

CMA response NEF 05-25

Neil Fraser BVMS MRCVS 0604793 Year of qualification 1983

Representing

Briar Vets Ltd, Briarcliffe, Halifax Road, Penistone, Sheffield S36 7EY

info@briarvets.co.uk 01226 766099 & 07733 120779

I am responding to the CMA interim report of 05-25

I am a director and senior vet in a 4-vet, independently owned, mixed practice in South Yorkshire which was established in 2017 and is 65% household pet animals. It provides in-house out of hours care and competes locally with other corporate and independent practices.

Summary of my response:

- A) Price list transparency has limitations in its ability to achieve the CMA aim to reduce veterinary fees. Pricing is like an inflated balloon. When squeezed in one area other parts of the balloon will swell as the air moves. Shop window prices may be published and have downward price tendency. Practices will need to maintain income so other prices have to be reviewed upwards to compensate. These are likely to be when a pet is sick and has to have unforeseen treatments that cannot be looked up in advance as a part of a comparison.
- B) Price comparison web based solutions will be satisfactory at comparing medicine prices and simple treatments. They will suffer the same difficulty as price transparency by transferring costs to other treatments. Medicine price comparison would push sales towards the LVG pharmacies (with superior buying power) promoting corporate dominance by the big few, at the expense of the smaller companies, and I believe will have the opposite of the aims of the CMA to promote supply diversity and quality of care. LVG share prices have lifted following this interim report with financial markets appearing to agree with this view.
- C) LVG referral centres have been created by investment in existing clinic buy-outs and large budget newly development sites. This investment has been accompanied by high cost inflation paid for in large part by the treatment of insured pets. Insured pets and the well off client are less price sensitive, enabling the companies to force profits with significant price rises. We now have newly established independent referral clinics providing lower cost treatment. This achieves some of the CMA aims without intervention. Internal referral within LVGs results in this downward pressure on prices being diminished.

- D) Requiring of FOP to provide prescriptions that can then be taken elsewhere or used within the same clinic adds a significant layer of bureaucracy and extends the time needed in the clinic to receive care. This increases costs of providing care. The argument that technology will make this a smooth process is very unlikely to be fulfilled at reasonable cost and is a fanciful dream. Online prescription supply has a much lower competition than other parts of the veterinary business and the dominance by few providers should not be amplified by CMA remedies trying to force small providers to hand market share to LVGs. Increasing opportunities of online pharmacies to compete will fail as newcomers to the market cannot obtain the high volume discounts the LVGs currently enjoy from suppliers.
- E) Providing OOHs care ourselves results in our clinic not being subject to the problem of contracts. Oohs care is normally more expensive at the specialized services than our locally provided service.
- Many of the proposed remedies will make the challenge of remaining profitable as an independent clinic much more difficult. Replying to this published report has been made really difficult by the sheer size of the report and number of questions expecting answers. Most independent practice owners will not be able to find the 3-4 days work to reply to a significant proportion of the 105 questions. Expect very few replies from this type of clinic. The large corporations seem to have had the majority of the say in the CMA remedies report it's compilation and will I believe provide many more replies and lobby more effectively than the independent sector can.
- F) Cremations are part of the process of a pet dying or being put to sleep. The total fee including cremation is what counts and the price should reflect the time and individual care at the time of the clients grief. Quality of these services is very difficult to measure and therefore value is also difficult to assess. The CMA report seems to simplify this to its detriment.
- G) Governance reform is needed to achieve the aims of the CMA in its investigation. The Governance needs to supervise the actions of businesses, not just the individual. This governance could be given the role of controlling excessive charges.
- H) Disciplinary procedures should be complimented by mediation and out of court remedies.
- I) Governance of veterinary nurses is also in need of change, as is a review of their in practice roles. I do not expect these changes to significantly achieve the aims of this enquiry to significantly impact on the price of services to customers. The rate of pay to an RVN is not significantly lower than a recently graduated vet.

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

The report implies that a price list and ability to compare will help the consumer choose the cheapest veterinary service for the customer's needs. The report has a list of services that could potentially be published and weight bands to assist comparison. Whilst an extensive list could be published, the providers will have to discount these prices and compensate with complimentary price increases in services not included. No pet owner can predict the next problem they may encounter with their pet, and the chances of the treatment being on the price list is quite low.

If 75% of treatments by frequency are discounted by 10% by competitive pressure as a result of being on the comparative list, other services would need to have price increases of 40% for a practice to maintain similar income. The likely treatments to be increased are the non-routine sick patient requiring investigation and urgent treatments. Potentially the veterinary care that is most important for the welfare and care of the household pet is going to become the least affordable. This is potentially a huge welfare concern created potentially by market distortion of a list which to be at all useable has to have severe limits to its complexity as compared with a theoretical full list that would be virtually impossible to compile and for the pet owner to use.

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.

Trials can be geographical or time limited. Geographical trials would be distorted by owners travelling in and out of the zone chosen to avoid or take advantage of the changes being trialled. Time limited trials would I suspect be required as I suspect that the remedies proposed will have adverse effects on provision and receipt of services.

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.

No price list can be comprehensive enough to predict the forthcoming costs a pet might require next. If it is implemented practices will have to discount some services and introduce complementary increases to maintain income. The total expense to the customer is likely to be unchanged, but the prices out-with the pricelist that offset competitive discounts will be detrimental to the welfare of pets when at most need of treatment and care.

Referral care is usually undertaken by specialist teams with a limited number of services and treatments. These are often already published as fixed price options. The

most expensive treatments are those not on the price lists requiring investigation that then requires care and treatment decisions as the pet is treated. This internal distortion of treatment pricing would be exacerbated by making price lists the reason for practice and hospital selection.

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.

The price list idea proposal is very limited compared with potential services that owners could be asked to pay for. Price lists have to be estimates as variability between patients and cases need allowances. No two diabetic care cases are the same, so predicting the cost of treatment for a defined period would limit the vet care to adapt for variations to the detriment of the welfare of the patient, for example.

The proposed price items are very different from how our price list is constructed, which potentially limits the choice of the provider to how to price items charged.

A comprehensive price list would be too complex to provide any viable information for the typical pet owner as most of the terms used are not interpretable by the lay customer.

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.

Weight ranges can be used to determine some costs. Age and pre-existing conditions can affect costs that cannot be conveyed on a published price list but need to be discussed with each individual owner

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.

I find it difficult to see how starting from prices or ranges can be helpful for comparisons that the CMA think might be a useful remedy. Average fees eventually charged would be a comparable figure but impossible to verify.

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.

I think that the lowest priced vets on a standardised price list may well end up charging the most when treatments not on the list are charged for. It could be very detrimental to clients and animal welfare.

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.

Price lists can be published. They will not predict unforeseen care requirements that may be complex. A surgical removal of a mass cannot be priced on a website, only by discussion after a clinical assessment. A price range on a website is of no value. I just worry that off price list charges will increase to a level where welfare of the sick pet is jeopardised.

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

In all my answers my concern that a published list cannot be effective or comprehensive and any price mitigation resulting will be offset by other price increases. The greater the lowering of published prices, the greater the potential for pricing distortion for the sick pet when predicted price list pricing does not apply.

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.

Our practice does not have a website. A website could be set up but it is a proportionately higher cost item for a small independent practice than a large or part of a group practice. Standardisation of a price list would in our circumstances be a competitive disadvantage as our prices are currently higher on shop window prices and lower for emergency and sick animal treatments than competitive practices. It would necessitate a distortion in our current pricing structure to the detriment of our relationship with our customers which currently has a google review rating of 4.9, higher than any other local practice. To be able to provide affordable treatment is very important to us and in trying to respond to excessive pricing this review jeopardises that. It seems to be a review that may produce the opposite effect of the intended

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

Quality has minimum standards that should be set by our governance. Bureaucratic quality evaluation would be unlikely to match owner perception and word of mouth recommendation which is the value test which as a small independent practice is the only marker that conveys reality of performance.

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.

A price comparison site I believe will massively favour businesses with bulk discount buying power and online resources to tailor the price structure to appear favourable to the public. Unfortunately the main reason for the CMA investigation is the unfavourable market conditions created by those same large businesses. One of the corporate companies has a current Facebook advert promoting the caring and professional side of their business. In response to this advert, as of May 2025, of 200 comments from the public regarding this company, there are only 2 that are supportive and complementary. Most are suggesting that the firm overcharges by this LVG. We as independent vets dislike the negative feeling towards any clinic, including the corporate run clinics. This creates ill feeling towards the profession as a whole, and distrust of the profession's ability to sensibly price, regardless of the actual value of the service provided. Any of the remedies that favour corporate dominance of the profession will create the negative repercussions of price distortion and CMA remedies will be ineffective.

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

Veterinary pricing is far too complex an issue to be simplified into the form of a comparison site useable by the public. Either it would be shop window pricing, leaving the public open to be drawn into a clinic for the best price, only to be overcharged for the services not easily displayed. It seems to me that it is not a tool that can be implemented and expect standards of veterinary care not to suffer. Services displayed will be delivered at the lowest cost to the provider, not at the care level that is best for the patient.

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?

I am not qualified to comment on the technical requirements needed to design and run a comparison website or decide how it would be best funded. I would not be happy paying a significant levy to fund a website that I think would be detrimental to my ability to compete in the veterinary market as a small provider.

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?

The proposed remedies are likely to require a website, not in place and regular updating of information. The posted price list option of the most frequently dispensed medication pricing as introduced after the last veterinary pricing review was a complete flop as the choice of medicines and pricing was completely ignored by the customers. The smaller the FOP the greater the burden and the less reward

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.

The greater the sub divisions of characteristics the fewer lines of treatment can be listed. Sub divisions are feasible, the added complexity could be very counterproductive without sophisticated and hence probably expensive software to present the data

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.

Most veterinary pricing is complex and often can't be determined until a clinical assessment. Grading of complexity e.g. mass type 1, mass type 2, mass type 3 for surgical removal, is subjective and cannot be comparative. Useless for client interpretation. Similarly ranges provide very little comparative information. Grade 1, 2 and 3 – Practice A always tends to charge grade 1 and is cheaper to the customer than Practice B who tends to always charge grade 3 and is more expensive. The comparison for the customer to choose is not relevant. Grading on complexity cannot work.

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.

The RCVS have very little chance of effective implementation as no one in the organisation has the i.t. skills manage a complex technology solution. Customers are unlikely to pay per use or subscribe. It somehow has to be an expense borne by veterinary practices, but with no control over the cost or the benefit.

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.

Our practice has no health plans. Our customers can purchase all the elements include at a lower cost than the competitor practices "discounted" schemes total up to over a given period. The promote over prescription of anti-parasitic medicines which are now building up as environmental contamination of rivers and now are detected in marine life. They should be banned from including prescription medicines on repeat supply. The large (and some small) FOP are reliant on them for client bonding and regular income.

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

Pet plans should be clearly published and easily amended or stopped. This remedy will do nothing towards the objectives set out for the CMA

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?

They should be in place already

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.

A good FOP should have a good knowledge of the qualities and costs of available referral services. Owners very rarely have that knowledge and are completely reliant on the FOP. There should be no other inducements for a particular referral centre to be advised. Estimates from the referral centre should be obtained as part of the referral process by the FOP and passed to the owner. Alternatively the client can ask the referral centre as an appointment is booked. Some cases are complex and pricing is by necessity done stage by stage. The suggested remedies are not particularly helpful.

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

They promote good practice and reduce internal referral within a business when a better choice may be available. The remedies should be controlled by good governance of the profession, and hopefully will not affect many referrals

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?

Apart from the discouragement of only allowing referrals within a group, the changes would not affect most current practice. If it is required to obtain information about more than one referral option the referral process will be longer and administrative costs to the client will inevitably increase. The client may opt for an option the FOP may regard as inferior in terms of expected quality of care.

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.

As a FOP we recommend referrals to several referral centres depending on the discipline involved. We try and refer to the most highly regarded specialist in the required field with the caveat of also wanting good value. We use peripatetic services which are definitely chosen by the FOP for quality and cost. We do not expect the client to have any knowledge of the supplier and trust the FOP in that choice. Prices of these services are fixed and available as estimates to the client as an alternative to transfer to a referral centre.

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.

Location, expertise available, estimates of cost, availability of appointments, facilities provided, techniques employed for treatment.

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.

Firstly there would be a need to define a treatment. Examination £50 medicine supply for 3 months at £100/ month = £350 treatment cost

Or Examination £50, medicine supply or prescription for 1 month = £150 treatment cost + 2 more £100 medicine supplies at a later date.

How much is the treatment cost?

Example 2

Surgical procedure £250 + £250 required as part of the treatment medicine supply = £500 treatment cost

Surgical procedure £250 + £20 prescription for £230 online medicine = £ 270 treatment cost + £230 additional required cost. Client spends £500 – no difference to client but different treatment costs.

We provide written estimates for cases admitted and verbal estimates for referral cases. We assume the referral centres will give written estimates on arrival to the client.

If we dispense an expensive medication and client finds it too expensive, we don't sell the medication. It does not need a written estimate even if the value is greater than and admitted surgical procedure that cannot be reversed if retrospectively the cost may be less. It is a different form of transaction and the client has less control.

This is all good normal daily practice.

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.

This idea has been devised by someone without a clue about client/ vet/ patient interaction. If an animal is in pain, it needs treated. If a client has travelled to a clinic, where possible the treatment is given at that visit. We have clients travelling 2 hours to an appointment. They don't want to be told they need a cooling off period, please fight with the M1 again twice, and then we can treat your pet after you have thought about it.

Some procedures do require thought before opting for them. Clients may need to sort finance, time for thinking, discussion with another party, or sometimes a second opinion. This is all part of good veterinary procedure , not as a regulation.

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.

There are many times when this should not apply. It is normal to make a decision whilst receiving advice from the consulting vet in FOP and referral clinic. The notion of this question is nonsense IMO.

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?

The idea is from someone who has not experienced veterinary care in a clinic, but read reports about banking transactions. Professional care with good governance is what is required

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?

Clinical discussion is prior to admission and consent should provide treatment options. These are recorded in clinical notes. Consent forms need to be clear and precise and not cluttered with information that could confuse.

This again is a proposal by someone with minimal or no clinical knowledge or experience of working in a veterinary clinic. It is another non-starter and would be very detrimental to everybody involved.

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?

This remedy protects no one and helps no one. The main detriment is that it involves a repeat of the clinical discussion when booking the appointment for the procedure, and detracts from the vital functions of the consent form of procedure information, risks to the patient of the procedure, contact information of the client, estimated cost and current health information of the patient. A discussion of options with the original consulting vet not present will lead to confusion and make errors more likely to the extreme detriment of the client and patient.

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.

No obvious challenges when the full extent of the procedures are known when consent is being given. Severe challenges for the patient being investigated or treated for variable illness where treatments are adapted during the course of treatment. Updates and treatment options with updated costs and estimated are usually given verbally as often as the case requires. Clinical notes need to record these discussions and ongoing consents and estimates.

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?

CPD is an ongoing requirement. Targets and reflection on an individual's needs is part of that requirement. This can include client interactions, communication and required recording if the vet feels this is the CPD needed in their development. Such CPD already exists and is available

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.

These options should not be mandatory either in numbers or in written form. Many discussions and choices are made remotely, often on the phone, so a written instruction may not be practicable.

The number of options available is often limited, and if available may be very similar procedure at a similar price, with minimal advantage to the client to be offered several options resulting in confusing advice.

It should be required as governance and good practice that a potentially substantially better option should not be kept from a client. Travelling a longer way to a more cost effective treatment may not be in the knowledge of the referring vet so is difficult to mandate.

Referral of patients is often an added task to a vet that may be fully booked with work. If the procedure is made more complicated by requiring more options to be investigated, the referral may then be delayed until that time can be found within the vets' schedule. This can be to the detriment of the patient delaying treatment and the welfare of the vet attempting to maintain a reasonable workload.

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.

Referral is often one of the options for further treatment and the options for treatment may include continued treatment within the FOP, peripatetic treatment, internal referral within a group of FOP clinics or referral to a specialist hospital (clinic). Regulation and governance should require the vet to offer the best options to be discussed with the client. The care route should not be pre-determined by FOP policy to the detriment of the patient. Internal referral within a group to a referral clinic may come with a pre-arranged discount to the advantage of the client so any regulation should be careful not to disadvantage the client. The RCVS should have a role in ensuring best practice.

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.

The RCVS has no role in governing practices and monitoring best practice. This leaves businesses free to behave in un-competitive ways that can be to the detriment of the client. The recent disciplinary case of a vet carrying out surgery well beyond their training and capability should result in sanction of the business, not just the vet herself. Similarly if a practice only refers cases to referral centres within the same financial group as FOP policy this could be to the detriment of the client. Governance should be in place to control this.

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.

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.

Currently it is only the vet that can be sanctioned by the RCVS. Many LVGs and now many smaller FOP are owned and operated by shareholders have limited veterinary oversight. Decisions and policies may within the business may be different from those in veterinary ownership, such as many of the smaller independent FOP. It is how the business actually operates, not how the policies may appear on paper that is experienced by the client. This currently has minimal governance and oversight.

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.

No country in the world, even those that don't allow on site medicine dispensing at a clinic, restrict the ability of a veterinary surgeon to administer medication that is required or is beneficially administered by the veterinary surgeon (or under their supervision). It is for legal advisers to frame any wording to frame to outcome of this investigation. It will not be an easy task.

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

Repeatedly the remedies refer to a prescription being offered to the client at the time of treatment. Not once does it mention the likely scenario of several prescriptions being required. If it is regarded that 2 prescriptions on average are required per consultation of an unwell pet, and could be as many as 6, the time taken is quoted as 10 minutes per prescription. Added to the 12 minutes average consulting time (our clinic 15 minutes) is between 20 and 60 minutes prescription administration time. The resulting cost to the FOP could be requiring 30 minutes per client of veterinary time, this hugely impacting on the cost to the consumer of veterinary care, as these costs have to be passed on for a clinic to remain trading. Once again remedies proposed are detrimental to the client in terms of veterinary costs, the opposite of the CMA's remit to control costs.

Online prescriptions are normally fulfilled by the LVG online pharmacies. For the independent FOP the remedies are a transfer of profits from small businesses to the

largest few businesses. The reason for the CMA needing to review the industry is mainly based on the perception of the public that larger groups LVG, are less invested in the care of individual clients and more profit orientated. The public comments seen regularly on social media support this view and the buyout of so many clinics has resulted in reduced standard of FOP care and increased costs. The proposed remedies will exacerbate that transition in the market by promoting LVG medicine sales at the expense of the small practice's turnover and profits. Only significant changes in pricing structure could offset that, to the detriment of the consumer.

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

Our practice only supply hard copy written prescriptions, and the original rules precluded the pharmacy from dispensing from copies. With electronic copies now allowed security of the prescription is limited. Only emails direct to the pharmacy can be regarded as secure, but delivery and payment still needs the responsibility of the client.

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

Control of the price of prescriptions is deliverable quickly. Mandating writing prescriptions for every dispensed medicine would require recruiting up to 25% more staff (vets and support staff) if available, and could take a number of years for the industry to adapt. PMS system adaptation could be implemented in a year in most circumstances.

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

A prescription should have all the information required for safe prescribing and security to not facilitate illegal supply. A comparison website providing lowest cost option favours the highest turnover buyers of medicines in the industry, the LVGs. Growth of this sector has resulted in the need for this review and is completely counterproductive for the consumer trying to obtain the best standard of care.

For a comparison site to be effective it would need to be funded. A percentage of the medicine price could be diverted. This is an additional cost equivalent to a booking fee when buying event tickets. Additional fees added to the purchase is detrimental to the customer and in a free market is likely to escalate over time as have event booking fees which now match the amount the CMA is likely to be thinking of as a maximum prescription fee. All to reduce the effectiveness of the CMAs proposals. Most veterinary prescriptions are short courses that are not subject to significant savings. Any administration costs imposed by the CMA will negate the savings in most cases. Longer

term therapy can be cheaper with online purchase and is already taken advantage of by most clients when the FOP has high mark-ups.

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

The FOP vet can provide information about medicine costs as supplied by the veterinary clinic and that further medication required will be assessed at each follow up appointment. The staff will then have to explain how a prescription fee works and how it affects medicine costs relative to the time period the medicine is required. The vet FOP cannot be expected to advise on other suppliers costs. Any error puts the FOP at risk of complaint and the medicine sales market information is too complex for a small clinic to be able to be accurate with. The customer must have responsibility for themselves in this area.

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

It is not realistic to expect prescription forms to be written at the time of consultation without incurring huge extra costs on the FOP. No veterinary customer wants to see consultation fees to be increased by a significant percentage as a result of the CMA review.

Our practice current consultation fee is £48 for 15 minutes. To deal with written prescriptions, comparison websites, other supplier prices, followed by the required dispensing, which for short courses of medication will be cheaper and loss of income from medicine sales would require a £96.00+ consultation fee for 30 minutes per patient.

Any failure of the internet, power supply, printing capability or PMS would render the practice incapable of fulfilling the remedy requirements. Any such failure currently sees us fall back on manual systems and we carry on tending to patients. Adding huge complexity to the sale of medicines by mandate adds to costs and reduces reliability of provision.

We currently charge £23 for providing a written prescription. This reasonably covers the 10 minutes veterinary time involved. A mandated maximum prescription fee may, or may not be reasonable depending on the selected amount.

A prescription supplied retrospectively will give the customer the opportunity to source from their chosen supplier and time to consult a comparison website. The animal will have delayed treatment whilst the medicine is obtained especially at weekends and holidays which could take 4-6 days even with costly next day delivery. . Animal welfare is then jeopardised as with many of the CMA suggestions

Refrigerated transport is even more expensive. Currently pharmacies dispatch temperature controlled medication in insulated packing and cold packs. Temperature is not monitored and contravenes the cold chain requirements expected by the manufacturer data sheet of a 6 degree Celsius window.

These remedies mainly pre-suppose the clinic can supply prescriptions at the time of an appointment, when now most clinics request 48 hours to process a prescription. If a client is waiting it pre-supposes that the clinic has room in the waiting area for clients waiting to be seen and those waiting for mandated information to be provided. Our aim at our clinic is to minimise the number of patients in the waiting room as conflict between animals and the anxiety of animals waiting is much increased by having too many in a limited space. Extending consultation time and costs on owners would be the only way to maintain the current service level. As a clinic we have a Google approval rating of 4.9 so the proposed remedies will potentially either disrupt a level of service that if replicated across the industry would negate the need for this CMA enquiry or increase costs to the client. LVG generally have lower approval ratings and would be less affected.

Any failure of the internet, power supply, printing capability or PMS would render the practice incapable of fulfilling the remedy requirements. Any such failure currently sees us fall back on manual systems and we carry on tending to patients.

The requirements will require a client with access to technology. It will require the vet to incrementally supply prescriptions as a case is reviewed. Increase in consultation fees inevitably required to comply with the suggested remedies can be multiple if the patient needs ongoing care. This reduces any saving the CMA might envisage, disadvantaging the customer.

We are a rural practice with customers regularly travelling for between 30 minutes and 90 minutes to attend. Returning for prescriptions between appointments is not going to be favoured by many clients. A significant proportion do not have access to a smart phone or internet. The local library for such clients has limited opening times and is 30 minutes brisk walk away.

QR codes are inherently insecure and are currently being used by criminals to access customer devices as a route to adding malware. The technology will be out dated very soon as the risks for those who provide QR codes is significant. Owners of devices are now being advised by some computer security experts not to use QR codes to gain information in case the code has been doctored. I would be very reluctant to advise or implement the use of QR code in my clinic as I am not in apposition to mitigate potential risk to my clients. The CMA should be exceedingly careful pushing the profession into a dangerous area. Please consult industry experts before going down this route.

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

The CMA is proposing adding huge complexity to an area that has evolved to protect the safety of medicine supply and reward manufacturers for developing novel therapeutics to the benefit of the patient. Clients are often using a medicine obtainable at their FOP either on prescription or by direct purchase. The prescription supplied by the FOP often is a matched product such that if the internet supplied medication runs out the FOP can fulfil the prescription. If the pharmacy substitutes for an alternative product it is normally as a result of availability problems rather than price. The CMA proposals are muddled, complex and of little benefit to the consumer.

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.

If medicines with no product differences had a medicine code to allow a pharmacy to substitute with no risk when substitution occurs i.e. same ingredients, formulation and efficacy, that code could be used in addition to the medicine trade name and price could then allow a change of medicine used. The VMD would need to implement a system. Allergies and exclusion diets often preclude the change of product. The pharmacy has no clinical details to allow safe substitution with many medications.

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

Differences in formulations is a problem. The reasons for substitutions of product may not be clear to the client or author of the prescription. It could be prejudiced by deals between pharmacies and the supplier of which no one has any control of. As the number of online pharmacies is so small and all controlled by LVGs formulations and options could easily be forced out of the market resulting in competition deficits and price increases as a result.

The proposals add complexity with no discernible reward to any part of the industry or customer

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.

The main challenge to FOP dispensing in the current market has been availability of supply. The maximum number of suppliers and products must be supported. Any change to the way the market operated will have the potential to make the supply chain

less predictable and affect the customer worse potentially than is currently the case. This would affect the welfare of the patient.

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

Any area of the market that has had supply issues in the last 10 years that might be adversely affected by the proposed remedies. This includes antibiotics, heart medications, anti-inflammatory products, vaccines, diuretics, anti-seizure drugs, diabetic products, lateral flow tests and others.

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

Licensing medicines that are identical could have a medicine code that identifies that to allow substitution from a prescription. The vet cannot be expected to know the technical variances distinguishing products beyond the active ingredients.

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?

That would need to be for the licencing authorities to decide. Lowest common denominator pricing of medicines with such dominance of the few LVG in the market risks loss of choice for the consumer. Down the line that would be followed by uncontrolled price increases through lack of competition.

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.

A FOP is going to e-prescribe the product normally stocked such that the customer can purchase directly from the FOP if needed. Supply of regular medication through online pharmacies is often interrupted by failure of ordering on time, failure of delivery or manufacturer shortage. The FOP needs a regular stock to be able to fulfil the sometimes urgent need. Licencing would be needed to identify which products have the same ingredients and characteristics.

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.

Customers should be expected to pay the cost of any service received which includes the time spent on administration and certification of medicine prescription. Any high cost item deters the purchase across all retail and commercial activities. Prescription costs can reasonably be restricted if excessive. This is currently done by market forces

as costs of £10 to £30 is in line with costs of secure certified documentation in all industries such as banking. It is part of the owner choice when selecting a supplier of services.

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

Undercharging for one service will have the effect of additional charges being moved to other services for maintenance of the health of a business. The CMA are not given the remit of lowering profitability and impair the ability of clinics to provide good veterinary care. The CMA does not seem to understand the real cost of prescribing

Our current understanding is that the writing of a prescription – versus dispensing a medicine within a FOP – is unlikely to reflect a materially higher cost for a FOP in a well-functioning market (including a market where investments had made the process at least as efficient as dispensing).

This statement is in my opinion patently wrong. The remedy proposes a procedure to

- 1) write a prescription (which with i.t. investment and subscription to a i.t. publishing platform such as docusign or adobe could be automated following input of medicine, dose and duration of treatment),
- 2) pricing as a FOP supply (=dispensing without a sale),
- 3) Online pricing,
- 4) owner vet discussion as to the merits of each,
- 5) discussion of when an online purchase is needed or could be reasonably expected to allow commencement of treatment,
- 6) awaiting a decision by the owner,
- 7) dispensing the medicine or signing the prescription,
- 8) attaching the signed copy to medicine records,
- 9) printing or emailing to the chosen supplier,
- 10) verifying receipt of the email,
- 11) Recording clinical notes of the discussion and process such that it can be verified correct procedure is followed.
- 12) This may need repeated for however many medicines require dispensed.

Taking payment, making clinical notes on the consultation and arranging follow up care are then done as previously. This is to be completed prior to the next customer being seen and is in my opinion adding 10 minutes to the duration of the appointment + administration time + space requirements in the waiting room for clients waiting for the completion of administration

This cannot be done without material cost and a substantial staff time input. !!!!!

YOU MUST RECONSIDER THE ABOVE OPINION AS IT IS OBVIOUSLY WRONG AND COULD WREAK HAVOC IF IMPLEMENTED.

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?

Our current fee which is equivalent to 10 minutes of veterinary time does not prevent fair competition in the market. It is mainly used for regular prescriptions on dearer medicines. Most written prescriptions are supplied by the LVG online pharmacies. The shift to online pharmacy provision of more medicines would be anti-competitive because that income directly supports LVG FOP with whom independent FOPs are in competition with. Pharmacy sales in LVG FOP are notoriously inflated and the highest in the industry as the alternative for the client is to buy the medicine online so the LVG retain the sale (or have a 25% likelihood of doing so, shared with the other LVGs).

The CMA proposals facilitate more of the sales of medicines to stay within the LVG's income and is anti-competitive. Totally against the original remit.

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

The costs are as they have always been. We charge for about 10 minutes of veterinary administration time.

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)?

The costs are much less than a written prescription as it involves storage of medicines, counting and packing the medicine, giving directions on their use and applying a label. Most of this is done by a support staff member allowing the vet to write clinical notes and prepare for the next customer. We charge a dispensing fee 1/3 of our written prescription fee, unless whole packs are dispensed and in which case we do not charge a dispensing fee for applying a label and giving use instructions. The medicine mark-up is deemed to cover that expense in our clinic. Some FOP have a labelling fee for this.

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.

Medicine prices have risen in line with purchasing costs. A price cap on FOP sale price does not prevent wholesale price rises which has recently driven the increased costs the CMA are investigating. The veterinary pharmaceutical industry is suffering badly in recent years and the supply has been intermittent with many products withdrawn due to lack of viability. There is no mention in your report of the lifting of mark-up by FOP. After

18 months of survey to offer no method of proposed price control or regulation suggests the CMA has no clue how it would implement any of these ideas which makes it very difficult to advise and comment.

Independent practices do not have the buying power on the LVGs. We minimise purchase costs by buying group membership. This helps the Independent FOP compete with the LVG but their margins are much more favourable. They give little care to the price they sell in the FOP because any sales fulfilled by prescription the LVG pharmacies will fulfil maintain the advantage over independent and smaller group clinics. This is not addressed or recognised in your report.

The CMA needs to take a proper look at the market they have been investigating with open eyes. Apparent hoodwinking is taking place by the larger entities in the market resulting in some nonsensical and impossible to implement proposals.

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.

The CMA needs to look at which FOP types are charging excessive prices. Are they high such that a practice membership scheme membership brings them down again. Are they high in LVG practices that can divert customers to their own online supplier. Are they high in practices that have high insured pet levels in order that higher costs are met by insurance premiums.

Any price reduction in medicines will result in higher fees for other veterinary services. Market manipulation may be to the detriment of the customer. The tighter the squeeze on one part of practice income the more severe effects will be seen elsewhere.

Price increases limited to the rate of purchase costs could result in minimal price distortion.

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.

The previous CC report tried to control the top 12 most frequently prescribed medicines. The policy completely failed to achieve any of the objectives. The list published in the waiting area for clients to compare prices was in general ignored by customers.

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

Each practice can upload a current price list for subsequent review. Who reviews the data is for CMA provide suggestions and possible funding. Practice governance is currently absent from legislation.

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 assume that the CMA has taken some advice on the feasibility of these ideas and have an idea of estimated set up costs.

My main concern is the dominance of the buying power of the LVG to undercut all potential competition. This would supercharge their resources to out compete with practices in terms of investment and practice buy-outs. In terms of long term competition in the veterinary sector this could be more disastrous than the reputation marring of the veterinary profession that these firms have achieved in the last 20 years. Look at the current Facebook advert posted by [REDACTED] and read the 200+ comments by members of the public. There is a 1.0% favourable endorsement rate in comments from the public to this post which is absolutely shocking. The CMA is proposing to favour these businesses in their proposals. Yes pricing is the most frequent complaint recorded, but if the care provided is good, customers do not complain about price normally.

Comparison websites and a huge push to online sales risks much worse to come in terms of veterinary care and huge shifts in the price of veterinary treatments at clinics. This is likely to be regretted hugely in the future by veterinary clinic customer.

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.

I fear it has to be supervised by our governance body which is subject to change as it is poorly designed and is to be updated. The RCVS is poorly equipped to manage such a project. The 4 main online pharmacies are likely to get 95% of sales if price is the only factor being considered, and the CMA could admit this at this stage, and expect them to fund it.

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.

We do our own out of hours work. Occasionally we have cases we would like to refer to clinics with more facilities and expertise and exclusive deals often preclude accepting patients from clinics that are not signed up with a contract. This maybe to the detriment of the customer, even if “non-members” had a higher fee to pay.

Contracts need to be long enough to support the staffing and expenses incurred to look after the contracted clinic. If a clinic only refers a small percentage of an OOHs clinic's work, there is minimal financial risk for the provider if short termination was required

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.

This seems to have very little relevance to the CMA's original remit. I also have minimal knowledge of the subject so will refrain to comment

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.

Communal cremation was once the expected norm for pet disposal, and previous to that (1980's) council disposal in landfill was commonplace. Customers have become more discerning and are requesting more individual cremations and additional services such as paw prints and retained hair for jewellery. Now we do more individual cremations than communal cremations. The difference in cost and communication type is well explained in all our consultations relating to passing of pets. Customers often request small local crematoria as the large national firms have received negative publicity. We therefore provide different services, such as home visit euthanasia at different prices that the LVGs do not offer. This is one bespoke feature of the small independent practice that much of the CMA proposals will potentially undermine

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?

I cannot think of a sub set of FOPs that would need to be exempt if controls were deemed appropriate. It is the use of different types of crematoria which should not be restricted by CMA imposed controls as again it is the LVGs that dominate the cremation market.

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.

We as a practice use a local crematorium providing bespoke care, we transport the animal to there on the day of death and have the ashes returned in 72 hours. It would be a real shame if price controls by CMA would restrict our ability to care more carefully than most for our deceased patients.

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

That pre-supposes price control is needed. Our clients can take their own pets to a council owned pet crematorium 2 miles from the practice with displayed prices. This is sufficient competition to satisfy local competition in my opinion. All pet crematoria that I know of offer similar service. The convenience of not handling the deceased pet is what the client is paying for.

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.

If the CMA introduce controls it is for that body to review and revise. If it cannot do that the controls should not be in place.

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.

I believe that regulation review is required and would address many of the concerns that the CMA remit covers. Businesses should be regulated and minimum standards set and monitored.

The presumption that a mediating body is unknown to the average veterinary client should not be a concern as most mediation services and complaint forums across society are only discovered to solve problems experienced by consumers. Any organisations should have well flagged procedures in place that can be easily discovered from online searching or contacting the relevant overseeing bodies such as the RCVS. An ombudsman of final resort and provider of direction information for the troubled consumer would be a useful compliment to the RCVS which is currently often seen as the defender of its members rather than an auditor

I am not a believer that market interventions as suggested throughout the remedy options above in this report will benefit the consumer or achieve their aims. Pricing in a veterinary clinic is hugely complicated and comparisons on shop window targeted pricing have in the case of LVG and similar large practices have an area of the price list that entices the client, to be relatively overcharged for other services. Vets4Pets introduced vaccine for life, Many have below cost neutering, discounts on Health Plans and recently introduced is the Animal Trust free consultation. All these organisations attract the client for the good value offered but have other ways of recouping profits, such as the £23 injection fee at one of these organisations. 3 injections at a consultation wipes out the apparent cheap offering that drew the client to register.

The CMA proposals of price transparency will either be too complex to be useful for the consumer or will have holes in the system that can be exploited to recoup revenues and leave the consumer no better off. Treating veterinary like a plumbing business broken

down into site visit, labour and parts which a comparison website could cope with stands little chance of being useful in veterinary

In my opinion an audit of a price list as part of a practice standards inspection looking for unreasonable fees, and with the auditor having guidelines to work with would be a much better approach. If excessive injection fees are noted in favour of a special offer inducement, that can be addressed as part of the audit. The excessive charge can be reduced and then the practice can decide whether to persist with special offer or not.

Getting rid of the excessive charging should be the CMA aim. The current proposals fail to do that and will likely make the situation worse. Better governance is the key to the desired improvements.

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.

Core standards are straightforward to demonstrate or otherwise. Quality above these standards is very subjective and more prone to proving that something is done by bureaucratic recording rather than showing favourable clinical outcomes and client satisfaction with the service provided. It should still be attempted but with limitations noted.

Additional services and qualifications are recordable and can be published.

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.

The PSS could be a vehicle for practice improvement but without expectations that it will be very useful when selecting service providers. Word of mouth and online reviews are much more powerful tools.

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.

It would need to be mandatory and published information would need to be accurate and verifiable.

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

Consumer satisfaction surveys carried out independently of the service provider would be a good measure of the level of service.

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.

One would hope that a mandatory government body might have a better clue as how to effectively monitor and regulate that the CMA does. The CMA believes in market intervention and distortion, without regard for “the equal and opposite” reactions usually found in complex systems. A governing body can guide, regulate and enforce. A much better method for the consumer

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

There should be encouragement and requirement of good clinical practice, good communication and presentation of options in treatment types and pricing. Excessive hidden pricing should be prevented. The online pharmacies should be separated financially from the LVG to encourage LVG FOPs to charge reasonable medicine prices at their clinics or loose custom to separate organisations. This would excerpt downward pressure on medicine prices.

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

The monitoring is unlikely to detect problems the customer may notice in a typical clinic. It may discover practices falling well below standards as most will be able to prepare and meet standards on the day of inspection

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

By changing gradually from the current minimalistic plus voluntary approach to extend organically to a more encompassing system

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

The benefit would be to promote a better standard of management across all providers. The costs may increase considerably of the schemes chosen. The burden will be bureaucratic proof of what is done rather than actually to be seen to be doing it

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

All costs are ultimately paid by the consumer in increased fees

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.

Regulatory inspections should in the main be supportive to the practice visited with increasing scrutiny and exertion of powers related to the severity and persistence of the misdemeanour. Inspections cost time and effort on the part of the inspected practice. A fee is charged for the inspection. Therefore an issue that requires remedy and re-inspection is effectively a fine.

Regulatory bodies should be able to prevent the right of operation in extreme situations, that involve severe legal breaches, bringing the profession into disrepute and provide care that is deemed unsafe for the recipient of care. A range of sanctions should be available.

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 danger of a regulator being able to continually redraw the guidelines it has to impose itself and gradually making the guidelines more onerous in order to justify its own inspections and existence, as has happened with RSPCA and Red Tractor inspections of participating farms. The inspected practice should know and understand the criteria of inspection and be able to maintain that standard as a minimum.

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

Whilst as a business owner I am fortunate not to have had to deal with many complaints, I would be happy to have minimum standards to achieve when responding to complaints. This could be monitored at regulatory inspections.

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

A person in the practice to deal with complaints, a requirement for adequate investigation and recording, a time frame to operate within. Information on other routes of redress if not resolved at practice level.

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

A reasonable and well-designed mediation process could be the right of a consumer to have access to. The decision would require some form of appeal process for both parties, but hopefully would normally be abided by, especially if indemnity insurers who may be acting on behalf of the vet or vet practice would normally accept the decisions taken.

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 process where each party may invite the other party to mediation. A fixed period of evidence submission, maybe initially a synopsis for the mediator to advance or reject at the initial stage. Written submissions follow and then an adjudication, with or without a face to face hearing. Appeals may follow to an ombudsman or body with power to review.

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

By having a limit on the powers of redress in terms of financial award and sanctions on the clinic involved. More serious redress should be either by RCVS disciplinary hearing or the courts.

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

There should be absolutely no need for clients in harmony with their service provider to know how redress can be sought. The practice and RCVS should have the duty to provide information both regularly on published information, website etc. and detailed information on request.

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?

The veterinary business can record the frequency of complaint and the action taken to resolve. Minor complaints immediately resolved should be exempt. Governance when implemented can review this information.

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

The customer can feel a process has been fairly adjudicated upon, rather than be seen as the profession protecting their own members.

The redress sought is often exceedingly inflated relative to the value of the animal concerned. This is often encouraged by no-win-no-fee legal representation. The process must have limits to the value of a claim accepted through the process which may vary with different animal types. The process should not cause the loss of ability of the vet or company to trade. Again sanctions would have limits unless referred to other methods of resolution with a higher level of evidence requirements, judicial review and representation by the parties.

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

I have no knowledge of the current system and defer to others

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

Some complaints may exceed the limits set on the system, so some element of voluntary use would be needed IMO. If requested by the complainant the practice may need to comply with at least the preliminary stages.

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

Increased cost. May be a secondary system of oversight if built on existing structures

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

By observing other industries and using established ideas

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

It would need to be statutory to be effective, with redress to judicial process if not accepted by either party

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?

RCVS gives guidance on the interpretation of their regulations. They can continue to do this with further clarification

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?

I have seen the role of the veterinary nurse develop and clinics now try to maximise their use to support and take work away from the frontline vet and improve efficiency. The staff shortages experienced of vets (and RVN nurses) has seen some clinics maximise the role of the RVN in delivering services. The CMA should not expect much additional cost savings for customers from these suggested remedies

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?

The danger is expanding the role of the RVN without enough training to match the vet's knowledge and skill in doing these tasks currently. We hope any changes do not reduce the quality of care

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

I think any reasonable changes introduced by the CMA will be mainly achieved effectively by regulatory control rather than attempting to manipulate prices and methods of prescription. Businesses would have to fund reasonable fees associated

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

By building on the framework already present and adapting to achieve the desired changes

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

The benefits of reform are measured in terms of customer satisfaction of the services provided by veterinary practices. The CMA must have had a level of satisfaction and dissatisfaction that triggered the current investigation. Without this benchmark there is no way of determining improvements achieved. We have to assume that the investigation started with measurement of the concern factors otherwise the investigation can be regarded as useless.

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 funding of regulation is going to come from practices. Some measure of practice size and type should determine how much is paid. This could be in terms of FTE vets employed, turnover declared, per premises or other method of measurement.

Complaint handling should be per complaint at each level the complaint is taken to. The complainant should have some payment required to prevent the procedure being a "shot to nothing" and bogus complaints and maybe rejected complaints should have financial repercussions. Refunds may be given to upheld complaints.

Neil Fraser BVMS MRCVS on behalf of BRIAR VETS LTD 15/05/25