[redacted]

Response to CMA remedies proposal

Overall comments:

My overall concerns are that the burden of administration for a lot of proposals will be disproportionate to small IFOP's (Independent FOP's) compared to LVG's. The burden of legislation and administration is already heavy on these smaller practices. This is already the main reason a lot of practice owners chose to sell their practices and I fear this increased burden will be the catalyst for many to now consider it all too much. This report misses some of the true challenges and concerns within the industry on not only pricing and monopoly but also levels of care. In addition, the potential loss of IFOP's would have a considerable impact to the employment market, reducing the availability of much sought after jobs within the independent sector. The industry already has a frighteningly short 'working life span' due to burn out and dissatisfaction with the ethics of their working environment. Applications to vet schools have been reducing year on year. A significant number of experienced vets left the industry with the advent of the LVG's and if there is a contraction in the independent sector, it will be more of the experienced vets that will be lost.

There has also been no mention or consideration of the impact of the expect loss in revenue and the concurrent increase in costs for smaller IFOP's. The veterinary business model has long been one of spreading overhead over both fees and sales of medication and other consumables such as prescription food to keep prices reasonable across the board. Akin to the restaurant model where a bottle of wine that can be purchased for £6 in the local supermarket might retail for £30 to allow for the food to remain at a reasonable cost. I wonder how the hospitality industry would survive if they were mandated to allow and indeed advertise for customers to purchase their drinks elsewhere and be mandated to charge a fixed corkage fee yet to keep their service the same and incur additional costs whilst doing so.

With the advent of the LVG's veterinary fees have increased way beyond inflation and to the point where they really cannot be reasonably justified e.g., [redacted] There is also a push to overtreat or over test all done under the guise of offering 'gold standard' care. Most LVG's offer a new graduate scheme and so I was not surprised to learn that vets felt they did not always have the training to offer contextualised care (2.10.IV). Contextualised care had been what all vets provided prior to the advent of the LVG's and what IFOP's have continued to provide. This is of greater concern for pet owner's ongoing vet costs than that of medication and will have a far greater negative impact on animal welfare. Smaller FOP's will now also be forced to increase fees to make up for the impact of what could be a decimating effect on revenue.

The remedies proposed must take into account the financial and time burden they will place on small IFOP's where the owner and other management are vets and also working clinician's vs the LVG's where the management may all have specialist knowledge or e.g., IT departments on hand to navigate the challenges with relative ease. There must also be increased regulation and legislation for the alternative/on line veterinary pharmacy industry that will now grow exponentially as a result of some of

the proposals. Just as the Competition Act of 1998 is what opened the doors to the current situation of corporate ownership without putting in a frame work for the regulation of the seismic change to the veterinary industry, the proposal to mandate written prescriptions must also be accompanied by a robust and equivalent regulatory (to veterinary practices) and legislative system for the future changes within this sector.

Another aspect not mentioned is that a significant number of online pharmacies will not sub dispense medication. Owners are obligated to purchase full pots of medication which is often at odds with how long the vet would like the patient to have the medication for or how much medication they can have at home. This would be especially important for medication such as antibiotics. A lot of online pharmacies do not stock items that are sold in smaller quantities as it is not economically viable for them to do so. Would they now be required to stock these to allow for competition and choice to exist for pet owners? Would they now be required to sub dispense so the correct amount of medication is supplied vs forcing the vets to change their prescription when this is medically the wrong thing to do. There are many nuances to mandatory written prescriptions that have not been considered.

From reading the report in full, I have had the impression that not enough IFOP's or individual vets have contributed to the discussion and the voice of the LVG's has been far more vocal. I suspect this is again down to time and resources. As with this document, to read through, annotate and formulate a response to the 165-page document within a few weeks whilst also managing clinical, personal and management work load is onerous.

There are a few specific areas I would like to comment on further.

Standardised price list:

Some parts of this are very reasonable, others are just not realistic.

The inclusion of medical conditions is one of those, especially for conditions chosen. They may the most common but they also have the largest number of variables. Diagnosing and stabilising one diabetic patient compared to another can be vastly different. For example, I recently diagnosed a diabetic patient just based on a urine sample alone, this was necessary because the patient was fear aggressive and the owner was very short of funds, this would vary vastly from a patient with other co morbidities that would necessitate a far more in-depth investigation along with a longer time to stability. Which insulin or other alternative treatment we prescribe depends again on breed, temperament and clinical findings. So, it would be almost impossible to give a 'standard' price. We could of course publish costs for a bottle of insulin, but how long this will last a patient with vary even for the same signalment e.g., one 20kg dog could be on 10 units, another on 25. If we had to publish a 'standard' price this could negatively influence owners to come for a consultation when in reality we could tailor both investigation and treatment to budget better than what would be advertised.

The same goes for dermatitis and arthritis. It is impossible to really say how long a course of treatment would last for something like steroids, especially for chronic skin cases, some might require a very low ongoing cost, others a higher dosage. So, a 10kg dog could be on a 1mg prednisolone tablet every other day and another 10kg dog could be on a 5mg tablet daily. How can you give a 'standard dose'? The same

goes for arthritis medication. A lot of owners titrate dosage to the lowest effective dose, so what one patient is stable on does not in any way relate to what another would be stable on.

Far better is to have a set price list for medication (e.g., 30 prednisolone tablets, 10ml Caninsulin) if that is the wish, although if there was a mandatory written prescription that send clients to a price comparison site, they would have this information already by the time they were in possession of a 'chronic' diabetic etc. If the mandatory prescriptions do not go ahead then having a simple standardised price list as suggested above for the three chronic conditions mentioned would actually allow owners to compare far better as they would know how long that amount of medication would last them.

The standardisation of treatment to allow for standardised price lists really does fly in the face of contextualised care and should absolutely not where we should be going.

Standardised feedback:

I am really sceptical of how much this will truly influence decision with choosing a practice and I feel people are just saturated with the request to provide feedback every time you visit any shop, restaurant or make and purchase online. I suspect the response rate to the numerous requests for feedback everyone receives daily is very low so you are not really getting any true feedback. Those with strong views one way of the other will respond, and the vast but satisfied majority will not engage. I suspect this is the case for most industries that already use this model for feedback.

RCVS PSS accreditation and rewards:

As you have alluded in your report, the PSS is already considered quite burdensome and input heavy especially I suspect by smaller and mid-sized IFOP's. It really very much plays into the hands of LVG's where the required wealth of policies and protocols can easily be churned out by a non-clinical management team. I agree there is no current accreditation scheme that truly reflects the standard of a practice. It really isn't about what or how many qualification people have or how many policies there are in place. The standard of a practice ultimately really is dictated by the quality or care and experience of its staff, the empathy and ethics shown towards the patients and the pet owners and the moral compass of the business. Adherence to the PSS or any other scheme will never reflect this.

Create a comparison website:

I feel this would need to be a single site, ideally managed and regulated by the RCVS, to really allow for owners to navigate it and get reliable and genuine information. Again, this sector does need to be legislated to stop multiple sites from popping up which although in theory allows for more competition, in reality would confuse the consumer and create the potential for incorrect information to become available.

Information should be provided via a portal again to allow for accurate and reliable information to be made available to the consumer.

I might have missed this, but I'm not sure what the proposal for funding this was. If it is the RCVS or a third-party provider then again there will be a burden of costs which would impact more on the smaller IFOP's vs the LVG's if the businesses would need to fund this or impact all vets as their RCVS fees would increase the provide the funding for this. This really should be at least initially funded by government until the implementation fees have been paid thereby removing the more substantive costs.

Remedy 3:

There is no issue with publishing clearly what is included in the pet care plans or a direct comparison to what these items would cost outside of the plan. Making it easier to cancel plans is also straight forward and already in place at most IFOP's.

The issue is the suggestion that we would have to send an annual statement to pet owners listing what they have and have not used, how much this would have cost outside of the plan and effectively encouraging them to leave the plan if they have not used it enough. There surely has to be a level of self-management here, as there is in other aspects of life. If this is to be mandated in this industry then surely it also needs to be mandated to all other industries offering something similar, the gym should encourage you to cancel your membership if you have not gone enough, Disney or Netflix should contact you if you haven't watched enough movies on their platforms.

The burden of administration for smaller and medium sized IFOP's again will be onerous and really for no gain to the business. Surely good clear advertising at the outset with a reasonable leaving policy is sufficient for people to make a solid informed decision as to whether to join in the first place and to leave if they feel they have not had the value they expected to have.

Remedy 4:

Whilst nice in theory to be able to peruse the price list for nearby referral practices there really is no substitute to speaking to a clinician there, explaining the situation, presentation, getting a more bespoke estimate and evaluating the ability of the referral centre to accept the patient. Having a price list for the more 'routine' procedures is good e.g., TPLO but again for medical cases it will be more complex and potentially misleading.

Referral centres are chosen not just on cost but often also personal experience of the individual clinician and their compatibility to the patient or owner, or a confidence in their standard of work.

With the recent increased acquisition of referral practices by corporate owners there has been again a reduction of clinical freedom and an increase in pressure to work to 'standards' and therefore follow a prescriptive pathway reducing the clinician's ability to make a bespoke clinical choice for each patient. This has led to an increase in specialists leaving referral practice and therefore a shortage in certain specialisms. By enforcing a standardised price list, once again there is a risk to further push to standardise care, which as I have said before is absolutely not where we should be going.

As a result of the dissatisfaction facing a lot of specialists in corporate owned referral, there has been an increase in peripatetic specialist offering within IFOP's. Presumably the prices for these would sit with the IFOP where they are providing their services and be displayed on their websites. How would pet

owners find these or would the comparison site filter per treatment e.g., TPLO. As a pet owner, you would then of course need to know exactly what your pet needs.

I can see the administrative burden of helping owners navigate these sites and option being far more onerous than they are now.

Remedy 5:

I am not at all surprised that a large percentage of estimates are given verbally. This is usually done whilst in a consultation and whilst discussing treatment options and choices with the owner. The need to now also provide all estimates in writing in advance of procedures to allow for 'thinking time' will place a burden of time and administration on the vets concerned. Currently, most practices allow 15 minutes per consultation, some 20. This time is already taken up by some administrative tasks such as writing up clinical notes and additionally now pre authorising some medications such as POM-V flea and worming treatments, ensuring consent forms for off label drugs are signed, if prescribing CD drugs, writing what allowance they can have ongoing and the instalments allowed.

Now add having to create a written prescription with all the variables, including predicting what will be needed for the entire course of treatment, the timescales for treating the condition, including after care, predicting how many visits they might need and sending/printing this out for the owner to give them reasonable thinking time (how much is reasonable?) but if they decline the thinking time you have to get this in writing. On top of that to have to potentially create a written prescription, including alternatives and explaining this to the client. What if the client gets out the door and then decides they do want to go ahead with the treatment, how do we now fit in administering the agreed treatment when the consultation slot may be gone, the vet has moved on to the next patient. Or do we then have to book them in again the following day? Will an appointment be available with the same vet? Or at all? What if it's a Friday afternoon and we cannot provide the treatment until the Monday.

Exceptions to this would be emergencies where providing a written estimate would negatively impact the patient and lower value treatments e.g., less than £250. I presume the £250 threshold would apply to the complete course of treatment which in some cases cannot be predicted in advance.

You mention that this will drive innovation and investment but burden to a IFOP of researching the options out there and the cost of implementing them in the practice will be significant. The burden on the individual vet of this amount of administration for almost every consultation will also significantly impact the profession.

Remedy 6:

Is unlikely to be a challenge for most IFOP's

Remedy 7,8 & 9:

The survey alluded to the 2003 CC report and implied that as 38% of customers were not aware that they could ask for a written prescription the measures were unsuccessful. From memory the percentage of customers who were not aware they could ask for written prescriptions in 2003 was in the mid 90% so there has been significant improvement.

Currently, because there is little regulation to written prescriptions and the online retailors there is nothing preventing owners from sending the written prescription to multiple pharmacies, especially as they are only required the send a photo of the prescription. There have also been numerous cases of clients forging written prescriptions. As a result, most practices have started sending the prescriptions directly to the pharmacy. This is cumbersome currently as you have to have an order number on the prescription in order for the online pharmacy to match it to the client, some cannot seem to do this by matching patient and customer details. So, the process often now is that the client asks for a written prescription, we have to ask them to place the order for their product first, let us know the order number and which pharmacy it is with and then create and send the prescription. This takes several days; we have to allow vets a few days to process prescription requests alongside all their other administrative tasks (as do the doctors etc). It is not an easy system for the pet owners and makes it feel like we are being obstructive.

For this reason, if there was a push to increasing the number of written prescriptions issued there would have to be some safeguards in place to reduce the chance of using a prescription more than once or of forging a prescription. If this was robust and reliable then printing out a written prescription each time is not overly onerous but is a tremendous waste of paper and a step backwards for sustainability. For this reason, I would favour the e-portal, but it would need to be a single centralised e-portal. Both for ease of administration and for easy regulation. They could be linked to the PMS as microchip portals are now. So, the vet would click a button on the PMS and create the prescription. This would automatically upload to the e-portal. The owner can then choose which vets or pharmacy they wish to send it to. It could then be considered redeemed. If the client chose to purchase the medication from the FOP, this could create a link line on the PMS (a bit like the link line we get now when registering a microchip via the PMS), the receptionist could click this and the relevant label would be generated for the pharmacist or nurse to dispense the medication.

This would not be overly onerous to use but the costs of implementation would need to be borne by someone plus the ongoing maintenance costs. If this was distributed across all users equally then of course the IFOP's would again be disproportionately affected.

As mentioned before the online pharmacies would be required to sub dispense and provide an equivalent and equally regulated service.

The e-portal would have to have the infrastructure to support the proposed generic prescribing. It would be simply too onerous to expect a vet to be able to check the data sheets for every drug to check if it a direct equivalent or not. The VMD would have to assess and keep up to date the e-portal so the vets can easily access the information for compatible medications (4.87)

The requirement for the vet to discuss the cost at the practice and work out the saving the client could make is unnecessarily onerous and will use up a lot of the vet's valuable clinical time, especially if more than one medication is being prescribed. If this is going to be a requirement then using an e-portal again makes this less work. By clicking on the e-portal the owner could be taken directly to the price

comparison site so they can do the research in the waiting room and make their decision. The e-portal must have the facility to direct the owner to the price comparison site and to the relevant medication especially if we are having to prescribe generics.

Some medications would have to be exempt from these mandatory prescriptions e.g., injectables that are used short term (vs something like insulin) and medications for use with inpatients. It would be farcical to have to wait for an owner to allocate a prescription to the practice every time we wanted to change an inpatient to oral medication from injectables or to start a new medication.

As much as this will drive competition and lower medication costs for owners, it will also be a hassle for those who just want to get their medication at the practice as normal or for those who do not have access to smart phones or the internet. For these it would actually make things worse and more onerous than they are now.

Remedy 10:

To make it a level playing field the price of written prescriptions should be capped or mandated as a standard charge.

This may inadvertently negatively impact some clients as currently we would include all medications with the same repeat schedule on one written prescription therefore only charge one fee for multiple items. For those with a different repeat schedule it would be prescription fee per item. This we feel is fair. With an e-portal system each prescription would be a standalone prescription and so would incur a fee per item.

There are also often times when an online pharmacy order is delayed and the client requests a week's worth of medication or similar, this would now be another written prescription and therefore incur another cost for the client.

Remedy 11:

Again, things are not a level playing field between the online pharmacies (OLPs), LVGs (who own a lot of the OLPs) and IFOPs when it comes to procurement of medication. Often the OLPs can sell a product for at a price below IFOP's wholesale purchase list prices. The price discrepancy is so wide for many products that we couldn't even hope to compete. As I mentioned before, traditionally practices have spread the significant overhead costs of running a practice across all profit generators within the practice. If the ability to do this is removed, especially when practices will also be facing increased costs to make the necessary changes that will be imposed on us, ultimately vet fees will rise for IFOPs or they will sell up and abandon the industry. Both of which will negatively impact on animal welfare, pet owners and the industry as a whole.

Given where we are at with the proposals so far, my preference would be to avoid the imposition of price controls

Remedy 12:

The reality is that there are relatively few OOH providers and the business is not an easy one to staff, manage or make profitable. I'm not convinced long tie ins are the problem, there is just usually no one else to use. In my opinion animal welfare has certainly been compromised by the loss of inhouse OOH provision but this is where the industry is at. Vets seek jobs with no OOH work and with shorter and less onerous work hours. It is no longer a vocational profession but just a job for many, a stressful one at that with few rewards in many situations hence the haemorrhaging of vets and vet nurses out of the profession.

Remedy 13:

This is unlikely to be a challenge for most IFOP's.

Remedy 14:

Again, refer back to comments on spreading overhead costs. A reasonable limit to mark ups is acceptable and already implemented in many IFOPs

Remedy 15:

It is high time regulation was applied to practices and not just vets. As per my previous comments, this also now needs to be extended to OLP's as currently the vet is still ultimately responsible for the medication dispensed but they will be losing control over the dispensing. It is now also time to make pharmacy owners responsible for their businesses and for the dispensing pharmacist to carry the responsibility for what they are dispensing. As I mentioned before, the loss of control of veterinary practices happened in 1998 after the Competition Act and only now, some 27 years later are we catching up with the needed regulations.

Remedy 16:

As have previously mentioned, complying with the PSS does not mean the practice is a good one or that the staff within it are experienced and that it is an ethical business with a good moral compass. It is a box ticking exercise for a large part of it, weighing heavily on providing a lot of SOP's and policies and little proof of how they are used or implemented.

For me, and I suspect most pet owners, a good practice is one where there is a good level of veterinary expertise (a good level of experience not necessarily advanced qualifications), a genuine level of care and compassion amongst the staff, a positive work culture where everyone is there to advocate for the patient and owner and where the business is run ethically and with compassion and high morals. So, in short, where the practice really cares and is there to help the patients and the pet owners. How this can be quantified in an accreditation scheme I do not know.

For my part I am very lucky to have worked in many such practices and have been lucky enough to have been a position to vote with my feet when I have not. In my personal experience, the IFOP's that have fit the bill of a good practice in my eyes might not always ticked every administrative box and conversely the practices I have chosen to walk away from often did. So, care has to be taken that we are not using a system that rewards administration in favour of good, ethical clinical practice.

Remedy 17:

See my comments re regulation of OLPs and other pharmacies entering the market as a result of these measures and the need to regulate now and not many years down the line when irreparable damage has been done as it has in the vet practice sector.

Remedy 18 & 19:

As mentioned, several times now, the burden of compliance has to be proportional to the size of the practice. The LVGs have a wealth of admin and management staff to handle the administrative load whereas small and medium IFOPs often have working vets who are also handling all the administration. Any compliance regulation would need to not be overly burdensome

Remedy 20-24:

Again, for most small and medium IFOPs this will not be overly onerous. We generally have a close working relationship with clients and staff and are very hands-on with complaints handling and resolution. As it's a small business, we always learn from complaints and would welcome any further positive framework for handling the few complaints where we do not get satisfactory resolution in house.

Remedy 25:

Even when I qualified in [redacted] there was talk of increasing the scope of veterinary nurses, of protecting the title and of creating advanced specialisms such as prescribing nurses or nurse practitioners. Here we are 30 years later and nothing has moved forward, if anything the vet nurse role has ben reduced and there is wholescale dissatisfaction within the sector. RVN's are highly capable and highly qualified professionals and it is high time the talk stopped and the action started to get these proposals implemented. It can't come soon enough.