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Institute for Employment Studies

RCVS Covid-19 Survey 2020

Survey report

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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.

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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

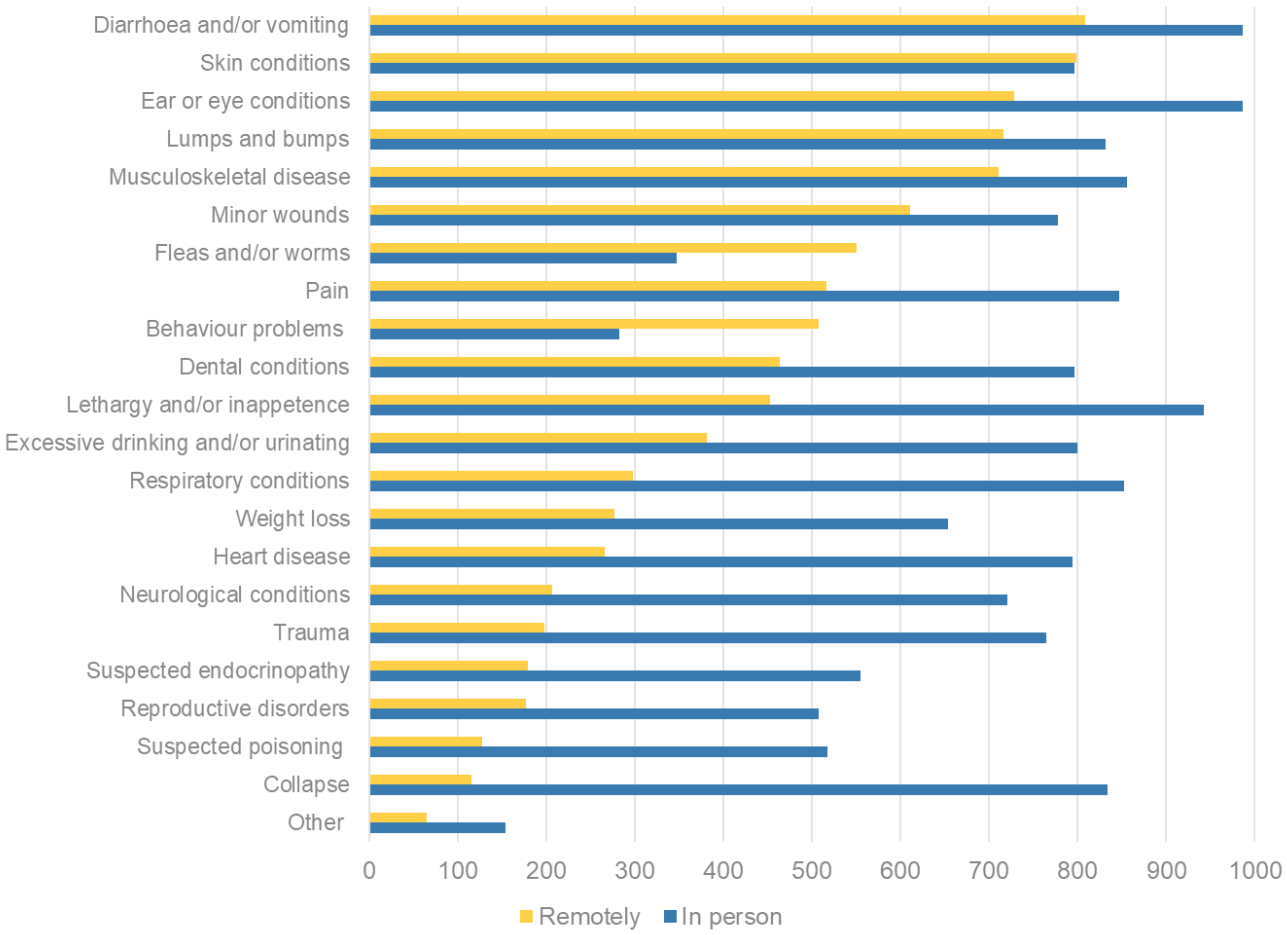
The types of equine case seen most frequently by VS respondents remotely during the two-week period, looking at number of respondents, are lameness (54 VSs) and skin conditions (47 VSs).

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).

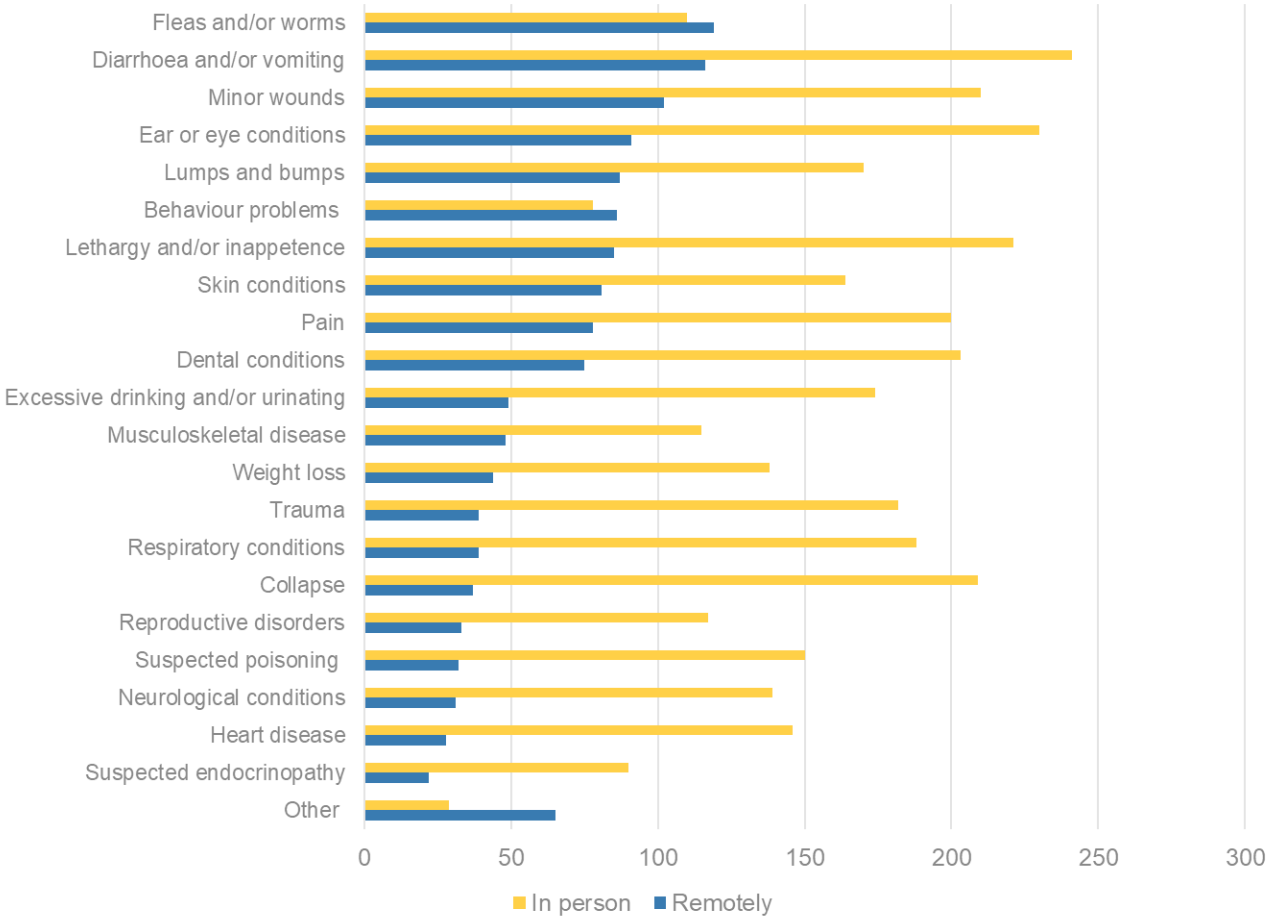
Figure 1 Number of VSs seeing different types of small animal cases seen remotely and in person 1 to 14 June 2020



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

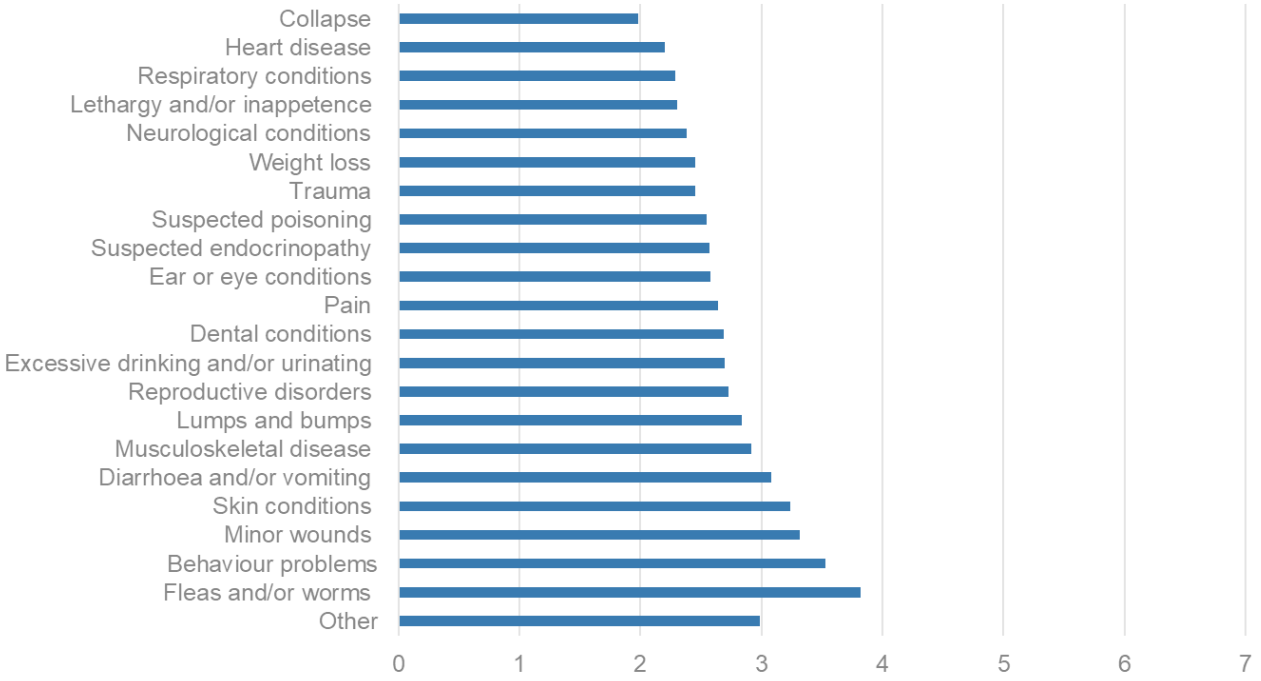
Further analysis by practice type, however, shows that VSs in equine practices are more favourably-disposed to the time-efficiency of remote consultations: 45.9 per cent find them more efficient than pre-Covid-19 face-to-face, and 59.5 per cent find them more efficient than face-to-face using the regime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

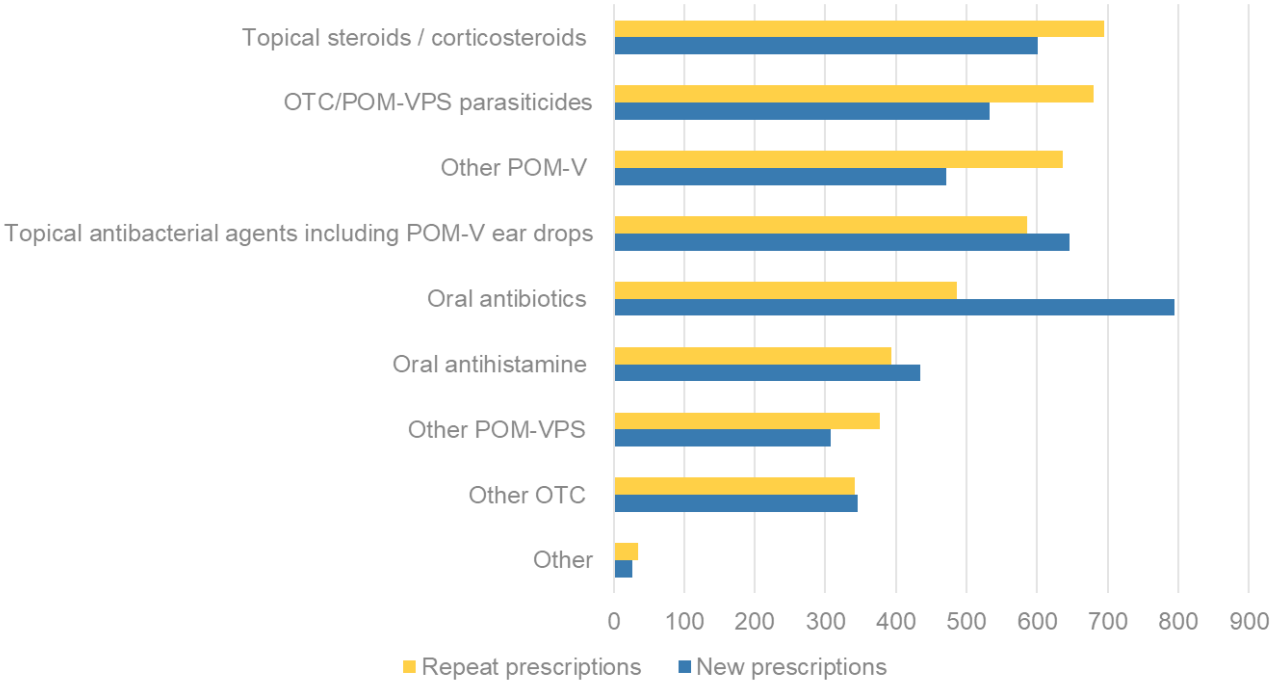
Table 14 Percentage of cases seen remotely 1 to 14 June 2020 resulting in remote prescriptions: VS and VN SQP

	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

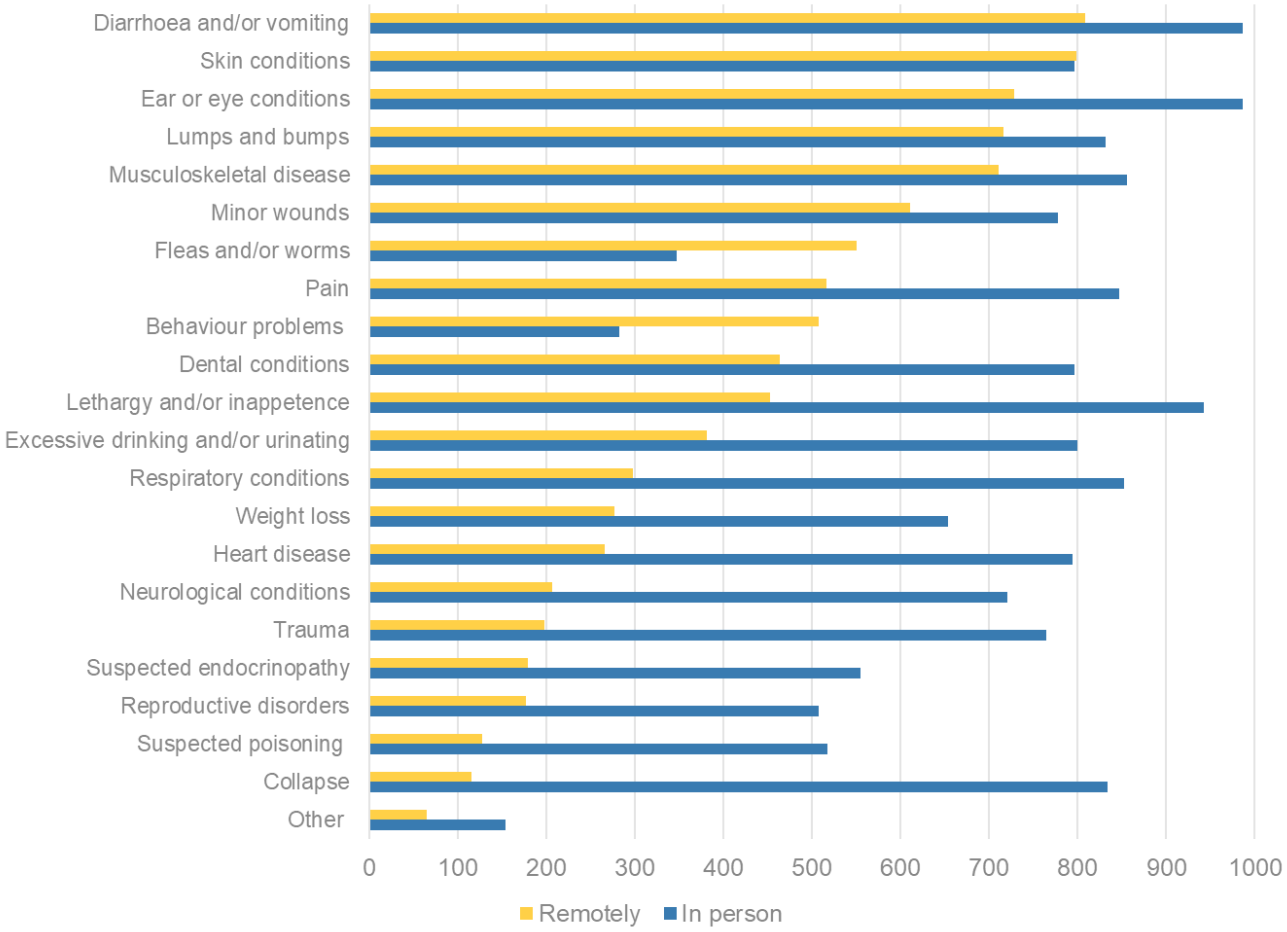
Fleas and/or worms	551	1	145	9.80	2	5
Heart disease	266	1	40	3.26	1	2
Lethargy and/or inappetence	453	1	50	5.45	2	3
Lumps and bumps	716	1	32	5.34	2	4
Minor wounds	611	1	29	3.94	2	2
Musculoskeletal disease	711	1	50	6.09	2	4
Neurological conditions	207	1	15	2.73	1	2
Pain	516	1	70	5.79	2	4
Reproductive 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

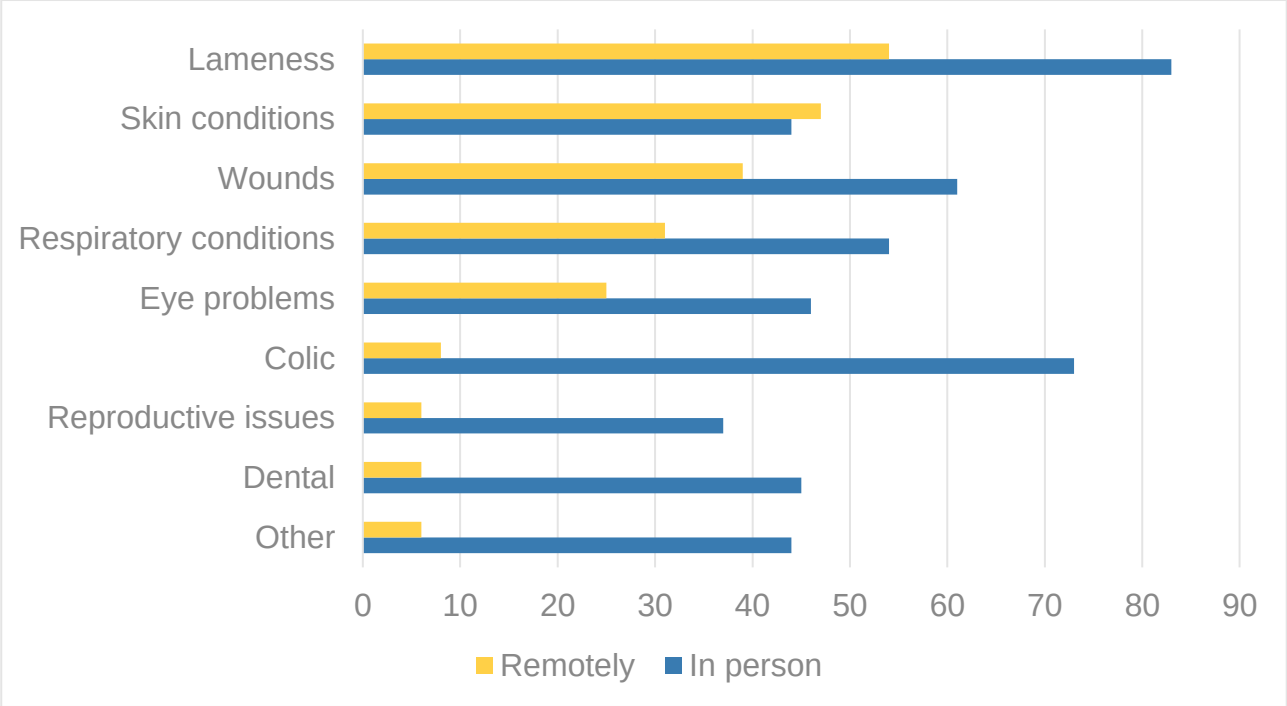
Reproductive issues	6	1	3	1.83	1	1.5
Respiratory conditions	31	1	20	2.58	1	2
Skin conditions	47	1	8	2.17	1	2
Wounds	39	1	6	1.95	1	2
Other	6	1	5	2.5	2	2

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.

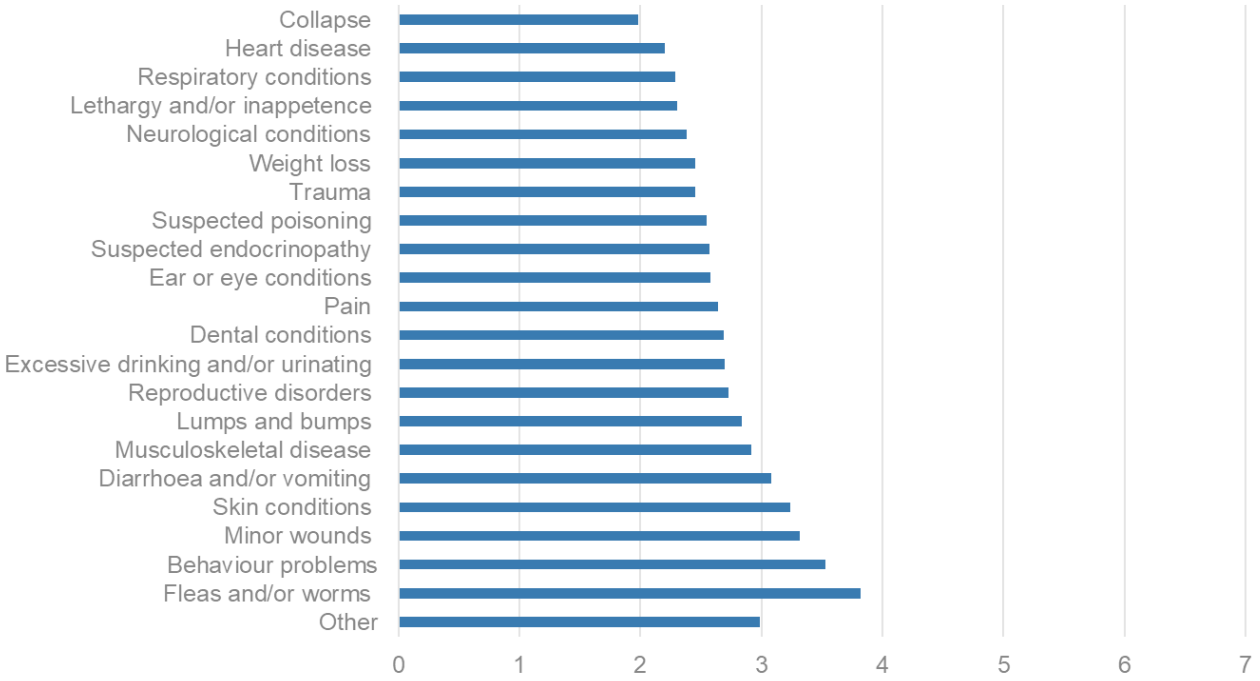
Compared with face-to-face diagnoses pre-Covid 19

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

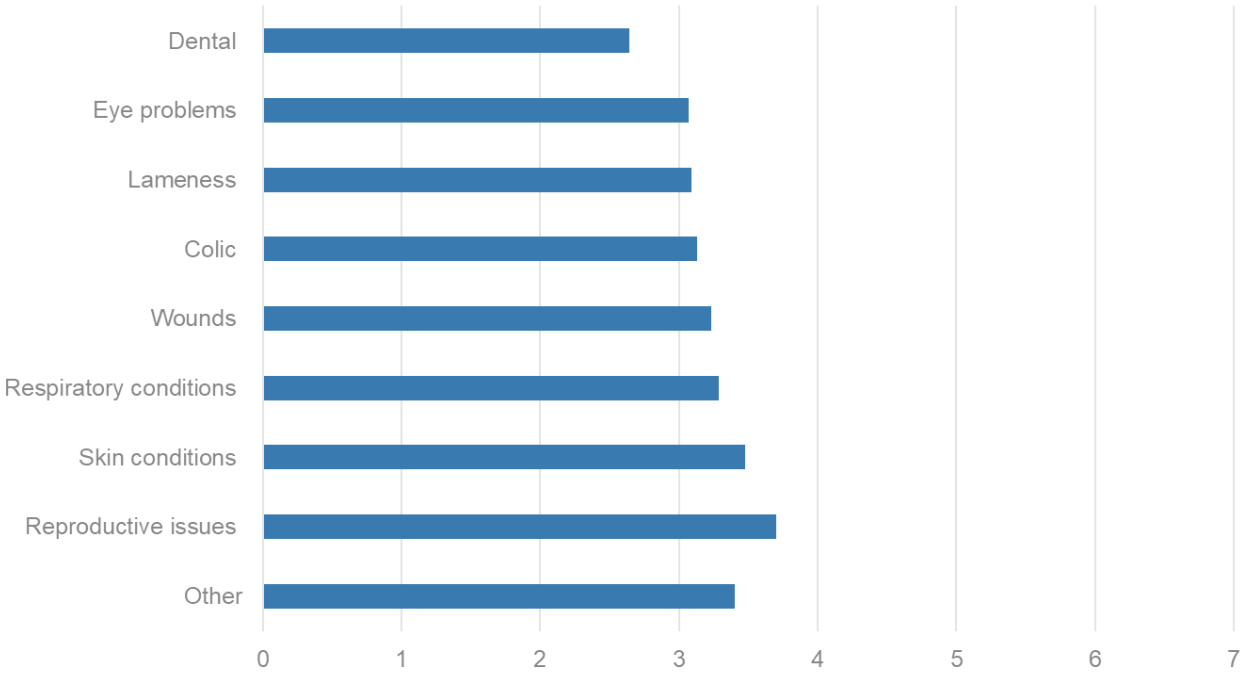
- The lowest average scores, indicating the lowest levels of confidence (all of which are below 2.5), are for the following conditions:
  - Collapse: 1.98
  - Heart disease: 2.20
  - Respiratory conditions: 2.29
  - Lethargy and/or inappetence: 2.30
  - Neurological conditions: 2.38
  - Trauma: 2.45
  - 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

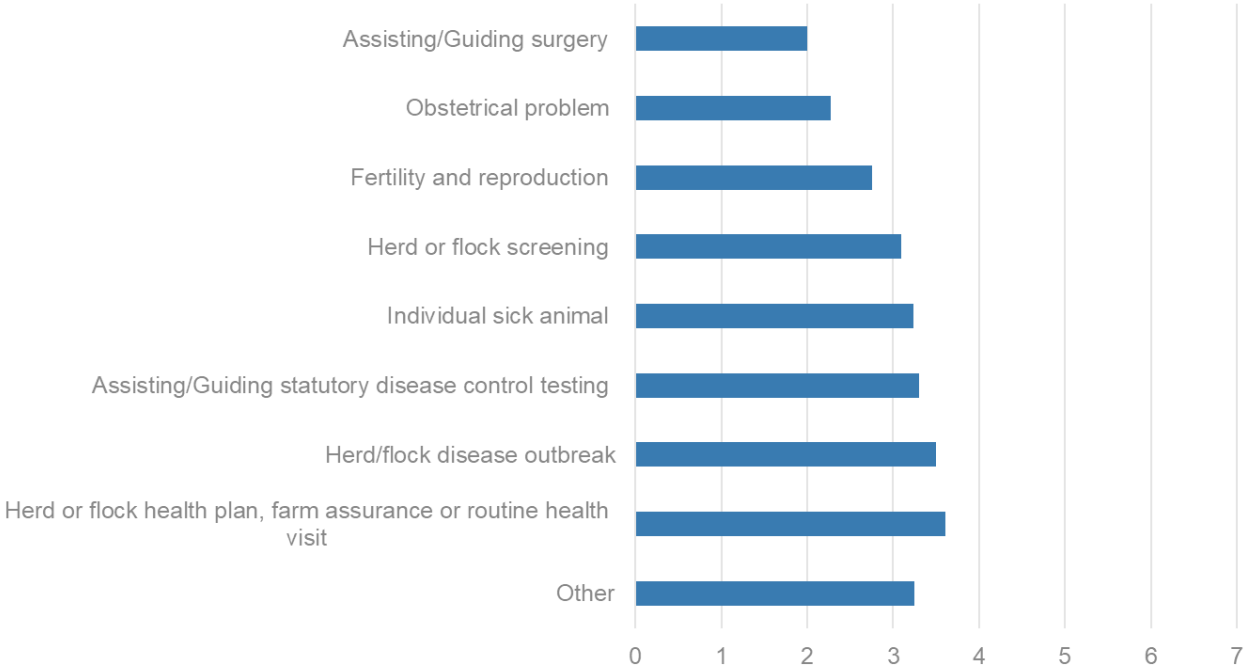
Farm animal

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

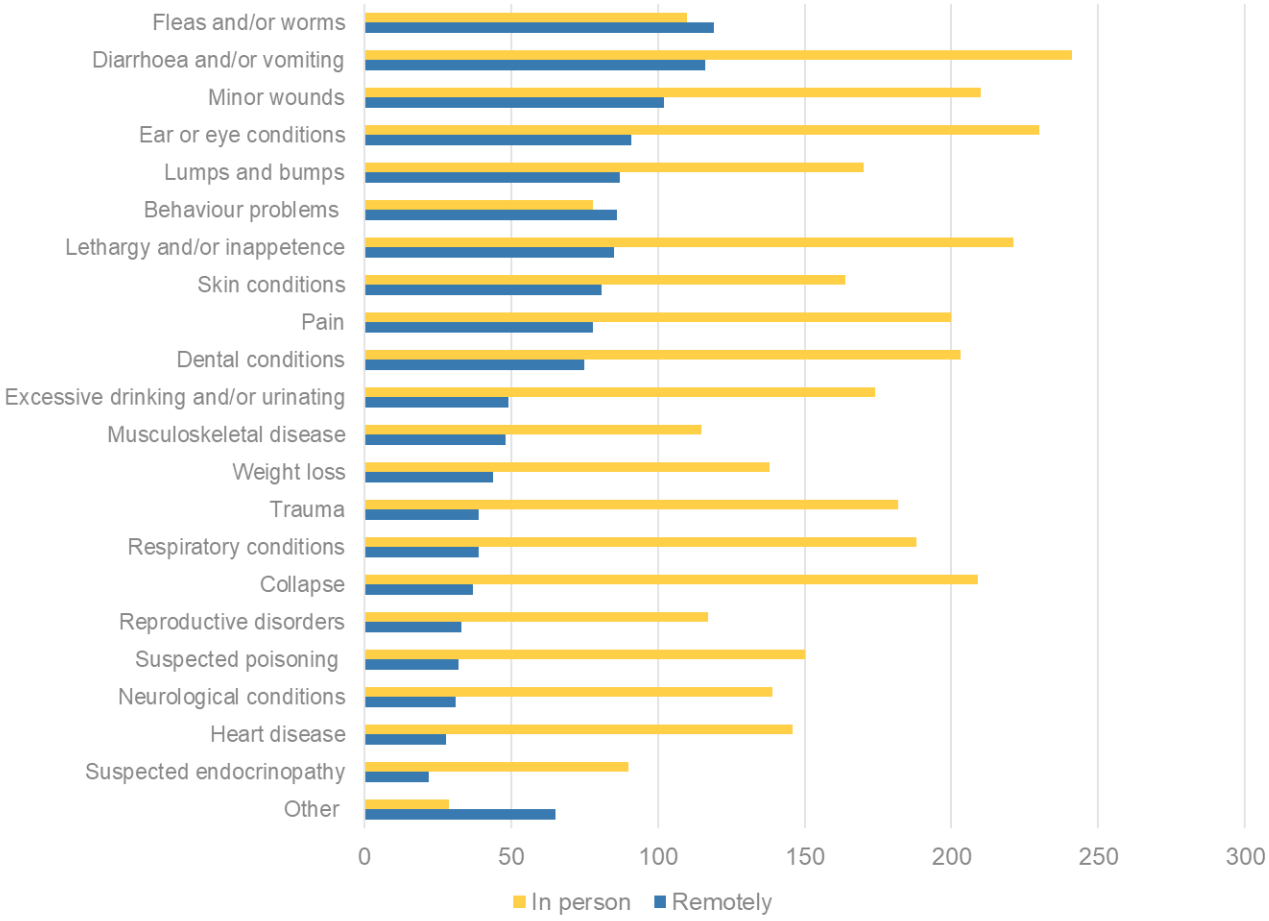
Behaviour problems	86	1	25	3.49	2	2
Collapse	37	1	40	5.16	2	3
Dental conditions	75	1	30	4.43	2	2
Diarrhoea and/or vomiting	116	1	60	8.24	2	5
Ear or eye conditions	91	1	50	6.85	2	4
Excessive drinking and/or urinating	49	1	50	6.12	2	4
Fleas and/or worms	119	1	100	13.92	10	10
Heart disease	28	1	20	4.71	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.

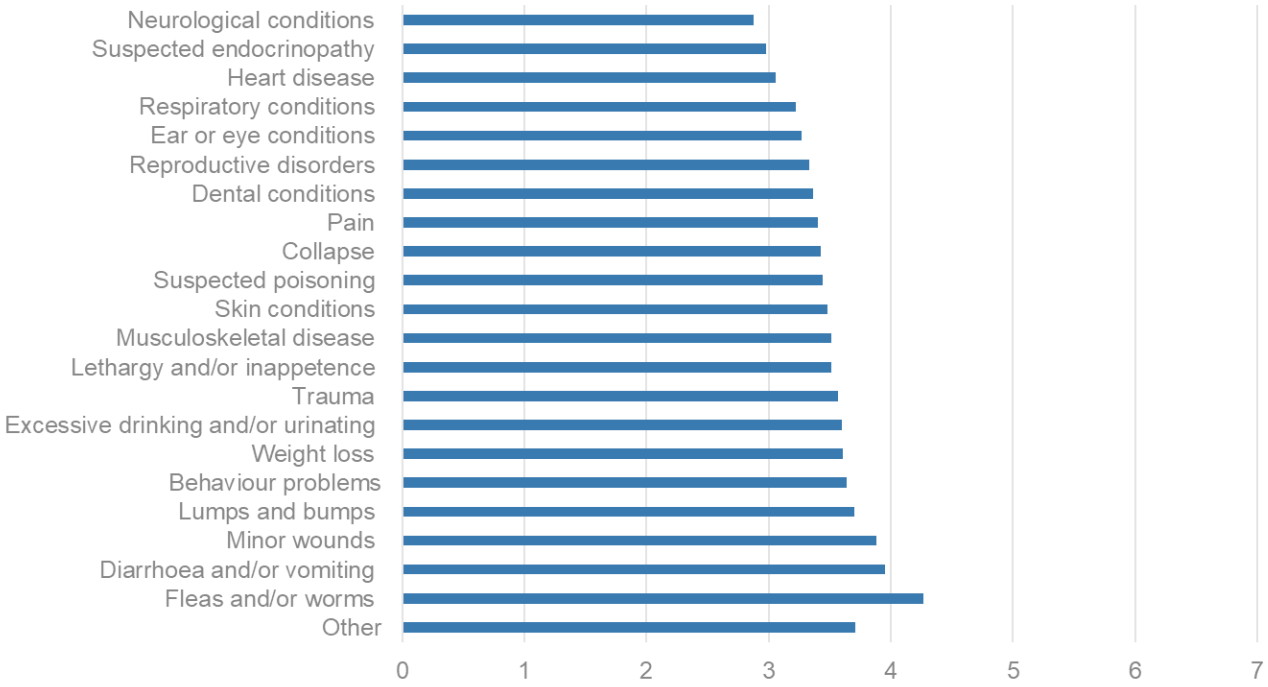
Compared with face-to-face diagnoses pre-Covid 19

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

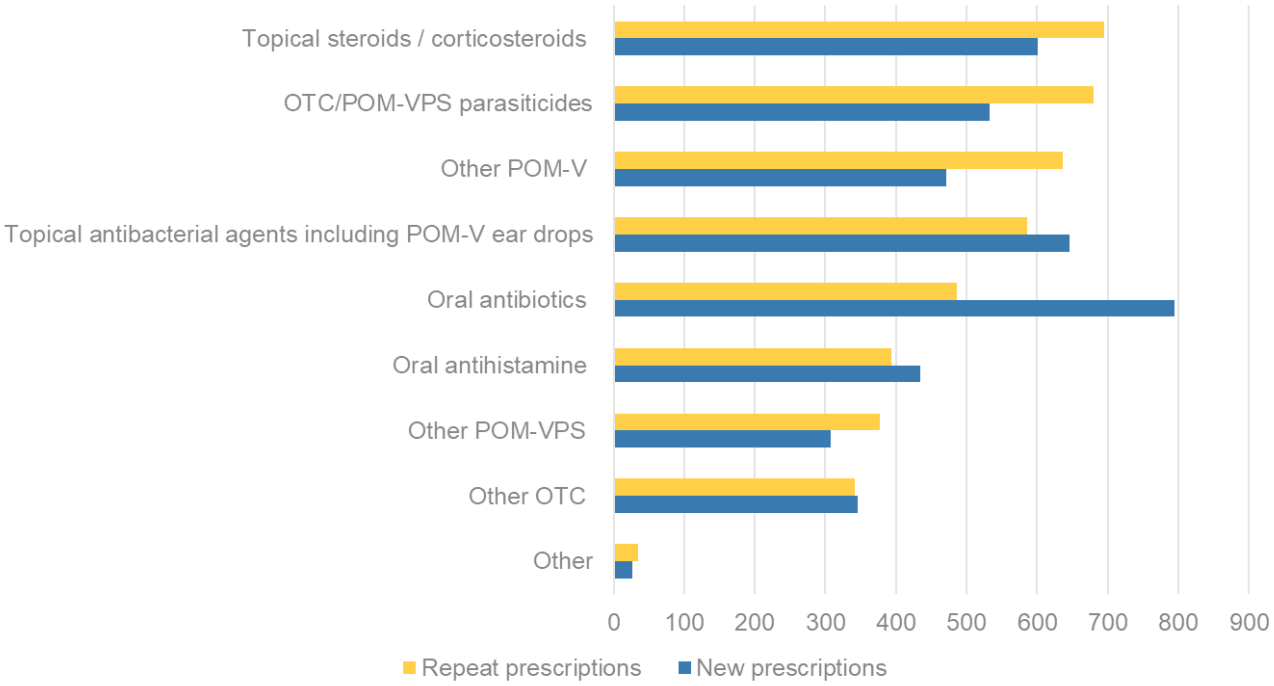
prescription is oral antibiotics. Oral antibiotics is also the medicine with the biggest difference between the number of repeat and new prescriptions.

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 certaIn 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.