Response to the CMA's 5 Papers – February 2025

A. Paper 1 – How People Purchase Veterinary Services

General comment: much of the narrative of these reports is very transactional. This approach might be appropriate for retail, or for a profession in which a discrete service is purchased (conveyancing for a house purchase, for example), but is at odds with the nature of the veterinary profession.

Vets provide treatment and other services for animals **under their care**. This care is within the context of a relationship that has been built with the owner of an animal that transcends a simple transaction. The clinical record for an animal is an holistic picture of this nuanced relationship such that **animal health and welfare is always better served through strong continuity** – both between the client and the individual vet, and the client and the practice.

This is the essence of the VCPR – vet-client-patient-relationship. This is personal for the animal owner and undermined by any behaviours that seek to disseminate an animal's care across a number of different providers. The CMA's own research shows that pet owners highly value the trusting relationship they have with their veterinary surgeon.

Increased transparency regarding the costs of treatment at different practices, together with the levels of service that can be provided for those costs (to include preventative health care, out of hours care, hospitalisation and surgical care, etc) is to be welcomed. However, it is important that it is seen in the context of the VCPR (which best promotes animal health and welfare) so that a client has clarity over the cost of the package they are buying. In other words, there should first be absolute clarity about the services that are available at the practice so that pet owners can choose a practice that best supports their whole needs, and then to understand the pricing. Simple price comparisons of unit costs without the wider context is confusing for pet owners and can lead to too many players involved in an animal's care such that it may be detrimental to animal health and welfare.

Furthermore, vet practices, as businesses, must set their fees to balance the provision of all services to create the package offering to the client. Any approach that seeks to encourage a client to shop around may have the unintended consequences of upsetting the financial equilibrium of the practice which might subsequently lead to price increases of other services.

In a perfect world the total care package is reduced if delivered by one provider, providing there is consumer choice for the provision of that holistic care package – however, this can only exist where businesses avoid the exploitation of their clients. Historically, this was best served when all the businesses in a market were owned by veterinary surgeons who are bound by their professional ethics, so that business owners are regulated in line with the oath they declared, which lies at the heart of being a professional.

Comments on specific paragraphs of the paper

2.3 – Choice of pet

It should be noted that the choice of pet (species and breed) is strongly influenced by current marketing trends that lie outwith the veterinary profession. Vets will be very experienced in understanding the different health problems (and relative risks) of different species and breeds, which may significantly

affect the anticipated veterinary costs of the lifetime of that pet. However, it is extremely rare for a prospective pet owner ever to seek the advice of a vet regarding which pet might be most suitable for their circumstances.
For example, the French Bulldog is a breed associated with significant and varied health problems (respiratory obstruction, skin allergies, developmental orthopaedic issues, spinal disorders, etc). The demands of ownership of these dogs will generally necessitate considerable financial outlay. In 2006 only 526 puppies were registered with the Kennel Club. By 2021 the annual number of registrations had reached over 54,000, making it the UK's most popular breed.

2.12 – OOH services

The sentence "FOPs are required to make OOH services available to their clients" is somewhat simplistic. A vet who accepts an animal under care has a professional obligation to provide care 24/7. This can be delivered personally, or delegated (through an appropriate pathway) to a colleague or third party provider.

It should be noted that considerations for animal health and welfare are important here. There is a sliding scale for the suitability of an OOH service for a client and the implication for animal welfare:

- The vet who has the animal under care provides the service personally. The vet will have full and recent knowledge of the animal and access to its clinical records. The animal and client are seen in familiar surroundings.
- The vet who has the animal under care delegates the care of the animal to a colleague in the same practice. The colleague will be familiar with the way of working of the primary vet, may have discussed an ongoing case directly, will have access to the clinical records, and in an emergency may be able to contact the primary vet if not on duty. The animal and the client are seen at the usual premises in familiar surroundings.
- The vet who has the animal under care works in a practice which outsources its OOH care to a third-party provider. In this situation the OOH vet will be unlikely to be able to access clinical records and will be unfamiliar to the animal and the client. Furthermore, it is likely that the client will have to transport the animal some distance to an unfamiliar practice.

It is important to note that when a client needs the service of a vet OOH the client is unable to choose between the three options outlined above. The service provided is that used by the FOP. Consequently, a client needs absolute clarity about what the OOH service is (and the costs involved) as part of the process of choosing the FOP, not at a later stage.

4.6 – Choice of Treatment

Regarding the statement that "close to half of respondents reported not receiving any options for the treatment they were recommended", this is blunt and potentially misleading in its interpretation. A pet owner may not receive multiple options for treatment for a variety of reasons:

- There may be no alternative options
- The vet may have actively withheld information which could have been useful (this is not a good thing and would be unlikely given the ethical code under which we work)
- The vet may have worked through various avenues in the course of a consultation such that options were effectively ruled out along the way – the client has effectively been given the options but not explicitly recognised it because it was not presented as a discrete list

The trust in the relationship between the vet and the client is the key thing here.

4.11 to 4.25 – the Relationship of Pet Owners with their Pets

This clearly supports that the bond between humans and pets is strengthening ("pets seen increasingly as part of the family"). Consequently, there will be a demand from owners to do more for their pets. The effect is that the cost of one year of pet care will increase because more services are demanded, not necessarily because individual prices have increased ahead of inflation. In other words, apparent inflation costs of pet care may have little to do with the actual costs for individual services and more to do with the completeness of the whole package sought.

The Emerging View on how Pet Owners Choose FOPs

I agree that it is not easy for a pet owner to choose between FOPs based on information that is currently available to them. Details of the costs of different services may be helpful. However, it is essential that costs of individual services are not viewed in isolation, but in the context of the whole service that is offered by the FOP.

For example, one FOP may, superficially, appear to charge higher costs for some services, but if these services are part of a more extensive package that might include OOH provision, additional expertise such that more cases are handled in-house, etc, it may actually provide a more economic holistic package of care than another practice which superficially appears cheaper but outsources OOH and complicated case management to expensive third-parties.

Transparency is essential, but it has to be all-encompassing.

5.9 Telemedicine

It is worth noting that telemedicine services can be used very successfully. However, our experience is that they are of benefit primarily where they are used to deliver services for animals that are already under care (as defined by a real relationship between the vet/practice, the animal and client, built on a face-to-face consultation and physical examination). They are much less effective for new cases / clients and may simply add an extra layer of treatment costs for clients where an animal requires subsequent physical examination.

Consequently, telemedicine is of most benefit to clients when delivered as part of the whole service package rather than as a standalone service.

I have monitored the uptake of telemedicine services for my own practice very closely. Our client base was introduced to telemedicine due to the restrictions in place around Covid-19. During 2020 7.6% of all consultations were performed by video-consulting (the proportion during lockdowns obviously would have been much higher).

Today, despite proactively encouraging its use, only 1.5% of consultations are performed through telemedicine. Furthermore, the majority of these are for ongoing cases (including post-operative checks) and only 0.5% are for clinical cases, half of which subsequently require a visit to the practice for a physical examination.

5.27 – Independence vs LVG

As an independent practice owner it was frustrating to see that LVGs actively trade on a false pretence of retaining the practice's pre-sale name in order to gain a competitive advantage.

5.98 to 5.114 – Routine Treatments and Pet Care Plans

There seems to be little reference to the underlying desire of vets to be able to do the right thing for their patients. I own dogs myself and keep up to date with their routine preventative care. Consequently, I will advise my clients to do the same for their pets. The use of a healthcare plan enables the delivery of these services in the most economical way and is the primary reason for their existence. The text of the paper rather implies that they exist as a means for exploitation.

Our healthcare plans are highly valued by pet owners and ensure they can access preventative medicines at the most economical rate and which are appropriate to their needs.
One assertion in the paper is that there is concern that pet owners are paying for services that they aren't using. Our healthcare plans offer a range of options so that pet owners can choose the plan that most suits their needs. A well-functioning market should see a very high uptake of healthcare plans together with a high level of awareness of their advantage amongst both pet owners and veterinary staff.

5.226 – shopping around for an OOH service provider

As already stated, the choice of an OOH service provider is made when choosing the FOP, not when OOH service is required. It is important that pet owners are given full and clear information about the level of service that a FOP provides, including whether the FOP provides its own service OOH or utilises a third party.
Furthermore, this information should be prominent, easily accessible, and include the likely costs incurred (including those of a third party).

B. Paper 2 – Business Models, Provision of Veterinary Advice and Consumer Choice

1.5 – the use of the term "chain" is misleading

and suggests that the CMA does not fully understand the structure of veterinary practices. Broadly, veterinary practices fall into four categories:

1. Independent single site practices – the practice is owned by one or more of the staff who work within the practice; it has no branch practices.
2. Independent multi-branch practices – essentially larger versions of the first model. Business owners work within the various branches and staff may work from several of the different sites. In essence it is one practice (which may be quite large in terms of staff and client numbers) which works out of several sites – primarily to bring the services of the practice to a local client base. Clients may visit several of the branches according to availability of appointments, specific staff, or specific services.
3. Chains – these may or may not be independent and may vary in size. The difference between this and the previous model is that each of the practices within the chain is distinctly independent from each other, using staff who are fixed to any one site and who don't mix. The owner/s are separate from this structure and manage the whole as a group of separate sites within the one business. These chains may be consolidating models and a precursor to onward sale into an LVG. Clients are unlikely to move freely between the individual practices within a chain.
   Some of the chains are smaller consolidators of previously independent practices.
4. LVGs – the six names that have been identified by the CMA

The term "independent" when used in the context of a veterinary practice, refers to its **ownership structure**, not its size. Independence is synonymous with the ownership being people who work in the practice, day-to-day, on the ground with staff and clients. This could be as a sole trader, partnership, LLP, Ltd Co, or EOT. LVGs are all examples of "Corporate" practices ie multiple practices are owned by a separate body which is remote from the practice.

Independent practices will usually use bank borrowing to fund the capital; corporate practices will tend to PE or public listing.

It would be useful to see clarification of this in any future CMA reports.

2.14 – Increase in Unit Prices and Professional Salaries

It is correct to state that the increase in the price of 12-months of pet care has been in excess of the increase in veterinary professional salaries. However, this is a misleading and blunt statistic.

A practice has to consider its total salary bill as a ratio of its income. There has been a trend in recent years for individual salaries to increase but for the number of employed hours (and intensity of the work performed) to decrease, even though the salary is higher.

For example, it is now commonplace for vets to work 4 days per week and reduce the number of hours working at nights or weekends. Furthermore, the length of time given over to a standard consultation has increased from 10 minutes to 15 or 20 minutes. These are employment changes in the profession that have been driven by the pressures on workforce recruitment and retention, as well as client demand.

Put simply, it required more staff to do the same volume of work in 2023 than it did in 2015. Factor in the demand for increased treatment complexity and this will account for the increase in unit price.

A further issue is the demographic of staff working within vet practices who are often paid at, or near, the minimum wage. The minimum wage has risen by more than double inflation, which will have a strong effect on the overall cost of providing a service that is very labour-intensive.
It is clear that the increase in price above inflation affects both LVGs and independent practices and is an indication that these pressures on practice staffing (to deliver improved employment standards for staff and to meet increasing demands of pet owners) are universal regardless of practice structure.
A much more interesting analysis would be whether there is a difference in the total treatment costs for an animal (for true like-for-like care) between LVGs and independent FOPs and whether the provision of a more complete service in a practice that provides all round care (including OOH and surgical expertise) delivers better overall economies for pet owners. Hopefully this will come in the paper on profitability.
NB a true apples-with-apples approach will be required such that a practice group that uses a hub and spoke model accounts for the treatment costs incurred at the hub, not just the spokes. This may then allow comparison with a practice that delivers a fuller range of services.

2.53 - % revenue from surgeries

This seems to be a key part of the difference: the independent model lends itself to a more complete in-house service and as such the average spend per pet may appear artificially high compared to an FOP in a LVGs hub and spoke model where more of this type of work is carried out centrally.
To perform a true comparison would require merging the data from both the hubs and the spokes- see above.

2.62 to 2.71 – Competition Based on Price

The various papers support that clients trust their vets and follow recommendations because a trusting relationship has been built up over time. This is the essence of a well-functioning profession. Pet owners don't want to compete on price, but on service and relationship. In return they expect to pay a fair price for this service.
The potential for exploitation was kept in check whilst ever ownership of veterinary practices was in the hands of vets – there was a clear and well-functioning balance between the professional obligations of the vet to the animal, its owner, the governing body, the wider profession, and the need to function as a sustainable business (discussed further below in response to the paper on regulation).
The RCVS, by default, is able to act as a regulator on the businesses owned by vets. If the RCVS is unable to act as a regulator on the businesses which are not owned by vets (the LVGs), then a simple way for the balance to be regained would be for mandatory regulation of all practices – and close regulation of the business of those practices not owned by vets.
This is a concern that was voiced by many vets 25 years ago when the first practices were owned by non-vets. Indeed, the feeling amongst practising vets at the time was so strong that one incoming president of the BSAVA felt obliged to stand down from office because he had sold his practice to a non-vet owned LVG.
In short, these challenges are the end result of the unintended consequences of decisions taken by College/Council in 1999 and have reached the stage they have because of the sheer volume of the profession no longer in the ownership of MRCVS.

C. Paper 3 – Competition in the Supply of Veterinary Medicines

General comment: the thrust of this paper seeks to separate medicines from the rest of the holistic health-care package delivered by practices. Medicine sales are one source of income for a practice and whilst reduction in this income can be achieved, it will need to be balanced by an increase in fees elsewhere to maintain the financial sustainability of the business. In other words, the statement that "pet owners may be overpaying for veterinary medicines because of a lack of awareness of the options available" is only accurate in the context of comparing medicines as a unit cost; however, medicines are only one part of the cost of a pet's health care, so a more expensive charge for a medicine might actually reduce the overall cost to the client if it is cross-subsidising other services provided by the practice.

Furthermore, loss of sales of this income to a third party may simply result in even higher fees such that pet owners pay more in total for their pets' care because more suppliers are involved. This is a very real unintended consequence of increased competition where competition is for unit components of an overall care package (cherry-picking).

To consider true price comparisons between practices would require an assessment of the holistic package of care. Ideally this should be by comparing the cost of a lifetime's care, including the costs of third-party services that are outsourced (for example referral surgeries if the practice does not have the expertise, and OOH services). At the very least these costs should be considered in any 12-month assessment of the sort undertaken by the CMA.

There is also insufficient understanding of all that is involved in the prescribing of a medicine (including pharmacovigilance, maintenance of a practice team's knowledge, auditing, etc). The traditional model of veterinary practice is such that these prescribing costs are absorbed into the income made through the sale of a medicine rather than charged for separately. Forced reduction in the sale price would inevitably have to be balanced by explicit invoicing for the cost of all prescriptions whether redeemed at a third party or in-house.

1.1 to 1.2 – Provision of medicines

The convenience to a pet owner of purchasing a medicine at the point of prescription cannot be overstated. Furthermore, the cost of the medicine will include the cost of the prescription. Paragraphs 1.1 and 1.2 omit to mention the fact that the cost of prescribing is included as part of the cost of the sold medicine and imply that they are an additional charge that is made only when a medicine is purchased elsewhere.

1.7 to 1.12 – Veterinary medicines and a well-functioning market

As previously stated, this is only relevant if taken out of the context of the whole package of care. Given that the requirement for prescribed medications rests on a pet owner needing to engage in a practice's other services it is highly inappropriate to consider medicines as a unit without considering this unit within the holistic service.

1.13 to 1.16 – theories of harm

The arguments here are similarly flawed because they consider medicines alone and out of context.

2.8 – defining "prescribe"

It is important to recognise in part 2.8a that "deciding to use a particular medicine" includes the ongoing costs of maintaining the training of a team with regard to the use, effect, interactions, contraindications, adverse side-effects, etc.

The paragraph ought to include:

- part d) pharmacovigilance of medicines that have been prescribed, and
- part e) audit of medicines prescribed.

For a vet to prescribe also requires full knowledge of the health of an animal, any concurrent illnesses, and whether the route (and frequency) of administration of a medicine is applicable for the animal and its owner.

Prescribing is **not** simply transcribing these details into an animal's record or onto a written script, and it is the understandable ignorance of all that is involved in prescribing that may contribute to concerns about the cost of medicines (where the cost includes that of the prescription) or the cost of a written prescription.

2.13 – classification

The final sentence cannot be overemphasised and is the fundamental part of seeking to protect the public and focus on animal welfare.

2.55 – frequency of prescriptions

The statement "65% said their pet was prescribed a medication in the last two years" is likely an underestimation and reinforces the comments to 2.8 above. Pet owners may not recognise when a medicine has been prescribed. For example, if a medicine was prescribed and tablets dispensed to a client this would be obvious prescribing. However, if a vaccine is administered, anaesthesia performed, intravenous fluids, or even euthanasia, then a POM-V medicine would have been used and therefore prescribed by the vet. However, what is the awareness of pet owners that prescribing is still taking place?

2.58 to 2.61 – gatekeeper role

It is disappointing to see no reference to the role that vets as gatekeepers undertake with regard to the protection of animal health and welfare, and wider one-health. There is implication that by acting as gatekeepers, vets maintain a high price for medicines and it would be a dangerous precedent to set to seek to improve access to medicines without a prescription merely to influence price at the expense of protection of animal health, the public, and the wider environment/one-health concerns.

2.62 to 2.70 – procurement decisions

There is an implied assumption that by streamlining procurement around certain products, vets are seeking to maximise profits at the expense of passing on cost-savings to pet owners. I note that the paper states that LVGs have average retail prices of "300-400% above purchase price" which is four times that of independent FOPs.

The implication is actually therefore that LVGs may streamline procurement to maximise profits, but that independents streamline procurement to be able to retail medicines at an affordable price to clients.

Furthermore, it has been noted in several paragraphs that clients value the convenience of being able to purchase a prescribed medicine from the practice at the point of prescription. It would be impossible for a practice pharmacy to carry every generic version of every medicine, and therefore streamlining plays a role in being able to stock medicines to deliver this valued convenience for its clients.

2.72 – costs covered by fees associated with medicines

The paragraph fails to consider the cost of waste disposal. Any product contaminated with a pharmaceutical residue should be disposed of through an appropriately audited channel and not simply through domestic waste. This includes vials, needles, syringes, and packaging.

2.74 – revenue from injection and dispensing fees

The marked difference between LVGs and independents imply that independent practices are not seeking to exploit the important role played in the areas outlined in the response to 2.72 above.

2.77 – fees for written prescriptions

It should be noted that the work involved in producing a written prescription is considerable (as it is for any prescription) – see response to 2.8 above. This is veterinary time that must be charged to a client and it can be estimated that any individual written prescription involves approximately half the time of a standard consultation.

2.82 – uploading written prescriptions

Sadly, there has been an increasing incidence of fraud such that some pet owners have tampered with written prescriptions to enable supply of additional or different medication. Because of this, many FOPs will now send the prescription directly to the nominated pharmacy.

3.13 – increase in unit cost

This is a very crude assessment that fails to take into account advances in types of medication that have become available in the last 10 years. There have been several new products brought to market that have enabled treatment of disorders in a novel or much improved way (for example, monoclonal antibodies). New products carry the costs of the underlying R&D and will therefore appear to distort price increases above the CPI.

3.30 to 3.36 – retail prices at independent FOPs

Again, there is no reference to the fact that when a medicine is dispensed and sold from the practice, the mark-up applied to the medicine will include the cost of the prescription component which is not charged separately.

It would be possible (and would obviously be more transparent) to charge a considerably reduced mark-up on sale and to charge a separate prescription fee. NB whilst the total cost for some medicines may reduce, the cost for others could increase substantially, especially tablets in low volumes with low unit prices where the prescription cost is essentially cross-subsidised to maintain affordability for clients.

By not charging separately for prescriptions but by covering the cost in margin made on the sale of a medicine, practices are seeking to ameliorate the effect of the cost of prescribing and therefore helping affordability for pet owners.

3.37 to 3.40 – retail price from on-line pharmacies

Again, there is a need to understand the comparison. The price from an online pharmacy is the dispensed medication and does not include the cost of a prescription. Furthermore, it is bricks and mortar practices which will carry the cost of disposal of unused medicines and medicine residues irrespective of from where they were dispensed.

3.42 – outcomes of competition

The statement "the sale of veterinary medicines by FOPs is an important source of profit to these businesses" is blunt and misleading. FOPs provide a range of services, they don't simply sell medicines. Rather than consider that medicines are an "important source of profit" it would be more accurate to consider that the sale of medicines represents a marginal return that is part of the whole financial package of a practice. "Excessive" profits on medicine sales only becomes relevant if there are "excessive" profits from the whole package of services. Paragraph 3.44 is very relevant here. Furthermore, the evidence from consumer research provided indicates that pet owners would be better served by considering the competition offered by the whole pet-care package and transparency around the holistic service-offering is of far greater importance.

4.10 – prices on FOPs websites

There has been understandable reticence amongst FOPs to publish prices. Fundamentally this is because simple prices do not convey the complexity of the range of services that may be provided. Price publication would be much more commonplace if there was absolute transparency about what services and standards of care were provided. NB the caveat to this is that if lower prices from practices offering only a reduced range of services encouraged clients to use those practices, this may be detrimental to animal welfare if pet owners do not have ready access to a broader range of services or have to pay over the odds for these services from another FOP or referral centre.

4.40 – emerging thinking

At the risk of repetition, "overpaying for medicines" is a crude analysis of a unit cost which is only part of an holistic package of care. The unintended consequence of filleting out aspects of this holistic care could be to increase the overall cost to pet owners (because more players are making a marginal return – the opposite of economy of scale) and the risk to animal health and welfare if it results in the holistic clinical record of an animal being split across too many sources.

5.8 – frequency of pet owners requesting written prescriptions

What is the evidence behind the statement "we might plausibly expect the number of pet owners who consider using third-party retailers to buy veterinary medicines to be significantly higher if the market for veterinary medicines was working well"? The survey showed that 20% of pet owners had requested written prescriptions. Given the nature of health care for pets, there will be many interactions with a FOP by a pet owner where a prescription is not required and a large number where a medication is required sufficiently promptly (sick animals, inpatients, surgery, etc) where the delay introduced by redeeming a prescription from a third party (including the time of delivery) is not in the interests of the animal's welfare.

It is really only medicines that are required for long-term use for chronic conditions where the need for written prescriptions may exist. Consequently, 20% of all pet owners seems a reasonable number given that many animals will not have chronic conditions necessitating ongoing medication.

The requirement to make pet owners aware of the option to ask for a written prescription has been around for 20 years and should therefore have reached a stable state.

5.37 to 5.38 – competition between FOPs and online pharmacies

The paper presents evidence that lower prices of medicines online is driving down the price of medicines in FOPs. This is competitive pressure. Only a small proportion of pet owners use online pharmacies according to the evidence. Therefore this supports that competition is working – it is driving down prices which reduces the need for pet owners to use online pharmacies; this is a different conclusion from that reached in paragraph 5.38

Indeed, if competition was at its greatest, there would be no difference in price between FOPs and online pharmacies (after the cost of prescribing). Given the convenience of collecting medication from the source of its prescription this would then negate any need to visit an online pharmacy. Consequently, competition could be said to be working well if there is reducing use of an online pharmacy, not the opposite. Evidence in the consumer surveys highlights the convenience of obtaining the medicine from the FOP.

5.48b and 5.55 to 5.59 – prescription fees as a barrier

Given that a prescription fee is for a large piece of work (see response above) and justifies a charge equivalent to approximately half a standard consultation, if the difference between the price online and that of the FOP is only the cost of the prescription it shows that FOPs are fully competitive and that the market is working, not the converse.

It is completely wrong to state that prescription fees are a barrier, because the fee for a prescription is a justifiable cost in its own right. It is simply the case that there has been a lack of transparency and therefore misunderstanding of the whole value chain – ie out of the total cost, how much constitutes the medicine, how much the retailing (dispensing) of that medicine, and how much is prescribing. The prescription is a set cost regardless of what medicine is prescribed.

5.59 especially is insulting – implying that FOPs increase prescription fees to act as a barrier simply shows that the research has failed to understand what constitutes the whole act of prescribing. If the medicine online is no cheaper after a prescription fee has been charged, then competition has already worked.

5.75 to 5.82 – restrictions

Given the critical role that vets play in safeguarding the use of veterinary medicines, to protect animal health, the public, and the wider one-health implications. **It would be very dangerous** to suggest that the regulation of the supply of medicines and the complex considerations of a prescription should be relaxed simply to reduce costs to pet owners. Commercial factors should never be seen to take precedence over good pharmacy practice.

5.83 to 5.96 – injectable medicines

It is understandable that these will tend to be sourced from where they are prescribed. In this way the vet is able to prescribe, dispense, administer, and dispose of all waste products in one single act. Consequently, this delivers an economical service to pet owners, the costs of which if dealt with individually (a cost for a prescription, a charge for administering the product, a charge for disposing of pharmaceutical waste sourced from elsewhere) would be greater.

There may also be very real H&S reasons why injectable medicines are best administered by trained veterinary staff.

6.1 to 6.8 – negotiating power

Please see previous comments regarding statements like “the sale of medicines is a highly profitable activity for FOPs”. The sale of medicines provides a marginal return for one component of a business that provides a much broader holistic service. At this stage it is not profit and cannot be considered as such until all aspects of the business have been taken into account.

Furthermore, if independent practices are making a much smaller marginal return than LVGs, it is clear that whilst there is still a good margin for independent practices, they are seeking to pass on a greater proportion of the savings to the pet owner.

D. Paper 4 – Regulatory Framework for Veterinary Professionals and Veterinary Services

General comments

The veterinary profession is a true profession – ie in order to be able to "practise the art of veterinary science" a vet must profess an oath to the Royal College and agree to be bound by the ethical code of conduct. There is no NHS for animals and veterinary services have to be delivered through private businesses. When these businesses were exclusively owned by the vets who worked in them there was a happy equilibrium between the needs of the business and those of the staff, pets, and their owners, kept in check by the oath that we profess and the code within which we work. The cost of regulation was minimal because there was little requirement for time-consuming red tape in a profession where the norm was for practice owners to do the right thing because it was the right thing to do (professional ethics!).

Furthermore, the ownership cycle of veterinary practices, when in the hands of vets, was a long cycle of 25+ years built on the affordability of repaying capital borrowed from banks. The evidence presented in the papers states that, in contrast, the ownership cycles of the LVGs is typically 4 years or so before moving onto the next PE owners. Inevitably this will drive up the need for financial return over a shorter timeframe.

Delivering a financial return over 4 years instead of 25 will put pressure on the need to generate profits and in a market where there is no regulation of the business of veterinary practice, and in which the owners and key decision-makers are no longer MRCVS, the natural ethical control is no longer in place.

Attempts at regulating businesses is limited to the PSS which is a) voluntary, and b) focused on clinical standards. There is no regulation of practices as businesses and this review should be an opportunity to deliver a return to a level playing field on which all veterinary practices are regulated by the ethics encapsulated in our oath and code of conduct. However, it should be cautioned that any overtly bureaucratic system of regulation carries the risk of the burden of increased staff costs to "ensure the boxes are ticked" – costs that invariably have to be passed on to the consumer.

There are three main issues with the current system of regulation:

1. Inability to regulate businesses
   As a veterinary surgeon and owner of a veterinary practice I carry the ethical responsibility to ensure that I am acting within the code of practise, not only for the clinical work I undertake personally, but also for the work undertaken by the veterinary surgeons that I employ (who themselves are also acting within the code).
   Where I set practice protocols, I must ensure that they are acting within the spirit of the code and are used to ensure that they protect both the health and welfare of the animals, but also the animal owners and wider public.
   There is therefore a need to ensure that any veterinary business which is not owned by veterinary surgeons (ie does not have a majority vote of veterinary surgeons as shareholders and on any Boards of directors) can be held to the same standard of ethical practise.

2. Sanctioning of individual vets
   There are two aspects to this. Firstly, definitive sanctions are only used in cases where there is proof of a vet acting at a standard far below that which would be expected. This is an extreme

level. The client mediation service is a good initiative, but strengthening it so that lesser cases of poor practise can be appropriately recognised and monitored would be useful.
Secondly, with the majority of vets now employed by non-vets, there is the potential for a vet to be acting in an unprofessional way due to pressures from the employer. The RCVS is, understandably, reluctant to make an example of an individual for something that should be directed at en employer which falls without the jurisdiction of the College, and this reduces the effectiveness of the powers of regulation.

3. Acting as a Royal College
   The RCVS is a "Royal College that regulates". This is a good thing (and worked well when practices were owned by individuals who were answerable to the College). It encompasses the unique role of the vet as the primary voice for the health and welfare of animals but who also has an ethical responsibility to the public and animal owners.
   The Royal College aspect of this would be to observe, monitor, assess, and analyse trends in the provisions of veterinary services, and issues that arise (through proactive engagement with pet owners and monitoring of complaints received), and then using this information to raise issues of ethical standard within the profession.
   To date the RCVS has appeared reluctant to take a critical voice due to a desire not to appear to be interfering in the business of veterinary practices. However, to be a well-functioning Royal College that Regulates it should be able to be openly critical of behaviours and practises that it deems to transgress its ethical code.

I would support the retention of the RCVS as the regulator of the profession, but welcome it to have wider powers, including regulation of any practice not owned by veterinary surgeons, and for it to take a more critical role as a College. This would be true upstream regulation that seeks to set vets up to succeed, not seek to sanction them when they fail.

Summary Paragraph 4 – well-functioning market

There is some caution required here. The animal health and welfare needs are enhanced where the clinical records for any animal are held within a single database, with a specific provider responsible for the overall care of the animal. The need to involve other parties (to access services not available at the primary FOP) should be mediated through the vet who has the animal under care.
Subsection c) states that the market will work better when consumers shop around for services. However, there is a danger that this can be at odds with the needs of the animal for its health and welfare.

1.11 to 1.13 – public interest and externalities

These concepts are critical when considering the regulation around veterinary medicines. It is vitally important in the wider public interest that improved access to medicines is not enabled by the slackening of regulations simply to reduce costs for consumers. Veterinary surgeons are the gatekeepers for POM-V medicines for a reason – only the veterinary surgeon who has had this full training and experience, can juggle the competing demands of the needs of individual animals, their owners, and the wider society (one-health).

1.14 – The purpose of a profession

This is not the sole purpose. In 1844 the petitioners to Queen Victoria (Turner, Goodwin, Mayer, Dick, Sewell, Spooner, and Simonds) noted that vets had been trained by universities for many years in order to "improve the veterinary art which had been theretofore practised generally by ignorant and incompetent persons, which had been long and universally complained of" and that trained vets had

been shown to deliver greater success in treating horses used by the military than lay people. Consequently, for a profession such as ours, the purpose goes beyond simply providing access to a body of learning, and is actively focused on the improvement of animal health and welfare.

1.15 to 1.19 – credence goods

There is no mention that a market in which a clinician diagnoses, identifies the solutions, and then sells the goods or service to the pet owner is also able to concatenate all aspects of the care such that the total package is delivered more economically than if it was split across several providers. This may be a feature of why the consumer response to competitive dynamics is weak (1.20) – consumers value the ability to access care as a package from clinicians they trust through the relationships they have built with them.

For example, an independent practice that provides standard first opinion services backed up by 24/7 in-house hospital provision and an extensive surgical expertise, may deliver an economy for treating a specific condition when compared to an LVG hub and spoke model where the services are dealt with by two or more separate teams working out of different business units.

2.24 – entry requirements and vet shortages

From the perspective of a vet working within the profession I would disagree with the comment that entry requirements are contributing to a shortage of vets. The number of new registrants increased year on year from 2000 to 2019 such that 2019 registrants had increased 156% on 2000 registrants. There is no shortage of people wanting to enter the profession and meeting the requirements to do so.

However, over the same period the total number of vets on the register increased by only 108%.

Absolute shortage is primarily due to poor retention within the profession. However, this is exacerbated by other factors such as the reduced productivity of a “full time” vet (see earlier comments); increased proportion of vets working “part time”; and increased numbers taking career breaks (usually for maternity).

Brexit, often cited as a reason for shortage, is less clear-cut: EU graduating vet registrants increased in record numbers after the 2016 referendum and only dropped during and post-Covid. The Covid effect seems to be more pronounced than Brexit.

2.28 – regulatory reform

The need for regulatory reform is key. In a profession where vets are regulated personally and professionally by their governing body, but in which the majority of vets are employed by non-vet owned businesses, there is an unhappy conflict. The only push-back the regulator currently has, against any employment demands that may seem to be exploiting the boundaries of what is ethically acceptable, would be to target the individual vets who themselves are as much victims of the system.

This situation is different in independent practices where the employers and practice owners are, themselves, regulated vets.

2.29 and 2.30 – primacy of animal welfare

In my opinion, the primacy of animal welfare does not preclude a focus on the protection of the public. As a vet I can only practise my professional art because I have professed an oath. That oath makes explicit that I have responsibilities to my clients and the wider public. Primacy of animal welfare is therefore viewed through this context. What I do is treat animals, how I do it is by working with the owner of the animal – building a relationship with the pet owner so that the most appropriate care (fully communicated) is delivered.

Commercial exploitation of a pet owner under the pretence of the primacy of animal welfare conflicts with the declared oath. Indeed, the declaration ensures that the vet is responsible for working with pet

owners to ensure that the most appropriate solution is found to deliver animal welfare in the context of the needs of the pet owner and protection of the wider public.
This is the reason why it is fundamental that vets (who have satisfied the appropriate training and made the statutory declaration) are the gatekeepers of the provision of services of this kind. The bigger issue is when non-vet employers make demands on vets that conflict with the vet's professional declaration. As it stands any vet can only defend their professional obligations by countermanding the direction of their employer in such a circumstance. This is where reform of regulation should be focused, not the diminution of the important role of vets as gatekeepers.

2.48 – monitoring of compliance

Of note, historically, the active monitoring of compliance would have been performed by business owners who were themselves MRCVS (this would still be the case in an independent vet-owned practice). The need for regulatory monitoring has only arisen because of the growth of businesses that are not vet-owned. However, this itself is the end game of the decisions taken in 1999 to allow non-vet ownership, without simultaneously changing the VSA to enable a different form of regulation that such a change in ownership necessitated.

2.52 to 2.73 – available sanctions

This is pertinent. A better system for investigating and a range of sanctions would be welcome. However, it is key that within this an individual vet should not be held accountable for the actions of their employer. Employers who are vets can be investigated and sanctioned by the RCVS; employers who aren't cannot and this should be addressed.

2.74 – emerging views

Part a) disagree with this view based on my comments above about the pivotal role that vets take as gatekeepers of animal health and welfare in the wider context of protection of pet owners and the public.
Part b) – partly agree, but this is most apparent when vets are employed by non-vets.
Part c) – agree, as outlined above.

3.3 – duties of vet nurses

I would urge caution here. Currently, the list of tasks that remain the exclusive preserve of the veterinary surgeon is actually quite limited:

1. Diagnosis
2. Prescription of POM-V medications
3. Anaesthesia (or at least the responsibility for anaesthesia and its induction)
4. Invasive surgery

There are very good reasons why these remain the preserve of the vet, who is the one professional that has been able to demonstrate (through robust training, assessment and continuing development) the broad understanding of the holistic needs of the animal placed "under care". It is the essence of the importance of the vet-led team.
This does not seek to diminish the skills or value of veterinary nurses. Indeed, there are many opportunities that could already be taken up by veterinary nurses within the existing scheme of delegation.
Before expanding the scope of what nurses can perform it is first necessary to understand why the profession may not be being utilised within its current scope. This might include aspects that could be performed by a nurse but which also require a vet to be present and active – in such a situation delegating to a nurse may simply duplicate staffing and increase costs to the pet owner. There will be other examples where a nurse could lead aspects of an animal's care for an already diagnosed condition

(through the use of consulting nurses in practice clinic sessions) but where pet owners do not yet see the value in paying for this aspect of care.
It should also be noted that in the medical field, where there is already a much more advanced programme of training of nurses and other allied professionals, there is considerable concern and pushback against the introduction of physician associates and anaesthesia associates where there are real concerns for patient welfare.

3.22 and 3.28 – expansion of role

Given the reported lack of understanding about what can be delegated under Schedule 3, it is highly likely that the high number of vets and nurses reporting that nurses should be able to undertake additional areas of work may be based on a misunderstanding of what the role can already include. As previously stated, there are only 4 areas that are the exclusive preserve of the vet – with valid reasons relating to the protection of the animal and the public for all of them.

3.29 – job satisfaction etc

From this it would appear that the BVNA recognises that their efforts to get nurses to expand their role would "free up vets 'to do what only a vet can do; diagnose, prescribe and perform surgery'." This supports my view above that the need and ability to expand the role of the nurse can already be achieved within the remit of what can already be delegated; it does not require expansion of Schedule 3.

3.30 – activities

Part a) – anaesthesia is one of the most complex and critical activities that is undertaken and every anaesthetic procedure carries a risk of fatality (though currently only very small, thankfully). One of the most critical times during an anaesthetic is the induction. It would seem dangerous to public protection and animal welfare to delegate this.
Part b) – POM-V medications are reserved to vets for a reason: their use requires an holistic understanding of the patient and its environment. There is already an underutilised opportunity for nurses to be involved in the care of patients to which POM-V medications have been prescribed, but it would create ambiguity to attempt to lessen the control surrounding the prescription itself.
Part c) – community nursing is already possible where nurses are working as part of a vet-led team under the direction of the vet who has the animal under care. Fragmenting this primary care into potentially multiple hands risks compromising animal welfare and protection of the public.

3.32 to 3.36 – staffing pressures

If greater utilisation of nurses will ease staffing pressures, there is first a need to explore fully how nurses can be used within a practice setting under existing legislation. Given that this is obviously poorly understood (see above), it would seem counterproductive to add to the confusion by expanding a role that may not actually need to be expanded if utilised to its full existing capability.

Section 4 – regulation of veterinary practices

As already commented, indirect regulation exists where practices are owned by veterinary surgeons. Mandatory regulation of all practices is essential. However, it is vital that it addresses the practices as businesses (not just clinical standards) and should be delivered in such a way that the inevitable bureaucracy does not impact too heavily on prices to consumers.

Section 5 – Consumer Redress and Complaints

In a well-functioning vocational profession such as ours, most complaints could be handled satisfactorily by the vet who has the animal under care, as part of the professional duties inherent in their professional declaration. A greater focus on communication skills generally, and the importance of building a trusting relationship with clients that underpins having animals under care, should be part of all veterinary undergraduate curricula.

An unintended consequence of an inappropriate approach to "Consumers' ability to complain effectively and have their complaints resolved can discipline businesses in terms of the quality of the goods and services they provide" could be that the potential for practising defensive medicine could increase, driving up prices, which paradoxically may lead to even more complaints.

6.3 – Prescribed medicines

As a vet who was familiar with the use of medicines before and since the introduction of the prescribing cascade, my general opinion is that the cascade has had an overall positive benefit on the health and welfare of animals and protection of the public. It ensures medicines are appropriately regulated, efficacious and safe, and promotes beneficial R&D.

It may be easy for clients and the media to focus on "expensive medicines" but only because of a focus on absolute price and not overall value.

Part b) – the concern about restriction on being able to prescribe parasiticides is based on a misunderstanding. These POM-V medicines have always had to be prescribed following a physical examination, it is some other POM-V medicines where this restriction has been relaxed. Furthermore, a veterinary surgeon who has an animal under care and who has physically examined it within a timeframe for which a prescription would have been active, can still prescribe based on that examination without having to examine the animal physically again.

Part d) – POM-V classification is not undertaken lightly and is in the interests of animal health and welfare and protection of the public (one-health).

6.52 – under care and parasiticides

Again, to reiterate, in relation to the statement "these changes were badly received by vets and pet owners; for example, one vet suggested animals are sometimes unnecessarily required to attend consultations", the requirement for a physical examination before prescribing these products was already in existence. However, there had previously been a tacet acceptance / interpretation of the VMR such that one vet in a practice, armed with full clinical notes and knowledge of a colleague who had previously examined an animal physically, might prescribe on the basis of that colleague's physical examination.

This was all part of the practice team functioning well in a vet-client-patient-relationship. Where the new regulation for remote prescribing missed an opportunity was to recognise that prescribing by a colleague in the same practice where a robust VCPR was in place, was simultaneously beneficial to pet owners and adequately protected animal health and welfare, and public interest.

In other words, remote prescribing for an animal where a VCPR already existed based on a recent physical examination would be fine; remote examination (through telemedicine) to substitute for the physical examination in creating that VCPR in the first place would always be inappropriate.

6.54 – requirement to re-examine pets

Again, there is a misconception. The vet should examine an animal physically in order to prescribe. However, any prescription can be verbal or written (when vets choose to use and administer the medicines themselves, they are effectively making a verbal prescription, to themselves, and merely recording the use of the medicine in the clinical records, not its prescription). A vet who has examined an animal physically can have made a verbal prescription (to him/herself) at the time of the examination

but not written the prescription in the clinical notes. This would preclude another vet from dispensing on that prescription at a later date because there is no written record. However, the initial vet could legitimately access the clinical notes at a later stage and formalise the written prescription in the records such that dispensing could take place by another vet. The need for re-examination is not required if the same vet was making the written entry and if their previous physical examination had been recent.
Much of the voiced concern was down to this misunderstanding and it is important that the CMA does not seek to impose any knee-jerk changes based on the perpetuation of this misunderstanding.

6.57 to 6.66 – reclassification

It is worth noting that many veterinary medicines that were previously classified as POM-V have had their classification reduced to NFA-VPS or even GSL. The parasiticides imidacloprid and fipronil are two examples. These are products that are now implicated in environmental toxicity and there are strong arguments that by removing the control afforded by POM-V classification, the ability for the profession to play an important role in safe-guarding the environment has been removed.

6.73 to 6.107 – innovation

As explained above in the response to the paper on how pet owners select providers of veterinary services, our experience of the use of telemedicine (a necessity during Covid-19 restrictions and in continued use since) is that it works well where a VCPR already exists and it seeks to augment access to that VCPR, but that it is deficient in its ability to create a meaningful VCPR.
My concern would be that attempts to increase access to remote-only providers in order to reduce costs to pet owners could a) have a significant impact on animal health and welfare, and b) actually increase costs where subsequent physical examination by another provider proves necessary.

6.108 to 6.120 – limited-service providers

Whilst increased access to LSPs could reduce certain unit costs in an animal's care, it is likely that the overall cost of care would increase due to the need to access services from multiple parties, and the increased costs of services from bricks and mortar practices who may see a reduction in certain streams of income in the holistic package that is provided. These are unintended consequences of which the CMA should be mindful.

E. Paper 5 – Analysis of Local Competition

Summary paragraph 4

It is worth noting that the competition of FOPs and OOH practices is linked. There are 168 hours in a week and illness and injury don't respect the clock or calendar. Where a practice does not perform its own OOH service it is likely that it is only providing a direct service for one third of any week. Consequently, the choice between FOPs and competition in a local area must take into account the provision of OOH services.

In other words, if there are six different practices in a local area, all with different owners, there is implied competition, but is this competition real if they all make use of the same OOH service provider?

Summary paragraph 6

Expanding on the above, all vets have a responsibility for the care of a patient OOH if they took that patient under their care within hours. Consequently, the provision of OOH should be considered in conjunction with daytime services from FOPs, not separately from them.

2.5 – inclusion criteria

See above regarding the need to consider OOH in tandem with daytime services.

2.12 to 2.15 – unconfirmed / duplicate sites

Given that a premises has to be registered with the RCVS in order for it to be used as a veterinary practice it is likely that unconfirmed sites that are in the insurance data but are not in the RCVS data are duplicates due to formatting of datasets and the RCVS number is more accurate.

2.31 to 2.34 – concentration metrics

There appears to be a paradox. A local geographic area could have several competing practices all of a similar size, with a similar number of FTE vets and therefore appear to be functioning well with respect to competition, especially if there is a high level of movement between practices. However, if the quality of service delivered to pet owners is poor in all those practices (prompting client dissatisfaction and increased "shopping around") the apparent competition has not been effective in protecting the public. Conversely, a local geographic area could appear to have one dominant practice and minimal client movement, and therefore appear to be anticompetitive. However, if the practice has grown organically because clients have selected it preferentially due to the good level of service it provides, then it is a well-functioning local geographic market even though it appears anticompetitive.

It would be sensible for the CMA to investigate any local markets with respect to the **evolution** of those markets – especially to understand the difference between an apparently dominant practice that has attained this position through acquisition as opposed to growth due to the level of service it delivers.

2.35 to 2.38 – share of sites

Related to the above comment on concentration metrics, there should be consideration to whether the number of sites owned by one practice in a local area is due to acquisition, or whether expansion has been required due to demand for the service by pet owners.

Both of the above comments relate to a need to understand the difference between a large independent practice that operates from several branches (ie a single practice that just uses several locations through necessity; staff and clients freely move between the branches) and a chain of small practices, or a LVG, (ie a single common owner / group of owners, but practices that function independently of each other where neither staff nor clients would freely move between them).

Section 3 – OOH competition

The nature of the provision of OOH service is part of the whole offering of a practice to the pet owners which become its clients.

It is in the interests of animal health and welfare and the interests of the pet owner if a practice provides its own OOH service, for several reasons:

- There is ready access to the clinical records of the animal
- The animal is treated by members of the practice's own team
- Accessing the practice is familiar for the pet owner
- Ongoing care can be provided in the same practice during normal surgery hours

25 years ago all practices would have provided their own OOH cover, or possibly cooperated with close neighbouring practices to look after each other's clients on certain nights. The trend to outsourcing OOH cover (now reaching 80% of all practices according to the paper) has been to the benefit of clinical staff who no longer have to work nights or weekends, but, arguably, to the detriment of the pet owner and the welfare of their pet.

It is likely that a pet owner would prefer to use a practice that provides its own OOH cover and given what has been discussed above this ought to convey a competitive advantage when a pet owner chooses with which practice to register their pet for normal practice services.

However, whilst there is a requirement for all practices to inform their clients of the nature of their OOH cover and ensure it is clear on their websites, this appears to be poorly enforced and many practices do not make it explicit that a) they are closed at night / weekend and a client would have to be referred elsewhere, and b) that the scale of any fees incurred OOH may be radically different at the third party.

Section 4 – referral centres

For clarification, if an animal requires treatment for a complicated condition that exceeds the ability of the vet to whom it is presented, the vet may need to refer the case to a more experienced clinician. Whilst this may be a specialist in a dedicated referral centre, it could equally be to a GP vet in a FOP who has the expertise to handle the case.

Consequently, the list of competitors is very high, but may be restricted by a perception that any referral has to be sent to a specialist.

Summary

1. From the perspective of both animal and client: a well-functioning marketplace provides 24/7 physical care at an affordable price. These five papers portray a very transactional perspective more in keeping with retail, or off-the-peg service provision (for example a funeral, or property conveyancing). This is in contrast to how a well-functioning veterinary marketplace works and I note that:

- The CMA's own research shows that pet owners value most:
  - Having a **trusting relationship** with their vet
  - The **convenience** of being able to access all that they need from their community practice
- Pet owners don't want to shop around, they simply want a "**fair deal**" from their practices
- The thrust of the CMA's arguments is that a well-functioning market should see pet owners "shopping around" for services. However, this is not what pet owners want and risks the health and welfare of animals (and the one health agenda)
- A well-functioning Royal College that Regulates CAN and should be the best system of regulation – and historically worked when all veterinary practices were de facto regulated because they were owned by MRCVS
  - Practices not owned by vets should be regulated to the same standard – a mandatory requirement
  - This standard should include justification for business practises, not just clinical standards
  - The Royal College could take a more proactive role in working with the profession to improve professional standards – and therefore set vets up for success so that they are less likely to fall foul of the regulator.

  In short, a well-functioning veterinary market would see very low levels of pet owners changing vets and shopping around for services, because they would be accessing everything they need through their trusting relationship (VCPR) and perceive a fair sense of value. In contrast, the measures proposed by the CMA (shopping around etc) are signs of a dysfunctional market in a profession such as this.

2. Vets are trusted, ethical people, working within a robust professional code that seeks to balance the health and welfare of the animal with the needs of the pet owner. Through their role as gatekeepers, vets possess a unique knowledge that helps to set these needs within a wider societal one-health context.

3. There are legitimate concerns about the rising costs of veterinary care. However, there are several drivers of this relating to staff costs in a post-Covid society, coupled with an increased demand of pet owners, and a trend towards ownership of breeds that have considerable health problems.

4. There are two pieces of research into finances that are still absent:

- A complete apples-with-apples comparison of the total package of health care costs incurred at an independent (vet-owned) community business that provides a complete service (including OOH and advanced surgical procedures), with the LVG hub-and-spoke model where costs are incurred at a range of providers.
- The cost of pet health care (line by line item) in veterinary practices before and after corporate buy-out – in other words, does the increased cost of funding private equity debt lead to higher prices to pet owners?

5. There is indication that the CMA does not yet fully understand the veterinary model and makes no account for independent practices that have multiple sites and how this is very different from practice chains. Understanding the complexity of OOH care is still a concern.

6. There is a concern that the CMA is seeking to place commercial competition above the important one-health role that vets play as gatekeepers in the supply of medicines.

7. There is a need for better regulation of the profession:
- A more flexible approach to dealing with concerns and complaints
- An enhanced Royal College role acting as the voice that defends the ethical code of practice
- A need for practices that are not owned (or led) by vets to be regulated to the same standard as those whose vet-owners are already held to account by the code of practice
  This is best achieved by increasing the powers of the Royal College in a more flexible system.

8. There is a need for the nursing profession to recognise and develop what it can already do within the existing scope of the legislation before any wider changes to this profession are considered.

9. There are areas where the profession should improve and develop. These are centred around the teaching and training of vets so that the primary focus is on being able to communicate a spectrum of approaches for an animal's care, not to be fixated on a text-book gold-standard technique.

10. The CMA should be aware of the potential for unintended consequences of increasing the overall cost of pet care, risk to animal health and welfare, and protection of the public (one-health).