

## **CMA investigation vet consultation remedies**

Q1 – No comment

Q2 – No comment

Q3 – Yes

Q4,5,6 – Consultation fees seem fair

Prescription fees seem fair

Medication and chronic problems difficult as they are too complex to generate a quote

There is a legal issue in that specifying a product can be seen as advertising a prescription medication and generic names would need to be used, which clients are unfamiliar with

Medication price quoting is not practical due to constant variations in wholesale price – different pharmaceutical companies increase prices at different times in the year so medication prices do vary quite significantly. Prices quoted may quickly become outdated and it is a lot of work to calculate the potential cost for different clients. Purchase pricing of generic products varies massively between different brands and availability of medicines is a constant issue in both human and veterinary practices, with some medications going out of stock for long periods of time, so quoting for the ‘preferred’ generic would leave practices significantly out of pocket if forced to charge this quoted price when only an alternative, more expensive, generic is available. This is a source of client complaints when an alternative product is dispensed at a higher price.

There is a big variation in what is needed. A ‘one size fits all’ approach does not exist to provide a price. Arthritis for example, can the owners give a tablet or would the dog need a liquid? Is there any evidence of renal or hepatic impairment? Is there a history of intolerance to one of the products? Do monitoring tests need to be done and if so which one? Does the animal have a history of gastrointestinal signs that make side effects of some medications more than others? Do multiple arthritis medications need to be prescribed? The size of the animal and dose is also highly variable. A large dog and small dog price would also not be appropriate.

Where health plans currently exist for parasite treatments, I have looked to provide treatment plans for my clients to include consultations, monitoring tests and required medications which can be broken down into a simple monthly payment, enabling clients to spread the cost of treatment into affordable monthly payments. I cannot find an easy way to market this due to the massive individual variation. While I can provide a treatment plan, it needs to be individually tailored to the client rather than having a fixed price and what is included needs to be very specific given the massive individual variation necessary. For arthritis, I looked at a ‘liquid NSAID plan’ and a ‘tablet NSAID plan’. I came up with the following specifications:

- The tablet would have to be carprofen (as cost variations would be different for other NSAIDs such as coxib type NSAIDS, which vary between product for daily or weekly administration, or EP4 receptor antagonist)
- Includes 1 blood test (standard biochemistry – there are various blood tests and other tests may be appropriate at the same time depending on individual need)

- 6 monthly consultation included (some dogs may require more frequent monitoring)

A similar amount of work and thought would need to be undertaken for allergic skin disease and products etc. This is just not practical to do for every weight and tablet size variation for every chronic disease.

I don't think this would achieve what the CMA are setting out to achieve, it creates extra work for the businesses involved and does not allow a fair comparison between practices who may quote for a cheaper product yet 'sell' another, more expensive product once the client is through the door. This suggested approach in the appendix provided is at best misleading to clients.

If medications have to be quoted in a visible way, clients can calculate themselves the cost by using the consultation fees that you are recommending. Medication costs can be discussed during consultations (as owners may opt to go online anyway). The costs of medications from the practice can be estimated by having a comparison of commonly used products which can be kept up to date more easily for veterinary practice staff.

This is something that I have to fill in annually anyway for my accountant. If this were standardised amongst the profession and made compulsory to fill in, it should provide sufficient comparison data for clients if presented in an appropriate way, be less work and time for veterinary practices than your remedy suggests and provide more accurate and less misleading information to clients than what you are suggesting.

Listing surgical prices is also potentially misleading and any comparisons should be very specific to give clients a fair comparison, e.g. rather than 'price for lump removal', it should give a specific scenario to provide a fair comparison to, e.g.

"Lump removal requiring 30 minutes of surgical time from a 20kg dog, ASA grade 1, with pre-anaesthetic bloods, perioperative fluid therapy and histopathology, no underlying health issues, on no medications and will be going home with 5 days of pain relief and a standard Elizabethan buster collar"

Diagnostics seems fair

Specialised treatment/procedures, CT, MRI – This should only be applicable for practices that offer these or potentially limit this section to referral centres. As some first opinion practices are able to offer these it could potentially be an 'optional' field for FOP practices to complete.

Q7 – Yes, if done correctly, a standardised pricelist would be of massive benefit to clients. However read above points as some of these might not be appropriate or may be misleading in their currently drafted way.

Q8 – see above, the specialised treatment/procedures would not necessarily be appropriate for FOP. On the flip side, some of the other prices may not be appropriate

for referral centres and so a separate price list for comparing FOPs and referral centres would be more appropriate

Q9 – As already mentioned. In its current form the pricelist may be misleading for some items as they may imply a fixed price for what their pet has rather than to be used as a guide for comparing practices overall pricing structure.

Other issues may include driving prices up for clients. Currently FOP are in the dark to pricing of competitors and there is massive variation in costs. It is unlikely that making this information clearer will drive down prices. Given the profitability of FOP and how busy they are, if business owners see that other practices are charging significantly more (from my experience of individual clients moving to my practice I can see that other practices are charging prices 3 figures more than me for some surgical procedures), to be competitive I know I can increase some of my prices quite substantially and still be competitive. Making pricing clearer will enable, particularly small independent practices, to significantly increase their prices, which will overall have a negative impact on clients and may risk price fixing between practices.

Price lists also do not take into consideration the potential for complications and additional costs associated with these.

Q10 – There would be increased time and cost pressures associated with generating price lists and keeping them up to date. See Q4-6 above as a solution to minimise this has been suggested. This would hit small independent practices most hard (however the information gleaned would enable prices to be adjusted to compensate for this, which will ultimately be passed on to the clients.... This extra cost to the client needs to be taken into account)

Q11 – Quality means could include post graduate qualifications of staff or any additional accreditations received by the practice, which could include environmental accreditations as well as formal recognised accreditations such as Cat friendly status or PSS status. Presumably clients would expect to pay more for a practice achieving certain accreditations/seeing staff with higher levels of education and enables fair comparisons of cost differences if shown to the client appropriately.

Q12 – See Q4-6 response. Medicine prices would have to be displayed in terms of 'generic' products name but also highlighting that these 'generics' must have a veterinary license as some human equivalents are illegal for us to prescribe under the veterinary cascade. Listing every price would be unnecessary for clients to get a feel of practice pricing comparisons and specifying possibly a 'top 10' that the cma are most concerned about and most frequently prescribed would be a good starting point to help clients make a fair comparison while not providing unnecessary work for practices. Additional rules may need to be put in place for this to prevent 'deals' creating misleading information to clients. E.g. standard price of meloxicam in april 2025 (but this cannot be subject to a "50% off month" to appear cheaper on the comparison sites, but also bear in mind that prices may be increased following supplier increases).

Other things to consider including it the comparison would be:

- Whether or not the vets at the practice are financially incentivised when invoicing as this will likely affect the overall cost in an upwards direction to the client.
- Facilities available (e.g. CT/MRI/Endoscopy/Orthopaedic surgery)
- Average transaction value? (see Q23-26 later)
- Whether a practice is corporate or independently owned
- Any accreditations (see Q11)
- Expertise of staff (e.g. certificate holders/diploma holders/special interests)

Q13 – I am a vet... marketing is not where my strengths lie and independent marketing advice should be sought here!

Q14 – I believe a single price comparison website operated by the RCVS or a commissioned third party (such as vethelpdirect as mentioned in the report) would be most appropriate to demonstrate integrity and honesty rather than multiple sources that can manipulate the data with search engines sponsorship to suit the needs of the person (or corporate practice) that is paying them to make their needs most easily accessed by clients, which would not be in the best interests of the client nor the best way to address your concerns.

Q15 – See Q4-6 response. Some suggestions have been made. A large issue may be the ability to extrapolate the required information from some practices practice management system and the time needed to do this.

Q16 – See Q4-6. This may not be feasible in some cases, particularly to further provide pricing information based on type, age, weight etc. Some medications are set up for dosing in lb, some are in kg, so the dose ranges of different medications may not fall into the same weight bracket. Parasite treatment for example for a 21kg or 25kg dog; Product A has a weight bracket of 11-22kg and 22-44kg, and product B has 20-40kg. The 21kg dog would be cheaper with product A, yet the 25kg dog would be cheaper with product B due to tablet sizing. This makes fairly comparing many medications impossible and possibly misleading on a comparison site, particularly if a practice stocks both product A and product B. The more variables that are added, the more time is needed to generate the required information. It would be fair to pick a middle size dog and a cat for comparison. It is likely that the price difference for a large dog or small dog would be proportional between practices to enable clients to fairly compare.

Q17 – See Q4-6 response: Either a very specific scenario e.g. “Lump removal requiring 30 minutes of surgical time from a 20kg dog, ASA grade 1, with pre-anaesthetic bloods, perioperative fluid therapy and histopathology, no underlying health issues, on no medications and will be going home with 5 days of pain relief and a standard Elizabethan buster collar”

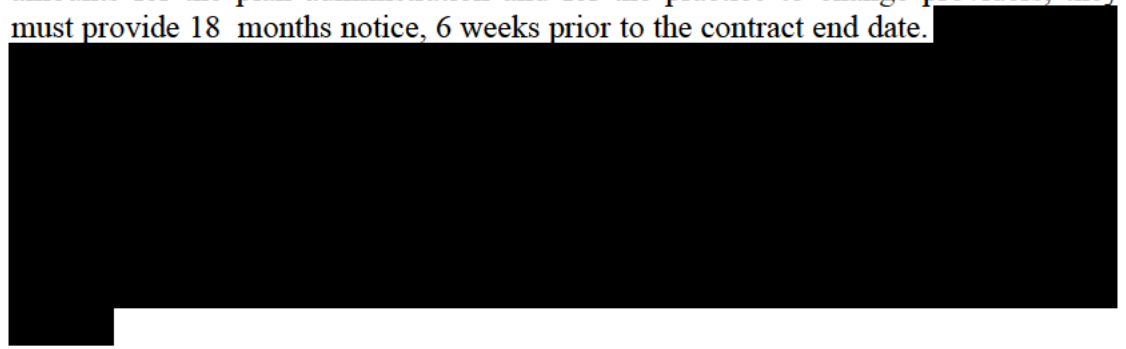
Or an average price over a set time period

Q18 – Practices have various obligatory costs, the most appropriate would be the annual RCVS register of practice premises and if they were the ones responsible for maintaining/producing/delegating to a third party it would make sense for them to foot the bill (which I appreciate would ultimately be passed on to the practices themselves, who would pass on to the client!)

Q19,20,21 – In general this remedy seems fine, however the small print of the suggestions is concerning in places. 3.84a and 3.84e are reasonable. One of the main advantages of a pet health plan is to simplify procedures and pass on savings. Administration costs of the health plan are already a burden for small independent practices who need to utilise a third party provider to ensure they are compliant with the FSA direct debit taking rules. 3.84b and 3.84c you have eluded would be difficult/impossible for some items even if the practice management system were to generate that report (which mine does not). This would be a very time consuming and unwanted additional time and cost commitment to the practice as each health plan member would need to be calculated individually. Given the relatively small monthly payment made, 1-2 hours of time added per year to a plan could see a 10-20% increase in cost to the client per month to make this process worthwhile. This would be less burdensome for a large corporate practice with a centralised health plan team but a massive burden for small independent practices. 3.84d would depend upon the amount of benefits the client has had. If a client has had lots of the annual benefits in the first month of the plan, a 3 month notice period would still leave a practice out of pocket.

A reasonable adjustment to that plan would be a confirmation statement advising clients that 12 payments have been made (annual statement) and a reminder of what that plan covers. I'm sure the clients can work out for themselves if they have taken the benefits of the plan and whether it is worthwhile. If they have failed to take the benefits of the plan/have not made a saving then cancellation should be a simple process for them if this is what they wish. My health plans are individually tailored to the pet (as they should be), so the product and prices are highly variable, meaning calculating the cost would have to be individualised. The third party provider of my health plan would be able to issue a 12 monthly statement alongwith a summary of what those payments provide in terms of benefits with a minimal burden to the practice.

With regards to cancellation and the need for this to be a month/a quarters notice. For perspective, there are some health plan providers that charge the practice excessive amounts for the plan administration and for the practice to change providers, they must provide 18 months notice, 6 weeks prior to the contract end date.



Q22 Most referral providers are very active in making themselves known to FOPs including the services they offer. A similar 'directory' containing a price comparison listing the level of expertise of staff at the referral centre and the facilities/procedures that are performed should suffice. Most referral centres seem to have an online portal enabling the sharing of clinical notes and lab results and with the individual information, a more patient specific pricing can be provided to the client. There is

nothing stopping a client requesting the referral to be sent to more than 1 provider and the client then making the final choice, the FOV can guide the decision of the client based on local knowledge of the individual clinician and facilities at the referral hospital.

Q23,24, 25, 26 I don't think there would be a massive detriment to this availability other than some increased admin time for the referral centre, of which most have got an administration team that could cope (assuming the pricing required is not too arduous.. many centres are offering fixed price surgery anyway now). Referral centres are probably better placed to answer these questions. Main things clients should know is:

- Expertise of vet at referral(certification holder/advanced practitioner? Diploma holder/specialist?)
- What the specialties are provided at the referral centre (e.g. Medicine/surgery/ophthalmology etc.)
- For some procedures equipment available (e.g. CT vs MRI vs Ultrasound vs Endoscopy)
- Ownership of practice (corporate or independent)
- Whether veterinary staff receive financial incentives linked to their invoicing
- Whether the Out of Hours provider has access to client clinical history (i.e. do they provide their own out of hours, however with the big corporates they may claim to do their own out of hours if another practice in their group provides the out of hours care if not worded in this way!)
- Access to some degree of cost comparison – basic, routine prices should suffice.
- Average transaction fee would be a better baseline for comparison between practices as it is easily visible on practice card machine statements and it is a KPI regularly monitored by most accountants/practice management software providers and provides a good overall cost of the service provided including medication fees, so would be minimal work for business practices to publish. This may not be appropriate for referral centres due to the complexity and smaller number of cases seen, but would be a good benchmarking figure for comparison that takes away the 'cheaper' fees quoted on websites to draw clients in, would be less misleading than a pricelist of procedures that can only really be estimated and will be difficult to monitor compliance. This would enable FOPs to maintain their own balance of fees between service fees and medication fees at a level they feel ethical while avoiding risks of industry price fixing and giving some way of identifying practices that are potentially overcharging. This may need to be read in conjunction with the services available at the practices – those with CT and orthopaedic surgeons are likely to have a higher average transaction value than those without high cost equipment/more advanced surgical facilities.

Q27 A written estimate should be provided upon request rather than as standard as it adds unnecessary time to most consultations that is impractical. If a written estimate must be provided I would suggest £500 is a reasonable level and owners can then seek comparisons from other surgeries if unhappy. A £250 estimate is going to take a disproportionate amount of time to generate the estimate and the savings that are likely to be made are going to be more trivial for the client

Q28,29 Thinking time is not always appropriate. Generally if a problem is identified, the sooner treatment is instigated, the better it is for the patient. This can be further complicated by weekends and bank holidays. Although the practice may stop functioning routinely for a few days, the patients body will continue to deteriorate at the same rate! It would be dangerous to animal welfare to implement a 'thinking time' requirement. Allowing clients appropriate 'thinking time' should be something the RCVS code of professional conduct should consider rather than the CMA and should be judged in a clinical light not in a commercial light.

Q30 This should already be recorded in clinical notes at the time of consultation. It is very easy to forget to document everything that has been said in a short consultation so there is a risk that some options may be reported and not documented. AI scribing of consultations may ensure this information is captured and documented with minimal additional workload for the individual, however the technology and cost required for this is not currently commonplace but would be an option for the future. It also may not ethically fit with some clients privacy concerns with respect to recording.

Q31 The idea of putting a line on a consent form to ensure clients are acknowledging that various treatment options have been discussed and 'this one' is most appropriate is a good idea but is a paperwork exercise as clients rarely read the consent forms anyway and the more information on a consent form, the less likely it is to be read. It would however 'cover the vets back'. Generally this would only be feasible for surgical treatments as signed consent is not generally given for medical treatments and would be additional time in a consult vets do not have if this were introduced.

Q32 This remedy is very vague and so the question is not very useful. It would depend on how the remedy is implemented. If it simply refers a client to a website it would be fair enough. The problem is that there are many different diseases all with a different list of possible treatment options. A standardised 'flow chart' of different treatment options for every disease process with advantages and disadvantages of each to provide to a client does not exist and so any treatment plan and options to be given in writing for every eventuality is unrealistic and will be impossible for practitioners to achieve. This should be something that is available upon request rather than essential and ensuring clients know this would be important. Many clients trust the veterinary practice and do not need this information in writing and to do this routinely for every case would be absurd. An exclusion for emergency treatment would also be essential. I think this remedy is very much appropriate, however the "in advance and in writing" should be removed as it is not practical and irrelevant in most cases.

Q33 There is always going to be the grey area. If a figure of £500 is used as criteria for this remedy, treatment may be anticipated to cost £450 but end up being £550 due to unforeseen circumstances, in which case the client can then argue that they were not correctly informed in writing

Q34 Not sure.

Q35 This is going to be very variable depending on the clinical context. In some situations there may only be 1 viable option, in others there may be 5 viable options.

This would be impossible to monitor. Expertise of the veterinary surgeon will also play a role. The viable options a new graduate is aware of will differ from the viable options of an experienced vet or certificate holder. An expectation for this would create unnecessary stress, particularly on newer graduates.

Q36 I think this is a good idea and the RCVS (or similar body) should be able to identify specifics to prohibit. Self certification should be sufficient, with veterinary staff and clients given the right to whistleblowing to prompt investigation by an appropriate body of any practice that is failing in this respect. Over time a comprehensive list of 'rights' and 'wrongs' can be developed with the veterinary profession with due attention to the primary goal of ensuring animal welfare. A specific and commonly used 'business practice that constrains choices offered to pet owners' is "preferred products", particularly amongst corporate ownership with respect to medicines. There are some medicines that vets in corporate practice may be unaware of due to some pharmaceutical companies being prohibited from mentioning certain products to staff, which may have advantages over the "preferred product". Some "preferred products" are available only from practices owned by the same corporate or their owned internet pharmacies, which give clients the perception that they cannot change practice and they are forced to overpay for medicines due to lack of competition for those products. Staff are also often prohibited from or penalised if prescribing products that are not on the "preferred product" list.

Q37 I do not think routine monitoring/auditing would be necessary. This is a strong topic that I believe staff and clients would be more than happy to report if concerned and the development of an ombudsman/ better utilisation of VCMS may be useful to have reports sent to, which could trigger an investigation by an appropriate body. If an offence is found, an 'improvement order' should be given to highlight where the business is failing and make recommendations for improvement. Failure to improve at this point could then lead to penalties. Removal from the RCVS practice premises list could be an ultimate penalty, particularly for a large offense that is not corrected when identified and requested.

Q38 I am a bit biased here as an independent practice owner. Unfair business practices have grown since the emergence of the LVGs and these are likely to be the biggest offenders from my experience, so yes I believe they should be monitored more closely. I do however believe that they will also be reported more by clients and staff if monitoring was predominantly done via whistleblowers. Changes would be made more quickly and centrally to other practices within that group if identified as being non-compliant too (particularly if appropriate penalties were provided for non-compliance) so I do not feel that publicly discriminating against them is appropriate.

Q39 I do not understand the question. An initial broad definition is fine to start with as stated in the remedy, however these should be made more specific over time with appropriate guidance to enable practices to understand specifically what they can and cannot do.

Q40 Medications administered by vets should definitely be excluded from mandatory prescriptions. There is always the concern as to where medications have been obtained. The vet cannot be certain of the source of medicines obtained by clients and whether they are genuine and obtained legally. I would not want to be complicit with

illegal activity and the only way to guarantee this would be by only administering products I have obtained myself legitimately.

Q41 Most remedies seem to have the ability to put additional administration pressure onto an already time constrained consultation. Where appropriate, most vets will recommend written prescriptions to ensure the animal gets the best treatment, particularly if medication is unaffordable. The conflict of interest in this scenario is where vets are financially incentivised based on their turnover, so pressure is put on clients to purchase from the veterinary practice so that the individual vets financial turnover is higher to achieve a financial incentive. I hypothesise that removal of these will increase communication around written prescriptions within the consultation. I do not agree that the promotion of written prescription availability should be primarily via the veterinary practice. I do not walk around Waitrose and expect a sign next to the apples advising me that they are cheaper in Aldi, so why am I expected to put the time, effort and wall space into selling a product for someone else? While I agree that the provision of a written prescription should be mandatory if requested and a reasonable fee paid for this, I do not believe it is my job as a veterinary surgeon to ensure all clients are aware of the price difference between my products and the same product available elsewhere. This has been a requirement since 2003. Perhaps marketing from the online pharmacies direct to pet owners would be more appropriate and a fairer way of ensuring clients are aware?

When considering the prescription fee, it is not just the time taken to write the prescription/dispensing fees etc. Due to the legal requirements on veterinary prescriptions, many prescriptions have to be repeated due to omissions made to comply with individual online pharmacies. We may also need to scan/email these direct to clients and liaise directly with online pharmacies if there is a concern. The number of 'repeats' allowed and potentially illegally obtained from multiple sources with the same prescription by sending to multiple pharmacies is a real concern. The current legal requirement of putting a line on the prescription to inform clients that doing this is illegal is not really a deterrent! There is also the risk of clients obtaining excessive quantities and selling them on illegally (which can be seen regularly on social media).

While this has improved cost and access to most clients, it has also increased the risk of abuse and welfare detriment to some animals.

Q42 A centralised, electronic online system for inputting the prescription information that online pharmacies can then draw down would help ensure the medications were obtained legitimately from an accredited source would be a massive improvement. It must be made clear that any reduction in sales of medication for a veterinary practice must be recouped in service fee costs, which could then lead to unaffordable consultation fees to compensate, which would be disadvantageous to low income clients.

Q43 – the first two options could be implemented with a short time frame. The third could be implemented with a short time frame, however it would be unfair to independent practices that do not have their own online pharmacy. Most online pharmacies are owned by one of the LVGs and the mandatory provision of written prescriptions would put independent practices at a significant competition

disadvantage. If the CMA were to proceed with the last 3 options, they should remove the ability of LVGs to dispense against their own prescription or provide 'free prescriptions' for use in their 'preferred internet pharmacy' which they also own [REDACTED]. Also any price cap on fees should be reviewed annually in light of inflationary rises. The implementation of this remedy could have a significant detriment to the viability of some practices, particularly if option c,d or e is opted for.

Q44 No price information should need to be provided on the prescription form. This is up to the client to find out. A QR code to a price comparison site is reasonable

Q45 Option A or C linked via a QR code is a reasonable option with the prescription only being redeemable at an approved pharmacy on that link. This would give better certainty to prescribing vets of what products are available. This should be limited to veterinary licensed medicines, particularly if changes to VMD recommendations are made to enable vets to list generic drug names to enable better choice of product for clients. This is important as 'meloxicam' for example is a veterinary licensed drug with various veterinary formulations with varying pricing. There is also a human licensed meloxicam which is illegal for vets to prescribe on the cascade, yet would be available from a high street pharmacy if a generic was put on the prescription. In some cases the veterinary formula has a distinct advantage over some human preparations, cyclosporine is an example of this where the microemulsified veterinary formula has significantly higher bioavailability than the human generic. Veterinary surgeons that give a prescription of a generic product will not necessarily know what is being administered to the patient under their care unless a specific product is listed on the prescription. A compromise would be a centralised database with a list of veterinary licensed products that can be dispensed against by a pharmacy. Option B is not practical as prices are constantly changing and this would require constant updating of practice management systems which may be unable to cope with the requirement being suggested. A QR code linking to option A or C would enable a centralised source to be responsible for accurate pricing information that should not be the responsibility of the veterinary practice as this is not our primary aim, we would rather spend the time looking after our patients than constantly price checking everything to ensure the pricing advice we are giving is accurate.

Q46 I do not believe option B to be feasible. Options A and C would be feasible, the cost of which should be borne by the pharmacies wishing to take part (which should be any pharmacy dispensing against a veterinary written prescription). Failure to do this would lead to disregulation of the veterinary medicines industry and put animal welfare at risk.

Q47 – generic prescribing is possible, however it should be strictly done under VMD guidance with any generic product only being acceptable if on a list of 'equivalents' as guided by the VMD. Generic products not listed by the VMD should be prescribed on a trade name basis. Generic products are open to abuse from pharmacies and human medicines and as highlighted in the report there can be differences in the formulation. The ability for a vet to specify a trade name where a VMD generic exists should still be allowable in extreme circumstances where there is a clinical justification that can be documented. The process needs to be kept simple for vets as this is time consuming and the generic name or trade name of the drug should suffice.

The QR code as suggested elsewhere would direct clients to any further information they require.

Q48, 49 – VMD guidance to vets is very vague. I specifically asked the question at the start of the CMA enquiry and was told by the VMD that the VMD recommend using the trade name and NOT using the generic name when writing a written prescription. What they appear to have told the CMA is slightly more vague and in favour of what you want to hear rather than what we as vets are being told. Specific guidance/updates to the legislation needs to be provided if this remedy were to be selected for vets so the rules are clear as to what we should and should not be putting on the prescription. The veterinary cascade legislation has not been mentioned here either, which means a veterinary licensed product must be prescribed above a human licensed product (which may have the same generic name). If a generic name is listed on a prescription, a human generic that has not been prescribed could be dispensed. Implementation of this remedy needs to ensure that both veterinary practitioners and pharmacists are working to the same rules and stating a generic may create some complications here if not done correctly. In some cases this will save the client significant amounts of money for an equivalent human generic (but is illegal for a veterinary practitioner to prescribe), in some cases it will be detrimental to the animals welfare as the equivalent human generic will be of a different formula.

Q50 This would be for the VMD to decide.

Q51 Drugs with a human equivalent. Drugs administered by the veterinary surgeon. Control drugs – these create further legal issues in terms of prescription that do not appear to have been considered in this report so should be excluded from any mandatory prescription

Q52, 53 The VMD would be better to answer this

Q54 See Q45 and Q46. This should be overseen by the VMD

Q55 I agree that some form of price control on prescription fees would be beneficial

Q56 Options A and B seem reasonable. Option C would seem to unnecessarily penalise veterinary practices that are operating fairly. Option B seems a bit excessive. Option A would seem the fairest option in the short term. As your research has demonstrated a prescription fee range of £12-36, it may be worth specifying that the price cap would be Option A or £36, whichever is lower, the date of option A should also pre-date this consultation report but be within the last 6-12 months.

Q57 Option A

Q58, 59 The cost of dispensing a medication is less than the cost of providing a written prescription. As the clinical notes are typed, the drug label is produced. The medication is then selected by a member of staff and checked by another member of staff. The owner is contacted and the medication handed over. A written prescription requires an additional step to produce a written prescription, print the written prescription and sign the written prescription (all done by a veterinary surgeon). The written prescription then needs to be issued to the owner either electronically or

handed over in person. It is not uncommon for the pharmacy to have questions, which then takes additional veterinary time to reissue or discuss the requirements. I would suggest 10-15 minutes of veterinary time would be justifiable for a written prescription to take in to account the admin/stationary costs as well as the veterinary time to produce the prescription.

Q60, 61, 62, 63 Any limit on drug cost should be balanced by a limit of supply cost to the practice. The medicine pricing across the industry is not ideal but accounts for about 50% of the practice income so reducing the cost of medicines while still allowing pharmaceutical companies to increase their costs is only going to affect practice viability. In my practice (like many others) there is a mark-up applied to the wholesale price of the drugs. As the wholesale price increases, the prices automatically increase. The problem with this method is that it does not take into account the rebates that are provided on the drugs, meaning that for some individual products, the mark-ups are excessively high. The availability of medications and the agreements in place with providers means that the rebates received are very variable. For example, brand A of meloxicam I may receive 0% rebate, brand B of meloxicam I may receive 60% rebate. If brand B goes out of stock I have to purchase brand A and receive a significantly smaller profit margin. It would be very difficult to fix prices to those charged in 2024. It would be a manual process of identifying the cost in July 2024 and over-riding the practice management softwares standard mark-up. The standard mark-up would then decrease over the timeframe of the implementation as the pharmaceutical company increase the prices but I am unable to increase mine. The rebate schemes are also complex with some rebate being paid via a buying group and some being paid direct to the practice. Some FOPs may not have a buying group to help them with this.

I don't think the way in which price controls has been considered very well here and the remedies suggested are not fit for purpose. Most veterinary practitioners are unaware of the cost of the medication they are purchasing due to complex buying arrangements from suppliers. The only way to fairly implement a price control would be to state a maximum allowable mark-up on the drugs, which requires practices to be able to quickly and easily calculate what the cost of the drugs are.

The simplest way to do this would be to ensure all practices are part of a buying group. The LVGs will have their own departments able to do this for them and provide a drug mark-up based on the true net purchase price of the drug.

All practices could be made to charge for medicines by marking up from a net purchase price rather than wholesale price. This is likely to be an excessive administrative burden, but can be avoided by joining a veterinary buying group, where the administration of this will be done for them and csv files can be uploaded into the practice management system to enable pricing based on true net purchase price of the drug. The savings made with bulk buying as a large group of practices through a buying group will more than offset the costs associated with being part of the buying group. The only complication to this model is the pharmaceutical company offerings of free of charge stock offers and additional rebates, which makes the true net purchase price more difficult to calculate. Reviewing offers allowable by pharmaceutical companies, with the majority of any offer being paid via a buying group should be implemented... An example of one 'additional offer' I have seen by

1 company is a “buy 2 get 3 free” offer on one of their products, which significantly affects the overall net purchase price.

Differing mark-ups may be appropriate for different classes of drugs, emergency drugs that often go out of date but need to be on site for example would need to carry a higher markup to account for wastage.

Q64/65 This online e-prescription/price comparison tool seems like an appropriate remedy to many issues you are investigating. Funding for this could be made from the RCVS (via their Practice Premises annual fee, essentially giving each veterinary practice a compulsory membership fee) and the pharmacies that would gain the most benefit from this through a membership fee to this portal. All prescription should be uploaded to this portal by the vets. Clients then request the medication from their preferred supplier, who would obtain the prescription from this portal. They could just receive a QR code that can be redeemed and contain further information

Q66. Whilst I agree that out of hours providers long contracts are unreasonable and will deter practices from changing provider, I do not think that changing the notice period will make a significant difference to the level of service provided. There is generally a lack of out of hours service providers which is limiting competition and reducing the level of care experienced by clients. This may be different in some geographical areas and where there are multiple oohrs providers in a given area, this may be having an impact.

Q67 3-6 months would be reasonable as this would be sufficient notice to give to make redundancies if required due to reduced workload.

Q68 This is a very distressing subject for clients, and while some clients would want to know the cost difference up front, others get offended when costs are discussed and I have seen clients get frustrated when I start to talk about costs. To make a bigger deal about this for some clients will be detrimental. Grief can cause clients to become angry and violent. Pointing out how much more it will cost for ashes to be returned is likely to result in abusive behaviour towards veterinary staff, particularly if they want individual cremation and cannot afford it. Giving different options of different providers can also be overwhelming to some clients and by discussing costs and options it gives the impression that the vet ‘only cares about the money’. In an ideal world, having a pre-euthanasia appointment to prepare an owner for what is to come in chronic diseases is preferable where this can be discussed at an appropriate pace for the owner. In a sudden death or rapid deterioration to euthanasia, this may not be possible and forcing vets to focus on the financial aspect of cremation options would be seen as insensitive. Perhaps having this information on a practice website would be most appropriate?

Q69, 70, 71, 72 Pricing of cremations has complexities, however this should be easier to manage than medications as there is less legislation directly affecting veterinary surgeons that surrounds it. The traditional approach to external services such as cremation and lab fees is to double the list price and add VAT. Again discounts provided here have lead to excessive profits for veterinary practices. Different crematoriums have different approaches to pricing. Most crematoriums I have come across will allow clients to go directly to them with their pet and have a ‘walk-in’

price for cremation. I think any price controls placed should be related to the 'walk-in' price for the cremation, which enables practices to make a profit/take a commission for introducing clients to their service (which can be limited by a price control on the mark-up on this price), yet practices can still achieve a negotiated discount from the supplier. If necessary, additional price controls can be placed on crematoriums if their 'walk-in price' is set to an uncompetitively high value, while giving unreasonably high discounts to veterinary practices. The RCVS does not have a commercial regulatory role and this should continue. The RCVS only needs to stand in to discipline practitioners for not following the code of conduct and specifying commercial aspects that should be regulated is not appropriate. A second body would be better placed to be created to develop and monitor commercial aspects of the veterinary industry, meaning that non-veterinary directors can be held accountable. The RCVS only has the ability to monitor and regulate veterinary professionals, who are not necessarily involved in commercial decision making processes relating to pricing, particularly within the LVGs.

Q73 Holding non veterinary directors to the same standards as veterinary surgeons in the RCVS code of professional conduct with respect to veterinary practice standards would certainly address concerns in a proportionate way. A new regulatory body may need to be created for this to work though.

Q74 – the remedy described sounds appropriate, ensuring all veterinary businesses are operating to 'core standards'. Veterinary surgeons are currently obliged to do this, however non-veterinary directors are not so enabling a way to enforce this is needed. Further additional standards/accreditations via the PSS can then be optional and voluntary and may help to differentiate levels of service provided by different practices to clients.

Q75, 76, 77 – it would be silly to try and reinvent the wheel when the PSS exists for this purpose. Marketing of this scheme to clients so they are aware of the benefits of the different levels would make it more meaningful. As fees are paid for the PSS, the PSS should be responsible for this marketing

Q78,79 – I think increasing the responsibilities of the current regulator would detract from its original purpose to regulate veterinary professionals. I think another regulator should be responsible for the commercial and competition aspects of veterinary practice. As most complaints to the RCVS relate to fees/pricing/cost and not to professional misconduct so to speak. This second regulator should include veterinary surgeons to be able to ascertain if procedures have been conducted unnecessarily out of commercial interest. The second regulator can then take action against a veterinary practice if deemed appropriate on competition/commercial grounds or refer individual veterinary surgeons to the RCVS disciplinary process if they are deemed to be acting outwith the guide of professional conduct (i.e. deliberately doing something wrong rather than being forced to act/invoice in a particular way by a business owner). The VCMS may form the basis of this second body?

Q80, 81, 82, 83 – This sounds a bit like 'ofsted inspections' for schools. We do get inspected every few years by the VMD to ensure we are compliant with the medicines legislation (and we pay for the privilege of that inspection). An 'Ofvet' type regulator

may be an extension to this to not only ensure practices are meeting legal medicines requirements but also other deemed appropriate standards. A lot of what is inspected during these inspections with respect to the building, security, processes, standard operating procedures etc. would apply and adding a few more relevant questions and incorporating this into the same visit would incur minimal additional cost and perhaps an hour or two of additional time for the practice every few years, with improvement notices being able to be issued if necessary and more frequent visits to ensure compliance (similar to what we already experience with veterinary medicines inspections).

Q84,85 – The RCVS should definitely have the appropriate powers as described, the reasons were adequately explained in the document

Q86, 87 – I am happy that a complaints process would make sense to implement. Small independent practices do not have access to the same range of resources as the LVGs. It would make sense to standardise this complaints process across the industry to allow better comparisons between practices. Small independent practices should be provided with adequate support to ensure they can comply with this remedy as the owners of most practices trained as veterinary surgeons, not complaints handlers so a guide should be available to simplify the process for them

Q88, 89, 90, 91 – The VCMS I believe is a new scheme to which I am fairly unfamiliar with. More details about how it works would be needed to fully appreciate what is being recommended.

I have concerns about clients in an emotional state putting undue pressure on veterinary practices to take part in mediation, which may entail a lot of time and cost to the veterinary practice with no cost to the client. If a pet has died through no fault of the veterinary practice, clients may decide that the invoice received was not value for money and aim to get a partial refund. The more aware clients are made of being able to 'complain and get some money back', the more clients will do so, potentially at the expense of the practice unnecessarily. A charge to the client for taking the case to mediation should be considered that would be refunded to the client by the practice if they are deemed to have a reasonable case

Q92 No comment. Open to suggestions!

Q93, 94, 95 As reported the costs of making this a statutory requirement seem counterproductive if this is not a service that is actually needed. It has been established that the current complaints handling procedures are variable and in need of some standardisation. Better utilisation of the VCMS may be sufficient for now to generate data and if this data indicates an ongoing problem then the development of an official ombudsman in the future could be considered. This should be voluntary for all practices, however for those practices that are having excessive reports to the VCMS it could be made to be obligatory, thus making the costs predominantly borne by the practices that need it rather than penalising the practices that don't have a problem.

Q96 This would be a massive advantage to clients as there is no cost implication to them whatsoever and they are likely to get a fair hearing. This could provide

advantages to practices that need help developing complaints procedures. The cost of establishing this may not be worth the advantages to many veterinary practices, particularly if statutory, as some practices have a significantly low number of complaints that are handled quickly and efficiently at practice level with no need for escalation. There are other providers that are doing some of the work here such as VCMS and VDS that could be better utilised rather than creating a new regulator from scratch.

Q97 The most reasonable and cost effective way of doing this would be as an extension of the already existing VCMS

Q98 I think it could work on a voluntary basis and this would be the fairest approach, however there should be a way to enforce statutory membership for practices that are having a large number of complaints, that could be identified through a better standardised in house complaints handling/reporting process that has been covered elsewhere in this consultation

Q99 The RCVS could go a long way here to better articulate what is expected. This would make things more clear to the vets who are delegating and more clear to the nurses who are wondering if they can do something. The framework is in place, the guidelines just need to be made clearer. There is already a schedule 3 list (which is vague in places). This could be modified to show what all Registered Veterinary Nurses are able to do from day 1 and there are certificates that can demonstrate competence in more complex procedures that are either already on the list or that could reasonably added to the list with appropriate guidance

Q100 Veterinary practices are very busy and better utilisation of veterinary nurses would help improve workflow for those businesses. It must also be recognised that one registered nurse with a vocational qualification has not got the same theoretical knowledge as a veterinary surgeon and so the ability for them to be performing surgeries under general anaesthesia and other potential schedule 3 procedures without the theoretical knowledge as to what to do if something goes wrong is dangerous. Particularly in terms of emergency prescription of life saving drugs if a veterinary surgeon is not present. Ensuring adequate training for specific schedule 3 procedures through advanced certificates, which would then enable them to provide appropriate treatment in those circumstances would be a solution to this. The quality of the work performed by an inexperienced veterinary nurse will not be the same as that produced by an experienced veterinary surgeon, particularly with respect to surgical skills, where nurses have traditionally not had the experience. It may need to be made clear to clients who is performing procedures so that their expectations are met... it may risk clients being charged the price for a procedure they expect to be carried out by a veterinary surgeon with a certificate in surgery that is listed on the website, yet could be carried out by a recently graduated registered veterinary nurse with an unfair profit margin therefore gained by the practice.

Q101 In general I think this has more advantages than disadvantages to the veterinary profession and clients on the whole, however this needs to be done and properly regulated through the RCVS in a similar way to veterinary surgeons are regulated.

Q102-105. This seems fair. As mentioned earlier, there is a concern that some clients just wish to complain as there is no cost associated with doing so and there is a chance they will benefit. Complaints made in this instance would cost the veterinary practice, even if the outcome is 'the practice has done nothing wrong'. Practices must have veterinary indemnity insurance, for most practices this is provided by the veterinary defence society (VDS). With many in house complaints, the VDS are able to assist practices to ensure they are doing the right thing. I'm not sure how this extends to complaints around the commercial aspects of veterinary practice rather than the liability part, however conversations should be had with the VDS around this. If there is a system already in place that will cover 80% of the complaints, another body and the costs associated with this do not need to be made. The VDS are very proactive in helping practices with complaints handling and perhaps making statutory membership to the VDS (even if just for a complaints handling department that can be extended to include areas that are not currently covered but that the CMA require) would be much more beneficial and be significantly lower cost than starting from scratch.