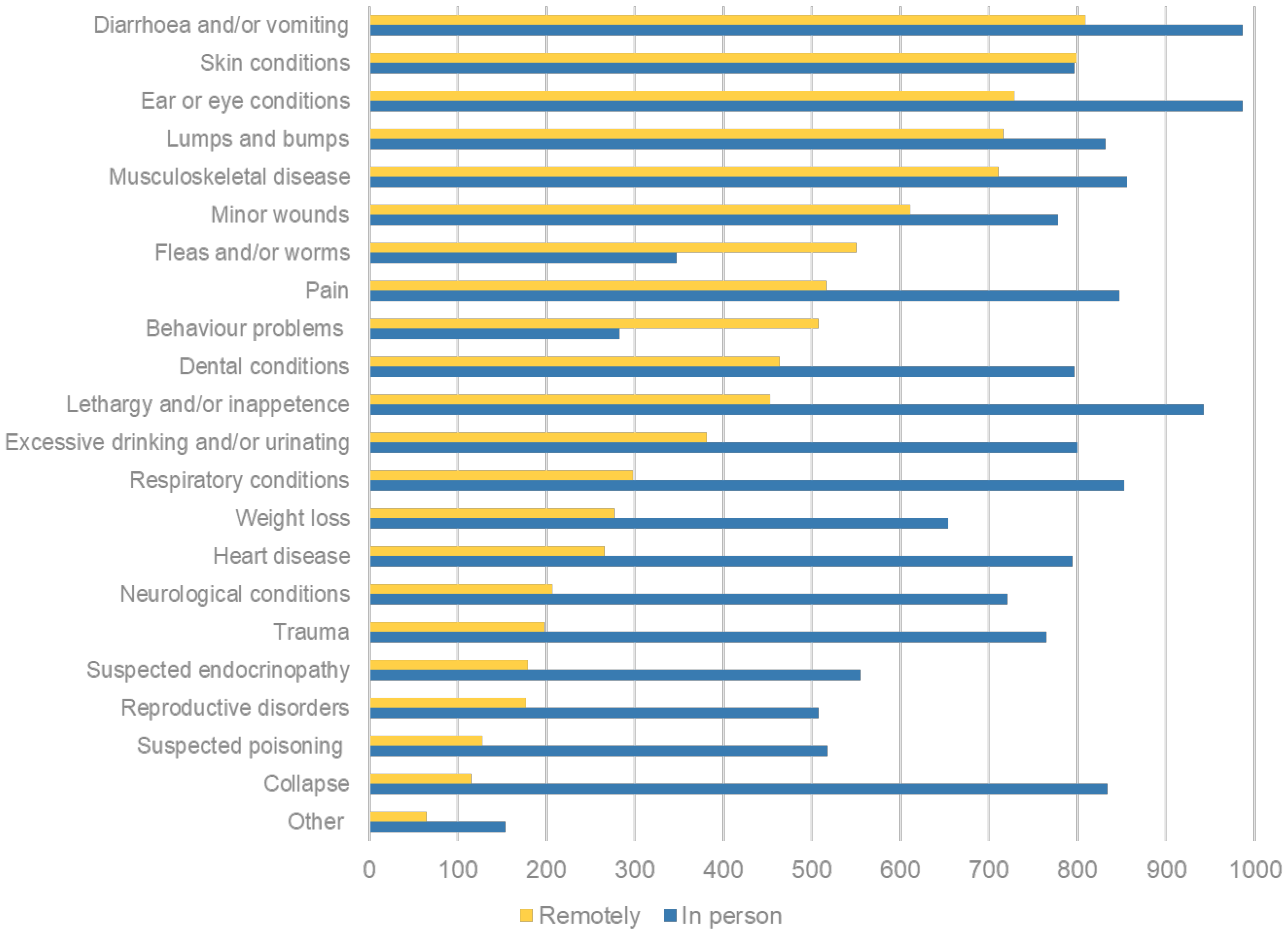
Fleas and/or worms	551	1	145	9.80	2	5
Heart disease	266	1	40	3.26	1	2
Lethargy and/or inappetence	453	1	50	5.45	2	3
Lumps and bumps	716	1	32	5.34	2	4
Minor wounds	611	1	29	3.94	2	2
Musculoskeletal disease	711	1	50	6.09	2	4
Neurological conditions	207	1	15	2.73	1	2
Pain	516	1	70	5.79	2	4
Reproductive disorders	177	1	31	3.28	1	2
Respiratory conditions	298	1	69	3.64	1	2
Skin conditions	799	1	70	7.01	2	5
Suspected endocrinopathy	179	1	20	3.22	1	2
Suspected poisoning	128	1	31	2.41	1	1
Trauma	198	1	20	3.72	2	2
Weight loss	277	1	32	4.04	1	2
Other	65	1	44	7.03	1	14

Source: RCVS Covid-19 Survey, 2020

‘Other’ conditions seen are very varied, and many respondents provided the condition but not the number of cases. Examples include checks for repeat prescriptions (eight mentions), cancer/oncology consultations including palliative advice (five mentions), postoperative checks (seven mentions), advice on new puppies/kittens, including giving vaccines but with the owner not being present (four mentions), ticks (three mentions) and general advice/reassurance (three mentions). In addition, one respondent specified 24 claw/beak cases, presumably with the animal being present without the owner.

Figure 4.1 compares, for each type of small animal case, the number of VSs who saw animals with these cases in person and remotely. This illustrates the most frequently-seen types of cases, and the differences between cases seen remotely and in person.

Figure 4.1 Number and type of small animal cases seen remotely and in person 1 to 14 June 2020: VS



Source: RCVS Covid-19 Survey, 2020

Equine cases

Table 4.11 indicates that the types of equine case seen most frequently by VS respondents remotely during the two-week period, looking at number of respondents, are lameness and skin conditions; lameness also has a mode and median of two. However, dental has the highest mean. These findings should be treated with caution as the overall number who saw equine cases remotely is even smaller than the number who saw equine cases in person, and there is a lot of variation among respondents.

Table 4.11 Type of equine case seen remotely 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Colic	8	1	4	1.75	1	1.5
Dental	6	1	20	4.83	1	1.5
Eye problems	25	1	15	1.80	1	1
Lameness	54	1	15	2.98	2	2

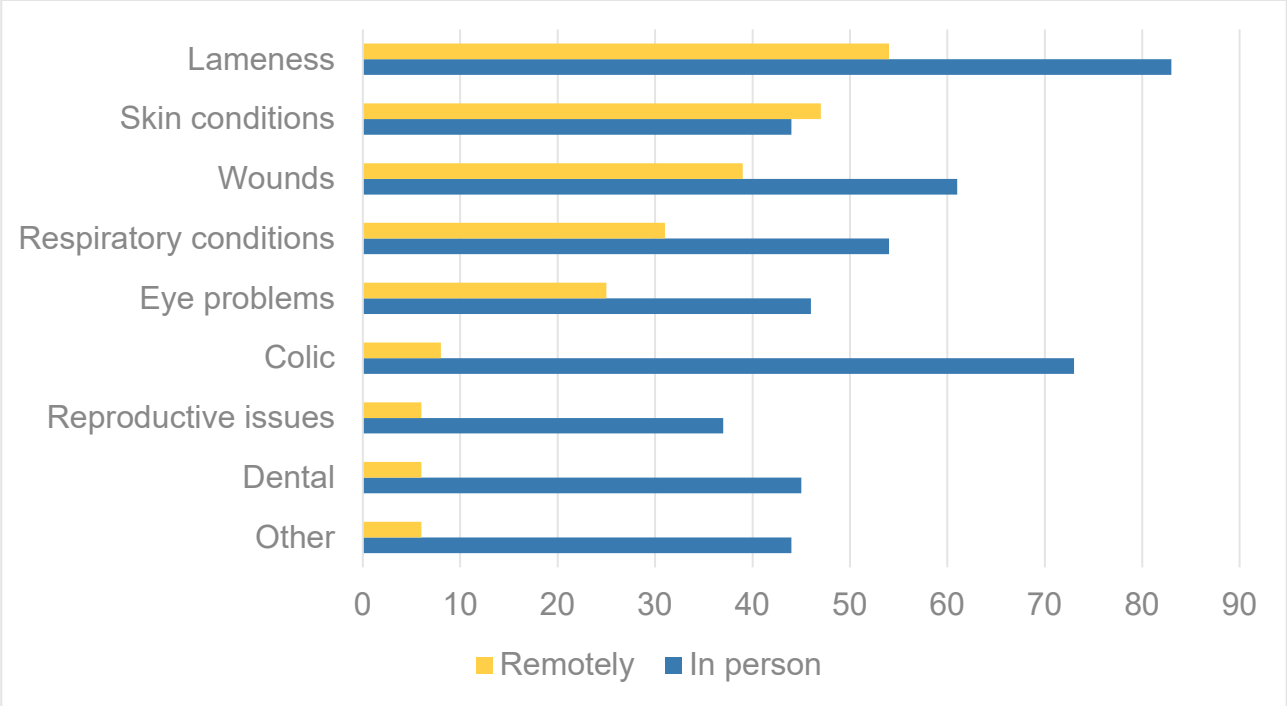
Reproductive issues	6	1	3	1.83	1	1.5
Respiratory conditions	31	1	20	2.58	1	2
Skin conditions	47	1	8	2.17	1	2
Wounds	39	1	6	1.95	1	2
Other	6	1	5	2.5	2	2

Source: RCVS Covid-19 Survey, 2020

'Other' conditions seen remotely are described in various ways, with no type of case being mentioned more than once.

Figure 4.2 compares, for each type of equine case, the number of VSs who saw animals with these cases in person and remotely.

Figure 4.2 Number and type of equine cases seen remotely and in person 1 to 14 June 2020: VS



Source: RCVS Covid-19 Survey, 2020

Farm animal cases

Table 4.12 indicates that the types of farm animal case seen most frequently by VS respondents remotely during the two-week period, looking at number of respondents, are individual sick animal, herd/flock disease outbreak and herd or flock health plan, farm assurance or routine health visit have the highest medians. These findings should be treated with extreme caution as the overall number who saw farm animal cases remotely is very small, indeed smaller than the number seeing farm animals in person.

Table 4.12 Type of farm animal case seen remotely 1 to 14 June 2020: number seeing each type, and number of times seen: VS

	N	Min	Max	Mean	Mode	Median
Fertility and reproduction	10	1	10	4.40	1 and 2	3.5
Individual sick animal	51	1	50	6.86	2 and 4	5
Obstetrical problem	2	1	1	1.00	1	1
Assisting/Guiding surgery	0	-	-	-	-	-
Herd or flock health plan, farm assurance or routine health visit	24	1	15	4.71	2	3.5
Herd/flock disease outbreak	24	1	10	2.75	1	2
Assisting/Guiding statutory disease control testing	0	-	-	-	-	-
Herd or flock screening	6	1	10	4.00	2	2.5
Other	5	2	6	3.80	4	4

Source: RCVS Covid-19 Survey, 2020

'Other' conditions seen remotely are varied, including two mentions of poultry issues.

A graph comparing in person and remote consultations for farm animals has not been included due to the small numbers involved.

4.1.5 Time-efficiency of consultations

Respondents were asked to compare the time-efficiency of remote consultations during 1 to 14 June with firstly face-to-face consultations pre-Covid-19 and secondly with face-to-face consultations using the regime adopted during Covid-19. Tables 4.13 and 4.14 give the results, and indicate that whereas more than half (58.2%) of respondents found remote consultations less time-efficient compared to pre-Covid-19 face-to-face consultations, opinions are more divided about the comparison of remote and face-to-face consultations during Covid-19.

Table 4.13 Time-efficiency of remote consultations compared to face-to-face consultations pre-Covid-19: VS

	N	%
More efficient	205	16.8
Neither more nor less efficient	305	25.0
Less efficient	711	58.2

Source: RCVS Covid-19 Survey, 2020

Table 4.14 Time-efficiency of remote consultations compared to face-to-face consultations using regime adopted during Covid-19: VS

	N	%
More efficient	453	37.3
Neither more nor less efficient	287	23.6
Less efficient	426	35.0
Not applicable - I saw no face-to-face cases during Covid-19	50	4.1

Source: RCVS Covid-19 Survey, 2020

Further analysis shows that the overall percentages in Tables 4.13 and 4.14 mask some differences by practice type. While only 14.3 per cent of VS respondents in small animal practices, and 15.6 per cent of respondents in mixed practices, found remote consultations more time-efficient than face-to-face consultations pre-Covid-19, almost half (45.9%) of those in equine practices found them more efficient. Similarly, over half (59.5%) of those in equine practices found remote consultations more time-efficient than face-to-face consultations using the regime adopted during Covid-19, compared to a lower 36.6 per cent of small animal respondents.

The age of respondents also appears to make some difference to views about time-efficiency. The average (mean) age of respondents finding remote consultations more efficient than face-to-face consultations pre-Covid-19 is 39.2, compared to 43.1 for those finding it less efficient. Similarly, the average age of those finding remote consultations more time-efficient than face-to-face consultations using the Covid-19 regime is 40.1, compared to 43.9 for those finding it less time-efficient.

4.1.6 Confidence in diagnoses

In two areas, respondents were asked to assess their confidence in making diagnoses remotely. Firstly, for each type of case seen remotely, they were asked to rate their confidence compared to face-to-face diagnoses pre-Covid-19. Secondly, in general terms they were asked whether their confidence in their remote diagnoses was affected by whether the animal was known to them or was new to them.

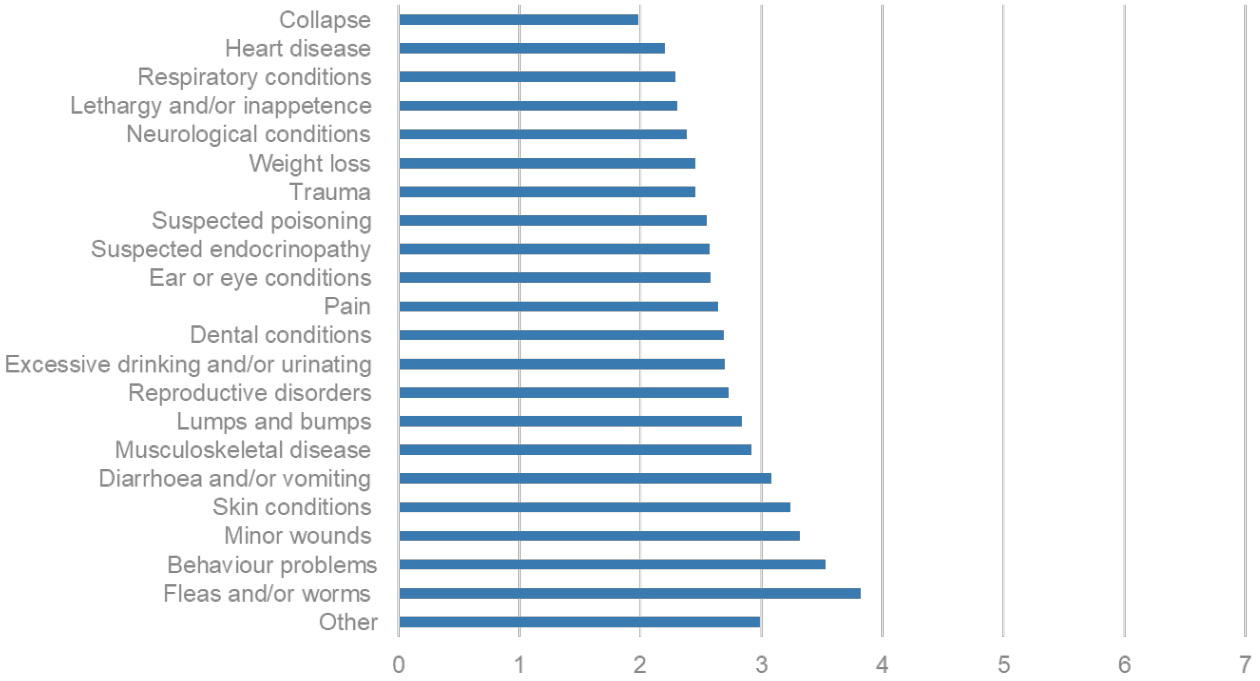
Compared with face-to-face diagnoses pre-Covid 19

Small animal

For each type of small animal case seen remotely, VSs were asked to rate their confidence in their remote diagnoses compared to face-to-face diagnoses pre-Covid-19, using a seven-point scale. The scale ranged from ‘much less confident’ (scoring 1) to ‘much more confident’ (scoring 7), with a mid-point of ‘equally as confident’ (scoring 4). The overall mean scores for each type of case were then calculated, discounting any ‘not applicable’ responses.

Figure 4.3 shows that all 22 of the mean scores, which ranged from 1.98 to 3.82, were below the midpoint of four. This indicates that VS respondents were, on average, less confident about their diagnoses in every type of case in comparison with face-to-face diagnoses pre-Covid-19.

Figure 4.3 Confidence in small animal diagnoses compared to face-to-face diagnoses pre-Covid-19: mean scores, VS



Source: RCVS Covid-19 Survey, 2020

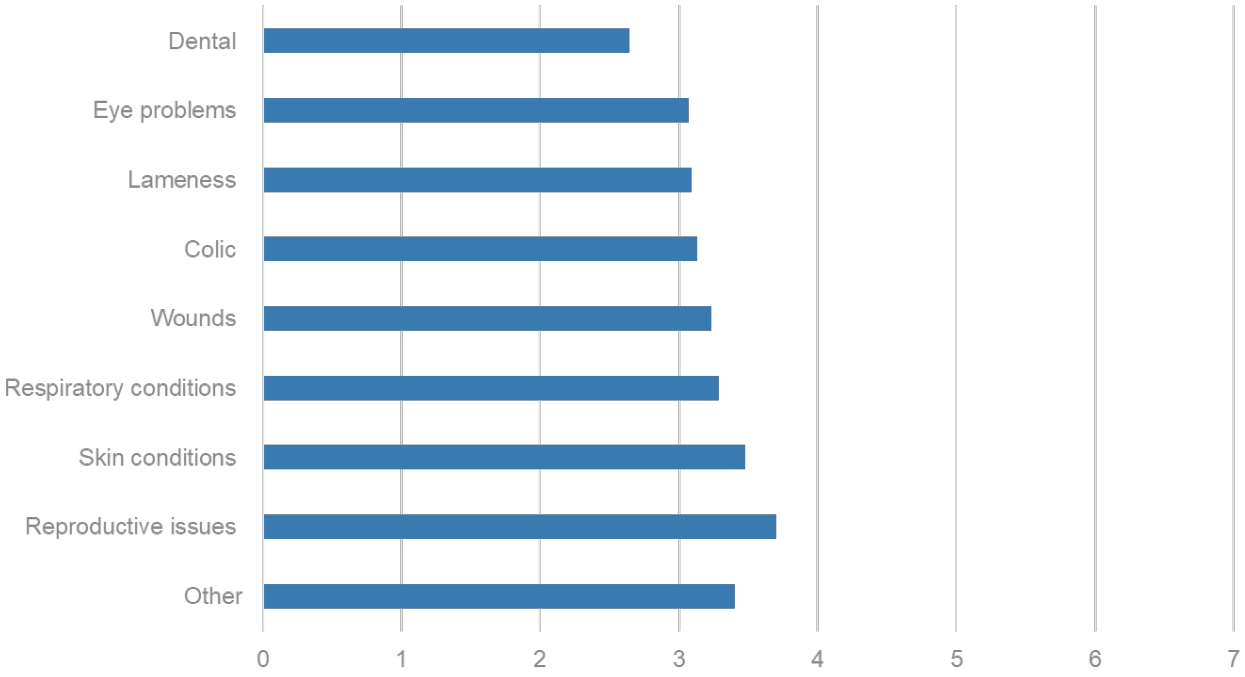
- The lowest average scores, indicating the lowest levels of confidence (all of which are below 2.5), are for the following conditions:
  - Collapse: 1.98
  - Heart disease: 2.20
  - Respiratory conditions: 2.29
  - Lethargy and/or inappetence: 2.30
  - Neurological conditions: 2.38
  - Trauma: 2.45
  - Weight loss: 2.45.
- The highest scores, indicating the greatest confidence (higher than 3.5, but still below the midpoint of 4) are for the following conditions:
  - Fleas and/or worms: 3.82
  - Behaviour problems: 3.53.

Equine

For each type of equine case seen remotely, VSs were asked to rate their confidence in their remote diagnoses compared to face-to-face diagnoses pre-Covid-19, using a seven-point scale. The scale ranged from 'much less confident' (scoring 1) to 'much more confident' (scoring 7), with a mid-point of 'equally as confident' (scoring 4). The overall mean scores for each type of case were then calculated, discounting any 'not applicable' responses.

Figure 4.4 shows that all nine of the mean scores, which ranged from 2.64 to 3.70, were below the midpoint of four. This indicates that VS respondents were, on average, less confident about their diagnoses in every type of case in comparison with face-to-face diagnoses pre-Covid-19. The lowest average score, indicating the lowest level of confidence, was for dental cases (2.64), while the highest was for reproductive issues (3.70). In comparison to the small animal scores reported above, it appears that equine VSs were somewhat more confident overall in their diagnoses, although caution is required due to the relatively small number of VSs who diagnosed equine cases remotely.

Figure 4.4 Confidence in equine diagnoses compared to face-to-face diagnoses pre-Covid-19: mean scores, VS



Source: RCVS Covid-19 Survey, 2020

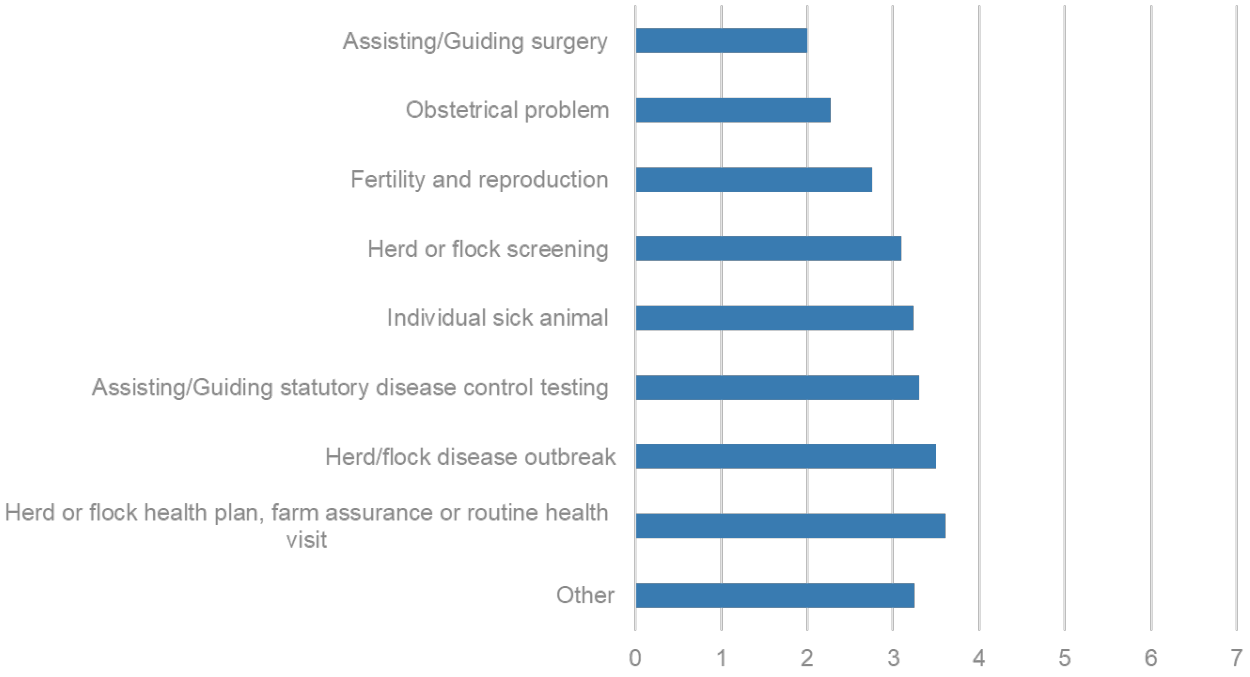
Farm animal

For each type of farm animal case seen remotely, VSs were asked to rate their confidence in their remote diagnoses compared to face-to-face diagnoses pre-Covid-19,

using a seven-point scale. The scale ranged from ‘much less confident’ (scoring 1) to ‘much more confident’ (scoring 7), with a mid-point of ‘equally as confident’ (scoring 4). The overall mean scores for each type of case were then calculated, discounting any ‘not applicable’ responses.

Figure 4.5 shows that all nine of the mean scores, which ranged from 2.0 to 3.61, were below the midpoint of four. This indicates that VS respondents were, on average, less confident about their diagnoses in every type of case in comparison with face-to-face diagnoses pre-Covid-19. The two lowest average scores (both below 2.5), indicating the lowest level of confidence, were for assisting surgery (2.0) and obstetrical problem (2.27), while the highest two were for herd or flock health plan, farm assurance or routine health visit (3.61) and herd/flock disease outbreak (3.5). Caution is required due to the relatively small number of VSs who diagnosed farm animal cases remotely.

Figure 4.5 Confidence in farm animal diagnoses compared to face-to-face diagnoses pre-Covid-19: mean scores, VS



Source: RCVS Covid-19 Survey, 2020

Existing compared to new animals

Table 4.15 indicates that VS respondents were generally less confident in their remote diagnoses during 1 to 14 June when the client/animal was new to them. For a minority of VS respondents, the question was not relevant, either because they only attended clients/animals remotely who were known to them (14.9%) or, more unusually, only attended clients/animals remotely who were new to them (1.6%). It appears that only a little over one quarter (27.4%) of respondents felt it made no difference to their

confidence; most (72.6%) were less confident, with 15.6 per cent admitting to being 'much less confident'.

Table 4.15 Confidence in remote diagnoses if client/animal not known to respondent: VS

	N	%	% without 'N/A' options
Yes, I was much less confident when attending to a new client/animal remotely	190	15.6	18.7
Yes, I was less confident when attending to a new client/animal remotely	256	21.1	25.2
Yes, I was a little less confident when attending to a new client/animal remotely	291	23.9	28.7
No, it made no difference whether the client/animal was known to me or not	278	22.9	27.4
Not applicable as I only attended clients/animals remotely known to me	181	14.9	-
Not applicable as I only attended clients/animals remotely new to me	20	1.6	-

Source: RCVS Covid-19 Survey, 2020

Further analysis shows no significant differences between different respondent groups apart from in one area, that of age. Although there is not a consistent link between respondents' average age and their confidence level, the average age of those saying they were much less confident when attending to a new client/animal remotely is somewhat higher than average (43.1 compared to 42.2 overall), while the average age of those who responded 'not applicable as I only attended clients/animals remotely known to me' is a relatively high 46.6.

4.1.7 Animals needing to be seen face-to-face

Table 4.16 indicates that VS respondents are fairly cautious in making diagnoses and treating animals via remote consultations: over half (55.3%) said that at least 50 per cent of the cases they saw remotely between 1 to 14 June led to their giving advice that the animal needed to be physically seen, and indeed 7.5 per cent say they gave such advice for 90 per cent or more of the cases they saw.

Table 4.16 Percentage of cases seen remotely resulting in advice that the animal should be physically seen: VS

	N	%
90% or more	90	7.5
75% to 89%	209	17.4
50% to 74%	365	30.4
25% to 49%	323	26.9
Fewer than 25%	212	17.7

Source: RCVS Covid-19 Survey, 2020

Further analysis shows that practice type, size and ownership structure make little difference to these percentage breakdowns. However, 62.9 per cent of male VSs, compared to a lower 51.8 per cent of female VSs, say that at least half of their cases led to advice that the animal needed to be physically seen. This finding is probably related to age, in that a notably higher percentage than average of VSs in the 50 to 59 and 60 plus age groups advised that at least half of their cases led to advice that the animal needed to be physically seen (58.6% and 61.8% respectively).

Re-checks of animals previously seen remotely within the practice

During the two-week period, more than three-quarters (78.5%) of VS respondents were personally involved in carrying out face-to-face re-checks of cases they, or someone else in their practice, had previously seen remotely. Table 4.17 presents the drivers for these face-to-face re-checks, and shows that many VS respondents feel that further investigation, medication changes and diagnostic certainty all require a physical examination.

Table 4.17 Drivers of face-to-face re-checks of animals previously seen remotely within the practice: VS (multiple response)

	N	%
Required further investigation that could not be performed remotely	887	92.6
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	749	78.2
Accurate diagnosis was considered essential and that this required physical examination	685	71.5
Diagnostic uncertainty was too great to continue remote management	653	68.2
Patient was deteriorating and required hospitalisation	486	50.7
Other	31	3.2

Source: RCVS Covid-19 Survey, 2020

‘Other’ drivers specified by respondents are predominantly client-related (13 mentions), e.g. the client asked for a re-check, was unable to explain the animal’s issues adequately or administer medication/treatment, or required a face-to-face explanation of the animals’ treatment. In addition, the following drivers were mentioned by more than one respondent: euthanasia (two mentions), check-ups or second opinion (four mentions), and severity of condition/new symptoms/requiring further diagnostics (three mentions).

Further analysis shows that VS respondents in small animal practice were particularly likely, and those in equine practices notably less likely, to have been involved in face-to-face re-checks: 82 per cent, compared to 48 per cent.

VS respondents involved in face-to-face re-checks said this happened between one and 90 times, with a mean of 11.9, a median of eight and a mode of ten. The overall mean masks considerable differences when the means in practice types are compared small animal 12.7, mixed 9.2, referral 7.7, farm 4.4 and equine 2.6. However, practice size and ownership structure make little difference.

When asked if this number was higher or lower than would have been expected had the initial consultation been face-to-face, 44.7 per cent selected 'about the same', 42.6 per cent 'higher' and a considerably smaller 12.7 per cent 'lower'. Further analysis shows that a higher percentage of those in independently-ownership practices say 'higher' (47.2%) compared to those in corporately-owned practices (40.9%).

Re-checks of animals previously seen remotely elsewhere

During the two-week period, slightly over one quarter (28%) of VS respondents were personally involved in carrying out face-to-face re-checks of cases that had previously been seen remotely by another practice or provider; 60.9 per cent said no, they had not been involved in such re-checks, and the remaining 11.1 per cent did not know. Table 4.18 presents the drivers for these face-to-face consultations, and shows the most important driver to be the requirement for further investigation that could not be performed remotely, although all other drivers attracted at least a 50 per cent response.

'Other' drivers mentioned by more than one respondent are client unable to afford fees in another practice (nine mentions), referrals/second opinion (seven mentions), being an out-of-hours provider (five mentions), and the other practice not being able to provide the necessary treatment and/or medication.

Further analysis shows that, unsurprisingly, those in referral practices are most likely to say they carried out face-to-face re-checks of cases previously seen elsewhere (47.5%); those in small animal practices were also more likely than average to have been involved in such re-checks (29.6%). However, for those in equine and farm practices, this was much less likely (10.8% and 12.5% respectively).

Table 4.18 Drivers of face-to-face consultations with animals previously seen remotely by another practice or provider: VS (multiple response)

	N	%
Required further investigation that could not be performed remotely	256	75.5
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	202	59.6
Accurate diagnosis was considered essential and that this required physical examination	192	56.6
Diagnostic uncertainty was too great to continue remote management	191	56.3
Another veterinary practice was not able to see or did not feel it needed to see the animal	188	55.5
Patient was deteriorating and required hospitalisation	181	53.4
Other	34	10.0

Source: RCVS Covid-19 Survey, 2020

The VSs who were involved in such consultations involving animals previously seen remotely elsewhere said that this had occurred between one and 80 times, with a mean average of 7.5, a mode of two and a median of four.

4.1.8 Interactions with clients

Several questions towards the end of the survey relate to interactions with clients during the two-week period.

- When asked about **clients' willingness to pay for remote consultations**, almost two-thirds (63.9%) of VS respondents said their clients were willing to pay something, but not as much as a face-to-face consultation; one quarter (26.8%) said they were willing to pay the same amount; but 9.3 per cent selected 'unwilling to pay anything'. Further analysis shows:
  - VSs in independent practices are more likely to experience clients being unwilling to pay anything for a remote consultation, and less likely to say clients are willing to pay the same as for a face-to-face consultation, than those in corporate practices: 13.8% (independents) compared to 5.4% (corporates) say their clients are unwilling to pay anything, while 19.9% (independents) compared to 34.9% (corporates) say their clients are prepared to pay the same amount.
  - Practice type and size of practice, however, make little difference.
  - UK country also makes little difference, although when analysed by region in England, it appears that VS respondents in the West Midlands, the North West, the East Midlands and Yorkshire and The Humber find their clients somewhat more willing than average to pay the same amount for a remote consultation as for a face-to-face consultation.
- **Clients' ability to operate any technology required for remote consultations** during the two-week period is rated as 'adequate' by over half (56.7%) of respondents and 'good' by 20.4 per cent, although 22.9 per cent regard it as 'poor'. Further analysis shows few differences by respondent group, apart from by practice type:
  - VS respondents working in small animal practices are more likely than average to rate their clients' ability as poor (24.3%) and less likely to rate it as good (18.6%); by contrast, respondents in equine practices rate their client's ability relatively highly, with 42.4 per cent saying it is good.
- **The technical quality of the remote consultation** on average (in terms of audio and/or visual quality) is rated as 'adequate' (57.8%) or 'good' (22.6%) by most VS respondents, although 19.7 per cent experienced it as 'poor'. Further analysis shows:
  - Type of practice makes some difference to the overall response pattern, in that VS respondents in referral and telemedicine practices are far more likely than average to rate the technical quality as adequate or good (94.6% and 100% respectively).
  - Ownership structure makes little difference, but size of practice appears to be relevant in one respect: VSs in large practices are somewhat more likely than average to rate the technical quality as adequate or good (85.8%).
  - There is a relationship between response pattern and age, in that the mean age of respondents rating the technical quality as good is a lower-than-average 40.0, while those rating is as poor is a higher-than-average 44.3.

- Finally, on average most VS respondents rate their **clients' ability to provide relevant information** such as the animal's history, clinical signs or weight during the two-week period as 'adequate' (51.9%) or 'good' (27.8%); however, in keeping with the previous two questions, around one-fifth (20.3%) rate it as 'poor'. Further analysis indicates:
  - Respondents in independent practices are somewhat more likely than those in corporate practices to rate clients' ability as poor (23.9% compared to 18.0%).
  - Those in mixed practices are less likely than average to rate clients' ability as good (19.8%).
  - Those in referral and telemedicine practise are notably more likely than average to rate it as good or adequate (92.1% and 100% respectively).

4.2 VNs

4.2.1 Use of remote consulting

When asked about the animals they saw remotely during the two-week period, it is clear that, as for VSs, the extent to which the animal and/or client was already known to the practice and the VN personally was an influencing factor (see Table 4.19). In particular, the large majority (90.8%, representing 90.4% of VN respondents and a higher 93.4% of VN SQP respondents) saw animals/clients existing to the practice that they had personally seen within the last 12 months, whereas only around half (52.8%, representing 54.3% of VNs and a notably lower 42.6% of VN SQPs) saw animals/clients new to the practice.

Table 4.19 Personal use of remote consulting during 1 to 14 June 2020: VN (multiple response)

	N	%
Existing (to the practice) clients and animals you personally have seen within the last 12 months	423	90.8
Existing (to the practice) clients and animals that you personally have not seen for more than 12 months	313	67.2
Existing (to the practice) clients and animals that you personally have never seen	258	55.4
Clients that are new to the practice	246	52.8

Source: RCVS Covid-19 Survey, 2020

Existing animals

VNs used remote consulting for existing (to the practice) animals/clients in fairly similar ways to VSs, as Table 4.20 shows; however, their second most frequent use was triage, and their involvement in prescriptions, especially new prescriptions, is much lower than for VSs. VN SQPs are more likely to have been involved in repeat prescriptions than VNs (75.4% compared to 65.2%).

Table 4.20 Personal use of remote consulting for existing (to the practice) clients/animals: VN (multiple response)

	N	%
Advice	447	94.7
Triage	407	86.2
Repeat prescriptions	314	66.5
Prescriptions for new conditions	127	26.9
Not applicable - I only used remote consulting for new animals and/or clients	1	-
Other	42	8.9

Source: RCVS Covid-19 Survey, 2020

'Other' uses mentioned by more than one respondent are post-operative checks/follow-ups (18 mentions), admitting and discharge processes (six mentions), and behaviour consultations (three mentions).

New animals

Respondents were asked about the ways in which they used remote consulting for new animals. The number of people responding to this question suggests that, in line with VS respondents, many VNs interpreted this question as relating to animals/clients existing to the practice, but not seen before by them, in addition to animals/clients new to the practice.

Table 4.21 shows that, although 17.3 per cent did not use remote consulting for new animals/clients, the majority of VN respondents used it to give advice (77.3%) or for triage (71.1%). Much less common, as for VSs, is the use of remote consulting to issue prescriptions, either repeat or for new conditions.

Table 4.21 Personal use of remote consulting for new clients/animals: VN (multiple response)

	N	%
Advice	361	77.3
Triage	332	71.1
Prescriptions for new conditions	90	19.3
Repeat prescriptions for a pre-existing condition	66	14.1
Not applicable – I did not use remote consulting for new animals and/or clients	81	17.3
Other	20	4.3

Source: RCVS Covid-19 Survey, 2020

'Other' uses mentioned by more than one respondent are pre- and/or post-operative checks (four mentions), and initial registration of and advice for clients with new puppies and/or kittens (three mentions).

4.2.2 Approach to remote consulting

Table 4.22 shows the ways in which VNs provided remote consultations during 1 to 14 June; for each method, the number of respondents using it for existing clients/animals is given first, followed by the number using it for new clients/animals. It is clear that telephone consultations – with or without supplementary visual evidence such as photographs and videos – was the most frequently-used method, while relatively few respondents used a bespoke platform. These results are fairly consistent with the findings for VSs.

Table 4.22 Approaches to providing remote consulting: VNs (multiple response, number providing each method)

	N
Phone consultations supplemented with photographs or videos from the client - existing clients/animals	427
Phone consultations supplemented with photographs or videos from the client - new clients/animals	297
Phone consultations (no additional visual information) - existing clients/animals	377
Phone consultations (no additional visual information) - new clients/animals	245
Email consultations supplemented with photographs or videos from the client - existing clients/animals	244
Email consultations supplemented with photographs or videos from the client - new clients/animals	149
Email consultations (no additional visual information) - existing clients/animals	128
Email consultations (no additional visual information) - new clients/animals	64
Live video consultations using free-to-access options (e.g. Skype, FaceTime, WhatsApp, Zoom) - existing clients/animals	111
Live video consultations using free-to-access options (e.g. Skype, FaceTime, WhatsApp, Zoom) - new clients/animals	79
Live video consultations using a bespoke video consult platform - existing clients/animals	62
Live video consultations using a bespoke video consult platform - new clients/animals	40
Other (please specify) - existing clients/animals	10
Other (please specify) - new clients/animals	8

Source: RCVS Covid-19 Survey, 2020

The only 'other' method given by two or more respondents is the use of specific applications or messaging applications not mentioned in the options provided for the question (four mentions).

When asked if any specific training was provided by their practice in relation to remote consulting, before or during the two-week period, 29.1 per cent of VN respondents (27.8%

of VNs and 37.7% of VN SQPs) said yes. Of those who received training, for most (80.1%), it took the form of in-house training. However, 20.6 per cent took part in external webinars open to all involved and 11.8 per cent in external webinars for managers, while 5.9 per cent received 'other' training. Respondents were asked to select all the options that applied, so these results indicate that some respondents received more than one type of training.

Examples of 'other' training mainly refer to written guidance, flowcharts or emails (seven mentions).

- Two-thirds (66.4%) of VN respondents say their practice developed written policies or protocols for remote consulting, before or during the two-week period; this is notably higher than the percentage of VSs (51.4%).
- When asked if their practice recorded remote consultations (other than taking written notes) during the two-week period, the majority (62.2%, somewhat lower than for VSs) said no, while 32.4 per cent said this happened routinely and 5.4 per cent in specific situations. A slightly higher percentage of VN SQPs say this happened routinely or in specific situations than VNs: 44.1 per cent compared to 36.9 per cent.
- A low 11.0% of VN respondents (compared to a higher 19.2% of VS respondents) say their practice was not actively following up on cases seen remotely during the two-week period. The majority (61.4%) said this happened in specific circumstances and 27.6 per cent said it was routinely done.

4.2.3 Animals seen in person

Before asking in more detail about respondents' experiences of remote consulting, they were asked about cases they saw in person during 1 to 14 June. Table 4.23 indicates that the majority of VN respondents were fairly active in seeing animals in person, although 10.8 per cent (higher than the 5.1% of VSs) say they only saw animals remotely during this period.

Table 4.23 Types of animals seen in person between 1 to 14 June 2020: VNs

	N	%
Small animal	368	88.7
Equine	7	1.7
Farm animal	5	1.2
Not applicable, I did not attend to any animal in person	45	10.8

Source: RCVS Covid-19 Survey, 2020

Respondents were then asked about the number of different types of cases they saw in person between 1 and 14 June. This question revealed that hardly any VNs saw equine or farm animal cases in person, so these are not reported here, and no further analysis was undertaken. However, VNs saw a wide variety of small animal cases, and Table 4.24 below shows: the number of VN respondents who saw at least one case; the minimum

and maximum number of cases (with very high outliers removed); and the mean average, the mode (most commonly-occurring value) and the median (middle value). None of these measures of average are ideal, due to the wide variety in the number of cases seen, even with outliers removed; however, taken together they give some indication of the number of cases of different types seen in person.

Small animal cases seen in person

Table 4.24 indicates that the three types of small animal case seen by the highest number of VN respondents in person during the two-week period are diarrhoea and/or vomiting, ear or eye conditions, and lethargy and/or inappetence. These types of case are all selected by more than 220 respondents and also all have a mean, mode and median of five or greater. They are also three of the four of the most frequently-seen conditions by VSs. One other condition, fleas and worms, has a much lower number of VN respondents seeing cases in person, but a high mean, mode and median, indicating that the VNs dealing with these cases saw them frequently.

Table 4.24 Types of small animal case seen in person 1 to 14 June 2020: number seeing each type, and number of times seen: VN

	N	Min	Max	Mean	Mode	Median
Behaviour problems	78	1	40	3.60	5	2
Collapse	209	1	30	4.19	2	3
Dental conditions	203	1	50	5.01	2	4
Diarrhoea and/or vomiting	241	1	80	10.99	10	10
Ear or eye conditions	230	1	50	9.55	10	8
Excessive drinking and/or urinating	174	1	50	5.43	2	3
Fleas and/or worms	110	1	60	12.19	10	8
Heart disease	146	1	20	3.77	2	2
Lethargy and/or inappetence	221	1	50	8.42	5	5
Lumps and bumps	170	1	50	6.15	2	4
Minor wounds	210	1	20	4.47	2	3
Musculoskeletal disease	115	1	30	6.26	3 and 5	4
Neurological conditions	139	1	40	3.45	2	2
Pain	200	1	50	8.06	5	5
Reproductive disorders	117	1	30	3.79	1	2
Respiratory conditions	188	1	30	4.50	2	3
Skin conditions	164	1	50	6.87	2	5
Suspected endocrinopathy	90	1	16	3.40	2	3
Suspected poisoning	150	1	30	3.03	1	2
Trauma	182	1	23	4.91	2	4
Weight loss	138	1	20	4.40	2	3
Other	29	1	50	13.00	1	10

Source: RCVS Covid-19 Survey, 2020

'Other' conditions mentioned more than once are post-operative checks (six mentions), vaccinations (five mentions), euthanasia (three mentions) and nail clipping (three mentions). Several VNs took this opportunity to say that although they saw animals, these were not consultations, as VNs do not carry out consultations, this being a VS responsibility.

4.2.4 Animals seen remotely

Small animal cases

Table 4.25 shows the type of cases seen remotely by VN respondents during 1 to 14 June. A comparison with Table 4.23 indicates that notably fewer VNs saw animals remotely than face-to-face. It also shows that almost all the VNs who saw animals remotely saw only small animals; the handful of equine and farm cases are not described further.

Table 4.25 Types of animals seen remotely between 1 to 14 June 2020: VNs

	N	%
Small animal	284	99.3
Equine	6	2.1
Farm animal	4	1.4

Source: RCVS Covid-19 Survey, 2020

Table 4.26 below shows, for small animal cases seen remotely: the number of VN respondents who saw at least one case; the minimum and maximum number of cases (with very high outliers removed); and the mean average, the mode (most commonly-occurring value) and the median (middle value). As previously stated, none of these measures of average are ideal, due to the wide variety in the number of cases seen, even with outliers removed; however, taken together they give some indication of the number of cases of different types seen remotely.

The table indicates that the three types of small animal case that the highest numbers of VNs report that they saw remotely during the two-week period are fleas and worms, diarrhoea and/or vomiting, and minor wounds. These types of case are all selected by more than 100 respondents. This indicates that VNs saw somewhat different types of case remotely than VSs, in that the only one of these three conditions to appear in the top five seen by VSs remotely is diarrhoea and/or vomiting.

Table 4.26 Types of small animal case seen remotely 1 to 14 June 2020: number seeing each type, and number of times seen: VN

	N	Min	Max	Mean	Mode	Median

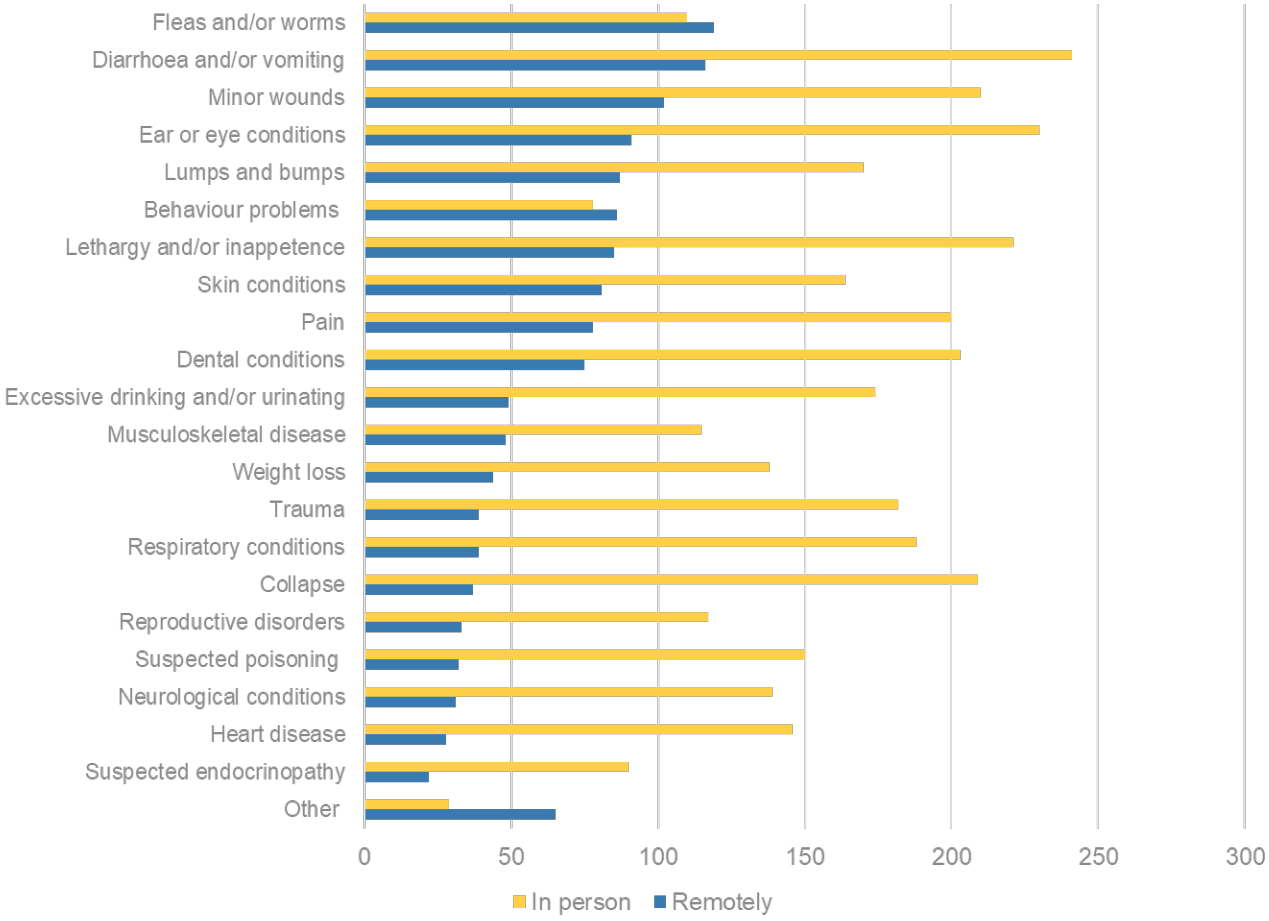
Behaviour problems	86	1	25	3.49	2	2
Collapse	37	1	40	5.16	2	3
Dental conditions	75	1	30	4.43	2	2
Diarrhoea and/or vomiting	116	1	60	8.24	2	5
Ear or eye conditions	91	1	50	6.85	2	4
Excessive drinking and/or urinating	49	1	50	6.12	2	4
Fleas and/or worms	119	1	100	13.92	10	10
Heart disease	28	1	20	4.71	2	2
Lethargy and/or inappetence	85	1	40	6.24	2	4
Lumps and bumps	87	1	40	6.64	2	5
Minor wounds	102	1	25	4.38	2	2.5
Musculoskeletal disease	48	1	50	7.13	2	4.5
Neurological conditions	31	1	35	4.58	1	2
Pain	78	1	60	7.49	2	4
Reproductive disorders	33	1	20	4.67	2	3
Respiratory conditions	39	1	25	4.97	2	2
Skin conditions	81	1	30	7.40	2	5
Suspected endocrinopathy	22	1	15	3.82	1	2
Suspected poisoning	32	1	25	3.38	1	2
Trauma	39	1	24	5.51	1	3
Weight loss	44	1	50	6.43	1	4
Other	65	1	20	7.20	5 and 10	6

Source: RCVS Covid-19 Survey, 2020

‘Other’ conditions are mostly pre- and post-operative checks (eight mentions), with no other condition or type of case being mentioned more than once.

Figure 4.6 compares, for each type of small animal case, the number of VNs who saw animals with these cases in person and remotely. This illustrates the most frequently-seen types of cases, and the differences between cases seen remotely and in person.

Figure 4.6 Number and type of small animal cases seen remotely and in person 1 to 14 June 2020: VN



Source: RCVS Covid-19 Survey, 2020

4.2.5 Time-efficiency of consultations

Respondents were asked to compare the time-efficiency of remote consultations during 1 to 14 June with firstly face-to-face consultations pre-Covid-19 and secondly face-to-face consultations using the regime adopted during Covid-19. Tables 4.27 and 4.28 give the results, and indicate that well over half of VN respondents (63.2%, higher than the VS percentage) found remote consultations less time-efficient compared to pre-Covid-19 face-to-face consultations. VNs also found remote consultations less time-efficient than face-to-face consultations during Covid-19, unlike VSs who were more divided in their opinion.

Table 4.27 Time-efficiency of remote consultations compared to face-to-face consultations pre-Covid-19: VN

	N	%
More efficient	35	14.5
Neither more nor less efficient	54	22.3

Less efficient	153	63.2

Source: RCVS Covid-19 Survey, 2020

Table 4.28 Time-efficiency of remote consultations compared to face-to-face consultations using regime adopted during Covid-19: VN

	N	%
More efficient	40	16.6
Neither more nor less efficient	54	22.4
Less efficient	126	52.3
Not applicable - I saw no face-to-face cases during Covid-19	21	8.7

Source: RCVS Covid-19 Survey, 2020

4.2.6 Confidence in diagnoses

In two areas, respondents were asked to assess their confidence in making diagnoses remotely. Firstly, for each type of case seen remotely, they were asked to rate their confidence compared to face-to-face diagnoses pre-Covid-19. Secondly, in general terms they were asked whether their confidence in their remote diagnoses was affected by whether the animal was known to them or was new to them.

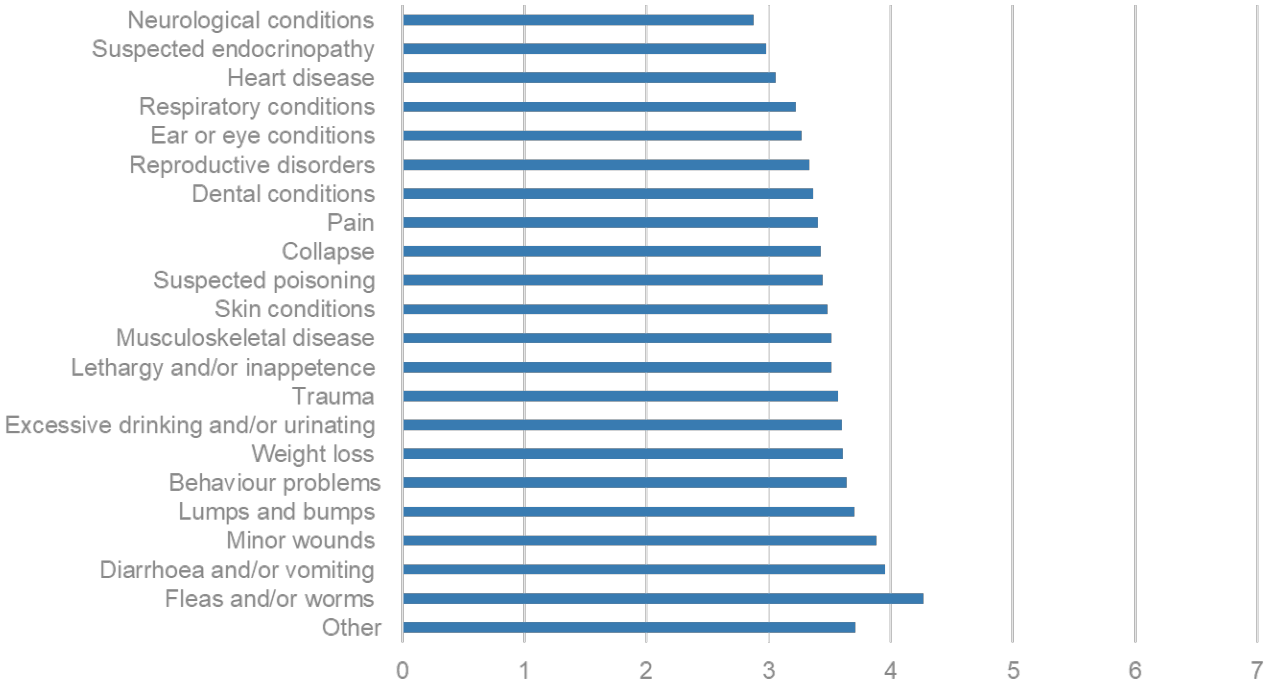
Compared with face-to-face diagnoses pre-Covid 19

Small animal

For each type of small animal case seen remotely, VNs were asked to rate their confidence in their remote diagnoses compared to face-to-face diagnoses pre-Covid-19, using a seven-point scale. The scale ranged from ‘much less confident’ (scoring 1) to ‘much more confident’ (scoring 7), with a mid-point of ‘equally as confident’ (scoring 4). The overall mean scores for each type of case were then calculated, discounting any ‘not applicable’ responses.

Figure 4.7 shows that 21 out of 22 of the mean scores, which ranged from 2.88 to 4.27, were below the midpoint of four, the exception being fleas and/or worms. This indicates that VN respondents were, on average, less confident about their diagnoses in almost every type of case in comparison with face-to-face diagnoses pre-Covid-19. However, they are considerably more confident than VSs, possibly because, as some point out in various places in free text comments, the responsibility for accurate diagnoses lies with VSs. The lowest average scores, indicating the lowest level of confidence (both below 3.0), are for neurological conditions (2.88) and suspected endocrinopathy (2.98).

Figure 4.7 Confidence in small animal diagnoses compared to face-to-face diagnoses pre-Covid-19: mean scores, VN



Source: RCVS Covid-19 Survey, 2020

Existing compared to new animals

Table 4.29 presents VN respondents' views regarding whether their confidence during 1 to 14 June was affected by the client/animal being new to them. For around one quarter of VN respondents, the question was not relevant, either because they only attended clients/animals remotely who were known to them (22.6%) or, more unusually, only attended clients/animals remotely who were new to them (0.9%). When respondents for whom the question was not relevant are removed, it appears that opinions are more or less equally divided, with 51.9 per cent saying it made no difference to them, and 47.1 per cent feeling less confident. This is a different picture from VSs, most (72.6%) of whom were less confident.

Table 4.29 Confidence in remote diagnoses if client/animal not known to respondent: VN

	N	%	% without 'N/A' options
Yes, I was much less confident when attending to a new client/animal remotely	13	6.1	8.0
Yes, I was less confident when attending to a new client/animal remotely	31	14.6	19.1
Yes, I was a little less confident when attending to a new client/animal remotely	34	16.0	21.0
No, it made no difference whether the client/animal was known to me or not	84	39.6	51.9
Not applicable as I only attended clients/animals remotely known to me	48	22.6	-

Not applicable as I only attended clients/animals remotely new to me	2	0.9	-

Source: RCVS Covid-19 Survey, 2020

4.2.7 Animals needing to be seen face-to-face

Table 4.30 indicates that VN SQPs (VNs who are not SQPs were not asked this question) are, like VSs, cautious in treating animals remotely: three-quarters (74.2%) said that at least 50 per cent of the cases they saw remotely between 1 to 14 June led to their giving advice that the animal needed to be physically seen.

Table 4.30 Percentage of cases seen remotely resulting in advice that the animal should be physically seen: VN SQP

	N	%
90% or more	4	12.9
75% to 89%	7	22.6
50% to 74%	12	38.7
25% to 49%	6	19.4
Fewer than 25%	2	6.5

Source: RCVS Covid-19 Survey, 2020

Re-checks of animals previously seen remotely within the practice

During the two-week period, 25.9 per cent of VN respondents were personally involved in carrying out face-to-face re-checks of cases they, or someone else in their practice, had previously seen remotely. Table 4.31 presents the drivers for these face-to-face re-checks, and shows that many of these VN respondents feel that further investigation and accurate diagnosis in particular require a physical examination.

Table 4.31 Drivers of face-to-face re-checks of animals previously seen remotely within the practice: VN (multiple response)

	N	%
Required further investigation that could not be performed remotely	117	87.3
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	69	51.5
Accurate diagnosis was considered essential and that this required physical examination	89	71.5
Diagnostic uncertainty was too great to continue remote management	68	66.4
Patient was deteriorating and required hospitalisation	76	56.7
Other	7	5.2

Source: RCVS Covid-19 Survey, 2020

'Other' drivers specified by respondents are mostly related to post-operative checks including problems with surgical wounds (four mentions).

VN respondents involved in face-to-face re-checks said this happened between one and 80 times, with a mean of 18.95 and a median of ten.

When asked if this number was higher or lower than would have been expected had the initial consultation been face-to-face, 34.9 per cent selected 'about the same', 31.7 per cent 'higher' and a considerably smaller 33.3 per cent 'lower'. This is somewhat different from VS respondents, only 12.7 per cent of whom selected 'lower'.

Re-checks of animals previously seen remotely elsewhere

During the two-week period, one quarter (25.5%) of VN respondents were personally involved in carrying out face-to-face re-checks of cases that had previously been seen remotely by another practice or provider; 51.5 per cent said no, they had not been involved in such re-checks, and the remaining 23.8 per cent did not know. Table 4.32 presents the drivers for these face-to-face consultations, and shows the most important driver, as it was for VS respondents, to be the requirement for further investigation that could not be performed remotely

The only 'other' driver mentioned by more than one respondent is the client unable to afford fees in another practice (three mentions).

Table 4.32 Drivers of face-to-face consultations with animals previously seen remotely by another practice or provider: VN (multiple response)

	N	%
Required further investigation that could not be performed remotely	45	76.3
Patient was not responding and changing medication without seeing face-to-face first was not felt appropriate	24	40.7
Accurate diagnosis was considered essential and that this required physical examination	31	52.5
Diagnostic uncertainty was too great to continue remote management	27	45.7
Another veterinary practice was not able to see or did not feel it needed to see the animal	27	45.8
Patient was deteriorating and required hospitalisation	35	59.3
Other	8	13.6

Source: RCVS Covid-19 Survey, 2020

The VNs who were involved in such consultations involving animals previously seen remotely elsewhere said that this had occurred between one and 50 times, with a mean average of 13.9 and a median of six.

4.2.8 Interactions with clients

Several questions towards the end of the survey relate to interactions with clients during the two-week period.

- When asked about **clients' willingness to pay for remote consultations**, two-thirds (67.4%) of VN respondents said their clients were willing to pay something, but not as much as a face-to-face consultation; one quarter (25.5%) said they were willing to pay the same amount; but 7.1 per cent selected 'unwilling to pay anything'.
- **Clients' ability to operate any technology required for remote consultations** during the two-week period is rated as 'adequate' by almost two-thirds (64.7%) of VN respondents and 'good' by 24.8 per cent, with 10.5 per cent regarding it as 'poor'. They are a little more positive about clients' ability than VS respondents, 22.9 per cent of whom rated it as 'poor'.
- **The technical quality of the remote consultation** on average (in terms of audio and/or visual quality) is rated as 'adequate' (57.0%) or 'good' (29.4%) by most VN respondents, although 13.6 per cent experienced it as 'poor'. Again, VN respondents are a little less critical than VSs, 19.7 per cent of whom rated it as 'poor'.
- Finally, on average most VN respondents rate their **clients' ability to provide relevant information** such as the animal's history, clinical signs or weight during the two-week period as 'adequate' (52.6%) or 'good' (28.2%); however, around one-fifth (19.2%) rate it as 'poor'. These percentages are very similar to those of VS respondents.

5 Experiences: remote prescribing

This chapter describes the experiences of VSs and VN SQPs who were involved in remote prescribing during 1 to 14 June. It also covers methods used to provide remote prescriptions and verify client identity; these questions that were asked of all VNs, regardless of whether or not they hold SQP status.

As the majority of the questions about remote prescribing were asked only of VSs and VN SQPs, this chapter does not split the responses of VSs and VNs, instead reporting them together.

Chapter summary

- 94.6% of VSs and 92.6% of VN SQPs issued prescription for small animals during 1 to 14 June, either in person or remotely.
- 7.4% of VSs issued prescriptions for horses and 6.8% of VSs issued them for farm animals.
- On average, practices appear to have used two or three different methods for providing remote prescriptions. The most frequently-mentioned are the client collecting medicines themselves from the practice, or having medicines posted.
- The three most frequently-mentioned methods of verifying the client's identity for remote prescriptions are: only prescribing to known clients with animals previously seen (59.3% of VSs and 67.9% of VNs); sending medicines to the client's address as registered on the practice's system (58.6% of VSs and 62.9% of VNs); and telephoning the client only on numbers already on the practice's system (36.4% of VSs and 45.5% of VNs). Practices appear to have used two or three different methods, on average.
- 53.6% VSs and 62.9% of VN SQPs estimate that more than half of the cases they saw remotely during 1 to 14 June resulted in remote prescriptions being given.
- The small animal medicines prescribed remotely during 1 to 14 June by the highest number of VSs and VN SQPs as a repeat prescription are topical steroids/corticosteroids and OTC/POM-VPS parasiticides, while the medicines prescribed by the highest number as a new prescription are oral antibiotics and topical antibacterial agents including POM-V ear drops.
- Pain medication is the equine medicine prescribed remotely during 1 to 14 June by the greatest number of VSs and VN SQPs, both as repeat and new prescriptions.
- For farm animals, injectable antibiotics and NSAIDs are the medicines prescribed remotely by the greatest number of VSs during 1 to 14 June, both as repeat and new prescriptions.
- Only 20 VSs and no VN SQPs say that any animal experienced any suspected adverse drug reaction(s) to medication prescribed remotely by them during the two-week period, that meant the animal had to be seen urgently.

- 69.8% of VSs and 58.6% of VN SQPs say that clients expected a remote prescription as often as they would have done for a face-to-face consultation. The overall percentage saying 'more often' and 'less often' are more or less the same.
- 75.9% of VSs and 79.3% of VN SQPs say they are somewhat or notably less confident about estimating the weight of animals for dosage requirements remotely, compared to face-to-face consultations.

5.1 Overview of prescribing 1 to 14 June

Before focusing on remote prescribing only, VS and VN SQP respondents were asked about the type(s) of animal for which they issued prescriptions during 1 to 14 June, either remotely or in person. Table 5.1 gives the results, and shows very clearly that prescriptions for small animals dominated, with well over 90 per cent of VSs and VN SQPs issuing prescriptions for small animals during the two-week period.

Table 5.1 Type of animal for which prescriptions issued 1 to 14 June 2020: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
Small animal	1157	94.6	25	92.6
Equine	91	7.4	2	7.4
Farm animal	83	6.8	2	7.4

Source: RCVS Covid-19 Survey, 2020

5.2 Provision of remote prescriptions

Table 5.2 shows how VSs' and VNs' practices provided remote prescriptions and medicines, including POM-Vs, to clients during the two-week period. Respondents were asked to select all the methods that were used; the overall numbers and percentages suggest that, typically, practices used two or three different methods. The most frequently-used methods are the fairly traditional ones of the client collecting medicines themselves from the practice, or having medicines posted, although almost half of VS and VN respondents say that the practice delivered medicines to the client in person.

Table 5.2 Provision of remote prescriptions and medicines to clients during 1 to 14 June 2020: VS and VN (multiple response)

	VS N	VS %	VN N	VN %
Client collected medicines from the practice	1377	92.5	433	96.4
Medicines posted to client	1042	70.0	341	75.9
Practice delivered the medicines to the client in person	686	46.1	219	48.8
Prescriptions sent to internet pharmacy for delivery to client	370	24.9	84	18.7
Medicines sent by secure courier to client	178	12.0	54	12.0
Prescriptions sent to bricks and mortar pharmacy for clients to collect	116	7.8	29	6.5

Medicines provided directly from wholesaler	98	6.6	41	9.1
Other	84	5.6	15	3.3
Not applicable	37	2.5	6	1.6

Source: RCVS Covid-19 Survey, 2020

'Other' methods described by at least two respondents are prescriptions emailed to client (44 mentions), prescriptions posted to client (26 mentions), prescriptions collected by owner or owner's representative (27 mentions), and prescriptions either sent to client's regular practice, or referral practice asked regular practice to prescribe (four mentions).

5.2.1 Verification of client identity

Table 5.3 describes the methods used by the practices of VS and VN respondents to verify the identity of clients given remote prescriptions, including POM-Vs. Further analysis of VN respondents indicates that VNs are notably more likely than VN SQPs to select 'sending medicines to client's address' (64.7% compared to 51.7%) and 'emailing to clients' (29.9% and 16.7%). For all other methods, the responses of VNs and VN SQPs are fairly similar.

Table 5.3 Methods of verifying the identity of clients given remote prescriptions during 1 to 14 June 2020: VS and VN (multiple response)

	VS N	VS %	VN N	VN %
Only prescribing to known clients with animals previously seen	876	59.3	302	67.9
Sending medications to client's address as registered on our system	866	58.6	280	62.9
Phoning client only on numbers already on our system	537	36.4	201	45.2
For new clients, other verification of address and details such as records from their previous practice	458	31.0	155	34.8
Emailing to clients with address already on our system	385	26.1	125	28.1
For new animals, needing to see some video footage	246	16.7	82	18.4
Other	47	3.2	14	3.1
Not applicable	112	7.6	28	6.3

Source: RCVS Covid-19 Survey, 2020

'Other' methods mentioned by at least one respondent are: requesting benefit details and proof of ID due to being a charity practice (nine mentions); checking name and address from client in person, over the telephone or via email (ten mentions); requesting proof of ID, address or animal chip/passport (four mentions); clients having to come in person to collect medicines (three mentions); new clients having to register and have their animal seen face to face at the practice (six mentions); prescribing only certain medication and/or in minimum quantities, with particular caution being taken for POM-Vs (three mentions); and requiring photographic or video evidence of the animal's condition (three mentions).

However, six respondents say no methods were used in all or most cases, with clients being taken on trust, being known to the practice, and/or clinical judgement being used.

5.3 Cases leading to remote prescriptions

VSs and VN SQPs were asked to estimate the percentage of cases they saw remotely during the two-week period that resulted in remote prescriptions. Table 5.4 gives the results, and indicates that for 53.6 per cent of VS respondents and 62.9 per cent of VN SQP respondents, more than half of the cases they saw remotely resulted in remote prescriptions being given.

Table 5.4 Percentage of cases seen remotely 1 to 14 June 2020 resulting in remote prescriptions: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
90% or more	87	7.3	3	11.1
75% to 89%	222	18.6	7	25.9
50% to 74%	330	27.7	7	25.9
25% to 49%	268	22.5	3	11.1
Fewer than 25%	286	24.0	7	25.9

Source: RCVS Covid-19 Survey, 2020

Further analysis of the VS responses only (due to the small size of the VN SQP sample) shows:

- Those in corporately-owned practices are somewhat more likely to say that 50 per cent or more cases seen remotely resulted in remote prescriptions: 55.5 per cent, compared to 48.6 per cent of those in independently-owned practices.
- Women are more likely than men to say that 50 per cent or more cases seen remotely resulted in repeat prescriptions: 58.3 per cent compared to 44.6 per cent.
- The above finding is probably linked to age, in that the percentage of those saying that 50 per cent or more cases seen remotely resulted in repeat prescriptions decreases in line with age: 65.5 per cent of those aged under 30, 59.1 per cent of those in their 30s, 51.6 per cent of those in their 40s, 47.1 per cent of those in their 50s, and 37.1 per cent of those aged 60 and over.

5.3.1 Remote prescriptions: small animals

Table 5.5 gives the number of VSs and VN SQPs who personally prescribed different types of medicines remotely for small animals over the two-week period, as repeat or new prescriptions. Figure 5.1 gives the same information in graphical form. The medicine prescribed by the highest number as a repeat prescription is topical steroids/ corticosteroids, while the medicine prescribed by the highest number as a new

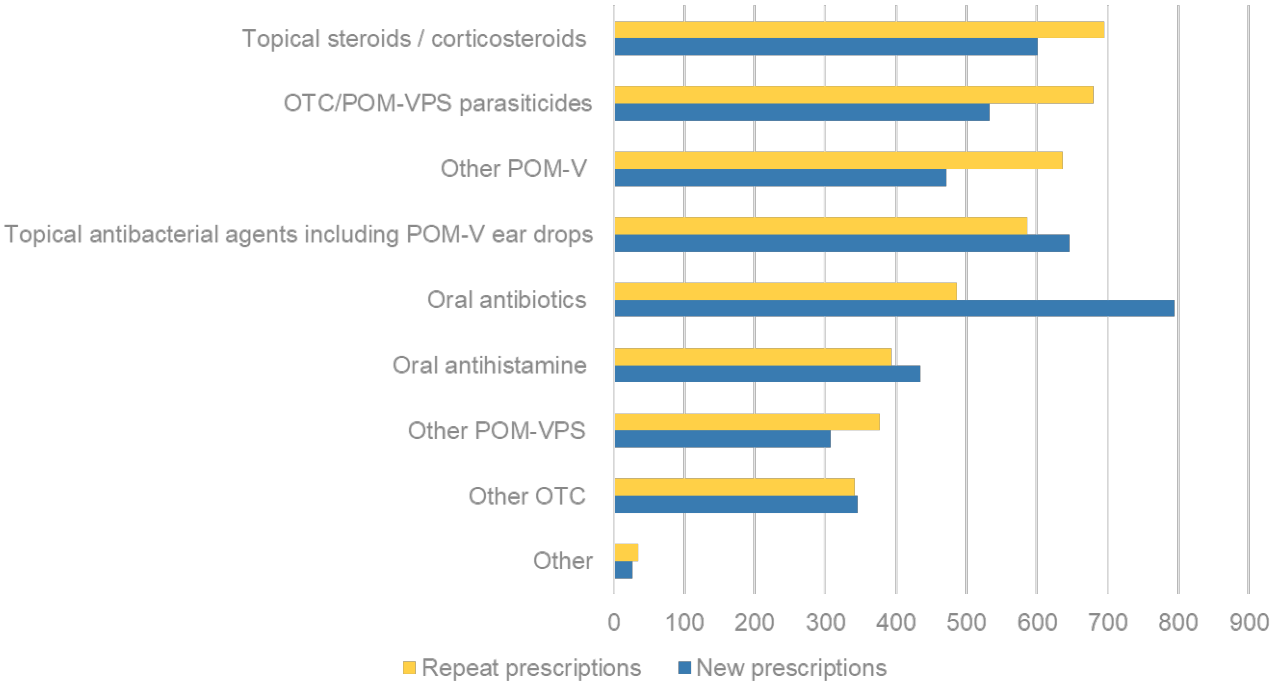
prescription is oral antibiotics. Oral antibiotics is also the medicine with the biggest difference between the number of repeat and new prescriptions.

Table 5.5 Number of respondents prescribing different types of small animal medicines 1 to 14 June 2020 remotely: VS and VN SQP

Type of medicine	VS	VN SQP	Total
Topical steroids / corticosteroids - Repeat prescriptions	688	7	695
Topical steroids / corticosteroids - New prescriptions	599	2	601
OTC/POM-VPS parasiticides - Repeat prescriptions	671	9	680
OTC/POM-VPS parasiticides - New prescriptions	530	2	532
Other POM-V - Repeat prescriptions	632	5	637
Other POM-V - New prescriptions	471	-	471
Topical antibacterial agents including POM-V ear drops - Repeat prescriptions	581	5	586
Topical antibacterial agents including POM-V ear drops - New prescriptions	646	-	646
Oral antibiotics - Repeat prescriptions	478	8	486
Oral antibiotics - New prescriptions	792	3	795
Oral antihistamine - Repeat prescriptions	390	4	394
Oral antihistamine - New prescriptions	432	2	434
Other POM-VPS - Repeat prescriptions	371	6	377
Other POM-VPS - New prescriptions	305	2	307
Other OTC - Repeat prescriptions	340	2	342
Other OTC - New prescriptions	343	3	346
Other - Repeat prescriptions	35	-	35
Other - New prescriptions	27	-	27

Source: RCVS Covid-19 Survey, 2020

Figure 5.1 Number of respondents prescribing different types of small animal medicines remotely: VS and VN SQP



Source: RCVS Covid-19 Survey, 2020

'Other' small animal medicines mentioned by more than one respondent are anti-epileptic medication (seven mentions), herbal and/or homeopathic remedies (three mentions), chronic heart disease medication (three mentions), chronic thyroid medication (two mentions), joint supplements (two mentions), anti-fungal treatments (two mentions), and prescription diets (two mentions).

5.3.2 Remote prescriptions: equine

Table 5.6 gives the number of VSs and VN SQPs who personally prescribed different types of equine medicines remotely over the two-week period, as repeat or new prescriptions. This shows that pain medication was the medicine prescribed by the greatest number of VSs, both as repeat and new prescriptions.

Table 5.6 Number of respondents prescribing different types of equine medicines remotely 1 to 14 June 2020: VS and VN SQP

Type of medicine	VS	VN SQP	Total
Antibiotics (injectable) - Repeat prescriptions	6	-	6
Antibiotics (injectable) - New prescriptions	6	1	7
Corticosteroids - Repeat prescriptions	13	-	13
Corticosteroids - New prescriptions	19	-	10

Pain medication - Repeat prescriptions	63	1	64
Pain medication - New prescriptions	54	-	54
Other POM-V - Repeat prescriptions	20	-	20
Other POM-V - New prescriptions	18	-	18
Other POM-VPS - Repeat prescriptions	14	-	14
Other POM-VPS - New prescriptions	10	-	10
Other OTC - Repeat prescriptions	7	-	7
Other OTC - New prescriptions	8	-	8
Other - Repeat prescriptions	6	-	6
Other - New prescriptions	5	-	5

Source: RCVS Covid-19 Survey, 2020

'Other' equine medicines mentioned by more than one respondent are eye drops or eye gel (three mentions) and herbal and/or homeopathic treatments (two mentions).

5.3.3 Remote prescriptions: farm animals

Table 5.7 gives the number of VSs who personally prescribed different types of medicines remotely for farm animals over the two-week period, as repeat or new prescriptions. No VN SQPs said they prescribed any farm animal medicines, so the table is for VSs only. Injectable antibiotics and NSAIDs are the medicines prescribed by the greatest number of VSs, both as repeat and new prescriptions.

Table 5.7 Number of respondents prescribing different types of farm animal medicines remotely 1 to 14 June 2020: VS

Type of medicine	VS
Antibiotics (injectable) - Repeat prescriptions	49
Antibiotics (injectable) - New prescriptions	50
Antibiotics (oral - including pig and poultry) - Repeat prescriptions	15
Antibiotics (oral - including pig and poultry) - New prescriptions	18
Other group treatments e.g. coccidiostats - Repeat prescriptions	26
Other group treatments e.g. coccidiostats - New prescriptions	25
NSAIDs - Repeat prescriptions	48
NSAIDs - New prescriptions	51

Vaccines - Repeat prescriptions	42
Vaccines - New prescriptions	27
Fertility treatments including hormonal treatments - Repeat prescriptions	17
Fertility treatments including hormonal treatments - New prescriptions	12
Lactating cow intramammary treatments - Repeat prescriptions	37
Lactating cow intramammary treatments - New prescriptions	17
Antibiotic dry cow intramammary treatments - Repeat prescriptions	31
Antibiotic dry cow intramammary treatments - New prescriptions	14
Teat sealants - Repeat prescriptions	25
Teat sealants - New prescriptions	11
Parasiticides – all including oral, injectable and pour-on preparations - Repeat prescriptions	39
Parasiticides – all including oral, injectable and pour-on preparations - New prescriptions	28
Other POM-V - Repeat prescriptions	19
Other POM-V - New prescriptions	12
Other POM-VPS - Repeat prescriptions	12
Other POM-VPS - New prescriptions	8
Other OTC - Repeat prescriptions	7
Other OTC - New prescriptions	6

Source: RCVS Covid-19 Survey, 2020

5.3.4 Adverse reactions to drugs

When asked if any animal experienced any suspected adverse drug reaction(s) to medication prescribed remotely by them during the two-week period, that meant the animal had to be seen urgently, only 20 VSs and no VN SQPs said yes; 1,053 VSs and 23 VN SQPs said no, although 149 VSs and three VN SQPs did not know.

The VS respondents who said yes were asked for further details. Nine reported gastrointestinal issues such as diarrhoea and vomiting; six said this was a side-effect of nonsteroidal anti-inflammatory drugs (NSAIDs), one that it occurred after steroids, one after eczema medication and another after medication for otitis. Two reported unspecified side-effects of NSAIDs, and one reported serotonin syndrome.

5.3.5 Client expectations

Respondents were asked about the extent they felt clients expected a prescription to be given when they saw cases remotely, compared with face-to-face consultations pre-Covid-19. Table 5.8 indicates that the majority of both VS and VN SQP respondents think this occurred about the same as face-to-face, although VSs are more likely to say this than VN SQPs (69.8% compared to 58.6%). For VSs, the percentage saying 'more often' and 'less often' are more or less the same, while VN SQPs are twice as likely to say 'more often' than 'less often'. This finding should be treated with caution, however, as the number of VN SQP respondents is small.

Table 5.8 Client expectations about prescriptions, comparing remote with pre-Covid-19 face-to-face consultations: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
Less often than face-to-face	172	14.1	4	13.8
More often than face-to-face	196	16.1	8	27.6
About the same as face-to-face	852	69.8	17	58.6

Source: RCVS Covid-19 Survey, 2020

Further analysis of the VS response to this question does not show any significant differences among respondent groups.

5.3.6 Confidence in estimating weight

Table 5.9 shows that, overall, both VS and VN SQP respondents were less confident, when seeing cases remotely during the two-week period, in their ability to estimate weight for dosage requirements in comparison to face-to-face consultations; around one quarter of respondents (25.0% of VSs and 20.7% of VN SQPs) felt notably less confident.

Table 5.9 Confidence in estimating weight for dosage requirements when seeing cases remotely compared to face-to-face: VS and VN SQP

	VS N	VS %	VN SQP N	VN SQP %
As confident	295	24.4%	6	20.7%
Somewhat less confident	613	50.6%	17	58.6%
Notably less confident	303	25.0%	6	20.7%

Source: RCVS Covid-19 Survey, 2020

Further analysis of the VS response to this question does not reveal any significant differences by practice size or ownership structure. However, an analysis by gender shows that men are more polarised in their responses than women: they are somewhat more likely than women to say they felt notably less confident (29.0% compared to

22.8%) but also a little more likely to say they felt as confident (25.0% compared to 23.4%). There is also a relationship with age, in that the mean age of those who are as confident is higher than average, at 44.4, while the mean age of those who are notably less confident is lower than average, at 40.9.

6 Views

The focus of this chapter is an overview of the free text comments provided by respondents in response to a request at the end of the survey to provide any feedback or comments on firstly the current temporary change to the RCVS Guidance which allows remote prescribing, and secondly remote consulting and prescribing in general.

Chapter summary

Free text comments were sought on firstly the current temporary change to the RCVS Guidance which allows remote prescribing, and secondly remote consulting and prescribing in general. For each topic, separate random samples of 250 comments were taken and analysed for themes. Views on both were very varied, suggesting there will be difficulties in seeking agreement.

Current temporary change to the RCVS Guidance:

- Seen variously as a useful change, a hindrance and a nuisance, and a necessary evil.
- Has helped animals according to some, but for others has put animals at risk.
- Has helped owners, and protected staff, during lockdown – but has possibly laid open VSs to complaints.
- Clients have been appreciative and co-operative, or demanding, or sometimes both.

Remote consulting and prescribing in general:

- Variously these should be allowed to continue, should not be allowed to continue, or should continue only under certain conditions.
- Regardless, more guidance and support are needed if they are to continue.
- Might help VSs to focus their skills – but could lead to lower standards.
- Will benefit animals according to some, while others think animals' welfare will suffer.
- Clients could benefit, but alternately might exploit the situation to their advantage.

6.1 Current temporary change to the RCVS Guidance

Several random samples were taken of the free text comments provided by respondents, in approximate proportion to the overall survey response:

- 100 VS comments, under the headings of small animal practice, equine practice, farm practice, mixed practice and referral practice.
- Regardless of type of practice, 100 VS comments, under the headings of independently owned and corporately owned.
- 50 VN comments, under the headings of VNs (not SQP) and VN SQPs.

Any comments that were not usable (such as 'No comment' or 'Nothing to add') were discarded, as were any duplicate VS comments; any text within the comments that might enable the respondents to be recognised (such as references to a particular company or practice) was removed, and any obvious grammatical or spelling errors were corrected.

These comments, which have been analysed for theme and content, can be found in full in the Appendix to this report. An overview of the comments is given in this section, under sub-headings representing the themes that emerged from the analysis. Views are wide-ranging, with some respondents being very positive about the temporary change and some definitely not in favour; many themes have emerged.

6.1.1 Useful change

Some respondents say they have found the temporary change useful for various reasons, sometimes going further to say they would like it to continue.

A useful tool in our veterinary armoury.

Small animal practice VS

Remote prescribing has taken the pressure off and allowed us to focus on our more urgent cases.

Small animal practice VS

This change must be maintained to provide vets with another pathway to provide veterinary care for patients where attendance to practice is not considered essential. This will give more pets access to veterinary care.

Small animal practice VS

This has been a useful change, allowing wormer, flea treatment, NSAID, gastroprotectants to be given as repeats beyond the normal period, or to mild novel cases.

Small animal practice VS

Please allow to continue.

Equine practice VS

I feel that remote prescribing has its place in the future of veterinary medicine for some easy to diagnose conditions.

Independently-owned practice VS

I personally think there is a long term place for remote prescribing as it removes a lot of stress from the daily schedule in real practice.

Corporately-owned practice VS

I found it useful to be able to check post op wounds remotely, allowing patient owners to remain safe.

VN

I feel this has given the profession a fantastic opportunity to provide this care permanently to our patients … I truly hope it is a tool we are allowed to use in the future.

VN SQP

6.1.2 Hindrance and nuisance

Respondents who have not found the change helpful often express frustration and exasperation.

Very time consuming and most ended up being seen.

Referral practice VS

… time consuming, expensive and unproductive.

Equine practice VS

I found video consultations highly frustrating – the use of technology was a problem for many clients … most of the video consultations I did ended up needing to be seen in person, so the whole video thing was a waste of time.

Small animal practice VS

6.1.3 A necessary evil

Frequently-expressed view is that the change was necessary because of the situation, but is a second best; some go further and say they would not want it to continue.

It's not fit for purpose in normal circumstances.

Corporately-owned practice VS

I would not welcome it as a 'blanket' use permanent change.

Corporately-owned practice VS

The guidance should revert to avoiding remote consulting.

Independently-owned practice VS

This has been a valuable asset during this crisis but not one I feel I would be in the patient's best interest in the long term.'

Small animal practice VS

It is definitely a poor substitute but better than no care.

Small animal practice VS

A necessary evil. I would NEVER want to continue remote prescribing or telemedicine phone/video consults!!!

Small animal practice VS

6.1.4 Helped animals

Some respondents believe that the change has been beneficial to animals and has helped their well-being and welfare generally.

It has helped us to provide care and alleviate pain and suffering in animals that otherwise could not have been seen.

Independently-owned practice VS

I work for a charity and remote consulting has been a godsend without which I feel we may not have been able to provide such good quality of service based on the fact that many more people are now experiencing difficulties with paying extortionate vet fees and have nowhere else to look for help apart from charities. Without remote consulting we would never be able to help so many pets and animals' welfare would undoubtedly suffer.

Small animal practice VS

These changes allow us to improve animal welfare, wellbeing, and quality of life at this time.

Small animal practice VS

6.1.5 Put animals at risk

However, many comments describe respondents' fears that animals are being put at risk due to misdiagnoses.

… we are trying to operate with our hands behind our backs … difficult to ascertain an accurate diagnosis, 'best guess' veterinary and missing ALL the important findings that could be picked up on a physical examination.

Small animal practice VS

… for conditions with minimal external visual markers … there is a huge risk in misdiagnosis of many cases.

Corporately-owned practice VS

I feel I am giving a poorer service and delivering worse care when doing it remotely.

Small animal practice VS

Clients' ability to assess and describe their animals' problems are very poor when compared to examination and assessment by a veterinary surgeon.

Independently-owned practice VS

It was a necessary measure, but shouldn't continue for a longer period of time, as seeing patients is the safest way to prescribe medication.

Independently-owned practice VS

6.1.6 Helped owners

A commonly-occurring theme is that the change has helped many owners, especially those who would otherwise have found it difficult to bring their animals to the practice and who are worried and isolated.

The remote consult has helped in ensuring a client gets a good understanding of the animal's health and whether it warrant a one to one consult … the feedback we got at the hospital was very positive.

VN

Really good as some clients who were shielding could have access to the vets.

VN

It allowed us to help the most vulnerable clients.

Corporately-owned practice VS

I've been able to help stiff old dogs with their owner not being able to travel or being isolated.

Small animal VS

6.1.7 Protected staff

Respondents also think the change has helped to protect staff and keep them safe, while enabling them to keep working and, in some instances, keep an income stream.

Temporary remote prescribing has allowed us to function as a business, where we might otherwise have been unable to do so.

Independently-owned practice VS

Remote prescribing has enabled me to continue working at a time I would otherwise have been unable to work.

Small animal practice VS

It helped to provide care without being terrified under difficult and exceptional circumstances.

Corporately-owned practice VS

It ensures that practices could continue to manage their workflow whilst doing it in a socially distanced and safe manner.

Independently-owned practice VS

6.1.8 Possibly laid VSs open to complaints

While not a frequently-expressed view, there is some concern that VSs might not be fully protected if clients choose to complain following a misdiagnosis or adverse reaction to medication.

We had a client make a complaint based entirely on the owner's lack of compliance and inability to follow instructions which scared me.

Independently-owned practice VS

I don't believe the RCVS would support you in any disputes – not worth the risk.

Corporately-owned practice VS

6.1.9 Clients have been appreciative

Many clients seem to have been very appreciative and grateful that their animals can be seen and treatments prescribed.

Clients have accepted willingly. Clients have overall been understanding.

VN

A lot of things are really basic and owners would appreciate a reduced fee for this and allow us to physically see things that actually need to be seen.

Corporately-owned practice VS

Many owners have been so grateful when we have been available for advice and reassurance, it has stopped them worrying.

Independently-owned practice VS

Allowed more patients to be treated. Owners very grateful for the service.

Corporately-owned practice VS

6.1.10 Clients have been demanding

However, some respondents give instances of demanding, critical clients and poor behaviour.

I have been horrified by the clients' demanding and difficult behaviour.

VN

Many clients are not keen to pay a fee, especially if no treatment is dispensed.

Corporately-owned practice VS

I worry that client expectations will have changed now so going back to the previous system is going to be difficult to present in a way that won't potentially be interpreted

as 'money-grabbing veterinary practices' and frankly, a bit of my soul gets eroded each time I have to have this wort of discussion.

VN

Clients liked it but didn't feel they should pay for that service and were rather rude and on occasion abusive about it.

VN SQP

6.2 Remote consulting and prescribing in general

A second set of random samples were taken under similar headings to those described for section 6.2 above:

- 100 VS comments, under the headings of small animal practice, equine practice, farm practice, mixed practice and referral practice.
- Regardless of type of practice, 100 VS comments, under the headings of independently owned and corporately owned.
- 50 VN comments, under the headings of VNs (not SQP) and VN SQPs.

Any comments that were not usable (such as 'No comment' or 'Nothing to add') were discarded, as were any duplicate VS comments; any text within the comments that might enable the respondents to be recognised (such as references to a particular company or practice) was removed, and any obvious grammatical or spelling errors were corrected.

These comments, which have been analysed for theme and content, can be found in full in the Appendix to this report. An overview of the comments is given in this section, under sub-headings representing the themes that emerged from the analysis. As in the previous section, views are wide-ranging; some similar themes have emerged, together with some additional ones.

6.2.1 Should be allowed to continue

Some respondents state very clearly that they would like remote consulting and prescribing to continue beyond the Covid-19 emergency.

I fully support remote prescribing. It's time to change.

Mixed practice VS

I think video and telephone consulting has a future in veterinary medicine, especially as we now have such advanced technology for viewing and speaking to our clients.

Referral practice VS

It's a really good idea and works really well for our organisation.

VN

I believe there is a place for this in normal practice with some regulation and discretion.

Corporately-owned practice VS

6.2.2 Should *not* be allowed to continue

However, other respondents are emphatic that the change should not be made permanent, and the regulations should return to the previous situation as soon as possible.

Dreadful idea. Patients must be seen and examined physically. Even simple things get missed/ overlooked.

Independently-owned practice VS

I'm not in favour of it because I worry that cheaper providers will cherry pick the easy profitable medicine prescribing work leaving face to face practices who provide out of hours services to do the less profitable work – this will either result in more practices giving this up or increased charges for clients who already remark that vets are too expensive.

Independently-owned practice VS

I don't think it is a good way forward for the profession and you miss a lot of detail and a physical exam that only a veterinary professional can interpret.

Corporately-owned practice VS

I was always fond of telemedicine and a great believer that it would be the future but this trial has changed my mind. The diagnostic ability was much poorer … Clients in general far more rude than face to face … Overall high number of misdiagnoses and treatment failures solved after physical exam. I feel we are not ready yet, not us or the clients.

Corporately-owned practice VS

USELESS, DANGEROUS. WILL NEVER DO AGAIN … This should be completely stopped and back to original prescribing laws once covid-19 outbreak over. Need a physical consultation, phone or video is doing the animal and client a disservice.

Corporately-owned practice VS

This experience has convinced me that remote consulting should only be allowed in extreme circumstances e.g. Pandemic.

Corporately-owned practice VS

6.2.3 Should continue only on certain conditions

Other respondents seem to want to steer a pragmatic middle course, with conditions attached to remote consulting and prescribing, such as limiting their use to certain conditions, situations and medicines.

Remote prescribing should only take place with animals already known to the practice and very recently examined.

Independently-owned practice VS

I think that telemedicine has a place for clients already registered with a practice and a known history for rechecks/reviews and minor problems ... I firmly believe that all POM-V should only be prescribed for clients with an established relationship with a practice, so that full responsibility is taken for any adverse effects and treatment instigated in a timely manner. Given the potential for error, under normal circumstances no new prescription should be dispensed without a physical/clinical examination.

Independently-owned practice VS

I would favour continuing it but with the caveat that the patient must be 'recently known to the practice' – in other words a recent weight is recorded, and a physical exam has occurred in the past.

Small animal practice VS

Would be very unwilling to prescribe POM-Vs after Covid by only a remote consultation. It wouldn't be long before a disaster occurred.

Independently-owned practice VS

Providing a 6 monthly in clinic physical exam can be done I don't see why routine prescribing for ongoing conditions could not continue in this was for the future, including routine flea and worm treatments.

VN SQP

Remote prescribing is fine for ongoing cases and horses known to me.

Independently-owned practice VS

6.2.4 More guidance and support are needed for continuance

If remote consulting and prescribing are to continue, some respondents would like clearer guidance and assurances of protection from client's complaints.

I am concerned that, if [owners] get bitten or scratched, I would be responsible for their injuries if I asked them to do a certain check.

Small animal practice VS

Would be nice to clarify liability – if we're doing a remote consultation and the owner is bitten/scratched is that still our responsibility?

Corporately-owned practice VS

Would like there to be further clarification for 'under care' for out of hours scenarios.

Small animal practice VS

Could the RCVS also take the opportunity to firm up guidance about 'under our care' for repeat prescriptions, the current code of practice is open to too wide interpretation.

Equine practice VS

I think it has its place with the correct guidelines.

VN

I think vets need a definite RCVS guide on how often is minimum animals should have a physical exam, though, to ensure continuity throughout the profession and to ensure clients are clear as to what can and cannot be done.

VN

6.2.5 Will enable VSs to focus their skills

Some respondents believe that remote consulting and prescribing, including the use of VNs for triage, will enable VSs to make better use of their expertise in future.

We need to develop this more. It has saved me a lot of miles in the car and has meant I can focus on more technical advice.

Farm animal VS

Using nurses to triage and give advice is very helpful, also it is having a benefit that nurses can have more of a discussion around health and welfare … It allows better utilisation of nurse and vet time.

VN

6.2.6 Will lead to lower standards

Equally, there is a view that standards will slip if things are allowed to change permanently.

I strongly feel that remote consulting and prescribing undervalues our work as vets. It sends the message to clients that doing a clinical examination is of negligible value, and that owner assessment at home is adequate.

Small animal practice VS

It is a bad idea. It will allow a small handful of clever people to cream off the easy work and leave large areas of the country (typically the poorer and more remote areas) with a dearth of physical veterinary practices.

Equine practice VS

If it were to continue I think we need to be careful not to devalue the consultation.

Corporately-owned practice VS

Remote consulting is completely in appropriate under normal circumstances. Without a full clinical exam mistakes will be made, animals will suffer and the profession will come into disrepute.

Independently-owned practice VS

You can have a good job, or a cheap job, but seldom a good cheap job!

Independently-owned practice VS

6.2.7 Will benefit animals

Some respondents believe that the change, which has proved beneficial to animals during lockdown, will continue to benefit them, particularly certain types of animal.

A huge positive impact on pets' welfare/ level of stress – they didn't have to be chased throughout the house to be put in a carrier/ muzzled, then put in a car or bus in order to be brought to the vets. Happier pets, less stressed clients also.

Small animal practice VS

Helpful specially to people who find coming into practice hard or with animals who find it stressful coming to the vets.

VN SQP

6.2.8 Will continue to put animals at risk

Others, however, feel strongly that animals will continue to be at risk of they are not diagnosed via a face-to-face examination.

Vets in our practice have had to pick up the mess of 2 patients that have been detrimentally affected by clients using online service … where vets with no knowledge of patients and their history have prescribed and sent OUR patients drugs in the post. This must stop!

VN

The skills of a veterinary surgeon which we were trained in are the physical examination of an animal in relation to its history. Clients are not adequately trained to perform this role without errors being made and animal welfare being compromised.

Mixed practice VS

6.2.9 Owners would like it to continue

Many owners, according to some respondents, would be very happy to see the change made permanent.

I have found clients to be extremely grateful for the remote consults. The majority of my calls have been putting clients' minds at rest, this has improved welfare!

Small animal practice VS

Clients have been surprisingly willing to use it and it has opened up new consulting methods.

Independently-owned practice VS

We have had a great response from owners on remote consulting … Cat owners seem to really like the service.

Independently-owned practice VS

6.2.10 Clients will exploit it

On the other hand, there are fears that some clients will exploit the situation to their own advantage, with animals possibly suffering as a result.

Difficulty in persuading clients in the future that their pet needs to be seen for repeat prescriptions.

Independently-owned practice VS

I will be glad when it is all over. Clients might want it to continue so they get a cheaper service!

Mixed practice VS

I think developing remote consulting for 'normal' time is a bit of a slippery slope to a point eventually where clients will self-diagnose and buy medicines (potentially without prescription) online.

Independently-owned practice VS

Clients will want a cheap option but then be ever so quick to go down the RCVS / litigation route when honest mistakes are made.

Corporately-owned practice VS

7 Conclusions

Chapter summary

The survey data suggest that it will be difficult to find a way forward with remote consulting and prescribing that satisfies everyone. Analysis has shown few substantial variations in the experiences and opinions of different groups of VSs and VNs when analysed by personal and job characteristics.

- Confidence is clearly a major issue: in diagnosing remotely, especially when there are few visual signs and/or the condition is potentially serious and non-routine; in estimating weight for medication; and when the animal is not known to VSs and VNs. This has led to a high percentage of remote cases resulting in advice that the animal needs to be seen physically, and a substantial number of physical re-checks, for accurate diagnosis.
- There can be benefits, e.g. to clients who find it hard to come to the practice, or animals who are nervous and/or have chronic conditions. However, respondents worry that clients may resent a return to physical examinations and will demand price reductions; and that some suppliers may start to specialise in remote consulting for routine cases, disadvantaging those offering the full range of services. Managing expectations, and re-educating clients, may be challenging.
- VSs and VNs will look to the RCVS to provide very clear advice and guidance about the conditions under which remote consulting and prescribing can occur, should they be allowed to continue, and will also expect support should honest mistakes occur.

The VSs and VNs who responded to the RCVS Covid-19 survey reported a wide range of experiences and opinions, including their views about remote consulting and prescribing in general and whether or not these should continue.

The result show clearly that, on average, respondents are less confident about their ability to diagnose accurately via remote consultations, and estimate weights for medication doses remotely, in comparison to face-to-face consultations during which they can examine animals physically. Free text comments suggest that, for all types of animal, VSs are particularly concerned about diagnosing serious conditions remotely, such as collapse, and conditions that may have little by way of external visual signs, such as heart disease and respiratory problems; their confidence increases for conditions like skin diseases, when they are able to see visual evidence provided by clients. Respondents are also more confident in their diagnoses and advice, on average, when the animal is already known to them. The results also show that a high percentage of remote consultations resulted in VSs advising that the animal needed to be seen face-to-face. Free text comments confirm these findings, with VSs being more comfortable about prescribing certain types of medicines remotely than others (e.g. they are relatively confident about prescribing routine treatments for fleas and worms, but some think that POM-Vs should not be prescribed remotely long-term); VNs also say they found it

reasonably straightforward to carry out post-operative checks and give advice about routine aspects such as fleas, worms and vaccinations remotely.

Some respondents have seen some benefits to clients and animals arising from remote consulting and prescribing. This is particularly the case for clients who find it hard to visit the practice, and animals who have chronic conditions and/or are nervous and liable to become stressed during physical consultations. However, there is some anxiety that clients may be so used to remote consulting and prescribing that they will resent returning to face-to-face consultations; some respondents also have financial concerns due to a minority of clients being unwilling to pay for remote consultations. A further worry, if the temporary change is made permanent, is that some veterinary providers may start to specialise in certain ‘easy’ conditions, offering low priced consultations and medicines that will disadvantage smaller, more traditional practices that offer a full service.

On a personal basis, some respondents have enjoyed remote consulting much more than they thought they would; others thought at first it would be a good way forward, but changed their minds after experiencing it; and others have hated it. A fairly frequently-expressed view is that it had to happen due to the Covid-19 pandemic, and has been a good way of continuing to provide a service to clients and animals, but it is less than ideal.

Judging by the free text comments, VNs have often been the first point of contact for clients. VNs have had differing experiences of clients, with some saying they were appreciative, understanding and co-operative, and others finding them rude, demanding, and unprepared to pay for remote consultations. Both VSs and VNs have often found it difficult to obtain accurate information about animals from clients, due partly to technological limitations and partly to inability to describe the animal’s condition adequately. Some comments indicate that, post Covid-19, it might be difficult to re-educate clients and manage their expectations.

The findings suggest that, if remote consulting and prescribing are to continue, the RCVS will need to provide detailed and clear guidance to VSs and VNs. Issues raised by respondents include: requests for more guidance about the meaning of ‘under our care’; rules about the types of medication that can be prescribed remotely, and about the conditions that can be diagnosed remotely without a further physical examination; suggestions that remote consultations should only be permitted when the animal is known/registered to the practice and has been seen recently; and further suggestions that remote prescribing should only be allowed if the animal’s weight is recorded at the practice. The survey findings on the very varied practices around the verification of clients’ identities suggest that RCVS guidance may also be required here.

Although a considerable amount of analysis has been carried out on the survey data, there have been few very marked differences among respondents when grouped by personal or job details such as gender, type of practice and practice ownership structure. One consistent finding has been a small ‘age effect’, with older VSs being a little less confident about their remote diagnoses, less happy with the quality and reliability of technology, and less inclined to think that remote consulting and prescribing should continue, than their younger counterparts; however, this is an overall average finding and is not very pronounced.

Appendix: Samples of free text responses

Feedback/comments on the current temporary change to the RCVS Guidance which allows remote prescribing

Small animal practice VSs

I think it has been practical in the short term but will need to start doing health checks soon to ensure patient care is optimised and there isn't a back log of check ups.

A necessary change at the start of the pandemic.

A necessary evil. I would NEVER want to continue remote prescribing or telemedicine phone/video consults!!! It was a necessity to limit face-to-face consults and ensure public and staff safety during the initial pandemic but we are trying to operate with our hands behind our backs, time consuming, more complaints, difficult to ascertain and accurate diagnosis, 'best guess' veterinary and missing ALL the important findings that could be picked up on a physical examination. I will NEVER recommend this sub-par service; it is just an accident/misdiagnosis/liability waiting to happen

Although not as good as face to face consulting a really valuable tool that I personally will miss if removed. A useful tool in our veterinary armoury.

Although there are some flaws - the vast majority of sick animals got appropriate treatment by remote prescribing without the ability to remote prescribe there is no way the practice could have coped - these animals could not have all been seen face to face logistically, and would have received no treatment at all. I think without it there would have been a huge cost in compromised welfare and animal suffering

As soon as it is possible to safely return to pre Covid rules I would be in favour of that. Remote consults are from what I have seen and personally experienced not a way to provide good quality care. There is however a place for remote consults as long as the pandemic requires restrictions. Some clients must shield and some staff too so remote provision of care may be the only option in those cases. Where possible, an in person physical examination of the animal is definitely the best way to begin diagnosis. The temporary change to the guidance is necessary, pragmatic and useful in these challenging times.

The first 3 weeks it was although not ideal [were] justified when considering the need for social distancing was a national emergency. However to consider this care beyond this point I think is affecting animal welfare but there is the consideration for

a lot of practices of being able to cope with the work load of seeing all animals again while social distancing which is having a great impact on the time each consult is taking.

For me the majority of situations where I am remote consulting, they are advice calls rather than involving prescriptions. I've found the temporary change in guidance most useful for odd cases where I have a bit more confidence in giving the owner something to try, with a plan for assessment by phone and photos a few days later or in the practice. It's also given me more confidence to do phone follow ups for cases I have seen in person, some of which I've then needed to see back that day or the next, others that have been doing well or had a recheck a week later. I think the issue with remote prescribing isn't the thing itself but can be the change in pitfalls when we work in this way, that it will take us some time to get as proficient at - where I am not necessarily seeing every patient an owner has concerns about, I need to be more careful in my history taking so ensure I do see them where it is necessary, in particular to pick up on cases where the owner doesn't seem as perceptive and could miss vital signs.

Good to have the ability to do this when needed. Certainly was helpful with certaln conditions to reduce caseload where the practice was working on skeleton staff.

Had a few cases misdiagnosed by remote consultation. Felt guilty as due purely to not having thorough clinical exam. Felt less confident. Delighted to be having hands on again when restrictions eased and immediately jumped back to examining most cases.

Has been useful during Covid 19 crisis but frequently needed hands on examination either before prescribing or if initial prescription not effective. Useful in some cases t alleviate symptoms until hands on examination possible

I am worried that this will allow the owner to ask for remote prescribing also in the future because he/she has not understood the reason why this is the way to do it now.

I feel that I have to offer it despite being uncomfortable with it.

I found video consultations highly frustrating - the use of the technology was a problem for many clients, especially the elderly. In addition most of the video consultations I did ended up needing to be seen in person, so the whole video thing was a waste of time

I have no idea of numbers but generally remote consulting is very limited value for new conditions and I saw of lot of misdiagnosis that would not have happened with a face to face consult. We are doing them far less in our practice and doing a lot of open air consults instead

I hope it continues!

I personally found telephone consulting very unsatisfactory but our set up was not ideal. We had no support staff to help with the emails or payments and clients were

not aware they would be chargeable which made it tricky. I found them quite time consuming and often repeat phone calls required to get all the information to be confident to prescribe. There have definitely been more missed diagnoses - thankfully none serious, but things that would normally have been picked up earlier by a face to face consult.

I think remote consulting could lead to mistakes in diagnosis, leading to welfare issues.

I think that it has been necessary and will continue to be so, but for a fewer number of people.

I think the temporary changes in the RCVS guidance are currently necessary in order to protect human health and safety during covid-19 however there were definite cases that would have been diagnosed on initial exam in person rather than remotely.

I think we have seen a higher incidence of failure to respond to treatment as I am reluctant to prescribe some meds without examination. Clients resent paying for a consultation unless medication is provided

I was previously employed in agricultural practice where remote prescribing on a herd/flock basis was more accepted. Therefore this change to guidance was less of a leap.

I was told me aren't allowed to do it now so that's why we are doing face to face.

I work for a charity and remote consulting has been a god send without which I feel we may not have been able to provide such good quality of service based on the fact that many more people are now experiencing difficulties with paying extortionate vet fees and have nowhere else to look for help apart from charities. Without remote consulting we would never be able to help so many pets and animals welfare would undoubtedly suffer.

I would welcome remote prescribing to be a permanent feature for registered patients.

If a patient was new to us we still requested previous history before consulting. If this was not available or if the patient had not been seen for over a year at our practice then we did request, if possible, that the pet was weighed at home or at the surgery. I still feel if an animal is under our care we should have as much information as possible and physically examine the pet and many of our remote consultations we either seen at the surgery later that day or as a repeat follow up shortly after. I have noticed insurance companies offering remote consultations and I am concerned about the temporary relaxation in guidelines opening this door, they may not have the full information and medication will not be available on the same day, many of the pets we had to see following a video consult needed injectable medication or more thorough exam.

In certain situations I feel remote prescribing is just as effective as seeing them face to face. Whether the animal needs a physical consultation face to face should be up to the vet / the quality of the remote examination. Telemedicine can wean out unnecessary trips to the vets and give them more time to focus on the sicker patients. There are obviously going to be some urgent or emergency cases which need to see physical vets for work ups etc. A good first line of veterinary medicine can be done via telemedicine - this remote prescribing should be kept long term in my opinion.

In my experience remote prescribing is at best a calculated gamble, and in nearly all cases that I have requested the patient to attend (all owners staying outside the building) I was satisfied the personal examination of the patent added to the diagnosis and treatment plan. Remote prescribing may help in niche scenarios, but ultimately is a poor substitute for physical examination in most cases.

In my opinion working with remote consulting this provides the Veterinary clinician and practice with a valuable resource to provide health care and ensure welfare standards to clients and pets. It allows people who may not be able to routinely access pet health services or who feel travelling to a physical practice is too stressful for their pet to be assessed professionally in their home environment. I feel that assessment through video consultation does fall under the auspices of under our care as it is possible to assess the physical well-being of the animals for POM-V prescribing.

In the questionnaire you repeatedly referred to 'face to face cases' This is a misnomer as we saw no clients face to face ie we had no clients actually inside the surgery - as I suspect very few vets did. We did see animals in the practice with a nurse acting as holder and the client waiting outside and contactable for history and permission to treat on the phone. This difference may skew the results of this survey. In the current situation the ability to remotely prescribe has been a benefit to animal health and welfare. As our ability to provide a diagnostic service to our patients returns to 'normal' I am concerned that this remote prescribing facility will be abused and will compromise our professional raison d'etre to look after animal health and welfare

It has been essential to ensure ongoing care for our patients during the Covid pandemic, but it is fraught with difficulties and would not be appropriate under more normal circumstances.

It has been helpful in these exceptional circumstances to be able to do the job in a different way to the best of our ability with the backing of the RCVS

It has been useful but caution is required. My cases of remote prescribing involved primary care vets and i was available for any questions or issues. The client can contact me through the app

It is still a good idea especially for clients who are shielding or have had symptoms.

It provided some reassurance that we wouldn't face repercussions for issues arising from not seeing animals in person. However I still lacked confidence in making

diagnoses and still worried that I could have faced problems if the animal health issues weren't resolved. We had a client make a complaint (against another vet in the practice) based entirely on their (the owners) lack of compliance and inability to follow instructions which scared me.

It was needed when we were uncertain about the impact of COVID 19, protecting clients and staff. I can't say its 100% safe practice and should not be used outside extraordinary circumstances.

It was really helpful to continue to provide care in such unusual circumstances but in most cases I would have preferred to be able to examine the animal. It is definitely a poor substitute but better than no care.

It was very necessary and clients understood the drawbacks.

It was very useful, but I don't think I would like it to be an option in future post-covid as if owners are aware it's an option then it makes persuading them to come in for a clinical examination more challenging and I would not feel satisfied the patient is under my care if myself or my colleague hasn't seen it.

Many clients prefer remote prescribing. In some cases this is client preference despite it being preferable for the patient to be examined. However in many cases it has been a relief to all involved - eg supply of repeat prescription meds for end-of-life care where revisits are performed solely to satisfy legal obligations despite being disadvantageous to the patient (stress), client (cost) and vet (time).

Necessary but stressful.

Ok for short term but not good long term

Remote consultation for the COVID emergency has been useful for the "worried" client and for triage but has exposed its shortcomings. Video consults are usually not much help if the client cannot use the technology properly.

Remote consulting allows for some remote prescribing especially to straightforward cases and also with trusted regular clients. Unfamiliar clients may have a more unreasonable expectation of systems, methods and processes. I found it often led to doubling up of time because a person to person consultation was found necessary, also clients would keep you on the phone for longer periods as they felt there was no time limit or pressure of other clients waiting. I think in the longer term remote consulting would be used by the less honourable vets, companies etc to provide a discounted and inevitably poor service, however it could be used to service existing clients well esp if their movements are compromised.

Remote consulting increases the prescribing of medication especially antibiotics and reduces accuracy of diagnosing significantly.

Remote prescribing has allowed us to continue to provide long term medications to those patients whose owners were shielding/self isolating where they had maybe gone beyond the time interval that we would normally want to re-check them by.

For some this has been a God-send, for others it has meant we were able to continue to use POM-V parasiticides, instead of the owners going to source their own (often inferior) products, which ultimately has been better for our patients.

Remote prescribing has enabled me to continue working at a time I would have otherwise been unable to work - we have had a system in place facilitating examination of patients that require a physical examination, however the ability to triage and remote prescribe has had a positive impact in : 1)maintaining animal welfare as increased number of patients that can be assessed and given treatment until it is possible to see them (if necessary) 2)Maintaining colleague welfare by spreading workload when working under extremely difficult conditions. Of note - the system we were using would often involve a follow up slot for examination in non or less urgent cases depending on the condition but a very significant proportion of such appointments were not required as the condition had resolved. To further note, both myself and the other veterinary surgeon have been at the practice long term and hence know many of the patients well, this did facilitate remote consulting but also due to closer of a neighbouring practice, we also had dealings with patients previously unknown to us and this was generally uneventful.

Remote prescribing has really helped during this pandemic. But the shortfalls are marked particularly when dealing with clients who have poor technological ability and are unable to provide a decent history. I feel it is very useful for repeat prescribing but it's not accurate enough for new conditions. Working in a small practice like mine it is impossible to dedicate one vet to just remote work and another for face to face consults. Telephone consults prove time consuming and owners often don't answer first time, issues with reception were also prevalent. Video telemedicine would be desirable but my employer did not provide or invest int he technology to get this up and running. I also felt that out main client base would have been unable to use video technology. Working from home was not possible either due to expense of increasing the server license. I think this would have helped allowing access of the consulting diary from a home computer and allowing a furloughed member of staff to work from home. Again this was mainly down to failure of the employer to look into investing in the future of the business and the benefits of telemedicine.

Remote prescribing has taken the pressure off and allowed us to focus on our more urgent cases. We are working in small split teams so we are already very stretched.

Remote prescribing was essential to be able to provide veterinary care to patients who were not in an emergency situation but would had suffered or deteriorated if they had not had this way of accessing treatment. With changes in the way members of the practice were working a partner who was shielding started to take over phone consultations and so remote prescribing, whilst those of us still working from the practice could concentrate on the patients needing face to face consults/treatment.

RVC should award people that everyone have been working in this period is exposed to high risk and inform member of public to understand and accept to

follow the directives to maintain distance in any environment in order to protect everyone.

Seems OK to me given the circumstances but I feel I am giving a poorer service and delivering worse care when doing it remotely, particularly in the areas of not having an accurate weight for the pet in some cases and not being able to physically examine the animal.

Thanks to the current temporary change to the RCVS Guidance which allows remote prescribing, since April 2020, I've been able to help: stiff old dogs with their owner not being able to travel or being isolated, itchy dogs, cats and dog who were limping and only needed rest and NSAIDs, snotty cats/dogs with a mild URTI, weepy eyes secondary to allergies or infectious disease. I've treated successfully minor wounds and broken nails. I've been prescribing flea/worming treatment.

These changes allow us to improve animal welfare, wellbeing, and quality of life at this time. It also helps owners care for their pets when they are self- isolating or shielding. Many owners have been so grateful we have been available for advice and reassurance, it has stopped them worrying.

This change must be maintained to provide vets with another pathway to provide veterinary care for patients where attendance to practice is not considered essential. This will give more pets access to veterinary care.

This has been a useful change, allowing wormer, flea treatment, NSAID, gastroprotectants to be given as repeats beyond the normal period, or to mild novel cases.

This has been a valuable asset during this crisis but not one I feel would be in the patient's best interest long term. There is a serious risk vets will be under pressure to keep prescribing things such as ear/eye preps on repeat because owners' perception will be that 'it's the same as it had before'. It's hard enough getting owners to be compliant with medication review checks as it is.

This has been an incredibly useful change and has been most welcome

This period has highlighted to us the often severe limitations to remote consulting. for example a client presented a patient as pain/behavioural and it turned out to be a pseudopregnancy - not possible to diagnose remotely needed physical exam. Also notably poorer response to ear infection treatment when seen remotely of course this is expected because it's not possible to look down an ear with a mobile phone.

This temporary change has allowed animals whose owners were shielding to receive veterinary care. It also allowed us to reduce face to face contact where appropriate.

This temporary change made treatment of animals possible whilst prioritising human safety. Although challenging it enabled veterinary workers to reduce their risk of

disease significantly and still give basic care. I think without this change we would not have been able to work safely during lockdown.

Too little too late.

Unable to justify remote prescribing for repeat prescriptions now lockdown restrictions have been eased if animal not seen within the 3months period. Taking care only to prescribe when good justification and risk to animal low. Have been informing clients this is not the norm and unlikely to remain, as concerned of back lash from public when guidance is amended to normal restrictions for prescribing The current guidance is possibly allowing too much veterinary discretion and likely to be causing disparity in how different practices by remotely prescribing.

Under the initial restrictions remote prescribing allowed us to continue to provide a service to our clients whilst keeping our staff safe and with limited numbers able to look after the urgent cases that required to be seen. It also meant that for a member of staff that remained at home they were able to assist with remote consultations and prescribing medications where indicated.

Useful however there is always a concern as clients tend to over and under plat symptoms.

Useful to provide a short term solution due to COVID restrictions but would not be happy to continue with this long term feel a little bit stressed and under pressure from clients to continue this as they are aware of this possibility feel a little like using it as a firefighting tool rather than a professional service.

Useful whilst we are limited either to emergencies only as at the start of the lockdown and to limit number of clients attending practices whilst limited appointments due to increased time consults are currently taking. However, only think remote consulting generally useful due to current circumstances. Seeing animals face to face clearly makes diagnoses more accurate and less educated guessing. Have seen addisons missed from inaccurate description of signs meaning dog finally was seen face to face in collapsed state.

Video conshots proved impossible for clients to do. Would not be keen to continue the ability to prescribe pom-v remotely as will cause significant difficulty in persuading clients to bring animals in for proper assessment. Many more remote consults were one prior to the chosen weeks and we had pretty much given up on them by this point

Video consults are unsatisfactory but provide a compromise during this difficult time

We believe this has helped pet owners to access medicines during C-19, who may not otherwise have been able to do so. However there should be strict regulations around this should it become a permanent measure, perhaps requiring owners to take their pet to the vet at least once a year, to ensure they are genuinely (not just theoretically) under our care, for that pet's safety and wellbeing.

Whilst I appreciate that it has been useful to do remote consultations and prescribing in the initial phase of the pandemic, I truly believe that a physical examination of animals is essential to get an accurate diagnosis and I would choose to not remotely prescribe in the future.

Equine practice VSs

Clients responded positively at first but resent paying for online consultations Almost all resulted in needing a physical consultation which was then free of charge This makes the whole thing time consuming expensive and unproductive It looks attractive in the first instance but doesn't really solve any problems and in practice results in dissatisfied clients wasted veterinary effort and doubling up of work

I worry that the temporary change will become permanent leading to a lower quality of service and poorer ability to control antimicrobial resistance to antibiotics - particularly when it is impossible to perform antibiotic sensitivity testing remotely.

It is good especially for animals seen before face to face.

Not been applicable in many situations in our practice, but been useful for some e.g. providing Sedalin gel etc for farriers so difficult horses do not have to be held by owner.

Please allow to continue.

Remote prescribing should only be in emergencies such as a pandemic.

Risky strategy. There are limited occasions where remote prescribing may be useful, particularly for an ongoing case. However huge risk in new cases in particular that animal welfare is compromised for no good reason.

Useful - thank you.

Farm practice VSs

Farmers have been allowed a store of POM-V products for many years. We monitor what and how much. We encourage discussion of the use and will discuss a specific case and potentially suggest specific treatment of decide that the animal needs reassessing. COVID has made the possibility of first line treatment without a visit more likely but follow up of treatment success by phone call or checking when next on farm is more likely now. Easing restrictions may reduce likelihood of not visiting.

It has been safer and more time efficient for us to remotely prescribe.

No different to normal practice work except one instance of reduced remote QA audit which are a joke.

Not relevant to my herd health advisory service.

Mixed practice VSs

I would like to see these changes made permanent.

The guidance has allowed us to communicate with clients we already have a good working relationship with and a reasonable level of knowledge of them, their care level and ability, and of their animals, and assess if a physical consultation was needed prior to dispensing treatment, or if we were better seeing the patient for proper assessment prior to dispensing medication. My preference is for physical examination following a Socially Distanced consultation or conversation, as some things cannot be picked up remotely, or owners do not have the skill set to detect nuanced signs of illness. We were contacted on a few occasions by clients of other practices who were unhappy with the results of remote consultations, where practices had effectively refused to attend cases in person, even on a non-client contact basis at the surgery. We are privileged to be a rural practice working on giving small animal clients in particular additional time for consultations, and felt the arrangements we made worked well in providing a service and medicine supplies during a difficult time, enabling those needing contact to get it, while allowing people in more difficult situations to access advice and medicines without feeling they were putting themselves at any additional risk. Some medicines were posted while others were collected securely on a non-contact basis, monitoring visitors by careful staff attention along with use of our external CCTV system.

Useful at this time.

Useful for a period of time but now not required unless further restrictions come back into place.

Referral practice VSs

Many of these questions were not really geared towards our work. We only had remote consults in long term cases of ours that already have a diagnosis - cases where we discussed whether the parent remained stable and judged it appropriate to delay the routine recheck.

Not as useful in referral practice as in primary care, but has provided us with confidence that we will be able to address in particular issues requiring analgesia.

People seem very respectful - both within the profession and clients that conditions are unusual. History taking and yield of useful information has always been led by the vet and all our consultations have occurred over telephone not face to face - history not hindered by this. No increase in complaints without face to face consultation - good level of client trust despite virtual consultation. Impressed with how profession has handled it.

Recommend to continue.

The guidelines have been satisfactory. A more central information delivery would have been good and would have avoided differences in interpretation (for instance between the BVA and BSAVA).

Useful to allow remote prescribing for existing patients who are reasonably stable on medication. Assists in following COVID-19 restrictions re reduction in face to face contacts and social distancing.

Independent practice VSs

All consultations done by speaking with owner outside whilst socially distancing, then taking animal into surgery for examination before returning to discuss with owner. Has been useful during the lockdown, especially for repeat prescriptions and for those owners who have been shielding.,. although at times have been concerned re accuracy of diagnosis and treatment. Have found it difficult to assess the patient accurately and often end up going out to talk with the owner 3-4 times to gain more information as I examine the animal.

Allowed treatment of cases where owners shielding and unable to attend practice. Very time consuming and most ended up being seen - often when seen much clearer communication helping diagnosis and owner compliance with treatment given. Was never certain owners would give medication correctly or call back if symptoms worsened. Always uncertainty that something important was not being asked that would have been prompted by physically seeing animal. Often owners really wanted to be seen - definitely felt remote consulting was second best as did I - some actually refused and insisted on being seen.

Antiparasitics incl pomvs should be allowed in my opinion.

Excellent, just continue like this.

Fine in short term only.

For some cases remote prescribing is appropriate, but many cases require a hands on physical exam

Good idea, less unnecessary exposure.

Handy for simple conditions where a picture and/or a good description is provided where the animal is not particularly unwell.

Happy for the temporary relaxation of prescribing rules during an exceptional circumstance such as a pandemic, but it in no way replaces a face to face / hands on consultation. It MUST be just temporary otherwise there will be a mass exodus from the profession as most vets enjoy the day to day interaction with clients face to face - which is very different from through a screen.

I believe it is right to extend remote prescribing. We should be protecting staff and clients.

I believe remote consultations and prescribing should be allowed going forward.

I feel a complete roll back of remote consulting will be a challenge for the general public to accept given that over the last 14 weeks they have become very used to the first point of veterinary contact, when in a non-emergency situation has been a remote consultation.

I feel remote prescribing was a necessary tool to help through the initial stages of lockdown. I am happy to repeat prescriptions for animals that are stable or minor complaints where I have either spoken to the client and or seen some photo/video evidence. But the quality of the photos was often very poor and did not really allow me to make definite diagnosis. Also I do not feel comfortable to rely on the judgement of the client/owner and their skills as photographers. I used to do emergency OOH so it is not a lack of experience but more the fact that clients just often do not have experience and expertise to judge the condition of their animal.

I feel that it has been very useful over the last few months but should be a temporary measure and normal prescribing should resume now.

I feel that the standard of the profession has slipped dramatically during Covid 19. Animals in urgent need of care are being refused consults at their first opinion practice or being prescribed wholly inappropriate medication for conditions that have not been adequately investigated. I feel ashamed of how many colleagues in my profession have behaved during the crisis with many local practices charging vast sums of money for a phone consult that lasts a few minutes which leads to the client then visiting the surgery and in effect being charged twice. Both client and patient welfare have been disregarded at times and I can see no rational for continuing to prescribe and refusing to carry out further investigations in the face of deteriorating clinical signs. In some cases with some clients, remote consulting can be beneficial but for many cases it gives no insight at all into the animals pain score and vital parameters. I would feel extremely let down by the RCVS if the present guidelines remain as I feel that it will just serve as a money spinning exercise by many of the larger groups to charge twice for the same consultation.

I feel the remote prescribing has its place in the future of veterinary medicine for some easy to diagnosis conditions eg mild lameness, ruptured abscess, pyoderma etc and could continue providing the veterinary clinic fully records the digital discussion with visual evidence.

I find this very useful if client is elderly/shielding, I feel like I can prescribe with a bit more confidence. 2. It limits people coming to the surgery and protects staff and myself.

I personally don't feel we are doing our jobs properly without physical exams, hands-on examinations cannot be replaced by remote consults. I don't feel the ability to prescribe POM-V drugs from remote consultations should be a long term allowance, it was necessary when the human health risk was really high but it is not necessary in normal times.

I think it is a good idea, there are some conditions that I feel can be adequately assessed without having to physically see the animal, and owners can be trained to provide the right information and get some details themselves (e.g. weight, respiratory rate).

In current situation is reasonable, however longer term I think this is dangerous for both animal welfare and for keeping practices open and vets in jobs.

In my experience remote prescribing is at best a calculated gamble, and in nearly all cases that I have requested the patient to attend (all owners staying outside the building) I was satisfied the personal examination of the patent added to the diagnosis and treatment plan. Remote prescribing may help in niche scenarios, but ultimately is a poor substitute for physical examination in most cases.

It has been helpful during this period of Covid-19 restrictions but is dramatically inferior to in person consultation. Clients' ability to assess and describe their animals' problems are very poor when compared to examination and assessment by a veterinary surgeon. This has been confirmed by the cases which have had both remote and in person consultation during this period. I would like to see remote prescribing returned to its previous prohibited status once Covid-19 restrictions are lifted.

It has been really good to allow some urgent work to be done when due to child care I could not have worked otherwise.

It has been useful to provide advice and medication over the phone for non-urgent cases because it is much quicker than physical consults (for which we required owners to wait outside the building) and has reduced the amount of face to face contact for all staff involved. However I worry that the transition back to requiring physical consults may not be smooth for all clients, particularly those with recurrent conditions who do not want to pay the full price for a physical consult. Ear disease is a common one!

It has been very helpful to be able to prescribe remotely, especially in the early stages of lockdown, when risk to clients and staff was higher.

It has helped to provide care and alleviate pain and suffering in animals that otherwise could not have been seen.

It has saved us a lot of time and resource by being able to provide this service. And we made sure that clients were receiving meds for their pets while keeping a safe distance.

It has worked safely and effectively.

It is helpful to be able to remotely prescribe during Covid times.

It must not be allowed to continue once the virus is under control. We are trained to use PPE and we must do so if we need to break social distancing. I feel secure in

my ability to protect both myself (as an older vet with comorbidities) and also my client's with proper use of good PPE.

It was a necessary measure, but shouldn't continue for longer period of time, as seeing patients is the safest way to prescribe medication.

It was vital to allow remote prescribing during the Covid-19 pandemic. It has been very useful during this time.

It's something that must be bought in to prevent over working underpaid vets and lesson depression. This is something as a small practise with regular clients we feel is a necessity.

My own take on remote prescribing is this: Only registered pets/clients requiring repeat medications for known, previously diagnosed conditions - ie repeat prescriptions. Only registered pets/clients with NEW CONDITIONS AND could be assessed remotely with certainty AND were not considered serious cold have POM meds if considered to be required - otherwise over OTC products were suggested. Unknown/new clients and pets were either referred back to their own registered practice (if open and available) OR had to have initial remote triage and, on the basis of the triage, OTC products were suggested OR arrangements were made to register the new client and the pet seen face-to-face. Difficulties arose regarding supersession cases concerning previous case-histories. i.e. these pets would still be required to be "under our care" - even if that definition was slightly more stretched.

On animal welfare grounds it should only be a temporary change.

Remote consultation for the COVID emergency has been useful for the "worried" client and for triage but has exposed its shortcomings. Video consults are usually not much help if the client cannot use the technology properly.

Remote consults are essential because of the back log of routine cases needing care. It is far more efficient to do remote consults.

Remote prescribing has been useful for covid 19. But i cannot see that it would have any benefit to the animal once restrictions are limited. Nothing replaces a clinical exam and that cannot be done remotely.

Remote prescribing has enabled our practice to continue to provide a pharmacy service for existing clients whilst the vets in our 2 vet practice were self- isolating. We were able to do this as we live above the surgery and we could operate a system of timed collection slots from just outside the surgery.

Remote prescribing is helpful to clients - I only use it for known patients.

Remote prescribing should be a tool that we can use regardless of COVID-19. It should be extended further as an extended trial.

Remote prescribing was essential to be able to provide veterinary care to patients who were not in an emergency situation but would had suffered or deteriorated if they had not had this way of accessing treatment. With changes in the way

members of the practice were working a partner who was shielding started to take over phone consultations and so remote prescribing, whilst those of us still working from the practice could concentrate on the patients needing face to face consults/treatment.

Remote prescribing was extremely invaluable for clients that were shielding and for key workers that would have been a high risk for us to see. Also very useful for patients that were difficult to handle or transport to surgery.

Temporary remote prescribing has allowed us to function as a business, where we might otherwise have been unable to do so. As a small independent practice it was extremely welcome during these difficult times.

The guidance should revert to avoiding remote consulting.

The temp change has been useful for more minor problems and or where people have been shielding. It was useful when there were more cases. There haven't been any Covid cases here since April 18th. We are the only practice on a small island. Thus our practice spends a greater than average amount of time on emergencies.

This has been of some limited help during the (hopefully) once-in-a-lifetime pandemic scenario.

Useful for triage.

Very helpful in the early days of the pandemic when clients and staff were very anxious. I personally prefer talking to clients face to face and was doing so out on the street / car park at a 2 metre distance, then taking the pet away from the client for examination. The client stayed outside. Remote consulting works ok if dealing with a skin pyoderma for example.

Very pleased to be able to remotely prescribe and support patients/ clients while keeping everyone safe.

Very useful and sensible given the circumstances.

Was glad we were able to remote prescribe especially in the initial lockdown period

We believe this has helped pet owners to access medicines during C-19, who may not otherwise have been able to do so. However there should be strict regulations around this should it become a permanent measure, perhaps requiring owners to take their pet to the vet at least once a year, to ensure they are genuinely (not just theoretically) under our care, for that pet's safety and wellbeing.

We have extended services back to almost normal - there is no need to use remote prescribing any longer.

We were still not able to work from home via remote prescribing.

Worked well in the initial stages when clients reluctant to contact the practice. Client need to contact us face to face increased & also patient needs indicated that teleconsults were inadequate.

Corporate practice VSs

Allowed more patients to be treated. Owners very grateful for the service.

Allows a reduced number of consultations when it was difficult to see every case that needed help. Not comfortable with a number of the cases, poorer standard or care but making the best of a bad situation and hopefully not causing harm. Some cases just cannot be dealt with remotely. Will set us back a number of years, regarding client compliance to keep meds checks without an 'argument'. Video consultations were too slow to set up, so we used the phone. Post op pictures worked well. Doing videos for clients , eg how to inject insulin worked well - and we got them to video back them doing it (on a cushion or toy animal) to check their competence. I have for a few years used footage of 'vestibular' rabbits at home before being brought To the surgery for their actual consultation as very useful information (they always look terrible once they have travelled). We kept clients onside as most were strongly bonded and we knew them / they had confidence in us; but for new clients, it's not so easy to build up a relationship. Hearing clearly on mobile devices can be difficult, and older clients can have limited ability to use the technology. Many clients are not keen to pay a fee, especially if no treatment is dispensed. This adds to the 'stress' of the situation if they are reluctant to pay or dispute the fee. Asking for payment prior just makes us look money grabbing or distrustful.

Although I have answered that we did provide remote consultations for animals which we had not previously seen, this was very rare- every effort was made to persuade clients to seek advice from their normal practice if this was at all possible. I believe that the temporary change in RCVS guidance was necessary in the circumstances. Please note that the weeks which you have asked about were the last two weeks in which we provided any significant number of remote consultations, and the answers to the questions would have been different if you had asked about the first two weeks in April when we were only providing physical consultations to genuine emergencies.

Although originally designed to be temporary the changes have opened up veterinary care to a wider patient base. I think this has increased the standard of veterinary services, general animal welfare and is another step forward for the welfare of the veterinary profession and it would be a mistake for the RCVS to revert back to 'the way things were' it would appear to be for the sake of 'how things are always done' The temporary changes have improved the work life balance of my family situation which is not unique in any way. Without the flexibility to work from home and to provide appropriate care at least one of us would have had to either give up work, change employer or request furlough to look after our children. I do not think there has been any reduction in welfare standards for any patients treated remotely, in fact I believe it has increased with more flexible easier to access care.

Currently remote consulting is best used as a triage tool, post op checks and some nurse consults. I don't rate it in terms of client satisfaction, patient care or clinical outcomes in the majority of cases.

Definitely a big help during this crisis; it allowed us to help protect the most vulnerable clients as well as ourselves. It was important for me to explain to people who 'weren't bothered about getting coronavirus' and wanted to come down that by seeing them remotely we're reducing footfall at the practice to protect vulnerable people who don't have a choice and have to bring in their pets as an emergency, as well as limiting our own exposure and reducing the likelihood of losing staff over the crisis period, or having to close the hospital. (together with assurances that if we weren't happy with the diagnostic quality of the teleconsult and the pet needed to be seen, we would book a hands-on appointment at no additional cost). most were understanding after this. I worried that trying to convince people they needed meds checks arbitrarily every 6 months (when they think their pet is ok on its pred dose for skin, for example) in the future may be difficult after this period, but I think that explaining that it is below ideal standard of care, but necessary to protect human lives at the moment as well as explaining that the regulations regarding prescribing were relaxed to allow this, will help in getting people back on track with better standard of care for their pets.

During strict lockdown enabled provision of care to shielding clients.

During the first few weeks of lockdown the permission to remote prescribe was invaluable to ensure animals received treatment, owners concern were met, and staff were able to protect themselves as far as possible. The practice I work in though has no IT infrastructure to provide anything other than a phone consultation; some cases we ended up seeing because it wasn't possible to accurately assess over the phone.

Essential to have the option in early stages of Covid 19. No longer required; of limited benefit given changes to lockdown.

Good for animals with long term medical issues wanting repeats. Harder for new symptoms as concerns over missing the real issue.

Good for the lockdown situation but despite established client-vet relation some cases were not treated appropriately as owners underestimating the severity of the clinical signs and not provided full history, only what was their concern.

Has allowed for flexibility during an unprecedented time and meant offering greater options to clients many of whom were shielding or extremely anxious about face to face consultation.

Helpful in this situations but I don't think of long term benefit.

Helpful, would want to continue for some long term, repeat prescriptions.

I am glad that we had it when it was necessary and glad to have trialled it but I'll also be glad to see it returning to previous legislation.

I am happy to have had this opportunity. It allowed us to provide our service and to reduce our and clients risk of exposure to Covid 19.

I am pleased that this has been extended and i think it should be extended again while we still have any covid19 restrictions.

I am worried that this will allow the owner to ask for remote prescribing also in the future because he/she has not understood the reason why this is the way to do it now.

I applaud the RCVS's response in allowing remote prescribing but do not think it is appropriate in the long term unless the client has been examined by a vet.

I believe that there was no other way of doing our job.

I don't believe the RCVS would support you in any disputes - not worth the risk.

I don't think is needed anymore. Sadly I have seen an abuse of its use by insurance companies and other online providers. Those pets were not under their care and we received phone calls from clients asking us to prescribe medication. These providers didn't request histories either. Just unprofessional. We refused and explained we were doing phone and video consults for pets under our care. If we had a new client we would ask why and the if appropriate refer them back to their practice. Also you can examine pets by phone, it's ok for certain ongoing cases but I'm sure a lot of us feel very unease about them long term. I had a couple near misses and I'm fairly experience vet, 20 years as a GP vet. I found the phone or video consults were good for just advice and triage and post op checks. Owners can't palpate abdomens, listen to lungs and hearts, etc. Not many clients have devices with good cameras that give enough detail.

I feel it is appropriate at this time.

I found video consultations highly frustrating - the use of the technology was a problem for many clients, especially the elderly. In addition most of the video consultations I did ended up needing to be seen in person, so the whole video thing was a waste of time.

I personally think there is a long term place for remote prescribing as it removes a lot of stress from the daily schedule in real practice. It means that less urgent cases can still be seen through a video call and prescribed medication which makes the process much more efficient. I have found that the general public are more likely to use video calls as the first line and we see cases much earlier than we would've if they had to come into the practice for a consultation.

I think a lot of things should be able to be prescribed with at least a telephone conversation to clients if needed ongoing into the future. A lot of things are extremely basic and owners would appreciate a reduced fee for this and allow us to physically see things that actually need to be seen. This is more relevant for busy practices with inadequate staff or building size.

I think keeping remote consultations long term would be of great benefit, particularly for more routine things like parasite treatment, management of low grade GI signs, minor wounds etc. As it allows me to do more consults during the day, as I can squeeze in a remote consult when I have a free minute, I've also found a lot of the older generations who struggle with mobility have found it be a great help.

I think the decision to allow the temporary change was a good one. It ensured that practices could continue to manage their workflow whilst doing it in a socially distanced and safe manner. Importantly it also meant animals could obtain repeat prescriptions and medications for the large number of cases that are a concern but not deemed us urgent or an emergency.

It allowed many animals to be treated that couldn't be seen face to face during the challenging time of March and April. We utilised a shielding vet who could then consult from home and it worked well, easing the pressure on the staff working at the 'coal face'.

It has allowed for a safer working environment and meant we can help with minor and routine as well as major issues which we otherwise would not have been able to do during the main lockdown period. As we are also with reduced staff numbers it has meant we can help more clients than if they all had to physically be seen to be prescribed medication.

It has been a useful temporary measure given the limitations of the pandemic but i still feel that for conditions with minimal external visual markers eg heart disease, abdominal masses, etc there is a huge risk in misdiagnosis of many cases. Not a lot of cases are genuinely suitable for remote prescribing.

It has been a useful tool to allow us to provide veterinary care to animals which we would otherwise have been unable to treat. I would not welcome it as a 'blanket' use permanent change.

It has been an extremely useful tool to use in certain situations and I think the safeguards in place ensure safety to patients. I don’t feel owners have shown any concern about their pets treated this way they seem happy that a digital consult has targeted treatment appropriately. Lack of clinical examination may have missed some incidental findings which although not related to presenting concern may be of clinical significance.

It has been invaluable in allowing us to support clients in this crisis when social distancing has been critical and whilst we adjust to the new ways of working. The criteria laid down are fully reasonable and necessary.

It helped to provide care without being terrified under difficult and exceptional circumstances.

It is really useful to have the option to prescribe remotely.

It provided some reassurance that we wouldn’t face repercussions for issues arising from not seeing animals in person. However I still lacked confidence in making

diagnoses and still worried that I could have faced problems if the animal health issues weren't resolved. We had a client make a complaint (against another vet in the practice) based entirely on their (the owners) lack of compliance and inability to follow instructions which scared me.

it was a necessary change to allow us to still treat animals during the pandemic.

It would be nice to see it continue and trust given to vets to judge whether it is appropriate.

It's not fit for purpose in normal circumstances.

More clarification on the length of' under your care' means, is it 6 months, 1 year etc etc.

OK.

Online pharmacies now using it to remote prescribe POM-V medication rather than requesting it through a practice. I think this is wrong, it should not change how they operate. It should allow practices during COVID-19 where applicable to minimise human contact prescribe remotely.

Remote consulting and prescribing allowed a good way of treating pets under difficult circumstances , and the practice was always mindful that animals were seen if deemed necessary. I do not recall seeing any cases where there was obvious mis diagnosis or over treatments.

Remote consulting sounds like a good idea on paper, but in reality it is a poor substitute for face to face consulting. Examination of the animal and the ability to observe it, weigh it, ... are invaluable.

Remote prescribing has allowed us to treat more animals, than seeing them all face to face. Without remote prescribing I would not have been able to continue. I am exhausted enough with the workload I have with almost all staff furloughed. Having remote prescribing took the pressure off some of the more trivial and lower risk cases.

Remote prescribing has proven very useful during this period and, on the whole, has been successful and appropriate. We are an extremely busy practice and could not have managed in any other way as we were split into two teams of 5 vets and 7 nurses who worked opposing shifts and we regularly had over 80 phone consults, 8 ops and 30 physical appointments daily.

Temporary change was required to offer information and support to people who couldn't come in. It is not an equivalent to a proper examination of the animal.

The current temporary change allows practices to provide some sort of service. It also allows for some to work from home to take pressure off those who are at work so they can focus on what is happening at the practice itself. Many clients are happy to have their pets treated remotely for minor issues and no major issues have resulted. Some vets have found that not having clients in the building and having

distance communication allows them to more effectively treat patients. This is mainly through being able to succinctly explain issues due to time constraints. The temporary change allows vets to still treat minor issues remotely and be able to catch up on physical appointments for ill pets requiring treatment, as well as catching up now on some of the routine work delayed during initial COVID-19 work (ie vaccinations and neutering).

The current temporary change has reduced footfall and travel which was useful at initial lockdown, but I don't feel is of benefit now.

The temporary change has been valuable in cases where the pet would not have received any treatment because of restrictions but in most cases I would consider that remote prescribing is more likely to a less complete and less efficient procedure.

The temporary change was a good decision in the circumstances of a pandemic. It enabled some degree of patient examination and prescribing whilst minimising risk to staff.

Think this is good to help protect those client who are shielding.

This has been useful although I'm not convinced it has changed my own approach hugely - in the past I have prescribed medication to known clients / animals after phone calls, though perhaps generally for previously known conditions (be they long-term or recurrent). I have not personally prescribed any medications for new conditions to any animals though I know my colleagues have. Had it been necessary, I would only have prescribed a short course medication and requested a follow up from the owner, be that by email, phone or them sending in a photo / video - for new conditions / new patients, I would be very reluctant 'simply' to prescribe anything (except parasite control) and then 'presume' the problem was dealt with if I had only consulted remotely.

This was necessary during the lockdown to provide care safely.

useful in the circumstances but I wouldn't like to have as a default.

Very difficult, our practice did not offer a reduced cost for telephone or video consults and so owners were not happy with this.

Very happy with the current changes but I think there is more to be done which I have detailed below.

Very helpful to keep staff safe, although I was under the impression under practice protocol that this was no longer possible.

Well communicated with us, necessary during this pandemic to try and keep animal welfare top of our list whilst allowing us to manage our caseloads so as not to swamp our staff and to reduced risk to clients and staff from COVID-19.

VNs (not SQPs)

All remote consults were done from practice as we were 1 vet 1 nurse team

as a large animal charity the remote triage approach was extremely helpful as we would have been over worked. At present we are still only treating emergencies but the volume of work has been exhausting and over whelming. The remote consult has helped in ensuring a client gets a good understanding of the animal's health and whether it warrants a one to one consult. Clients were very happy to post photos and receive call backs and the feedback we got at the hospital was very positive. Our clients do not have much money, are sick and or injured themselves and most rely on taxis to transport their animals to and from the hospital and this provided a well needed respite. Most prescriptions were then picked up by a friend or relative with ID. Probably of all the telephone consults and the ability to obtain prescriptions via the hospital or through the post only 10% needed a further work up or were told to go to the hospital immediately.

As a nurse although I am involved in cases I am not making diagnosis so many of these questions do not apply to me. I have been horrified by the clients' demanding and difficult behaviour. Also by the number of animals presented that have clearly been ignored for months prior to lockdown. Eg mammary tumour the size of a melon just appeared this week. Aged poodle enlarged abdomen virtually hairless just happened and many more.

As a nurse, I found it useful to. be able to check post op wounds remotely, allowing I patient owners to stay safe.

At our busy hospital we've found it a great help for staff to be at home consulting remotely, we think it would work in the future also.

Being able to remotely prescribe was definitely beneficial at the beginning of lockdown where there was a much higher risk of covid19, but now as other places have started to open up clients are expecting the same from us, and are not as happy to pay for a remote consult when businesses over the country are opening up more to see people in person. Also found it more time consuming in some cases where a vet felt the case was serious enough to attend the practice, we'd then have to find a time slot to examine them physically later on but often all the slots were taken by remote consults.

Clients have accepted willingly. Clients have overall been understanding. I would prefer this to continue with specific guidelines.

Clients were generally keen to come into the clinic. When told we were seeing emergencies only they were convinced their animal was the emergency, even for nail clips!!

Good idea for the easily manageable cases. Mild diarrhoea cases etc.

Good in some circumstances but then clients presume this should be done all the time, ie skin /ears shouldn't need to be seen just give meds, hard sometimes to

explain why we have been able to do it when normally has to be seen and also with 6 monthly check up for meds.

Great idea that is keeping staff members and clients safe. You don't always need a physical examination to reassess a course of meds that has already started. The same if you see a physical problem (wounds).

I feel for some clients it was an excuse to not have to bring their animal in for a health check when they haven't been seen for a year or now more for repeat prescription, I understand some clients have been self isolating and normally when discussing the patient they are quite open and upfront and happy to discuss. but some have been very blunt and just saying I just want my prescriptions and these are the animals that need to be checked and looking previously at notes these are the clients who normally try and get out of paying for treatment/ ongoing/check up tests so for some I feel it is and easy way to get out of these checks.

I feel it will be more difficult to go back to the previous guidance after as clients have got used to a new way of operating. Clients are certainly happier with a telephone consultation rather than bringing their pet in for meds checks.

I think it was necessary to have this and it did help with the treatment of minor injuries and keeping footfall of people into the practice.

I worry that once we no longer are in Covid times people will expect this service as it has been easier, quicker and cheaper for them than usual. We are storing up future annoyance when we can no longer see clients remotely.

It has allowed valuable and necessary treatment to animals that would otherwise have suffered during this situation.

It has been very useful in these times, being able to post medication out to keep people safe who have been shielding. Keeping the number of people visiting the hospital to a minimum reducing the risk to staff on site who are dealing with emergencies. As we work so closely to each other it's very important that contact with unknown factors is kept at a minimum.

It was very beneficial in the initial instances of the lockdown to allow us to practice telemedicine and prescribe to an animal without seeing them first, however we had the issue when we had never seen the animal before - our vets did not feel that they could prescribe to these cases without seeing first.

It's fine with trusted/known clients but ours far preferred telephone to video consults. Doesn't feel safe at all in the case of newly registered clients.

OK, for 1st instance of something like diarrhoea, repeat medications etc Not good for eyes and ears - ulcers etc.

Please keep the changes!

Prescribing medications for repeat medications over the phone has been very useful and I can see that being helpful in the future by saving in house appointments for new/deteriorating cases.

Really good as some clients who were shielding could have access to the vets. Some people did complain a lot about costs as they didn't understand why we needed to charge a consult fee. It was also good for simple cases where we could try initial treatments i.e. if they have developed lameness could trial anti inflammatories we did end up having to see a lot more things than we thought. A lot of people also got puppies as well and we needed to fit them in for vaccs too.

Remote prescribing has been useful and helpful but I worry that client expectations will have changed now so going back to the previous system is going to be difficult to present in a way that won't potentially be misinterpreted as "money grabbing veterinary practices" and frankly, a bit of my soul gets eroded each time I have to have this sort of discussion.

Remote prescribing is still necessary to protect human health.

Remote prescribing isn't really relevant to us as we are referral practice so it will get bounced back to the referring vet.

Remote prescribing process takes much longer than in house consultation and makes internal phone lines much busier than usual with clients returning calls if they have missed their call from the vet and then again to call to take a payment for the prescribed treatments. If a physical examination is still required in practice following the remote consult then the combination of time taken on the phone and additional time take to complete the examination in practice ends up far greater than if done in practice first off.

The zoom telephone conversations can take a while just to get connected and last a lot longer than the usual face-to face consult with the client. However clients were very understanding because of the pandemic and were happy to pay by card over the phone for the tel cons.

This has been a huge help in allowing us to protect human health by limiting the number of cases we need to see at the practice as the process of an animal attending with the client not allowed in is lengthier and puts huge pressure on the workload.

This is an area that can be expanded and developed for the future. I believe telemedicine is an excellent addition to our treatment options, and with guidance and training we can develop this area further in the veterinary profession. Vets must trust their own clinical judgement in these cases but the rcvs could help by giving them broader guidelines for the future (as in covid). We have had no complications as a result of remote medicine... So thoroughly happy.

Useful and necessary under the circumstances, but would not consider it to be 'best care' for patients.

Useful for this time but clients now expecting it as routine.

We have staff only inside the practice. Vets would go outside (distanced) and discussed with owners their needs and problems. The animal would be taken from the owner (Vet would be wearing all PPE) brought inside the practice for treatment them returned to owner. Payments would be done over the phone.

Works well and has not caused any major issues for us.

VN SQPs

As a nurse could not answer all person questions, however, from a practice point of view due to restrictions imposed from Covid remote consultations have been invaluable. We have operated telephone consultations and emails with photos. They have proved popular. The only issue is it has occupied telephone lines meaning it takes longer for clients to get through. One of our vets has been able to do telephone consults from home whilst shielding, then informs practice of medication requiring dispensing and ensures it is all written on clients notes on computer. It has enabled us to keep appointments for emergencies as per regulations and use these for minor or non emergency cases.

I do feel that animals on long term medications it has been great to provide remote prescribing. Although gold standard would adv possible blood tests at med check ups some clients feel it's a money making recommendation. I know it isn't but our clients feel they are already doing their best in paying for the medication already and often struggle or worry about the med check ups due to additional added costs to the already expensive medication they are already having to purchase on a monthly basis.

I feel this has given the profession a fantastic opportunity to provide this care permanently for our patients and I feel we have been able to provide care for animals that may not of have ever been brought to the surgery. I truly hope it is a tool we are allowed to use in the future.

I thought this was a really good idea for clients that were not able to get into the practice.

It has been beneficial for the practice in order to stay safe during the Covid-19 pandemic; however the clients perception of this is that we can continue to prescribe without the need to see the animal post lockdown. This therefore means we are facing a larger number of complaints and abuse from clients on a day-to-day basis.

It is very useful especially for those patients which do not like visiting the vets and gives a better visualisation of them moving about normally.

Measures in place at our practice have made it easier to treat animals at this time. These measures are staying in place until instructed otherwise by RCVS.

Now it should be only for people with symptoms of covid 19.

Some concerns again about this as clients will always expect their drugs to be supplied without seeing the animal and no consult fee. (Again our vets weren't charging their time because the usual consult fee of £40 was supposed to be charged to ALL consults.

Think it helped a lot with repeat prescriptions and some easy to diagnose cases. Client liked it but didn't feel they should pay for that service and were rather rude and on occasion abusive about it. They would rather pay and be seen. They didn't understand that they are paying for the time and expertise the same admin a face to face consult.

We are lucky to be rural. The last question re face to face, we are still not allowing clients in the building. We have a secure clip on the front of the building when ready we ask client to put dog on the clip. We are there with a slip lead 2 mtrs away and then take to dog in. (Cats put in secure box on doorstep) we assess the animal and talk to the client either through the window or on the phone. The clients are able to watch through the window. We then take payment over phone. We feel this system has worked very well. Clients are happy and animals are better without them!

Feedback on remote consulting and prescribing in general

Small animal practice VSs

A lot of the questions in this questionnaire ask 'on average' which is hard to answer; I've tried to go with my experience of the majority. examples from this page: I definitely had a lot of people come back with complaints about paying for the 'chat over the phone' when I was doing debt collection days (our vets took on all of the roles for part of COVID, and I continued helping with the debt collection until the first week in june); but I think on the whole, the people I personally consulted with who started off with "I was told I can't be seen at the practice" or "I can't believe I have to pay for a phone call", I was able to explain why they had to pay for a teleconsultation in a way they agreed to continue the consultation with. In a couple of instances, we had to see the client because they were so passive-aggressive and making the teleconsultation process difficult (eg, "I can't send photos, no. No, I don't have a way to email them. No, I don't have whatsapp, I can't do that I'm sorry". or "I don't know" as a response to basic questions.) these were memorable, but probably few and far between. maybe two per consult list? I did find myself fighting two people back from the edge of putting the phone down and making a complaint during the period - this was from an inability to read them and how they were feeling during the consult - this was the hardest part, and I needed some time away following them as they were mentally very draining. It also made the rest of that block of consults a bit more difficult as I'd lose confidence. Most people sent great pics and videos, but some sent poor quality and some people needed step-by-step instructions in how to operate their phone, which really slowed down the consults (they were supposed to send them before the consult or call if they were having

problems, but they often couldn't get through as our phones were so busy). I had a couple of people just out and about at the time of their consult, with vague history information and the pet not in front of them - I would have to explain why this was inappropriate and make a new appointment time.

As above. And for clarity I am not in favour of remote prescribing. I think examining the pet is vital as part of good pet care.

As detailed, we only provide for known clients with known patients. I cannot approve of remote consulting when so much of our work requires 'hands on'. From the simple hands on of clearing anal glands to injections required to provide immediate relief, to surgery or dentistry or collapse. I therefor remain against remote prescribing, except as detailed for known clients and patients the practice has physically met and knows, within the practice locality.

Connectivity was a major problem. A remote consult took much longer due to connections dropping out and inability of owners to provide useful images via FaceTime etc. Also animal rarely cooperated adequately for the owner to get good images.

Consulting 'kerbside' without clients present has made ECC consulting overnight a lot more efficient. Remote consults useful for minor wounds etc. Some clients experiencing heightened anxiety over smaller problems with their pets due to COVID 19.

Convenient in certain cases but no substitute to a clinical exam.

Disappointing in our area. We speedily provided this form of communication with clients who tried to adopt it but poor picture quality meant that staff didn't feel it was particularly successful /rather limited and adopted email photo & phone calls in preference.

Found the whole period extremely busy, consultation and communication was very slow making very little time for routine work. I was very stressed to the point of wanting to give up work. It is time inefficient and there were quite a lot more difficult and rude people expecting the same level of service pre covid 19.

Generally it did result in appropriate treatment of patients and clients were happy with it. The only exceptions that I can remember were: 1. a dog with apparent conjunctivitis which turned out to have an indolent ulcer 2. an elderly lame dog which was prescribed a week of nsaids but was then presented 3 weeks later 10/10 lame with obvious bone cancer. Teleconsults were very time consuming and although some clients were pleased to not have to come to the practice, some felt that they shouldn't have to pay for telecons or were insistent that they had to be seen for conditions which were not considered genuine emergencies.

Generally it's far less efficient if it's a new problem. It can take a while to question the owner to work out what is going on and getting them to describe things. Pictures are often not that useful as owners not very good at capturing what you need to see.

Some owners get it right others get it very wrong and this can be hard to judge over the phone. The lack of a physical exam does make a big difference, I personally don't think I want to be using it longterm. However for certain things (rpt meds checks, stable patients) that have a high level of certainty it is a big time saver compared to getting them into the clinic, I would happily use it. Also I think it would be good to offer it as a service for elderly or vulnerable clients who would otherwise struggle to bring their animal or access medications. We may still need to see some cases but generally feel it would benefit animal welfare for those who otherwise would struggle to attend.

Hate it!

Helpful for certain scenarios, particularly triage and behavioural consults, possibly also very helpful for nurse consults but with other consults very limited in what can be achieved.

I believe it has value in triaging but is very limited in its ability to provide good quality first opinion veterinary care.

I believe it is a useful adjunct during pandemic depending on case. Does need to be used safely and appropriately though.

I believe it is dangerous and Can easily result in misdiagnosis and allowed local vets to become lazy / refuse to see animals the should of been seen in person for animal welfare.

I believe there are very few cases where remote prescribing is a clinical equivalent to physical examination and diagnosis.

I do not feel remote prescribing should be allowed in the longer term. While it has allowed us to provide care for animals that cannot come into the practice due to the exceptional circumstances created by a pandemic, I feel it is not as safe prescribing medications for an animal that has not been seen in person.

I don't think for the majority of consultations that remote consulting is useful both in terms of diagnosis but more in terms of the time it takes to do one consultation, the amount we can charge for that consultation and then not charging for any clinical examination that is required.

I feel remote prescribing could be utilised more. For a stable patient on long term medication (that does not require blood tests as part of monitoring) I feel a phone consultation which then allows remote prescribing would be suitable even under normal circumstances.

I found telephone consultations with emailed photos to be the most efficient & accurate way to carry out remote consultations. If carried out thoroughly I felt confident in my prescribing.

I generally felt comfortable knowing that remote prescribing was only for the short-term, but the necessity for prescriptions checkups should have been relaxed-perhaps for certain listed conditions (e.g. incontinence, patients with early heart

disease). I worry a lot that after this period of being able to prescribe remotely, some clients will expect remote prescriptions on a routine basis.

I have found clients to be extremely grateful for remote consults. the majority my calls have been putting clients' minds at rest, this has improved welfare! as I have been able to educate my clients about behaviour, signs of pain etc. Personally I have found clients to be actually happy to have video consults, I myself prefer them to telephone consults as I can gauge the mental condition of the client and the behaviour of the patient as they are both in a comfortable surroundings and are more likely to be forthcoming with concerns. In cases where I feel the pet should be seen, I think the clients who have had a video consult prior are more willing to bring the pet straight down and show more confidence in me. I think that it is insulting to insinuate that I cannot diagnose over the phone, of course not, I am not a telepathic animal communicator! if I were, I would not have had to go to vet school! What I am doing is triage and confirming what the client already knows. There does seem to be more than logic when making decisions, an emotional side seems to be helped by talking through the issue with the vet/nurse (I think this might be a good graduate study, "how people make decisions") and this appears to make them more confident to bring their pet for treatment. I have been horrified in the past by the condition of some pets when they are finally brought in to be seen, the o appears to rationalise waiting! I'm pretty sure having experience doing remote consults that those clients would have come down sooner had they been able to speak to a vet/nurse, via video. Sorry about the ramble, I really feel telemed has a place.

I loved it! Never done it before, but I discovered that remote consulting has a lot of advantages: - relaxed clients, giving plenty of information in regards to their pet's conditions/symptoms (even more than I needed, in some cases), and, surprisingly, sometimes even more accurate information than in a face-to-face consult. A great difference in their attitude also in admitting fault/guilt comparing to their "defensive" behaviour in a face-to-face consult. - clients did seek the vet advice more often than before the lockdown, the explanation could be that they were probably interacting with their pets more often, but also because it was much easier to dial a number and get professional advice than travelling to a certain place for the same thing. - a huge positive impact on pets' welfare/level of stress- they didn't have to be chased throughout the house to be put in a carrier/muzzled, then put in a car or bus in order to be brought to the vets. Happier pets, less stressed clients also. - and the most important one: I strongly think that during this time the pets benefited from professional advice more often and for considerably more conditions than before the lockdown. Health conditions were addressed at an early stage, pets were treated even for minor conditions, which means better health care- improved pet welfare.

I personally am absolutely certain that I cannot deliver the same quality of care to sick animals remotely. I believe checkups, eg annual checks for prescription only parasiticides remain essential for their role in detecting medical conditions which may not be obvious to an owner.

I strongly feel that remote consulting and prescribing undervalues our work as vets. It sends the message to clients that doing a clinical examination is of negligible value, and that owner assessment at home is adequate. Getting an accurate weight is also a concern as the owners try to balance on bathroom scales. I do not feel that I am doing my job properly when remotely consulting. I cannot examine the animal so I am completely relying on the owner's comments and interpretation. The animal is often moving around in the video, and the quality is not good enough to see detail. Owners vary a lot in the interpretation of symptoms and degree of severity. I feel constantly worried that something is being missed or misdiagnosed. I feel that the remote consultations reassure the owner and make them feel better, however I think they are hard to justify if animal welfare is held as the main priority. Additionally, I am nervous to ask owners to do things like check gum colour or manipulate a painful leg. I am concerned that, if they get bitten or scratched, I would be responsible for their injuries if I asked them to do a certain check. I think, as a profession, we need to be clear with the public that remote prescribing was used during lockdown due to necessity, but that it will not be continued long term since adequate veterinary care cannot be provided remotely. Remote prescribing undermines and undervalues our skill in clinical examination, and does not make animal welfare the priority. It concerns me that there are now a few companies providing online consultations and prescriptions that are not linked to a vet practice. They have been prescribing medications to animals that they have not examined, and they do not have the clinical history. This service could be used as a triage, but they should not be prescribing medication. Again, I feel that these services undervalue the skill of a vet in doing a clinical exam. I can see certain situations where remote consulting could be useful. E.g. for shielding clients in the next few months or for a recheck of an animal who gets very stressed coming to the clinic (e.g. blocked cat post hospitalisation). It also could be used for triage for owners to ask whether they should see a vet. However there would be very few situations where I could justify remote prescribing of POM-V meds. Overall, I do not see it playing a large part of veterinary practice.

I think remote consulting is an exceptionally useful tool. In my experience, clients are very keen to use this service in combination with visiting the vets for face to face consultation. I think there is a place for remote prescribing, but very clear unambiguous guidance is needed from RCVS on this. I would like to see some element of remote prescribing to continue into the future

I think it is the way forward. It will enable better access to veterinary care for pets.

i think there is a place for remote consulting and prescribing even after covid but i think it needs to be well regulated and supported. for example, the telemedicine vet should be able to refer patient to a physical clinic for physical consultation and further diagnostic work up if needed - unless of course that they make it clear that their service is only for advice/triage and not for assessment/diagnosis.

I would like to be able to continue remote prescribing but from over 20 yr experience nothing compares to the patient in front of you. There are risks of inexperienced owners giving incorrect information. Covid has created a huge demand for pups

from first time owners. High levels of anxiety needing lots of “hand holding”. Remote prescribing has some benefits but is open to exploitation if not used with strict attention to detail and an experienced clinician’s radar for the “feel “ of how a case is presenting.

In general under normal circumstances I would find remote prescribing unsatisfactory. Many of the images/videos are of poor quality due to technical issues or poor restraint by owners. A full examination is simply not possible and in most cases even the basics such as temperature cannot be obtained. If remote consulting were to continue indefinitely I feel it would further strip practice income, we already have had to adjust to alternative medicine suppliers, resulting in increased financial pressure on practices and price rises to clients. Covid 19 has already resulted in significant price hikes by corporates at least, soon veterinary treatment will be unaffordable to many.

It has been a very steep learning curve - no training or instructions were given, understandably with the suddenness of lockdown, but if it is to continue there would be an opportunity for some training before commencing remote consulting for those new to it I think it has been surprising now many things can be fairly accurately diagnosed and treated without a face to face consult There are always going to be some conditions that will need further investigation before diagnosis so there needs to be a good balance between the 2 modalities On balance I think it is a good thing and hope that it continues in some form after covid. It can be very helpful if clients can't travel or animals get very stressed at vets, especially for routine check ups

It has in a sense always been done as long as the veterinary profession has existed – but in a manner both professional and scientific. "Under his care" has always had real meaning. Until now. It doesn't trouble me too much. My style is that I must have face-to-face consultations, though I will also provide repeat prescriptions after a telephone consultation if I see fit. If clients don't like my style and my policy, they can go elsewhere and one hopes for their animals' sake that they don't get too bad a service.

It’s not all bad. It has worked well for many and I see a use for it in future for certain things. Video consultations useful to see relaxed pet and get a good history. Also possible to get insight into home environment which can be important from welfare perspective. Used by people who had not sought vet care in years on many occasions. Still concerned about long term remote prescribing, there is no way to be sure or as confident in so many cases but it has been good enough given the times we have been in. My worry is who will regulate those who abuse this? Are trading standards set up to regulate online pet health sites who prescribe medicines with no vet? I see the potential, lots of positives but I issue a care warning in unintended consequences.

Many older clients cannot handle any of the tech Accuracy of diagnosis woeful Ok for parasites as long as an "accurate" weight Would never prescribe drugs with narrow therapeutic margins. We consulted outside for much of this, vastly superior accuracy and more rapid resolution of the problems.

Not enjoyed - impossible to assess the majority of illnesses over a video link. Easier to assess videos owners sent in but would still not be happy prescribing without physically seeing the pet. Lazy vetting encouraged - worry re irresponsible and inappropriate use of antibiotics Not satisfactory for clients - clients want their pets examined - we could manage this with a lobby that allowed pick up and drop off of pets and no owners in the building.

Not sure if we have the true anamnesis, not sure for diagnosis and possible overusing antibiotics in cases may not need one.

Not to be encouraged.

Only for a small amount of situation is a good enough substitute of a live consult.

OOH vets tended to perform a type of 'remote consulting' with triage calls before COVID-19. Would like there to be further clarification on 'under care' for after hours scenarios. E.g. if we have access to other clinics records etc.

Over the 3 month period many video consults were of limited use and involved clients trying to film down a dog's ear or in its mouth with little success. I often found myself struggling to come up with things for the clients to do to fill the 15 minutes. It has very limited use.

Personally I feel knowing that prescription regs had been relaxed was imperative and generally most clients verbally accepted the possible increased margin of error in diagnosis. Many clients were just grateful that there was some help available / practice was open and drugs obtainable.

Really as above, useful at the moment but misses a lot of information garnered from clients during the consultation and from physical exam of the patient. Often while in the owner will mention something else they have noticed which may end up being of more concern than the primary presenting complaint.

Remote consultations have several draw backs and carry many inherent risks. They have been useful for assessing animals with conditions such as masses or wounds as to whether medical management could be tried or whether that animal needs to come in for assessment of the mass / treatment of the wound or a fine needle aspirate biopsy. They can be used well for dogs with diarrhoea and the additional supplementation of photos or videos of the faeces. I find them inadequate for assessing dogs with vomiting as in general palpation of the abdomen is needed. Any animal with GI signs also cannot be adequately assessed for dehydration. Unfortunately they carry many severe limitations for the diagnosis and management of eye and ear conditions as the quality of the video is not good enough for eyes and a physical exam needs to be taken place to adequately assess ears and eyes, They cannot be used for any animal that is collapsed, lethargic or with heart and lung issues other than providing a very basic triage system, the animal must be seen but booking a video consultation may delay this animal receiving a clinical exam and treatment and have detrimental consequences. The prescribing of medications has limitations. I have found this difficult when prescribing topical ear medications, most ear preps are ototoxic unless the tympanic membrane has been

assessed and not perforated and this cannot be done remotely. I think remote consulting and prescribing in general has a place but can really only be used in specific circumstances which need to be consulted on and guidelines need to be constructed.

Remote consulting can never be as effective as face to face and should not be allowed except in exceptional circumstances or primary assessment before physical examination. POM's should never be given after remote consulting except as repeat prescriptions to an animal physically examined in the recent past.

Remote consulting for repeat prescriptions in certain instances should continue to be permitted, especially in cases such as seizure medication, urine incontinence medication etc. In these cases a physical examination rarely provides more information than a detailed history from the owner.

Remote consulting has enabled the practice to screen and triage cases. Without remote consults the team were swamped with consults and given the face to face consults are less time efficient it's was a challenge to provide necessary care to all our clients and their pets. Remote consults have allowed the in practice team to remain socially distanced where possible, limit contact with public and remote consulting from home (with access to medical histories etc) has allowed team members to remain in work without furlough and still be critical key workers to our business.

Remote consulting I do think really has a place, there are clients who would physically find it difficult to attend or are shielding, and many clients liked the convenience. I think vets are well placed to decide whether they have enough information in order to provide a remote prescription. We used the service to augment the work we did in practice. We had 3 vets working in the practice with one at home doing telephone consultations all day with email photos/ videos as appropriate. The vet could then triage cases and prescribe or send into the working team as appropriate. There was no pressure on the remote vet to prescribe anything if they were not happy. We would find some mornings almost everything was sent into the practice for a face to face check, and on others much of the work was done remotely. Usually around 75% of the work could be done without physically seeing the animal. We found that the client taking photos of videos beforehand worked the best - that way they were not trying to operate technology and hold an animal in the correct position and they could devote their attention to giving us a good history. We charged £30 for the phone consult, and topped up to the normal consult price of £36.50 (additional £6.50) if the patient was examined physically. I would favour continuing it but with the caveat that the patient must be 'recently known to the practice ' - in other words a recent weight is recorded, and a physical exam has occurred in the past.

remote consulting was unnecessary and dangerous, we reverted asap to on site consultations with proper examinations at the earliest instance, the onset of remote services will in my opinion cause a negative reaction in the public to the use of veterinary services locally as opposed to distanced and open questions on

insurance liability and consequences of mis consulting and prescribing.. the rcvs does not have the staff to oversee such a change and its consequences

Remote consults longer term are where I feel the profession needs to head to increase the armoury of ways in which we can supplement the routine consult. I don't believe it should replace routine consult and the physical examination is critical to most situations, however continued care and medication/health checks where an already strong and existing relationship exists could be by remote tele consultation in the future. I feel we should keep this option available but with guidelines as to what would be considered under our care in these circumstances and client-patient-vet face to face relationships are paramount in how we work as a profession. This cannot be replaced in the current time.

Remote consulting provides poorer patient care for the sake of increased convenience for their owners - and I suspect the increased convenience of many vets. However - the importance of a physical examination in most of our patients cannot be overestimated - whilst remote consulting works well in humans where we have the ability to communicate signs and symptoms to our physician - animals do not have that ability - and we must use a physical exam to find the things that our other senses cannot detect from a distance.

Some clients prefer text to a phone/video call and it is useful for that.

Some situations it works well, other situations it doesn't, can be good for triage.

Staff have been fantastic at knowing when to remotely prescribe and diagnose, and when to book that client in for a hospital appointment. Remote consulting and prescribing has greatly limited the traffic to the hospital, and is essentially used as a triaging tool. A lot of conditions can be adequately diagnosed remotely. And vets in first opinion can generally (in our experience at our practice) gauge when an animal needs a physical exam and when remote consult will suffice. I do not feel in my experience that this service has been abused or misused. And I do not believe, in my experience, that there have been any detrimental effects to animal welfare.

The quality of the service you can provide is much poorer and the risk of making an error much higher. Whilst clients may see it as more convenient in some instances, I do not feel the standard of care provided to their pet can be adequate.

The remote prescribing should continue, we can then use our vet judgement if we need to see the patients on case to case basis.

This should not become a permanent change. Remote consulting can never be as good as a physical examination and should not be encouraged outside of the extreme situation we currently find ourselves in.

Under certain, sensible conditions, at the veterinary surgeon's discretion, remote consulting is a vital tool to aid in animal care. The temporary change by the RCVS to allow remote prescribing should be extended indefinitely.

Very easy and practical to see the pet and have the owner communicating on the phone. But animals need to be seen. No owner remote info is trustworthy. There is no epidemiological reason to refuse to see pets. Use of medication needs to be explained and demonstrated face to face with owner using mask, visor and physical distancing outside in the carpark. Owner required to use mask too.

Very limited on what we felt could be achieved ie which cases felt suitable for telemedicine - ended on only doing mild first episodes of D, first skin complaints and old dog stiffness on telemedicine. Clients also complaint about cost of telemedicine consult (we did reduced charge to normal consult fee) didn't feel they should be paying for a phone call ('when you didn't even touch the animal). Multiple complaints of this nature made us stop most telemedicine. Useful for elderly and those shielding. Worry for those that have used it will now expect us to put up medications without seeing the animal.

We welcomed the freedom and it put us under less pressure to have to see animals. We found it took more time than a routine consultation because of the time taken to read emails, call clients, and review photos and videos. The clients found it more convenient. We even had a client call and ask what we charged for telephone advice - before we could say that we give advice FOC over the phone - she said because if it's more than "X amount" I will call another practice as I know they charge less than 'X' amount! We just said that it sounded like she should do what she was comfortable with and left her to it.

Would be good to carry forward with careful monitoring.

Equine practice VSs

As above asking as some good information is collected and with video and pictures these systems will be fine , some cases will go wrong but then new graduates are probably more risky than an experienced vet remotely.

Even as a vet with over 20 years' experience I found remote consulting very difficult and stressful you just don't have the same amount of information available to make accurate decisions. As a practice principle remote consulting was a nightmare, clients often felt very aggrieved at paying for "an advice call" which they were used to receiving free. After a week or two when social media got involved we had clients try to insist that they could have the drugs they wanted over the phone without paying for a call out, undoing years of client education regarding NOT handing out prescription medication on request. I would strongly urge the RCVS to remove the temporary change as soon as safely possible, we provide a better service when we see the animal, clients give more value to our time and I have significant concerns that should remote consulting/prescribing become accepted practice those practices (like ours) which take our 24hr commitment seriously will be undercut by practices further afield who remote prescribe to "registered clients" and then can't provide emergency services as they are too far away. Could the RCVS also take the opportunity to firm up guidance about "under our care" for repeat prescriptions, the current code of practice is open to too wider interpretation.

In general remote consults are helpful for clients mainly as triage- I do not use it as a substitute for face to face consults.

It is a bad idea. It will allow a small handful of clever people to cream off the easy work and leave large areas of the country (typically the poorer and more remote areas) with a dearth of physical veterinary practices. When clients actually need to see the vet (You can't fix a GDV over the internet) the practices will not be there because on-line completion has destroyed their commercial model. It is shameful and any member of the College who has MRCVS after their name should feel personally ashamed if they are involved in this nonsense.

It is a perfectly sensible and feasible way of providing veterinary care as long as it is used sensibly. The risk would be a 'corporatisation' of the method - ie a remote vet giving advice to 'non-clients', cheap and cheerful to drive meds sales etc, further eroding the profession. The method of remote consulting would have to be for animals under the care of the practice with previous history and physical examinations in person.

It is more flexible but carries too much risk with it. I had two cases over lock down where I remotely examined via video and prescribed and had an adverse effect on the horse as I had misdiagnosed the problem.

Pictures and videos of wounds and lameness are very useful for advice and triage.

Please allow to continue long term.

Remote prescribing is fine for ongoing cases and horses known to me. Some clients are better at providing info than others. Most people expected it to be a free telephone cons. Those emailing in were more accepting of a fee.

Very hard to charge appropriately. Difficult to get clients to show you the evidence you need. Clients misunderstanding the necessity for this and the fact that it was a human heath prioritising compromise.

Farm practice VSs

Clients seem less willing to pay for this. We need more reassurance that things missed on remote consultations will not result in sanctions. Clients are terrible at taking pictures.

Farm clients are visited routinely every 3mths including health plans, preventative medicine advice training, QA etc. Communication with clients between those visits is regular and assumed. If problems arise between visits unless dramatic or new in nature remote consulting has worked successfully for decades but getting better with improved technology (video conf, precision farming reports, production data, phone discussion, submission of samples submission of carcasses to remote lab Remote consultation and prescribing is an essential part of production animal medicine and only occurs where there is full knowledge of the client, system in operation, staff and their abilities and history of health. It is not appropriate for auditing purposes for QA and RCVS should convey to Red Tractor that veterinary

involvement on farm requires a lot more that ticking boxes for them and that it is totally inappropriate for RT to decide whether or not vets should visit farms.

Farmers and vets are in a long term partnership and farmers often have many years' experience both of treating animals themselves and witnessing what a vet has used. There is also more health planning and agreed farm protocols for diseases, due to supply chain and Red Tractor Farm Assurance requirements than in the past. The job of a pro-active vet is to monitor health and adjust these protocols to prevent disease rather than be involved in every individual treatment decision on farm. As such remote consulting and prescribing is part of the normal activity. The point at which an in depth reassessment of the individual and herd is required depends on the judgement of the vet regarding the described circumstances but also the capabilities of the farmer. I think the duration of the relationship and the amount of knowledge and education specifically regarding animal disease a client has is easier to judge in farm practice. Equine practice may have some clients in the same bracket. For occasional small animal clients I can see this justification harder.

In farm animal practice the farms involved and the problems about which farmers require advice are usually familiar to the vet even if a specific visit has not been requested. Cases will usually be followed up at the next routine visit to the farm which will usually be within a month and advice is always given that if the situation does not progress as hoped or particularly if an animal deteriorates then a more urgent visit should be requested.

We need to develop this more. It has saved me a lot of miles in the car and has meant I can focus on more technical advice. I need to learn to be more efficient in reporting and adding value remotely.

Mixed practice VSs

I fully support remote prescribing. It's time to change. Some clients found it convenient and cheaper. I cannot think of any severe side effect or poor outcome during the time we were using it.

I will be glad when it is all over. Clients might want it to continue so they get a cheaper service!

Is unsatisfactory, time consuming, lacks detail, disliked by clients, difficult to make an accurate diagnosis, potentially leads to over prescribing "just in case" and is not for the future.

Remote consulting can work well in some situations provided clients understand the limitations it has and the responsibility they have to pass on information correctly and monitor the case as requested.

The skills of a veterinary surgeon which we were trained in are the physical examination of an animal in relation to its history. Clients are not adequately trained to perform this role without errors being made and animal welfare being

compromised. Remote consulting is suitable for triage only in my opinion. I am not sure modern technologies make a huge difference from phone triage which has been possible for a long time.

There is a role for this in the future - but it has to be mixed in with face to face consultations. The process works better when you know the animal or the owner in advance.

Referral practice VSs

I think that for many cases remote prescribing can be extremely useful. Some animals do not travel well or need sedating to be examined and in these cases it is ideal to prescribe remotely where possible. I do a lot of referral work, so where the case has been recently or previously seen for the same condition, but the owner lives far away from me, it makes all of our lives much easier to remote consult, without the risk of mis-diagnosis or anything similar. I have had only 2-4 cases over the whole of the pandemic where I have felt that examining the animal would have helped me more than just speaking with the owner, and in these cases I have usually sent them back to their local vet practice to be seen again if needs be. I think video and telephone consulting has a future in veterinary medicine, especially as we now have such advanced technology for viewing and speaking to our clients.

I would support the use of remote consulting and prescribing.

If a patient is not doing well, really needs a physical examination so many initial repeat consultations initially remote became face to face.

In my particular field (ophthalmology), remote consulting was useful for triage but of limited use when it came to treating/managing patients.

More specific guidance on remote consulting would have been helpful rather than doing one's best in the unprecedented circumstances.

Remote consultation is a useful tool, especially given the current technology capabilities. It does not replace hands on consultation, and for us orthopaedic surgeons this is useful. However for an array of other medical conditions, the value or remote consultations may be lower. The clinical must bear in mind when a face to face/hands on assessment is required, and perhaps the use of remote consulting as standard may increase the risk that errors are made. The use of standard protocols should be considered to ensure a thorough teleconsultation is performed, and owners made aware that if not happy or concerned this should not replace a physical assessment. We are currently looking into adapting our practice to make remote consulting an option for the future.

Remote consulting is inadequate to perform a basic professional service except possibly in case of a national emergency such as COVID19. It is my opinion that a patient should always be examined prior to making a diagnosis or prescribing medication. Our patients (and our profession) deserve no less. I have been concerned for some years that medications that have been acquired on the Internet

from online pharmacies are delivered in inadequate containers which are certainly not temperature controlled as is required for those destined for a veterinary practice. This is not acceptable. Insulin might be a good example. An answer to this problem might be to ensure that medication is only to be dispensed from a veterinary practice and that the practice should not be allowed to charge more than 50% markup of the list price. This would perhaps mitigate accusations of profiteering by vets. At present the online pharmacies can and do sell medication cheaper than the vets can buy them. This is very unfair indeed and must be addressed.

VSs in an independent practice

A proper examination relies on so much non Verbal communication and the use of many other senses that remote consulting will never be as accurate as having the patient with you. Also explanations and communication to the client are dependent on non verbal communications It is also Far less efficient - to do remote consulting requires far more time to try and gain an accurate picture and understanding to treat appropriately as well as to deal with the issues which arise that are missed in remote consulting that would be picked up in a physical examination.

A small number of clients have no access to digital media to aid remote consulting. In these cases, when inadequate history or no video or pictorial information was available, there was a higher likelihood that the client was advised to attend the practice.

All consults should include a physical exam. Remote prescribing should only take place animals already known to practice and very recently examined.

As above, I think that remote prescribing can only be considered to be appropriate and safe where the animal has a prior registration and examination recorded at the practice including an accurate weight. Owners are very variable in their ability to weigh their pets at home. It is much easier to do so with a 2KG chihuahua compared to a 50kg mastiff for example. If remote prescribing is to be extended in the longer term then POM-V should only be able to be prescribed in cases where the animal is under the care of the veterinary surgeon/practice prescribing the medication. In many instances, we have been successfully asking owners to provide cytology samples prior to a prescription of antibiotics (especially well received by owners in cases where ear drops have been needed).

As detailed, we only provide for known clients with known patients. I cannot approve of remote consulting when so much of our work requires 'hands on'. From the simple hands on of clearing anal glands to injections required to provide immediate relief, to surgery or dentistry or collapse. I therefor remain against remote prescribing, except as detailed for known clients and patients the practice has physically met and knows, within the practice locality.

As stated above - remote consult & prescribing has allowed us to continue providing essential & ongoing care for our patients, while safeguarding our staff & clients. Our staff have felt confident & secure at working during lock down partly because we have been able to carry out some of this work remotely. It is time consuming & can be technologically frustrating but generally has worked well- the staff have become more adaptable & flexible. The clients generally have been appreciative & willing to pay for remote services, although this is better when a visual link is used rather than just phone. Our vets feel the same. Generally it is not the same as seeing patients/clients face to face & had limitations diagnostically & with communication but has been a god send during the crisis. I think post lock down it may have a role to play more with triage, post op checks & repeat consultations where the owner had mobility issues. I do not think it will ever replace the traditional face to face examination for routine & emergency work but may be a useful option in some situations. Our staff enjoy meeting with clients & physical consultations - they find remote working not as satisfying. Remote consults are easier with clients I know & patients I have experience with rather than new cases or people I have never met before. By allowing the remote work we have been able to keep some income coming into the practice stopping us from major financial disaster or from being forced into opening more than we would feel safe & comfy with.

Covid has given an insight into remote consulting and prescribing and it is useful in some cases but it also had severe limitations as we had lots of cases that did not improve and needed to be seen in practice and the delay would have affected animal welfare and caused some unnecessary discomfort /suffering.

Difficulty in persuading clients in the future that their pet needs to be seen for repeat prescriptions

Disappointing in our area. We speedily provided this form of communication with clients who tried to adopt it but poor picture quality meant that staff didn't feel it was particularly successful /rather limited and adopted email photo & phone calls in preference.

Dreadful idea. Patients must be seen and examined physically. Even simple things get missed/overlooked.

During my work experience I worked in various practices. All use different approach to control of long term medicated patients and level of control required. Sometimes derived by owners wealth, other practice policy. Sometimes the vet personal believing is put between all above. Well controlled patient may or may not need 3-6 monthly blood work-up, and other conditions are happy to be assessed based on clinical presentation and patient comfort. Remote prescribing helps to maintain good communication between owners needs, animal care and vets. But at some point sampling and analytics are essential.

I am the senior director of the practice and have been responsible for most of the covid19 protocols. As a practice we have been consulting with the front doors shut to owners since mid March and will continue to do so for the foreseeable future till the risk to staff and public is demonstrably reduced to insignificant levels. In these

circumstances you might have imagined that remote consulting would have been a significant amount of our consulting. In fact it has been about 5% of all consulting if that. The reasons for this, for us, are: - lack of confidence in providing a good level of care unless we are actually physically examining patients - most conditions are just not appropriate to assess fully remotely - perceived greater risks of vets and vet nurses falling foul of RCVS duty of care responsibilities if using remote assessment. so ....should this be relevant to the views gained from this survey..... this practice strongly believes that in order to provide professional care for animals in our care - in covid19 or in normal circumstances - any permanent relaxation of prescribing rules as far as remote assessment is concerned, PARTICULARLY FOR OUT OF HOURS PERIODS, would be inappropriate and lead to reduction in standards of care by some veterinary surgeons.

I didn't like or encourage remote consulting as I feel again could remote prescribe if I felt necessary otherwise needed seen for accurate diagnosis. Can see its application on occasion but not as an everyday practice. Clients did complain of charges were applied to a teleconst.

I feel remote consultations have a place but for triage or easy post op checks - they cannot replace being able to physically examine the animal. We tried to introduce the service in December 2019 but met with resistance from the team, who were concerned about missing things. Covid meant there was little choice for us all but to embrace the technology sadly with absolutely no chance of training people for this very different role bar suggesting watching the VDS video on how to conduct these consultations. My team found remote consultations difficult and it raised anxiety levels about what they might be missing. We also found that clients wanted to have their animals examined physically so transitioned to a more normal service once the BVA said to do so on 01st June. Prior to this we had only being physically examining emergencies which had been triaged via video iconsultations in accordance with the BSAVA triage tool.

I feel that although remote prescribing has its place in the current time, nothing can replace a hands-on exam!

I find it really hard to feel that the consultation is thorough enough without a hands on examination; and I struggle to charge properly for remote consulting - both from my perspective and the clients accepting it. I think developing remote consulting for 'normal' times it is a bit of a slippery slope to a point eventually where clients will self diagnose and buy medicines (potentially without prescription) online. With remote consulting I think we may see a considerable number of vets set up an on-line service only with no actual practice premises or OOH cover, and thus cherry-pick the 'easy' income. I feel strongly with the growth of corporate practices, on-line veterinary services and internet medicine buying, that regrettably we are 'dumbing' down our professional status.

I plan to continue to do initial consultations remotely prior to examination of animals where needed - new cases and existing cases where the skin problem is suboptimally controlled. I have only prescribed non-POM-V drugs to new cases that

I have not yet examined, such as topical skin therapies. But the ability to prescribe for existing cases where the diagnosis is known has been invaluable. For cases that I have not seen I do not plan to prescribe any POM-V medications directly, but happy to advise referring, primary care, veterinarians. As a principle I have concerns about remote prescribing of POM-V medications to new cases that have not been examined personally by me or the primary caring vet.

I think it is the way forward. It will enable better access to veterinary care for pets.

I think it would be great to be able to consult and prescribe remotely (with a reduced fee like at the moment) even post covid; it may improve rather than worsen, animal care on the long run. In fact I think that there is always going to be a certain percentage of clients that are reluctant to bring ill pets to the vet's attention early enough due to :lack of time, lack of transport, limited finances, not been sure if "bad enough" to disturb the vet at the surgery. When dealing with clients on the phone I think communication style, empathy and a sense of really "being there" for them is even more essential than before, as people need to feel connected and listened at ..when the care is provided from a distance and via technological "cold" media. I think that also it is very important that only/ mainly experienced vets are put in the position of performing remote consulting/prescribing , for various reasons (prescribing not appropriately, over complicating medical cases and ending up making the face to face case load of the practice even busier , the vet suffering of severe stress /anxiety because of "unknown" etc) I also think that the success of remote vetting can depend on the type of clientele a practice has . Of course observative, educated people tend to easy the process, allowing a vet-owner bond based on trust and reliability. I realise that this could be more of an issue in some parts of the country.

I think it's an excellent change. So many small animal appointments are wasted with appointments that can be dealt with over the phone: poc- photos sent in via email, and only seeing the problem cases; single episodes of mild GIT upset - no need to see majority of these cases - o feel like they are "doing something" when going to practice, this can easily be done via telephone. Lumps/bumps/skin lesions could be "seen remotely" as first line, then seeing down the line of required. This will free up appointment times and allow vets to work more flexibly - fitting around child-care etc at home. Being able to charge for our time is a welcome change - and something I would like to remain if possible.

I think many owners are unable to provide accurate information about their pet's physical examination over the phone eg gum colour. I saw pets with pink gums that the owners had described as white and marked jaundice that the owners had says were pink. Owners ability to photograph/video their pet and produce something that is helpful is also often poor! I therefore feel that remote prescribing and consulting should be stopped.

I think that telemedicine has a place for clients already registered with a practice and a known history for rechecks/reviews and minor problems. I have seen more cases with poor response/recurrent disease because we have tried to reduce face

to face contact and physical rechecks which has meant the increased risk of antimicrobial resistance etc and further expense for the client. I firmly believe that all POM-V should only be prescribed for clients with an established relationship with a practice, so that full responsibility is taken for any adverse effects and treatment instigated in a timely manner. Given the potential for error, under normal circumstances no new prescription should be dispensed without a physical/clinical examination.

i think there is a place for remote consulting and prescribing even after covid but i think it needs to be well regulated and supported. for example, the telemedicine vet should be able to refer patient to a physical clinic for physical consultation and further diagnostic work up if needed - unless of course that they make it clear that their service is only for advice/triage and not for assessment/diagnosis.

I would not want to continue remote consulting and prescribing long term. You get a much broader picture when you physically see the animal.

I'm not in support of it because I worry that cheaper providers will cherry pick the easy profitable medicine prescribing work leaving face to face practices who provide out of hours services to do the less profitable work - this will either result in more practices giving this up or increased charges for clients who already remark that vets are too expensive.

In my opinion an established Vet-Client-Patient-Relationship represents the only opportunity for remote prescribing of POMV medicines. POMV medicines should not be prescribed unless a VCPR is in place as this supports the deployment of responsible prescribing of veterinary medicines. Responsible prescribing must be ensured when clinical assessment is by remote means and this is determined and enabled by the nature of the VCPR.

Is good to have the option, specially on uncomplicated cases but nothing can compare to a proper physical examination.

It is very difficult to properly examine an animal, or really any part of an animal, without physically being able to touch it. Remote consults took longer and were a much less efficient way of talking to owners. Medication can be prescribed as a temporary measure only, until the animal can actually be seen, but remote consults are definitely not in the animal's best interest. Also clients got very quickly used to describing something, sending in a picture or attempting to show something on a video, and expected medication. Later, on actual examination, the actual problem was found to be something else.

It should be allowed to continue.

Long term I feel face-to-face consults are better. Initially I thought cases such as DJD would be suitable, but quickly realised owners underestimate the level of their pet's pain.

My fish work has involved remote consulting for over a decade so there is no real change with COVID although I'm avoiding visiting clients. Remote consulting is as effective as "in-person" so long as you can elicit the correct information from the client in obtaining a diagnosis. Where I undertake a visit it is more to examine the facility first hand to verify the clients information and assess the environment of the facility. Remote prescribing means I can prescribe without seeing the animal, whereas usually I would need to contact a local practice. Whilst this is advantageous in terms of turnover I would not otherwise get I still firmly believe that POM-V's etc. should only be prescribed to animals I have seen, which is more to do with making sure the client knows how to use the drug correctly than anything else.

Not the same as face to face. Too much uncertainty with some cases. Clients have been surprisingly willing to use it and it has opened up new consulting methods. Would be very unwilling to prescribe POM-V's after Covid by only a remote consultation. It wouldn't be long before a disaster occurred imo.

Our vets are somewhat scared of doing the wrong thing via remote prescribing, and many are choosing to do face-to-face consults. But we have been in an area of very low risk for COVID so that has allowed us to continue offering a wide range of consults after the initial emergency only period. Some of the apps on the market appear quite good, but I don't feel they can ever replace a face-to-face consult eg detecting corneal ulcers, checking tympanic membranes, feeling for pain. I have multiple cases every week (pre and during COVID) of lameness or signs of pain in dogs, where the owner does not believe it is pain because 'they've pulled the whole leg around and the dog hasn't cried'. Often the only way I have been able to show the owner their pet is in pain is to physically show it, by manipulation, palpation etc. This can't be done remotely.

Pictures and videos of wounds and lameness are very useful for advice and triage.

Remote consulting and prescribing has for the above reasons allowed my practice to continue providing a service and provided funds to prevent possible closure. It has taken the pressure off the workload both my remaining receptionist and myself had to endure and allowed time to physically deal with more urgent cases and given us time to maintain as professional service as possible.

Remote consulting I have learnt is appropriate in certain cases and I will have more confidence to do these and charge properly for my time in future if we are able to continue to do them. They should however never be appropriate for clients and animals that are new to the practice.

Remote consulting is a slippery slope that needs to be avoided in my opinion. I have repeatedly heard comments from clients that vets at other practices didn't even examine their animals. This seems like common practice among human GPs and is something I have first hand experience with on more than one occasion. Relying on information from the pet owners is problematic and after 20 years of veterinary work at a very high level I have to admit that I find it necessary to disregard an awful lot of what my clients tell me. I suspect there will be a push in the new IT age to

accept remote consulting as the norm but it will diminish our ability to provide the very best service.

Remote consulting is completely inappropriate under normal circumstances. Without a full clinical exam mistakes will be made, animals will suffer and the profession will come into disrepute. A TPR is the cornerstone of every clinical exam and this is simply not possible with remote consulting, never mind the expertise required to examine particular conditions or the discovery of conditions for which the owner has no knowledge.

Remote consulting is inappropriate for the majority of conditions.

Remote consulting is overrated, unless the animal has a skin condition that they can send pictures of then nothing makes up for a face to face consultation where you can physically examine the animal. It is fine for basic advice, ongoing conditions and updates but that is all. Increases chances of misdiagnosis and client dissatisfaction.

Remote consulting is playing percentages. You provisionally enter the statistically most probable diagnosis based on the history and clinical signs reported by the owner, the accuracy of which is often questionable. It must be a poor second best, when the preferred option is unavailable for some. It is not progress. You can have a good job, or a cheap job, but seldom a good cheap job!

Remote prescribing is fine for ongoing cases and horses known to me. Some clients are better at providing info than others. Most people expected it to be a free telephone cons. Those emailing in were more accepting of a fee.

Remote prescribing may have its place in future for drugs with wide spectrum of safety e.g. POMV ectoparasiticides. But it has no place otherwise. A large amount of patients that were seen remotely, and prescribed for, have since had to come in and be seen in person anyways. Nothing replaces a clinical exam where this is possible.

Telemedicine is difficult and only useful in some circumstances but to feel like able to do a good job need to examine an animal, there is no suitable alternative to providing an examination. For flea treatments and worming telemedicine can be useful and in more conversations, eg 1st day of diarrhoea etc, but it also causes concerns if it is the only option.

Telephone consulting and prescribing is commonplace in farm practice. We have made better use of phone / email for health planning and certification during Covid-19.

The advice was not stringent enough. Our practice is basically seeing anything and everything including vaccines (with social distancing in place i.e. no clients in the building). I however feel we shouldn't be effectively business as normal, but the owners seem to have interpreted the guidance to mean we can see everything as long as socially distanced.

The majority of clients have been happy with remote consultations in the height of lockdown but with time the demand for physical, in person clinical examination of animals has increased so I feel in the long term it would make more, not less work when we are able to go back to normal consulting practices as so much time and energy is taken triaging and deciding if a case can be managed remotely or if needs to be seen in person and I feel I have done more follow ups by trying medications at home than i would from a standard consultation in the first instance.

Think I'd be wary about remote consulting becoming a permanent thing.

This has been a good opportunity to try out the advantages and disadvantages of remote prescribing. I would still not be happy to remote prescribe for new conditions without seeing the animal.

Video consults are impractical, but video/photos provided ahead of a phone appointment can work for certain cases ONLY. We find them most useful for pets on long-term medications, who both owner and vet deem to be stable.

We have had a great response from owners on remote consulting - without the ability to prescribe remotely the proposition would be far less useful. We have seen a number of cases that due to transport difficulties/client sensitivities/other reasons, would not have presented at the practice. Cat owners seem to really like the service. Stress and aggressive dogs, some lameness consultations and some behavioural consultations actually work better remotely. Remote consulting and prescribing brings Vets into the modern age - otherwise clients look for more accessible services - advice comes from breeders/groomers/etc and 'treatments' from non-veterinary sources. There is now a golden opportunity to level the playing field and allow easier access to the most qualified people. In addition, home working for vets is possible! Who would have imagined that?!

We trialled video consultations at an early stage and found the clients were in some cases very uncomfortable with downloading apps, or facing cameras. They also were very poor at thinking they could point their camera at an issue on their pet and expect an intelligent diagnosis - mostly not possible! We elected to stop using live video for these reasons. We do find quality photos sent in advance really helps triage, and in some cases allowed an acceptable quality of diagnosis. We would request better photos if the first ones were not of good enough quality. But I cannot imagine a situation when this would replace actually seeing a patient with my own eyes, from varying angles and with excellent focussed lighting, as well as the opportunity to assess the patient holistically, not just the area the client is anxious about.

VSs working in a corporate practice

Ability to remote prescribe would allow an improved service to clients for existing conditions/existing clients with minor conditions in the future.

Again I felt that it was necessary, but there have definitely been incidences when we were doing more remote consultations where a face to face consult would have resolved issues sooner or prevented misdiagnoses.

As an experienced vet I have found remote prescribing very challenging, and less experienced vets in my practice have found it even more so. We have generally found clients emailing photos or video in initially and then following up with a phone or video consultation has been better than a video consult initially, as the quality of most web cams was fairly poor, and resulted in blurry/moving images etc, whereas in focus photos were much more useful, or a carefully done video of a lame dog etc. We have had several complaints on the back of remote consulting - clients unhappy with a charge for it (less than our normal cons fee), and even more happy if no meds dispensed as they feel it was 'pointless', or clients refusing to pay if the problem hasn't resolved and then needed a follow up face to face consult. We have also had a couple of serious conditions which were missed on remote consulting - a remote consult for an itchy cat, appeared likely stress overgrooming, and a slightly watery eye. Owner stated eye normal other than slightly watery that day, appeared normal on a poor quality web cam image, presented 48 hours later with a severe corneal ulceration. Another case, which is ongoing complaint, likely to progress to the RCVS was a dog that had mild vomiting/diarrhoea, it deteriorated, but the owner did not indicate seriousness of the condition (despite appropriate questions), ultimately the dog passed away at the OOH providers. The owner is unhappy that her dog was not seen in person. To me, remote consulting and prescribing feels like we have resorted to relying strongly on 'pattern recognition', which in many cases will result in a correct diagnosis treatment, as 'common things are common', but it risks missing the 'zebra' cases, and relies very strongly on clients descriptions, which is very difficult. I am strongly opposed to the continued use of this in future, and would not feel comfortable continuing to use it. We have now stopped as a practice offering this, except to clients who are 'shielding'. We feel it has also resulted in more inappropriate antibiotic usage (our order quantity for ABs has increased!) due to worry about missing something, and dispensing them 'just in case', or dispensing best guess ear meds etc. I would go so far as to say, that I feel strongly that remote consulting and prescribing should not be the future of veterinary medicine, and if it becomes expected, in my role as a clinical director, I would be strongly opposed to my practice offering it. It would also make me question my role in this career in future as remote consulting is not something I would continue to want to do.

Clients are very good at over-exaggerating and also under-exaggerating conditions.

Frankly, not actually having to spend time in the same room as many if not most clients has proven to be the highlight of the lockdown. Post CoVid, we will be looking to work on developing remote consultation as the new norm.

I am against remote prescribing apart from maybe for registered clients. I am certainly against changes to the definition of under his/her care which would allow remote prescribing based on video consultations but leaving bricks and mortar

practices to deal with emergencies and OOH cover. I suspect the idea behind this is to flog lots of POM-V flea and worm treatment without responsibility for the animal. Allowing 'cherry-picking' of the profitable side of vet work will damage the ability of practices to provide a comprehensive service.

I believe that remote consulting will have a part to play going forward. I think it can work as a triage tool especially if a client is wavering as to whether the animal needs to be seen. I do not think animal health and safety is well served if the 'remote' vet does not have access to the animal's records. I am not convinced of the situation around remote prescribing POM-V's for various reasons 1: if no access to animal's history safety and adverse reaction a potential problem 2: accurate dosing for weight 3: inability to 'diagnose' conditions with the same degree of accuracy as a physical exam and hence increase the likelihood of speculative and potentially inappropriate treatments. I have a concern about the potential for an increase in litigation associated with the 'arms length' diagnosis and treatment of patients. We produced guidelines for the receptionist as to which calls were amenable to remote consulting. With all the remote consults I performed there was one which was 100% better as a video call. It concerned a St Bernard presented for a musculoskeletal problem and the diagnose was easy watching the dog slipping around on the slick flooring in its home environment. A visit to the surgery would have been less informative and would have required more detective work.

I believe there is a place for this in normal practice with some regulation and discretion.

I did not have any video technology available for the remote consults. I am an experienced vet who made a couple of errors the most notable being a cat who I presumed to have conjunctivitis and prescribed topical antibiotic. When the cat did not respond I examined the cat to have a lacerated 3rd eye lid with an associated (because of the flap of loose third eyelid) deep corneal ulcer. This was luckily easily rectified with trimming off the flap of tissue. I doubt if video technology had been available that the client could have manipulated the eye and video for me to have seen the problem and the cat could have lost his eye a result of my mis diagnosis. I was happy to provide the service for client during the lockdown but do not believe that it was in the best interest of animal welfare.

I don't think for the majority of consultations that remote consulting is useful both in terms of diagnosis but more in terms of the time it takes to do one consultation, the amount we can charge for that consultation and then not charging for any clinical examination that is required.

I don't think it is a good way forward for the profession and you miss a lot of detail and a physical exam that only a veterinary professional can interpret.

I felt very unprepared for remote prescribing. As a new graduate I did not feel confidence in my diagnoses was sufficient to do most of these calls. I feel it undermines anti-microbial stewardship to have to remote prescribe anti-biotics though i was comfortable prescribing pain relief. I did not feel confident in my ability to describe how to administer medication such as metacam without the usual props.

I found very difficult to assess base on what owners report and giving medication ´blindly´.

I think it should only be applicable to known/follow up cases with good enough technology for an accurate assessment.

I think that it will very useful and convenient for certain recheck exams, and triage of patients that have been examined within the last 6 months.

I was always fond of telemedicine and a great believer that it would be the future but this trial has changed my mind. The diagnostic ability was much poorer. Clients measured interaction with the vet and refused paying for x minute consultation or not having had physical exam (despite having being informed). Clients in general far more rude than face to face Clients telling us that they had done at-home urinalysis with Vets4Pets urine strips and reaching their own diagnosis therefore asking directly for treatment or even having performed an ECG at home with husband's ECG machine and made full diagnosis and asking for treatment (never seen before in 30 years!) Overall high number of misdiagnosis and treatment failures solved after physical exam. I feel we are not ready yet, nor us or the clients.

I was very hesitant about this prior to the Covid -19 situation but I consider that it was a necessary change to have been made. However I still feel that it increases the risk of misdiagnosis considerably and should be limited in its application. Obviously for the foreseeable future there will be a lot of time constraints within practices limiting the number of cases that can be safely seen at each practice premises and there is already a shortage of vets and nurses available so if some remote consulting and prescribing is allowed , it provides another option . Prior to Covid -19 a lot of patients would have had delayed treatment due to the owner's time constraints e.g. due to work or transport limitations and this could facilitate , even for just triage. The clients in future need to be more aware of how to choose representative photos and to add some background information about size of lesions, rapidity of onset of symptoms, etc . Several people just send a photo to their practice and expect we can diagnose and treat from that alone.

I would absolutely not like to see this become the normal. I believe there is a risk to animal welfare if we allow remote prescription in cases where the animal has not been see. I think it is appropriate for a minimal Number of cases for follow up appointments and first appointments.

In general I found this method of working stressful unless it was clients/cases I was already familiar with, with only phone calls and no video it was too hard to assess many of the new cases. It was too time consuming trying call owners back who then didn't answer their phone at their given appointment time!

It is useful in some situations and I suspect post covid it will be used mostly for advice rather than much prescribing.

May be suitable on certain cases - ongoing chronic disease etc. but definitely require very careful case selection.

I think that the clinical examination is an essential part of the veterinary consultation process in small animals. I feel that in its absence I have made more errors in treatment than I would normally expect to have made and that this has resulted in harm for an unacceptable number of patients.

Promotes the irresponsible use of POMVs, puts the vet at risk of litigation, is a poor substitute for in face consultations and clinical exam. Massively deskills the entire team.

Provided cases are selected appropriately and particularly for follow up consultations of established cases remote consultations and prescribing are appropriate. They may help clients who have issues with transport, are housebound or self isolating to access veterinary care that they would otherwise be unable to. Occasionally it does help to assess the more relaxed pet in its own environment. I think keeping remote consultations and prescribing for appropriate cases and situations will be a useful addition to standard veterinary care.

Remote consultations have several draw backs and carry many inherent risks. They have been useful for assessing animals with conditions such as masses or wounds as to whether medical management could be tried or whether that animal needs to come in for assessment of the mass / treatment of the wound or a fine needle aspirate biopsy. They can be used well for dogs with diarrhoea and the additional supplementation of photos or videos of the faeces. I find them inadequate for assessing dogs with vomiting as in general palpation of the abdomen is needed. Any animal with GI signs also cannot be adequately assessed for dehydration. Unfortunately they carry many severe limitations for the diagnosis and management of eye and ear conditions as the quality of the video is not good enough for eyes and a physical exam needs to be taken place to adequately assess ears and eyes, They cannot be used for any animal that is collapsed, lethargic or with heart and lung issues other than providing a very basic triage system, the animal must be seen but booking a video consultation may delay this animal receiving a clinical exam and treatment and have detrimental consequences. The prescribing of medications has limitations. I have found this difficult when prescribing topical ear medications, most ear preps are ototoxic unless the tympanic membrane has been assessed and not perforated and this cannot be done remotely. I think remote consulting and prescribing in general has a place but can really only be used in specific circumstances which need to be consulted on and guidelines need to be constructed.

Remote consulting has many draws backs. Restrictions in clinical exam lead to delays and missed diagnoses. Case selection from initial clinical signs very important as only a few cases can be fully assessed without a physical exam. Video quality and technology difficulties make some very poor experiences.

Remote consulting I do think really has a place, there are clients who would physically find it difficult to attend or are shielding, and many clients liked the convenience. I think vets are well placed to decide whether they have enough information in order to provide a remote prescription. We used the service to

augment the work we did in practice. We had 3 vets working in the practice with one at home doing telephone consultations all day with email photos/ videos as appropriate. The vet could then triage cases and prescribe or send into the working team as appropriate. There was no pressure on the remote vet to prescribe anything if they were not happy. We would find some mornings almost everything was sent into the practice for a face to face check, and on others much of the work was done remotely. Usually around 75% of the work could be done without physically seeing the animal. We found that the client taking photos of videos beforehand worked the best - that way they were not trying to operate technology and hold an animal in the correct position and they could devote their attention to giving us a good history. We charged £30 for the phone consult, and topped up to the normal consult price of £36.50 (additional £6.50) if the patient was examined physically. I would favour continuing it but with the caveat that the patient must be 'recently known to the practice ' - in other words a recent weight is recorded, and a physical exam has occurred in the past.

Remote consulting in my opinion has resulted in some animals receiving inappropriate treatment, or requiring more invasive treatment (IV fluids / hospitalisation) because diagnosis or condition severity was not picked up early enough remotely. This has meant increased stress and 'suffering' for the animal, and increased cost for the client.

Remote consulting really can only replace the initial history gathering portion of a consult. Asking clients to examine, take photos or videos is almost entirely useless. As such it is only really acceptable for triage and a very small number of problems where a vet can be confident in diagnosis through history alone Physical examination by a vet is an essential part of diagnosis and monitoring, and as such remote consulting and prescribing should be strictly limited to a very small number of issues and triage. The current rules pre-COVID worked well.

Remote consulting should only be allowed for animals already under veterinary care that have been seen physically within a reasonable time frame and for restricted conditions for example behavioural.

Remote prescribing can be a useful tool in certain circumstances but needs careful client education and case selection to safely make decisions regarding case management.

See above. Fine for emergency pandemics in a 'needs must' situation but certainly not a sensible option going forward. Faith in the profession is currently high - this will be significantly eroded by disastrous misdiagnoses / mistakes made by vets unable to perform the physical exam. Clients will want a cheap option but then be ever so quick to go down the RCVS / litigation route when honest mistakes are made for all the reasons given above.

The industry is not currently set up for remote consulting and this has made the current situation slow and very stressful particularly when guidelines were conflicted between different veterinary bodies. Clients and colleagues have been

understandably frustrated at the variation in care provided between different practices. The use of nurses for remote consulting could have eased the work load.

This experience has convinced me that remote consulting should only be allowed in extreme circumstances e.g. Pandemic.

This is a special circumstance and if it were to continue I think we need to be careful not to devalue the consultation. Therefore remote consultations should be properly charged. It is very difficult to do a good examination especially in the same amount of time. However there are a lot if cases where if you can get a good video or pictures of the patient remote consulting is adequate. I think it would be helpful if there were protocols to follow for specific cases. For example at gp they can prescribe over phone if 3 certain criteria for a condition met. This could apply to chronic cases e.g. skin OA but can also be really useful for triage as well to eliminate patients who need to come in.

This is being driven by corporates and should be nipped in the bud. Remote consulting may have its place but remote prescribing should never be allowed. There will be a serious risk of incorrectly diagnosing conditions to the detriment of the animal and the owner and the profession. We have a responsibility as professionals to ensure we do our best and remote prescribing is simply a business tool, not in the interests of the animal. Do not allow long term remote prescribing. If it is allowed then who takes responsibility if, for example, a vet abroad remotely makes a remote diagnosis and prescribes and they are wrong / animal has reaction etc and a local practice has to sort out the mess....what powers do the RCVS have to reprimand that vet? Who gains from such a scenario? Remote prescribing goes completely against the oath we took upon qualifying and is being driven by the corporates. It is time for the RCVS to stand up for the profession and the individual vets and not be persuaded and coerced by larger organisations.

Time consuming. Clients want reduced cost for remote consult but take longer.

USELESS, DANGEROUS. WILL NEVER DO AGAIN. STRONGLY recommend against and a good veterinary surgeon needs to examine the patient, do any diagnostics necessary and prescribe appropriately. This should be completely stopped and back to original prescribing laws once covid-19 outbreak over. Need a physical consultation, phone or video is doing the animal and client a disservice

Was useful for stable pets requiring repeat medications without having to see them to reduce risk of Covid19 spread.

Whilst necessary during this pandemic, it has been eye opening how 'wrong' we can get it by going just off of a client's history and a few photos rather than actually getting our hands, eyes and ears on an animal. Whilst not on purpose 'everybody lies' does apply, as clients will only report what they feel to be wrong when there may be other clues as to what's going on too. Sometimes a best guess isn't good enough.

Worried clients will now get used to it and will want to have advice rather than a consult. Was hard to figure out how to price remote consulting.

Would be nice to clarify liability - if we're doing a remote consultation and the owner is bitten/scratched is that still our responsibility?

VNs (not SQP)

At the beginning of remote consultations I felt that I wasn't doing my job to the best of my abilities due to the situation and that was very hard to accept, mentally and emotionally. We have all had ups and downs during working throughout this pandemic but have pulled together and worked brilliantly as a team.

Been an interesting time positive and negative feedback.

Brilliant concept, difficult in delivery initially. Did serve a purpose.

Clients unhappy they are not having face to face consult with a vet, unhappy to pay a consultation fee even though remote consult often takes longer. Clients don't feel the remote consult is value for money.

Compared to pre covid, nurses have been doing far less remote consultations in my practice as all enquiries were passed to veterinary surgeons. It became difficult with needing authorisation for most prescriptions and decisions as to whether the animal should be seen or not.

From observations of my colleagues working with this service have nearly always resulted in the patient needing physical examination at a (distanced from owner) consultation. I do think, however, that the service has a place longingly, if only in exceptional circumstances. It is, of course, indispensable for those patients in covid households and the housebound in general.

Good.

I am only a RVN so did no diagnosing or prescribing except for flea & worm products. I did a lot of triage over the phone. The whole of C-19 has been very stressful for all of us in our practice but we have survived so far and are now back as a full team. Hopefully things will slowly become a little easier and we will continue to survive.

I do find remote consulting very stressful as getting a history from a client over the phone is hard. Sometimes they over exaggerate a problem to be seen even though it's not an emergency. I also find remote consulting from home makes it difficult to switch off from work.

I have really quite enjoyed remote consulting for the most part with minor things and wound checks but nothing can replace a physical examination and face to face discussion. It is very helpful for time-managing clients who are particularly chatty.

I prefer face to face as you can truly assess and examine the animal as clients cannot be expected to pick up on certain things that we will, ie mild unilateral facial paralysis that one dog had but owner thought it was due to his lack of teeth when in actual fact he had neurological disease after a full neurological exam was done.

I think a change in allowing RVNs to prescribe more would be very beneficial and efficient.

I think it has its place with the correct guidelines I think it would be something that could be used well going forward.

I think remote prescribing can and should be ok for emergency situations. Not all the time. I strongly believe that RVNs should have an SQP as part of their qualification and should be able to undertake further studies to allow the prescribing of analgesia and certain other medications. Not only would this give the RVN more autonomy and job satisfaction allowing them to use their professional judgement but would also help our veterinary surgeons when incredibly short staffed.

I think remote prescribing is a wonderful addition to general practice and feel it would be an asset to be allowed to provide this long term.

I think the prescribing has worked well and could be a useful tool after Covid-19.

I thought that remote consultations worked well especially in cases where people couldn't get in as some clients were quite happy with it however I would say the majority were not happy that we were not physically checking the patient's it made our job very hard in some cases to explain why this was not possible. Some clients made us feel that we were not looking after their pets in the slightest when this was not the case. We are still now offering telephone consultations but the clients are constantly pushing and pushing for us to see the patients therefore I don't feel that they are working any more.

I would highly recommend this type of remote consultation and prescription continues as it provided a much needed service to our clients.

I'm some ways it is quicker as not so many distractions for the owner. Many animals are better without the owner so physical examinations are quicker.

Is restricted to vets for prescribing of drugs. Consider extending to nurses (especially those with degrees whom have covered SQP requirements and studied pharmacology in detail). Set procedure required for remote consulting and improving public awareness of the service and expertise needed.

It is much more time consuming than a normal face to face consultation, increasing the stress workload on the team overall.

It was a useful way of triaging patients during lockdown, and most clients were happy with this service.

It was only the first 3 weeks of lockdown we remotely prescribed, then we would get history in car park and take the animal in to the practice. There was a very short period of remote prescribing so I can't give much feedback.

It's a good thing.

It's a really good idea and works really well for our organisation.

Most cases needed to be seen for full assessment, thus using up 2 appointments instead of 1.

Not ideal – can't beat hands on.

Our clients have been very appreciative of the remote consultation and prescribing option during the 2 week period stated and have generally been helpful and accommodating, allowing face to face consultations to take place for emergency cases.

Remote consultation I think definitely has a place in the future, especially for nervous or fractious patients. It has allowed my veterinarians to prescribe treatment to animals that would otherwise have been left untreated due to their behaviour or their owners' transport and mobility limitations and that has been great. I think vets need a definite RVCS guide on how often is minimum animals should have a physical exam, though, to ensure continuity throughout the profession and to ensure clients are clear as to what can and cannot be done.

Remote consulting has allowed us to provide treatment to animals that may not otherwise have been able to receive any. It was particularly useful for regular clients, where we had a good clinical history, and often personal knowledge of the case.

Remote consulting needs to be further encouraged to protect human health, because the guidance is vague we are seeing the majority of patients in person by examining animals in practice with owners outside. We are still seeing 90+ clients pets a day and operating on 10+ procedures a day. Advising practices for return to normal practice at this stage would result in us being inundated with clients expecting service as normal and the current infrastructure cannot withstand this as almost all staff are feeling the strain!

Remote consulting was beneficial in the way the consults generally took less time - less general chat from clients, less "can you look at this too while he's here" and things like that. But it was also difficult in the way we were having to chase up photos that we'd requested from clients and they'd not sent, occasionally phone numbers got typed wrong, and there's only so much accurate history you can receive from an owner who is not trained in veterinary medicine. For example we've seen a number of stress cystitis cases in cats - owners have told us their cats not peed at all and it's really unwell, so we arrange to see it at the practice and it turns out that we could have just remotely prescribed medication as they were not blocked after all. We've also found as a general more clients have been "challenging", getting upset and verbally abusing staff because they need to pay a consult fee for a remote consult, or just generally upset that they can't just bring their pet to the clinic. We are seeing more animals in person now, but clients are not allowed in the building and the vet/nurse speaks to them via telephone. Many clients will not answer the phone even after being told to keep it handy. Others have gotten upset they can't come in with their pet. Some forget their phone or don't have one despite being told to bring one when they book the appointment. Generally remotely

consulting and prescribing has been difficult and I feel it has reduced our standard of care to patients, and has contributed to an already massive amount of stress on our team working through covid19.

Using nurses to triage and give advice is very helpful, also it is having a benefit that nurses can have more of a discussion around health and welfare, providing a more in depth consultation and history taking before escalating to the vet where necessary for diagnosis and treatments. It allows better utilisation of nurse and vet time. Without it our vets would not get through the vast amounts of telephone consultations, also we would not have the capacity to cope with face to face consultations if we were unable to do remote consultations, without there being a severe effect on health and safety of staff during Covid-19 and the health and welfare of pets.

Vets in our practice have had to pick up the mess of 2 patients that have been detrimentally affected by clients using online service … where vets with no knowledge of patients or their history have prescribed and sent OUR patients drugs in the post. This must stop! At no point did they ask for medical histories from ourselves! One of the patients is incredibly sensitive to NSAIDS, had they bothered to get the history they would've known this. Whose care is this patient under? A pet is going to die through this at some point and then who is responsible? It is neither safe or responsible or in the best interest of the patient and needs to be stopped!

When working out of hours (weekends) asking clients to email pictures and videos has been very helpful determining which are true emergencies that need to be seen.

VN SQPs

A very useful tool and one that would be ideal to keep available since veterinary surgeons only prescribe what they feel to be right and request appointment if unsure.

Clients are using the previous flexible rules against us now that we are returning to normal. The flexibility was essential to save lives now they are putting too much pressure on an exhausted team and is increasing animal suffering.

Helpful specially to people who find coming into practice hard or with animals who find it stressful coming to the vets.

I feel that a permanent change to guidance may well be a move forward for the profession. It has been very useful during lockdown and has been taken well by a number of clients, especially owners of very nervous pets or those who have difficulties with transport. Most owners have preferred this way of doing things and very few have actually made demands for face-to-face consultations in the first instance. The vets have found it a useful tool, which has allowed them to reduce

the number of face-to-face consultations although if an animal has needed a physical examination this has been performed to the best of our ability.

I feel that some clients will not be happy when things go back to normal as when remote consulting allowed meds to be given without seeing the animal physically, some will expect this to continue.

Most of our clients would have a phone call and then the animals brought into the building. Therefore in every case there is face to face contact, of whom the vets send the nurses to collect the animals, increasing the risk for the nursing team.

Some conditions really need to have a physical examination (heart/eyes), however is is a very useful way of triaging patients to understand the urgency of their needs. Providing a 6 monthly in clinic physical exam can be done I don't see why routine prescribing for ongoing conditions could not continue in this way for the future, including routine flea and worm treatments.

Some vets have been very concerned about remote consultations as feel they could miss something and then be in trouble for it without doing a full clinical exam. Some pets have had consults outside but they feel again the clients are not getting what they are paying for. Again some vets really worry about dispensing medication without seeing the pet.

We have done a few face time consults for those self isolating but I will give a couple of examples of how this concerns me. 1 a lady called to say her placid cat tried to bite her finger when stroked. We saw it for a consult...physically to look at there was nothing wrong with it... it was bright and eating. However it had a temp of 103 and a bite wound on its back that took some looking for. Had this been done over phone you would not have known it had a temp or the wound, so I would question how any vet would have proceeded with this? 2 a lady sent pics in of her horse rump which appeared to have 3 minor horizontal scratches on it. From the pics we probably would have advised to keep clean and let granulate. On exam the cuts were deep and required stitching. So an example of pics not showing the true extent of the problem.

RCVS Covid-19 Survey 2020

Presentation of results

Dilys Robinson, Principal Associate

dilysrobinson@employment-studies.co.uk

ies institute for employment studies

The survey

- Launched 26 June, closed 7 July 2020
- Focused on clinical practice work undertaken 1 to 14 June 2020
- Invitations sent to UK-practising veterinary surgeons (VSs) and veterinary nurses (VNs)
- 3,673 usable responses (70% VSs, 30% VNs)
- 87% respondents worked in clinical practice during two-week period

Respondents: VSs

- 65% female
- Ages from 23 to 77, mean average of 42 (40 for women, 46 for men)
- 35% have dependent children, 4% an adult dependant
- 99% usually work in clinical practice: 86% of these give small animal as their main practice area

Respondents: VSs continued

- Type of practice:
  - Small-animal-only 77%
  - Mixed 11%
  - Referral 4%
  - Equine-only 4%
  - Farm-animal-only, telemedicine, other <2%
- 82% in England, 10% Scotland, 6% Wales, 2% N Ireland, 1% outside UK
- 35% work in a small practice (<4 FTE VSs), 47% medium (4-10 FTE VSs), 18% large (>10 FTE VSs)
- 44% work in an independently-owned practice, 48% corporately-owned, 8% other (e.g. charities, veterinary school hospitals)

Respondents: VNs

- 97% female
- Ages from 20 to 69, mean average of 37
- 29% have dependent children, 5% an adult dependant
- 99% usually work in clinical practice: 94% of these give small animal as their main practice area

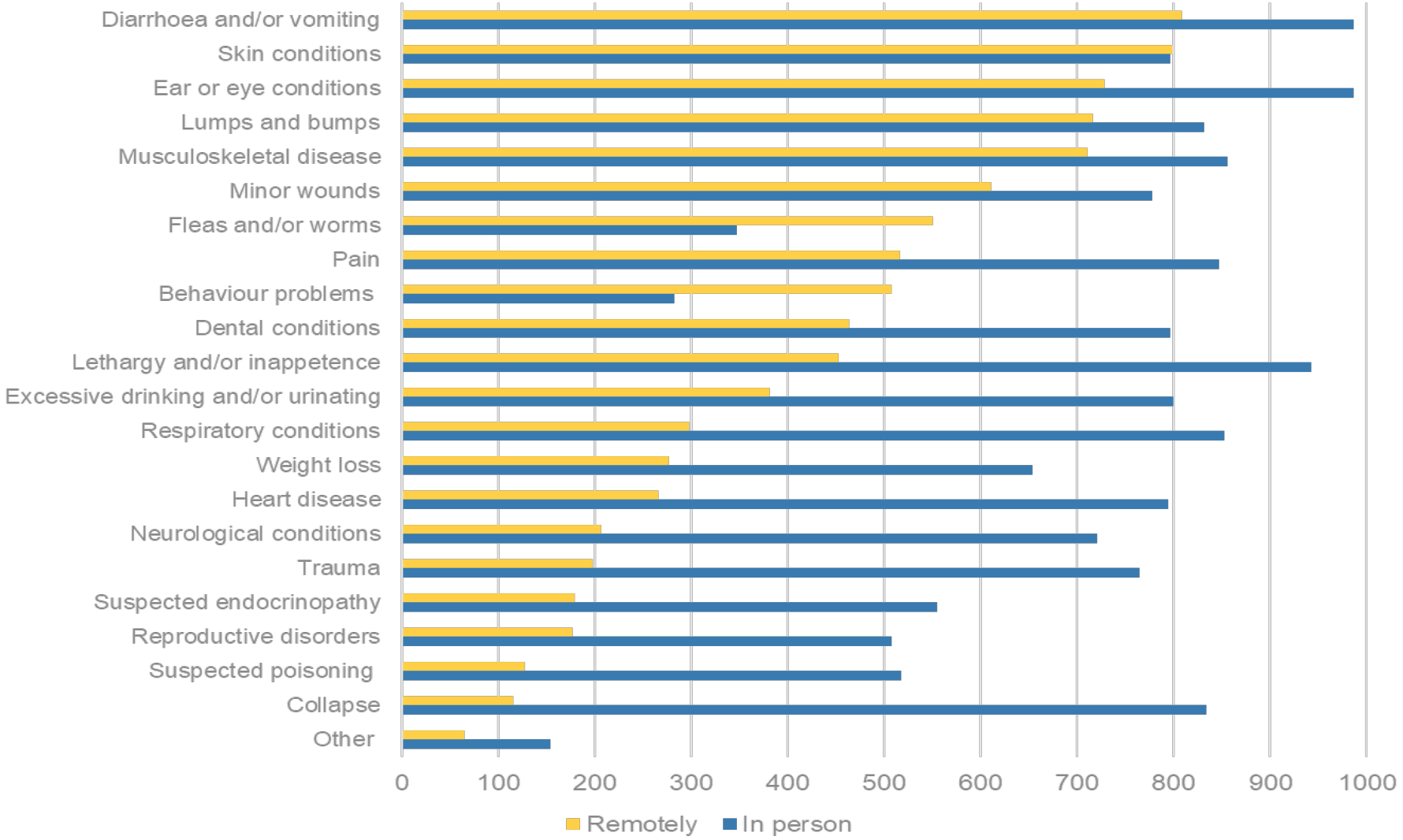
Respondents: VNs continued

- Type of practice:
  - Small-animal-only 84%
  - Mixed 9%
  - Referral 4%
  - 3% in equine-only, farm-animal-only, telemedicine or other
- 88% based in England, 7% in Scotland, 4% in Wales, 1% in Northern Ireland, and <1% outside the UK
- 38% work in a small practice, 44% medium, 17% large
- 37% work in an independently-owned practice, 54% corporately-owned, 9% other

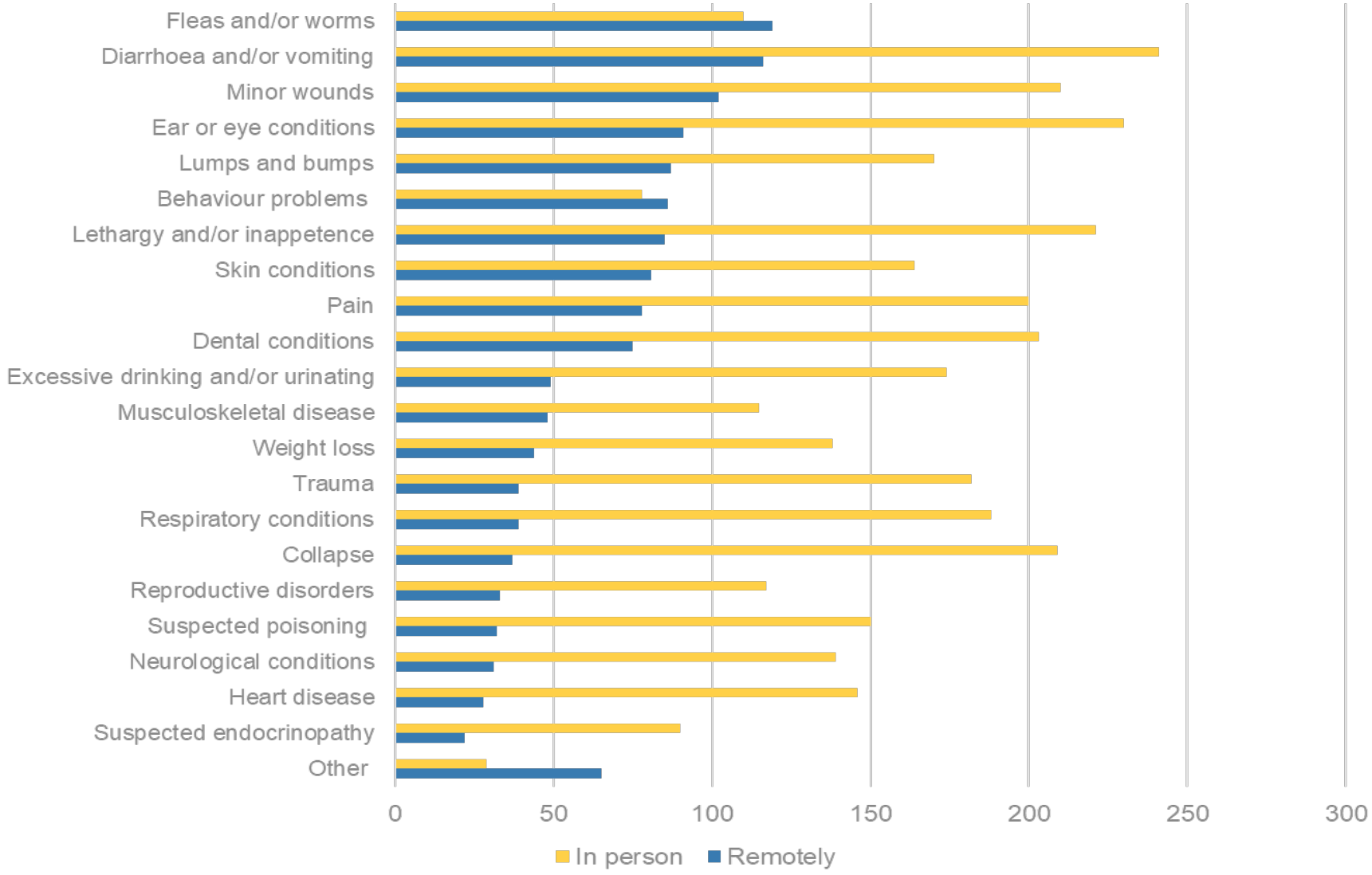
Caseload 1 to 14 June

- Almost all respondents provided some type of ‘in person’ service
- For 78% of VSs and VNs, ‘in person’ services meant a reduced workload or near normal caseload rather than business as usual or emergencies only
  - Equine and farm animal VSs more likely to report business as usual or near normal
- 72% VSs and 63% VNs provided remote consulting 1 to 14 June
- 20% VSs and 15% VNs used remote consulting it before 1 June but not during the fortnight
  - Why stopped? VSs: lockdown easing, concerns about accuracy of diagnosis, concerns about owners’ ability to describe animals’ problems, and a preference for face-to-face consultations. VNs: lockdown easing and practice policy.
- 8% VSs and 22% VNs had not used remote consulting at all
  - Why? VSs: continued to see clients face-to-face, concerns about accuracy of diagnosis, concerns about owners’ ability to describe animals’ problems. VNs: practice policy also important.

Number of VSs seeing different types of small animal cases 1 to 14 June, in person and remotely compared



Number of VNs seeing different types of small animal cases 1 to 14 June, in person and remotely compared



Equine and farm animal cases 1 to 14 June

- In person
  - Equine: lameness and colic
  - Farm: individual sick animal and obstetrical problem
- Remotely
  - Equine: lameness and skin conditions
  - Farm: individual sick animal and herd/flock disease outbreak or health plan
- Overall, equine and farm animal VSs notably less likely than small animal VSs to see animals remotely

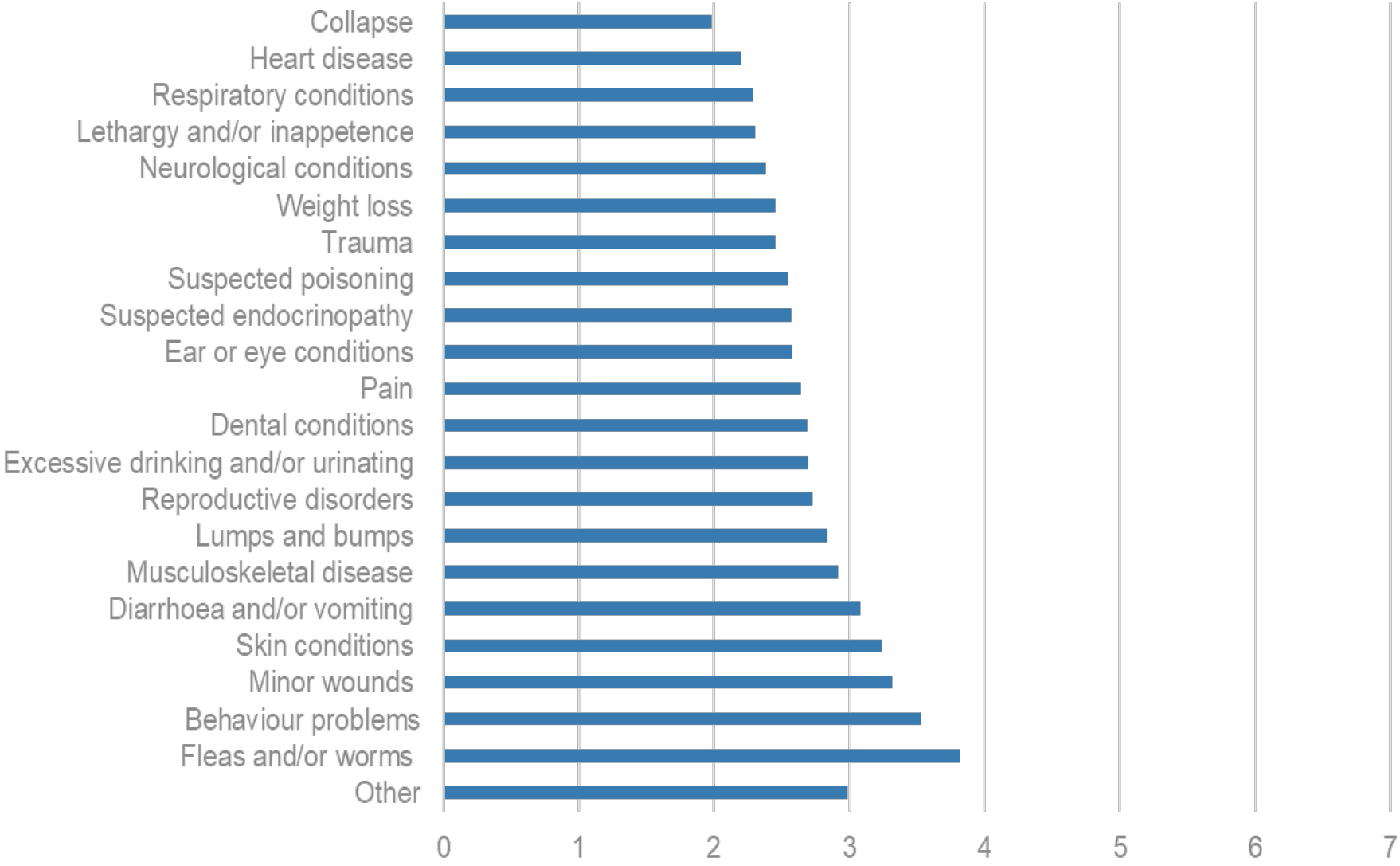
Remote consulting: uses and methods

- 93% VSs and 91% VNs using remote consulting saw animals/clients known to them personally
  - For majority of VSs, this was for advice, triage, and prescriptions for existing and new conditions
- A lower 52% VSs and 53% VNs saw animals/clients new to the practice
  - This was mainly for triage and advice: only 22% VSs prescribed for existing conditions and 36% for new conditions
- Most frequently-used methods:
  - Telephone with supplementary visual material
  - Telephone without supplementary material
  - Email with supplementary visual material

Time-efficiency of remote consultations

- Compared to face-to-face pre-Covid 19:
  - More efficient 17% VSs and 5% VNs
  - Less efficient 28% VSs and 63% VNs
- Compared to face-to-face using Covid-19 regime:
  - More efficient 37% VSs and 17% VNs
  - Less efficient 35% VSs and 52% VNs

Confidence in small animal remote diagnoses compared to face-to-face consultations: VSs (mean score out of 7)



Confidence in diagnoses continued

- Equine VSs: confidence scores ranged from 2.6 for dental cases and 3.7 for reproductive issues
- Farm animal VSs: confidence scores ranged from 2.0 for assisting/guiding surgery to 3.6 for herd or flock health plan, farm assurance or routine health visit
- VNs more confident overall: for small animal cases, confidence scores ranged from 2.9 for neurological conditions to 4.3 for fleas and/or worms (the only score over the midpoint of 4)
- 73% VSs were less confident if the animal was not known to them personally
- 55% VSs and 74% VN SQPs said at least half the cases they saw remotely led to their advising the animal needed to be seen in person

Drivers for face-to-face re-checks

- 79% VSs were involved in face-to-face re-checks of animals previously seen remotely within the practice 1 to 14 June. Main reasons (given by 60% or more):
  - Required further investigation
  - Patient not responding
  - Accurate diagnosis essential
  - Diagnostic uncertainty too great
- 28% VSs were involved in face-to-face consultations with animals previously seen remotely by another practice/provider. Main reasons (given by 60% or more):
  - Required further investigation
  - Patient not responding

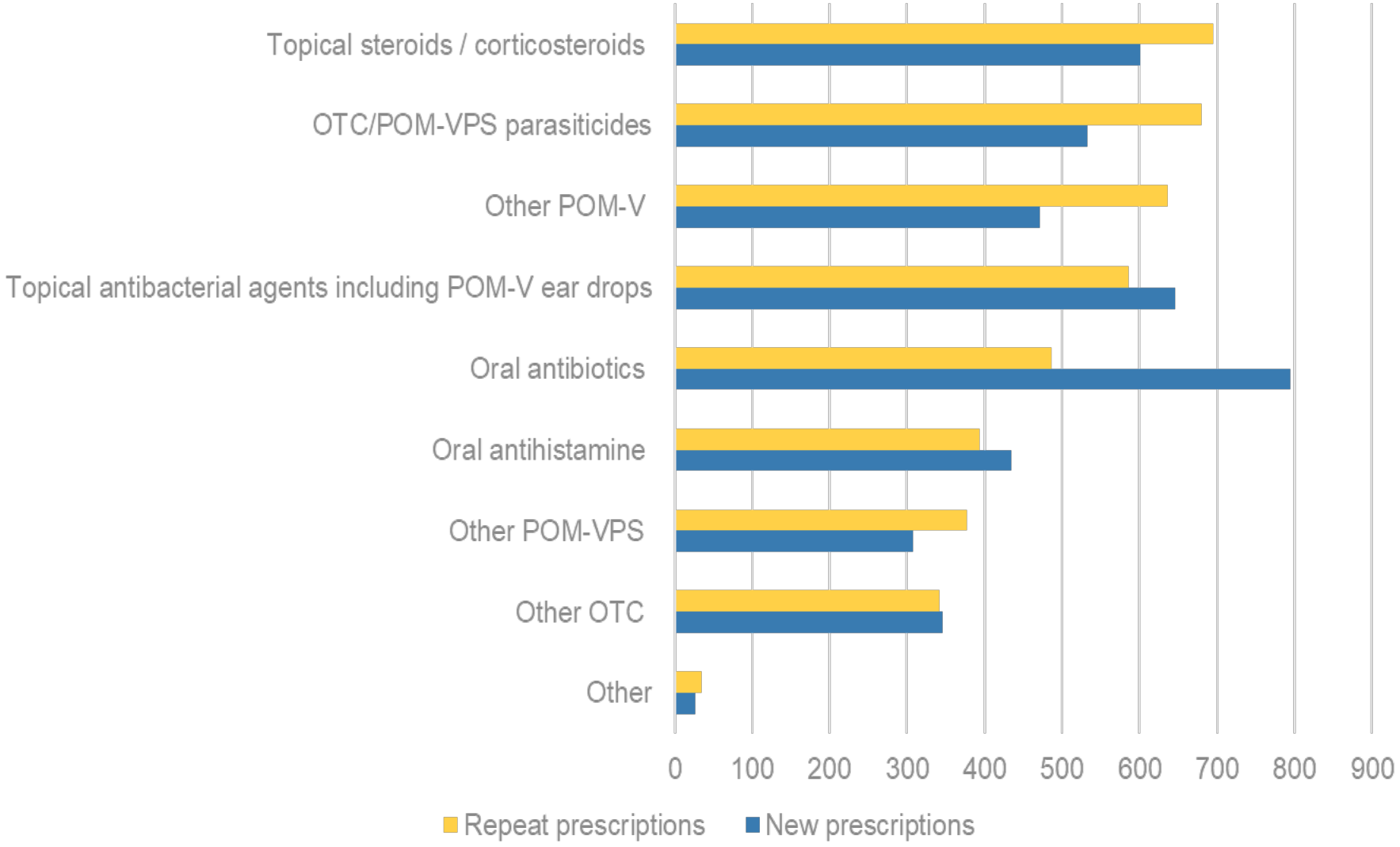
Client interactions 1 to 14 June

- **Clients' willingness to pay for remote consultations:**
  - 64% of VSs and 67% of VNs say clients willing to pay something, but not as much as a face-to-face consultation
- **Clients' ability to operate any technology required for remote consultations:**
  - Rated as 'adequate' or 'good' by 77% of VSs and a much more generous 90% of VNs,
- **Technical quality of the remote consultation:**
  - Rated as 'adequate' or 'good' by 80% of VSs and 86% of VNs
- **Clients' ability to provide relevant information about the animal:**
  - Rated as 'adequate' or 'good' by 80% of VSs and 81% of VNs

Remote prescribing 1 to 14 June

- For 54% VSs and 63% VN SQPs, over half of cases seen remotely resulted in a prescription
- 95% of VSs and 93% VN SQPs issued small animal prescriptions
- 7% VSs issued prescriptions for equine and 7% for farm animals
- Methods of providing remote prescriptions to clients (most practices used several methods):
  - Client collects medicines from the practice: 93% VSs and 96% VNs
  - Medicines posted to the client: 70% VSs and 76% VNs
  - Practice delivering medicines to client in person: 46% VSs and 49% VNs
- Methods used to verify client identity when issuing remote prescriptions (most practices used more than one method):
  - Practice only prescribed to known clients with previously-seen animals: 59% VSs and 68% VNs
  - Practice sending medicines to client's address as registered on the system: 56% VSs and 63% VNs
  - For new clients, verification of the client's address e.g. obtaining records from the previous practice: 31% VSs and 35% VNs

Number VSs and VN SQPs prescribing small animal medicines 1 to 14 June: repeat and new prescriptions



Remote prescribing continued

- Equine prescribing: pain medication prescribed by greatest number of VSs, both as repeat and new prescriptions
- Farm animals: injectable antibiotics and NSAIDs prescribed by the greatest number of VSs, both as repeat and new prescriptions
- Only 20 VSs said an animal experienced suspected adverse drug reaction(s) to medication prescribed remotely by them during 1 to 14 June, resulting in the animal having to be seen urgently
  - Most common reaction was gastrointestinal e.g. diarrhoea and vomiting, usually as side-effect of NSAIDs
- VSs are less confident in estimating weight for dosage requirements compared to face-to-face:
  - 51% ‘somewhat’ less confident
  - 25% ‘notably’ less confident

In their own words

Free text comments indicate a wide variety of views

- Remote consulting and prescribing are useful and should continue:
  - *Temporary remote prescribing has allowed us to function as a business, where we might otherwise have been unable to do so.* - Independently-owned practice VS
  - *We need to develop this more. It has saved me a lot of miles in the car and has meant I can focus on more technical advice.* - Farm animal VS
- They are unhelpful, a 'necessary evil' at best:
  - *… time consuming, expensive and unproductive.* - Equine practice VS
  - *This experience has convinced me that remote consulting should only be allowed in extreme circumstances e.g. Pandemic.* - Corporately-owned practice VS

In their own words continued

- They could be useful in future, but with rules, restrictions and more protection for VSs:
  - *Remote prescribing should only take place with animals already known to the practice and very recently examined.* - Independently-owned practice VS
  - *I firmly believe that all POM-V should only be prescribed for clients with an established relationship with a practice, so that full responsibility is taken for any adverse effects and treatment instigated in a timely manner. Given the potential for error, under normal circumstances no new prescription should be dispensed without a physical/clinical examination.* - Independently-owned practice VS
- Clients and animals have benefitted – or have they?
  - *It has helped us to provide care and alleviate pain and suffering in animals that otherwise could not have been seen.* - Independently-owned practice VS
  - *It allowed us to help the most vulnerable clients.* - Corporately-owned practice VS
  - *… for conditions with minimal external visual markers … there is a huge risk in misdiagnosis of many cases.* - Corporately-owned practice VS

In their own words continued

- More guidance from the RCVS is needed:
  - *Would be nice to clarify liability – if we're doing a remote consultation and the owner is bitten/scratched is that still our responsibility?* - Corporately-owned practice VS
  - *Could the RCVS also take the opportunity to firm up guidance about 'under our care' for repeat prescriptions, the current code of practice is open to too wide interpretation.* - Equine practice VS
- Standards are at risk of being lowered:
  - *I think developing remote consulting for 'normal' time is a bit of a slippery slope to a point eventually where clients will self-diagnose and buy medicines (potentially without prescription) online.* - Independently-owned practice VS
  - *I strongly feel that remote consulting and prescribing undervalues our work as vets. It sends the message to clients that doing a clinical examination is of negligible value, and that owner assessment at home is adequate.* - Small animal practice VS
  - *It is a bad idea. It will allow a small handful of clever people to cream off the easy work and leave large areas of the country (typically the poorer and more remote areas) with a dearth of physical veterinary practices.* - Equine practice VS

PDSA Head Office
Whitechapel way
Priorslee
Telford
TF2 9PQ

Dear BVA and RCVS,

In light of the current review of the RCVS dispensation to permit remote prescribing and the wider consideration of the ‘under his or her care’ guidelines, PDSA would like to share some analysis and insight into the impact of remote consultations and prescribing upon our patients, clients and staff; and also provide our perspective on some considerations for the under care review.

PDSA moved to an emergency and essential service relatively early in the pandemic curve as a result of safety concerns and the impact that shielding had upon staff availability within our teams.

A remote veterinary service and digital client support framework was rolled out rapidly, resulting in a switch to 80% of consultations taking place in the remote environment within just 2 weeks. Between 17 March 2020 and June 2020 PDSA has delivered over 150,000 remote consultations; a proportion of which include remote prescribing of medication following the revised guidance from the RCVS.
PDSA has diverted its established quality improvement frameworks and capabilities to ascertain whether remote consultations, and associated prescribing, has had any detrimental effect in four key areas.

The detail behind this analysis may be found in the accompanying document, which we are sharing in the hope that it will provide useful insight at this time. The main findings in each area are as follows:

1. Regulatory compliance – Audit of individual remote consultation histories would suggest that the move to remote consultations and the introduction of the ability to remotely prescribe have been implemented effectively, with good compliance to the regulatory requirements surrounding these service elements e.g. clear notes were made to justify prescribing and dispensing decisions. One area that may need further analysis is the recording of the sharing of medicine safety information in the clinical history.
2. Patient outcomes – Prescribing behaviours, euthanasia rates, surgical procedure prioritisation, clinical incidents and longer term case progression following remote consultations have all been analysed as key clinical outcome indictors for the service. These analyses have showed that:
    a. It appears that the change from a consulting model that is majority based on face to face consulting, to one that is majority based on remote consulting has had little discernible impact upon prescribing behaviours and the overall approach to the medical case management of PDSA patients.
    b. There has been no significant change in euthanasia numbers or rates over the period since remote consulting was introduced, this provides reassurance that those patients most critically in need are still being attended.

   c. The introduction of remote consulting as a filter for emergency and essential cases, has been successful in ensuring that those cases most requiring surgical intervention to protect their welfare have continued to receive the level of care they require.
   d. There have been no clinical incidents reported that relate specifically to harm caused as a result of the move to a largely remote service.
   e. In a sample of remote consultations audited to ascertain regulatory compliance and patient outcomes, no animals were recorded as having died unexpectedly at home following a remote consultation, and the long term results do not appear to be out of alignment with how cases often progress historically.
3. Client experience – Survey of those clients that have received a remote consultation has revealed that 87-92% of clients strongly agreed or agreed to a number of service quality statements designed to ascertain their satisfaction, and that the majority of clients (92%) answered yes or maybe when asked if they would like to continue having access to telephone or video consultation services.
4. Staff experience – A small staff survey was carried out shortly after the introduction of remote working, key findings being:
   a. Hospital managers reported little resistance from vets in undertaking remote consults.
   b. A high percentage of clinical staff were happy with training received and felt confident consulting remotely.
   c. The majority of clinician concerns related to their ability to make clinical judgements.
   d. The majority of clinical team staff were good at taking breaks when working remotely, typically replicating the breaks they would take in a hospital.
   e. A quarter reported benefits of dividing their time between working at home and in a hospital.
   f. A fifth (19%) reported negative effects; although it was not possible to compare these results with pre-pandemic face-to-face consulting. PDSA has since rolled out a number of wellbeing activities.

PDSA therefore concludes that all of the indicators analysed would suggest that the incorporation of remote consultation capabilities into its service offering has been a major enabler for PDSA to continue to provide an important service to its large client base and has had little or no impact upon animal welfare, service quality, key clinical decision making, clients or staff members.

The ability to prescribe medication during remote consulting has been a critical element during the lockdown period; there is no question that the decision by RCVS to allow remote prescribing has had a major impact on our ability to provide continued care for our registered clients. In an environment where social distancing, staff and client safety and an absolute need to maintain accessibility are paramount it is hard to imagine how we could have provided the patient care required in a safe and effective manner otherwise.

The analysis carried out would suggest that it is difficult to identify why there should be any overriding regulatory or animal welfare reasons to remove this capability.

PDSA would strongly recommend that RCVS continue to permit remote prescribing for the duration that any form of social distancing, or other such public health restrictions, are in place that could impact upon our ability to deliver our charitable care to a large number of clients.

Related to this are our concerns regarding the economic impact of the pandemic and its impact both on PDSA (with the reduction of income forecast to be in the order of £3m per month) and the general public, with significant rises in the numbers of benefit claimants predicted over the coming months or years. This contributes to concerns over our ability to deliver much needed charitable care and support in the face of increasing future demand for service. Any option to provide meaningful care to as many patients as possible, whilst effectively protecting and utilising the limited capacity of our Pet Hospital services to deliver care that cannot be provided in any other way, will become more critical (and not less so) as the pandemic progresses and its long term impact becomes clear.

For this reason PDSA would also like to share its perspective on the current consideration taking place around the phrase ‘Under his or her care’; BVA have recently called for evidence or opinion to be submitted for consideration by its working party and PDSA would like to take this opportunity to do so with both parties:
PDSA feels that:

a. The Codes of Professional conduct do present a rather confusing picture for professionals, there are a number of paragraphs that are inter-related but it is not clear which take precedence:
    a. *4.9 c - the animal or herd must have been seen immediately before prescription or,*
    b. *4.9 d - recently enough……*
    c. *4.10 - What amounts to 'recent enough' must be a matter for the professional judgement of the veterinary surgeon in the individual case.*
    d. *4.11 - A veterinary surgeon cannot usually have an animal under his or her care if there has been no physical examination; consequently a veterinary surgeon should not treat an animal or prescribe POM-V medicines via the Internet alone*
    e. *4.12 The Veterinary Medicines Regulations do not define ’clinical assessment‘, and the RCVS has interpreted this as meaning an assessment of relevant clinical information, which may include an examination of the animal under the veterinary surgeon's care.*

    There is a mixture of judgements, absolute and non-specifics within the current guidance that PDSA feels is right to address; we do understand that as a regulator the RCVS is concerned with creating a regulatory framework within which professionals can make decisions and operate, and therefore feel that the absolute in these paragraphs i.e. should not, which applies to just one small element of the service is not in alignment with the remainder of the statements.
b. The guidance should seek to address the risk presented by the intervention as well as defining the circumstances in which the intervention is permissible, therefore the overriding consideration in any under care review should be the overall ability to protect patient welfare, not just a physical examination. In order to be considered under the care of a veterinary surgeon that individual should be able to show that

they can provide veterinary services of a standard that is suitable to protect the welfare of its patients.

c. If the aim of the statement is to define the point at which the ongoing welfare of that patient becomes the professional responsibility of a veterinary surgeon, or practice, then it would appear to be a rather arbitrary (and small) point in the patient journey that has been chosen; particularly when a practice could provide advice and sell a client GSL/NFA-VPS products without a physical exam and still not overtly be considered to have that patient under their care. The recent addition to the codes stating the more specific the advice given the more accountable the veterinary surgeon becomes for that advice helped somewhat, but still leaves a lot of uncertainty as to what that actually means in practice.
d. All of the professional responsibilities and expectations of veterinary surgeons are already set out in the Codes of Professional conduct, Veterinary Medicines regulations, Controlled Drugs legislation etc, and they provide the frameworks for ensuring that a veterinary surgeon will behave and make decisions in a responsible manner. The making of a decision to prescribe is based upon an amalgamation of these responsibilities and not just a physical examination.
e. Given the range of conditions attended by veterinary surgeons, the spectrum of signalment and presenting signs associated with those conditions, the varying value of physical examination in diagnosing those conditions, the wide range of medications available with varying degrees of risk associated with those medications and the variety of ways that different conditions may be managed depending upon which medication is being utilised; the blanket rule that medication should not be prescribed without a physical examination would appear to be a blunt instrument that creates a profession wide barrier to effective case management as a result of perceived risk over a small number of situations.
f. It should therefore be left to the individual veterinary surgeon to consider whether they have sufficient information to prescribe that particular medicine responsibly, can provide the products in a safe manner, can provide the necessary safety information effectively and whether they are able to provide follow-up contact and further treatment if required. If veterinary surgeons fail to provide for any of these elements then they can already be held to account under existing requirements regardless of the platform over which the interaction takes place.

PDSA would therefore like to make suggestions around the two elements which we feel need further clarification:

1. The point at which a patient becomes under a veterinary surgeon or practices care in relation to remote prescribing, not-withstanding the other scenarios as covered in other elements of the codes, is that point at which a decision to prescribe is made. At that point very specific advice has been provided and decisions have been made that mean the patient is unequivocally ‘under care’. Rather than stating the conditions in which a patient **can** be considered under care (which does not necessarily logically cover all situations), we feel the guidance should state the absolute conditions in which a patient **cannot** be considered under care (which would absolutely apply to all situations) – which will then link to the point below.
2. What under care then means in practical terms, this could be qualified in order to address some of the concerns that have been raised with regards remote prescribing

specifically. If a veterinary surgeon cannot provide reassurance that they are able to provide:

a. A framework for case succession – this would create the conditions in which responsibility for the patient is real
b. A means of contact for further advice if it should be required
c. Supply of veterinary products in a responsible, safe and legal manner
d. All necessary safety information
e. The means to attend to that patient in the event of an adverse reaction or unexpected deterioration within a reasonable time period, at a registered practice which complies with the core requirements.

Then they should not be able to consider a patient under their care for the purposes of remote prescribing.

This approach would:

1. Allow existing practices to choose whether they wish to provide services for their own existing client base
2. Ensure that case succession is carried out in the correct manner if a client is moving between practices.
3. Ensure that pet welfare is protected in the event of adverse reaction or deterioration
4. Address some of the concerns raised regarding the establishment of 'internet only' veterinary services; it would compel any provider of this kind to establish an agreement with registered practices to attend those cases that may require it, within any geographical area over which they wish to provide services.

I hope that the PDSA experience has shown that provision of remote veterinary services with the inclusion of remote prescribing can be achieved in an ethical and controlled manner which protects the welfare of patients and provides a valued client experience. PDSA feels that the continuation of the ability to remotely prescribe in the current environment is critical to our ability to provide services whilst any socially disruptive constraints are in place; and in the future where it is predicted that increasing demand for charitable services will potentially outstrip our ability to physically manage cases in a Pet hospital only environment. We are therefore keen to partake in the discussions and activities surrounding the under care review, provide clarification on our views and be challenged on those same views, if we can be of any assistance please do not hesitate to contact us.

Yours sincerely,
Steve Howard, BVMS MRCVS, Head of Clinical Services, PDSA

PDSA experience of remote consulting and prescribing during Covid-19

Background

PDSA was established in 1917 to help ensure no pet suffered needlessly, since that time PDSA has grown into the UK's leading veterinary charity, helping pets and their owners in need every day. Over recent years our vet teams have been providing vital, life-saving care, to 470,000 pets every year through 48 Pet Hospitals across the UK. As PDSA has grown the risks associated with delivering a veterinary service on such a scale have also grown, there has also been an increasing duty to all of its stakeholders (Clients, patients, employees, volunteers, supporters, donors, Trustees and the charity commission) to demonstrate that charitable funds are used as effectively as possible. Therefore the PDSA veterinary service must be:

- Defined in scope, breadth and depth
- Delivering an appropriate standard of clinical and customer service
- Operating within regulatory and legislative requirements
- Operating as effectively as possible
- Delivering the pet welfare outcomes and client care required
- Identifying and mitigating risks associated with delivering a veterinary service

In order to demonstrate this PDSA has established and operated within a Clinical Governance/Quality Improvement framework for many years.

The recent changes in response to COVID-19 implemented across the veterinary profession have also been implemented at PDSA; our need to provide reassurance that we continue to deliver the service quality criteria, as listed above, remains. In response to the risks posed by the dramatic changes implemented over a short period of time PDSA has carried out quality assessment in a number of areas.

PDSA feels that our experience and quality monitoring of remote consultations during this time may be of interest to the BVA and RCVS as they consider future changes to guidance.

Introduction

PDSA had been making plans and preparations for the pandemic impact for the two months prior to the UK-wide lockdown, as a result of our routine environmental scanning having picked up the potential risk at an early stage. We were therefore in a good position to move rapidly as an organisation and veterinary department when it became necessary to do so; with the Government announcement of the intention to shield vulnerable individuals we took immediate action to protect our people and shielded those that fell under the criteria announced at the time. This had the immediate impact of reducing staff availability in many of the Pet Hospitals, with over 250 staff affected. As a result of the staffing impact and the assessment that the situation had reached a point where there was a risk to the safety of our teams, the decision was made to implement the pandemic plan, which for our services included:

- Moving to emergency and essential service only from 17.03.2020

- Achieving a rapid reduction of footfall through the Pet Hospitals by providing remote client support
- Implementing a range of measures to manage the safety of our teams and PDSA clients.

Shortly after PDSA implemented the change to emergency and essential services, recommendations were made to the profession by both British Veterinary Association (BVA) and Royal College of Veterinary Surgeons (RCVS) to implement social distancing and a reduction of footfall through veterinary practices through the implementation of emergency and essential services only and ensuring that all Practices adhered to the conditional requirements, set in place by the Government for the delivery of essential services during the full UK lockdown which was announced on 23.03.2020, providing reassurance of our approach.

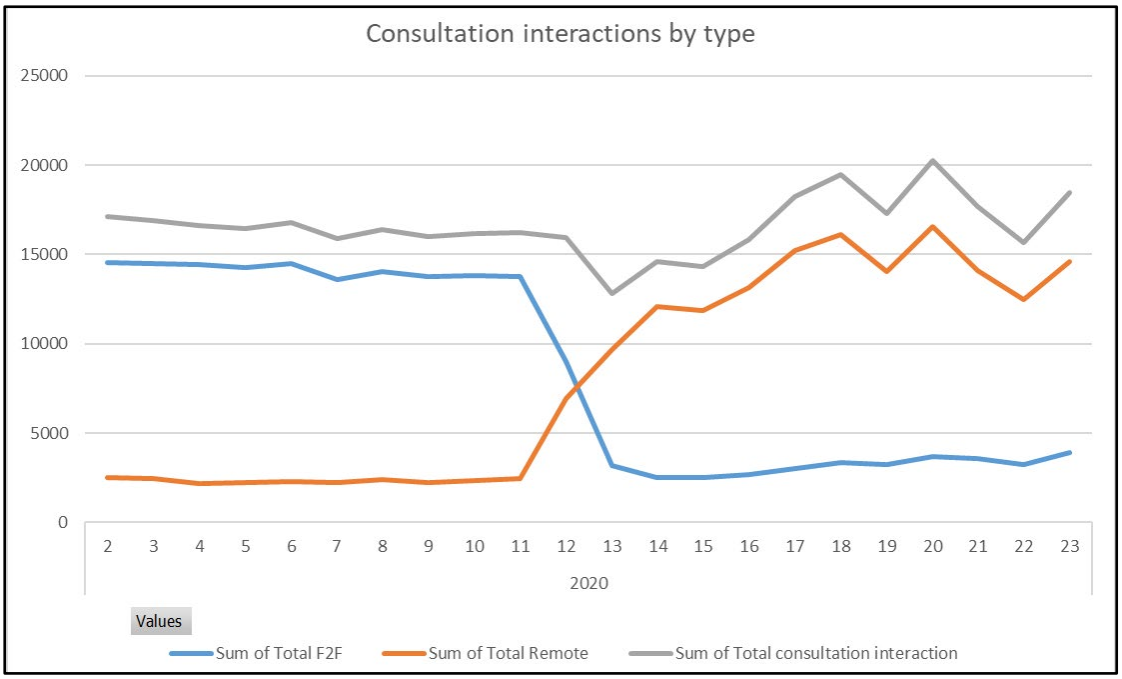
The RCVS reacted quickly to the lockdown and introduced temporary measures to enable vets to prescribe medication through remote digital consults where there was no other safe means to do so. This welcome change allowed us to maximise the potential of our own digital services through effective use of the veterinary surgeon and veterinary nurse remote consults for every Pet Hospital. This ensured that through the lockdown we have been able to protect our teams and support many of our clients by carrying out as much veterinary work as possible remotely.

PDSA rolled out a web form which is automatically able to check if a client is registered, and enables them to request a call back from either a veterinary surgeon or veterinary nurse and adds them to a newly created on-line virtual waiting list. A remote team of veterinary surgeons and veterinary nurses was set up with the ability to access the on-line waiting list and to undertake remote consultations. The majority of these consults are telephone consults but video technology is available for veterinary surgeons to use when they feel it is necessary.

Through the client dedicated area on our website, our hospital Interactive Voice Response (IVR) phone messages and through remote consultations our clients with non-urgent enquiries were, and continue to be, directed to use the PDSA Pet Health Hub (https://www.pdsa.org.uk/taking-care-of-your-pet/pet-health-hub) and pages on our website for digital advice, unless there is a concern that their pet requires emergency attention, both the website and Pet Health Hub are a useful source of support and advice and are available to all pet owners. The website and the existing Pet Health Hub content was enhanced to include COVID information pages, additional first aid advice, advice on management of conditions and content tailored to manage the expectations of clients regarding the service being delivered in the current situation.

Both the COVID website pages and COVID-specific Pet Health Hub pages have seen large increases in traffic volume during this period, for example the Pet Health Hub has seen over 938,000 unique visitors just this year and traffic has almost doubled since the COVID-related changes were made during March 2020.

PDSA therefore rapidly put in place a move to digital engagement, advice and remote service provision; the impact upon our service model was profound. The chart below shows consultation interactions by type for each week of the year to date, with PDSA moving to emergency and essential services during week 12. Over a 2 week period PDSA moved from a position where approximately 15% of consultation interactions were carried out remotely, to a level where approximately 80% of consultations are now carried out remotely:



These figures provided significant reassurance that the objective of limiting footfall through our Pet Hospitals was being met, with the subsequent safety benefits for our teams and clients. We have now delivered over 150,000 remote consultations since week 12, which have undoubtedly helped to ensure that the almost 44,000 face to face consultations have been delivered to those patients most in need. Whilst these figures provide information regarding footfall management it has also been necessary to ensure that service quality has been maintained during this period.

PDSA has diverted and utilised many of its established Quality Improvement frameworks and activities to provide reassurance of the quality of the newly established remote services in the following areas:

1. Regulatory compliance
2. Patient outcomes
3. Client experience
4. Staff experience

We have achieved this through utilisation of management information, utilising our dedicated veterinary service quality audit team (Quality Standards Managers), staff survey and client survey.

1. Regulatory compliance

Randomly selected remote consultations provided by vets and vet nurses were audited remotely by the Quality Standards Manager team in order to ascertain the level of regulatory compliance relating to:

a. The requirement for clear clinical history recording
b. Justifiable clinical decision making
c. Provision of veterinary medicines.

14% of vet consultations were preceded by a VN consultation. Of these, appropriate notes were taken by the VN (i.e. without making a diagnosis) in 95% of cases, 100% were judged to be appropriately passed to a vet for further assessment.

574 Veterinary surgeon (VS) remote consultations were then audited and the outcomes are shown in the table below:

	Outcome of Vet Consult				
	Observation	Home care advice only	Advice with medication prescribed/approved	Hospital appointment	Medication check
Total	21	145	261	127	20
% total	4%	25%	45%	22%	3%

Based upon the recorded history a reasonable case management approach was judged to have been taken in 98% of both vet and VN consultations.

Vets advised a follow-up hospital visit in 22% (n=127) of cases.

Medication was recorded as having been approved or prescribed on 281 occasions, 48% of VS consultations, in 279 of those consultations it was possible to ascertain that 51% of were for a new condition, 48% for an existing condition and 1% a combination of both, as shown below:

	What was medication prescribed for?		
	New condition	Existing condition	Both
Total	143	133	3
% of Total	51%	48%	1%

This means that overall just over 20% of remote consultations resulted in medication being approved for a condition for which the patient had not been previously presented. The classes of medicines prescribed and dispensed by vets are shown in the table below:

	POM-V	POM-VPS	GSL	POM-V & POM-VPS	POM-V & GSL	POM-V & Other	POM-VPS & other
Total	206	5	7	8	47	3	2
% of total	74%	2%	3%	3%	17%	1%	1%

Analysis of the clinical histories showed that clear notes to justify prescribing and dispensing decisions were made in 97% of vet consultations and 88% of VN consultations.

For POM-V medicines, safety information and potential side effects were recorded as having been discussed in 44% of prescribing occasions; this area needs further analysis to ascertain whether:

a. Those occasions where it has not been recorded correlate with those patients that have received the medication previously (48% of cases) and the warnings have been provided historically,
b. The conversations were taking place and that it is a history recording omission,
c. It is an area that is picked up elsewhere in the client journey; over 40% of medications were collected from the Pet Hospital during this period, so it is likely that instruction and/or documentation will have been provided at that time,
d. It is a true reflection of a gap that requires action to be taken

The prescribing vet wrote their own label on the clinical system in 98% of cases, when a label was not inputted by the prescribing vet the auditors checked to ensure that the final label produced was in accordance with the prescribing VS instructions, they were found to match in 100% of cases.

In conclusion, the audits carried out would suggest that the move to remote consultations and the introduction of the ability to remotely prescribe have been implemented effectively, with good compliance to the regulatory requirements surrounding these service elements. One area may need further attention.

2. Patient Outcomes

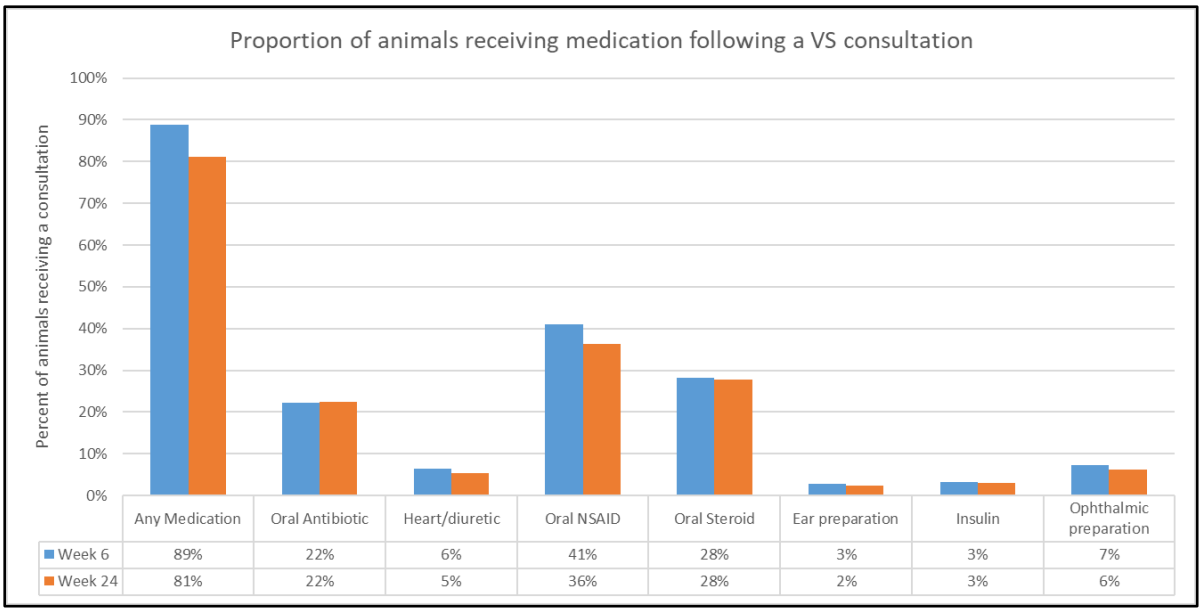
Management information was monitored to ascertain whether the proportion of key outcomes for patients had fluctuated during the period.
The key outcomes monitored were:

a. Prescribing behaviours

The introduction of both remote consulting and the ability to prescribe medications remotely at the same time was a major change for clinicians and could have resulted in significant changes in the approach to case management. A precautionary approach could have been taken that may have resulted in changes due to:

a. Precaution on a case management basis in the remote consultation - resulting in an increase in medication dispenses.
b. Precaution on a medicines regulatory basis in the remote consultation – resulting in a reduction in medication dispenses.

In order to ascertain the impact of the changes upon prescribing behaviours and the overall impact on service provision, the proportion of patients receiving a selection of medication types were monitored and compared to the period prior to implementation of the changes. Week 6 (w/c 2 February) has been taken as a typical pre-lockdown week and most recently compared to week 24 (w/c 7 June). A total of 12,989 animals received a VS consultation (either Face to face or remote) during week 6, and 11,456 animals received a VS consultation in week 24; the percentage of this patient base that went on to have different types of medication dispenses recorded on their clinical record during that week were analysed.



	Any Medication	Oral Antibiotic	Heart/diuretic	Oral NSAID	Oral Steroid	Ear preparation	Insulin	Ophthalmic preparation
Week 6	89%	22%	6%	41%	28%	3%	3%	7%
Week 24	81%	22%	5%	36%	28%	2%	3%	6%

Whilst there have been some minor changes across the medications analysed, the majority have remained very similar and variations could be as a result of natural variation in case mix. The only category that has reduced to any degree is that of the oral NSAID dispenses (which has also driven the majority of the change in the any medication category). This may be more driven by the COVID-19 situation than a change in case management approach suggesting that patients have not been receiving adequate analgesia, during this period of lockdown it is possible that clients are more willing and able to access readily available alternative safe and effective NSAID drugs more locally or at home and have been advised accordingly. Further analysis will be required to ascertain whether this is the case.

In summary, it appears that the change from a consulting model that is majority based on face to face consulting to one that is majority based on remote consulting has had little discernible impact upon the overall approach to case management through provision of medication to PDSA patients.

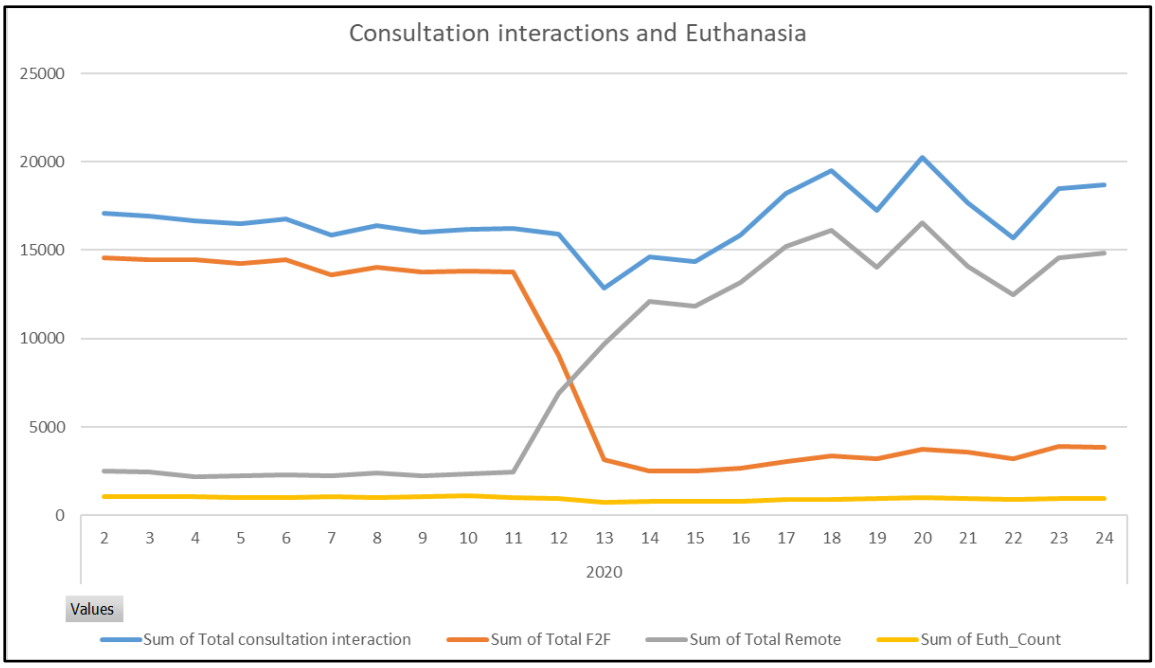
c. Euthanasia rates

Significant changes in euthanasia rates would flag as a concern, it was possible that either:

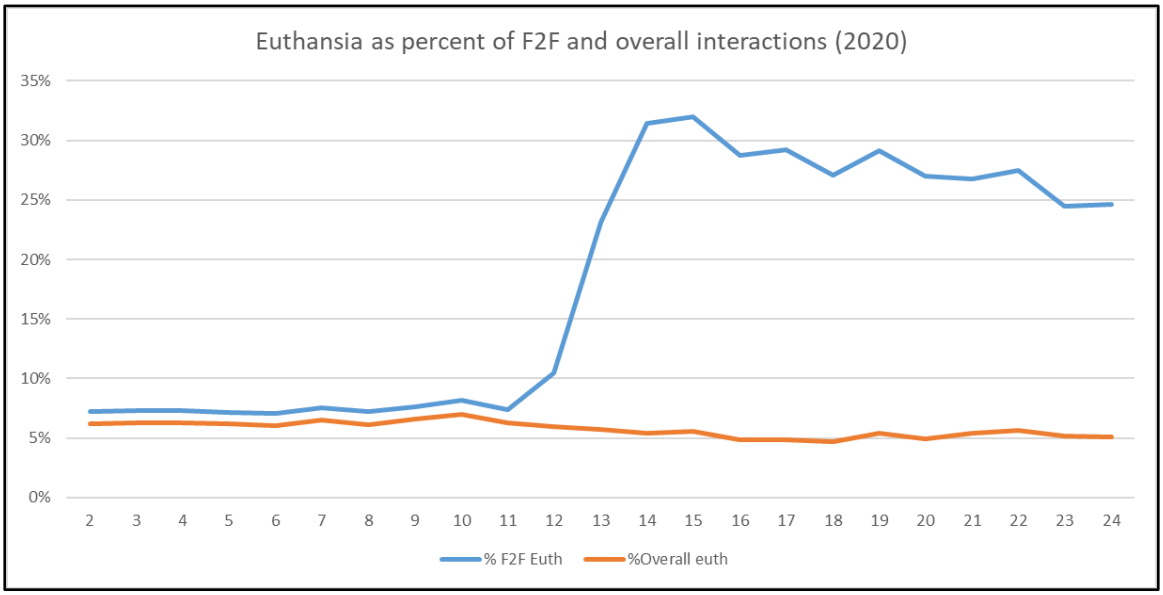
a. The implementation of unprecedented social restrictions would drive pet owners to decide upon early euthanasia for their pets, particularly those with ongoing conditions – showing as increases in euthanasia rates
b. The implementation of PDSA service changes would unintentionally restrict accessibility and as a result we not be able to attend critically ill cases, which would suggest potential welfare concerns – showing as reductions in euthanasia rates

PDSA has been monitoring absolute and relative euthanasia levels and rates throughout the period.

The chart below shows the absolute level of euthanasia in the context of the switch from largely face to face, to largely remote consulting. It may be seen that the absolute numbers of euthanasia taking place has remained largely constant throughout the period (Yellow line), as would be expected from what at the time was a static patient base.



The chart below shows the relative proportion of euthanasia as a percentage of overall consultation interactions (orange line); there have been minor variations of approximately 1% or less over the period which have been largely driven by changes in overall consultation numbers which at times exceeded previous levels (as can be seen in the graph above),



The Blue line in the graph above does highlight one unintended consequence of the move to remote consulting; whilst overall the numbers of euthanasia's has been relatively constant, the move to a large proportion of the work being delivered remotely has resulted in a concentration of euthanasia interactions for the teams providing face to face services, to the point where they have constituted 25-30% of the workload of that team. This has generated some concerns regarding the impact of a high proportion of workload being euthanasia on the wellbeing of the face to face team, it has been an additional driver for PDSA to focus on specific wellbeing initiatives for the veterinary teams over this period.

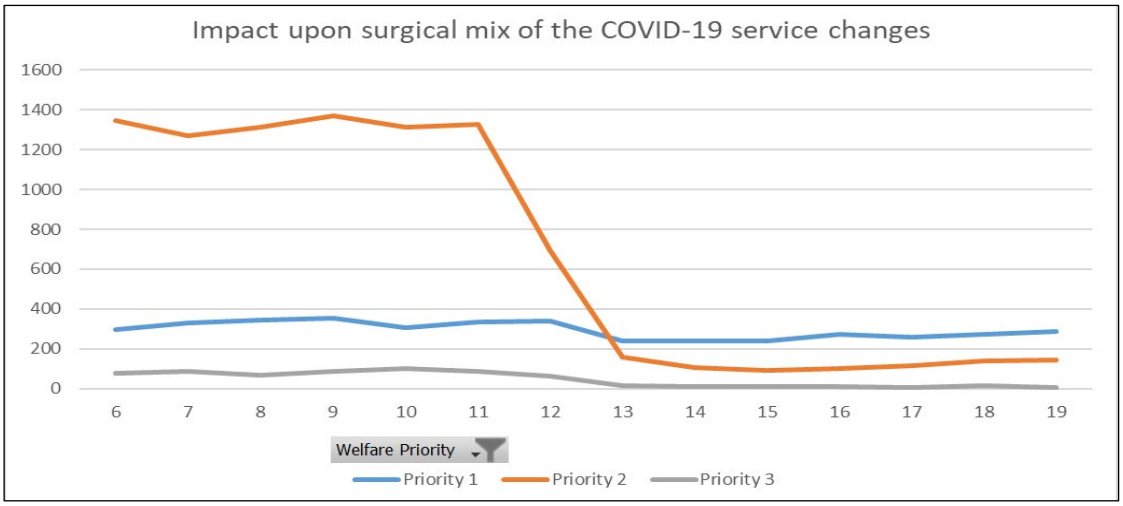
The analysis above suggests that there has been no significant movement in euthanasia numbers or rates over the period since remote consulting was introduced, this provides reassurance that those patients most critically in need are still being attended.

d. Surgical procedures performed

In order to support decision making by our clinicians all PDSA surgical procedures have been categorised by welfare priority, according to whether they can be considered:

- Priority 1 – Emergency and essential
- Priority 2 – Can be delayed for a period (including preventive procedures)
- Priority 3 – Elective

The relative proportions of these procedures have been tracked on an ongoing basis and the results of the changes may be seen below:



The data shows that following implementation of the changes during week 12, which included the move to remote consulting for 80% of interactions, the surgical mix changed dramatically; however, those procedures considered to be emergency and essential procedures continued at approximately the same levels, suggesting that PDSA remained largely accessible for our clients and that the introduction of remote consulting did not deny patients the ability to receive critical care when required.

Those procedures that can be delayed have been, elective procedures have reduced to very low levels, PDSA is now working on safely expanding the range of services that can be delivered in order to provide a wider range of procedures.

This analysis shows that the introduction of remote consulting, as a filter for emergency and essential cases, has been successful in ensuring that those cases most requiring surgical intervention to protect their welfare have continued to receive the level of care they require.

e. Clinical incident reports

The PDSA clinical incident reporting system has been monitored throughout the period and there have been no clinical incidents reported that relate specifically to harm caused as a result of the move to a largely remote service.

f. Remote consultation outcomes audit

In addition to analysis of management information, in order to ascertain the effectiveness of the VS remote consultations in managing the condition of the patient the Quality Standard Managers carried out a follow-up audit of the 574 remote VS consultation cases analysed in the section above, 466 (81%) 1 week after their remote consultation and 222 (39%) of remote VS consultation cases 1 month after their remote consultation.

Of those 466 cases followed up after 1 week, 111 (23%) had made contact with the hospital in the 7 days after their original consultation (excluding those that had been advised to attend a hospital during the consultation). The breakdown of the nature of these 111 contacts occurring within 1 week is provided in the table below:

	What contact was made within 7 days of original call							
	Client called - condition deteriorated	Client called - Animal died	Client called - condition improved	Client attended hospital - recheck	Client attended OOH - recheck	Client attended - Euthanasia	Pet Hospital called client for update	Telephone contact made - Hosp/Client?
Total	47	0	8	6	1	11	7	31
% of Total	43%	0%	7%	6%	1%	10%	6%	28%

When applied to the overall number of VS remote consultations examined (n=466), the figures above would suggest that:

a. No pets had been reported as having died following the remote consultation
b. Approximately 10% of contacts were due to the owner seeking further assistance with concerns that their pets condition had deteriorated following the remote consultation, this does not feel out of line with what could be expected following face to face consultations.
c. 0.2% had attended out of hours (presumably due to deterioration of the condition)
d. Approximately 2.4% of clients had decided upon euthanasia for their pet and had attended the Pet hospital.
e. 11% of cases had reported improvement or a further check had been made on progress

To date a total of 222 remote consultations have been followed up 1 month later, the results may be seen below:

	Follow up 1 Month Has the original condition resolved?				
	Condition ongoing	Condition resolved	Lost to follow up - assume resolved	Animal has been	Animal died at home

				euthanased at hospital	
Total	46	23	109	44	0
% of Total	21%	10%	49%	20%	0%

The long term results do not appear to be out of alignment with how cases often progress historically, for example, PDSA has traditionally had a relatively high number of chronic cases that would be expected to require ongoing care. The only result that may appear slightly high is the euthanasia rate at 20%, this has been put into context by looking at overall euthanasia rates.

3. Client perspective

PDSA created and distributed an SMS client satisfaction survey to those clients who had received a remote consultation; between 13.05.2020 and 08.06.2020 the survey received 5923 responses. A number of PDSA service elements were explored in the survey, however, those questions most relevant to the remote consulting service elements received the following results:

	Satisfaction	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
My vet/nurse listened to me and I felt able to ask question	82%	4%	1%	3%	20%	71%
I feel confident in the treatment plan/advice offered by my vet/nurse	75%	5%	2%	5%	23%	64%
Overall I am satisfied with the outcome of my phone/video consultation	76%	5%	2%	5%	22%	66%
I would recommend PDSA to a friend	69%	4%	1%	3%	15%	77%
	YES	**MAYBE**	**NO**			
Would you be interested in continuing to have phone or video consults in the future?	58%	34%	8%			

It may be seen that the vast majority of clients (87-92%) either strongly agreed or agreed with the statements in all questions; at PDSA we create satisfaction scores which is subtracting the strongly disagree, disagree and neutral scores from those who agree or strongly agree. The Net Promoter Score (NPS) question, “I would recommend PDSA to a friend” gives a satisfaction score of 84% and when calculated in alignment with NPS methodology gives an NPS of 69%, which is considered excellent.

It may also be seen that the vast majority of clients (92%) answered yes or maybe to continuing having access to telephone or video consultation services.

Client complaints are a key performance indicator for PDSA veterinary services and have been tracked throughout the period of change as a high level indicator of service levels and client satisfaction. A significant risk to the rapid change in services was that clients would not understand the rationale for the changes and would respond to them poorly, it was anticipated that this could result in a significant rise in the number of complaints received.

For the period covering weeks 12-23 PDSA has experienced an increase in complaint volume of 30% over the same period in 2019, however in real terms this represents an increase from 157 to 204 complaints handled by our dedicated veterinary complaints team,

an additional 47 complaints. The majority of these additional complaints are related to the decision to delay certain treatments in the current emergency and essential environment e.g. lump removals. In the context of the situation where an unprecedented and significant change in service delivery and case management approach has taken place over a period of just a few weeks, which has affected all of our client base and patients these results would suggests that PDSA has effectively communicated its change to service, the service levels available and how they can be accessed; also that the service being delivered is at present generally meeting the expectations of our clients.

4. Staff perspective

Pet Hospital managers and clinical team staff were surveyed separately between 21 - 29 April, to explore whether messages and training had been cascaded and interpreted effectively, and assess impacts of the transition to remote consultations, including on staff wellbeing.

Managers (n=10) and teams (n=16) were surveyed from 10 hospitals, selected for having a range of high, medium and lower call volumes, the key findings of those surveys are outlined below:

- 100% of team members surveyed said clients have reacted mostly positively to the changes in service. Clients have welcomed remote prescribing, particularly for repeat medication
- 38% had not encountered any significant negative reactions from clients.
- 56% had experienced occasional negative reactions, usually linked to frustrations around lockdown rather than the service.
- 38% Veterinary professionals had concerns with not wanting to be seen or being worried about managing client behaviours
- 64% of concerns initially raised related to the challenge of making clinical judgements remotely and gauging the severity of a case based on an owner's perception
- 93% of team members rated their confidence in undertaking phone consults as 7 out of 10, or higher. 6% rated their confidence as 6 out of 10.

Managers reported little, if any, resistance from staff in carrying out remote consults:

- 50% reported they had no resistance at all
- 30% said they had no resistance from vets but VNs raised some concerns.
- 10% received resistance related to use of technology

Remote consulting wellbeing

Teams appear to have been generally good at taking rest breaks with:

- 87% either choosing to replicate usual hospital breaks & lunch times, or ensuring they take regular breaks when it suits their workload for the day.
- 13% said they forget to take breaks when they are busy.

When asked about the impact remote consults had had on their personal mental health and wellbeing

- 25% liked the split of home & hospital working and felt it was a good recruitment opportunity

- 19% said it was a different way of working which they found a bit stressful at the beginning but have adapted well to now
- 13% said remote consults haven't had any effect on their personal mental health & wellbeing
- 19% were struggling with work/life balance and work becoming monotonous.

PDSA Head Office
Whitechapel way
Priorslee
Telford
TF2 9PQ

Dear COVID taskforce,

Many thanks for considering PDSA's submission of evidence (PDSA experiences of remote prescribing during COVID-19) on the last occasion that you reviewed the matter of remote prescribing, I hope that you found it informative and useful. PDSA would like to submit a further update in the hope that it will inform decision making as you once again consider the matter.

Your rationale for extending the dispensation to remote prescribe in the communication of 6 August was most welcomed, as it provided insight into the criteria that were used in order to reach a decision at that time, and which I will use below to structure our submission on this occasion:

1. Situational analysis
    a. "Taking into consideration the pandemic's progress"

PDSA agrees that the current progress of the pandemic is a critical factor in decision making, but would suggest that the likely future progress should also be considered in any decision making criteria. On the face of it the pandemic had been in decline until August but there are now some concerning signs that the rate of infection is rising again and that this is taking place not just in specific locations but more generally at community level.

Whilst the case numbers currently being reported cannot be directly compared to those reported earlier in the pandemic, due to the inclusion of pillar 2 testing results, they are providing a greater insight into the immediate situation that we face and the potential impact that may have as we enter the winter period, which is of greater concern.

The Academy of Medical Sciences report 'Preparing for a challenging winter 2020/21' contained the outputs of a number of models predicting the progress of the pandemic based upon the UK's ability to control the R number at different levels (please see Appendix 1 which is a section of a situation report submitted to the PDSA board on 16 July 2020). PDSA conclusion at that time was *"Whether PDSA is impacted through measures put in place to maintain the Rt rate at a level that will prevent a resurgent wave ……. or measures to mitigate the impact of a realised resurgent wave ……..; PDSA should assume that socially disruptive measures will be required in all scenarios to control infection rates throughout the autumn and winter period."*

PDSA would suggest that the likely progress of the pandemic over the coming months would result in the need to re-instate the ability to remotely prescribe if it were to be removed at this stage.

b. “latest government guidance”

As stated above, indicators would suggest that the government is highly likely to be faced with the need to re-impose some of the more socially disruptive measures in order to control the infection rate and keep schools open, as they have committed to do. The first elements of these interventions have been implemented already in ‘the rule of 6’.

It is impossible at this stage to know exactly what additional measures may be imposed, when or in what order, but they are likely to comprise of some of those past mitigations which had a direct impact upon the veterinary profession and its ability to provide direct services to clients e.g. travel restrictions, shielding and closure of some businesses.

Even in the absence of increased measures the existing government guidance is still having a profound impact upon PDSA’s, and much of the rest of the veterinary professions, ability to deliver services at anywhere near the levels previously possible. PDSA has now opened over 75% of its Pet Hospitals to clients again (the remainder of the sites with more challenging layouts will be opened by the end of September), but the COVID secure ways of working severely restricts the flow of clients through those Pet Hospitals and limits the overall numbers of people allowed in a building at any one time.

If a physical intervention were required for every prescription there would be no possible way to service our existing client base, ensure that the number of emergencies we are able to attend remains at the constant level we have delivered to date and accommodate increased demand for services (which is already being seen at some sites, as a result of the economic impact of the pandemic).

As was the case in the last update provided to the COVID taskforce, the ability to remotely prescribe remains critical to our ability to maintain a service to our existing clients in the current climate, and is likely to become ever more critical over the coming months as additional restrictions are imposed and demand for our services grows.

2. Professional matters
    a. “the need to continue to provide practices with flexibility in the face of possible local or national lockdowns”

PDSA has documented its planned response to escalating levels of local and regional interventions in alignment with the government guidance “COVID-19 contain framework: a guide for local decision-makers”; a key element of our planning is the flexibility to redeploy members of the team to provide services and support for our clients in the remote environment in order to manage risk for our teams and our clients.

PDSA believes that the threat of local and national lockdowns remains just as relevant as it was when the COVID taskforce last considered the ability to remote prescribe, and is likely to become more so over the coming months at both local and national level.

b. “the need for inclusivity of those practice teams members and clients who may still be shielding”

Whilst shielding itself was suspended on 15 August, there remains a significant portion of the population who are more susceptible to developing severe disease from COVID-19 and they are understandably still very concerned and nervous of being exposed to the risk that remains and appears to be growing. Many of our clients are in this situation and have expressed their gratitude and appreciation of the ability to access remote care safely.

Our planning for response to local and regional lockdowns, as described above, includes the redeployment of clinically vulnerable and clinically extremely vulnerable team members to provide remote services preferentially, and at a relatively early stage, in order to protect their physical and mental wellbeing.

PDSA believes that the ability to protect the wellbeing of our clients whilst providing a meaningful service; and protecting our team members whilst maintaining the ability to be productive and included members of the team, remains just as important as when shielding was in place.

c. “the likelihood of quarantine of members of the team due to travel and/or Test and Trace”

PDSA has experienced both of these scenarios and given the nature of the governments approach to foreign travel, and the inability of PDSA to be able to influence behaviours and contacts outside working hours, it is envisaged that this will remain a likely occurrence in the coming months.

PDSA’s HR processes reflect the need to maintain the ability of team members to work during enforced periods of self-isolation or quarantine whilst they are well and able to do so.

PDSA believes that the likelihood of, otherwise well, team members being required to self-isolate or quarantine has not reduced since the taskforce last considered this matter.

d. “the fact that no major safety issues had been identified as part of the RCVS-commissioned survey into the immediate impact of the temporary guidance.”

PDSA hopes that its previous submission provided the taskforce with reassurance over and above the survey findings, and that the conclusion we reached “that all of the indicators analysed would suggest that the incorporation of remote consultation capabilities into its service offering has been a major enabler for PDSA to continue to provide an important service to its large client base and has had little or no impact upon animal welfare, service quality, key clinical decision making, clients or staff members.” was shared by the taskforce.

PDSA has carried out further analysis (see supporting data, below) and has concluded that after six months overall experience of remote consulting and prescribing there remains no direct evidence that the addition of these new service elements have had a negative impact upon the safety of our patients; and have indeed provided great benefit to the charity, our teams, our clients and our patients.

In summary, PDSA would suggest that there is little evidence that the key factors, acknowledged by the taskforce as informing their decision to extend the ability to remotely prescribe medications, have changed in any significant way. The ability to prescribe

medication during remote consulting remains a critical element during the post-lockdown period; there is no question that the decision by RCVS to initially allow remote prescribing, and subsequently extend that permission, has had a major impact on our ability to provide continued care for our clients and helped to safeguard our teams.

Evidence and recent experience would suggest that we are still far from a time when PDSA, and veterinary practices in general, are able to efficiently provide services in the way that we used to. PDSA would suggest that a further extension of the ability to remotely prescribe is critical over the coming months, we would also request that a longer term view be taken when making the decision. We consider it highly unlikely that the factors above will change over the autumn and winter period; we would therefore suggest that stability, and the ability to effectively plan the delivery of veterinary services over a longer period, would be achieved through a commitment from the COVID taskforce to allow this important service element to be delivered until such a time as a far greater degree of normality is returned to society and the profession, which we would suggest will not be until well into 2021.

As always, if I can be of any further assistance on this matter please do not hesitate to contact me.

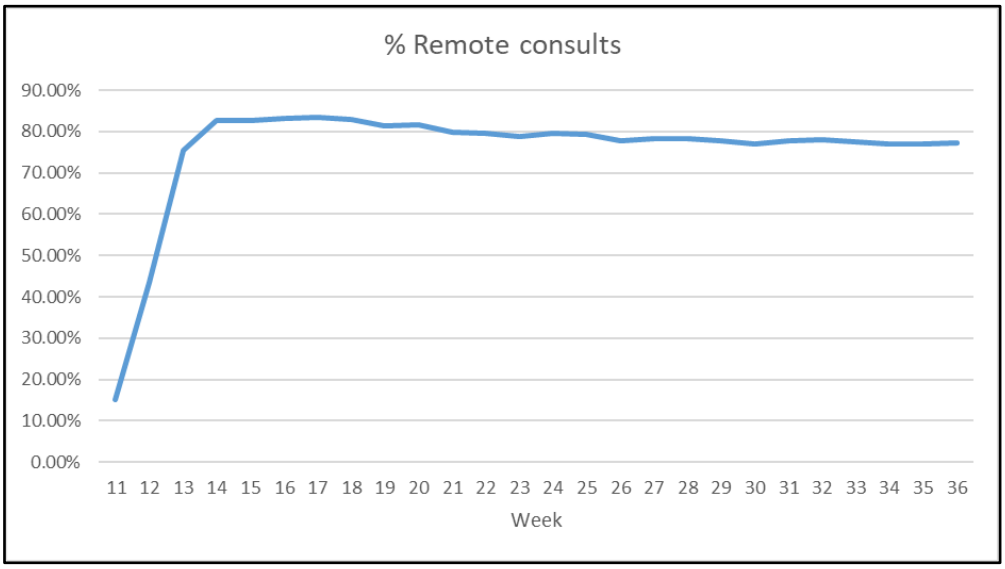
Yours sincerely

Steve Howard BVMS MRCVS
Head of Clinical Services, PDSA

PDSA supporting data

As shared in the previous update, PDSA moved to an emergency and essential service on 17 March 2020, in advance of the national lockdown which was announced on 23 March, as a result of safety concerns and the impact that shielding had upon staff availability within our teams.

A remote veterinary service and digital client support framework was rolled out rapidly, resulting in a switch to 80% of consultations taking place in the remote environment within just 2 weeks, this proportion of remote to Face to Face service provision has been maintained throughout the period since:



Between 17 March 2020 and the end of August 2020 PDSA has now delivered over 350,000 remote consultations; an estimated 45-50% of which includes remote prescribing of medication following the revised guidance from the RCVS.

The following data is intended to be an update on that already shared in the initial document.

Regulatory compliance

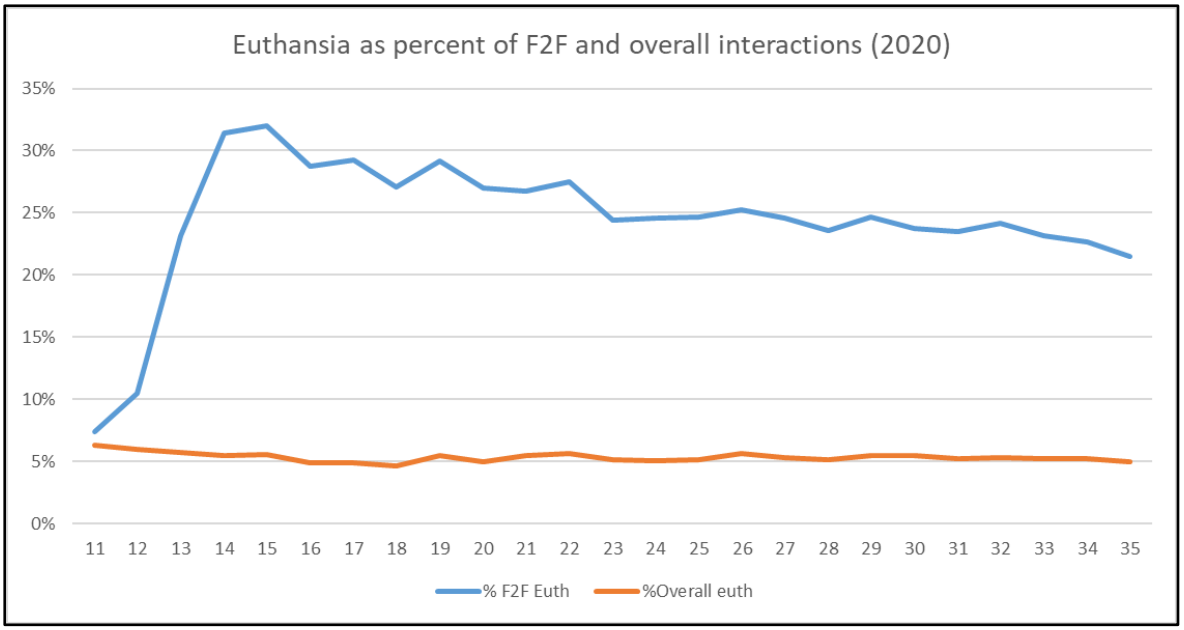
Our previous update included extensive insight into our internal auditors' findings following their audit of remote consultations. These audits showed a very high compliance rate and the very few issues of concern have been further investigated. Shortly afterwards the decision was made that ongoing utilisation of resource in this area was delivering limited additional value and the team were redeployed to support Pet Hospitals in other ways, particularly in ensuring compliance to COVID secure working practices.
This area will be audited again as part of the normal ongoing audit cycle at a later date.

Clinical outcomes

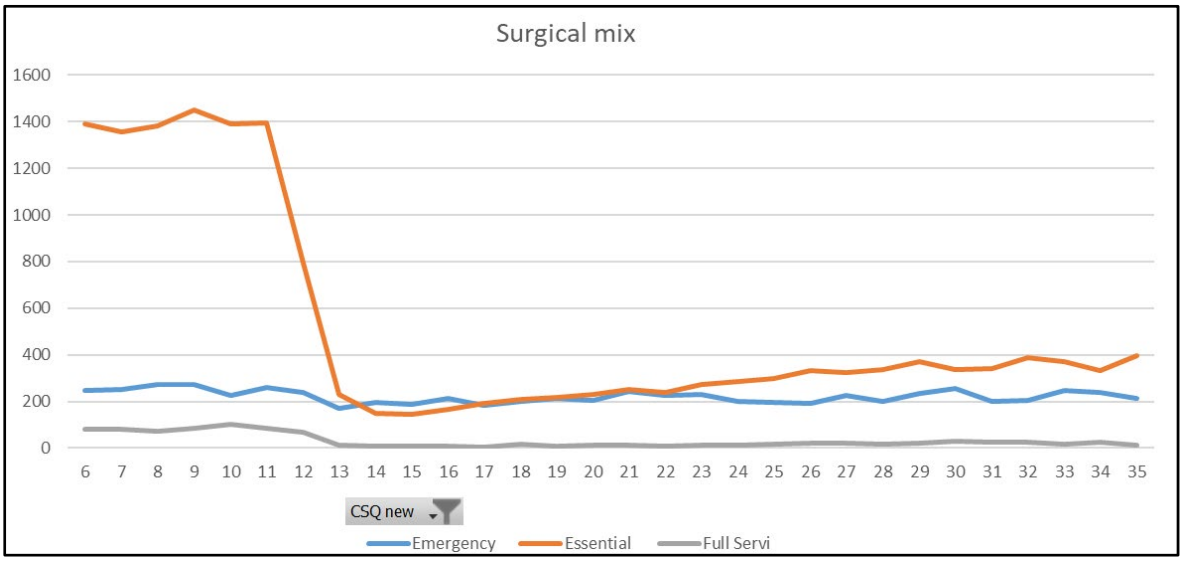
Euthanasia and Emergency care

In the previous update the levels of euthanasia and emergency procedures were used as a measure to demonstrate that clients were still able to access care for their pets when it was most needed. The following graphs illustrate that there have been no concerning trends emerging as a result of our continued high proportion of remote service delivery.

Euthanasia rates have continued to run at approximately 5% of all consultation interactions, the relative proportion of euthanasia's for our face to face teams has gradually reduced as we have been able to deliver additional face to face interactions through focusing on efficiency of that element of the service (but still remains higher than pre-COVID levels)

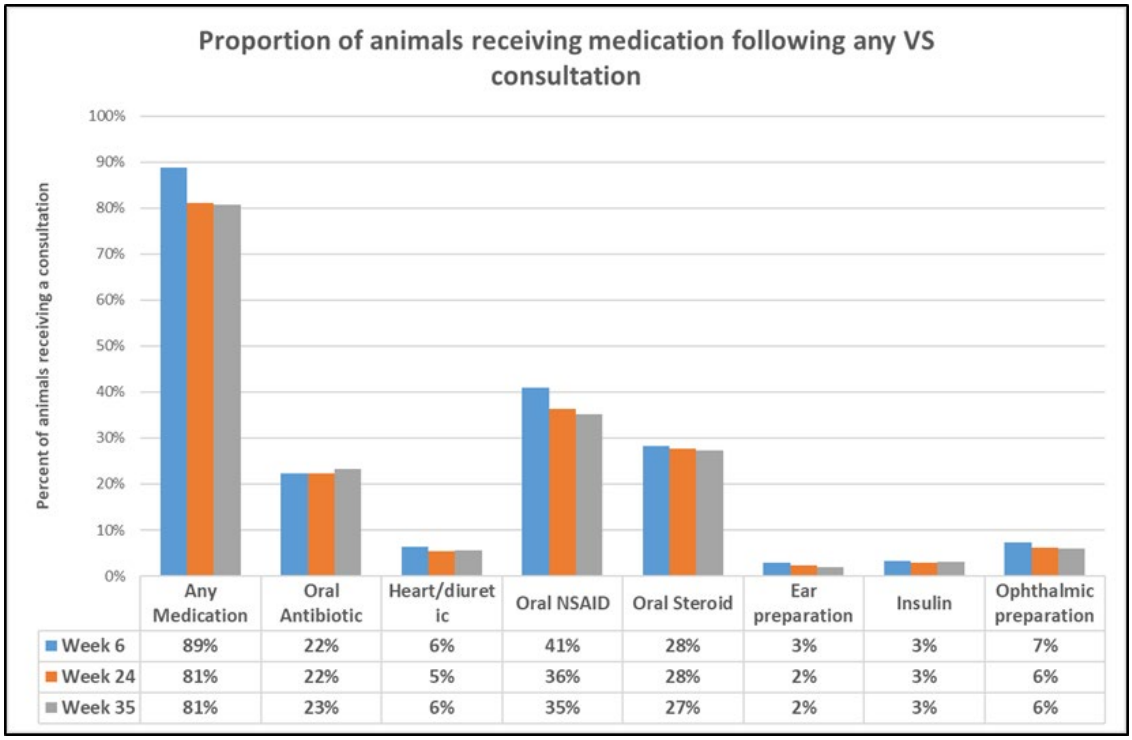


Emergency procedures have continued to be delivered at approximately the same rates as pre COVID, case selection in the remote environment has allowed the volume of essential surgeries to be gradually increased in line with resource availability at Pet Hospital level.



Prescribing behaviours

In the previous update, data was shared relating to the monitoring that takes place to ensure that overall prescribing behaviours have not changed as a result of the introduction of remote prescribing. The chart below incorporates both remote and face to face prescribing and shows week 24 (13 weeks post lockdown) and week 35 (24 weeks post lockdown) as representative comparisons to week 6 of 2020, which was a typical pre-lockdown week almost entirely consisting of Face to face prescribing.



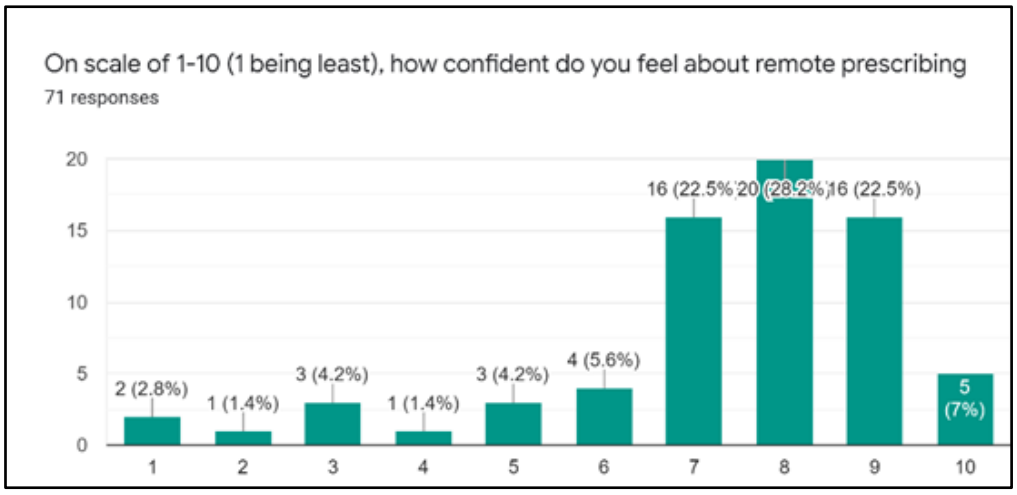
	Any Medication	Oral Antibiotic	Heart/diuretic	Oral NSAID	Oral Steroid	Ear preparation	Insulin	Ophthalmic preparation
Week 6	89%	22%	6%	41%	28%	3%	3%	7%
Week 24	81%	22%	5%	36%	28%	2%	3%	6%
Week 35	81%	23%	6%	35%	27%	2%	3%	6%

Whilst there are some minor variances it does not appear that any of the categories have moved significantly beyond what could be considered week on week variations, and do not suggest any concerning trends. This would suggest that, six months into a service heavily biased towards remote prescribing, the prescribing habits of clinicians have still changed very little.

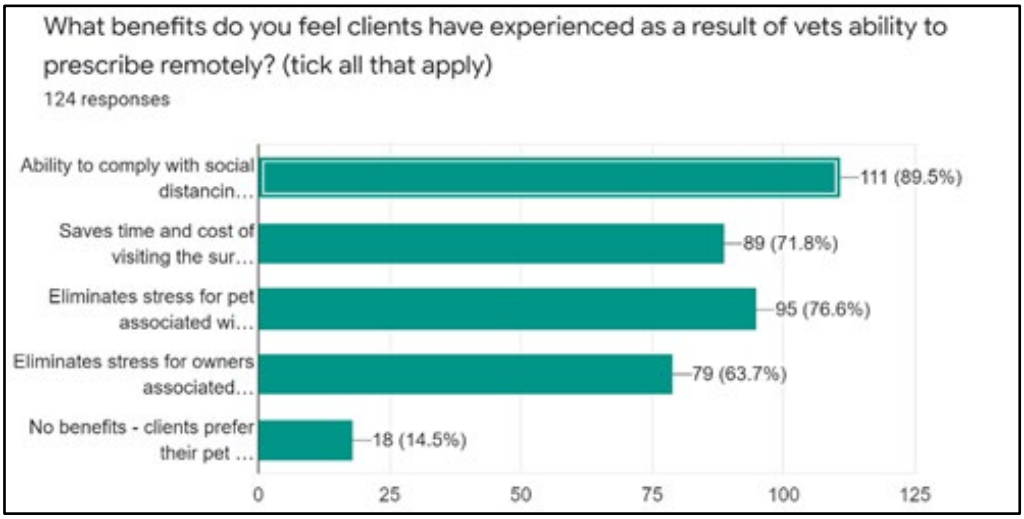
Adverse events
A clinical incident report has been run comparing reported clinical incidents during COVID 2020 with the same period in 2019. The results showed 68 prescribing/dispensing errors in 2019, for the same period in 2020 this has reduced to 42 (hopefully reflecting some of the focus PDSA has had in this area following analysis of clinical incidents in 2019), of these there were 17 incidents reported from 23 Mar – 21st Aug.
The vast majority of these were actually dispensing errors rather than prescribing errors – only 2 were identified as being as a result of incorrect doses being prescribed, one of which was prescribed by an Out of Hours provider. This demonstrates that the move to largely remote prescribing at PDSA has not increased the volume or risk of incidents of prescribing errors.

Clinician perspective
In the previous update the results of a small scale VS/VN survey were shared, a larger scale survey of 124 of our vets and nurses has been performed during August, which now reflects the perceptions of the clinicians following an extended period of remote consulting. The key findings relating to remote prescribing are as follows:

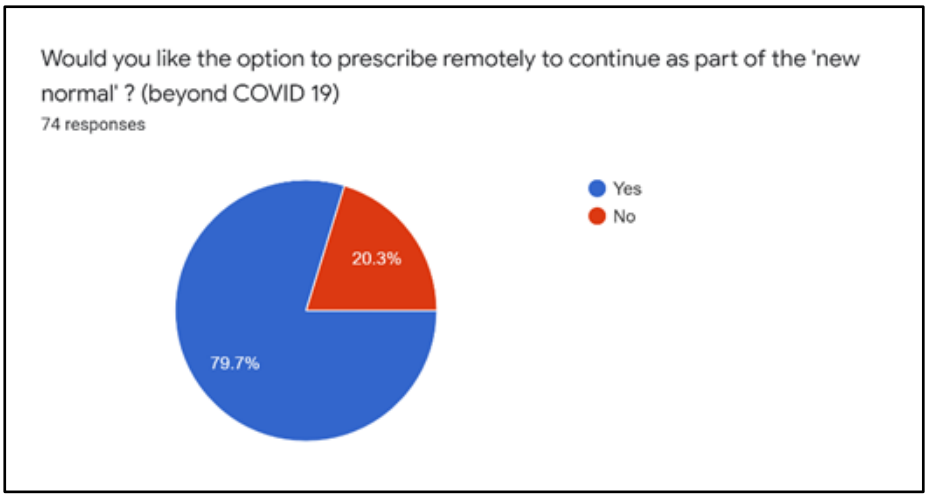
a. When asked on a scale of 1-10 (1 being least), how confident do you feel about remote prescribing - 80% scored in the upper quartile.



b. When asked around perceived benefits to clients around remote prescribing there were a variety of responses – perhaps most obvious, the ability to comply with social distancing saw a majority benefit, around **90%**, generally our teams felt there were additional benefits to clients and their pets both financial and stress related in not having to attend the surgery in person.
Of the 12 vets and 6 nurses that responded with 'no benefits to clients' 11 (7 vets & 4 nurses) also then selected one or more other benefits from the list.
Only 7 (5.6%) respondents (5 vets & 2 nurses) indicated they felt no benefits to clients at all by selecting just that answer.



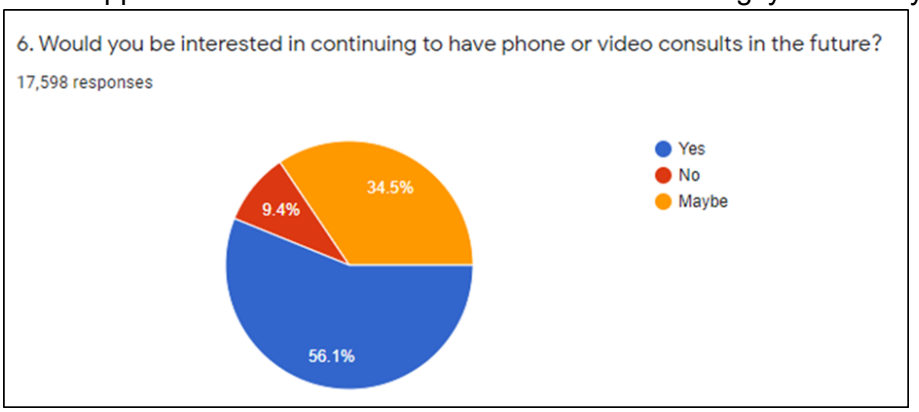
c. The clinicians were asked whether they would like the option to prescribe remotely as part of the new normal i.e. beyond the impact of COVID, nearly 80% of them indicated that they would.



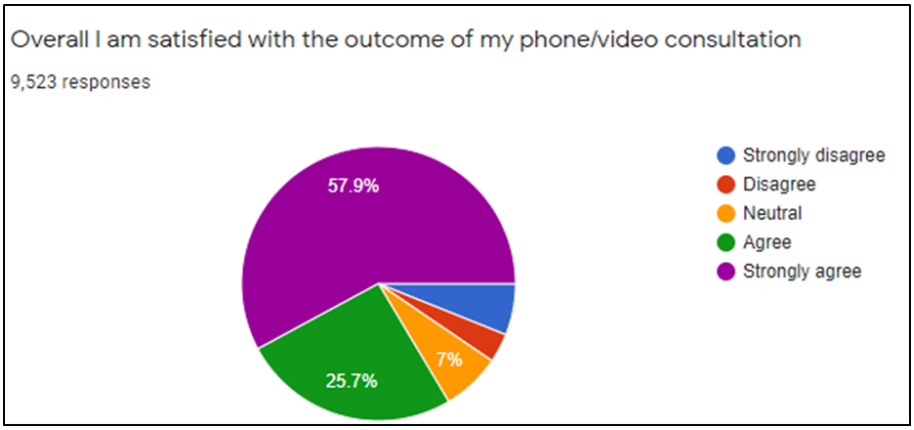
Client perspective

Our previous update contained the relevant results of our ongoing client survey which were based upon 5923 responses at the time, of which 92% of clients had answered 'yes' or 'maybe' to being interested in continuing having phone or video consults available in the future.

We have now received 17,598 responses to the same question and there appears to be little change in clients' appetite for the remote service with 91% answering 'yes' or 'maybe':



This is also reflected in the question relating to client satisfaction with the remote consultation they had received, with 90.6% indicating that they were neutral or agreed with the following statement:

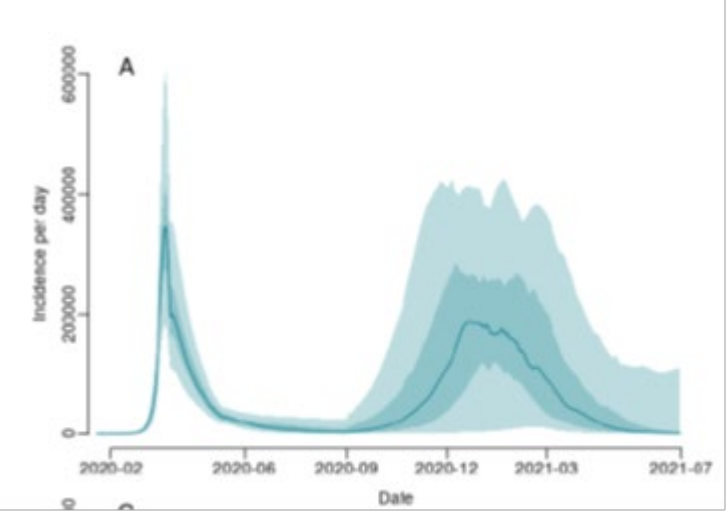


Appendix 1 – PDSA interpretation of the Academy of Medical Sciences publication: 'Preparing for a challenging winter 2020/2021' (https://acmedsci.ac.uk/file-download/51353957)

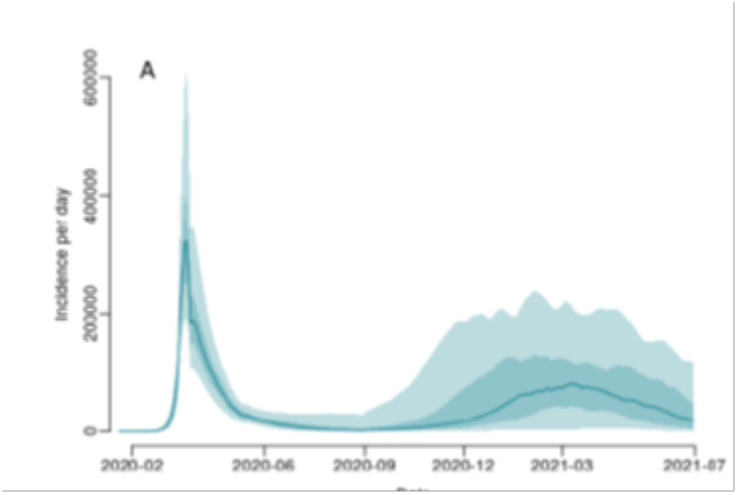
On 14 July 2020 ICL published their latest report containing forecast for the progression of the Pandemic within the UK.
PDSA has modelled financial projections based on the March report published by ICL which forecast a resurgent wave in winter.

Infection modelling
The forecasts are based upon the ability of the UK to control any rises in the Rt or effective reproduction rate (the number of new infections each infected person causes with mitigation measures in place).

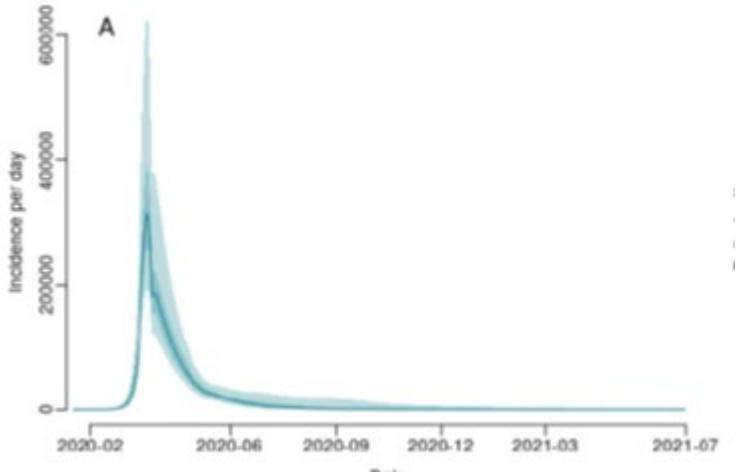
The three modelled scenarios are:



The reasonable worst-case scenario for the winter COVID-19 epidemic in the UK. The model assumes that Rt rises to 1.7 from September 2020 through to July 2021. The graph shows daily infections, in all graphs the solid line shows the median, dark band the interquartile range, and pale band the 95% credible interval (CrI).



This model assumes that Rt = 1.5 from September 2020 through to July 2021, the graph shows daily infections.



This model assumes that Rt = 1.1 from September 2020 through to July 2021.

Interpretation
Whilst the lower graph may look hopeful, it should be read in the context that it assumes the Rt is kept at or below 1.1 which may be a significant challenge in the face of autumn/winter natural rises which are likely and expected (as seen in countries in the southern hemisphere recently), therefore the government may need to make significant socially disruptive interventions similar to those experienced in the initial wave on a national or regional basis, in order to keep the Rt to this level.
The other graphs both suggest that the pandemic impact may last until July 2021.

Recommendation
Whether PDSA is impacted through measures put in place to maintain the R rate at a level that will prevent a resurgent wave (as illustrated in model 3) or measures to mitigate the impact of a realised resurgent wave (as illustrated in models1 & 2); PDSA should assume that socially disruptive measures will be required in all scenarios to control infection rates throughout the autumn and winter period.

PDSA Head Office
Whitechapel way
Priorslee
Telford
TF2 9PQ
02.10.2020

Dear RCVS Council members,

PDSA has submitted two updates (July and September) covering our experiences of remote consulting and prescribing during the period where permission has been granted to remotely prescribe without having physically examined the animal.

In the July update PDSA suggested that any veterinary surgeon who wishes to remotely prescribe should be able to demonstrate:

1. A framework for case succession – this would create the conditions in which responsibility for the patient is real
2. A means of contact for further advice if it should be required
3. Supply of veterinary products in a responsible, safe and legal manner
4. All necessary safety information
5. The means to attend to that patient in the event of an adverse reaction or unexpected deterioration within a reasonable time period, at a geographically appropriate registered practice which complies with the core requirements of the PSS.

Principles that applied to all PDSA remote consulting and prescribing at that time, and still do apply now.

Our immediate focus and concern, however, remains in the short term position and the impact that removal of the right to remotely prescribe could have upon the charities ongoing ability to provide a service to those pet owners already registered for care, and furnish the increase in demand for our services that we fully expect to materialise over the coming months.

In our September paper we stated the following:
“The ability to prescribe medication during remote consulting remains a critical element during the post-lockdown period; there is no question that the decision by RCVS to initially allow remote prescribing, and subsequently extend that permission, has had a major impact on our ability to provide continued care for our clients and helped to safeguard our teams.”

I would like to briefly expand upon that point to illustrate the impact that a removal of that option would have upon our services.

Our veterinary surgeons are, at present, delivering over 10,500 remote vet consults per week and are ensuring that those cases in need of face to face care are receiving it, this is resulting in 4200 on-site vet consultations per week. We know, as outlined in our July paper that approximately 40-45% of remote consultations are resulting in a remote prescription, of which of which about 50% of animals have had the same medication previously.

If the ability to remotely prescribe were removed whilst COVID secure working were still in place it would move approximately 4800 interactions per week from the remote environment, which would need to be delivered as additional on-site consultations; we would be in a position of asking sites to deliver more than double the number of on-site consultations than they currently are able to. Even if we were able to continue doing repeat medication prescriptions remotely, that would still drive an additional 2,400 on-site consults per week (a 57% increase) through our sites.

The requirements of COVID secure working, which are likely to continue for a considerable time, mean that there are physical limits to the number of people we can have in our building at any one time, and that the flow of movement of our teams, clients and patients is significantly slowed compared to pre-COVID times. In anticipation that the winter period would make keeping clients outside the building unsustainable (especially given a large proportion of our clients do not have cars to sit in) we have worked hard to get to a point where the vast majority of our sites are now letting clients into our buildings.

Whilst this has made our patient journey more efficient and has created some stability for our teams, the fact remains that as a result of physical distancing our capacity has been dramatically reduced. A site that formerly had six consulting rooms is now only safely able to operate three at any one time, consultations that used to take 15 minutes now take 30 minutes. Our teams are working to the maximum of their ability at the moment to provide care to as many patients as they are able.

As we have already structured our service to deliver the appropriate cases at the optimum level to match our ability to provide on-site consultations, within the COVID secure guidelines, the diversion of these volumes from remote consulting is likely to be a physical impossibility.

So we will be left with very few and difficult choices with regards how we could deliver the charitable service going forward:

1. Where we are able to safely open additional consult rooms (which is a limited number of sites) but are not able to accommodate more bodies within the building, we could consider diverting resource from surgery. However, the reduced number of procedures we would be able to deliver, which are already focused on emergency and essential procedures, could result in increased need to refer to private veterinary surgeries or increased euthanasia levels.
2. We may have to reconsider the numbers of clients we can ethically continue to have registered as charitable clients, where we are in a position of not being able to offer the degree of services that we want to deliver, or that the clients would expect. Often leaving those pet owners and vets in extremely difficult and challenging circumstances from a pet welfare and mental wellbeing perspective.
3. A limit or reduction in client numbers would include an impact on our ability to accept the currently frequent referrals of financially constrained clients from private practice,
4. We would almost certainly have to enforce a reversion back to a basic emergency only service and undo all of the great work our teams have done over the past few months and leave many clients and staff dissatisfied.
5. We would not be in a position to provide additional services to those people who have found themselves newly out of work and claiming benefits, our charitable services would

be forced to contract at the very time they will be most needed. We forecast that for every 1 million additional Universal Credit claimants we will see an increase in demand representing approximately 50,000 additional pets.

In summary, the removal of the ability to remotely prescribe appropriately at this time without having physically examined the patient, would be a major set-back for PDSA, our teams, our clients and could have a major impact on private veterinary surgeons and the practices they work in. PDSA would urge RCVS Council to continue to permit this important service element whilst COVID restrictions remain in place.

If I can be of any further assistance or you require any further clarifications please do not hesitate to contact me.

Yours sincerely

Steven Howard, BVMS MRCVS
Head of Clinical Services, PDSA

Veterinary Client Mediation Service

VCMS – Working together

Q3 Report 2019-20

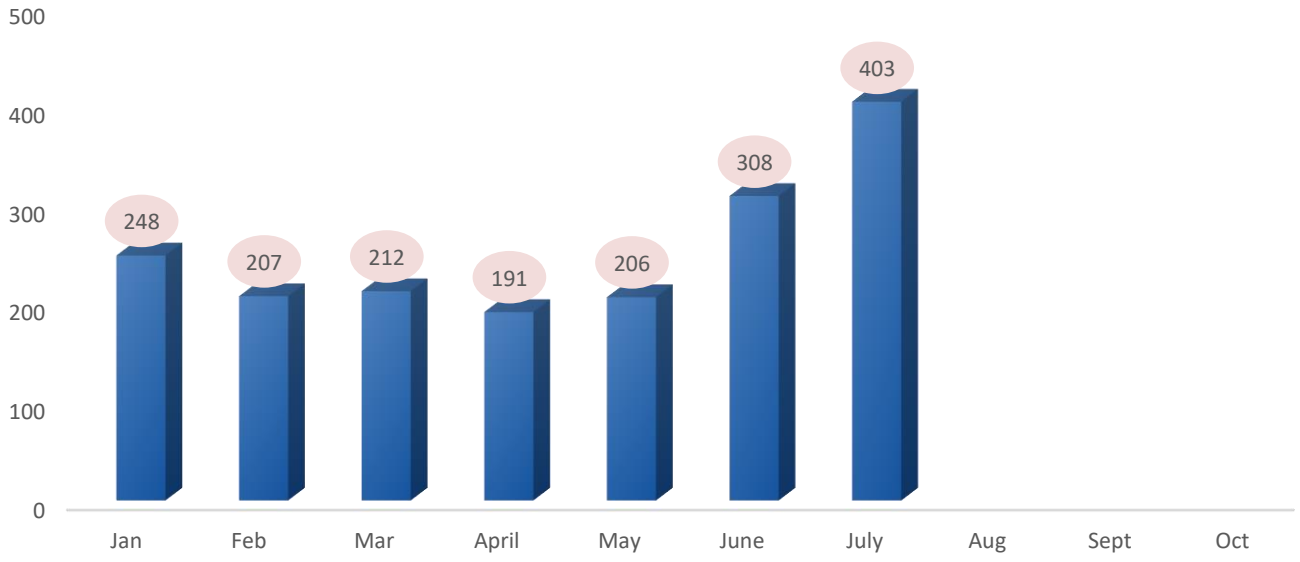
Contents

This quarterly review is provided for internal use by the RCVS.

1: Activity Summary

1. Volumes

Fig 1. Enquiries received - per month (2019-2020)



Following the lockdown restrictions imposed on 23 March 2020, interactions between animal owners and practices were drastically reduced as practices delivered only emergency veterinary care. As guidance evolved during April, interactions started to increase, and incoming referrals to the VCMS reflected this.

In June and July 2020, the VCMS then received a marked increase in referrals, (+51% compared to June 2019, and +92% compared to July 2019). The COVID19 pandemic and restrictions placed all practices in an unprecedent situation. This is also in the context of wider society challenges and pressures posed by a global public health crisis and financial impact of the lockdown restrictions.

Fig. 2 Comparison enquiry volumes by month

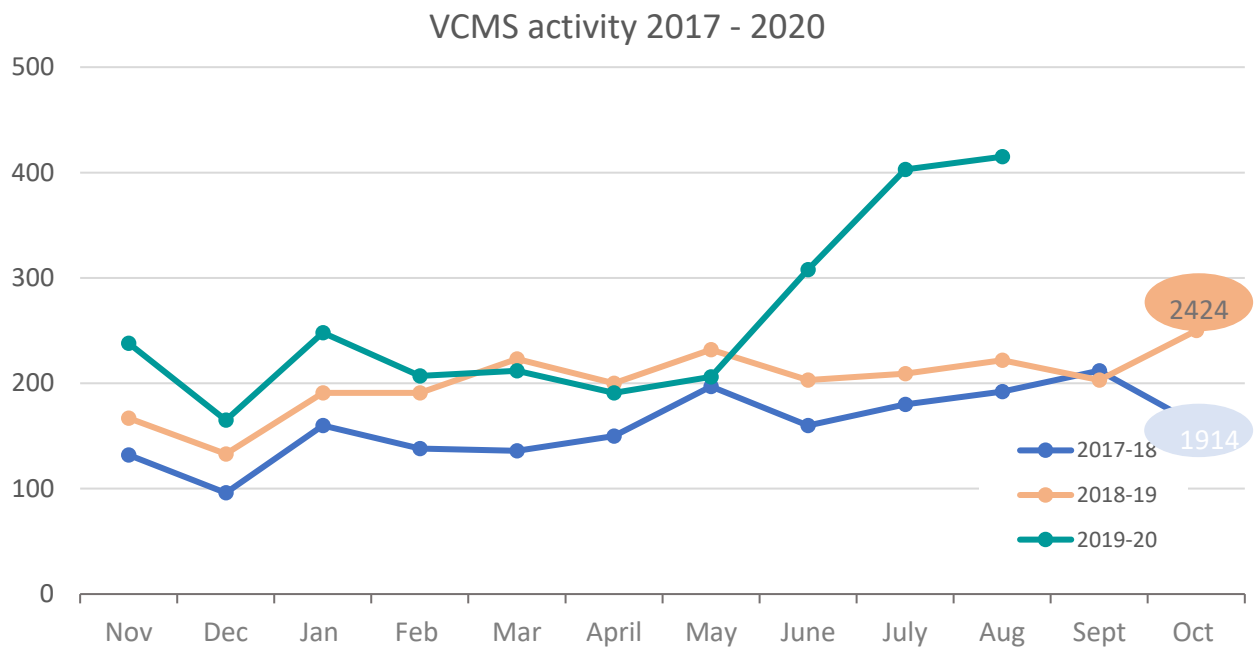
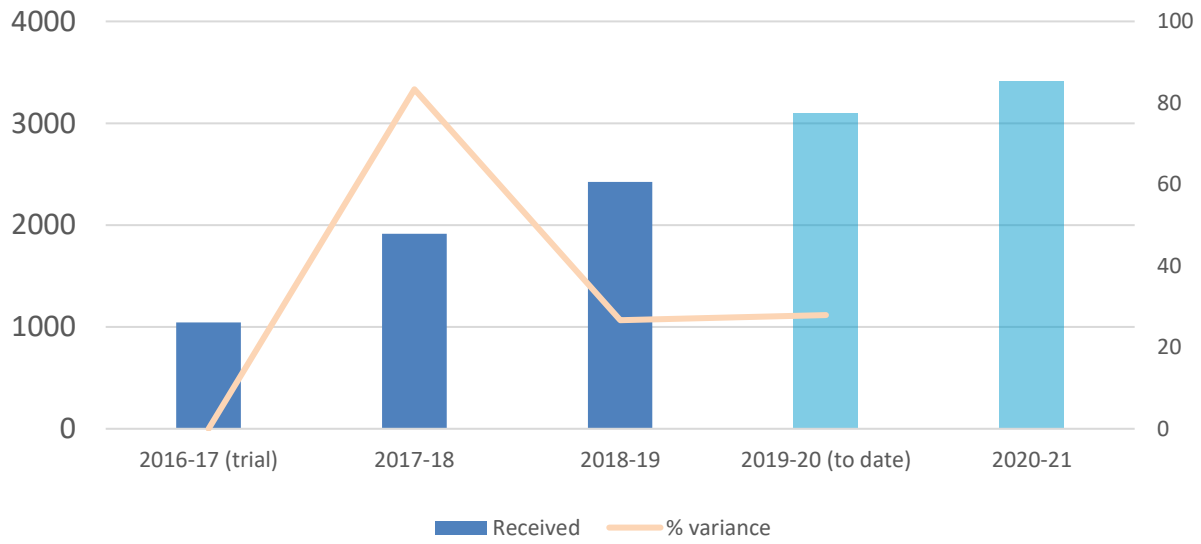


Fig. 3 Annual activity comparison and revised forecast

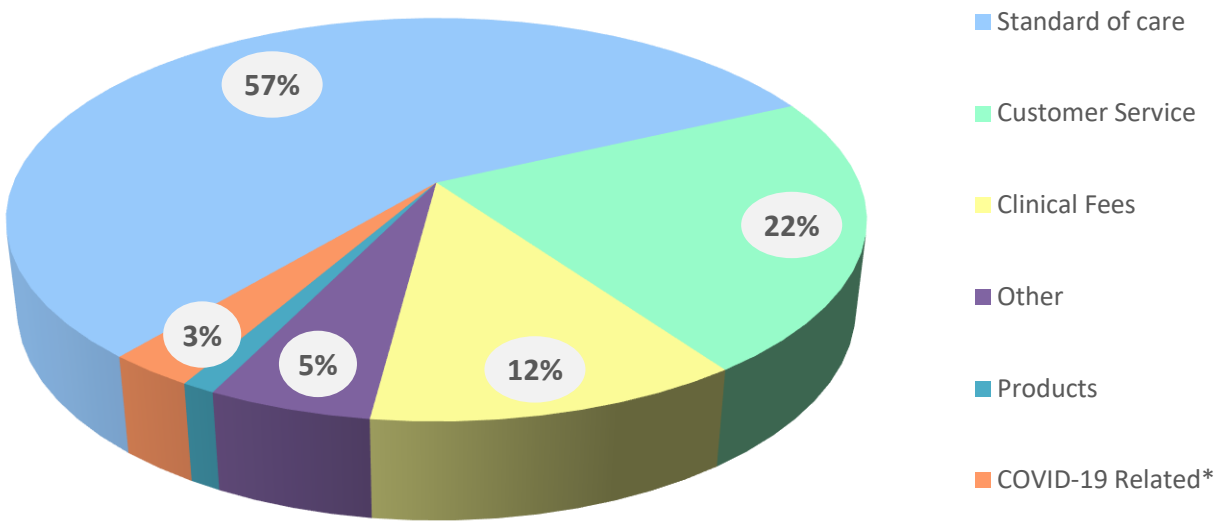


Forecast update

Following the increase in activity during June and July, the annual referral forecast has been revised. Activity levels remain high in August, and based on average monthly referrals, the VCMS forecasts a 25-30% increase compared to 2018-19. An increase less than 10% was forecast (2,500 in 2019-20). The total annual referral figure is likely to be in the region of 3,000 at year end, if the current situation remains stable.

2. Nature of complaints remaining largely static.

Fig 4. Complaints - nature (% 19-20 year to 31 July 2020)



The VCMS has included a "COVID19" category within data capture since 1 March 2020. Complaints involving p ure COVID issues remain low (3%), however the early analysis suggests that the impact of COVID19 is a contributing factor in complaints. This contribution takes the form of earlier escalation, less opportunity to resolve matters contemporaneously and communication challenges due to COVIDSecure restrictions.

The VCMS will undertake full analysis at the end of Q4, but current indications suggest that COVID19 may contribute and exacerbate complaints in the following areas:

- Remote Consultations – which must be seen in the context of the increase in remote consults during COVID.
- Client expectations particularly around services/care previously provided within plans or as part of wider consultations.
- Communication and client disputes around emergency care assessments
- Medication cost comparison
- Euthanasia when client presence is 'remote' due to COVID restrictions.

This provides an anecdotal overview for internal insight only and more detailed analysis will follow.

Fig 5 Species (2019-20)

3. Outcomes

Fig 6 Outcomes of in-remit referrals to the VCMS 2019-20 to date

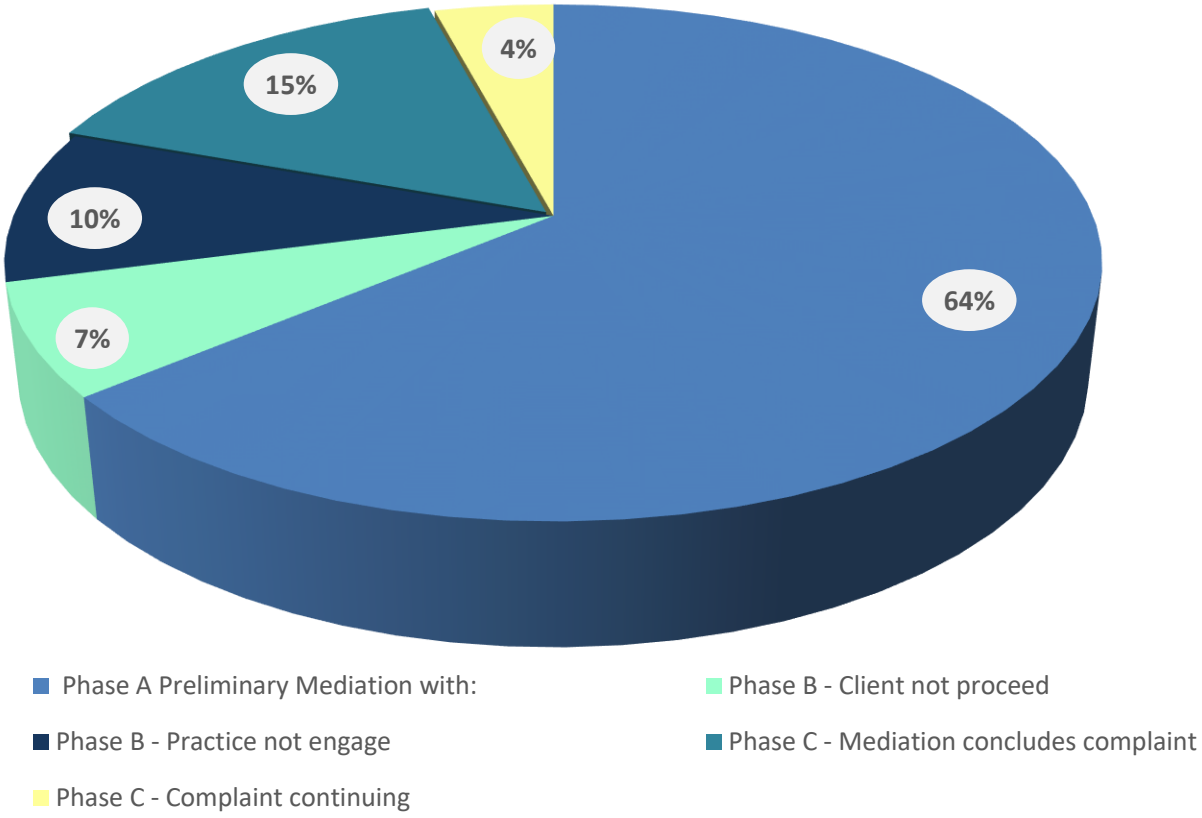


Fig 7. Mediation outcomes (YTD)

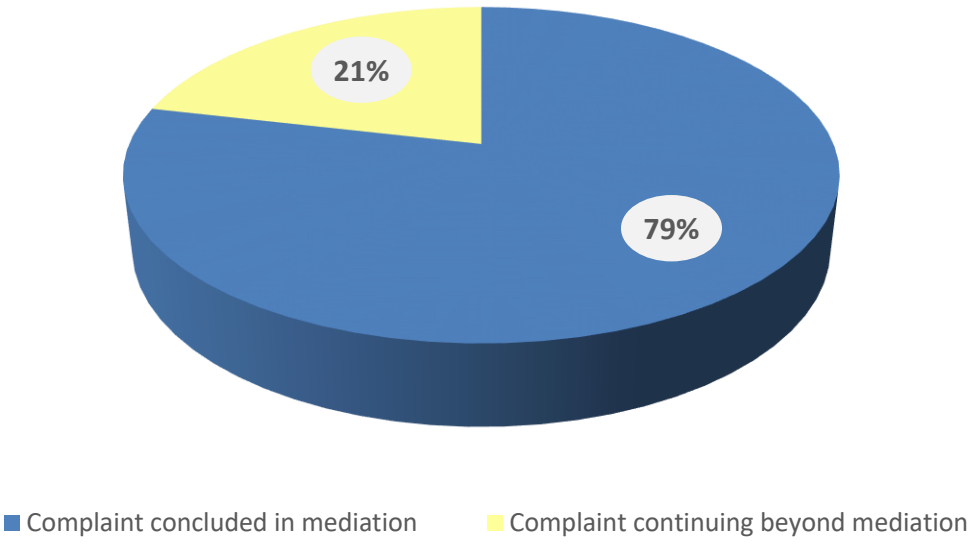
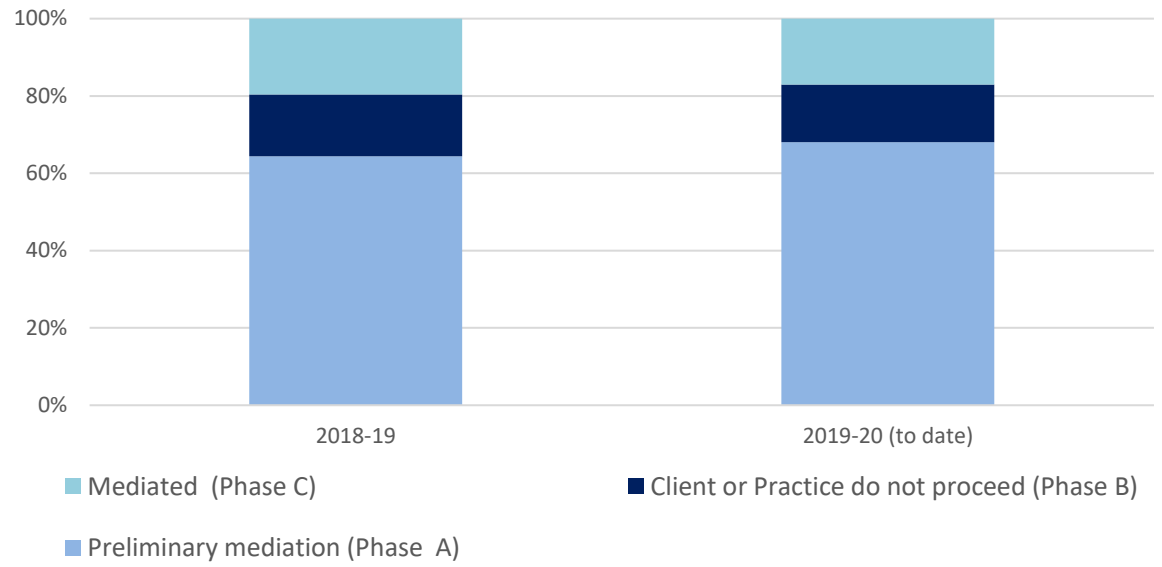


Fig 8. Outcome (Phase A/Phase B/Phase C) - YoY In remit



During Q3, the increase in activity resulted in an increase at all three stages of the process. On average 72% of complaint referrals were managed within Phase A Preliminary Mediation, and where necessary referred back to the practice for local resolution. Initial analysis indicates clients sought independent assistance at an earlier stage, or the capacity to respond to and resolve complaints locally was impacted by restrictions in the practice such as the availability of staff and all communication taking place remotely. The VCMS has focused blogs and information literature on areas where there seems to be an increase in complaint activity. The objective is to provide resources and information so parties can obtain input without direct contact with the VCMS.

When considering the reasons for the increased activity, we must be cautious in drawing any inferences from this 6 month time frame, and given the unique circumstances in which both practices and owners are functioning. In certain complaint areas, the increase will correlate with the increase in activity in that area of practice (such as remote prescribing).

In other areas:

- adapting to new team structures,
- adjustment to different operating practices for both the practice team and animal owners,
- difficult financial circumstances,
- general anxiety felt in the general population

appear to be contributing to an increase in complaint referrals.

Encouragingly, data shows practice engagement has continued to increase during this quarter, with only 9% of referrals concluding their interaction with the VCMS through a practice declining the invitation to mediate. The VCMS mediation team have flexed and adjusted timescales and approaches to facilitate practice input. This has been agreed with the veterinary client, and has allowed mediations to continue and progress during lockdown and the transition phase up to 31 July 2020.

Within mediation, resolution rates have remained steady and the year to date resolution rate remains steady at 79%. Achieving resolutions in Q3 has required more intensive mediation and creative solutions. The VCMS team will monitor this and continue to evaluate approaches and methods to maintain these rates. In the current climate, financial resolutions are more challenging as both veterinary clients and practices face economic and commercial pressures.

4. RCVS Referrals

As a direct access service, the VCMS must triage referrals to ensure they fall within remit and to identify any potential allegations of serious professional misconduct.

During this quarter, 6 referrals to the RCVS have been made following interaction with the VCMS team.

The RCVS have referred 96 complaints to the VCMS for mediation (accounting for 11% of all enquiries), and 47 have self-referred having visited the RCVS website.

5. Remit

Complaints triaged and falling outside VCMS remit Year to date:	
Referral to RCVS	26
Circumstances over 12 months old	14
Commercial animal/relationship with practice	8
Complainant is not the animal owner or appointed representative.	13
Non UK	8
Other reasons (examples include):	37
Insurance company dispute	
Complaint relates to information disclosed by an animal shelter	
Already been addressed through legal process	
	106

6. The Impact of the VCMS

Closed - outcomes		Nov - April	% (all)
	Outside remit	74	4
	Inside remit		
Phase A	**Preliminary Mediation with:**		
	referral back to Practice for local resolution	635	39
	advice – concluded	361	22
Phase B	**Local resolution exhausted – does not progress to mediation**		
	Client takes no further action following interaction	109	7
	Client not progressing seeking alternative forum	9	>1%
	Practice declines to engage	149	9
Phase C	**Mediation – resolution manager assigned**		
	Concluded as a result of mediation	239	15
	Mediation concluded – complaint continuing	65	3
	Total - conclusions (as at quarter end)	1649	

Summary of outcomes Q2	% all	% in remit	2018-19 % in remit
Out of remit	5 (-1%)	-	
Preliminary mediation	60 (+3%)	63	64
Client not to pursue – no further action	7 (-)	7	7
Client or Practice decline to mediation	10 (-1%)	10	13
Concluded as a result of mediation	15 (-2%)	16	16
Complain t continuing beyond mediation	4 (+1%)	4	3

7. Feedback

Response rates have fallen again Q3. This was anticipated as service users are focused elsewhere with other priorities. The VCMS team will continue to review response rates and seek to capture feedback through alternative mediums if necessary.

Feedback results remain consistent with Q2 report 'Year to Date'

The service has obtained feedback from professional bodies as stakeholders and the voice of the profession to ensure the service continues to evolve and meet the changing needs of clients and the profession at this time. They continue to report the positive impact of the service, and particularly, how an impartial and independent, non-judgmental approach benefits both animal owners and practices.

2: Objectives 2018-19

Achieved	Good Progress	Work in Progress	Not Yet Actioned

2019-2020 Proposed objective (to be confirmed):

1. Share insight and analysis from 2018-19.
2. Deliver proportionate and effective complaint mediation within 60-day timeframe.
3. Encourage engagement with the VCMS mediation process by practices.
4. Continue to engage with stakeholders and the professions.
5. Maintain trust and confidence in the RCVS→VCMS referral of SPM cases.
6. Continue to improve practice engagement at as wider level as is appropriate.
7. Share the insight into client complaints gained by the VCMS with veterinary professionals at a grass roots level, and to prioritise the promotion of insight sharing to generate practitioner discussions and best practice sharing. This will assist in improving efficiency of consumer communication and management of expectations.
8. Deepen constructive and productive working relationships with Major Employer groups & stakeholders– feedback meetings, complaint engagement and insight.
9. Support practices and individual veterinary professionals to further develop effective local complaint handling processes and skills to increase local resolution
10. Provide ongoing guidance to dissatisfied veterinary clients to support the raising of complaints with the practice in a constructive way to facilitate local resolution
11. Consider how the VCMS can support Quality Improvement within the Veterinary sector, to support reflective intelligence led practice and learning culture
12. Improve feedback response rates to ensure VCMS effectiveness can be quantified and monitored.

3: Insight

Insight sharing during Q3 (1 May – 31 July 2020)

Planned activity in this area has been revised and adapted given the current priorities across the profession, and restrictions in place. Remote activity has been effective and Q4 presents further opportunities to engage with stakeholders.

RCVS	Stakeholders
• Final presentation of the VCMS 2019 Annual Report; • Profile raising planning and insight sharing protocols discussed with the RCVS Comms team; • Internal planning for insight sharing within the RCVS; • Attendance at RCVS and BVA COVID19 webinars.	• Reaching out to representative bodies to share insights and feedback from our case load; • Ongoing dialogue with stakeholders to provide reassurance regarding VCMS activity during COVID lockdown, and highlight access to VCMS for complaints, particularly to Independent practices. This was discussed in detail during the following 1-1 meeting; • 1-1 meetings with BSAVA, SPVS and BVA to discuss role of VCMS, practice engagement and response to COVID19;
The Professions	**Major Employers**
• Media activity - editorial publications and journal discussions to implement planned activity for summer and autumn 2020 (when appropriate given the challenges and pressured posed by COVID); • Social media activity, following engagement with the RCVS Comms team;	• VCMS update meetings with Major Employers and Stakeholders • Strategic update meetings with Clinical and Practice Standards leads in the major employers; • Confirming attendance at Sept MEG Meeting.

4: Conclusion

The last three months have seen a significant increase in activty, and from engagement with the Profession, we understand this reflects the current challenges presented in practice at a local level This is not unique to t

he veterinary profession, and an increase in complaints is reported in human healthcare and other regulated sectors. The post lockdown transition has required agility and individual practice COVIDSecure risk assessment led changes. The VCMS has worked to share insight to suppport practices to foresee and manage potenitally escalating situations, which they can reinvest into their plans and approaches. The service will continue to do so in real time.

It is reassuring that practice engagement has improved during this period, and while resolutions require more intensive mediation, resolution rates have remained consistent. As such, the service has been able to assist more animal owners and practices to resolve complaints proportionately, which is increasinly important in the current crisis situation.

For further details contact:

Jennie Jones, Head of VCMS

t: 01279 712580

e:jenniejones@vetmediation. co.uk

Working Copy for a Press Release in an advertorial style for driving awareness for telemedicine and delivery options VetPost

New research shows the changes in our industry plus new, emerging ways of working and behaviours

Covid-19 has most definitely had an impact on the delivery of veterinary service, especially companion animal in the UK, so how are we going to adapt. Independent market research being conducted by CM Research is tracking how things are changing for veterinarians and what are the new challenges appearing. Since the 24th of March veterinary services have adapted to lockdown measures, updating ways of working to keep their clients and staff protected as best they could.

Veterinary Associations the RCVS and BVA have worked to create new guidelines and procedures for seeing and handling veterinary cases. Practices diverted their priorities and staff to delivery of essential consultations supporting the livestock sector and to carefully triage emergency cases for companion animal. Corporates veterinary practices have moved towards more of a “hub and spoke” model for treatment, seeing the temporary closure of so many practices and focus vital treatments in fewer locations. Independent practices are also working their way through similar challenges and having to make tough decisions around staffing levels. Overall this has created a depletion in the availability of the work force by around 70%.

Independent research of 208 UK veterinary practice owners, partners of small, large, independent and corporate practices reported the following:

As of the April 22nd (the last data point), the UK remains the market reporting the biggest reduction impact on footfall and revenue compared to seven other markets.

Focus on the UK

- 81% of the veterinary profession are “extremely-” to “quite concerned” about the risks posed by outbreak on their practice and business.
- Practice level responses
- 92% of respondents are asking pet owners to call the practice to assess the need to coming in
- 81% respondents reported seeing emergency-only cases in the practice
- 91% feel that the UK leads the way in telemedicine consultation
- 93% are asking clients to wait outside while a staff member brings the pet inside the practice

Effect on pet owners at the peak and post-peak outbreak

- 64% reduction in clients visiting
- 63% reduction in appointments being offered to clients
- 71% stocking up on medications
- Increase in on-line/delivered medicine solutions

Staffing at the peak of the outbreak

- 70% decrease in staff availability

Due to the changes on restrictions of living with COVID-19, impact on staff and continued risk factors for all, many practices have adopted new procedures for seeing and handling their cases.

As well as keeping safe social distancing, the use of telemedicine services in the UK shows the industry is working hard to create the opportunity to reduce risks for everyone by ensuring cases being handled via phone-consultation, either verbally or via video and that only the right cases are coming in to the practice for treatment.

With risk still in our communities and staff to needing to best use of their time and limited resources, it seems obvious that some new ways of working are going to stay and be needed for a while to come yet.

An Ipsos MORI survey showed 71% of Britons were nervous about leaving their homes even as businesses reopen and travel resumes. Gideon Skinner, head of political research at Ipsos MORI said: “Our latest polling across 14 countries show that Britons are the most cautious when it comes to reopening the economy, being the least keen for businesses to reopen if the Coronavirus is not contained. Furthermore, seven in ten Britons say that they will be nervous about leaving the house after the lockdown eases. These suggest that the turnaround in the economy might not be quite so fast as hoped for.”

The ability to provide remote consultations, sharing vital care notes to owners and remote bill-payment is a core part of how we emerge from COVID-19. For this reason, Zoetis’ partnership with *Video with My Vet* and *Vet-AI* with their JOII platform could provide that helping hand to create solutions for you now and for the future.

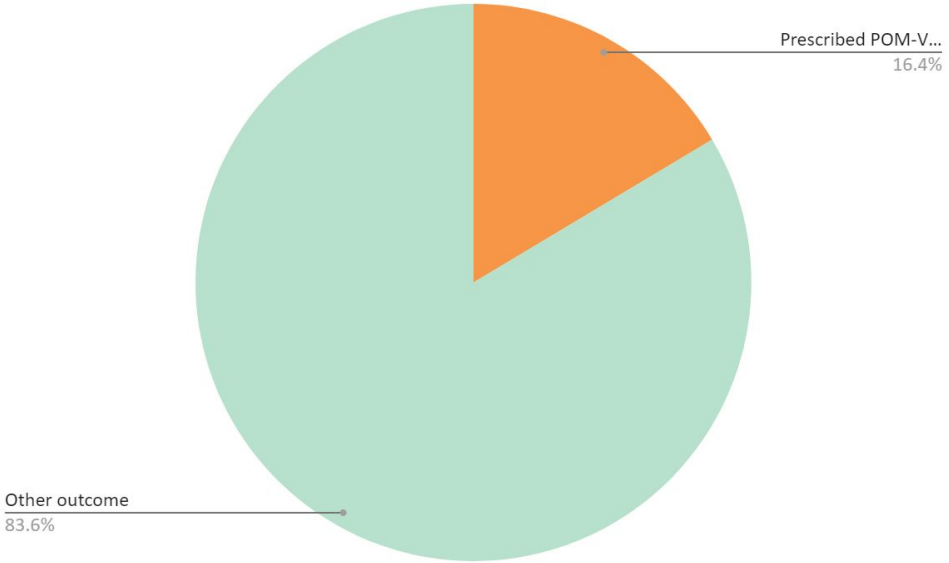
Joii - Remote Prescribing

What We've Learned So Far

Proportion of consultations resulting in prescription

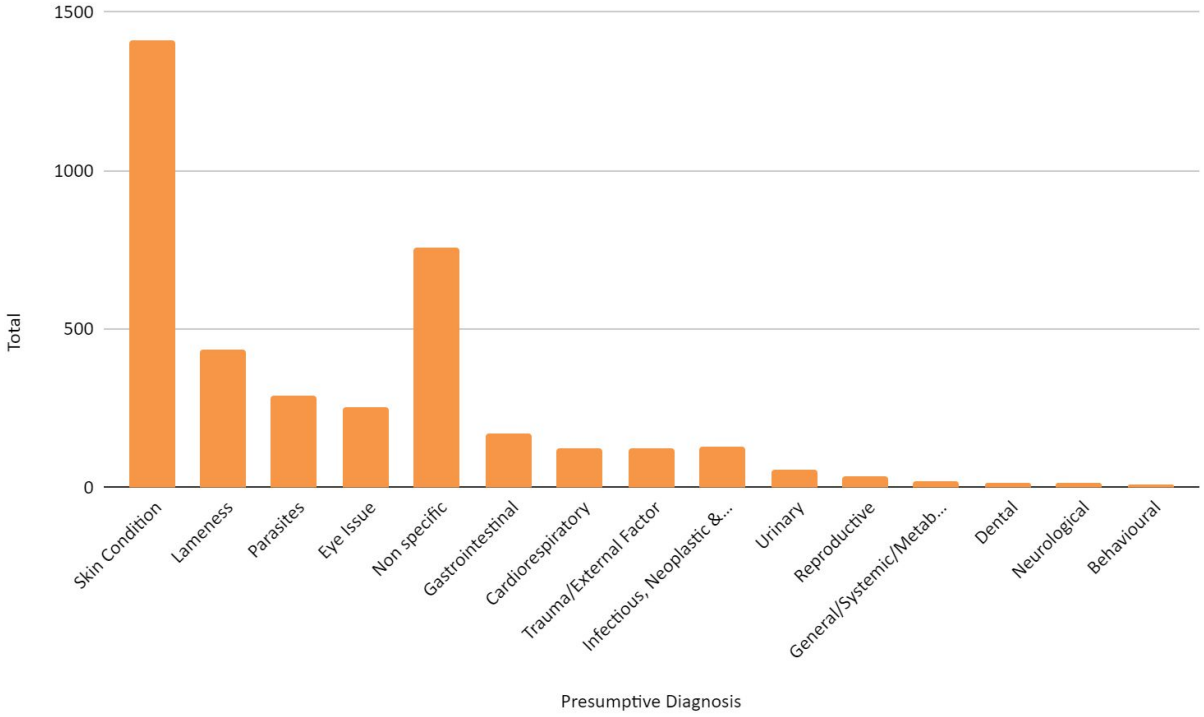
From 2nd April ‘20 until 1st October ‘20:

- Joii Pet Care undertook 17990 video vet consultations
- 3673 prescription medications were dispensed over 2955 consultations
- Less than 1 in 6 cases seen have been prescribed any prescription medication.



What are we treating?

Consultations Resulting in POM-V Medications



Accompanying Notes:
Slide 4

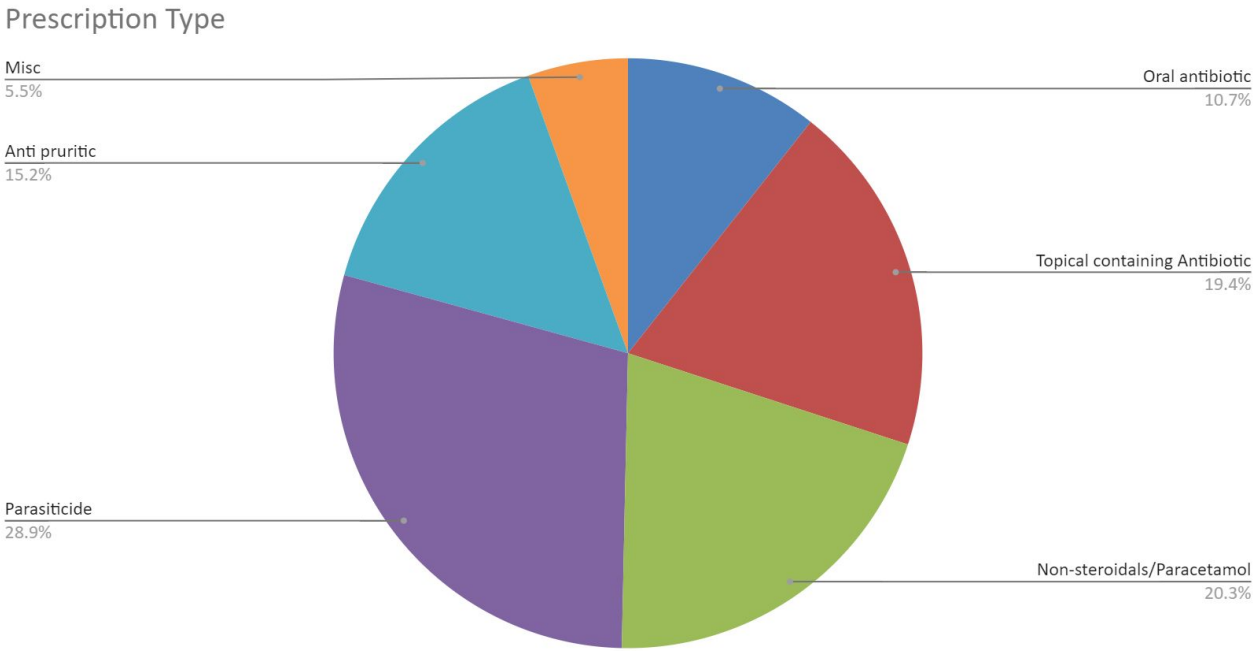
1. *”Non-specific data” in the histogram mostly constitutes incoming cases that:
- have presented without any specific presenting problem for the purposes of obtaining parasite control. These cases were preventative measures taken by the owner.
- or were follow-up appointments for cases in which the diagnosis was issued in previous consultations

A more detailed multivariate analysis is available on request.

2. The top 5 condition categories constitute 82% of consultations, and are all low-risk condition categories (skin, lameness, parasites, non-specific, eyes).

3. Of the categories containing potentially high-risk illnesses, a majority of conditions treated were low-risk

Medications classes being dispensed



Antibiotic Usage

Over-use of antimicrobial treatment is one of the main concerns raised as a potential issue of remote prescribing. We have a strict antibiotic usage policy in place and our vets prescribe responsibly in nearly all cases treating with first line antibiotics. All dispensed medications are overseen directly by a senior vet.

Topical Antibiotic Therapy	Oral Antibiotic Therapy
632 cases	346 cases

27% of overall prescribing contains an antibiotic

Only 11% of overall prescribing consists of oral antibiotics

Oral antibiotics only prescribed in 2% of overall veterinary consultations

Antibiotic Usage

Accompanying Notes:

1. Of all consultations conducted under the care of Joii vets from April 2020 - Oct 2020, only 2% resulted in the prescription of an oral antibiotic.

Outcomes

1928 clients have either had repeat consultations or have followed up via email

Response rate of 52%

Complete Resolution	1052
Expected response to treatment	627
Partial resolution - referred to clinic	126
No response to treatment	97
Adverse Event	26

Outcomes

Accompanying Notes:

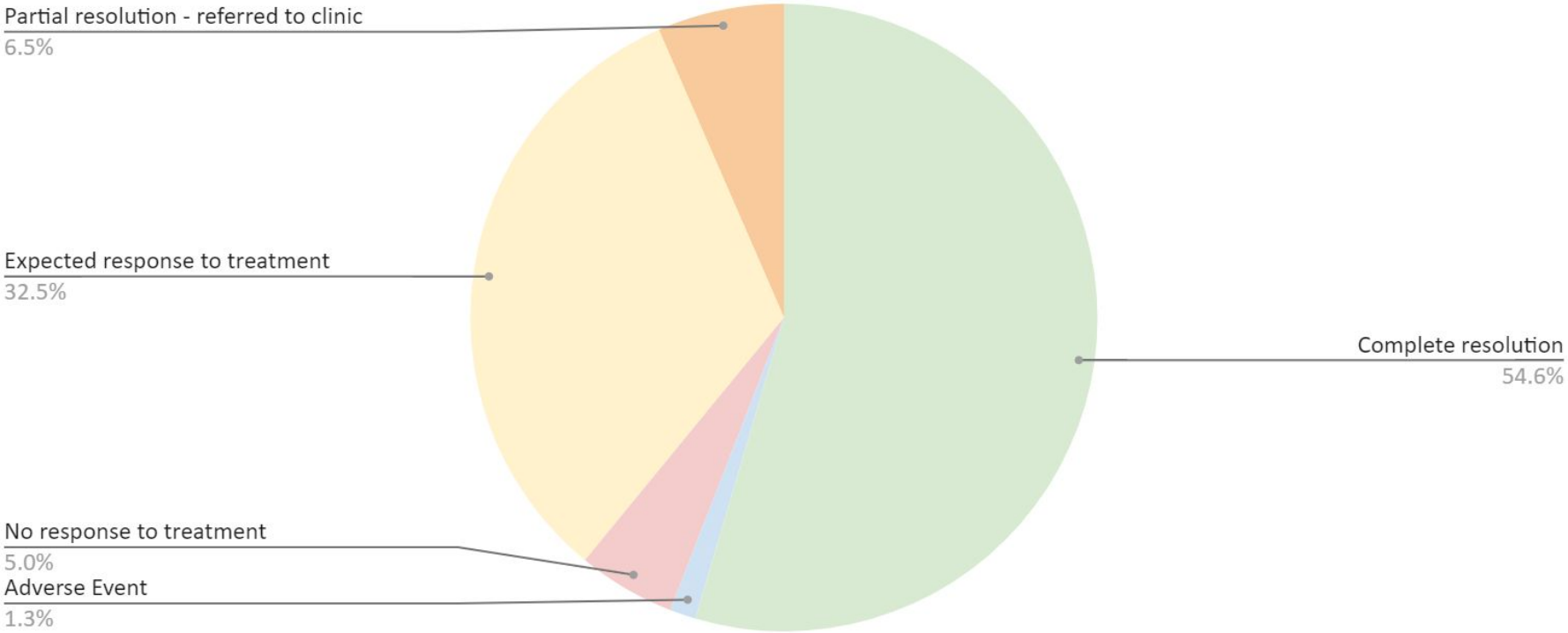
1. Only 1.3% of all repeat consultations ended in an adverse event (26 of 1928)

2. Expected response to treatment are cases where complete resolution is not expected and are primarily chronic conditions, such as allergic skin disease or osteoarthritis.

3. “Partial resolution - referred to clinic“ refers to cases directed to practices for further investigation, or for injectable treatments.

4. 87% of cases had a successful outcome as determined from the clinical outcome and owner satisfaction.

Outcome


Partial resolution - referred to clinic
6.5%
Expected response to treatment
32.5%
No response to treatment
5.0%
Adverse Event
1.3%
Complete resolution
54.6%

Accompanying Notes:
Outcomes slide

1. All owners who did not seek a follow-up appointment were contacted by email within 3 - 5 weeks

Adverse Reactions

Approximately 1% of all cases receiving prescription medication had a possible adverse reaction reported, all of which were mild.

Medication Type	Number of Adverse Reactions
NSAID	10
Parasiticide	8
Antipruritic	4
Antibiotic	2
Other	2

All adverse reactions are recorded, reported and followed up on to ensure symptoms resolve

In all cases of adverse events:

- Medication was used appropriately
- Medication was given at the correct dose
- A physical exam would have been unlikely to change the outcome

Our response:

- Thorough monitoring and follow up for all of these patients
- Company policy implemented on the use of specific medications likely to trigger adverse reactions

Closing Remarks

We keep detailed and comprehensive data on all patients. More detailed anonymised data is available on request.

We welcome independent scrutiny or audit of our data collection and subsequent analysis for further validation.

BVA
British Veterinary Association

From the President

10 September 2020

Dear Mandisa

Remote prescribing guidance

I'm writing regarding the decision taken in August by the RCVS Covid-19 Taskforce to further extend the College's temporary guidance that allows veterinary surgeons to prescribe POM-Vs remotely without first having physically examined the animal.

We recognise and accept that the original decision, taken in March, was a pragmatic solution in direct response to government restrictions relating to Covid-19. The decision in June to extend the guidance seemed to be based on a number of compelling factors including the ongoing need for some staff and clients to shield, and the potential impact of test and trace on the ability of veterinary practices to continue operating.

Since then, with increased relaxation of government restrictions, and with solutions to the matter of track and trace having been found, we would like to better understand the College's rationale for further extending remote prescribing. Even under local lockdowns veterinary practices have not returned to providing emergency services only and we cannot currently see any reason why a new client would be unable to access in person veterinary care in the first instance. At the time the decision was taken there was a commitment to publishing the headline results from a survey of practice experience of remote consulting on which the Taskforce based its conclusion. Please could you indicate a timeframe for the publication of those results?

We consider that the matter of remote prescribing should form part of the RCVS review of 'under care' and would appreciate assurance that this is still your intention, and that the current extension of the guidance is still considered to be a temporary measure.

Kind regards

Daniella Dos Santos
President

British Veterinary Association
Patron: Her Majesty The Queen

7 Mansfield Street, London W1G 9NQ

T 020 7636 6541 E bvahq@bva.co.uk
W www.bva.co.uk

4. Can I prescribe POM-V medicines via remote means without a physical examination? (29/09/20)

Under normal circumstances, this is not permitted by the *RCVS Code of Professional Conduct*; however, during the pandemic, RCVS Council has agreed a temporary departure from this position.

More recently, RCVS Council has decided to further extend the temporary remote prescribing guidance until 31 October 2020. It will review this position at its meeting on 8 October 2020, to allow practices time to make appropriate arrangements should anything change.

In recent months, animal owners have been more able to take their animals to practices, thereby allowing vets to establish the normal under-care relationship by physically examining the animal. However, Council recognises that the current situation is unpredictable and that physical examinations may not be possible in the face of certain circumstances (such as national/local lockdowns, quarantine arrangements, shielding by practice staff/clients etc), meaning access to remote prescribing would be necessary.

Consequently, in line with the **flowchart** referred to in FAQ 2, you should consider whether you already have the animal under your care (as explained in Chapter 4, paras 4.9-4.11) or, if not, whether it is possible to carry out a physical examination to bring the animal under your care. If the answer to both questions is 'no', you **may prescribe POM-V medicines via remote means**, providing you adhere to the following guidelines.

You must first be satisfied that:

- you have enough information to remotely prescribe POM-Vs safely without physically examining the animal,
- there is no suitable alternative medicine, categorised as a POM-VPS, NFA-VPS, or AVM-GSL, and
- the benefit to the animal and/or public health outweighs the risk.

If you are satisfied regarding the above, you should then consider:

- whether immediate action is necessary in the interests of animal welfare,
- whether treatment can be delayed until a physical examination is possible,
- whether it is possible to examine the animal without having contact with the owner and, if so, whether it would assist,
- the nature of the medication,

- the appropriate quantity, taking into account factors such as the length of time until a physical examination of the animal will be possible and the length of time until the owner will be able to access medication by other means,
- the risks and benefits to the animal, and
- the client's view and understanding of the risks.

You should also ensure that:

- any consent given by the client is fully informed,
- you make detailed notes of your decision and the reasons for it, and
- you can justify any decision that you make.

In cases where POM-V medicines are prescribed remotely, you should ensure that either you are in a position to examine the animal yourself, or, that another veterinary surgeon can examine it if its condition deteriorates to the point where remote support is inadequate. You should also provide the owner with all of the information they need to administer the medicine safely and ensure they have a means to contact you (or a colleague) in the event they have any questions or problems.

Approaching cases in this way is aimed at limiting the number of instances where animal owners need to leave their homes to access veterinary care, which is in the wider interest of maintaining public health.

When prescribing remotely, you should follow the *BSAVA Guide to the Use of Veterinary Medicines*, which contains useful information in relation to emailing prescriptions and posting veterinary medicines. See also the Royal Mail's guidance on posting prescription medication.

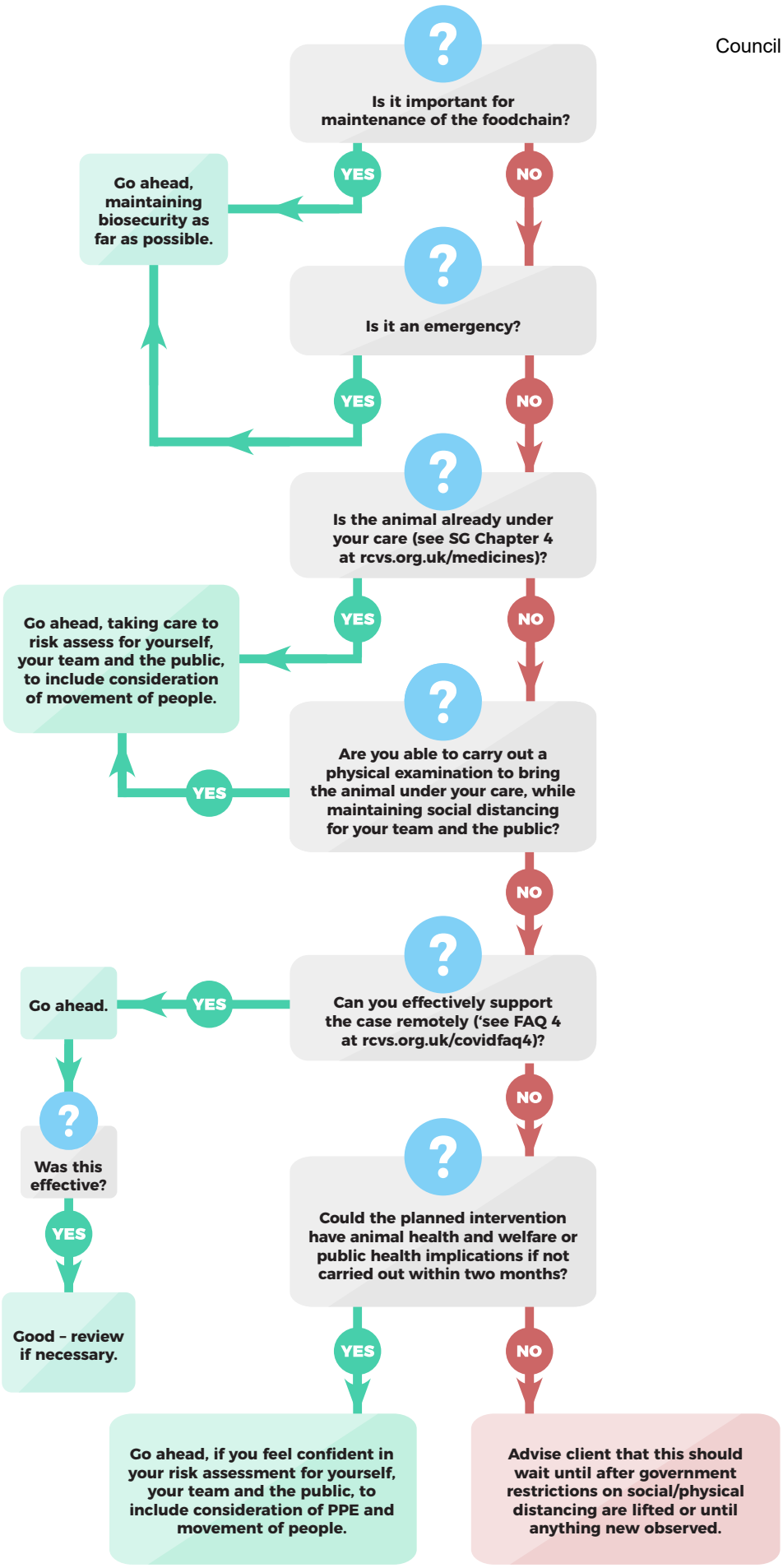
NB If you are approached by members of the public who are not existing clients of your practice, where possible you should in the first instance direct them to the practice where they are registered. Our current supporting guidance on 'Communication between professional colleagues' may be useful.

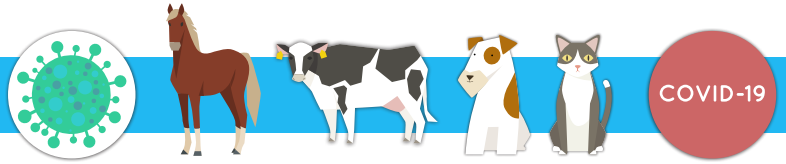
Contact the Advice Team: advice@rcvs.org.uk or 020 7202 0789

Last updated: 29 September 2020

Guidance for clinical practices during COVID-19: 'Can I do it?'

Council Oct 20 AI 06b An G (ii)





Notice of Motion: re: Council Oct 20 AI 06b (ref 6.2 on Boardpacks) – Remote Prescribing

Proposer: Dr J M Dyer
Seconder: Dr N C Smith (primary)
Dr D S Chambers, Mr M L Peaty and Dr R S Stephenson (additional)

"Council congratulates and thanks the Covid 19 task-force for making quick decisions in a rapidly-changing situation. They have made an invaluable contribution. Emergency measures have allowed vets to prescribe prescription-only medications remotely, both to animals already under their care, and to new clients/animals where circumstances dictate. Council believes that it is vital not to undermine or pre-empt the review of Under Care and out of hours emergency cover.

The PDSA report and the IES survey show that remote prescribing can be a pragmatic solution to the problem of clients and vets having to shield or living in lockdown areas, in order to minimise face-to-face interaction. However, both reports refer to telemedicine and remote prescribing within the context of veterinary practices where a physical examination and further investigation can be carried out if necessary, ie it is being used as a way of minimising physical contact, not eliminating it. This makes sense because animal welfare requires that physical examination will always be necessary in a percentage of consultations in order to make an accurate diagnosis and for the animal to be under the care of the veterinary surgeon or the practice. Not providing this follow-up care when necessary, or arranging for it to be provided, represents an abdication of the responsibility and accountability expected and required by RCVS of its members and the animal owning public."

***Council resolves** to enhance the protection of animal welfare by amending the wording of FAQ4, effective from the 1st Nov 2020, to:*

'Remote prescribing of prescription-only medications (POM-Vs) should only be carried out by veterinary surgeons who can provide a 24/7 follow-up service involving physical examination, plus or minus further investigation, if required; eg in the case where the animal does not improve, or suffers an adverse reaction, or deteriorates, subsequent to the prescription of said medicines. This follow-up service can be provided personally by the veterinary surgeon or practice, or by written agreement with a veterinary services provider which is local to the client (as with the current situation for 24 / 7 care provision)."

***Council further resolves** that:*

"This derogation from the requirement to conduct a physical examination before an animal is regarded as 'Under Care' to be reviewed as a standing agenda item of each Council meeting until the provisions of RCVS Guidance Section 4 "Veterinary Medicines" have been fully restored."

Summary

Meeting	Council
Date	8 October 2020
Title	The future of the Covid-19 Taskforce
Summary	This paper outlines a recommendation from the Officer Team for the future of the Covid-19 Taskforce.
Decisions required	Council is asked to agree the following recommendations from the Officer Team: 1. The continuation of the Taskforce until 31 March 2021, with the same terms of reference (with one amend, as indicated) and composition as now 2. To review at the 18 March 2021 Council meeting, taking into consideration the stage of the pandemic and government guidance in force at the time, and if the Taskforce is no longer required, to revert to decision-making processes via the Delegation Scheme that Council agreed at its June 2020 meeting 3. That the Taskforce could be re-mounted, following agreement by Council, at a later date if circumstances change
Attachments	Annex A – current composition and Terms of Reference for the Covid-19 Taskforce
Author	Lizzie Lockett CEO l.lockett@rcvs.org.uk 0207 202 0725

Classifications

Document	**Classification**[1]	**Rationales**[2]
Paper	Unclassified	n/a

The future of the Covid-19 Taskforce

Background

1. Towards the start of the global Covid-19 pandemic the Officer Team identified the need to set up an agile Covid-19 Taskforce to facilitate rapid decision-making on temporary policy changes in relation to the pandemic. There was also a need for a joined-up approach to such policy changes across the organisation as there were likely to be many interlinking factors. This came on the back of two decisions being made by full Council via email – around extra-mural studies and remote prescribing – where the decision-making process had taken time.

2. The plan to set up the Taskforce was emailed to Council on 23 March and a call was made for a lay and a veterinary Council member to volunteer to join. Eight veterinary and three lay volunteers stepped forward and one of each was subsequently chosen by the Officer Team. The composition and Terms of Reference are attached at **Annex A**.

3. The Taskforce first met on 30 March 2020. The setting up of such a group mirrored similar structures in other organisations at the time, in fact we were criticised by some for taking too long to take the step.

4. Initially the Taskforce, which meets remotely, convened twice a week, this fell to once a week and, latterly, fortnightly. It does not meet if there is no business to conduct.

5. Business for the Taskforce is raised via the Officer Team and Senior Team, and also the Taskforce itself has an horizon-scanning role. Other committees and working parties also send papers to the Taskforce (for example, VN Council, the Practice Standards Group and CPD Working Party) and, equally, the Taskforce will request additional follow up work from other bodies within the College where there is particular expertise, for example, a small group of Education Committee members was asked to review virtual abattoir resources. In the case of a change to the way veterinary fees were collected, the Taskforce reverted the decision to full Council as it was perceived to be a substantial risk – this was in line with the published Terms of Reference.

6. Since its inception, the Taskforce has made approximately 30 decisions, including the following (NB some of these have been reviewed several times during the period):

   I. Opted to extend vet school accreditations by 12 months
   II. Suspended OSCEs in the early stages of the pandemic and supported the Veterinary Nurses Council setting up a Taskforce to develop alternative student VN assessments
   III. Suspended Student VN clinical placements
   IV. Moved overseas and UK registrations online; allowed flexibility around registration in terms of whether the new UK graduate had secured a job
   V. Recommended to RCVS Council that veterinary retention fees were phased – 50%, 25%, 25% - which was subsequently approved by Council (see Terms of Reference for why this was flagged to Council)
   VI. Postponed the Statutory Membership Examination

VII. Approved a temporary change to the way in which Council voted for the Junior Vice-President, in light of the need for a virtual election
VIII. Approved online arrangements for our AGM and Awards
IX. Offered a full refund for Statutory Membership Examination candidates if their plans changed; for those who still wished to sit the exam
X. Approved Statutory Membership Examination candidates showing evidence of their English language competency up to a year after passing the exam (previously this had to be done before sitting the exam) and allowed an online option for the English test, which met our standards
XI. Extended the period during which Advanced Practitioners could complete their key skills for revalidation by three months
XII. Ran four Surveys on the Economic Impact of Covid-19 on Veterinary Practice, to help inform policy-making
XIII. Allowed remote registration for overseas veterinary nurses
XIV. Initially suspended Practice Standards Scheme (PSS) assessments; more recently approved virtual assessments; put PSS Awards on hold for a period of one year; delayed the roll out of new standards
XV. Ran a survey to understand the experience of clinicians in relation to remote consulting, to help inform future temporary policy in this area, as well as feed into our wider review of under care
XVI. Developed an approach to review vet schools' temporary assessment options, with a new working party scrutinising these
XVII. On an ongoing basis reviewed our flowchart and FAQ to support clinicians' decisions around what work they could do
XVIII. Agreed a 25% reduction in requirement for vets' and VNs' CPD (reviewed again three months on, but not changed)
XIX. Extended, free of charge, the enrolment period of a group of student veterinary nurses who were unable to take their OSCEs
XX. Approved proposals from the VN Council for a new patient-based assessment to replace OSCEs
XXI. Kept Council's initial remote prescribing temporary guidance under regular review
XXII. Approved a reduction in the requirement for pre-clinical extra-mural studies (EMS) from 12 to six weeks, with online resources supplementing learning gaps
XXIII. Approved a temporary amendment to the accreditation standard that requires core clinical teaching only to be carried out in practices that are approved under the RCVS Practice Standards Scheme, because assessments were at that point on hold and are now picking up again virtually but with delays
XXIV. Approved a temporary amendment to the requirement for students to have in-person experience in an abattoir, because this was not allowed under current rules, with use being made of virtual environments instead
XXV. Approved a temporary amendment to EMS requirements for third-year students, to use online resources to contribute to up to eight weeks of their 26-week clinical EMS requirement
XXVI. Agreed that the retention-fee window for veterinary nurses be extend by a month, so fees will fall due on 31 January 2021 instead of 31 December 2020

XXVII. Suspended, on a temporary basis, requirements for student veterinary nurses allowing them to register if they have met their Day-One Skills even if the full requirement for 1,800 practice hours had not been met

XXVIII. Confirmed to the veterinary schools that if graduation of the 2021 cohort is delayed because rotations are interrupted due to quarantine/lockdown, the RCVS will register holders of relevant qualifications at a time of these choosing rather than as 'batch' registrations

XXIX. Agreed to a trial of PDF certificates of registration as hard copy certificates cannot currently be issued

XXX. Decided that Council and Committees will continue to meet remotely until at least November

7. The existence of the Taskforce has been praised by key stakeholders and also our Audit and Risk Committee.

8. As can be seen by the range of decisions made, had ad hoc meetings had to be set up by all of the groups appropriate according to the Delegation Scheme, this would have meant a huge range of different meetings, which could have been time consuming and expensive.

9. Council has been kept up to date on decisions by the Taskforce by email and also in the public session of Council meetings. The vast majority of decisions have also been press released – the exceptions being those that only affect a small number of people, such as Statutory Membership Examination candidates, who were contacted directly. In addition, RCVS Connect emails have been sent out regularly to the professions during the pandemic, highlighting key guidance changes, and there have been a huge number of meetings and other communications with key stakeholder groups for both professions.

Current position

10. At its September meeting, Council opted to review the ongoing continuation of the Taskforce at the October meeting, as it was now meeting less frequently and it was felt that the number of decisions being made was slowing down. It was mooted that business should be handled by Council in full, although this would be against the currently agreed Delegation Scheme for routine business.

Proposal

11. The members of the Taskforce are willing to continue on the group and feel that the ability to make decisions quickly, often in response to stakeholder needs, remains important, and maintains trust in the College's handling of the pandemic. The Taskforce feels that the pandemic is 'far from over', something that has been backed up by recent strengthening of control measures by the government and ongoing local lockdowns.

12. The importance of speedy and clear decision making was highlighted in the most recent RCVS Survey on the Economic Impact of Covid-19 on Veterinary Practice, with some asking for advice in an even more timely way than is possible currently. Furthermore when we have had to mount a short-notice Council meeting for other purposes more recently this has received criticism from some Council members who are, not unreasonably, keen for their need to prioritise their day-jobs to be respected.

13. The issue that precipitated the motion regarding the future of the Taskforce was remote prescribing, which is well known to have been a contentious issue for several years. The Officer Team feels that care should be taken not to disband a useful structure for the sake of one issue, which will be a difficult one to handle regardless of the governance structure in place.

14. It is therefore proposed that the Taskforce is maintained for a further six months, the time-horizon that the government is currently considering for the next major review of Covid measures. At that point its future should be reviewed again, within the context of government guidance at that time (for example, taking account of the R number, the stage of the pandemic, local lockdowns, restrictions on travel, etc).

15. If at that point Council feels the Taskforce is no longer needed, decisions should revert to the committee, working group or other structure best placed to make them, according the agreed Delegation Scheme.

16. It is recommended that the same Terms of Reference (ToR) and composition for the Taskforce are maintained throughout this period, with the small exception that the ToR currently state that the group will meet ‘at least weekly’. It is proposed that this be changed to ‘as often as required’.

17. Finally, it is recommended that the provision for an emergency Taskforce be maintained so it can be remounted at short notice if necessary, at request of the Officer Team, with Council’s approval.

Decision required

18. In summary, Council is asked to agree the following recommendations from the Officer Team:

    a. The continuation of the Taskforce until 31 March 2021, with the same terms of reference (with one amend, as indicated at par 16) and composition as now
    b. To review at the 18 March 2021 Council meeting, taking into account the stage of the pandemic and government guidance at this point. If it is decided to close the Taskforce, then to revert to decision-making processes via the Delegation Scheme that Council agreed at its June 2020 meeting
    c. That the Taskforce can be re-mounted, following agreement by Council, at a later date if circumstances change

Annex A - Terms of Reference and composition of Covid-19 Taskforce

Membership

Voting members

- Dr Niall Connell MRCVS - Senior Vice-President
- Prof David Argyle FRCVS - Junior Vice-President & Chair, Advancement of the Professions Committee
- Linda Belton MRCVS - Council Member
- Prof Derek Bray - Council Member
- Prof Susan Dawson FRCVS - Council Member
- Dr Melissa Donald MRCVS - Chair, Standards Committee
- Dr Mandisa Green MRCVS - RCVS President (Chair)
- Dr Sue Paterson FRCVS - Chair, Education Committee
- Mr Matthew Rendle RVN - Chair, Veterinary Nurses Council

Non-voting members

- Lizzie Lockett - Chief Executive
- Eleanor Ferguson - Registrar
- Corrie McCann - Director of Operations

Terms of reference

The Taskforce was established on a temporary basis on 26 March 2020 in order to speed up decision making in a very fast-moving environment where time is of the essence and gaining the views of a large number of individuals is not always possible in a prompt fashion.

Its key function is to make decisions on temporary policy changes that pertain to the Covid-19 pandemic (for example, suspension of EMS, temporary changes to CPD policy, temporary changes to guidance).

Decisions on permanent changes, or those with the potential to have a far-reaching effect on the ability of the RCVS to function (such as fees) are retained by Council.

It also has a role in horizon-scanning issues likely to be affected by Covid-19 and feeding in relevant views from the profession and the public so that we ensure we are aware of matters that are important to them.

Decisions made by this Taskforce are reported to Council for information on a timely basis. Notes from the meetings will be available to Council on request.

Meanwhile some Covid-19 related decisions will continue to be made by senior staff, eg operational, and committees (as per current delegation scheme), while others will be escalated to Council as mentioned above.

It will meet virtually at least once per week, and will also communicate and make decisions by email.

The quorum is five voting members. The Chair has the casting vote, if required, due to even number of voting members.

Notice of Motion: re: Council Oct 20 AI 06c (ref: 6.3 on Boardpacks) – Covid-19 Taskforce

Proposer: Dr N C Smith
Seconder: Dr R S Stephenson (primary)
Dr D S Chambers, Dr J M Dyer and Mr M L Peaty (additional)

Motion re: Continuation of the Taskforce.

To amend the proposed paper (item 6.3) submitted to Council as follows:

> *Council notes with thanks the work of the Covid 19 task force but is mindful that the current pandemic will in all probability continue for many months and potentially years. It considers that returning to normal governance mechanisms established over many years is important to maintain confidence in the RCVS and that emergency measures should not be allowed to become a new normal.*

Resolved

> *Council agrees to the provisions of paper Agenda Item 6.3 (entitled: AI 06c Future of C-19 TF), subject to the following safeguards:*

- *that the continuance of the Covid-19 task force should require an affirmative vote supported by a majority of those present and voting at each regularly scheduled Council meeting;*

- *that the minutes of the task force should be made available within 5 working days of each meeting of the task force, along with any supporting papers for inspection by Council members and published to the fullest extent possible on the RCVS Website;*

- *that decisions of the task force should be submitted for ratification at the next Council meeting should an objection be raised within 5 working days of publication of the minutes by two or more Council members;*

- *any recommendation of the task force amending the normal provisions of the RCVS Code of Conduct or its Supporting Guidance should be agreed by Council before implementation.*

Summary

Meeting	Council
Date	8 October 2020
Title	Council culture – rebuilding trust and mitigating future risk
Summary	This paper outlines a recommendation from the Officer Team on how trust might be rebuilt following several breaches of Council confidentiality, and future risk mitigated
Decisions required	Council is asked to agree to the general direction of travel laid out by this paper, making additional suggestions where appropriate, and task the Officers and Senior Team with developing and implementing a plan
Attachments	None
Author	Lizzie Lockett CEO l.lockett@rcvs.org.uk 0207 202 0725

Classifications

Document	**Classification**[1]	**Rationales**[2]
Paper	Unclassified	n/a

Council culture – rebuilding trust and mitigating future risk

Background

1. Following a series of leaks of confidential information from an unknown Council member(s), and a subsequent investigation that was carried out under the auspices of the Code of Conduct for Council Members complaints process, now is the time to put in place measures to begin to rebuild trust, both within Council, between Council and staff, and between the College and the wider world, and also mitigate against the risk of future breaches of confidentiality. NB the report from the investigation remains confidential so if Council members wish to refer to its contents specifically as part of this discussion, this element will need to take place in confidential session.

2. Although the report from the investigators looking into the issue said that the breaches of confidentiality did not arise because of a lack of understanding about what constituted confidentiality or the need to observe it, it would be an opportune moment to reflect on the current picture and take positive steps to move forward.

3. A series of measures are suggested below, for discussion by Council. Following an understanding of whether this is the direction of travel that Council wishes to take, a more detailed programme will be drawn up and implemented.

Role and purpose of College and Council

4. The following set of measures aim to address issues that were raised by Council members in the September meeting about a need to restate the purpose of the RCVS and of Council members within this, to ensure there was clarity of role and responsibility, and underline the fact that the RCVS is a regulator in the public interest and not a representative body.

    a. **Improved information to Council/VN Council nominees** – right from the start we will ensure that there is greater clarity about the role of the RCVS and Council/VN Council to those aiming to stand for election or applying for appointment. We have run open days in the past but will endeavour to review and improve this information, developing a 'role spec' for potential candidates. This will not be enforceable as the professions will vote for their choice of candidates, but it might help those standing for election to better understand what their role would be should they be successful. It will also help with respect to appraisals (see below).

    b. **Improved induction for new Council/VNC members** – we will work to improve the induction that is provided to new Council members to ensure clarity over the role of the College and Council members, and, for lay members, a broader understanding of the veterinary landscape (this had been requested in feedback from lay members). This would also include specific training on handling confidential documents and data protection (the latter is currently included). In addition to a training session we will improve the materials available to support this on an ongoing basis, possibly via a specific section of the RCVS Academy.

    c. **Refresher training for existing Council/VNC members** – it would be useful to offer some refresher training on the role of Council members with respect to setting and monitoring strategy, the purposes of the delegation scheme, and the operational role of staff. This will be considered for an afternoon session of a forthcoming Council meeting.

Team building and culture

5. Improved clarity can only take us so far, strong relationships provide the resilience we need when times are tough. There exists a need to rebuild trust and positive collegiate spirit within Council, between Council and staff, and between the College and the wider world, for example, stakeholders such as Defra. This has been particularly difficult to maintain during the pandemic, when virtual meetings are more impersonal and there has not been the opportunity for informal conversation and interaction. The following activities aim to address this issue:

    a. **Shared work around our values** – following a positive session in September around unconscious bias (which supported our value on diversity), we will continue to provide opportunities to understand what positive behaviour looks like and how to best achieve this when working together. The very act of learning together can be cohesive.

    b. **Social spaces** – it looks as though we will not be able to return to having in-person meetings for some time, so we will need to use our creativity to develop some social spaces for Council members to share ideas and build relationships in a virtual way.

    c. **Cross-team working** – although relationships between staff and Council members are generally excellent, the leak of confidential information has had an impact on the perception of Council amongst the staff team. We will therefore endeavour to develop opportunities for Council and staff members to work more closely together on projects to re-establish this positive relationship.

    d. **Reaching consensus** – it has been reflected by several members of Council that the leak and behaviour around it has reduced their willingness to speak out and has had a negative impact on their confidence. We already have in our Strategic Plan an objective around investigating new ways of reaching consensus. The traditional Council meeting setting can be quite combative, especially when entrenched views are held over a period of time. We will be talking to other organisations about how consensus can be reached in such cases, without always resorting to votes, which can be divisive.

    e. **Clarity over expectations** – the Code of Conduct for Council Members should be reviewed, with greater clarity over what collective responsibility means, and also the process around handling media enquiries will be strengthened, with training offered where appropriate.

    f. **Council and committee member appraisals** – at present, members of the Audit and Risk Committee and Preliminary Investigation and Disciplinary Committees have an annual appraisal process, to help identify learning points and recognise positive contributions. It is recommended that RCVS and VN Council members, together with RCVS-appointed members of other committees, are reviewed in a similar way on an annual basis.

Risk mitigation

6. The following set of measures accept that, no matter how much work goes into improving culture and training, there may still be risk inherent in how we handle information. There is clearly a happy medium to be reached between 'total lockdown' (eg only having papers in hard copy at in-person meetings) and not learning anything from the situation we have recently been through. The implementation of hard-copy-only measures during the pandemic could be problematic. The following suggestions aim to mitigate the risk in a proportionate way:

    a. **Use of tighter security where it matters:** information is only ever presented to Council as 'confidential' where there is good reason (for example, personal information, commercially-sensitive information, early-stage proposals that require Council input before being ready for wider consultation). Earlier in the year an improved system of classification was introduced to give added clarity to those reasons on a case-by-case basis. Going forward, as an added level of security, if the document includes personal information or commercially-sensitive information, then the SecureDocs system that was trialled in September will be used. This has added layers of security over the regular BoardPacks system. It is recognised that juggling two systems is not ideal and it will be used sparingly. Users will also be prompted to change their passwords on BoardPacks, and the use of organisational emails will be considered, although there needs to be a balance around usability and security.

    b. **Tightening access to Council meeting lunches**: the investigation report noted with surprise that journalists had historically circulated during Council meeting lunches and breaks. The report recommended that this practice is stopped. Council members have also felt that having people other than Council and staff at these lunches could lead to confusion, especially as they may not always be aware who is external and who is internal. Wherever meetings are held remotely this is not an issue, but once in-person meetings recommence, only RCVS Council and staff will be allowed to remain on the premises when a meeting is not in session. Once we can return to in-person meetings, improved guidance will be given around not leaving laptops unlocked in the Council Chamber when it is unattended.

Decision required

7. Council is invited to discuss these suggestions, and make additional recommendations where appropriate. Following agreement on the direction of travel, a more detailed plan will be developed and delivered, with relevant elements (for example, updates to the Code of Conduct for Council Members) coming back to Council for approval, others (for example, topics for training sessions) being signed off by Officers and/or the Senior Team.

Summary	
Meeting	Council
Date	8 October 2020
Title	Consultation on the Report of the RCVS Legislation Working Party (LWP)
Summary	This paper presents the draft consultation document for the Report of the LWP, and associated disciplinary reforms.
Decisions required	Council is asked to approve the draft consultation document.
Attachments	None
Author	Ben Myring Policy & Public Affairs Manager b.myring@rcvs.org.uk 020 7202 0783

Classifications

Document	**Classification**[1]	**Rationales**[2]
Paper	Unclassified	n/a

Consultation on the Report of the Legislation Working Party (LWP)

Introduction

1. Following Council's discussion in June, a consultation document has been prepared for approval. This document invites stakeholders (both professional and public) to comment on the LWP's recommendations, and on related recommendations for disciplinary reform also considered by Council in June which are part of a modern 'fitness to practise' system but do not require primary legislation and could therefore be pursued in the short-term, for instance changing the Disciplinary Committee's standard of proof.

2. In many cases the original detailed descriptions of recommendations have been abbreviated; in these cases links will be added against each recommendation which would take the reader through to the full version of the recommendation in webpage versions of the LWP Report and DC reform Council paper.

Decision

3. Council are asked to approve the consultation document. It is intended that the consultation be opened in late October or early November for a six-week window. It is further intended to hold a stakeholder meeting in advance of the consultation going live.

Consultation on the Report of the RCVS Legislation Working Party (LWP) 2020, and related proposals for reform of the RCVS disciplinary process.

Introduction – The Legislation Working Party

1. Section 1 of this consultation seeks the views of members of both the veterinary professions and the public on the Report of the Legislation Working Party (LWP), and related proposals. In particular we would like to gather views on the potential impact that implementing the recommendations would have, and any evidence and arguments that our LWP might not have considered. The recommendations will then be reviewed in light of the consultation results before RCVS Council considers formally adopting the Report.

2. The Report of the Legislation Working Party (LWP) contains a series of recommendations on the shape of any future legislation governing the veterinary professions and the principles that would underpin this legislation, such as the need for greater clarity, the incorporation of the entire vet-led team under one regulatory banner, and introducing greater flexibility and future-proofing.

3. The LWP was set up in 2017 to consider the principles governing any new legislation affecting veterinary regulation and come up with recommendations for what changes could and should be included in any future replacement for the Veterinary Surgeons Act 1966 (VSA). The group comprises members of RCVS Council, RCVS staff and representatives from the British Veterinary Association and the British Veterinary Nursing Association, and has also made extensive use of external advice from other regulators and experts.

4. At all times, the LWP sought to examine what other regulators do, both at home and abroad. While each recommendation was made on its own merits, the LWP took the view that RCVS regulation should be brought in line with ‘best practice’, and while there may be a case for the regulation of the veterinary profession to differ from that of other professions, even in the healthcare sector, any such exceptions need to be carefully justified. In this consultation we are especially keen for submissions that suggest areas of best practice that we may not have considered. Alternatively, if respondents feel that the RCVS should not be adopting best practice in a particular area, this should be justified with arguments or evidence that show that the UK’s veterinary sector is substantially different from other professions or the veterinary profession elsewhere, such that a proposed reform is not appropriate for the RCVS.

5. Most of the proposals are for the RCVS to have powers ‘in principle’ with the details to be agreed by RCVS Council following further consultation, as appropriate. This is to ensure any new legislation can be principles-based, flexible and, so far as is possible, future-proof.

6. The recommendations are grouped into five key headings:
    a. embracing the vet-led team; enhancing the role of the veterinary nurse;
    b. assuring practice standards;
    c. introducing a modern 'Fitness to Practise' regime;
    d. modernising RCVS registration processes.

7. Questions within the consultation are grouped according to these themes, and focus on the main proposals, and respondees are given the opportunity to comment on each recommendation. We appreciate that some people will only wish to comment on some recommendations. The full list of recommendations can be found in the Annex to the report (LINK); many of these are minor 'housekeeping' changes, and respondents are invited to comment on any of these at the end of the consultation.

8. Further information about the LWP proposals can be found on the FAQ page.

Related proposals to reform the RCVS disciplinary process

9. The LWP report contains a range of proposals to create a 'Fitness to Practise' system for the veterinary professions. As with the other LWP proposals these would require new primary legislation to implement in full. However, the RCVS has also identified a number of reforms to the disciplinary process that would bring the RCVS closer to best practice and which could be achieved without primary legislation, and in some cases without legislation at all . Details of these proposals can be found here [link to modified version of the Council paper].

10. In Section 2 of the consultation below, respondents will be given the opportunity to comment on these separate but related proposals, and indicate whether the RCVS should seek to implement these changes where possible at the earliest opportunity, or only as part of a full package of reform.

Section 1: the LWP Recommendations

Part 1: Embracing the vet-led team

Recommendation 1.1: Statutory regulation of the vet-led team

At present, the RCVS is the statutory regulator of veterinary surgeons, and also regulates veterinary nurses via the RCVS Royal Charter. The LWP proposes that the RCVS should be able to regulate additional paraprofessions, with their agreement, in order to protect animal health and welfare and public health via the assurance of standards, and provide clarity for the public. Having a single statutory regulator for the vet-led team would create a coherent system of regulation, similar to the one implemented by the General Dental Council, with clear rules around delegation.

[Comments box]

Recommendation 1.2: Flexible delegation powers

The LWP recommends that, by default, acts of veterinary surgery should be reserved to veterinary surgeons, but that the RCVS should be able to determine which tasks should be eligible for delegation by a veterinary surgeon where such delegation can be fully justified and evidenced, subject to rules concerning consultation requirements and approval by the Secretary of State. At present, if Council determines that additional acts of veterinary surgery can be undertaken by a properly regulated and supervised paraprofession new legislation is required every time.

[Comments box]

Recommendation 1.3: Separating employment and delegation

At present, Schedule 3 of the Veterinary Surgeons Act 1966 (VSA) restricts such delegation to allied professionals (currently only veterinary nurses) who are in the employ of the delegating veterinary surgeon. This is in contrast to some other paraprofessionals who could be part of the vet-led team without necessarily being employed by a veterinary surgeon.

The LWP recommends that this restriction is removed. In practice, this would allow a ‘district veterinary nurse’ model, in which VNs could help clients to administer treatment to their pets at home under the direction of a veterinary surgeon who was not their employer. This could help to better use VNs to their full potential in the interests of animal health and welfare, and bring VNs more into line with other paraprofessions.

[Comments box]

Recommendation 1.4: Statutory protection for professional titles

The RCVS already has a longstanding recommendation that the title ‘veterinary nurse’ should be protected to prevent its use by unqualified, unregulated individuals. The protection of professional titles gives clarity and assurance to the public. The LWP reaffirms this recommendation, and recommends that protection of title be extended to any new paraprofessions who fall under the RCVS’s regulatory umbrella.

[Comments box]

Part 2: Enhancing the role of the veterinary nurse

In addition to the recommendations above of flexibility to allow future-proofing, the LWP made two specific recommendations aimed at enhancing the role of veterinary nurses:

Recommendation 2.1: Extending the VN role in anaesthesia

In 2015, following extensive consultation and discussion, RCVS Council approved a recommendation to increase the role of veterinary nurses in the induction and maintenance of anaesthesia via reform of Schedule 3. These proposals would allow the veterinary nurse to “assist in all aspects of anaesthesia under supervision”, pursuant to an animal-specific protocol, increasing utilisation of veterinary nurses while freeing up veterinary surgeons’ time. The LWP supports the retention of this recommendation.

[Comments box]

Recommendation 2.2: Allowing VNs to undertake cat castrations

At present, Schedule 3 explicitly prohibits veterinary nurses from carrying out cat castrations. This provision was introduced when laypeople were restricted from undertaking acts of veterinary surgery. The LWP concluded that this restriction is not appropriate for veterinary nurses, who are regulated and extensively trained professionals, and therefore veterinary nurses should be able to undertake this task under veterinary direction and/or supervision (potentially direct, continuous and personal supervision).

The RCVS has defines ‘direction and supervision’ as follows:

a. 'direction' means that the veterinary surgeon instructs the veterinary nurse or student veterinary nurse as to the tasks to be performed, but is not necessarily present.

b. 'supervision' means that the veterinary surgeon is present on the premises and able to respond to a request for assistance if needed.

c. 'direct, continuous and personal supervision' means that the veterinary surgeon or veterinary nurse is present and giving the student veterinary nurse his/her undivided personal attention.

[Comments box]

Part 3: Assuring practice standards

Recommendation 3.1: Mandatory practice regulation

Unlike other sectors, there is no body responsible for regulating veterinary practices. In human healthcare the Care Quality Commission fulfils this role, and some overseas veterinary regulators, such as the Veterinary Council of Ireland, have this responsibility. At present, the RCVS has no mandatory powers to regulate veterinary practices. This is increasingly at odds with a world in which practices may not be owned by the individual veterinary surgeons or veterinary nurses whom the RCVS does regulate. It is reasonable for the public to expect that all practices are assessed to ensure that they meet at least the basic minimum requirements, and at present this assurance is not in place for all practices.

The LWP therefore recommends that the RCVS be given the power to implement mandatory practice regulation, including powers of entry (see below), should RCVS Council decide to complement the RCVS Practice Standards Scheme (PSS) with a universally-applied scheme.

[Comments box]

Recommendation 3.2: Powers of entry for the RCVS

The RCVS has no power of entry, meaning it does not have the right to enter a veterinary practice without consent. This can be a problem in terms of investigating allegations of serious professional misconduct, including where there are allegations that a veterinary surgeon has breached the rules in relation to minimum practice standards under the existing PSS. Powers of entry would therefore be essential if mandatory practice regulation (Recommendation 3.1) was introduced. The LWP recommends that the RCVS be given powers of entry in order to remedy this omission in the veterinary sector, and to ensure that regulation of practices can be underpinned and enforced, in the interests of animal health and welfare and public health.

[Comments box]

Recommendation 3.3: Ability to issue improvement notices

The LWP recommends that the RCVS be granted the ability to issue improvement notices when a business is failing to fulfil a legal duty, and where improvement is required to ensure future compliance. This would provide better protection for the public, while being a more proportionate response than pursuing a disciplinary case. Improvement notices provide practices with a clear and concrete action plan to remedy any deficiencies.

[Comments box]

Part 4: Introducing a modern 'Fitness to Practise' regime

Under the VSA, the RCVS may only take action where there has been 'serious professional misconduct' (SPMC). The definition of SPMC is widely accepted as conduct that falls far below the standard expected of a veterinary surgeon – or, by extension, a veterinary nurse. As such, we can only deal with the most serious of allegations, while other conduct falling below the standard expected falls outside the scope of our powers.

By contrast, almost all human healthcare regulators operate a variant of the 'Fitness to Practise' ('FTP') model. The key characteristic of the FTP model is that it focuses on whether or not a registrant's fitness to practise is 'currently impaired', rather than whether they have been guilty of SPMC in the past. Prior to FTP, the prevailing model for regulation was the 'unacceptable professional conduct' ('UPC') model (a concept very similar to disgraceful conduct/SPMC); however, this model is now considered to be outdated as it is backward-looking, focusing on past misconduct. By way of contrast, the emphasis of FTP is forward-looking, i.e. focusing on whether there is any risk to the public or the public interest. Moving the focus away from disgraceful conduct would also allow us to consider matters where a practitioner's fitness to practise is impaired for other reasons (such as those currently addressed by the existing RCVS Health and Performance Protocols), which in turn would better protect animals and the public.

The Fitness to Practise model is a package of reforms, and the LWP agreed that it should be considered as a whole. Full details can be found in the LWP report [link to page] The individual recommendations, grouped by theme, are listed below. In addition, The Fitness to Practise model would be contingent on changing the standard of proof used by the disciplinary process from the criminal to the civil standard; an explanation of the implications of this change is set out

A 'forward-looking' process with the protection of animals and the public at its heart:

Recommendation 4.1: Introducing the concept of 'current impairment'

Under the current system, if a veterinary surgeon or veterinary nurse is found guilty of misconduct the Disciplinary Committee (DC) proceeds straight to the sanction stage, and the sanction is determined on the basis of that past misconduct. The LWP recommends that this is changed in line with the fitness to practise model. Under this system, DC would need to be satisfied that the veterinary surgeon's or nurse's fitness to practice is currently impaired before it could proceed to the sanction stage. This means that in circumstances where the veterinary surgeon or nurse has taken steps to remediate their failings and shown significant insight into what has gone wrong, the DC may conclude that there is no (or very low) risk of repetition of similar behaviour and as such, the veterinary surgeon's fitness to practise is not currently impaired. If the DC comes to this conclusion, it must dismiss the case without proceeding to sanction, even though the veterinary surgeon or nurse has been guilty of misconduct in the past. This approach is more consistent with the aims of regulation,

because it focuses on whether the veterinary surgeon or nurse currently poses a risk to animals and the public, rather than whether he or she has posed a risk in the past.

Recommendation 4.2: Widening the grounds for investigation

At present, the RCVS may only investigate where there is an allegation that could amount to SPMC. This means that the RCVS may not intervene in cases where a practitioner might pose a risk to animals, the public or the public interest for other reasons. For cases involving allegations of poor performance or ill-health affecting a veterinary surgeon or nurse's ability to practise safely, the RCVS has devised the Health and Performance Protocols, which provide a framework for the RCVS to work with an individual towards the common aim of becoming fit to practise, however these can only be engaged with the consent of the individual concerned. Where there is no consent, the PIC have no option but to refer the matter to the DC. A more satisfactory situation might be the option to refer such cases to a dedicated 'health' or 'performance' committee that has a range of appropriate and proportionate powers designed to support the veterinary surgeon or nurse in regaining their fitness to practise.

Recommendation 4.3: Introducing powers to impose interim orders

The LWP recommends that the RCVS should have the power to impose interim orders, i.e. a temporary restriction on a veterinary surgeon or nurse's right to practise pending a final decision by DC where a veterinary surgeon or nurse poses a significant risk to the public or to animals. The current lack of power to impose interim orders is not only problematic during the investigation stage, it is also an issue in cases that have been through the full hearing process and DC have decided to suspend or removal a practitioner's registration. In such cases, there is a statutory appeal period of 28 days and, as such, the sanction does not take effect until that time has elapsed (and if an appeal is lodged, not until that the appeal is dismissed or withdrawn). The result of this is an illogical situation where DC have determined that a practitioner is not fit to practise and yet they are permitted to practise for 28 days or significantly longer (sometimes up to a year) depending on whether or not an appeal has been lodged.

Recommendation 4.4: Introduce reviews of suspension orders

At present, DC has no power to review the suspension orders it imposes; in other words, if a practitioner is suspended for six months they are automatically restored to the Register once that time has elapsed, whether or not they are fit to be restored. The practical effect of this is that where DC has concerns regarding a respondent's fitness to practise, it has no choice but to remove them from the Register completely as it is the only way to retain any control over that person's restoration to the Register. The LWP recommends that DC be empowered to review suspensions and, if necessary, extend the suspension or impose conditional registration as part of that review; they would then be able to ensure protection of animals and the public and, at the same time, impose a less onerous sanction on the veterinary surgeon or nurse.

Recommendation 4.5: Introduce a wider range of sanctions

The range of sanctions available to DC is very limited, in that it may only issue a reprimand or warning or suspend or remove an individual from the Register[1]. The LWP recommends that DC be given the power to impose conditional or restricted registration (also known as 'conditions of practice orders'), a power almost all other regulators have. Again, the power to impose conditions of practice orders would allow DC, in suitable cases, to adequately protect animals and the public by imposing a less onerous sanction.

An enhanced suite of powers available to enable more effective investigations and case management

Recommendation 4.6: Introduce the power to require disclosure of information

Other regulators, including the healthcare regulators, have statutory power to require disclosure of information where that information may be relevant to a fitness to practise investigation. By way of contrast, the RCVS has no such power and instead must rely on the cooperation of the relevant parties, which is not always forthcoming. In recent times, the RCVS has had particular difficulty in obtaining information from a number of organisations, which has resulted in difficulties with investigations. This situation is unsatisfactory as it hinders the RCVS from effectively carrying out its investigative duties; the LWP recommends that this is remedied.

***A reduction in the length and cost of investigations/proceedings wherever possible*:**

Recommendation 4.7: Formalise role of Case Examiners and allow them to conclude cases

At present the RCVS does have a 'case examination' stage, but it does not operate a true Case Examiner (CE) model. In the case of other regulators that use the CE model (e.g. the General Medical Council (GMC), GDC, Nursing and Midwiffery Council (NMC) and General Optical Council (GOC)), CEs make decisions in pairs (one registrant and one lay) and, in some cases, one or both are employees of the regulator. CEs also have powers that allow them to dispose of suitable cases consensually where the threshold for referral is met (so long as the wider public interest can be satisfied by disposing of the case in this way). This model is more cost effective than convening the Preliminary Investigation Committee (PIC) for all decisions (NMC has recently reported a year-on-year decrease in FTP spending and has attributed this, in part, to the introduction of CEs). It allows for quicker and more consistent decision-making, and is less stressful for the respondent if the case is subject to consensual case conclusion. The CE model may be particularly useful in health and performance cases where undertakings or conditions are used (similar to the result achieved by the RCVS Health and Performance Protocols).

[1] DC may also take no further action or postpone judgment (with or without undertakings) for up to two years, however these are powers are not true 'sanctions'

Part 5: Modernising RCVS registration processes

Recommendation 5.1: Introduce provisions to allow limited/restricted licensure in principle

In the context of the veterinary profession, 'limited' or 'restricted' licensure' refers to the concept whereby a suitably-qualified individual would be licensed to undertake less than the full range of activities that could be considered to be acts of veterinary surgery, or work that would otherwise require someone to be registered as a veterinary surgeon. In principle such limitations could range from being restricted from undertaking a specified act or area of practice, through to only being licensed to undertake a specific procedure or area of employment.

At present there is limited appetite for a general introduction of limited licensure for domestic graduates, but this may change in future. Further, in future there may be an appetite for RCVS Council, after due consultation, to introduce limited licensure for overseas veterinary graduates whose degree does not qualify them for a general UK licence. This could allow the RCVS to help to address workforce shortages without undermining the assurance of standards.

The LWP specifically recommends that limited licensure should be permitted for UK graduates where disability prevents them from being able to undertake all aspects of a veterinary degree and veterinary practice. For instance, an individual may not be able work in practice due to a disability, yet still be able to teach, undertake research, work in pathology, veterinary regulation, politics or policy. Limited licensure could permit such candidates to complete the relevant education for a branch of veterinary surgery, and allow them to become Members of the College.

[Comments box]

Recommendation 5.2: Empower the RCVS to introduce revalidation

In 2007, a Department of Health report[2] proposed that all the statutorily-regulated health professions should have arrangements in place for 'revalidation', to ensure that health professionals remain up to date and demonstrate that they continue to meet the requirements of their professional regulator as they are now, rather than when they first registered. The professional standard against which each is judged is the contemporary standard required to be on the Register, and not the standard at the point at which the individual may have first registered.

Such revalidation aims to give assurance that individual doctors are not just qualified, but safe. It also aims to help identify concerns about a doctor's practice at an earlier stage and to raise the quality of care for patients by making sure all licensed doctors engage in continuing professional development and reflective practice. Revalidation schemes are not limited to doctors, and are regarded as best regulatory practice.

[2] Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century (Communications Department of Health 2007a)

Under the VSA, providing that conditions of registration are satisfied, a person may continue to be registered for the whole of their life (providing they pay their fees and are not removed by DC or for lack of response); there is no requirement to revalidate as there is with other professions. The LWP recommends that the RCVS be empowered to introduce a system of revalidation in future, should RCVS Council decide to do so.

[Comments box]

Recommendation 5.3: Underpin mandatory continuing professional development (CPD)

CPD is a requirement for all professionals wishing to register with the health professional and legal services regulators. However, unlike the abilities given to most other regulators, the VSA does not give the RCVS the ability to enforce this requirement except through the disciplinary process. Veterinary surgeons and veterinary nurses are asked to certify that they have satisfied the CPD requirement as part of the annual renewal process. However, if they do not there is no power to refuse renewal of registration. The LWP recommends that the RCVS should be able to refuse renewal of registration if a regulated professional fails to meet their minimum CPD requirement.

[Comments box]

Part 6: Additional LWP recommendations

Recommendation 8.4: Retaining a Royal College that regulates

The LWP recommends that the RCVS continues to be a 'Royal College that regulates'. This unique arrangement allows the RCVS to take an holistic approach to public assurance. It also ensures that the Royal College functions are properly funded; some RCVS activities might well not be carried out at all if the RCVS did not take responsibility for them. These includes some Charter-based activities carried out as part of the proactive and supportive approach to regulation such as initiatives in the area of mental health, diversity and inclusion, and leadership.

[Comments box]

Other recommendations

The full list of recommendations in the LWP report are found in the Report Annex [link]. Those not listed above are primarily 'housekeeping' recommendations, many of which involve minor amendments to the existing VSA as opposed recommendations that would shape any new Act. Respondents are welcome to comment on any of these recommendations here:

[Comments box]

Section 2: Interim proposals not requiring primary legislation

In this section, respondees have the opportunity to comment on a number of proposals that would form part of an FTP system but which could be achieved without new primary legislation, and in some cases without new legislation at all. One option is to pursue such available reforms in the short-term; this would bring the RCVS closer to best practice at the earliest opportunity without the need to wait a lengthy period to deliver the full FTP package, and could be pursued without losing sight of any longer-term ambition of full reform.

Respondents are invited to comment on these interim proposals and indicate whether the RCVS should seek to implement these changes where possible at the earliest opportunity, or only as part of a full package of reform.

Standard of proof

The RCVS is in a small minority of UK regulators – and the only major regulator – that still applies the criminal standard of proof, i.e. beyond reasonable doubt/so as to be sure, when deciding the facts of a case as other regulators have now moved to the civil standard, i.e. the balance of probabilities/more likely than not. The civil standard is also used by veterinary regulators in New Zealand, Australia, Canada and South Africa, often underpinned by court rulings concerning the appropriate standard of proof.

In light of the primary purpose of regulation, the civil standard is considered to be the more appropriate standard of proof because, as the Law Commission explained in its 2014 report on the regulation of health and social care professionals in England, *'it is not acceptable that a registrant who is more likely than not to be a danger to the public* [or, more often in the case of the veterinary profession, to animals]*should be allowed to continue practising because a panel is not certain that he or she is such a danger'*.

The civil standard of proof is an integral aspect of a Fitness to Practise regime. Changing the standard of proof can be achieved without the need for a change in primary legislation, therefore the LWP did not make a recommendation on this issue beyond asking RCVS Council to consider it. RCVS Council subsequently agreed that changing the standard of proof should be consulted upon, therefore we are including it here as part of the full Fitness to Practise Proposal requiring new legislation (Q4.1) as well as asking whether it should be introduced sooner, outside of a full Fitness to Practise scheme (Q4.2). Details of the proposals and their impact can be found here [link to modified version of the Council paper].

[Comments box]

Alternative means for concluding Disciplinary Committee (DC) cases (the Charter Case Protocol) – see also Recommendation 4.7

Similarly to changing the standard of proof, non-legislative proposals that could be implemented in the near term have been developed to deal with those cases (other than those dealt with by the College's existing Health and Performance Protocols) that cross the threshold for a disciplinary case, and where there is a strong public interest case or a need to protect the reputation of the profession, but where the likely outcome is either a finding of misconduct and no further action, a reprimand, or a warning.. A full hearing is arguably disproportionate in these cases, as well as costly.

By utilising the wide powers available to the RCVS under its 2015 Charter, it is proposed that an additional system, the Charter Case Protocol (CCP), is created to facilitate the giving of published warnings in appropriate cases, where a veterinary surgeon or nurse could be subject to a warning that is separate from the statutory process. The RCVS concerns process would run as it does now, however, in cases where the threshold for a referral to DC has been crossed, the Preliminary Investigation Committee (PIC) would decide whether or not it was appropriate to refer the matter via the CCP for conclusion.

The CCP would require the RCVS to establish a new Charter Case Committee (CCC), the remit of which would be to conclude cases referred to it by the PIC. The CCC would have a defined and limited range of disposals available to it, these could include, for example: a. issuing a public warning (i.e. a warning published on the RCVS website); b. issuing a private warning; c. issuing public advice (i.e. advice published on the RCVS website); d. issuing advice that would remain private.

If new evidence were to come to light that suggested the matter might be more serious than the PIC initially determined, the CCC would have the power to refer the matter back to the PIC for further consideration and / or investigation, which could, ultimately, lead to a Disciplinary Committee hearing. Further details of this proposal and its likely impact can be found here: [link to modified version of the Council paper].

[Comments box]

Structural changes to the concerns process ('mini-PICs') – see also Recommendation 4.7

A further short-term proposal, not requiring legislation, has been developed to introduce 'mini-PICs'. This would be a step towards the Case Examiner model detailed in Recommendation 4.7.

Schedule 2 of the VSA states that PIC must have no fewer than nine and no more than 15 members, with a quorum of three – of whom one must be a lay member and one must be a registrant. Currently there are 10 members appointed to PIC. Historically, all 10 sat for each of its monthly meetings. However, this increasingly became unwieldy and, from January 2018, the number was reduced to five members but with the Committee meeting every fortnight. There is, however, nothing to stop the full

quotient of 15 members being appointed and to apply the quorum of three – i.e. to have five ‘mini-PICs’.

Mini-PICs would create a speedier and streamlined process, with greater clarity in explaining decisions for both the public and the profession. Further details of this proposal and its impact can be found here [link to modified version of the Council paper].

[Comments box]

Summary	
Meeting	Council
Date	8 October 2020
Title	Advancement of the Professions Committee Report 8 September 2020
Summary	To note the attached minutes of the meeting held on 8 September 2020. In particular, to note the following: - Many workstream activities and events have been postponed or moved online due to the pandemic - The Committee heard from the CEO on plans to develop a new "Advancement of the Professions" department within the College. - The Committee noted that work is ongoing with the General Practice Project, with the intention to pursue some work objectives in the meantime before appointing a Director for the Advancement of the Professions department.
Decisions required	None
Attachments	Classified Appendix
Author	Ceri Chick Secretary APC c.chick@rcvs.org.uk / 0207 856 1034

Classifications

Document	Classification[1]	Rationales[2]
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**1**

[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

Minutes of the Advancement of the Professions Committee held on Tuesday, 8 September 2020 at 2pm via Teleconference by Microsoft Teams.

Members:

	Dr C J Allen	Council Member
	Professor D Argyle (Chair)	Council Member
	Professor J Innes	Chair, RCVS Fellowship Board
	Ms A Boag	Chair, Board of Trustees for RCVS Knowledge, and Leadership lead
	Dr N Connell	Senior Vice-President, and Chair, Diversity, and Inclusion Group
	Professor S Dawson	Chair, Mind Matters Initiative
	Ms L Lockett	Chief Executive
	Mr M Rendle	Vet Nurse Futures Project Board liaison point
	Dr C Tufnell	Innovation and Global lead
	Mr T Walker	Lay Council Member
In attendance:	Miss C Chick	Leadership Initiatives Officer
	Mr I Holloway	Director of Communications
	Mr C Gush	Executive Director, RCVS Knowledge
	Mrs L Quigley	Mind Matters Initiative Manager
	Mrs L Hall	Director of Human Resources
	Ms L Price	Head of Standards (Present for Agenda Item 6 only)
	Ms L Lipman	Senior Manager, Practice Standards Scheme Department (Present for Agenda Item 6 only)
	Ms E Ferguson	Solicitor, Registrar, Director of Legal Services (Present for Agenda Item 6 only)

*absent

Welcome and apologies for absence

1. The Chair welcomed all present to the meeting of the APC and noted that the meeting would be recorded for minuting purposes.

2. No apologies were received from the Committee.

3. The Chair welcomed Mr Matthew Rendle RVN to the Committee as Chair of the Veterinary Nurses Council. The Chair congratulated Ms Amanda Boag on her new position as Chair of the Board of Trustees for RCVS Knowledge.

Declarations of Interest

4. No new declarations of interest were received.

Minutes of the last meeting, held on 5 May 2020.

5. The minutes were approved as an accurate record of the meeting.

Matters Arising

6. The Chair emphasised that the Committee appreciated that workstream activity has been limited due to the pandemic.

7. The Chair noted that there is an effort to appoint a Green Initiatives lead. There has been a great deal of interest in the role and an intention to select the successful candidate before the next Advancement of the Professions Committee meeting in November 2020.

8. The Chair stated that the final matter arising, an update on the General Practice Project, would be discussed during agenda item 5 (APC Sept 20 AI05).

Updates from APC workstreams

9. The responsible Committee members or the relevant staff lead provided an update on each of the eight workstreams within the scope of the APC; this reflected the contents of the paper (APC Sept 20 AI01).

10. The Committee considered these updates, as well as other specific matters raised, that were brought to it for discussion and, in some cases, decision. These are highlighted below, in addition to the main questions and comments prompted by each update.

Diversity and Inclusion Working Group

11. It was noted that work is ongoing with a meeting being scheduled in the next months to keep the momentum going.

12. It was noted that the working group is organising a roundtable with the Veterinary Schools' Council looking at support for students from Black, Asian and Minority Ethnic (BAME) backgrounds. A questionnaire will soon be sent out to each school to better understand the work that has already been implemented and is working well, which will be circulated prior to the roundtable.

13. It was noted that a new three-tiered framework, "Promote, Understand, and Support" has been implemented to better focus this work.

14. It was noted that there was some discussion in the most recent working group meeting around how each organisation has been impacted by the Black Lives Matter movement. The lessons learned from this movement will now be imbedded into and become an integral part of work going forward, both internally within the RCVS staff team and externally.

15. It was noted that the language around disability and limited licensure that is used in connection with the Legislation Working Party report would need to be reviewed before it goes to consultation, as there is some concern from the Committee that a deficit model of disability is being manifested rather than something that may vary over the course of a person's career.

16. It was noted that this work should be thought of in the context of mental health as well as physical health. The Chair noted that training, such as the "See Me" training available for managers dealing with mental health in higher education, could be offered to the veterinary profession. It was explained a mental health for managers course was available via Mind Matters, and this was in the process of being reformatted for online delivery.

Fellowship

17. It was noted that out of a record number of 65 applications, 58 candidates were successful in receiving their Fellowships through the new Fellowship system (implemented in 2016).

18. It was noted that a member of the Committee was one of the successful Fellowship candidates. The Fellowship Chair and the Committee passed on their congratulations.

19. The Chair queried whether the gender demographic showed an increase in female applications and successful applicants. It was agreed that the Secretary would gather and provide this information to the Committee after this meeting.

    Action – Secretary to circulate Fellowship gender demographic details to the Committee.

20. It was noted that discussion is ongoing between the Fellowship Board Chair and Fellowship staff leads around ensuring that equality and diversity are borne in mind throughout all processes.

21. It was noted that due to the ever-changing demographic of the profession, an increase in the number of female applicants should be expected in the coming years. Nonetheless, the Fellowship Chair noted that the Fellowship should continue and improve their efforts to encourage women to apply for the Fellowship, and support them once they have been accepted.

22. It was noted that a review of the gender balance within the Fellowship assessment panels will soon be underway. The Committee highlighted that the Fellowship assessment panels and Chairs should reflect the demographic of those applying in terms of age range, gender and ethnic diversity.

23. The Committee noted that the gender balance within the Fellowship is currently poor with slow progress. It was suggested that the Fellowship should seek and discuss more active measures to increase equality and diversity.

24. The Fellowship Chair emphasised that a review of the credentials panels was expected to take place before summer 2021, including a campaign to recruit new members. New and existing credentials panel members, and the Fellowship Board, will be receiving training on how consistently and fairly to assess the applications, as well as Unconscious Bias training. A framework for a three-year rotation of the credentials panellists will also need to be developed.

25. In relation to other activities, it was explained that due to the pandemic, this year's Fellowship Day event will take place online with a slightly more limited programme. It is intended that some traditional aspects of the day, such as the Fellows of the Future competition, will take place at a later date due to timing restraints. The Fellowship Chair highlighted that the event will take place on 1 October 2020, from 7pm, and encouraged the Committee to attend.

26. It was noted that the election for Vice-Chair of the Fellowship Board is currently running, with four candidates. The voting period for this election will end on 16 September 2020 with candidates and the Fellowship being notified of the result within the following week. It was noted that a promisingly high percentage of the Fellowship had participated in the election.

27. It was noted that Fellowship Board member Dr Mary Fraser has taken the lead on the Fellowship Science Advisory Panel (FSAP). Work on this project is ongoing with the intention of creating a Fellowship newsletter to further engage with the Fellowship.

28. It was remarked that a review of the Fellowship's appeals process is needed, with applying candidates being given more clarity around the process. It was noted that as it stands, the appeals process focuses on the application process rather than the outcome, which may need to change.

29. It was noted that an extraordinary Fellowship Board meeting will likely need to be arranged before the end of the year to discuss the themes highlighted in this Committee meeting. It was noted that before this meeting takes place there is a need to collect feedback from the Fellowship, particularly from female Fellows as to their ideas of necessary processes to increase gender equality in the Fellowship demographic.

Action - Secretary to liaise with the Fellowship Chair to create a feedback framework.

30. It was noted that there was a project on mentorship for those with the intention of applying for Fellowship in the pipeline. The Committee stressed that any mentorship panel would also need to be appropriately demographically balanced.

31. It was noted that Fellowship applications were currently being accepted for 2021, with the deadline being set at 15 February 2021. It was stressed that no process changes would be put into place before the 2022 round of applications to ensure consistency across all 2021 applications and assessments.

32. The Committee Chair asked whether there had been any decisions made by the Fellowship Board around implementing a nomination based system for Fellowship. The Fellowship Chair noted that there had been extensive discussion around this subject within the Board. The Board had, however, come to the decision not to implement this in the near future, as there are concerns that this would create a more insular and discriminatory environment within the Fellowship. The Fellowship Chair noted that the Board would keep this idea under review.

33. The Committee enquired as to the popularity of the Fellows Directory. It was noted that the Fellowship (aside from this year's intake, who will be invited before the next Committee meeting) have all been invited to be featured on the Directory. This has had a positive response

from the Fellowship. It was agreed that the Secretary would gather and circulate information pertaining to the Directory's population and use after the meeting.

Action – Secretary to gather and circulate information pertaining to the population and use of the Fellows Directory.

34. The Fellowship Chair noted that there is an ongoing intention and workflow focused on increasing communication and participation throughout the Fellowship, to facilitate and meet the Fellowship's aim of becoming a thriving learned society.

Global Strategy

35. It was noted that there is a survey being prepared in conjunction with the European veterinary authorities, which will cast light on the way veterinary regulation works in other European countries, particularly concerning registration from third countries and practice standards. This will help to inform both post-Mutual Recognition of Professional Qualifications (MRPQ) policy and the Practice Standards Scheme's (PSS) global dimension.

36. It was noted that a key element of the Global Strategy work would be presented during the paper at agenda item 6 (APC Sept 20 AI06).

Innovation

37. It was noted that there has been a major staff change with Mr Anthony Roberts, former Director of Leadership and Innovation, departing the RCVS. The Committee recognised and celebrated his immense achievements throughout his involvement with the College's Innovation workstreams.

38. The Committee was invited to extend its congratulations and thanks to the staff Innovation lead, Miss Sophie Rogers, for her achievements in handling ongoing work in Anthony's absence.

39. It was noted that the RCVS Chief Executive Officer (CEO), Ms Lizzie Lockett, recently took part in a discussion panel online for the Digital Veterinary Summit, in which ViVet was an event partner. The panel discussion was 'A Global Regulatory Perspective on the use of Telemedicine in Veterinary Practice' with Jan Robinson, The College of Veterinarians of Ontario, and Jim Penrod, American Association of Veterinary State Boards.

40. It was noted that as part of the innovation workshop series, ViVet was recording six short podcasts focusing on innovation in the workplace, guiding listeners through skill development and self-reflection. Supporting resources and artwork would be hosted on the ViVet website.

41. It was noted that despite the pandemic, the innovation team was continuing to evolve ViVet, while ensuring that the website was up to date with resources to assist the profession to engage with the innovation process.

42. The Chair mooted that streams for lifelong education could take advantage of innovation resources brought to light due to the pandemic.

Leadership

43. It was noted that due to the departure of Mr Anthony Roberts, former Director of Leadership and Innovation, and Mr Oliver Glackin, Leadership Initiatives Manager, from the College; Miss Ceri Chick has been handling ongoing work in their absence, and she was praised for her hard work in this regard.

44. It was reported that an extraordinary run of the Jenner programme had been facilitated in July to cater in particular to students. This was done by liaising with university extra-mural studies (EMS) coordinators and promoted through these channels. The run had proved very popular so far with students from the Royal Veterinary College providing positive anecdotal feedback.

45. It was reported that a series of four weekly one-hour webinars had been facilitated in conjunction with the Tavistock Institute, which heard from experts in the field of organisational development and change as they addressed themes pertinent to leading and working with colleagues and clients through the coronavirus pandemic. These webinars had been recorded and were now available on the RCVS website.

46. The Chair extended his thanks to all staff members who have handled ongoing work after Mr Roberts and Mr Glackin's departure.

47. It was noted that the leadership initiatives will continue and likely pick up pace once the new Advancement of the Professions Department has been assembled.

Mind Matters Initiative

48. It was reported that the judging panel for the Sarah Brown Mental Health Research Grant met on 12 August and the decision was made to award two £20,000 grants this year. The first was for a collaboration between the Royal Veterinary College (RVC) and the British Veterinary Ethnicity and Diversity Society (BVEDS) looking at experiences of racism in the veterinary profession. The second is being led by Professor Neil Greenberg from King's College London, and will investigate the impact of moral injury on mental health. These grants will be formally

awarded at the RCVS Honours and Awards Evening on 10 September. Sarah Brown's family has been informed of the decision.

49. It was noted that face-to-face meetings and training events continue to be cancelled due to the pandemic, although work is being put into moving much of this work into a virtual setting. Online webinars and events are ongoing, with one recent webinar celebrating the five-year anniversary of the Initiative, and what has been achieved in that time.

50. Reference was made to the successful veterinary student mental health and wellbeing roundtable that took place last year. Following on from this, plans are underway for a similar event for student veterinary nurses. This will be held online due to the ongoing situation with the coronavirus pandemic.

51. The Committee noted that a recurring theme which was having a stronger effect on the mental health of veterinary professionals during the pandemic was euthanasia, due in part to the change in dynamic with pet owners being unable to be present during the procedure, also the fact that, as many other in-person procedures were not happening, euthanasia was taking up a larger proportion of a typical day's caseload and could seem relentless. It was noted that although euthanasia was a positive clinical tool, it could be the cause of stress. The Committee suggested that the MMI workstream could facilitate a resource on this issue, encouraging communication within the veterinary team around the stress the procedure may cause. It was reported that a blog on the topic was in process.

52. The Committee thanked the MMI staff leads for their consistent hard work.

RCVS Knowledge

53. It was noted that Ms Amanda Boag has been appointed Chair of the RCVS Knowledge Board of Trustees. The Committee extended its congratulations to Ms Boag.

54. It was reported that resources published by RCVS Knowledge supporting the public and profession in uncertain times around the pandemic had been well received and accessed over twenty thousand times.

55. It was noted that resources driving on quality improvement (QI) work had received a large amount of engagement as people started going back to work.

56. It was noted that RCVS Knowledge was currently seeking a clinical lead to take the National Audit for Post-operative Outcomes forward. This will be a voluntary position.

57. It was highlighted that RCVS Knowledge would be presenting its awards alongside the RCVS at the virtual Honours and Awards ceremony on 10 September 2020.

58. It was noted that Professor Ivan Morrison had been awarded the inaugural Plowright Prize for his wide-ranging contributions to the field of infectious diseases.

59. It was reported that Dr Kit Sturgess had been appointed Editor-in-Chief of Veterinary Evidence. The Student awards for Veterinary Evidence will be presented to the winners at the Honours and Awards ceremony on 10 September 2020.

60. It was noted that RCVS Knowledge had linked up with the Fellowship to provide knowledge summaries for common conditions. Fellows were being encouraged to donate information or clinical and scientific questions that the profession were interested in. There was the intention that this initiative, along with others, would assist the Fellowship to meet its aim of becoming a thriving learned society.

VN Futures - update

61. It was noted that a member change had seen the appointment of a new Chair of the Vet Nurse Futures Project Board, who is the current Junior Vice-Chair of the British Veterinary Nursing Association's Council.

62. It was noted that following the cancellation of the BVNA Congress 2020, the organisation had developed an alternative online event, open free-of-charge to all BVNA members.

APC Resources within the RCVS

63. The RCVS CEO gave an update on the decision made to create a new department within the RCVS, covering themes and workstreams under Advancement of the Professions.

64. It was noted that instead of seeking a new Director of Leadership and Innovation, the title of which was in-line with the RCVS's previous strategic plan, a Director of Advancement of the Professions would be appointed. There had been large amounts of applications received for this role, with the first round of interviews taking place at the end of September 2020. The CEO thanked the Human Resources team for their hard work in running the recruitment process for this new role.

65. It was noted that instead of promoting a set number of roles under the new department, the RCVS CEO had advertised the opportunity for current staff members to put forward ideas of potential projects they would like to be involved in which would align within this department's

themes. This will assist in job progression within the College. It was reported that there had been a large amount of interest in this initiative from current RCVS staff.

66. The CEO gave her thanks to staff members Miss Sophie Rogers, Innovation Executive, and Miss Ceri Chick, Leadership Initiatives Officer, for regulating the department's work while the new department was being composed. The CEO also gave thanks to Mrs Lisa Hall, Director of Human Resources, for supporting Miss Rogers and Miss Chick in the absence of a Director.

Discussion: The General Practice project and the APC

67. The Chair reminded the Committee that the intention of this project was initially to fully utilise the expertise and resources within the Committee by working together on a project celebrating General Practice. This project's underlying focus would be recruitment and retention within general practice. Due to the pandemic, the Chair suggested that resources developed by the Committee's workstreams on this project could be delivered on an online platform, such as the RCVS Virtual Academy.

68. The RCVS CEO gave an update on the progression of this project. It was noted that due to short staffing, progress has been on hold, however a strategic plan for the project has been outlined in the provided paper "The Primary Care project [later renamed General Practice project' by the Committee] and the APC". The CEO stressed that this project would be likely to cover a two-year period, and that while some aspects of the work would begin before a new Director of the Advancement of the Professions Department was appointed, the majority of it would take some time.

69. The Chair noted that this project might also need to cover accessible care in a post-pandemic world.

70. The Committee agreed that the scope of this project should cover the primary care of all domestic animals.

71. It was noted that RCVS Knowledge intends to apply to the Heritage Lottery Fund for money to explore veterinary practice's place in British society. It was mooted that this may be pertinent to this project in an effort to engage with the public.

72. It was noted that the RCVS was seeking a new Research Officer, whose role may be suited to work within this project

Globalisation of our Standards and Services Paper

73. This information is available in the classified appendix at paragraphs 1-5.

Any other business

74. The Chair thanked the Committee members their ongoing efforts throughout the pandemic.

Date of next meeting

75. The Chair closed the meeting noting the next meeting would be on the afternoon of 10 November 2020.

Summary

Meeting	Council
Date	8 October 2020
Title	Audit and Risk Minutes 7 May 2020
Summary	The Committee: Received a report from the CEO; Reviewed work to date on the Assurance map; Reviewed the risk register in the light of Covid-19; Reviewed in depth the HR departmental risk register; Thanked Professor May and Dr Sturgess for their work for the RCVS, and this committee in particular; Matters arising to be reviewed in October 2020 Meeting.
Decisions required	For review and recommendation to Council
Attachments	Confidential Appendix
Author	Alan Quinn-Byrne Governance Officer/Secretary a.quinn-byrne@rcvs.org.uk / T 020 7227 3505

Classifications

Document	**Classification**[1]	**Rationales**[2]
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**1, 2, 3**

[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

Minutes of the Audit and Risk Committee held remotely via Microsoft Teams on 7 May 2020

Members:

Ms E Butler	Chair
*Professor D Bray	
*Professor S May	
Mr V Olowe	
Ms J Shardlow	Vice-Chair

In attendance:

Dr C P Sturgess	Treasurer
Ms L Lockett	CEO
Ms C McCann	Director of Operations (DoO)
Ms Lisa Hall	Director of HR (agenda item)
Mr A Quinn-Byrne	Secretary to ARC / Governance Officer

*Not in attendance – apologies received

Apologies for absence

1. Professors Bray and May submitted their apologies.

Declarations of interest

2. Dr Sturgess reported that The Cat's Protection League (of which he is a trustee) has appointed Crowe as auditors. The committee concluded that this did not pose a conflict of interests.

Minutes of the meeting held on 13 February 2020

3. The minutes were accepted as a true record of the meeting held on 13 February 2020.

Matters arising

4. It was decided that a report from the RCVS Legislation Working Party will come before the Committee in September 2020. Prior to then it will be discussed at the RCVS June Council meeting.

5. An update on the RCVS progress regarding the European Association for Quality Assurance in Higher Education (ENQA) accreditation will come before the Committee in September 2020. The Director of Education and newly appointed Quality Assurance Manager will present the update to ARC in September 2020.

6. A review of the RCVS Contract and Procurement Policy will come before the Committee in November 2020.

7. HR Risk Register is an agenda item and will feature within these minutes.

8. The Secretary to the Committee had created a rota of departmental risk registers to come before the ARC. It was decided:

    - September 2020: Education
    - November 2020: Facilities and Veterinary Nurses.
    - February 2021 Registration

CEO Update

9. The CEO gave an update on activities since the last ARC meeting in February 2020. She highlighted:

10. Due to the Covid-19 Pandemic, working life had changed dramatically for RCVS staff. It was noted that a range of measures had been put in place since the outbreak had been declared a pandemic.

11. Prior to the pandemic, the IT team had implemented Microsoft Teams to replace current landline telephones at the College. The roll out of Microsoft Teams across the RCVS had meant that the impact of the transition on working from home was far less complicated from an operational point of view.

12. It was noted all teams had been working efficiently and managing well from home. The level of support some teams required has been different. Departments had assisted each other with workloads. This had allowed busier departments to manage larger workloads that had developed from the pandemic.

13. In terms of registration, the RCVS was now accepting virtual enrolments.

14. A Covid-19 Taskforce was established that consisted of the Chairs of standing committees, Officer Team, two additional Council members (one vet, one lay), and some Senior Team members. The group had been meeting three times a week, initially, as had the Officer Team, while the Senior Team had met twice a week. Now things were settling down, the Officer Team and Taskforce were meeting weekly, Senior Team still twice a week. The Covid-19 Taskforce was reporting its decisions to Council. A range of other weekly stakeholder meetings were also being undertaken.

15. In terms of guidance, the professions had received guidance from the Standards and Advice Team and regular updates, and the RCVS website was now hosting guidance on Covid-19.

16. Confidential information is available in the classified appendix at paragraph 1-9

17. The large volume of work undertaken by the CEO and RCVS team in dealing with the Covid-19 Pandemic was praised.

Assurance Map

18. The Director of Operations (DoO) introduced the RCVS Assurance Map. This outlined the various levels of assurance that the RCVS had for the top risks on the Corporate Risk Register.

19. Confidential information is available in the classified appendix at paragraph 10-16

Covid-19 Risk Register Discussion

20. The Governance Officer presented the Covid-19 risk register to the Committee. Due to the outbreak of Coronavirus (Covid-19), the RCVS had to undergo some major changes in terms of policy and operational matters. As workplace patterns changed, risks begin to emerge; the purpose of the exercise was to identify those risks across the board.

21. Confidential information is available in the classified appendix at paragraph 17-20

HR Risk Register

22. The Director of Human Resources (DoHR), Ms Lisa Hall, who had been in post for eleven months, presented the HR Risk Register to the Committee.

23. Confidential information is available in the classified appendix at paragraph 21-36.

Any other business

24. This was the last meeting for Professor may and Dr Sturgess, who will be demitting from Council. The Chair and CEO on behalf of the RCVS and the Committee, thanked Professor May and Dr Sturgess on their work for the RCVS, and in particular their work on this Committee.

RCVS SETTING VETERINARY STANDARDS

Summary

Meeting	Council
Date	08 October 2020
Title	Education Committee Minutes of the meeting held on 15 September 2020
Summary	Council to note Education Committee Minutes of the meeting held on 15 September 2020 and in particular the early findings of the Advanced Practitioner review. Also the ongoing review of Veterinary Schools plans while continuing to review policy to support schools and students on the light of the pandemic.
Decisions required	Council to note
Attachments	Classified appendix
Author	Britta Crawford Education Manager b.crawford@rcvs.org.uk/ 020 7202 0777

Classifications

Document	**Classification[1]**	**Rationales[2]**
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**1**

[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

RCVS SETTING VETERINARY STANDARDS

Education Committee

Minutes of the meeting held on 15 September 2020

Members:	Professor Ewan Cameron		
	Mr Danny Chambers	-	Also Adv Practitioner Panel Chair
	Ms Linda Ford	-	Lay member
	Professor Richard Hammond		
	*Mrs Susan Howarth		
	Dr Susan (Sue) Paterson	-	Chair
	Dr Cheryl Scudamore		
	Dr Kate Richards		
	Professor James Wood		
	Ms Katie Fox	-	Student representative
	Mr Tobias Hunter	-	Student representative
By invitation:	Dr Melissa Donald	-	CertAVP Sub-Committee Chair
	*Mr John Fishwick	-	Chair of Specialist Sub-Committee
	Dr Joanne Dyer	-	EMS Co-ordinators Liaison Group and PQSC Chair
	Professor Nigel Gibbens	-	Chair of Accreditation Review Group
In attendance:	Mr Duncan Ash	-	Senior Education Officer
	Mrs Britta Crawford	-	Committee Secretary
	Mr Jordan Nichols	-	Lead for Undergraduate Education
	Dr Linda Prescott-Clements	-	Director of Education
	Mr Jonathan Reid	-	Examinations Manager
	Ms Jenny Soreskog-Turp	-	Lead for Postgraduate Education
	*Ms Laura Hogg	-	Senior Education Officer
	Ms Sam Eady	-	Education Assistant
	Ms Beckie Smith	-	Education Assistant
	Mrs Kirsty Williams	-	Quality Assurance Manager
	Ms Lizzie Lockett	-	CEO
	Dr Niall Connell	-	Officer Team Observer

*absent

Apologies for absence and welcome

1. Apologies were received from Susan Howarth and John Fishwick.

2. The meeting was held remotely by “Teams” due to the Covid-19 pandemic.

3. The meeting papers reference the RCVS Council Covid-19 Taskforce. The Chair explained that this is a group brought together on March 6th 2020 to make key decisions on temporary policy changes due to the Covid-19 pandemic. The need for the Taskforce is under constant review as the pandemic continues. Full terms of reference are available on the RCVS website. All decisions are reported to Council and any decisions with far reaching effects will be decided by Council in the usual manner.

4. The Chair thanked the Education Department for their hard work, both in preparing for the meeting and for dealing with the added pressures caused by the pandemic. Her thanks were appreciated.

Declarations of interest

5. There were no further declarations of interest.

Minutes

6. The minutes of the meeting held on 5 May 2020 were approved.

Matters arising

7. The Committee was informed that there had been some small updates to the Day One Competences document, following the queries at the last meeting, and the updated version was available on the RCVS website. Hong Kong CityU had been contacted to inform them that an RCVS only interim visitation would be conducted in 2021. Matters concerning the AVMA recognition agreement had been referred to PQSC and would be brought back to this Committee in due course.

Education Department update

8. The Director of Education, Dr Linda Prescott-Clements, gave an oral update on the work of the Education Department. The Committee were reassured that whilst there were a number of temporary amendments to education policy due to Covid-19, these remained under constant review. The EMS policy would be reviewed again in the following week.

9. The review of vet schools’ alternative plans for the implementation of their programme during the pandemic had highlighted a need for the RCVS to look at regulations for future on-line / remote exams.

RCVS Covid-19 Taskforce update

Review of changes to the CPD requirement

10. The committee received and noted the paper about the review of changes to the CPD requirement. The CPD requirement was reduced by 25% in April and after reviewing the data from 1CPD, the Policy Working Party felt that no further changes to the requirement would be necessary. The policy and 1CPD data will be kept under review and the Working Party will keep the Education Committee updated.

SME: OET@home

11. Due to Covid-19, access to English language tests to enable candidates to prove their eligibility for the statutory membership exam had been difficult. The RCVS Covid-19 Taskforce agreed to accept the "OET@home" as an alternative to the (usual) IELTS/OET requirements during the pandemic, in addition to maintaining the temporary policy allowing candidates to enter the exam in 2021 without passing the IELTS/OET in advance (this would be required prior to registration should the candidate pass the exam).

Virtual abattoir resources

12. RCVS Covid-19 Taskforce had approved a proposal put forward to accept the use of virtual abattoir teaching resources for students in this area, whilst the risks of transmission within abattoirs remained high, and access for schools remained a challenge. The Taskforce agreed that this should be subject to review of the resources by members of Education Committee.

13. Dr Susan Paterson, along with committee members Dr Cheryl Scudamore and Professor Ken Smith (plus RCVS staff member Mr Jordan Nicholls), reviewed the virtual abattoir software/on line resources produced by three veterinary schools, to assess whether they were sufficient to temporarily fulfil the abattoir requirements of the RCVS Standards and to ensure that the Veterinary Public Health elements of the Day One Competences would be met.

14. After careful review, it had been decided that the virtual resources were sufficient to deliver the learning outcomes expected of a traditional abattoir visit, subject to a series of recommendations that were noted by the committee.

Temporary changes to EMS policy

15. Due to the Covid-19 pandemic, access to EMS placements has been substantially reduced and the RCVS Covid-19 taskforce had therefore agreed to reduce the required number of weeks of EMS to varying degrees, depending on year of study. All amendments are subject to ongoing review as the pandemic progresses. The students had been informed of the changes and the information is also available on the RCVS website.

16. The committee were informed that a range of online resources had been developed with support from the species societies, which are now available for students on our website. These focus on animal handling and are available to supplement the pre-clinical EMS and help students in this area. Further guidance had been developed in conjunction with the EMS co-ordinators around amended EMS requirements and resources available.

Temporary amendment to RCVS accreditation standards

17. Due to restrictions put in place as a result of the pandemic, Practice Standards Scheme (PSS) assessments had been placed on hold. This had the potential to impact on student learning where RCVS standard 3.7 required PSS accreditation for all practices where core clinical teaching took place. It was noted that a temporary amendment to the RCVS standards for accreditation of veterinary degrees was agreed by the Covid-19 Taskforce in June 2020, which stated that practices would be allowed to receive students on clinical rotations, where PSS accreditation was not yet completed, subject to a series of requirements which Education Committee noted.

Update from CPD Referral Group

18. The committee received the minutes from the Referral group meeting on the 15 August 2020. Ms Ford briefed the committee about the discussions at the meeting.

19. At the last meeting in May, the Education Committee approved the non-compliance procedures that will start from 2023. For the compliance process to work, it is essential that the majority of RCVS members use 1CPD but there will need to be an exemption process in place. The CPD Referral Group recommended that anyone who wanted to be exempted from using 1CPD, need to fill in a form that will reviewed by the Group and any member approved to be exempt need to submit their records on yearly basis to the RCVS.

20. The group discussed requests from corporations, CPD providers and Royal colleges about access to 1CPD so that their members/employees can record CPD using their system and import it into 1CPD. The group felt that considering the resources necessary this was not an area for consideration at the moment, but it will be reviewed again once 1CPD is mandatory in 2022.

21. For some cases referred to the group, members need additional support to create a development plan or identify learning opportunities. The group recommended that for those circumstances the group should have the option of appointing a CPD coach to support the member and help them reach the CPD requirement. The process to recruit coaches still needs to be reviewed but we could use members that are already in supporting roles such VetGDP advisers or clinical coaches.

22. Since the group was set up in 2015, further areas of work have been added to their remit. The group, therefore, reviewed and amended the terms of reference to reflect the purpose of the group and suggested a change of name to the CPD Compliance Panel. The group also recommended to expand the membership from four to six members, including two veterinary

surgeons, two veterinary nurses and two lay members. It was suggested that in the first instance, we ask RCVS Council for any volunteers to join the group and then possibly extend the invitation to the wider profession.

Action: JST to develop a role specification and send it to RCVS Council.

23. See appendix A for further discussion

Graduate Outcomes

Veterinary Graduate Development Programme (VetGDP)

24. The Committee was presented with the work completed on the VetGDP to date, including the bank of Entrustable Professional Activities (EPA's), a toolkit for developing new EPA's, and the draft guidance for the programme. The guidance gives an overview of the programme but also more in-depth information on the aims of the programme, and the roles and activities for each of the stakeholders.

25. The Committee suggested further work could be done in the guidance on including those not going into practice, and questioned whether the adviser needed to be a vet or could be another member of the team. It was also asked if the whole veterinary team could participate in some training so that all would be in a position to help the graduate. There is a further task and finish group meeting where these points can be considered.

Action: BC to feed back

26. The next steps are to set up the Accreditation and Quality Assurance task and finish group. Also to continue work on the e-portfolio, which will be based on the current 1CPD platform cutting down a lot of the work needed. There will also be a body of work to set up the training platform and develop the e-learning content for the Advisers.

EMS/Clinical Education Update

27. The minutes from the recent meeting of the EMS & Clinical Education Sub-group were received and noted. It was also reported that the next meeting of the group would be the day after the Education Committee, so a further update would follow at the November meeting of Education Committee.

28. Some concerns were raised regarding the discussion minuted regarding teaching in general practice and specialist practice, and whether or not the group was arguing that that clinical teaching delivered in a specialist practice was not effective. However, it was clarified that this was not the case and that the minutes captured a summary and the outcomes of the discussion. Therefore it was agreed that the minutes would be updated to include further detail and context.

Action: Education Department to update the minutes.

29. Concerns were also raised around the group's suggested figure of what the "majority" of clinical education to be delivered to students in general practice was, and clarification was asked around

how the group came to the figure. It was clarified that the vet schools had been asked to give rough estimations of the percentage of teaching that was currently taking place in a first opinion or general practice context, and the group had considered these when deciding on the figure, but there were still concerns around the lack of further evidence that the figure had been based on. It was acknowledged that it would be useful to look at further outcomes data, but unfortunately there was not a lot of data available. However, the comment would be put back to the group to consider at its next meeting, and Education Committee would be updated on the discussions at the next meeting.

Day 1 Competences (D1C): endoscopy

30. Following publication of the new Day One Competences (D1C), RCVS received correspondence from Professor Ed Hall at Bristol University regarding concerns over the accompanying guidance, and that the new D1Cs perpetuated an issue from the previous guidance, which had been raised before.

31. The Competence no. 32: "*Use diagnostic techniques and use basic imaging equipment and carry out an examination effectively as appropriate to the case*" was felt to be appropriate. However, Professor Hall commented that the guidance notes were a concern: "*Basic equipment includes, for example, x-ray, ultrasound and endoscopes, but a new graduate would not be expected to perform an MRI or CT scan*."

32. It was felt that whilst 'endoscopes' may refer to otoscopes and laryngoscopes, competence in either rigid (laparoscopy, arthroscopy) and flexible endoscopy were felt to be not achievable goals for new graduates.

33. Education Committee agreed with this summary and agreed to support a change in the guidance to read "*Basic equipment includes, for example, x-ray and ultrasound, but a new graduate would not be expected to use endoscopes or perform an MRI or CT scan."*

Action: RCVS to amend D1C guidance notes

Accreditation Review

Minutes from the meeting held on the 24th June and 24th August 2020

34. Professor Nigel Gibbens presented the minutes from two meetings of the Accreditation Review Working Party (ARWP) to Education Committee for note. Attention was drawn to considerations made by the working party surrounding abattoir teaching and requirements to specify a number of weeks of clinical, hands-on training within a veterinary programme.

35. It was noted that the working party had considered the requirement within RCVS standards which stated that students must experience red and white meat abattoirs in person. With a temporary amendment to standards in place during the pandemic, which allowed schools to use virtual abattoir materials to fulfil the learning objectives of a traditional abattoir experience. Education Committee praised the virtual abattoir experience for its usefulness at this time and for providing a

level playing field for students. However, they agreed that there was no substitute for the physical abattoir experience and that it was necessary for a complete veterinary education.

New 2020 standards

36. The new RCVS standards for accreditation, approved by the ARWP, were presented for comment. There was still some work to complete on standards relating to what constitutes a "majority" of teaching and the definition/context of "primary care", as well as the EMS standards; however, it was reported that these would be updated in light of the Graduate Outcomes working group currently considering these issues. The remaining standards had all been mapped to the current standards so that nothing had been missed out, and the next step was to develop the guidance notes to sit alongside the new standards themselves.

37. It was reported that during the PQSC meeting held on 11 September, the sub-committee had commented that the sequencing of the standards needs to be improved, which RCVS had agreed to review.

38. There was unanimous praise for the new standards, however, and it was commented that the RCVS had clearly put a lot of work into their development. Education Committee agreed that the standards could be approved so that work could begin on drafting the guidance to support them.

Action: RCVS to draft guidance notes for the 2020 accreditation standards

New 2020 methodology

39. Education Committee members were asked to consider a draft of the new accreditation methodology so that a formal policy could be developed. It was reported that this new process represented a shift towards a hybrid model of accreditation, where the focus would be on outcomes and demonstrable evidence, whilst still retaining the necessary inputs needed to determine quality. It followed a risk-based approach to accreditation that would take and consider the evidence acquired before a visitation to inform the structure and focus of the visit itself.

40. It was highlighted to the committee that there was a third strand to the review which had not yet commenced, looking at a complete revision of visitor training that would sit alongside the accreditation work.

41. It was also noted that both the annual monitoring cycle and the formal two-month consultation period, for schools to provide a response to the visit report, needed to be structured into the process chart.

42. It was reported that PQSC had highlighted the need for an additional step to be incorporated at the beginning of the process to describe the coordination with the vet school (and any international accreditors with an interest) regarding the scheduling of the visit.

43. Education Committee again commended the work undertaken and agreed that the methodology should be written up into a formal process.

Action: RCVS to draft full accreditation methodology

Statutory Membership Exam

2020 Diet Written Exam

44. The Committee heard that the written components of the Statutory Membership Exam had taken place during the week beginning 17 August. These took place remotely with ExamSoft's invigilation feature enabled. A full report on whether to consider permanently transitioning to remote, invigilated written exams is due for Education Committee's decision at end of the year.

45. Of the 26 candidates who entered, five passed the written papers and will proceed to the OSCE resulting in a pass rate for this first stage of the exam of 19%, which is almost identical to pre-appeal pass rate from the 2019 diet. One of the failing candidates passed all of the clinical domain papers but failed the Code of Professional Conduct (COPC) paper and as such under our current resit policy he will be entitled to re-sit the COPC paper which will take place on 9 October.

46. The OSCEs are scheduled to take place at the University of Glasgow, School of Veterinary Medicine during the week beginning 14 December.

Refugee Support Proposal

47. The policy for how the RCVS can administer financial assistance to refugee candidates who want to sit the Statutory Membership Examination was presented for information. The paper outlined the process as well as estimated costs depending on what level of support the RCVS would be willing to make available.

48. The figures quoted in the paper were based on the number of declarations from refugee candidates received during the application window for the 2020 diet.

49. Education Committee agreed that this was a worthwhile policy and were happy for it to be implemented.

Action: to go to Finance and Resources Committee for approval

Primary Qualification Sub-Committee (PQSC)

50. Members of Education Committee were presented with an oral update of the recent PQSC meeting. It was reported that the minutes and related actions from that meeting would be presented at the November meeting. One item that did require more urgent attention, however, was the proposed policy for undertaking virtual visitations due to the ongoing pandemic.

51. When lockdown measures were introduced in March 2020, all accreditation visits were postponed and accreditation periods for those schools due a visitation extended by 12 months, to facilitate rescheduling. With threats of a second wave of infection, and localised flare-ups both nationally

and internationally, it was reported that there was no guarantee that “traditional” accreditation visits would be possible within the next 12 months.

52. Since it was recognised that it would not be feasible to keep extending accreditation periods, another solution had been required. Through discussions with other international accreditors, RCVS had learned that many were moving to conduct online/virtual site visits, in order to continue their accreditation functions. It was reported that the American Veterinary Medical Association (AVMA) had already trialled a virtual site visit and developed policy/guidelines to help facilitate this.

53. As remote visitations would be new to the RCVS, and would represent a change to its published standards, a policy and guidelines needed to be agreed upon through the RCVS Covid-taskforce. It was pointed out that this guidance would apply only in situations where RCVS was the sole accreditor, and that for visitations involving members of IAWG, a separate agreement would need to be developed between those members for the conduct of international virtual visitations.

54. Education Committee were content with the policy and recommended to Covid-19 Taskforce that this policy apply where virtual visitations were used in the accreditation of UK veterinary programmes.

Action: Education Committee recommends to RCVS Covid-19 Taskforce that the policy for conducting virtual visitations be approved.

RCVS Review of Vet School Plans

55. Due to the constraints put in place at the start of the Covid-19 pandemic, which included restrictions on travel and a national lockdown, universities were no longer able to allow students on site, and alternative plans became necessary in order to continue the delivery of courses.

56. Vet schools were subsequently formally requested to submit those plans for review by RCVS in order to not only provide reassurance from a regulatory perspective, but also to provide a permanent record of changes made that could be considered by future visitation teams during accreditation visits.

57. These plans required formal review, which would normally take place through both PQSC and Education Committee. However, many of the members of these committees were directly associated with vet schools and therefore conflicted. Consequently, it was proposed that a new temporary group be established to review these plans, comprising the Chair of Education Committee, the RCVS Director of Education, and an independent expert.

58. Following review, vet schools had been provided with both generic and specific feedback relating to their plans. It was reported that the following themes had emerged:
    i. Vet schools should take a closer look at invigilation of examinations going forward
    ii. That a gap analysis around teaching and learning outcomes be conducted
    iii. Any hands-on practical experience lost should be caught up when possible, and not just through the use of simulations

iv. That vet schools needed to consider their ‘plan B’ in case of further restrictions

59. Committee members applauded the veterinary schools for the immense amount of work that had gone into supporting student learning during what were challenging times for everyone. It was reported that the next update from vet schools was due in October and that Education Committee would receive further updates in due course.

Certificate in Advanced Veterinary Practice (CertAVP)

60. Dr Melissa Donald, in her new role as Chair of the sub-committee, thanked Jill Maddison and David White for their years of hard work on the sub-committee. The Committee noted the minutes from the meeting.

Advanced Practitioner

List of new approved advanced practitioners

61. The Committee noted the lists of approved Advanced Practitioners.

Status Evaluation Research Report

62. The committee received the Advanced Practitioner (AP) status evaluation report and Mr Chambers highlighted some of the findings to the committee. Laura Hogg was unable to attend the meeting but Mr Chambers thanked her for all her hard work in producing an excellent report.

63. The results from the evaluation showed that there is a lot of confusion about AP status in general, the benefits of the status, and the difference between a Certificate in Advanced Veterinary Practice (CertAVP) and AP status.

64. Advanced Practitioners who responded to the evaluation reported a lot of personal benefits to holding the status, such as increased self-esteem, better standards of practice and patient care.

65. There is a lot of work for the RCVS to provide more clarity between CertAVP, which is a qualification, and AP status which requires applicants to demonstrate how they have met the full set of criteria including additional CPD. It was suggested that in order for the status to receive more recognition, we need to do more to celebrate the achievement of becoming an Advanced Practitioner.

66. The report showed that there is a limited understand amongst the public about AP status and the committee felt that it would be helpful if the RCVS could help practices to raise awareness of AP status and the vets in their practice that holds the title.

67. The next step is to conduct focus groups to develop a greater understanding about some of the issues raised in the report. Education Committee will be updated about the progress of the project.

Action: Set up focus groups

Additional AP designation

68. The committee approved the addition of Camelid Practice as an AP designation.

ENQA Update

69. The Committee heard that the ENQA (European Association for Quality Assurance in Higher Education) progress visit took place virtually on 2nd September 2020. The agenda covered the key recommendations that were made at the accreditation review in 2018, and the ENQA panel provided positive feedback on the work that had been done so far to address these points. Two of the items discussed related to the IQA Policy and procedures, and the Thematic Analysis Policy. ENQA gave some feedback on both these policies around how the results and outcomes should be published, but were happy with both policies.

QI policy and procedures

70. The committee understood that the policy and procedures were reviewed by ARC on 31st July 2020 and minor updates were made based on the recommendations of the committee. They were also reviewed by PQSC on 11th September. No further comments were made by the Education Committee.

Thematic analysis policy

71. The policy was presented to both ENQA on 2nd September and PQSC on 11th September 2020. No further comments were made by the Education Committee.

Specialists

72. A letter regarding concerns relating to apparent lack of availability of equine specialist training residencies and potential shortage of equine Specialists within the UK and Ireland was received and noted.

73. The Specialist Sub-Committee had also received the letter, and recognised that residency places were a problem more generally in other disciplines. Relating to the concerns of a shortage of equine Specialists, the data did not necessarily reflect this, with 32 new RCVS Specialists being listed across the equine disciplines since 2017.

74. The Committee were asked to comment, and it was agreed that based on the data there was not anything to suggest that there could be a shortage of equine Specialists emerging. It was also agreed that whilst it was acknowledged that there was a general, wider issue surrounding residency availability and specialist training, it is not within the remit of RCVS to act in this instance. It was agreed that the comments would be fed back to the Specialist Sub-Committee and a response letter drafted.

Action: Specialist Sub-Committee to draft a response

Risk Register

75. The committee received and noted the risk register for the Education department.

76. The committee reviewed the ratings and felt that it would be useful to receive further information about the reports and how the risks were calculated so it was suggested to invite Alan Quinn-Byrne to next meeting.

Action: Education Department to invite Alan Quinn-Byrne to the November meeting

77. The committee queried the risks in relation to Covid and were reassured that they only apply to the Education Department and not to Education more widely. The risks are being reviewed on a monthly basis by the department.

78. The Committee considered the departmental risk register and were asked to email Jenny Soreskog-Turp if they any questions or additions.

ACTION: Committee to email Jenny Soreskog-Turp with any questions or additions to the risk register.

Any other business

79. The Chair asked for volunteers for vice chair of Education Committee to email their interest to the committee secretary.

Date of next meeting

80. Tuesday 10th November 2020 at 10am

Britta Crawford
Committee Secretary
September 2020
b.crawford@rcvs.org.uk

Summary

Meeting	Council
Date	8 October 2020
Title	Minutes of the Finance and Resources Committee 23 July 2020
Summary	To Note: Minutes of Finance and Resources Committee
Decisions required	None
Author	Alan Quinn-Byrne Governance Officer/Secretary a.quinn-byrne@rcvs.org.uk / **T** 020 7227 3505

Classifications

Document	**Classification**[1]	**Rationales**[2]
Minutes	Unclassified	n/a
Confidential appendix	**Confidential**	**1, 2, 3**

[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

Minutes of the Finance and Resources Committee (FRC) held remotely via Microsoft Teams on Thursday, 23 July 2020

Members:

Professor Susan Dawson	Chair / RCVS Treasurer
*Dr C L Scudamore	Representative from Education Committee
Dr C W Tufnell	Representative from Advancement of Professions Committee
Ms J S M Worthington	Lay Member RCVS Council
Mr M L Peaty	Representative from Standards Committee
Mr M E Rendle	Representative from Veterinary Nursing Council
Dr M A Donald	Representative from PIC/DC Liaison Committee
Mr T J Walker	Lay Member RCVS Council
Ms Jane Davidson	Representative from Veterinary Nurses' Council
Mr Richard Stevenson	Elected member RCVS Council

In attendance:

Ms L Lockett	CEO
Ms E Ferguson	Registrar / Director of Legal Services
Ms C McCann	Director of Operations (DoO)
Mr A Quinn-Byrne	Secretary FRC/Governance Officer

Apologies for absence

1. Dr Scudamore had sent apologies for absence.

Declarations of interest

2. There were no new declarations of interest to note.

Minutes of the Meeting held on 7 May 2020

3. There were no comments / amendments to add on the May 2020 minutes, and it was held they were a true reflection of the meeting.

Matters Arising

4. As this was a special meeting to discuss one topic only, it was agreed that matters arising from the May minutes would be discussed at the regular September meeting of FRC.

Agenda Item 5

5. Confidential information is available in the classified appendix at paragraph 1-22

Date of next meeting

6. 10 September 2020 at 2pm

Summary	
Meeting	Council
Date	8 October 2020
Title	Standards Committee report to Council
Summary	Minutes of Standards Committee held on Monday, 7 September 2020 at 10am remotely. In particular, the Committee is to note: a. Standards and Advice update The Committee were advised that a draft preamble (to replace the current Chapter 25 of the supporting guidance) and framework awaited comment from key stakeholders and further consideration by the Recognised Veterinary Practice Working Group before coming to the Committee. b. Equine ID The Committee approved the proposed changes to Chapter 29 of the supporting guidance (following changes to legislation on microchipping equines), bar two paragraphs which they requested greater clarity on. The Committee agreed that Chapter 29 be separated in to two chapters for small animal and equine. c. Health Protocol The Committee discussed proposed changes to Chapter 15 of the supporting guidance (RCVS Health Protocol) and noted that the substance of the guidance had not changed; rather the proposed amendments were to ensure the protocol is easily understood by the profession and serves its purpose as supportive guidance. The Committee unanimously approved the proposed amendments to the guidance. The Committee's attention is drawn to paragraphs 8 – 10 and 22 - 23 in the classified appendix.
Decisions required	n/a
Attachments	Classified appendix
Author	Nick Oldham Standards and Advice Manager n.oldham@rcvs.org.uk Lisa Price Head of Standards l.price@rcvs.org.uk

Classifications

Document	Classification[1]	Rationales[2]
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**1, 2, 3**

1Classifications 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.

2Classification 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

Minutes of the Standards Committee held on Monday, 7 September 2020 at 10 am remotely.

Members:	Prof D Argyle	
	Mr M Castle	
	Mrs C Roberts	
	Dr M A Donald	Chair
	Mr D Leicester	
	Ms C-L McLaughlan	
	Mr M Peaty	
	Ms B Andrews-Jones	
	Miss L Belton	
	Dr C Allen	

In attendance:	Ms E C Ferguson	Registrar
	Mrs L Price	Head of Standards
	Mr N Oldham	Standards and Advisory Manager
	Ms B Jinks	Senior Standards and Advisory Officer
	Ms K Richardson	Senior Standards and Advisory Officer/Solicitor
	Mrs S Bruce-Smith	Standards and Advisory Officer
	Ms L Lockett	CEO
	Mr I Holloway	Director of Communications
	Dr M Greene	President (observer from RCVS Officer Team)
	Dr C Middlemiss	CVO
		Present for AI 3(a) only
	Dr A Ridge	APHA
		Present for AI 3(a) only
	Ms L Lipman	PSS Manager
		Present for AI 3(c) only
	Mr R Girling	Solicitor – Disciplinary cases
		Present for AI 3(e) only
	Ms G Crossley	Head of Professional Conduct
		Present for AI 3(e) only

AI 1 Apologies for absence and declarations of interest

1) The Chair welcomed the President to the meeting as observer and Mrs Roberts to her first meeting on the Committee. No apologies were received.

2) The following declarations of interest were made:

   a. Mr Leicester stated he had recently been appointed Head of Telemedicine Services at Vets Now.
   b. Mr Peaty advised he had been contacted by Food Standards Scotland in relation to the importance of Agenda Item 3(a) and that he had met with parties mentioned within the paper at Agenda Item 3(c) some years ago.
   c. Dr Allen stated that she had been contacted by a telemedicine provider offering to provide assistance following the closure of the RSPCA's Animal Hospital in Putney.
   d. Ms Andrew-Jones advised that her previous employer is related to the proposal set out in the paper at Agenda Item 3(c).

3) The Chair asked for consent to record the video stream of the meeting. There were no objections to this request.

AI 1 Minutes of last meetings held on 27 April 2020

4) It was agreed that the minutes of the last meeting are accurate.

5) In regards to the actions from the last meeting (unclassified minutes):
   a. Paragraph 6 – The Standards and Advisory Manager stated he would address particular themes to COVID-19 enquiries in his update.
   b. Paragraph 14 – The Committee were advised amendments approved to Chapter 17 of the supporting guidance on Professional Indemnity Insurance were live.
   c. Paragraph 16 – The Committee were informed that case studies on social media approved following its last meeting had been circulated as part of RCVS' Standards Update to the profession in June.
   d. Paragraph 17 – The Committee were advised that the social media case studies had been published as part of the RCVS' Standards update in June.

AI 2 Standards and Advice Update

6) The Standards and Advice Manager provided an oral update, confirming that since the peak of COVID-19 enquiries in March and April, the volume of calls/emails in relation to the pandemic has

slowly decreased. The Committee were advised that at the outset of lockdown enquiries related to matters including; RCVS contingency planning, remote prescription, advice for animal owners, Extra-mural studies, requests for ventilators, keyworkers, emergency/urgent treatment, and vaccinations. Following the introduction and development of the RCVS' flowchart to assist professionals decide what type of work they can carry out, subsequent and most recent enquiries and guidance have focused on matters such as; quarantine exemptions, travel corridors, animals and COVID-19, and face masks.

7) The Standards and Advisory Manager provided an update on the ongoing work of the Recognised Veterinary Practice (RVP) Working Group and its associated small group. The history of this group and its work was provided for new members of the Committee. The Standards and Advisory Manager advised a draft preamble (to replace the current Chapter 25 of the supporting guidance) and framework awaited comment from key stakeholders. It is anticipated this subject will be brought back for the Committee's consideration in November.

Matters for decision

AI 3(a) Certification – Confidential

8) Confidential information is available in the classified appendix at paragraphs 6 – 14.

AI 3(b) UCOOH – Confidential

9) Confidential information is available in the classified appendix at paragraphs 15 – 19.

AI 3(c) Equine ESC – Confidential

10) Confidential information is available in the classified appendix at paragraphs 20 – 23.

AI 3(d) Equine ID

11) The Committee were asked to review and approve amendments to Chapter 29 of the supporting guidance following changes to legislation on compulsory microchipping of equines throughout the UK which came into force in 2019/2020.

12) The Committee accepted the proposed changes, bar two paragraphs which they requested greater clarity on. The updated guidance will be circulated to the Committee, via email, following the meeting for further approval.

Action: Standards and Advice Team

13) The Committee observed that ownership issues arise with equines and details on passports and clinical records may differ. The Committee suggested Chapter 29 of the guidance, which covers 'Microchips, microchipping and animals without microchips', be separated in to two chapters for small animal and equine.

Action: Standards and Advice Team

AI 3(e) Health Protocol

Robert Girling and Gemma Crossley joined the meeting

14) The Committee were asked to review Chapter 15 of the supporting guidance which sets out the RCVS Health Protocol. The paper presented outlined that the substance of the guidance had not changed; rather the proposed amendments were to ensure the protocol is easily understood by the profession and serves its purpose as supportive guidance.

15) It was noted that the RCVS had consulted Vet Life, the Veterinary Defence Service and Preliminary Investigation Committee's Health Subgroup.

16) The Committee had no questions for the Registrar or Head of Professional Conduct and unanimously approved the proposed amendments to the guidance.

Action: Standards and Advice Team

Robert Girling and Gemma Crossley left the meeting

AI 4(a) DC report

17) The Registrar explained that the short report summarised two recent restoration applications, both of which were rejected.

18) Due to the pandemic, it had been difficult to arrange disciplinary hearings, and the use of larger facilities nearer to respondents is being considered in the hope three or four hearings can take place by the end of the year.

AI 4(b) Riding Establishments Subcommittee report

19) The Committee were advised that following the Subcommittee's July meeting the Inspector Form had been updated and the inspectorate notified.

20) At the Subcommittee's annual meeting scheduled in November, further consideration will be given to 2021 refresher and induction courses and details will be circulated to the inspectorate.

AI 4(c) PSS report

21) The Committee noted that PSG had agreed to the proposal for remote PSS assessments and that the decision would be referred to the COVID-19 Taskforce at their next meeting.

AI 5(a) RVP Subcommittee report – Confidential

22) Confidential information is available in the classified appendix at paragraph 24.

AI 5(b) ERP report – Confidential

23) Confidential information is available in the classified appendix at paragraph 25.

Any other business and date of next meeting

24) There was no other business.

Date of next meeting

25) The date of the next meeting is 9 November 2020.

Table of unclassified actions

Paragraph	Action	Assigned to
12	Update proposed guidance and circulate to the Committee, via email, for approval.	Standards and Advice Team
13	Consider splitting Chapter 29 of the supporting guidance in to two chapters for small animal and equine.	Standards and Advice Team
16	Update Chapter 15 of the supporting guidance with approved amendments.	Standards and Advice Team

RCVS SETTING VETERINARY STANDARDS

Summary

Meeting	Council
Date	8 October 2020
Title	Veterinary Nurses Council Report to Council
Summary	To note the minutes of the meeting of Veterinary Nurses Council (VNC) held on 9 September 2020. In particular, to note the following: • VNC accepted several recommendations of the CPD referral group, which are listed in the minutes. • VNC agreed that the veterinary nursing degree awarded by Castelo Branco University of Applied Sciences in Portugal should be added to the list of qualifications for which the holders are permitted to provide reduced documentation for consideration, when applying to enter the UK Register of Veterinary Nurses. • VNC agreed to recommend the draft budget for 2021 to the Finance and Resources Committee (FRC). The VN budget forms part of the 2021 RCVS budget which will be put to RCVS Council in November for final approval.
Decisions required	None
Attachments	Classified appendix
Author	Annette Amato Committee Secretary a.amato@rcvs.org.uk / 020 7202 0713

Classifications

Document	Classification[1]	Rationales[2]

Paper	Unclassified	n/a
Classified appendix	**Confidential**	1,2,3,4

[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

Veterinary Nurses Council

Minutes of the meeting held remotely via Microsoft Teams on Wednesday 9 September 2020

Members:		Mrs Belinda Andrews-Jones	-	Vice-Chair
		Miss Alison Carr		
		Ms Elizabeth Cox		
	*	Miss Jane Davidson		
		Mr Dominic Dyer		
		Dr Joanna Dyer		
		Ms Sarah Fox		
		Mrs Susan Howarth		
		Mrs Andrea Jeffery		
	*	Mrs Katherine Kissick		
		Mr Matthew Rendle	-	Chair
		Dr Katherine Richards		
		Ms Stephanie Richardson		
		Mrs Claire Roberts		

*absent

In attendance:	Mrs Annette Amato	-	Committee Secretary
	Miss Chloe Baxter	-	Comms Event Officer
	Mrs Julie Dugmore	-	Director of Veterinary Nursing
	Ms Eleanor Ferguson	-	Registrar
	Miss Shirley Gibbins	-	Qualifications Manager
	Mrs Victoria Hedges	-	Examinations Manager
	Ms Lizzie Lockett	-	Chief Executive
	Mrs Jenny Soreskog Turp	-	Lead for Postgraduate Education
Guests:	Ms Kathryn Clark	-	Veterinary Record
	Mrs Suzanne Edwards	-	Chair, Registered Veterinary Nurse Preliminary Investigation Committee

Apologies and welcome

1. Apologies for absence were received from Jane Davidson and Katherine Kissick. The Chair welcomed four new members of Council; Claire Roberts (elected veterinary nurse member), Sarah Fox and Stephanie Richardson (appointed lay members) and Kate Richards (appointed veterinary surgeon).

Declarations of interest

2. There were no new declarations of interest.

Obituaries

3. No written obituaries had been received. Council was encouraged to have a moment of quiet reflection for all members who had passed since the last meeting, and for all members of the veterinary, medical, and other professions, who were facing untold difficulties during the current pandemic.

Minutes of the meeting held on 6 May 2020

4. The Minutes of the meeting held on 6 May 2020 were accepted as a correct record.

Minutes of the meeting held on 17 June 2020

5. The Minutes of the meeting held on 17 June 2020 were accepted as a correct record.

Matters arising

6. There were no matters arising from the minutes of the two previous meetings.

CEO update

7. Council noted the CEO's update report, which provided a summary of activity against the 2020-2024 Strategic Plan.

8. Since the paper had been put together the European Association for Quality Assurance in Higher Education (ENQA) informal two-year visit had taken place. The team had been very complimentary about the agility and speed with which the RCVS team had made changes in meeting the recommendations identified at the original accreditation.

9. It was confirmed that the draft consultation document produced by the Legislation Working Party would be provided for VN Council to see, possibly between meetings due to the timing.

VN Education Committee (VNEC)

10. Susan Howarth, Chair of the VNEC, presented the report of the meeting held on 29 July 2020, and highlighted the following points:

11. The Committee had welcomed Sarah Fox, one of the new lay members on Council, as a member of the Committee.

12. The VN department had appointed a new enrolments officer, Jasmine Curtis RVN.

13. The Committee had noted from a recent survey conducted by the RCVS covering Covid-19 related issues in practice, that 39% of responding practices had cancelled student placements. The VNEC would try to monitor this situation in the coming months. It was not yet known how the student enrolment numbers would be affected. The Director of Veterinary Nursing added that a Covid-19 report form had been sent to all universities and colleges to complete, and information had been requested around student numbers. This information was currently being collated.

14. In response to a query regarding potential difficulties in completion of the required 1,800 hours' training in practice during the Covid-19 pandemic, the Director of Veterinary Nursing confirmed that this had already been addressed and a procedure was in place to consider situations where a student had been able to complete the Day One Skills in less than 1,800 hours, on an individual case-by-case basis.

15. Following the development of the Patient-Based Assessment (PBA) by the OSCE taskforce, information sessions and examiner training had been conducted by the Examinations Manager and the Qualifications Manager, and the process was now well under way. The number of students undergoing the PBA was not yet known. It was understood that, at present, City & Guilds was the only organisation intending to deliver the PBA.

16. There had been no new accreditations or changes to accreditation status. A number of updates had been provided on action plans. There were likely to be some additional programme changes and adjustments to take account of the Covid-19 requirements, and the department was gathering information from the colleges using the proforma which had been approved by the Committee. The department's auditing activities would be adapted to fit in with the amended risk banding associated with the Covid-19 changes and challenges.

17. Although some new accreditation visitors had been recruited, there was still a shortage of employer visitors.

18. In response to a query as to whether the membership of the Committee includes appropriate representation from all sectors of veterinary nurse education, the Director of Veterinary Nursing confirmed that it had been agreed that the terms of reference and membership of the committee would be reviewed. This had been overtaken by the current situation, but the review would take place to ensure that all aspects of veterinary nurse education were included.

CPD Referral Group

19. The Lead for Postgraduate Education introduced the main points from the minutes of the CPD Referral Group's meeting on 5 August 2020, which included the following recommendations:

a) To permit a process for exemptions from the use of the 1CPD platform, for the small minority who may have a valid reason for being unable to do so.
b) Not to allow third-party access to 1CPD (to be reviewed in 2022 again).
c) To allow the CPD Referral Group the option of appointing a CPD coach for referred cases.
d) To approve the updated terms of reference.

e) To appoint a further veterinary nurse to join the group.
f) To approve the change of name to 'CPD Compliance Panel'.

20. In relation to reasons for exemptions from the use of 1CPD, it was confirmed that there was not currently a list of exemptions. The group will work with the Comms department to discover the most common issues, but it is vital that there are only very few exemptions in order for the system to work properly.

21. Regarding third-party access to 1CPD, it was clarified that this was in relation to requests from other organisations, CPD providers and Royal Colleges to allow the transfer of data recorded on the 1CPD system to take place automatically to another system, or for individuals to import CPD recorded on another system into 1CPD, to avoid duplication of records. The reason for the recommendation to defer consideration of this point until 2022 was due to the significant resources which would be needed to build and maintain the functionality.

22. The updates to the membership and terms of reference of the group, and the change of name, were intended to clearly reflect the purpose of the group and to ensure that the group is not duplicating the work of other groups within the College.

23. One member expressed concern that consideration of third-party access to 1CPD would be deferred until 2022, as some large employer organisations would wish to access records to ensure compliance and assist their employees in CPD planning. It was clarified that the issue was not related to sharing a CPD record with employers and others, which would certainly involve GDPR issues. It was pointed out that it was currently possible for members to export their records from 1CPD as a pdf or spreadsheet. The question of employer access to employee data was not in the current agreement signed by all members, and completion of CPD was ultimately the responsibility of the individual.

24. After the discussion and clarification provided, Council agreed to accept all the recommendations set out in the paper. The Chair and Director of Veterinary Nursing would provide details of the second nurse member selected to join the Referral Group.

Action: Chair and Director of Veterinary Nursing

International Qualifications

25. **Annual update report.** The Examinations Manager presented the annual report summarising the applications for registration from nurses educated outside the UK, covering the period between 1 April 2019 and 31 March 2020, and drew attention to the fact that the number of applications and resulting registrations had fallen again, with the peak of new applications and registrations in 2016-2017.

26. Applications from nurses educated in the EU have remained stable but there has been a reduction in the number of applications from outside the EU. At the end of the reporting period there were 22 partial / incomplete applications, which is high in comparison to previous years. This is likely to be an effect of Covid-19, where applicants changed plans due to travel restrictions and the lack of employment opportunities.

27. As of 31 March, 473 current RVNs were educated outside the UK, which represents 2.6% of all RVNs registered at that date. The majority of overseas educated RVNs settle in the UK and remain on the Register.

28. Concern was expressed that it was still apparent that some applicants provided information which included details of procedures they had undertaken while working in the UK, which they were not legally permitted to undertake, and there seemed to be confusion about what was legally permitted. These individuals were required to complete an assignment covering the role of the veterinary team and UK legislation before entering the Register, and the employer was reminded of the legislation around delegation to people who were neither students nor registered veterinary nurses.

29. **Overseas registration application change.** The Examinations Manager explained that overseas applicants were required to demonstrate that their qualifications align with the RCVS Day One Skills (DOS) and Day One Competences (DOC), and to provide a copy of their syllabus mapped to the DOC. These are assessed by the equivalency officer and a decision made as to whether the applicant could enter the Register directly, or if they needed to complete further adaptation in the form of an examination or other assessment.

30. The RCVS maintains a list of qualifications for which VN Council had agreed applicants are no longer required to provide the mapped syllabus, as the details have been assessed for a number of applicants over a period of time, all with a positive outcome. This included holders of ACOVENE (Accreditation Committee for Veterinary Nurse Education) accredited qualifications. Such applicants were still required to provide details of their experience and evidence that they hold the qualification, and applications could still be rejected, but the required documentation was reduced.

31. Council was asked to consider adding the veterinary nursing degree awarded by Castelo Branco University of Applied Sciences to its approved list. Within the last three years there had been seven applications from holders of this qualification, all of which had been accepted by the equivalency officer for admission to the Register without further assessment. In earlier years, four applications were received and the applicants were able to register without further assessment. It was agreed, after clarification of certain points, that the veterinary nursing degree awarded by Castelo Branco University of Applied Sciences should be added to the approved list.

32. It was confirmed that if a qualification on the approved list was reviewed and changed, the RCVS requests the applicants who completed the revised qualification to submit the syllabus, and this will be assessed. Once a number of applications with the revised qualification have been received and assessed, VN Council will be requested to add the revised qualification to the list of accepted qualifications.

33. A member asked whether the RCVS encouraged institutions across Europe to apply for ACOVENE accreditation, in order to bypass this process. It was noted that it would be a matter for individual institutions to decide, and it was not thought likely that they would take this route solely to ensure that their graduates could enter the UK Register without further requirements.

34. It was confirmed that a paper had already been considered by VN Council at a previous meeting, covering the implications for veterinary nurses with EU qualifications after Brexit. This would come back to Council when the outcome of the Brexit negotiations is clear.

35. The Director of Veterinary Nursing reassured Council that should ACOVENE make any changes to its dossier of competences, which is mapped to the RCVS DOS and DOC, this would be brought back to VN Council for review. ACOVENE was due to undertake a review of its documentation and would be mindful of the requirements for UK registration.

36. **Report on temporary student enrolments.** Council noted a paper setting out information on the number of temporary enrolments from student nurses educated outside the UK, working or on placement for a short period in the UK as part of their training.

Reports from RCVS Committees

Registered Veterinary Nurse Preliminary Investigation Committee (RVN PIC)

37. The Chair of the VN PIC, Suzanne Edwards, joined the meeting to present the annual report of the Committee, which had been circulated with the agenda, and responded to a query. The report was noted.

Standards Committee

38. Claire Roberts provided a brief update from the Standards Committee meeting held on 7 September.

39. The Committee had reviewed and approved, with some small changes, amendments to the supporting guidance following changes to legislation on compulsory microchipping of equines throughout the UK, and had agreed that the guidance on microchipping would be split into two chapters, one to cover equines and one to cover small animals.

40. The Committee had also reviewed the supporting guidance setting out the RCVS health protocols, with amendments made to ensure that the guidance is easily understood by the profession and serves its purpose as supportive guidance. The substance of the guidance had not changed, and had taken on board comments from Vetlife, the VDS and Pix Health sub groups.

Communications report

41. The Comms Event Officer reported on a number of recent and forthcoming activities.

42. The Introduction to the UK Veterinary Professions course had been launched earlier in the week. This was aimed at overseas vets and veterinary nurses intending to work in the UK. There had been 290 registrations overall, including over 30 veterinary nurses.

43. Veterinary Nurses Day, which had originally been postponed from May to October, had

unfortunately been cancelled. There would now be virtual events on the evenings of 20 and 21 October to celebrate the achievements of newly registered RVNs and those who have gained their Advanced Diplomas.

44. A virtual Fellowship evening was due to take place on the evening of 1 October. All Fellows and members of the veterinary and VN professions would be invited by email. The Honours and Awards evening would be taking place on 10 September, with a total of 17 awards being presented. In addition, the launch of two new awards would be formally announced.

45. Council members were asked to spread the word about the Golden Jubilee Award and to encourage VNs to nominate peers and colleagues for any of the other awards, during the forthcoming awards nomination period.

46. The Comms team would be in discussion with the Chair about more direct channels of communication with VNs in practice in the future, including suggestions for webinars. The team would be producing a welcome video for veterinary students for freshers' week, involving the President and VNC Chair, and this would also be provided to the VN students at Bristol and the Royal Veterinary College (RVC). It was agreed that a similar presentation would be useful, tailored for new VN students, to be made available to universities and awarding organisations to use part of their student inductions.

47. The first *VN Futures e-newsletter* would be issued shortly, to help flag up the content for the new website.

48. The Chair added that the letter which is sent to newly registered veterinary nurses to welcome them to the profession will now include a dedicated email address to enable RVNs to communicate with the Chair of VN Council directly. He thanked the Comms team for their guidance and assistance.

Any other business

49. The Qualifications Manager made a plea to members to pass on suggestions for suitable accreditation visitors, especially from the employment sector.

50. A positive comment was made on the employment of a veterinary nurse to join the VN team as enrolments officer, and it was suggested that this would also be useful in communications showing the diversity of career opportunities available to VNs.

Date of next meeting

51. Wednesday 11 November 2020 at 10.30am

Summary

Meeting	Council
Date	Thursday, 8 October 2020
Title	Minutes from Preliminary Investigation Committee and Disciplinary Committee Liaison Committee Report of 17 September 2020
Summary	An update was given on the impact of the lockdown on the cases referred to the DC, and the plan going forward in order to hold them this year. Further cases were due to be held virtually, and others being organised with social distancing measures in place. The increase of the enquiries to the VCMS was discussed in detail and explained that there was currently no conclusion to draw from this until there was further data.
Decisions required	None
Attachments	Classified appendix
Author	Hannah Alderton Secretary, PIC DC LC 020 7856 1033 h.alderton@rcvs.org.uk

Classifications

Document	**Classification[1]**	**Rationales[2]**
Paper	Unclassified	n/a
Classified appendix	**Confidential**	**4**

[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

Minutes of the Preliminary Investigation Committee / Disciplinary Committee Liaison Committee meeting held on Thursday, 17 September 2020

Members:	Professor D J Argyle	Member of Council / Junior Vice President (Chair)
	Mr I Arundale	Chair, DC
	Professor S Dawson	Member of Council / Treasurer
	Dr M A Donald	Chair, SC
	Mrs S K Edwards	Chair, RVN PIC
	Dr N C Smith	Member of Council
	Dr C W Tufnell*	Council Member
	Dr B P Viner	Chair, PIC
	Ms J S M Worthington	Member of Council
In attendance:	Miss H Alderton	Secretary
	Ms E C Ferguson	Registrar / Director of Legal Services
	Ms L Lockett	CEO
	Ms G Crossley	Head of Professional Conduct
	Miss Y Yusuph	DC Clerk

*Denotes absent

Apologies for absence

1. Apologies for absence were received from Dr C Tufnell.

Declarations of interest

2. It was stated that there were no new declarations of interest.

Minutes of the meeting held on Thursday, 21 May 2020

3. The minutes from the previous meeting were approved.

Updates – general

4. The Registrar gave a general update about the Disciplinary hearings that had been delayed due to COVID-19. It was stated that currently arrangements are being made to hold three of the hearings remotely via Zoom and another four will be held in person. An RVN case is due to be held in the College where the space will allow for social distancing with the smaller committee of

three members, instead of the seven that would be needed on the veterinary cases. The remaining three cases that need to be held in person will take place in large venues near the respondents' locations. This will prevent those involved having to take public transport into central London, but will incur extra costs of renting venues and travel for the RCVS team.

5. It was questioned whether there was any flexibility with the committee numbers if the College had the space to hold hearings with panels of three. It was explained that the Disciplinary Committee numbers requirement for veterinary surgeon hearings was fixed via the Legislative Reform Order, and so this was not possible.

6. It was put to the Registrar that there was a risk for those having to travel to the location and asked whether this had been considered. The Committee was reassured that all issues were being addressed in relation to COVID-19 and that only those who consented were being asked to attend hearings in person. The Registrar explained that one of the driving factors for hiring venues close to the respondents' locations was the Committee members, whose main concern was not being at the hearing, where they felt they could appropriately social distance, but taking public transport into central London. The importance of finding a balance between holding the hearings safely but also not keeping the case hanging over the respondents' heads was discussed; all respondents have been offered remote hearings but some, for good reason, did not wish to go down that route and the College has not challenged this. It was acknowledged there was no perfect solution.

7. The buddy system discussed at the previous meeting was in the process of being set up. Training had taken place and discussions were underway on how this facility would be branded and marketed so that all vets and veterinary nurses in the UK were aware of its function.

8. New regulations for website compliance meant that the concerns part of the website has had be amended in line with the new rules. Further work needs to be carried out on related documents. It was confirmed that this work was on track so that we would comply with the new regulations.

9. The Statutory Committees' annual training would still be taking place and split over several days to prevent a whole day on Zoom. The topics of the upcoming training included unconscious bias, case studies, and a legal update.

10. It was asked whether there was an update on the timings for the consultation on the proposed changes to the Disciplinary process. The Registrar confirmed that a paper with a draft consultation would be presented to Council at the October meeting, and the aim was for the consultation to take place around November.

Disciplinary Committee Report

11. The Disciplinary Report was stated to be self-explanatory, only two hearings had taken place since the last meeting, both virtually.

Monitoring/performance/working methods/outcomes/dashboard/KPIs

12. For this information please see paragraphs 1-5 of the classified appendix.

Veterinary Client Mediation Service (VCMS) feedback

13. Until lockdown it was explained that the figures from the VCMS had been as predicted but the epidemic had now caused a spike in enquiries. The VCMS explained that there were very few purely COVID-related enquiries, but the spike was due to other factors. This included the fact that members of the public were in a more anxious state and the profession was under greater pressure with potentially fewer staff members to handle complaints, and those who were working had little time for anything other than their main roles. This all coalesced and resulted in higher enquiry numbers. It was determined that no conclusion could be drawn at this point in time, until the situation had further settled down.

14. The 80 enquiries outside of the VCMS remit were highlighted and it was questioned whether this was exceptional. It was agreed that currently this was not an issue but something that could be looked into if the number continued to rise. It was pointed out that the RCVS had received an increased number of complaints regarding breeders, with the increased number of people buying puppies during lockdown, and it was suggested that some of the figures may have also been in relation to that.

Feedback to Standards Committee v.v. Liaison Committee

15. It was confirmed that there was nothing to report.

Risk Register, equality and diversity

16. It was confirmed there was nothing to add.

Date of next meeting

17. The date of the next meeting was confirmed as Thursday, 19 November 2020 at 10:00 am.

Any other business

18. It was highlighted that the Terms of Reference still referred to the Operational Board. It was confirmed that the public Terms of Reference, on the website, were correct, and that this would be changed on the papers going forward.

Hannah Alderton
Secretary, PIC / DC Liaison Committee
020 7856 1033
h.alderton@rcvs.org.uk

Summary

Meeting	Council
Date	8 October 2020
Title	Preliminary Investigation Committee Report to Council
Summary	This report describes the work of the Preliminary Investigation Committee since RCVS Council's last meeting, including by reference to key stage indicators, and provides information about the nature of concerns being considered by the RCVS.
Decisions required	None
Attachments	None
Authors	Chris Murdoch Senior Case Manager c.murdoch@rcvs.org.uk Gemma Crossley Head of Professional Conduct g.crossley@rcvs.org.uk

Classifications

Document	Classification[1]	Rationales[2]
Paper	Unclassified	n/a

[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

Preliminary Investigation Committee

Report to Council 8 October 2020

Introduction

1. This report provides information about the activities of the Preliminary Investigation Committee from May 2020 to September 2020 (18 September being the date of writing the report).

2. Since the last Report to Council (which gave information to 21 May), there have been seven Preliminary Investigation Committee (PIC) meetings: 3 June, 17 June, 8 July, 22 July, 12 August, 2 September and 16 September.

New cases considered by the PIC

3. The total number of new cases considered by the Committee at the seven meetings referred to above is 30. Of the 30 new cases considered:

   - 18 were concluded at first consideration by the Committee. Of these:

     - 7 cases were closed with no further action, and
     - 9 cases were closed with advice issued to the veterinary surgeon.

   - 12 were referred for further investigation, that is, further enquiries, visits and/or preliminary expert reports, and

   - 2 cases were referred to DC.

4. No cases have been referred to the RCVS Health or Performance Protocols in the reporting period.

Ongoing Investigations

5. The PI Committee is currently investigating 20 ongoing cases where the Committee has requested statements, visits or preliminary expert reports (for example). This figure does not include cases on the Health and Performance Protocols.

Health Protocol

6. There are three veterinary surgeons either under assessment or currently on the RCVS Health Protocol.

Performance Protocol

7. There are no veterinary surgeons currently on the RCVS Performance Protocol.

Professional Conduct Department - Enquiries and concerns

8. Before registering a concern with the RCVS, potential complainants must make an Enquiry (either in writing or by telephone), so that Case Managers can consider with the enquirer whether they

should raise a formal concern or whether the matter would be more appropriately dealt with through the Veterinary Client Mediation Service.

9. In the period 22 May to 18 September,

- the number of matters registered as Enquiries was 1090, and
- the number of formal Concerns registered in the same period was 149.

10. The table below shows the categories of matters registered as Concerns between 22 May and 18 September.

Concerns registered between 22 May and 18 September

Description of Category	**Number of Cases**
- Advertising and publicity	0
- Certification	3
- Client confidentiality	0
- Clinical and client records	1
- Communication and consent	9
- Communication between professional colleagues	0
- Conviction/notifiable occupation notification	2
- Delegation to veterinary nurses	1
- Equine pre-purchase examinations	0
- Euthanasia of animals	1
- Giving evidence for court	0
- Health case (*potential)*	3
- Microchipping	2
- Miscellaneous	4
- Practice information, fees & animal insurance	3
- Referrals and second opinions	1
- Registration investigation	1
- Restoration application	0
- Social media and networking forums	0
- Treatment of animals by unqualified persons	0
- Use of samples, images, post-mortems and disposal	0
- Veterinary care	107
- Veterinary medicines	7
- Veterinary teams and leaders	0
- Whistle-blowing	1
- 24-hour emergency first aid and pain relief	3
- Unassigned	0
Total	**149**

Data source – Profcon computer system concerns data.

Referral to Disciplinary Committee

11. In the period 22 May to 18 September 2020, the Committee has referred five cases involving three veterinary surgeons to the Disciplinary Committee.

Veterinary Investigators

12. The Veterinary Investigators have carried out two visits during the reporting period, once restrictions had been lifted sufficiently to allow them to take place safely. One was a follow-up visit on a held-open case and the other was in relation to a practitioner who had failed to respond to correspondence from the Professional Conduct department.

Concerns procedure

13. At Stage 1 of the process, the aim is for the Case Examiner Group to decide 90% of cases within four months of registration of complaint (the Stage 1 KPI). For each of the months from May to August (the last complete month) the number of cases concluded and achieving the KPI is 83%, 85%, 77% and 78% respectively. While we continue to strive to meet the 90% target for compliance, circumstances have continued to pose challenges both for staff members working from home (some of whom have child care commitments in addition to work) and for practitioners endeavouring to respond to concerns either in light of their working arrangements or because some have been furloughed.

14. The Stage 2 KPI is now for the PIC to reach a decision on simple cases before it within seven months, and on complex cases within 12 months. A case is deemed to be complex where the PIC requests that witness statements and/or expert evidence be obtained.

15. In the period 22 May to 18 September, the PIC reached a decision (to close, hold open or refer to DC) within the relevant KPI:

    - in 12 out of 18 simple cases (67%).

16. There were a number of factors that caused delays in concluding those cases that did not meet the target; three cases were delayed to allow practitioners the opportunity to provide their responses and one case involved allegations relating to 24 different animals.

17. Six complex cases were decided, of which four met the 12-month KPI. In accordance with normal practice, cases and KPI compliance in general have been reported and discussed in more detail at the PIC/DC Liaison Committee meeting.

Operational matters

18. The Committee continues to meet remotely and Committee members in general feel that the virtual meetings are working well. A new veterinary member started in July to replace a member who had completed two terms. Two training sessions for PIC members have been arranged to take place in November and will be conducted virtually, having been postponed from April when they were intended to be held in person. Two new Case Managers started in the Profcon department in March, and while one of these has settled in well, the other did not and has not

been kept on. Recruitment is underway to find a replacement as soon as possible in order to keep the department fully staffed and seek to ensure that cases are progressed expeditiously.

Themes and learning for the profession

19. Many of the matters that are considered by the Committee reflect similar themes to those in past years. In many cases, communication lies at the heart of the problems.

20. Several cases relating to informed consent in respect of veterinary medicines have recently been considered by the Committee. Advice has been issued on a number of occasions to reiterate the importance of ensuring that pet owners are fully informed when medications are prescribed under the Cascade, and that written consent should be obtained as necessary where possible.

Summary

Meeting	Council
Date	8 October 2020
Title	RVN Preliminary Investigation Committee Chair's Report to Council
Summary	This report sets out the work of the Registered Veterinary Nurse (RVN) Preliminary Investigation Committee (PIC)
Decisions required	None
Attachments	None
Authors	Sandra Neary Professional Conduct Officer s.neary@rcvs.org.uk / 020 7202 0730 Gemma Crossley Head of Professional Conduct g.crossley@rcvs.org.uk / 020 7202 0740

Classifications

Document	**Classification[1]**	**Rationales[2]**
Paper	Unclassified	n/a

[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

Registered Veterinary Nurses Preliminary Investigation Committee

Chair's Report to Council

Introduction

1. Since the last Report to Council, there have been two meetings of the RVN Preliminary Investigation Committee, which took place on 30 June and 1 September 2020.

RVN Concerns received / registered

2. Between 28 May and 30 September 2020 there were twelve new Concerns received against RVNs. Of these twelve new Concerns:

    - Three were closed at Stage 1 of the concerns process.

    - Nine are currently under investigation by the Case Examiner Group (a veterinary nurse and lay member on RVN PIC and a Case Manager).

RVN Preliminary Investigation Committee

3. There have been two new concerns considered by the RVN PIC between 28 May and 30 September 2020. The first case was referred to external solicitors for formal statements and the second case was closed with advice issued to the RVN.

Ongoing Investigations

4. Three concerns are currently under investigation and will be returned to the RVN PIC for a decision in due course.

Health Concerns

5. One RVN is currently being managed in the context of the RCVS Health Protocol.

Performance Concerns

6. There are currently no RVNs being managed in the context of the RCVS Performance Protocol.

Referral to Disciplinary Committee

7. The last report stated that one case had been referred to the RVN Disciplinary Committee. The case was listed for a Disciplinary hearing but was subsequently postponed due to the outbreak of the Coronavirus (COVID-19) pandemic. The hearing has been re-listed to take place between the 2nd and 6th November 2020.

Summary	
Meeting	Council
Date	8 October 2020
Title	Disciplinary Committee Report
Summary	Update of Disciplinary Committee since the last Council meeting held on 5 March 2020
Decisions required	None
Attachments	None
Author	Yemisi Yusuph Clerk to the Disciplinary Committee Tel: 020 7202 0729 Email: y.yusuph@rcvs.org.uk

Classifications

Document	**Classification**[1]	**Rationales**[2]
Paper	Unclassified	n/a

[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

Report of Disciplinary Committee hearings since the last Council meeting on 5 March 2020

Background

1. Since the last update to Council on 5 March 2020, the Disciplinary Committee ('the Committee') have met on 3 occasions. The RVN Disciplinary Committee have not met.

2. Since the last update to Council, the Disciplinary Committee have heard one Inquiry. The Disciplinary Committee have met to hear two restoration application. All the hearings have been conducted virtually via Zoom.

Hearings

Mr Simon Wood

3. On Wednesday 24 and Thursday 25 June 2020, the Disciplinary Committee met to hear the restoration application of Mr Wood. Mr Wood was originally removed from the Register in 2018 following his conviction at Portsmouth Magistrates Court in late 2017 for possessing indecent images of children. Mr Wood was given a community sentence, fined, and was made subject to a sexual harm prevention order for five years, following his conviction of which he pleaded guilty.

4. At this application for restoration (which took place virtually via Zoom), Mr Wood's representative argued that he was professionally competent to be restored to the Register, that he had a strong mitigation for his original conviction (for which he had demonstrated remorse), that he had a low chance of reoffending, had engaged proactively with the Probation Service and rehabilitative courses, and that had completed his community service.

5. After hearing the arguments from Mr Wood's Counsel, the Disciplinary Committee went on to consider his application. They took into account a number of factors, which included the fact that Mr Wood accepted the Committee's original findings, the seriousness of those findings, the protection of the public, (for which he had demonstrated remorse), that he had a low chance of reoffending, had engaged proactively with the Probation Service and rehabilitative courses, and that had completed his community service.

6. After considering all the elements, the Disciplinary Committee concluded that Mr Wood was not currently fit to be restored to the Register. In its decision, the Committee stated "that the facts of the charge justifying removal from the Register and the underlying criminal behavior were too serious for Mr. Wood to be restored at this time." They also stated that Mr. Wood continues to be subject to the sexual harm prevention order, notification requirements for sexual offenders and because he remained on the Barring List by the Disclosure and Barring service until January 2023, he was not fit to be restored to the Register at this time.

7. The full findings can be found here: https://www.rcvs.org.uk/document-library/decision-on-application-for-restoration/

Mr Warwick Seymour Hamilton

8. On Tuesday 30 June and Wednesday 1 July 2020, the Disciplinary Committee met to hear the eighth restoration application of Mr. Seymour Hamilton. In 1994, Mr. Seymour Hamilton was removed from the Register following a practice inspection in 1993 which found that his operating theatre “showed a total disregard of basic hygiene and care for animals and was such as to bring the profession into disrepute”. Since being removed from the Register, Mr Seymour-Hamilton has made applications for restoration in 1995, 2010, 2015, 2016, 2017, 2018 and 2019. Each of these has been rejected.

9. Mr Seymour Hamilton attended the restoration application (which was held virtually via Zoom) and was not legally represented.

10. In his application, Mr Seymour Hamilton made it clear that he did not want to be restored onto the Register to Practice, but to facilitate his research in the area of herbal medicine

11. After making several arguments as to why the Committee should restore his name to the Register on this occasion, the Committee went to consider his application. The Committee took into account a number of factors such as his acceptance of the findings of the original hearing and their seriousness, protection of the public, the future welfare of animals should he be restored, length of time off the Register, his conduct since removal, efforts to keep up-to-date with veterinary medicine and impact on the individual of being off the Register.

12. The Committee found that, while Mr Seymour-Hamilton, had accepted some of the findings of the original case, he disagreed with key facts, such as whether his surgery was open at the time of the inspection, and showed ‘minimal insight’ into the seriousness of the findings. The Committee also voiced concerns over public protection and animal welfare should he be restored, saying that he had demonstrated little or no understanding of the purpose of regulation and had, furthermore, admitted to, in recent years, spaying two cats at a practice in Calais despite his long absence from the Register and unregistered status as a veterinary surgeon in the UK or France.

.

13. In considering his conduct since leaving the Register, the Committee found that Mr Seymour-Hamilton had admitted to several instances of conduct which it found ‘reprehensible’. This included carrying out spays; not self-isolating after testing positively for coronavirus and, in fact, travelling through France and Spain in breach of the lockdown put in place due to the pandemic; deliberately trying to re-infect himself with coronavirus and then visiting a vulnerable person without maintaining social distancing; treating his own animals with untested herbal remedies; and using his own remedies to treat people, which, in one case, included a nine-year-old boy in Greece.

14. In summing up Judith Way, who was chairing the Committee and speaking on its behalf, said: “The Committee has concluded that he has not satisfied it that he is fit to be restored to the Register. He has exhibited a disregard for regulation and compliance with the law. He lacks an understanding as to why he has not been restored in the past. He has not set about addressing any of his shortcomings. He relies wholeheartedly on his research, yet he does not support that research with any real peer-reviewed publications and he fails to acknowledge the consequences of being out-of-practice for so long. He has misplaced confidence in his own abilities and does not

recognise that his approach and/or actions can represent a danger to animals and to the public. The Committee has therefore reached the conclusion that the applicant is not a fit person to be restored to the Register."

15. The full decision can be found here: https://www.rcvs.org.uk/document-library/decision-on-application/

Mr Stephen Cargill Wilson

16. On Monday 28 September, the Disciplinary Committee met to hear the Inquiry into Mr Wilson. This Inquiry was in relation to two charges against him.

17. The first charge was in relation to Mr Wilson providing inaccurate information to pet insurers relating to the clinical history of a Labrador dog on or about 20 October 2017. The second charge was in relation to Mr Wilson's failure to have in place adequate Professional Indemnity Insurance arrangements; as well as failure to respond to a reasonable request from the Royal College of Veterinary Surgeons in relation to your Professional Indemnity Insurance.

18. The full charges can be found here: https://www.rcvs.org.uk/document-library/wilson-stephen-cargill-september-2020-charges/

19. Before the hearing, Mr Wilson made and application for the Committee to dispose of this matter by way of adjournment of the Inquiry into the heads of charge against him, subject to the Committee accepting his written undertakings.

20. The undertakings were to request the Registrar to remove his name from the Register with immediate effect, and to never apply to be restored to the Register.

21. The full undertakings can be found here: https://www.rcvs.org.uk/document-library/wilson-stephen-cargill-september-2020-undertakings/

22. Following Mr Wilson's application, the Committee considered all factors and decided that this was not a case in which the public interest or welfare of animals demanded that there be a full hearing. The Committee decided to accede his application.

23. The Committee's full decision can be found here: https://www.rcvs.org.uk/document-library/decision-of-the-disciplinary-committee-on-the-respondents/

Upcoming DC's

24. As it stands, there are two 'in person' Inquiries that will potentially be listed and heard by the end of the year. The two Inquiries that were listed to be heard in April 2020, were adjourned in March and the Clerk has now relisted them.

25. There is a resumed Inquiry that has been listed for Monday 9 November 2020. This will be carried out virtually, via Zoom.

26. There is one inquiry that will take place (via Zoom) on:
    - 12-14 October 2020