I am a veterinary surgeon who qualified in 2000. I have been working as a first opinion small animal vet constantly since that time, initially as an employee in three separate practices and, since 2012, as an owner and partner in my current practice. [redacted] Needless to say, the changes instituted by the CMA will have as much impact on me personally as on anyone and, in fact, more than on most. I have taken considerable time to read and examine the 'Remedies' document and would like to respond to the questions posed.

Consultation questions:

Implementation of remedies:

- **Question 1: We welcome comments regarding our current thinking on the routes to implementing the potential remedies set out in this working paper.**

a) Some of the increase in veterinary fees in recent years is justified. The profession has genuinely been confronted with multiple financial challenges ranging from a national shortage of qualified vets and vet nurses, increasing regulatory requirements (changes to the interpretation of the medicine regulations being a recent example), increased energy costs, increased employment costs, etc etc. It is inappropriate to compare inflation in vet bills with general inflation. It would be more accurate to compare it to inflation in human private healthcare.

Some of the increase, however, is undoubtedly difficult to justify. Huge numbers of practices were purchased by corporate entities for vastly inflated prices and these corporates have found it more difficult to make their money back than they were perhaps anticipating. [redacted]

b) You suggest throughout your document that the biggest increases are being driven by LVGs (to use your acronym) and not by smaller independent practices. I have major concerns that your suggested remedies will increase the workload disproportionally for the 'good guys' and be circumvented and more easily accommodated by the 'bad guys' who can spread the burden of administration across hundreds of practices without impact. Your comment at 1.22 is pertinent but falls short. If you put a blanket requirement, whatever it might be, on all practices, you will be rewarding the main drivers of price increases at the cost of those of us who try to keep prices down.

c) Veterinary surgeons are already under greater pressure than most individuals in society. They already have a higher suicide rate and a higher substance misuse rate than people in nearly any other job or profession. Many are leaving the profession because of this extreme pressure. If you put even more pressure on vets you will drive more of us out of the profession one way or the other. Please think about this when making your decisions. Your actions will have real world consequences. Even your preliminary comments have caused a noticeable increase in the volume of abuse the profession has to deal with. Decreasing the number of vets, even putting to one side the personal tragedies and the human cost, will be an inflationary pressure on clients' fees.

d) Many of your suggested remedies will be costly to the individual practices (and disproportionately costly to independent practices) and costly to the overall profession. This increase in business costs

is not likely to result in lower vet fees. Your measures will have to be carefully targeted to avoid having the same inflationary pressure as the Competition Commission's (CC) 2003 interference in the market.

e) As you are at pains to point out in parts of the document, individual vets are almost universally highly professional and driven by wanting to do the best for their patients and their clients and not at all driven by money or profit. If the CMA wanted an overnight fix to the problem in this market, they should restore ownership of vet practices exclusively to vets. Given this is not going to happen (although it would have the unique benefit of actually working), any measure that gives power over fees back into the hands of the profession (and out of the hands of non-vets) will give better results than trying to quixotically legislate against the corporate model.

f) You place a lot of emphasis on the cost of medication. I suspect this is because this is an area which you see as easy to examine, measure and compare between suppliers. When comparing services, in contrast, it is impossible to compare like with like in the same way. A market for medication appears on the surface to be relatively easy for an entity like the CMA to address. Unfortunately, it is probably more complicated than you might wish it to be.

My business makes some profit from medication and some profit from services. Historically, it was very often the case that practices would undercharge for their services and make the majority of their profit from medication sales. In 2003, the CC intervened and practices woke up to the danger of remaining with this model in the face of online pharmacy competition and switched their source of profit more towards professional services. Hence, they raised their professional fees.

If you reduce the profit made by practices through medication sales then I promise you that their other services will become more expensive.

g) One of my worries with your new set of suggested 'remedies' is that you are suggesting increasing the workload of vets in each and every consultation. What might sound like a trivial change to you – only two minutes extra work for the vet, say, to write out a prescription (the day I can produce a prescription in two minutes will be a great day, by the way) – is a 15% reduction in the rate they can do consults. If you make them work out all the possible treatment options and price each variation and provide this in written form ('remedy' 5) then you are making them sit and type rather than consult and treat animals. Vet time is expensive to provide. If you make their work less efficient it will directly, inevitably and inexorably make vet bills more expensive.

Further, and expanding on b) above, many of the 'remedies' will involve the production of large numbers of bespoke documents. The production of these is likely to be most easily accomplished with a vet adapting one of a large suite of pre-written templates. Writing these templates and instituting these systems will be a mammoth task but one which will need to be done once by me for my single practice and once by a single employee of a LVG for their hundreds of practices. Again, you are rewarding the 'bad guys' and punishing the 'good guys'.

h) You seem to be very keen on producing comparison websites. I fear that if you build it, they probably won't come. If it ends up being, in essence, a massive table of figures with links to protracted explanations of why a particular practice can justify a more expensive pyometra surgery because of the equipment and staff they have, it is going to be an unnavigable, impenetrable mess. Which no one ever bothers to use. Because that is not how people choose their vets.

h) I am often critical of employees who come to me with problems and not solutions. Seeing the flaws in something is the easy part. The difficult part is coming up with suggestions that would be

better alternatives. In that spirit, I have, in most sections below, offered you better solutions to what I would not deny is a problem in the veterinary market.

● **Question 2: We invite comments on whether these (or others) are appropriate information remedies whose implementation should be the subject of trials. We also invite comments on the criteria we might employ to assess the effects of trialled measures. Please explain your views.**

It is my considered view that many of the suggested remedies are likely to have little effect on reducing prices, no effect on prices or directly lead to increased prices. Use of small-scale trials to find out if you are right or if I am right would give everyone confidence the changes were justified. These particular 'remedies' (7 and 8) appear amongst the most expensive, complicated and, I predict, counter-productive of all of your suggestions.

When deciding whether these measures have had any effect, I would suggest measuring overall veterinary cost of the practices involved, not just the cost of medication. One of the effects of the 2003 interference was for practices to switch emphasis away from obtaining their profit from product sales and towards services. This made overall costs increase. Pet owners now pay for the profits of all the online pharmacies as well as those of veterinary practices. Little wonder that overall costs for pet owners has increased.

Remedy 1: Require FOPs and referral providers to publish information for pet owners

● **Question 3: Does the standardised price list cover the main services that a pet owner is likely to need? Are there other routine or referral services or treatments which should be covered on the list? Please explain your views.**

There are approximately 96 prices on the list before we get to the 'specialist procedures' which inhabit their own special world of 'it depends'. Approximately 10 of these prices could be considered relatively 'standard', the rest are not obviously comparable from one practice to the next. This list would already be a pointless, counterproductive burden specifically targeting and punishing small practices; please don't add to it. Are you really envisaging clients will visit your new website and trawl through dozens and dozens of prices (all with links to protracted explanations/ sales pitches) for each of their local practices and make an informed choice? You are going about this all wrong. There is a better way.

● **Question 4: Do you think that the 'information to be provided' for each service set out in Appendix A: Proposal for information to be provided in standardised price list is feasible to provide? Are there other types of information that would be helpful to include? Please explain your views.**

Anything is feasible, although it will take some hours of my time for a purpose I do not believe in.

● **Question 5: Do you agree with the factors by which we propose FOPs and referral providers should be required to publish separate prices for? Which categories of animal characteristics would be most appropriate to aid comparability and reflect variation in costs? Please explain your views.**

Every extra factor is more work for me and I do not think it is going to have any effect. You underestimate the complexity and variation of clinical cases and overestimate a client's willingness to go onto a comparison website to look at hundreds of numbers.

● **Question 6: How should price ranges or 'starting from' prices be calculated to balance covering the full range of prices that could be charged with what many or most pet owners might reasonably pay? Please explain your views.**

It is not possible without outside policing. This is a terrible idea on all counts.

● **Question 7: Do you think that the standardised price list described in Appendix A: Proposal for information to be provided in standardised price list would be valuable to pet owners? Please explain your views.**

No. I am confident that the proposed price list would be so overwhelming and confusing and easy to manipulate that it would be worthless to pet owners. I am not certain that even I would be able to decide value for money from it and I am someone who knows the veterinary world from the inside and sets my practice's prices personally.

There would also be the tempting incentive for practices to cut corners and reduce care for patients. For instance, the level of pain relief given to pets after neutering varies considerably between practices – there is no 'correct' level but I would prefer our patients have more rather than less. If I am publishing a price for spaying a cat and wish it to be as low as possible I will minimise pain relief, not maximise it. I have concerns your price list will drive standards down in this and in all other regards and incentivise bad clinical practices in a money-driven race to the bottom.

● **Question 8: Do you think that it is proportionate for FOPs and referral providers to provide prices for each service in the standardised price list? Please explain your views.**

I believe the work and expense involved in producing and displaying this price list will be wildly disproportionate to any good it might do.

● **Question 9: Could the standardised price list have any detrimental consequences for pet owners and if so, what are they? Please explain your views.**

Independent practices have suffered in the past from LVGs setting aggressively low prices for routine services and then hugely inflated prices for procedures when an animal is ill. I believe there is a danger that clients will be 'lured in' by the price-list items (however comprehensive) and then 'stung' for when things go wrong. The price list will tend to drive down standards and lead to lower quality care for their pets.

● **Question 10: Could the standardised price list have any detrimental consequences for FOPs and referral providers? Are you aware of many practices which do not have a website? Would any impacts vary across different types or sizes of FOP or referral provider? Please explain your views**.

The impact will be disproportionately felt by small independent practices and not by the LVGs. This is, however, less of an issue for this 'remedy' than it is for others; 'remedy' 7, for example, stands out in this regard.

● **Question 11: What quality measures could be published in order to support pet owners to make choices? Please explain your views.**

I'll use this question to offer you a better solution:

Step 1 – Make the PSS compulsory for every practice. The infrastructure is already right there, waiting to be used. The cost of the inspections would probably need to be increased by 10%.

Step 2 – Tack on a 'value for money' element to the inspection. I suggest use of experienced RVNs for this role alongside the current inspectors. The team of inspectors would need to be enlarged to take on the extra practices.

Step 3 – At inspections, the PSS assessors would ask to see prices for a list of procedures and examples of recent charges for real patients. The practice does not know in advance which charges are going to be assessed and they can explain on the day what equipment, personnel and expertise are available to justify the cost. The inspectors will examine actual clinical cases with the matching invoices that were produced.

Step 4 – The inspectors would take into account the standards and procedures in place for the care of the patient, the level of expertise and the amount the clients pay for this and allocate a banding, Ofsted-style. A practice might rate "Excellent standards, moderately priced", "Good standards, inexpensive", "Basic standards, expensively priced". This is what prospective clients need to be told about value for money – 4 words, not 200 prices. This summary would form part of a five-sentence summary of the practice (see question 13) that would be published on your comparison website.

Step 5 – Allow re-inspection within 12 months if a practice is dissatisfied with their rating.

This solution (in contrast to your suggested 'remedy') would have the advantage of using existing infrastructure to provide an objective, impartial, independent assessment of true pricing and value for money. Clients would have an immensely complex set of numbers and weighted factors translated by an independent expert into day-to-day language they can understand. There would be no additional work for practices (if they were already on the PSS) and no advantage of scale for the LVGs to exploit. It would provide a much more open and competitive market without damaging businesses within that market. In contrast to your suggested 'remedy', there would be no opportunity to 'game the system'.

Remedy 2: Create a comparison website supporting pet owners to compare the offerings of different FOPs and referral providers

● **Question 12: What information should be displayed on a price comparison site and how? We are particularly interested in views in relation to composite price measures and medicine prices.**

There is virtually no value in a price comparison website as you are proposing. You need to produce a very brief summary from an independent trusted source. I can describe the offering of any practice in five sentences (see Question 13) and it would take me an hour's visit to that practice to accurately so describe. Any vet or RVN could do this. This is what you need to publish so clients have a clear idea of what they are getting themselves into – people from outside the profession are not capable of appreciating the nuances from a bunch of prices.

For example: Practice A can do an enterectomy for £1800 in a 'General Practice' with a vet with no post-grad qualifications and an unqualified nurse and the dog will need to be transported to [redacted] for the night afterwards. Practice B can do the surgery for £2300 in a 'Hospital' with a vet with a surgery certificate, a team of nurses with a post-grad certificates and 24 hour monitoring on-site afterwards. Is either good value? Which is better? It is not at all obvious from the information in your proposal but if you let me visit the practices I could absolutely tell you. The public need curation from a trusted source. The PSS are the organisation who have the mechanisms in place to do it and has the considerable benefit of already existing.

● **Question 13: How could a price comparison website be designed and publicised to maximise use and usefulness to pet owners? Please explain your views**.

Keep it simple. Do not overwhelm people with tables of data. Summarise price levels in 2 words. They need to know the ownership model, size, number of sites, PSS assessment level and price level.

For example, someone might plug in a postcode and get:

0.7 miles - Practice A is a five site practice, including an RCVS-accredited Hospital. It is owned by a traditional partnership which own no other practices. Our assessor found them to be moderately priced for routine services (such as first consultations, vaccinations and routine neutering), reasonably priced for non-routine services (such as minor operations, investigations and imaging) and reasonably priced for more advanced procedures (such as major operations and advanced investigations). They provide 24 hour care for their own patients at their own site. Out-of-hours cover is provided by [redacted] at a separate site. They provide advanced care (but not specialist care) in orthopaedics, internal medicine, cardiology, ophthalmology and dentistry.

1.2 miles - Practice B is a one site practice, a RCVS-accredited General Practice. It is owned by a limited company which own no other practices. Our assessor found them to be moderately priced for routine services (such as first consultations, vaccinations and routine neutering), reasonably priced for non-routine services (such as minor operations, investigations and imaging) and not equipped to perform advanced procedures (such as major operations and advanced investigations). They transfer any inpatients to [redacted] at a separate site. Out-of-hours cover is provided by [redacted] at a separate site. They do not provide advanced or specialist care.

3.2 miles - Practice C is a three site practice, including a RCVS-accredited General Practice. It is owned by a limited company which own approximately 600 other practices. Our assessor found them to be reasonably priced for routine services (such as first consultations, vaccinations and routine neutering), expensively priced for non-routine services (such as minor operations, investigations and imaging) and very expensively priced for more advanced procedures (such as major operations and advanced investigations). Their inpatients are cared for at their own site by [redacted]. Out-of-hours cover is provided at their own site by [redacted]. They provide advanced care (but not specialist care) in internal medicine.

● **Question 14: What do you think would be more effective in addressing our concerns - (a) a single price comparison website operated by the RCVS or a commissioned third party or (b) an open data solution whereby third parties could access the information and offer alternative tools and websites? Why?**

Both these options are bad for slightly different reasons.

a) The RCVS is a trusted source but lacks the resources to manage this website, especially if it is required to police the accuracy of practices' responses. Policing it for accuracy will be vital but undoubtedly expensive if not impossible. There can always be reasons or excuses why an individual case cost a wildly different amount to what is published on the website and what punishments are you proposing for providing misleading information? The RCVS has no power over the corporates. If you make the profession pay for this website then vet bills will increase correspondingly.

b) If I were a corporate then I would be licking my lips at the prospect of being able to create my own website to compare vet practices which pitched my own practices favourably. A corporate budget would dwarf the RCVS's or anyone else's.

● Question 15: What are the main administrative and technical challenges on FOPs and referral providers in these remedy options? How could they be resolved or reduced?

It's a trade-off. Practices will have an incentive to put as low a price on items as they can get away with and, unfortunately, I cannot believe the policing of this system can or will be effective so it will reward the most unscrupulous. The more fiddly and precise the requirements are, the more onerous the task will be for me but the less wriggle room there will be to be unscrupulous.

LVGs can dedicate a single person to do the job for all their hundreds of practices and so there will be minimal cost to them. Independent practices (already facing all the considerable administrative burdens of running a small business) will be disproportionately penalised. There is a financial cost to all this administration and this expense is passed onto my clients in price increases.

If you were to adopt my system, of course, there would be no extra administrative burden on practices (as long as they already were part of the PSS). And it might actually work.

● Question 16: Please comment on the feasibility of FOPs and referral centres providing price info for different animal characteristics (such as type, age, and weight). Please explain any specific challenges you consider may arise.

We already split our prices into species/ weight categories. If your categories are different from mine then I will need to choose which price to publish or change my price list to fall in line with yours. Anything's feasible but it would be a hassle to change my system to conform with yours.

● Question 17: Where it is appropriate for prices to vary (eg due to bundling or complexity), how should the price information be presented? Please explain your views.

If you asked me how much it would be to remove a lump from a 30kg dog and gave me no other information, my honest answer would be, "probably between £350 and £5000, depending". Medicine is not engineering. Biological systems are not washing machines.

If you insist that I must give fixed prices for procedures then I will treat it like an insurance quote. In other words, I know some will be very challenging and expensive, some will be straightforward and inexpensive. I will price it so that, on average, the easy ones pay for the complex ones. This is how clinics have started to give fixed prices on TPLOs and BOAS surgeries.

Where I am allowed to account for variation, I would find it easiest to give a 'typical range' in which roughly 80% of cases would fall. Proving the accuracy of this would be challenging and policing it for hundreds of prices for thousands of vet practices would be close to impossible. And, of course, the system you are proposing is, in my opinion, pointless and valueless to consumers.

● Question 18: What do you consider to be the best means of funding the design, creation and ongoing maintenance of a comparison website? Please explain your views.

Your proposal is cumbersome, unwieldy and very difficult to maintain. Policing of its accuracy would be a nightmare and if it's not policed then it would have no value. If you lay the cost of this website on the veterinary industry then this will be an additional inflationary pressure on prices. I would

imagine the only conceivable source of funding would be the RCVS. This cost would ultimately be passed to veterinary practices and then on to medication prices.

I would make the PSS compulsory and increase the fee charged for participation by about 10%. This would allow the current RCVS website to be expanded to have a simple and comparatively cheap public comparison element with brief summaries of the practices as suggested in question 13 above. Most of the required infrastructure already exists.

Remedy 3: Require FOPs to publish information about pet care plans and minimise friction to cancel or switch

● Question 19: What would be the impact on vet business of this remedy option? Would the impact change across different types or sizes of business? Please explain your views.

This is a deceptively complex problem (to compare pay-as-you-go to care plans). Prices of most of the physical items included in our plans are set as a percentage increase on our wholesale price and change automatically so the calculated cost of pay-as-you-go might be inaccurate 24 hours after I've published it. We include unlimited free nail clips on our plan. How many of these should I price as a pay-as-you-go comparison?

One of the benefits of being small is that I can adjust prices quickly and having to recalculate every time would be a barrier to that 'nimbleness'. Obviously, as with most of your proposals, the LVGs would be advantaged and the independents would be disadvantaged. They would be able to spread the cost of this administration across their hundreds of practices and we would not.

● Question 20: How could this remedy affect the coverage of a typical pet plan? Please explain your views.

It would be a push towards fewer 'unlimited' offerings and fewer 'percentage discounts' offerings, just because these are a pain to calculate savings on. Whether this is good or bad is moot.

● Question 21: What are the main administrative and technical challenges on FOPs and referral providers with these remedy options? How could they be resolved or reduced?

It will vary between systems and practices. As a rule, it will be easy for LVGs and hard for smaller practices. In comparison to some of your suggested 'remedies', this would be relatively straightforward to achieve.

Remedy 4: Provide FOP vets with information relating to referral providers

● Question 22: What is the feasibility and value of remedies that would support FOP vets to give pet owners a meaningful choice of referral provider? Please explain your views.

The same issues remain with compelling referral centres to publish price lists as there are with first opinion providers. It is not possible to compare like with like using price lists - it is fundamentally a bad idea. It won't work, will provide meaningless information, will drive down standards and will be expensive to institute.

There is certainly a danger in FOP vets referring solely to referral centres within their own LVG although I have no means of knowing how much of an issue this is in reality. Ideally, owners of FOP should not also own referral practices (or crematoria or labs etc etc) because it is likely to lead to clients being funnelled into expensive options at time points when it is difficult for them to look for

alternatives. One finds oneself wishing that there existed in this country an organisation with the power to split up anti-competitive business groups. At the very least, the vets working within the FOP should have no pressure put upon them to refer within the LVG. How this would be achieved without separating ownership is not clear to me.

I have no financial tie-ins with referral centres but have built up relationships with individuals and teams at various centres. I recommend them to my clients because I think they are the best or the best value. I would not want my freedom to be compromised because of the dubious practices of others.

● **Question 23: Are there any consequences which may be detrimental and if so, what are they?**

Compelling practices to calculate and publish their prices and then arrange and publish that information in a bespoke comparison website is not cost-free. If you increase the costs on the profession, prices will tend to rise.

● **Question 24: What do you consider are likely to be the main administrative, technical and administrative challenges on referral providers in this remedy? Would it apply equally to different practices? How could these challenges be reduced?**

I would imagine most referral work is unpredictable. Their published prices, even with the best of intentions, would not be reflective of their eventual charges. They would reduce the comparison prices and increase non-comparison prices to compensate. The more 'corporate' the practice, the more they would lean into this tactic. Again, the 'good guys' would be the most adversely affected.

● **Question 25: If you are replying as a FOP owner or referral provider, it would be helpful to have responses specific to your business as well as any general replies you would like to make.**

I am a FOP owner and a vet.

In my experience, vets are very honest brokers for the referral market and, if freed up, would do a much better job than a comparison website at driving competition. You just need to take away pressure on vets from practice owners (or separate ownership of FOPs and referral centres).

I have no personal financial reason to recommend one referral centre over another and choose (or suggest to my clients) dependent on a number of factors including my relationship with a particular clinician in a particular field, my knowledge of what equipment and experience they have, price, geographical location etc etc. In general, price is not a factor that many owners place high on their own list of determinants.

● **Question 26: What information on referral providers that is directly provided to pet owners would effectively support their choice of referral options? Please explain your views.**

I think one of the roles FOP vets should play is to honestly and impartially recommend a referral centre. Non-vets are ill-equipped to be able to compare. Most referrals are made with no clear idea of what procedure will end up being performed and so price comparisons for particular procedures are unhelpful. An overarching idea of value for money is more useful and is not revealed by a table of prices.

Remedy 5: Provision of clear and accurate information about different treatments, services and referral options in advance and in writing

● **Question 27: If a mandatory requirement is introduced on vet businesses to ensure that pet owners are given a greater degree of information in some circumstances, should there be a**

minimum threshold for it to apply (for example, where any of the treatments exceed: £250, £500, or £1,000)? Please explain your views.

This is another terrible, counter-productive idea (possibly the worst so far) and so, if it is instituted, the higher the threshold the better. Please try to bear in mind that vet admin time is very expensive for me as a practice owner to provide and this measure would pile an enormous administrative burden on practices like mine. Vet time is the most expensive thing the business possesses; it is a finite resource and you are threatening to make us spend vast swathes of what little we have on this 'remedy'. I don't want to be increasing my prices but this measure would definitely force me to. The type of information you describe has always been provided to clients by vets – it is the old-fashioned way of doing things – but verbally and with some direction and help for clients to navigate their way through the decisions. I would still trust vets to do so, whatever practice they work in, if they were left alone. It is only practices that put pressure on vets from above that do not adequately perform this role. Take away that pressure and the problem would go away overnight. Vets truly are (in the vast majority of cases) model professionals if you leave them to do their jobs.

There is a further issue around how a vet is expected to know how much a procedure is going to end up costing. If I take an x-ray then I do not necessarily know in advance whether I will need to do £200 work or £3000 work. Do I produce the document in advance or not? How many 'if-this-then-that, if-that-then-this' scenarios do you expect to be produced, just in case? In writing. Dozens of times a day.

Each and every document, as envisaged, is likely to cost my practice approximately £2-£50 in vet time, depending on the complexity you end up insisting on. I cannot fund this cost without increasing my fees.

● **Question 28: If a requirement is introduced on vet businesses to ensure that pet owners are offered a period of 'thinking time' before deciding on the purchase of certain treatments or services, how long should it be, should it vary depending on certain factors (and if so, what are those factors), and should pet owners be able to waive it? Please explain your views.**

Remembering that this is a terrible idea and shouldn't be adopted, a period of 24 hours should be ample for anything – more would be dangerous to patients. In practice, procedures costing more than about £500 rarely take place inside this time-frame unless they are an emergency and I hope no one believes we should use a cooling-off period when it is an emergency.

The term 'emergency' is impossible to define, however. For example, if I find a non-bleeding splenic mass in an abdomen I know there is a chance it will rupture and kill the dog. Probably not today. Probably not tomorrow. Maybe not next week. But it might. Am I forced to wait 48 hours to let the owner decide and keep my fingers crossed? Is it an emergency? It's impossible to know. What about a cat that has a bit of vomiting? It's probably fine to wait 48 hours before x-raying it. 99% of the time it will be fine. But it might be dead of a linear foreign body by tomorrow. What about a wound that needs suturing? The dog is not going to suffer or die if it left while the owner is thinking but it will have a poorer outcome for having been left and suffer in the meantime. These are just three examples of hundreds I could describe. There is more grey area than non-grey.

Pet owners should definitely be able to waive the right to a cooling off period but I fear that this consent will have to be in writing and require yet more admin time. The organisation of systems to make sure we follow up on every client who is in their 'thinking period' after the time is up is going to be very difficult and expensive to achieve. I am not yet certain how I would go about it – possibly more staff, possibly less frequent consultations, definitely higher fees.

● Question 29: Should this remedy not apply in some circumstances, such as where immediate treatment is necessary to protect the health of the pet and the time taken to provide written information would adversely affect this? Please explain your views.

As outlined under question 28, it is impossible to predict when a case will or will not adversely affect a patient if left. Who is going to design these rules?

This sort of written information is going to be very, very time-consuming to provide. Each situation is unique and will require a bespoke document or at least substantial editing of a template. Each consultation is squeezed into 15 minutes (vets already have a huge requirement put upon them in this time-frame before you give them this on top). It is likely we would have to increase consult lengths to 20 minutes to allow vets time to produce the documentation. This will increase consultation prices by 33%.

● Question 30: What is the scale of the potential burden on vets of having to keep a record of treatment options offered to each pet owner? How could any burden be minimised?

Written information of this nature is going to be very, very time-consuming to provide. Each situation is unique and will require a bespoke document or at least substantial editing of a template. Each consultation is squeezed into 15 minutes (vets already have a huge requirement put upon them in the time before you give them this). It is likely we would have to increase consult lengths to at least 20 minutes to allow vets time to produce the documentation. This will increase consultation prices by at least 33%. This 'remedy' is going to have to be massively effective at reducing prices to compensate for that inflationary pressure.

To minimise the burden I would recommend abandoning this terrible idea.

● Question 31: What are the advantages and disadvantages of using treatment consent forms to obtain the pet owner's acknowledgement that they have been provided with a range of suitable treatment options or an explanation why only one option is feasible or appropriate? Could there be any unintended consequences?

Generic consent forms normally already contain this sort of wording. If you are intending to have a bespoke form with the degree of detail you seem to be suggesting then this would be very onerous.

I presume the significant increase in vet fees would count as an unintended consequence even if it is a predictable and inevitable one.

● Question 32: What would be the impact on vet businesses of this remedy option? Would any impacts vary across different types or sizes of business? What are the options for mitigating against negative impacts to deliver an effective but proportionate remedy?

The impact on businesses would be considerable. Vet time would be spent on producing these written documents and so fees would need to increase. Patient care would be compromised while forms were being filled. Delays to treatment would always make patients worse and not better.

One of my concerns is that this 'remedy' is evidently not designed to reduce fees for procedures, it is designed to encourage clients to opt for less expensive options instead of more expensive options. The considerable added time and paperwork involved in instituting this 'remedy' will inevitably drive up the cost of both the expensive options and the less expensive ones. The remedy presupposes that there is a significant number of clients currently being inappropriately steered towards an option that, after reflection and reading their bespoke essay on the subject, they would change their mind

about if given the chance. This would have to be a very significant percentage to justify deliberately pushing up the overall cost of veterinary care across the board.

● Question 33: Are there any barriers to, or challenges around, the provision of written information including prices in advance which have not been outlined above? Please explain your views.

There are normally four categories of options open to a client with an ill animal.

a) Trial treatment with some medication and see what happens,
b) Do some investigations to find out what is wrong and then treat appropriately, or not,
c) Refer to a specialist
d) Euthanasia when the animal's quality of life has diminished.

Option a) is often cheap, at least initially, but might waste money in the long run. It might cure the patient. It might make the patient worse. It might lead to one of the other options.

Option b) might lead to a further set of options ranging from a £2 bill to a £20,000 bill and anything in between. And it might lead back to one of the other options.

Option c) is likely to be expensive but might be 'cutting the corner' and going straight to what is required in the end anyway.

Option d) might prove necessary regardless of whatever else is done and might, with hindsight, have been the best option from the start.

No one can say in advance which is going to be the best route. It depends on multiple factors and is a hugely complex decision. How many prices and 'what-ifs' are you envisaging?

Clients are not in a position to accurately navigate these options on their own with a written document. They cannot know how to 'play the odds' to make sensible choices with their money. Vets cannot be expected to write out an essay every time they see a sick patient which outlines every path which might have to be taken and the percentage odds of each outcome. Or at least not for the current cost of a consultation.

Many of my clients do not come to me to be handed a menu of options to pick from while I stand back to let them choose as they wish. Ideally, I will have built up their trust and confidence over many years and they know and trust that I will suggest an option or options which in my opinion gives them the best use of whatever resources they might have. We can have a conversation and discuss pros and cons. My role is to guide them to what is a good option for them and their pet and they know that I will be giving that advice freely and without taking any account of profit or practice finances. Nearly every vet does this if they're given the space to do so.

● Question 34: How would training on any specific topics help to address our concerns? If so, what topics should be covered and in what form to be as impactful as possible?

I would be intrigued to see an example document outlining all the options, possible outcomes and possible costs for a 12-year-old Labrador with chronic arthritis, occasional vomiting, weight loss and a cough. It probably has moderate dental disease as well. This is a common scenario. I would expect this example document to be produced in a timely and efficient manner, ideally in under five minutes because then the consult cost would only need to be increased by 33%. Before putting this 'remedy' in place, I implore you to actually sit down and try to write one of these things, even a

simple one, and time yourself. I would struggle to summarise the options and costs for the situation above inside about 750 words.

Every minute spent writing is significant expense for the client.

When I have seen this example document produced by you I will have more of an idea of what I am expected to do and what the impact is likely to be. And, likewise, you might have an idea of what you are actually proposing.

● **Question 35: What criteria should be used to determine the number of different treatment, service or referral options which should be given to pet owners in advance and in writing? Please explain your views**.

I believe the same dubious benefit that you ascribe to your 'remedy' could be achieved without the associated increase in vet-load (and therefore vet fees) that it necessitates by instead requiring a standard document to be handed to every client. The wording could be something like:

Clinical decisions are difficult to make on behalf of our pets and it is important that you have considered all options open to you. It is not possible in advance to know for sure what the best choice is in any particular situation and it may turn out in the future that you wish that you had chosen a different option. We try to advise you to the best of our ability and recommend what we think is best for your pet and your circumstances. Please remember that:

There is always the option at any stage to change your mind about what treatment or procedure you would like to go for. Often there are less expensive options open to us and we will be happy to support you in pursuing those options. Remember that If we have started a procedure or test then we may not be able to stop part way through and you may still be charged for what has been done so far

There is always the option to seek a second opinion. This can be from another vet at this practice, from a first opinion vet at a different practice, or from a specialist team at a referral centre. We will gladly assist you in seeking this alternative opinion.

There is always the option to decline all treatment and opt to put your pet to sleep (euthanasia) when their quality of life has diminished.

We want the best for you and your pet and want to support you in making these decisions. Please speak to us if you would like to discuss alternative treatment paths.

I believe your 'remedy' will be worse than this alternative in every possible way. It will be more stressful and confusing to owners, will be hugely expensive in vet time and therefore client cost, will not reduce vet bills (just maybe slightly steer client choices towards less expensive options) and will increase stress and aggravation levels within the veterinary profession.

I believe my remedy will achieve at least 90% of the supposed beneficial effect of your 'remedy' without the inflationary pressure.

Remedy 6: Prohibition of business practices which limit or constrain the choices offered to pet owners

● **Question 36: Are there any specific business activities which should be prohibited which would not be covered by a prohibition of business practices which limit or constrain choice? If so, should a body, such as the RCVS, be given a greater role in identifying business practices which are prohibited and updating them over time? Please explain your views**.

This is an area in which the RCVS should certainly have power over practice owners and not just over vets but this requires a new Veterinary Surgeons Act. There has been an urgent call from the profession for a new VSA since at least 1995 (my first involvement in the profession). Thirty years later, there is still an urgent call for an updated Act. If I were you, I would not rely on this happening in the next decade or three.

● **Question 37: How should compliance with this potential remedy be monitored and enforced? In particular, would it be sufficient for FOPs to carry out internal audits of their business practices and self-certify their compliance? Should the audits be carried out by an independent firm? Should a body, such as the RCVS, be given responsibility for monitoring compliance? Please explain your views.**

No, it is not sufficient to self-certify. The LVGs currently deny that they constrain client choice (and, more pertinently, vet choice) but they absolutely do. The RCVS cannot police this without having the teeth to do anything about it and they do not have this power in law. We need a new Veterinary Surgeon Act.

● **Question 38: Should there be greater monitoring of LVGs' compliance with this potential remedy due to the likelihood of their business practices which are rolled-out across their sites having an impact on the choices offered to a greater number of pet owners compared with other FOPs' business practices? Please explain your views.**

Yes, there definitely should for the reason cited but there is no point without there being significant consequences for the businesses for failure to comply. Currently there is no disincentive to these LVGs.

● **Question 39: Should business practices be defined broadly to include any internal guidance which may have an influence on the choices offered to pet owners, even if it is not established in a business system or process? Please explain your views.**

There is a wide spectrum of business practices which would come under this remedy ranging from the trivial to the reprehensible. Clearly, practices would push the guidance 'underground' making it difficult to detect, prove or police.

This remedy is well-intentioned but impractical. The only solution that I can think of that might actually work is to go back to the days when non-vets were not allowed to own veterinary practices.

Remedy 7: Changes to how consumers are informed about and offered prescriptions

● **Question 40: We would welcome views as to whether medicines administered by the vet should be excluded from mandatory prescriptions and, if so, how this should be framed.**

It is madness to require vets to create a prescription for a product prior to administering it themselves. Vets have, often, 15 minutes to perform a consultation and struggle to keep to this time. Remember, every 30 seconds you add to their load increases the cost of this consultation by 3.3%. There is not as much slack in the system as you seem to imagine.

It is straightforward to exclude any medication that the vet (or a colleague of theirs) personally administers using phraseology such as – "except for medication that is personally administered by the vet or a SQP under their direction".

● **Question 41: Do these written prescription remedies present challenges that we have not considered? If so, how might they be best addressed?**

You are underestimating the impact of these 'remedies' will have on vet time. You think a prescription can be created more quickly than is possible. Obviously, expensive systems to streamline prescription creation are feasible but this will punish small businesses much more than LVGs because they will be complicated and expensive to create but simple to roll out across multiple practices. Veterinary prescriptions are more bespoke than human prescriptions and slower to create. I can imagine a purpose-built system that might create the document in two minutes. This would increase the consultation cost by only 13%. I have timed myself. My current system is pretty slick and I can create a simple written prescription in about 3 to 4 minutes (a complicated medication or a more unusual one takes me about 5 to 7 minutes because I have to look up doses and formulations). If I have to produce one every time I dispense medication then I will need to increase a consult charge by 27%.

● Question 42: How might the written prescription process be best improved so that it is secure, low cost, and fast? Please explain your views.

The VMD have recently made changes to the requirements for prescriptions so that they are more stringent and more time-consuming. If these changes could be reversed then that would help.

I note that you wish the production of a written prescription to be as fast as or faster than in-house dispensing. This is just not, by definition, possible because writing the label instructions is just one part of writing the prescription; you have to, in effect, create the in-house label first and then carry on with the other prescription requirements. The dispensing can be done by a non-vet (which is cheap). The prescription writing must be done by a vet (which is expensive).

A central, standardised, online prescription system that every practice subscribed to would be ideal. It would need to link to all seven commonly-used practice management systems so client and patient details could be pre-populated fields. Medication details could be text-predictive or on drop-down menus to speed the process. Perhaps there could be an AI function which examined the clinical notes of the patient to ensure that all the on-or-off-license details are correct for the species and intended use because that varies on a case-by-case basis. The label details could be pre-populated with editable templates. Secure, electronic signatures would be necessary. The electronic document could be then sent to the client so they could decide where to redeem it.

Obviously, the above system would cost many millions to create and then maintain. It is not obvious to me how this is being financed. Ultimately, it would need to come from pet-owners which rather defeats the object of the 'remedy'.

● Question 43: What transitional period is needed to deliver the written prescription remedies we have outlined? Please explain your views.

Assuming you continue with your preferred option of ensuring a written prescription is produced for every medication we prescribe, this is going to have a profound impact on the business and the more time you can give me the better.

Obviously, a centralised system of prescriptions as you so optimistically envisage would not be possible to create inside 5 years. If you decide to pursue this 'remedy' before having this sort of system in place then I would wish to have 12 months to prepare my systems and warn my clients of the impending cost increases you have caused. I would need to increase my consultation time from 15 to 20 minutes in anticipation and remove the checks and security measures we have in place to protect against prescription fraud. For example, we currently purchase the BVA labels to uniquely

identify every prescription. We would need to stop these because they would become unaffordable, especially if you are intending to prevent me from charging appropriately for these documents.

Remedy 8: Transparency of medicine prices so pet owners can compare between FOPs and other suppliers

● Question 44: What price information should be communicated on a prescription form? Please explain your views.

Anything that is not automated suffers from the same effect as with 'remedy' 7; if a vet is required to spend time on it, even for 30 seconds, it has a non-trivial effect on consultation cost.

Option A would be easy to institute and would not increase costs of business.

Options B and C involve the creation of another huge IT project which the veterinary profession has to pay for. They would be much more difficult to institute using our current internal systems and, once again, punish the small businesses and reward the large businesses. I assume these options envisage a central, independent, recognised, standard source for this information that is consistent across the profession. If not then it is a system ripe for abuse. It is not obvious to me how this live, constantly changing information is going to be uploaded to a document generated by our practice management system as it currently exists.

This entire section strikes me as pie-in-the-sky thinking. It might well be wonderful for clients to have a list of prices written out on each and every prescription but this is only possible if either –

> There is a multi-million-pound investment in a central system and massive investment by practices in updating their systems to be able to 'talk' to it.

or –

> Practice staff devote considerable time after nearly every consultation to producing this document.

Either way, clients will end up spending less on medication but considerably more on vet consultations.

What should be included on a prescription? I feel a version of Option A with a QR code and a compulsory message such as :

'Medication is likely to be considerably less expensive if it is purchased through an online pharmacy'

would be just as effective as Option B or C at persuading clients to shop around and not cost the veterinary profession (and subsequently their clients) millions of pounds.

If you insist on putting Option B or Option C in place, perhaps you could limit it to only when a client has a repeat medication. This would reduce the workload for the practice immeasurably and focus the benefit for clients to where it is most needed.

● Question 45: What should be included in what the vet tells the customer when giving them a prescription form? Please explain your views.

The vet should be required to say:

"I apologise that your consultation is so much more expensive than it was last year. This is a direct consequence of the measures introduced by the CMA aimed at reducing vet fees. I tried to warn

them but they ignored me. This prescription can be used either here or at an online pharmacy. It would probably be considerably cheaper at a pharmacy but your pet would benefit from the medication now rather than waiting three days."

● **Question 46: Do you have views on the feasibility and implementation cost of each of the three options? Please explain your views.**

Option A – feasible and inexpensive.

Option B – feasible if a multi-million pound central investment is put in or if consult costs are increased.

Option C – feasible if a multi-million pound central investment is put in or if consult costs are increased.

Remedy 9: Requirement for generic prescribing (with limited exceptions) to increase inter brand competition for medicine sales

● **Question 47: How could generic prescribing be delivered and what information would be needed on a prescription? Please explain your views.**

You describe vets who prescribe a single brand of medication as 'risk averse' but put yourself in our shoes. Each brand of medication with the same ingredients has a separate 'data sheet'. There are subtle differences between these data sheets which change periodically. It is the individual vet who is responsible for ensuring that a prescription is made under the licensing of the branded product and if they get it wrong there are legal and professional repercussions which fall on them personally. There are hundreds of data sheets and it is unreasonable to expect a vet to memorise and keep up to date with all of them. Therefore, rather than learn five different data sheets and all their subtle differences, I will generally learn and keep up to date on one and always prescribe that brand, knowing that I am safe to do so.

Therefore, to reasonably expect me to prescribe generically you must remove the legal and professional threat to my livelihood were I to mis-prescribe because I hadn't correctly memorised the fifth datasheet for a particular generic drug.

Your suggested solution to this issue is to have yet another central web-site or resource which publishes which generics I can and cannot prescribe for particular species, ages and conditions. This requires me, every time, virtually every consultation, to look up what brands are and are not safe for any particular situation and then write out an exhaustive list. To remind you, every 30 seconds of a consult is another 3% on the cost.

● **Question 48: Can the remedies proposed be achieved under the VMD prescription options currently available to vets or would changes to prescribing rules be required? Please explain your views.**

It is perfectly possible to list out which brands of a drug are and are not permissible on each and every prescription whilst staying within the VMD guidelines. It's just going to take a significant time for each and every prescription and vet time is not cheap. If you could somehow remove the legal responsibility on the vet to prescribe safely then perhaps they would be more willing to adopt your more gung-ho attitude.

● **Question 49: Are there any potential unintended consequences which we should consider? Please explain your views**.

As explained above, these measures as described will exert a significant inflationary pressure on vet bills. I am doubtful that the benefits are worth the costs.

● **Question 50: Are there specific veterinary medicine types or categories which could particularly benefit from generic prescribing (for example, where there is a high degree of clinical equivalence between existing medicines)? Please explain your views.**

No. I can think of individual drugs which are currently identically licensed regardless of brand but this is potentially liable to change in future and I have no control over this.

● **Question 51: Would any exemptions be needed to mandatory generic prescribing? Please explain your views.**

I sincerely hope, for the sake of clients' wallets and vets' sanity, you do not adopt this measure.

● **Question 52: Would any changes to medicine certification/the approval processes be required? Please explain your views.**

Vets currently have an umbrella of protection in the situation when an animal is adversely affected by a drug. If they have prescribed within the data sheet of the branded drug then that company and the VMD will help and support them in their dealings with an unhappy client. If a vet has prescribed 'off license' then they lose this protection which is why we ask clients to sign consent forms when drugs are so prescribed. You cannot remove this umbrella from vets and not replace it.

● **Question 53: How should medicine manufacturers be required to make information available to easily identify functionally equivalent substitutes? If so, how could such a requirement be implemented?**

Manufacturers run experiments on their products and make claims about their use according to what tests they have done and what those results are. It is unreasonable to require them to assert clinical facts about what their brand can and can't do without evidence. If you wish to make a change to this system you may need to roll back the last forty years of legal precedent in veterinary medication law.

● **Question 54: How could any e-prescription solution best facilitate either (i) generic prescribing or (ii) the referencing of multiple branded/named medicines. Please explain your views.**

The differences between drug data sheets are more subtle than you seem to assume. Different brands of the same drug have licenses for different indications, different treatment durations, different species, different ages and list different side effects and dosing mechanisms. They have different dose regimes and different potential side effects. There is not a simple answer to this if you insist on this 'remedy'. Your multi-million pound e-prescription solution sounds amazing. And expensive.

Remedy 10: Prescription price controls

● **Question 55: Do you agree that a prescription price control would be required to help ensure that customers are not discouraged from acquiring their medicines from alternative providers? Please explain why you do or do not agree.**

I partially agree that some practices have used high prescription prices to discourage clients from using pharmacies.

When a vet writes a prescription there are several direct costs to the business but also it is a legal document for which a vet can be held professionally accountable. It is easy to undervalue them. If you do indeed change the requirements to make them more long-winded to produce (as 'remedies' 7, 8 and 9 are designed to do) then it is unreasonable to expect their price not to also rise.

● Question 56: Are there any unintended consequences which we should take into consideration? Please explain your views.

A price cap sounds a reasonable idea but it sets a 'target' which everyone might increase their price to.

If you reduce the profit a practice obtains from medication sales then they will, I promise, increase the cost of other services.

● Question 57: What approach to setting a prescription fee price cap would be least burdensome while being effective in achieving its aim of facilitating competition in the provision of medicines?

I would suggest that a 'suggested cost' is published by the VMD, say, and every prescription must include the line: 'The suggested reasonable cost of a written prescription according to the VMD is £20. This prescription from this practice cost £xx'

This is not a price cap but an incentive for every practice not to look like they are profiteering.

If we were to decide to impose a cost based price control for prescriptions, we need to fully understand the costs involved with prescribing and dispensing activities. We are seeking to understand:

● Question 58: What are the costs of writing a prescription, once the vet has decided on the appropriate medicine?

Vet time – Currently I take about 5 minutes to write out a prescription. If I am to adopt all the 'remedies' you are proposing then this will increase to at least 10 minutes. With better systems (at considerable cost) and familiarity this might reduce to 8 minutes. A typical vet charges at approximately £4 a minute for most services – Five minutes - £20.00

BVA sticker – Unique sticker as an anti-fraud device - £1.53

Paper and ink and printer maintenance etc – £0.15

Professional risk and indemnity – Unquantifiable

Total - £21.68

Plus VAT - £26.02

Our current charge - £18.50

I would consider any charge that is currently under £30 to be reasonable and defensible. I choose to keep our prescription cost considerably lower than this.

● Question 59: What are the costs of dispensing a medicine in FOP, once the medicine has been selected by the vet (i.e. in effect after they have made their prescribing decision)?

SQP time – 1 minute. This probably costs the practice £0.23

Label and printing - £0.15

Packaging - £0.40

Professional risk and indemnity - Unquantifiable

Total £0.78

Plus VAT - £0.94

Remedy 11: Interim medicines price controls

● Question 60: What is the most appropriate price control option for limiting further price increases and how long should any restrictions apply for? Please explain your views.

I think the price control, if adopted, should be targeted solely at the worst offenders. Why would you wish to punish those of us who have kept our prices down for the past several years by forcing us to keep our prices at 2024 levels when we were behaving reasonably all along? You are advantaging those businesses which were the most expensive because they will continue to have higher profit from medication and we will be crippled in comparison. Please bear in mind that some drugs (potentiated amoxycillin being a prime example) have increased in wholesale price hugely above inflation since July 2024. I suspect that if you made us set them at July 2024 prices we would be selling them at less than we can buy them.

The only fair option is for you to look at the mean and variance of the price of a medication in a particular geographical region (for FOPs only, not for online pharmacies with whom it is impossible to compete on price) and set the price cap at, say, the 60th percentile. Practices such as mine would be unaffected and would benefit from having been behaving reasonably all along and practices which had been 'taking advantage' of their clients would have to reduce their prices.

● Question 61: If we aim to use a price control to reduce overall medicine prices, what would be an appropriate percentage price reduction? Please explain your views.

A percentage reduction across the board is punitively unfair on practices who have behaved the best in the past. As above, a price cap is a better approach than a percentage reduction. Obviously price of medication is not set in a vacuum and, in the event of you halving my medication sales, I will need to compensate for that with other price rises.

● Question 62: What should be the scope of any price control? Is it appropriate to limit the price control to the top 100 prescription medicines? Please explain your views.

I do not believe the problem is with first time prescribed drugs. I think you should be focusing all your 'remedies' on repeat prescriptions. This is a much more sensible, balanced, useful approach.

If you are insisting on your approach then I would suggest a top 50 is fairer than a top 100 – I agree with your analysis that concludes that most medication sales are of a limited range but think that 50 drugs encompasses what you aim to achieve.

I remain of the opinion that this 'remedy' will have an inflationary effect on overall vet fees either way.

● Question 63: How should any price control be monitored and enforced in an effective and proportionate manner? Please explain your views.

It is only certain practices that have been guilty of unfair pricing. I am worried that you will enact measures which indiscriminately punish all practices or, worse, damage the 'well-behaved' more than the 'sinners'. Surely there should be some recognition that not all businesses have been guilty of the excessive pricing you have identified?

How these measures are to be enforced or policed is not obvious to me. The RCVS has no power to intervene and I would not suggest that a wait for a new Veterinary Surgeons Act will be a short one.

Implementation of remedies 7 – 11

● Question 64: We welcome any views on our preferred system design, or details of an alternative that might effectively meet our objectives. Please explain your views.

I would like to be offering solutions, not pointing out the obvious flaws in your ideas. But there are a lot of flaws and I do believe there is a better, cheaper, less radical, more effective and less risky option. But first the flaws:

A nationwide central prescription portal sounds wonderful and I am in awe of the CMA's optimism in thinking there is a route to its successful creation and funding. The technical challenge involved in creating a bespoke single-use prescription code system, working effortlessly alongside a bespoke live-updating price comparison element, all accessible to different degrees by vets, pharmacies and clients, all with secure logins and dealing with about 9000 prescriptions an hour (if we're encouraging our clients to price compare while they're with us in working hours) would seem daunting to me.

There is unfortunately, in my experience, little to no chance of integrating PMS software systems with each other or with a central portal. If the PMS is not transferring client and patient details across to the portal then the vet will be manually transferring this information themselves. They will then be recording all the details of the drug they are prescribing and the various formulations that are appropriate. Then they will be writing out the label text. Even in a best-case world, where a slick, reliable user-friendly portal exists and vets have all the information they need in their heads or at their fingertips, it is still going to take at least five minutes to create each prescription. The CMA estimates 27.5m prescriptions would be needed each year, based on 2023 figures. This equates to approximately £550m worth of vet time which someone will need to pay for. I suspect this is a substantial underestimate.

The central portal will inevitably be designed to be easily integrated with the LVGs' systems, because they are the biggest users, and the designers will not care about whether or not it can be integrated with individual FOPs. This will be, once again, rewarding the [redacted] and punishing the 'good guys'.

When the portal is 'down', there needs to be a back-up plan.

When a client does not have access to the internet or is unable to use the technology for any reason, there needs to be a back-up plan.

When a practice loses power or internet connection, there needs to be a back-up plan.

When an animal would benefit from the medication immediately (nearly always) what is the plan? Do you expect practices to supply the first few days of medications and then the pharmacy prescription can take over? If I'm needing to stock all the current items for this purpose but can't rely on sales of more than a few tablets at a time then I am going to have to charge much more per dose. What about if the medication is indivisible. Meloxicam is a prime example. It comes in bottles

which can't divide up for a few days' dosing. If a dog needs it urgently then how do you suggest this will work?

Your suggested system is expensive, unwieldy and impractical. It is attempting to address the cost of medication without considering whether this is in pet owners' best interests. If there was any lesson to be drawn from the CC's intervention in 2003, it was that intervening in the veterinary medicine market led to (or at least was temporally related to) increases in overall vet bills. Your aim with this 'remedy' seems to be to reduce my medication sales to as close to zero as you possibly can and remove me from this market. I can buy medication at roughly the price it is available online and I have massively greater costs than online pharmacies so I am not able to compete with them on a fair standing. Your aim (to reduce my medication sales) is fine as far as it goes but there will still be demand for my services and I will therefore be forced to increase the cost of my professional services and what medication I can still sell to compensate for the loss in earnings. If you are also simultaneously increasing the work load of my vets then my prices will increase still further. This will be true for every single other vet practice in the country.

The net result of your 'remedies' will be:

> The pet owning public paying for online pharmacy profits,
>
> The pet owning public paying for vet practice profits,
>
> The pet owning public paying for vet time they would not have previously paid for, writing extra-complicated prescriptions,
>
> The pet owning public paying for the creation and maintenance of a huge IT project that did not previously exist,
>
> The thriving of profit-driven LVGs in place of smaller FOPs, as they are able to take advantage of the benefits of scale you are giving them when dealing with the administrative costs,
>
> Increasing strain on veterinary surgeons and an increase in vets leaving the profession,

I just do not believe that the possible reduction in medication cost (which we know from the CC's experience is likely to be disappointingly marginal) is worth the overall inflationary pressure you will create.

Enough of the flaws. A better solution:

Keep it cheap, simple and proportionate.

Ignore the first-time purchase medications completely. For the marginal benefit in price reduction, it is not worth the enormous increase in administration cost.

Put in a price control on these drugs if you must but set a limit as the 60th percentile of the price practices charge in a particular geographical area. Remove the limit after 12 months (or sooner if and when you find it has increased overall veterinary costs to clients)

For repeat prescriptions only, compel practices to provide a written prescription, even if they are dispensing the medication themselves. For repeat prescriptions, in contrast to first-time medications, I can organise and allocate staff to streamline the process and so make it much more

efficient. On this written prescription, compel practices to prominently write the cost of the medication if sourced from them followed by the line:

'Medication is likely to be considerably less expensive if it is purchased through an online pharmacy'

This solution will encourage reduction in medication prices in practices and so will still increase costs of other services but will not cause the massive increase in vet paperwork you are proposing and so will avoid the proportion of the inevitable fee increases related to that. I still think it is misguided of the CMA to be focussing on medication cost given the evidence of the counter-productive measures brought in by their predecessors but at least my solution will provide a more balanced approach.

● Question 65: What do you consider to be the best means of funding the design, creation and ongoing maintenance of an e-prescription portal and price comparison tool? Please explain your views.

Well, quite. It's pie in the sky. Has this proposal been even tentatively costed? What's your idea if none of the stake-holders want to pay for it? Are you going to compel the RVCS to pay? Do you have the power to do so? Can they even do so constitutionally without a new Veterinary Surgeons Act? Ultimately it will be the clients who will end up paying regardless, directly or indirectly.

Remedy 12: Restrictions on certain clauses in contracts with third-party out of hours care providers

● Question 66: What would be an appropriate restriction on notice periods for the termination of an out of hours contract by a FOP to help address barriers to FOPs switching out of hours providers? Please explain your views.

This is another sphere of veterinary practice which does not easily fit into the CMA's model of how markets should operate. The CMA seems to imagine that there should be choice for consumers (or for FOPs) as to what out of hours (OOH) provider to use. In order for there to be choice, in most geographical parts of the country there would need to be twice the number of OOH vets working. There are not enough vets in the country for this to be practicable.

I am required (by the RCVS code) to have a named and contracted OOH provider to offer my clients.

The biggest cost of running an OOH provider is the cost of employing vets willing to do the work. It costs roughly three and a half times as much to staff a practice from 1900 until 0800 as it does from 0800 until 1900. OOH providers understandably want to be able to have some long-term reassurance that there will be FOPs signed up to them to continue to operate and to offer contracts to their staff.

[redacted] There is no other OOH provider available for me to switch to and it is unlikely that one would ever appear because of the considerable costs of running one. If two OOH providers were competing for the same finite number of emergency cases in a particular geographical area, it is difficult to see how either business could survive without substantially increasing their fees.

● Question 67: What would be an appropriate limit on any early termination fee (including basis of calculation) in circumstances where a FOP seeks to terminate a contract with an out of hours provider? Please explain your views.

I genuinely believe that whether the notice period was 48 months or 48 hours, it would be unlikely to result in more competition.

Remedy 13: Transparency on the differences between fees for communal and individual cremations

● Question 68: Do you agree that the additional transparency on the difference in fees between fees for communal and individual cremations could helpfully be supplemented with revisions to the RCVS Code and its associated guidance? Please explain your views.

Alterations to the RCVS Code could insist on clients being given a price list for different cremation options but there is a danger of making a difficult and traumatic time worse for the client. I do not perceive enough of a problem in this area to require any specific attention. It is a rare client who does not know that there are a range of options and it is not a time they necessarily want to be bombarded with a price list.

Remedy 14: A price control on cremations

● Question 69: If a price control on cremations is required, should this apply to all FOPs or only a subset? What factors should inform which FOPs any such price control should apply to?

This is a measure that I can see having some benefit for clients. I suspect an investigation would reveal much higher profit margins on individual cremations in LVGs than in smaller businesses but I do not have any evidence to back up that suspicion other than word of mouth. Price control should apply across the board.

I would want there to be extra checks in place for any practice that is under the same ownership as the crematorium.

● Question 70: What is the optimal form, level and scope of any price control to address the concerns we have identified? Please explain your views.

I believe the fairest methodology would be to restrict every practice to a set maximum percentage mark-up on individual cremations.

If a practice and the crematorium are owned by the same entity then there should be a further requirement that the overall price is at or below the 60th percentile for all practices in a geographical area.

This would ensure that prices were fair and consistent between practices and would stop LVGs making use of their ownership of the crematoria to adjust prices 'at source'.

● Question 71: For how long should a price control on cremations be in place? Please explain your views.

I think it should be in place until ownership of veterinary practices is restricted to vets only.

[redacted]

● Question 72: If a longer-term price control is deemed necessary, which regulatory body would be best placed to review and revise such a longer term price control? Please explain your views.

I agree with your assessment. There is currently no control of business owners of veterinary practices. We cannot rely on a new VSA to give the RCVS the powers it needs within the next

parliament (or even the next 20 years) and there is no other body in existence. The RCVS could try but it would lack teeth in reality.

If you adopted my previously outlined solution (question 10-12), then there would be less need for any of these other measures.

Remedy 15: Regulatory requirements on vet businesses

● Question 73: Would regulating vet businesses as we have described, and for the reasons we have outlined, be an effective and proportionate way to address our emerging concerns? Please explain your views.

Yes. New over-arching regulation would be a far more effective and rational approach than all the other 'remedies' suggested. It would address the cause and not the symptoms. I fear the other 'remedies' suggested will make the situation worse rather than better.

The current system of regulation is wildly inadequate, outdated and not fit for purpose.

The profession has been crying out for updated regulation for decades.

There is undoubtedly (always has been and always will be) opportunity for clients to be exploited financially in small animal practice because of a mismatch of knowledge between vet and client and the frequent emotional and time-dependent pressure involved in treating sick animals. No amount of CMA intervention will alter this fact.

It has been vets who have historically resisted the temptation to exploit their clients and continue to so resist. I still maintain that the overwhelming majority of vets behave in an exemplary manner and act and advise purely in the best interests of their patients and clients. This is the case regardless of who they work for.

Some owners of vet practices set prices and put in place mechanisms to deliberately try to exploit clients. They are not currently regulated and the vets who work for them are put in difficult positions.

I do not know what regulatory framework would be effective to combat these bad actors but the current framework is inadequate.

Remedy 16: Developing new quality measures

● Question 74: Are there any opportunities or challenges relating to defining and measuring quality which we have not identified but should take account of? Please explain your views.

Assessment of quality is difficult to objectively measure. Clients are slow to switch practices and difficult to attract from a practice that is more geographically convenient for them. All the evidence I have in my own practice is that owners mostly choose to come to us on the basis of word of mouth. All other factors (PSS rating, Google reviews, social media, etc) are secondary.

Demand is extremely inelastic in terms of price and also in terms of quality of service. Clients just do not move practices unless things go really wrong.

Given this, I would be cautious in my expectations of what any of your 'remedies' in this area will achieve.

● Question 75: Would an enhanced PSS or similar scheme of the kind we have described support consumers' decision-making and drive competition between vet businesses on the basis of quality? Please explain your views.

Yes, I would be thoroughly supportive of an enhanced PSS. As detailed in my previous answers, I believe it should be compulsory for every practice and I think the PSS system is best placed to make an assessment of quality but, more importantly, of value for money. They should produce a five sentence summary of every practice which makes for easy comparison between practices. I outlined what these summaries could look like in answer to a previous question but I will copy and paste them again here. A client could enter their postcode and get something like the below:

0.7 miles - Practice A is a five site practice, including an RCVS-accredited Hospital. It is owned by a traditional partnership which own no other practices. Our assessor found them to be moderately priced for routine services (such as first consultations, vaccinations and routine neutering), reasonably priced for non-routine services (such as minor operations, investigations and imaging) and reasonably priced for more advanced procedures (such as major operations and advanced investigations). They provide 24 hour care for their own patients at their own site. Out-of-hours cover is provided by [redacted] at a separate site. They provide advanced care (but not specialist care) in orthopaedics, internal medicine, cardiology, ophthalmology and dentistry.

1.2 miles - Practice B is a one site practice, a RCVS-accredited General Practice. It is owned by a limited company which own no other practices. Our assessor found them to be moderately priced for routine services (such as first consultations, vaccinations and routine neutering), reasonably priced for non-routine services (such as minor operations, investigations and imaging) and not equipped to perform advanced procedures (such as major operations and advanced investigations). They transfer any inpatients to [redacted] at a separate site. Out-of-hours cover is provided by [redacted] at a separate site. They do not provide advanced or specialist care.

3.2 miles - Practice C is a three site practice, including a RCVS-accredited General Practice. It is owned by a limited company which own approximately 600 other practices. Our assessor found them to be reasonably priced for routine services (such as first consultations, vaccinations and routine neutering), expensively priced for non-routine services (such as minor operations, investigations and imaging) and very expensively priced for more advanced procedures (such as major operations and advanced investigations). Their inpatients are cared for at their own site by [redacted]. Out-of-hours cover is provided at their own site by [redacted]. They provide advanced care (but not specialist care) in internal medicine.

I believe this type of summary would be the best means of providing an objective, impartial, independent assessment of what is on offer in a client's local area. It would remove the need for many of the self-defeating, inflationary, punitive 'remedies' the CMA currently favours.

● Question 76: How could any enhancements be designed so that the scheme reflects the quality of services offered by different types of vet businesses and does not unduly discriminate between them? Please explain your views.

I have lived through a number of incarnations of the PSS and it remains imperfect but much better than nothing. Quality of care is difficult to objectively measure – I would rather have a really great vet nurse looking after my patients than a wall of tick-lists – but the inspectors are more than capable of judging equipment, procedures and staff qualifications.

There is a burdensome load and stress in complying with the PSS and preparing for an inspection (it's the equivalent of a school's Ofsted inspection) but I do not see significant discrimination between different types of business. It is laughable that the CMA should suddenly be concerned about this discrimination with regard to the PSS when they are so blindly cavalier with regard to all the other proposals they currently favour. The PSS burden is completely insignificant in comparison to the massive, punitive, unfair barriers they are in favour of constructing with their other 'remedies'.

The PSS requirements are a list of stuff practices should be doing anyway and it's merely a bit of a pain proving compliance with the hundreds of items. However, it is a pain spread over a decent time-frame and can be scheduled to fit conveniently with the rest of the practice's workflow.

● **Question 77: Are there any other options which we should consider?**

The PSS is already in place. The infrastructure is there and it would be perfectly manageable to expand it somewhat. It strikes me as madness to consider setting up anything new to replace it. As outlined in my answers to previous questions, I am in favour of bolting on a 'value-for-money' module to replace some of the CMA's more terrible ideas.

Remedy 17: A consumer and competition duty

● **Question 78: Should any recommendations we make to government include that a reformed statutory regulatory framework include a consumer and competition duty on the regulator? Please explain your views.**

This is not a question with a yes or no answer. It depends.

The RCVS (or whatever single regulator replaces it) will have a complicated and at times conflicting set of responsibilities. They will need to ensure standards of individual vets are monitored and maintained, standards of practices (and their owners) are monitored and maintained, standards of animal welfare are monitored and maintained. If they have a consumer and competition duty on top of these other responsibilities it is difficult to see how each will be balanced. My solution is below at question 79.

● **Question 79: If so, how should that duty be framed? Please explain your views.**

I believe there should be two bodies.

One should be responsible for standards of vets' (and other allied professionals') medical and surgical competence. Animal welfare should fall under this bracket. Individual vets would be responsible to this body and answerable to them for their conduct. The RCVS Code would apply to them. If standards fell short there should be a range of possible repercussions, mostly centred around people learning from their own and others' errors. The current system of 'struck off or nothing' is anachronistic and counter-productive. I think this body should still be called the 'RCVS' and vets should still be members of this body (MRCVS) because it has a historical and emotional significance to the profession.

The other body should be responsible for 'fair dealing' by veterinary practices. It should be, essentially, an ombudsman with powers to warn, financially penalise or even close down practices which are not dealing fairly with the public. Perhaps anti-competitive behaviour could be referred to the CMA (for instance if a chain of vets monopolised a geographical area). I think this organisation should be called the Office For Veterinary Practice Standards (or OfVet for short).

Remedy 18: Effective and proportionate compliance monitoring

● Question 80: Would the monitoring mechanisms we have described be effective in helping to protect consumers and promote competition? Please explain your views.

Yes. Some hybrid model between the CQC and the FSA would be appropriate, as outlined in my third paragraph under question 79 above. This will not happen without a new VSA and this is unlikely to be soon.

● Question 81: How should the monitoring mechanisms be designed in order to be proportionate? Please explain your views.

The PSS already exists. Make this compulsory. This would solve many of your problems in one hit (see my answers to multiple questions above).

● Question 82: What are the likely benefits, costs and burdens of these monitoring mechanisms? Please explain your views.

It depends. If it is a beefed-up PSS inspection every four years then this is proportionately burdensome. Practices not already signed up to the scheme will find it difficult to begin with but I have little sympathy because there is no excuse for not already having the requirements in place.

● Question 83: How could any costs and burdens you identify in your response be mitigated and who should bear them? Please explain your views.

The cost of the PSS is proportionate already. Individual practices would be in a position to pay the fees and an increase in this fee of, say 10-20% would be reasonable. If this measure was taken instead of the massive costs proposed by the CMA's other 'remedies' then I believe practices and their clients would be relieved and grateful.

Remedy 19: Effective and proportionate enforcement

● Question 84: Should the regulator have powers to issue warning and improvement notices to individuals and firms, and to impose fines on them, and to impose conditions on, or suspend or remove, firms' rights to operate (as well as individuals' rights to practise)? Please explain your views.

As outlined under question 79, I believe there should be a separation in regulation of individual vets and regulation of veterinary businesses. Ultimately, the business regulator should be able to close down a veterinary practice if they are found to be in contravention of 'fair-dealing'.

● Question 85: Are there any benefits or challenges, or unintended consequences, that we have not identified if the regulator was given these powers? Please explain your views.

The main challenge will be actually getting the required legislation into parliament. There has been a desperate need for decades and no government has yet found the time to include it in their schedule.

Remedy 20: Requirements on businesses for effective in-house complaints handling

● Question 86: Should we impose a mandatory process for in-house complaints handling? Please explain your views.

Yes, but with wide margins for individual practices to accommodate.

● Question 87: If so, what form should it take? Please explain your views.

Published contact details on website for complaints in first instance.

Expectation that there will be a response inside 15 working days, or explanation that a particular complaint will take longer to investigate with good reasons given.

If this response is not considered adequate, recourse to the VCMS (compulsory engagement by practices).

If still not happy then recourse to my new governing body (OfVet) or the RCVS (see my answer to question 79) depending on VCMS's view as to which is more appropriate.

Remedy 21: Requirement for vet businesses to participate in the VCMS

● Question 88: Would it be appropriate to mandate vet businesses to participate in mediation (which could be the VCMS)? Please explain your views.

Yes. It surprises me that any practice would not be very keen to engage with this service at the earliest possible opportunity. I have had two interactions with them and they are a very useful resource.

● Question 89: How might mandatory participation in the VCMS operate in practice and are there any adverse or undesirable consequences to which such a requirement could lead?

A mandatory complaints code as set out above could include this requirement. I suspect new regulation would be required to formally make it compulsory but I would be surprised by any opposition to this proposal.

● Question 90: How might any adverse or undesirable consequences be mitigated?

I do not see any negative effects.

Remedy 22: Requirement for vet businesses to raise awareness of the VCMS

● Question 91: What form should any requirements to publicise and promote the VCMS (or a scheme of mediation) take?

I believe all that is necessary is for vets to be required to mention the VCMS at the end of any response they make to a complaint and publish the resource on their 'complaints procedure'. If this is part of a loose requirement as outlined above then I do not think any further publicity is necessary.

Remedy 23: Use of complaints insights and data to improve standards

● Question 92: How should the regulatory framework be reformed so that appropriate use is made of complaints data to improve the quality of services provided?

Complaints can be clinical or non-clinical. I think it could be made part of VCMS's remit to be on the lookout for patterns within practices and within LVGs to alert the RCVS or OfVet of its findings if there is a persistent issue. Most clinical complaints are so individual and granular that I think it would be a poor way of improving standards. In fact, external threats to livelihoods from regulators are a terrible way to improve standards in any industry. They will kill a learning culture in a business stone-dead.

Remedy 24: Supplementing mediation with a form of binding adjudication

● Question 93: What are the potential benefits and challenges of introducing a form of adjudication into the sector?

This already exists in part in the form of the RCVS's Disciplinary Committee. They already face a challenge in dealing with their narrow band of clinical complaints in a timely manner. The stress that vets are put under when undergoing this kind of scrutiny is notorious, even when a complaint is obviously spurious. Vets already have a much higher rate of mental health problems than the general population (including a very high suicide rate). I would be cautious of adding to the strain on the profession.

Dealing with complaints is very time-consuming and stressful and the majority of complaints are completely unconnected to standards in that practice so it is a bad way to 'improve standards'. Some clients deal with grief by inappropriately blaming vets and lose any semblance of rationality.

● Question 94: How could such a scheme be designed? How might it build upon the existing VCMS?

I think the VCMS might be able to provide a 'recommended outcome'. If a vet practice (or client) disputed this outcome then there would need to be a final decision or appeal facility but with as little further input of time from the practice (or client) as possible.

● Question 95: Could it work on a voluntary basis or would it need to be statutory? Please explain your views.

I love engaging with the VCMS because they take an enormous amount of time-wasting out of the process for me. I would volunteer to engage at the earliest opportunity every time. I guess it should be made statutory but I doubt there would be much opposition.

Remedy 25: The establishment of a veterinary ombudsman

● Question 96: What are the potential benefits and challenges of establishing a veterinary ombudsman?

As mentioned above, I believe my newly named OfVet would be a sister regulator to the RCVS. Taking the business of veterinary practice away from the regulation of individual vets is an obvious solution to many of the problems the CMA have identified.

It remains, in my opinion, highly unlikely the required legislation will appear inside the next 5 years and I will be delighted if it appears inside the next 15.

● Question 97: How could a veterinary ombudsman scheme be designed?

OfVet would make the PSS compulsory and publish the five sentence summary (as designed by me above) of every vet practice in the country. Complaints would be funnelled to them through the VCMS and they would take action against the most egregious offenders. Their punishments would take account of the size of business and the offence itself but would range from warnings, to fines, to restrictions on work allowed, to closing of facilities.

● Question 98: Could such a scheme work on a voluntary basis or would it need to be statutory? Please explain your views.

This would need to be statutory. Any business conducting 'veterinary services' would need to register and have an OfVet number to be legally allowed to operate. They would need to be inspected by the PSS and comply with the VCMS service.

Remedies 26 – 28: Effective use of veterinary nurses

● Question 99: What could be done now, under existing legislation, by the RCVS or others, to clarify the scope of Schedule 3 to the VSA?

Under the current scope, RVNs conduct fewer procedures now than when I qualified in 2000. The profession has been instructed by the RCVS to narrow the role of the RVN rather than expand it. I believe new legislation would be required to reverse this trend.

● Question 100: What benefits could arise from more effective utilisation of vet nurses under Schedule 3 to the VSA, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

This would be of benefit to all parties. Vet nurses are very capable of a wide range of activities they are currently not permitted to perform.

● Question 101: What benefits could arise from expansion of the vet nurse's role under reformed legislation, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

It is difficult to predict the results. When I qualified in 2000, vet nurses were performing a different set of procedures than they are now. They were commonly performing dentistry and minor operations. Their role has reduced in those areas but in other areas has expanded and they are, in general, much better qualified and trained now than then.

Proportionality

● Question 102: Do you agree with our outline assessment of the costs and benefits of a reformed system of regulation? Please explain your views.

In the main, I agree with your assessment. The changes you propose are long overdue and the costs involved are necessary and proportionate. Indeed, they are completely dwarfed by the proposals you make in 'remedies' 5 and 7 which threaten to drastically cut practice profits and hugely increase fees to clients. It is astonishing that you can see the potential impact on client fees with this minor change in practice costs but do not apparently see the tsunami of increased fees that would result from your earlier suggestions.

● Question 103: How should we develop or amend that assessment?

No amendments.

● Question 104: How could we assess the costs and benefits of alternative reforms to the regulatory framework?

I do not know.

● Question 105: How should any reformed system of regulation be funded (and should there be separate forms of funding for, for example, different matters such as general regulatory functions, the PSS (or an enhanced scheme) and complaints-handling)

The RCVS charges an annual fee of approximately £400 per vet. My proposed change would reduce the remit of the college and they already have large reserves and take in more than they spend each year, so this fee could be safely halved. The new OfVet would need substantially more funding. This could be paid by practices on the same basis (per FTE vet) and include the compulsory PSS

inspections. It would be realistic to charge £800 per vet. I believe this would be sufficient to fund your proposals.