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I would like to congratulate the CMA on drawing attention to the regulatory shortfalls which affect the

- effective use and recognition of skills of RVN's
- narrow range of tools and remit of the RCVS disciplinary committee

I am not sure you can draw conclusions about the number of complaints successfully resolved in practice from the data you have but I would argue it is a significant number. I do believe it is important to have peer oversite of clinical complaints and complaints relating to fees and charging for clinical services.

It would be interesting to investigate how the PSS could be used for quality control in the future. Improving the penetration of the scheme into the pubic consciousness would be the first step

Regarding veterinary medicines

All first opinion practitioners acknowledge the need for the cascade – patient and consumer safety, to promote innovation, research and drug development etc however on the frontline it is difficult to justify charging a premium e.g for licensed lactulose (laxatract dechra)£12-16 for 50ml vs £8 including markup and dispensing fee for 500ml for generic lactulose that we have used for years with no problems so I whole heartedly agree with 6.31(Reg framework WP) that we should not be compelled to use newly licensed MA products in these circumstances.

It would be very difficult to allow vets to prescribe off cascade on welfare/ financial grounds because how would they decide, in a manner that robustly fits with regulation, which cases that would apply for. The majority of clients would like to have the same active ingredient for less money.

Written prescriptions

Written prescriptions are, for clinical reasons, offered primarily to patients on long term meds.

They are not suitable in acute clinical cases where medication is needed promptly to treat the presenting condition – e.g. antibiotics, ear treatments, pain or pruritus relief, anti-inflammatories where it is likely to take at least 48 hours to receive this from an online pharmacy. Additionally when prescribing for the short term either because it is expected that the condition will resolve or because to assess the effectiveness of a treatment it would not be financially sensible for clients to have a written prescription as the cost of providing thos would negate any savings. This not because practices are charging an unreasonable price - see

below.

Acute need is also the reason why most injectables are used. Where an oral alternative is suitable, whether to start with injectables or start oral medication would be discussed with the client. There are some longer lasting injectables formulated as monthly treatments. These are used on a case by case by in consultation with clients as one of a number of discussed alternatives. Written prescriptions can be and are provided for these, for clients to administer at home. However as part of responsible prescribing of veterinary medicines the prescribing veterinary surgeon must ensure that the client is aware and takes responsibility for transport and storage, side effects for the patient and of accidental self injection, is aware of and equipped for safe disposal of sharps and can administer the injection safely and competently. This is likely to require an additional appointment. The same process applies for the most commonly client administered injection - insulin.

Most online pharmacies request the trade name for the medication prescribed not the generic name – vets would be happy to write the generic name but there may be variations in presentation, palatability, ability to split tablets etc which make this problematic for clients e.g phenobarbital 60mg is available in a presentation which cannot be split to facilitate smaller doses and in a formulation which can be split. If the generic is written it would then be up to the online pharmacy to decide which product is suitable based on the dose prescribed (e.g give ¾ of a 60mg tablet every 12 hours)

Written prescriptions should be charged for appropriately – these are official documents, care must be taken to ensure accuracy of dose medication and duration of treatment and ensure this is recorded. Many veterinary products are dosed on a mg/kg basis c.f with adult dose vs child dose in human medicine which adds complexity to the prescribing process. This takes vet time. In addition the VMD suggests it is good practice to email the prescription directly to the pharmacy of the clients choice (to reduce prescription misuse)– this involves emails between the practice and client and practice and pharmacy to ensure the correct order is made and link the prescription with an order purchase number. All of which take time and staff.

Transparency around price for medicine supply

- It is reasonable for clients to be made aware of injection, dispensing and written prescription fees
- It is problematic to request a display of price of actual medication as prices change frequently with supply issues, swapping to different trade name etc. It is not feasible to display all meds and if you pick a selection then it is likely that these can appear heavily discounted while other services or medications increase significantly in price. Small groups and independent practices are not making vast profits. Overheads are huge. Pay for nurses has rightly improved significantly in recent years, veterinary surgeon salaries are fair and not comparable to a GP. At our

practice we have have a transparent payscale that is fair but we still have difficulty recruiting.

- If we reduce prices for clients in one area we will have to increase it somewhere else and this may be less transparent.

Switching between FOP's for medicines, using alternative OOH etc

As a general rule continuity of care, trust and valued relationships are at the heart of veterinary medicine. Putting in place marketing mechanisms encouraging owners to switch frequently on the basis of the price of one particular medicine or service greatly undervalues this aspect of the services provided. Additionally It is a requirement of the code of conduct that records are shared between all parties caring for a patient. GDPR rules require this to be consented for. Frequent switching places an administrative burden on practices and prevents continuity of care.

FOP must have a written agreement for the provision of OOH care. The FOP makes clients aware on registration and if there are any changes to OOH provision. Salarys and staffing for OOH are based on the expected volume of work from these arranged contracts . It is unreasonable to expect OOH service providers to accommodate other clients.

HPPVS working paper

5.37/8 Lack of standardisation of price lists and overall services

The provision of veterinary services is not the same as a standard retail activity. In most cases it is very difficult to compare like for like.

The price of cat spay could be

1. Heavily discounted to attract customers who then pay significantly more for other services e.g blood testing etc, other surgery, anaesthetics etc
2. Not like for like ie diffrerent standard of care e.g

   Vet A: cat spay £
   Vet B: Cat spay £££ as listed
   Vet A – not intubated, minimal ga monitoring and recovery performed by unqualified staff member, no pain relief to go home with no post op checks or not included
   Vet B – intubated – anaesthetic monitored by SVN/RVN with additional equipment, iv fluids given, pain scored and sent home with pain relief, post op checks etc included

Estimates vs fixed price

- Actual costs are likely to vary with weight, consumables actually needed, surgical time, complications etc e.g dentals – do not know how many teeth will be extracted until radiographed at same ga in which extraction takes place, lameness – cannot be sure how many radiographs will be needed etc

  As a general rule as a first opinion practice if you offer a fixed price for

services this will need to be higher than the average price vs clients paying for service actually received. At referral some things are more standard e.g.a tplo but the fixed price will still be > than it would have otherwise been for a fair proportion of clients and have caveats re complications etc.

Cremation

The CMA should be aware that there are significant responsibilities and increased time and staff required for processing individual cremations. The importance of checking, labelling and double signing identification and cremation requests should not be underestimated, this will involve 2 members of staff. Additionally if the ashes are returned to the practice they must be checked, stored and the clients contacted.

The CMA have gathered a huge amount of information and presented this in the working papers. I hope the complexities of veterinary practice are becoming apparent.

The profession is full of dedicated individuals from client care staff to administrators, vets, nurses and kennel assistants all trying to do their best for their patients and clients. We work as a team with our clients taking many factors into consideration to provide the best outcome for them and their pets. We are not salesmen, we do not push unnecessary tests or procedures. Vet Schools place significant emphasis on both clinical reasoning (including thinking about what you will gain from a test), and contextualised care (which can range from euthanasia, trial treatment, in house investigation and specialist referral). Veterinary medicine has advanced significantly in the last 25 years both in terms of diagnostics and treatments which are possible and client expectations have risen alongside this. Having a sick pet is incredibly emotionally and potentially financially challenging - veterinary teams across the uk are adept at helping clients navigate these challenges we cannot prejudge so offer options compassionately, with care doing our very best to estimate the costs and likely outcome of any recommendations. I sincerely hope this will be reflected in your final report.

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