

In this response, I have cited the parts of the report to which a response appears to me to be indicated and explained why I am in agreement or not with what has been proposed including commentary on the frequently inaccurate and in complete nature of the evidence on which the CMA recommendations have been based.

These responses are from the whole of the document which was made available for review.

We invited the main parties to comment on our working paper on our econometrics analysis of pricing and treatment data from two large insurance companies.²⁴ This paper analysed millions of insurance claims to explore trends in pricing and differences between veterinary businesses. Due to the confidential nature of the data we shared the paper in stages with the main parties. We disclosed the working paper and underlying data by way of a confidentiality ring to the external advisers of the LVGs and a version of the working paper with the LVGs. We later shared a version of the working paper with the non-LVG main parties

This is not the case. We a large independent practice did not receive any chance to challenge what was done at an early stage.

The BSAVA and the BVA do not represent our interests. Their representation is composed of corporate and independent veterinary surgeons. It is not a voice for the smaller independent practices and yet the CMA has given excessive credence to their views and has additionally favoured the LVG Corporates, who are the cause of this issue in their information trail and in their access to findings, having given these a preview of the findings before their release to the profession.

In addition, there was a 4 week window for consultation in practice which clearly demonstrates that the CMA did not, and does not, understand how veterinary practice works.

I saw the previous consultation document but during that period did a weekend of emergency call and worked 90 additional hours over and above my usual 40m hour working week (I am the boss, so employment law does not apply). Unsurprisingly, I did not get to compose my response on time. A far longer consultations window should have been allowed to permit those working without HR departments to respond. This was fundamentally unfair to those of us which are independent and are here to make animals better not to make profits for venture capitalists.

We invited the main parties to comment on our working paper on profitability and financial analysis of veterinary businesses (LVGs and independent vets). We disclosed the underlying data by way of a confidentiality ring to the external advisers of the LVGs.

This is yet more evidence that this inquiry left out the 40% of veterinary practices which are independents and favoured the views of the LVGs to an extent which has led them to findings which are LVG orientated.

This is especially clear in their decision to make us write prescriptions for long term drugs. The LVGs own the online pharmacies so they are very happy with this outcome.

Our practice charges internet markups for drugs to enable the clients to afford them from here. This means that they get to chat about their pet to RVNs and vets whenever they collect prescription, we get to ensure the treatments are being used properly and to address issues early rather than at a six month re-examination to issue a further prescription. These recommendations are very bad for animal welfare never mind for client communication and on-going care.

We later shared a version of the working paper with the nonLVG main parties and the independent veterinary businesses

Yet again CMA did not bother to consult the people who are the caring end of the profession. Conclusions drawn after conversations with political organisations such as BVA and LVGs are not valid for the profession as a whole. Independent practices are at least 40% of the market, and possibly as many as 51%, depending on whose figures you choose to believe.

We are a large practice in the North of England. Our input was never solicited.

How was the sample of practices which were asked to comment chosen?

I think we should examine that selection process closely that before this goes any further as this appears to have been a poorly-constructed and biased report from the very start.

Consultation was with:

Roundtables with different stakeholders including vets and vet nurses (working at a range of different practices); recently graduated vets and current vet students; consumer representatives; senior staff at the UK's vet schools; and chief veterinary officers at animal charities.

Discussions with our veterinary advisory panel.

How were these stake holders?

How was the advisory panel constituted?

This has the air of CMA choosing who to speak to in order to get the response it wanted, i.e. a stitch up which does not represent the independent end of the sector as this was set up to punish the LVGs but will actually harm the independent sector more.

Why was the sample limited to one branch independent practices?

They are the less successful end of the independent market. It would have been far better to speak to the successful independents and attempt to mimic the way in which they advise what is necessary and manipulate pricing to fall within what the local conditions can afford to provide the most treatment they can to local people.

If it was:

A series of roundtable conversations with members of the veterinary profession (including students and recently graduated vets),

New graduates and students have not the slightest idea about practice economics so why prefer their testimony to the people who actually do know how to run an independent practice? CMA bias well to the fore again.

In February and March 2025, we held hearings with each of the six LVGs, the RCVS, and the BVA, the BVNA, the BSAVA and the FIVP jointly, to discuss the issues we had set out in the February Working Papers. We published nonconfidential summaries of the hearings on our case page

Of these only the FIVP has any role in representing the independent sector of the profession.

RCVS has a long history of close association with the LVGs. This is evidenced even in the videos presented by RCVS Education of Vet GDP advisers at work. Not an independent among them and some [REDACTED]

BVA and BSAVA area mixture of the two groups, of which LVGs are the more cohesive and organised.

A failure by CMA to understand who they were talking to and whom owned what out with the veterinary practices (e.g. the commercial interest of the LVGs in getting on line prescriptions favoured over in practice supply)

This was certainly not an unbiased discussion of the industry as a whole whether intentionally or not. I feel that this represents laziness on the part of whoever at the CMA decided how to run this inquiry as it is much easier to speak to LVGs rather than to the independent part of the profession, which is still a significant service provider in its entirety.

This absence of good practice should be addressed forthwith before any further recommendations are made or the current proposals are enforced.

Context:

There is an obvious error in this section:

Some FOPs provide OOH services themselves, but most outsource to a specialist OOH provider. In principle, pet owners could choose to seek out and compare alternatives to their FOP-appointed provider, though the ability to do this may be restricted if there is an urgent need for care. In our pet owners survey, 15% of participants said they had used emergency OOH services in the last two years. 56 Of those that needed OOH services, 48%

went to their usual practice, which also offers OOH services, and 48% went to a different practice.

If only 'some' FOPs provide out of hours services, why was the split even between those clients who consulted their own vet OOH and those who could not. Basic maths would indicate that one or other statistic is in error.

Prices of vet services, and overall vet bills for pet owners have increased significantly in recent years, and increased much faster than general services inflation.

The CMA should really have investigated the forces which are driving this rise. Increased price does not necessarily equal profiteering. The UK does not produce enough vets and those it does produce, partly due to the actions of RCVS, do not all remain in the profession.

To import a vet from overseas to fill a vacancy is very expensive (by the time the practice has paid their costs and the Certificate of Sponsorship costs and provided the support and training which they need to survive in the UK environment, this is easily greater than £5,000 per vet but we do this repeatedly as there are no UK graduates available to hire.

The government has recently made the situation worse and will drive a vicious spiral of wage inflation as we now have to pay non UK vets over £40,000 simply to come here when the going rate for the job is far less than that. The salary for vets over the age of 26 (laughably referred to as 'experienced') is over £50,000. This is less than I take out of the practice in salary for a year and I own the place! If we have to pay this prices will inevitably rise as we do not make enough over costs to pay these salaries without passing costs on to the consumers. This is not profiteering. It is government stupidity.

CMA also has no concept of the effect of NI rises on the independent end of the profession. Our NI contributions went up by £175,000 per year as a result of the budget. Do you want an independent sector who is here to treat animals not make money, or not?

Had the CMA really wanted to understand the price increase they should have had a proper look at independent practice costs . I would happily have provided our accounts.

LVGs specialise in high throughput, low levels veterinary care FOPs and then refer to their own referral centres for more complex treatment, thus profiting from the same group of clients twice, and RCVS was supporting this view at the time the CMA spoke with them.

They are also profiting again when a client requests a prescription.

(RCVS are currently having a bit of a rethink regarding the level of veterinary care which should be available locally and how they might recognise the skills available in independent practice but, at the time, they simply wanted the profession to split into FOPs doing a standard of veterinary practice, which I, personally, as a veterinary professional cannot recognise or condone and do not seek to replicate, and referral centres which are often more expensive than the local clientele can afford).

If CMA wanted to understand practice economics, perhaps it should have spoken to those of us who practice at a high level. There are many practices providing complex long term care who wish to continue to do so and to monitor the medications their patients are taking in order for them to have long, happy and affordable lives. These practices have high fixed costs due to equipment maintenance and purchase and the training vets need to be able to help more pets more effectively. We have also not had the same increase in prices that the LVGs have imposed and have far higher fixed costs due to the absence of economies of scale.

The difference in level of veterinary practice which LVGs aim for compared to we, the more highly functioning independent sector, is visible in the CPD (Continuing Professional Development) costs and policies of the LVGs

e.g. [REDACTED]

e.g. Our independent practice Abbey Veterinary Centre: 5 days paid leave for all and 10 days if a vet studies for an advanced certificate, no budget limit as this discriminates against surgical training which is always more expensive than medical teaching due to group size and equipment costs)

The RCVS requirement is 5 days and a single surgical day course costs about the whole budget.

Training costs are then not reflected in cost to owners e.g. [REDACTED] versus this practice: £5,000.

I appreciate £5,000 is a lot of money but CMA should not attribute all costs to profiteering.

A closer examination behind the drivers of price increases would be needed to make this report a fair reflection of the veterinary industry and a proper consideration of the independent sector would be the first step in this process. Highly skilled multi-disciplinary teams working in independent FOP and referral sites have been completely ignored in this investigation.

In the last 10 to 15 years, it has become increasingly common for veterinary businesses to be owned, controlled and/or managed by non-vets.105 Prior to this veterinary businesses were typically owned and controlled by veterinary professionals.

Far greater consideration should have been given to this statement. It sums up in a phrase the reason for the advancing profit taking by the LVGs. [REDACTED]

[REDACTED] They are not controlled by RCVS even were the structures at RCVS capable of effectively exerting control.

A return to all practices having to be owned by a veterinary surgeon who worked in that practice as their primary role as it was before the rise of the LVGs would vastly reduce the current issue and also improve client confidence and animal welfare, but it is now probably impossible to achieve.

I would welcome legislation which required all future practices to be owned by a principal veterinary surgeon who took responsibility for the behaviour, administration and pricing policy at their site(s) and no more founding of random low value FOPs by LVGs. We might then get back to a veterinary market focussed on curing sick animals rather than making money.

The RCVS has told us that it operates a 'reactive, complaints-based system of investigation'160 under which its enforcement activities are driven by the complaints made to it by members of the public and the profession. However, it has limited powers of investigation. It cannot, for example, enter and inspect premises

Accordingly, save in the most exceptional cases, the RCVS would appear unable or unlikely to take enforcement action against vets who breach the Code's provisions on consumer protection or fail to follow the related Guidance

These statements in no way represent reality.

RCVS pursues minor misdemeanours relentlessly

The assumption that it is unlikely to take action is very far from the case. An assumption that RCVS cannot take appropriately targeted action would be far nearer reality.

Should RCVS pursue a worthy target, it takes more than 2 years for many cases to arrive at the Disciplinary Committee and there is neither compassion nor common sense in the system at any point. This is a major cause for despair amongst my younger colleagues and a significant cause of loss of younger veterinary surgeons to the profession. RCVS is not fit to perform its current role and certainly unfit to take on any further regulatory duties.

Neither can this organisation effectively run and update the Find a Vet site as it is. There is massive lack of up to date information so imagining that they can publish prices which are accurate is beyond optimistic.

In addition, getting RCVS to approve pharmacies which by the CMA's own admission in the report are largely LVG owned is just a way of LVGs profiting from their own clients and from the clients of the independents, whose drug cost negotiating powers are less than their own as economies of scale invariably apply.

As far the **limited sanctions** referred to, there is obviously a lack of understanding as to what this means. The sanction of '**removing professional registration**' means that the vet whose name is removed cannot legally practice veterinary medicine in the UK until their name is restored which can only be after a restoration hearing at which they have to convince the Committee of their reformed nature, their insight into the original transgression and that they have done sufficient Continuing Professional Development during the time in which they have been unable to practice to justify being considered competent to return to the register of UK veterinary surgeons.

If members of the CMA could be removed from their jobs and prevented from taking up a similar role anywhere in the UK when they produce biased and inadequate reports, perhaps that would enable them to better understand that this is a far from limited sanction.

The RCVS has sought to partially fill this regulatory gap with the PSS

PSS is not a useful regulatory arm of RCVS. Its membership is voluntary. Its standards are very much at the whim of whoever happens to be on the steering Committee and do not adhere closely to regulatory requirements. It is possible to practice to a very high standard out with the PSS and to a very low standard within the PSS. The general public appear oblivious to its existence.

We have evidence that veterinary businesses may see trends in pet humanisation as an opportunity to sell services including non-veterinary pet products. For example, in an LVG [%] document, humanisation was described as an opportunity in relation to secondary revenue opportunities, supplements, and nutrition.¹⁹¹ Another LVG [%] management presentation identified humanisation of pets as a driver of number of vet visits.

Yet again only the LVGs have been consulted on this important point. To give you an example of how independents differ, we have no sales targets; no veterinary surgeon is paid based on the work they do or the procedures they propose; investigations are there to confirm a clinical suspicion not just because the vet always proposes them for an animal of a certain age.

We adjust treatment regimes and medication courses to suit animal preference (some cats are a nightmare to give oral medication to) and to client finances although we are impeded in this by the cascade system which prevents us from prescribing cheaper alternatives e.g. Summit's Trilostane liquid rather than Dechra's Vetoryl capsules, because the government demands, and the VMD/ RCVS enforce, that we always choose the product with the Medicines Act license rather than what the client can afford.

In this study of veterinary price increases, I cannot see anywhere where the deleterious effect of the government stance on where we can buy our medications and what medications we can legally propose has been considered.

The CMA should really have done a better job in considering all aspects of its remit instead of just assuming that veterinary price increases equate to veterinary profiteering. Some of

the LVGs are only there to make money, but this is far from universal among the independent sector.

pet owners can only access prescription medicines for their pet after a vet has made a diagnosis and prescribed treatment and medicine. Vets are a clinical gateway to accessing medicines from other suppliers but are also a commercial seller of medicines.

This is depicted as a bad thing. In fact, it takes a veterinary degree to diagnose and treat animals (despite whatever the internet may be promoting this week).

The vets play a valuable role as gatekeepers for example in preventing antibiotic abuse as can be seen when you consider the situation in the UK compared to other places e.g. South America where anyone can buy what they feel their pet needs and give it however they wish, resulting in rampant multi drug resistance.

What is needed is a regulatory system which, as well as protecting the welfare of animals and public health, governs the conduct of veterinary professionals, and (if necessary) the businesses in which they work,

LVGs need reminding that they cannot have targets for clinical work e.g. treatment of skin (shampoos) or dental disease. This action alone would reduce the number of ineffective procedures and treatment given,. There should be a requirement for all veterinary surgeons when proposing referral to state clearly that other more cost effective options may be available if the client would like to look on line thus preventing the current closed shop between the LVG FOPs and the same LVG's referral network

Insurance companies should be prevented from discriminating against non LVG referrals e.g. by charging the client an additional £200 excess if they choose to use a more cost effective provider who just happens not to have a commercial tie up with that insurer.

I can see nowhere where the CMA considered this activity. It is worthy of consideration as it is certainly another driver of referral cost inflation. LVG referral centre are very insurance orientated and very likely to spend the whole of the client's insurance cover. There is at least one whose standard costs are £7,500 as this is often the upper limit per condition of the more comprehensive insurance policies.

has effective mechanisms for monitoring and enforcing vets' and vet nurses' compliance with their regulatory obligations

See earlier comment re RCVS activity in this area. The CMA seems to have emerged under the delusion that RCVS is not performing its disciplinary role. [REDACTED]

not all prescribed medicines can conveniently be supplied by both FOPs and third-party retailers. Even where medicines can theoretically be supplied by different types of

providers, FOPs can typically supply medicines more quickly and more conveniently and can offer in person advice on how to administer them

There is no awareness of animal welfare anywhere in this report.

When we dispense eye or ear treatment we show people how to correctly apply it. When we dispense flea control, we demonstrate its use. This is in contrast to the online suppliers.

I came across a gentleman last week who complained his flea control has not worked, and it manifestly had not, but he had rubbed it on to his fur with his hands. This is an illustration of how far wrong an effective treatment can go when supplied online.

For non-urgent medicines, pet owners would be able to select a supplier other than their FOP (such as an online pharmacy...

Written prescriptions are not useful for even such simple issues as strains.

e.g. The dog is limping.

- We can give an injection which starts to work in a couple of hours but needs following up next day.
- We provide a written prescription the owner has to find a supplier on line then provide the script to the supplier. Some of whom want the original paper version to avoid fraud, others simply do not seem to care about the veracity of what they have been asked to prescribe. There is no chance the dog will get its treatment the following day.
- It is likely that it will arrive next week.
- Just because it is 'not urgent' should a dog unnecessarily suffer pain in its leg which could have been effectively relieved?

This is terrible animal welfare never mind any consideration of the time and stress the client undergoes as a result of trying to fit in getting the pet's medication while going to work, collecting the kids and doing all the other things they already had planned before the dog had a bad leg.

For antibiotics where the course needs to be ongoing the situation is even worse. In an age of antibiotic resistance, this is just a recipe for encouraging multi drug resistance and not properly following treatment courses.

Written prescriptions work well only for pets whose problems are stably controlled long term medications, so the pet already has treatment at home and its type and dose does not need adjusting more than 6 monthly, and well organised clients, so they remember to ask for a prescription and then collect it and order their medication in good time. It is rare for a pet to fall into both these groups.

Had the CMA chosen to ask, we would have let them know that, often, clients of ours start having prescriptions for use on line for long term meds but then ask us to supply them as the costs we charge are little different and the hassle involved in the '*will the prescription arrive on time or won't it?*' is more than they wish to tolerate. This option needs still to exist

as we do a valuable job. If the client has forgotten to order their meds, and often they do with busy lives, we will supply the same day. No internet pharmacy ever managed that.

We would also have discussed the people who can only afford two weeks Apoquel for example (very expensive, still in its License of Right so no alternative supplier, a complete monopoly which, again, CMA did not trouble to question). Getting prescriptions even at the prices we charge, which are less than CMA has recommended, is impossible but we can supply a few tablets at a time at a reasonable price.

We would also have mentioned the elderly and not computer literate. Yes, there are still people who have on smart phone and no access to the internet. CMA has completely forgotten about them but then, as a London based organisation with no idea what proper north of England poverty looks, like why would we expect better?

The fact that we have not included the third-party supply of medicines as part of the retail vet services market does not mean that third-party retailers are incapable of offering a material constraint on medicine sales by FOPs

Why was this not considered?

Presumably because the CMA chose to primarily speak to the LVGs and then not to apply sufficient cynicism to what response they got. For reasons which are apparent in the CMA's own report, who supplies these on-line medications is very relevant to the outcome of this report.

Third-party retailers would provide a degree of pricing constraint on veterinary medicines at FOPs, especially those purchased on a repeat basis, or at high prices

The CMA has been completely hoodwinked by the LVGs who will happily supply prescriptions and then profit twice from the same clients as they own internet pharmacies. They will be laughing at the idea that independents will have to supply prescriptions for long term drugs as they will then have access to our clients and profit from them too.

We, the independents, are not here to profiteer from our clients but this CMA proposal opens the door to the LVGs profiteering from them even when they have chosen to consult an independent practitioner to avoid that fate.

Our current view is that, as there is a high cost to providing OOH services and the unit costs are lower if spread across a larger number of potential clients, many FOPs would be unlikely to switch to providing the services themselves in the event

There is less demand for vet services outside of normal working hours, and OOH care is more expensive to provide than FOP services due to the uncertain workload and the higher salaries involved.

There seems to be a misunderstanding of this market in this report.

The cost of OOH service e.g. provided by [REDACTED] to the individual practices is low so the impetus to change provider is also low and has no impact on what the clients pay in any case. There is often only one provider in an area so as to draw in sufficient out of hours clients to run the service. The OOH provider business model is to charge very much higher prices than the FOPs would do for all services provided and treatments administered.

A change in this business model so the greater cost was born by the FOPs who wished to evade their OOH service obligations and less was paid by the consumers would be better for animal welfare since the costs would be more affordable for the average client.

This is another area where a proper conversation with a practice which provides its own OOH would have been handy. We charge more for OOH consultations but anything we do after that is at the same cost as in the daytime. If everyone were like that, animal welfare would be better served.

I would advise that the CMA worries less about whether veterinary FOPs can change provider and more about what the OOH providers are actually charging to the clients and the selling protocols they impose on their staff:

'sell full bloods with everything' (= a comprehensive blood profile on every patient whether it is clinically necessary or not) as an instruction to nursing staff at [REDACTED]

For example, vet practices may increase prices by more than any increase in costs and, when there are cost savings, not pass these on to consumers. Such effects may have both consumer and animal welfare implications: some pet owners may pay more for veterinary services; other pet owners may not be able to afford the price increases and forego treating their pets or stop visiting the vet at all, with detrimental consequences for both the pet owner and their pet.

We are really unlikely to increase prices over costs as we have to compete with others even in the next town, nevertheless, this is no business of the CMA. This is and remains a capitalist system where we, the independent practice owners, often risk our homes to pay for the development of the business and are, therefore, allowed to make decisions about how we produce return on that capital. I feel that this is a 'champagne socialist' interpretation of veterinary behaviour which does whoever wrote it no credit.

There is a possibility that if we cannot make money on medications and the fixed costs remain the same or continue to rise as the anti-business policies of the current government will predicate, our professional fees will have to rise to keep the businesses functioning.

This means that poorer clients will pay more to see us, seek veterinary attention less often and increase animal suffering – and please do not think the charity clinics will pick up those people, [REDACTED]

[REDACTED], even if the CMA apparently does not or does not care about economic realities.

the increases we observe in average prices and vet bills across the whole sector could be explained by increases in the cost of supplying veterinary services, including through improvements or investments in quality.

Why this was not better considered as driver for increased costs is something which only the CMA can answer and for which they should be called to account.

Business rates, light, heat and people all have to be paid. These have all risen significantly, business rates being often cited as a major reason for closure of high street commercial premises. The UK as a result of government policy has the highest rate of electricity costs in Europe. These are the result of government policy but have an impact on all veterinary practices whether LVG or independent.

Other government initiatives have also driven veterinary fixed costs up in a poorly considered and excessive manner in recent years.

The minimum wage rises lead to us paying all RVNs more as why should you have a degree and be paid £1,000 more than the minimum wage p.a.? We have 27 student and qualified RVNs, so anyone can do the maths.

Equipment has to be replaced, repaired and upgraded. A new MRI scanner is £250,000. A new CT scanner is £150,000. Upgrading surgery premises can lead to a cost running into hundreds of thousands maintain modern standards which the general public rightly expect, but are unwilling to pay for.

Practices all have to make enough money to pay their fixed costs and to do at least a minimal amount of modernisation and development.

This income can be from drug mark up or from professional fees - one or the other. If the CMA prevents independent small animal practices like ours prescribing and making a small markup on medication (20% so very similar to what is available on the internet for long term drugs, in our particular case), all the other things we do will cost more. It is simple economics.

That means that consultations, vaccinations and repeated injectable treatments will all cost more. I note that the CMA thinks we should hand out injections to be given at home. How does the CMA consider that we should ensure that owners are using these injections appropriately, storing them appropriately or repeating them at the correct intervals?

Even the staff of the Veterinary Medicine Directorate, at least at the inspector level, are prepared to admit the misuse of prescribed medication by the general public. There is utter contempt for our ability to advise, treat and prescribe correctly in these proposals.

This includes LVGs contributing to the improvements in employment practices

████████████████████

[REDACTED]

[REDACTED]

[REDACTED]

This results in an exodus of staff as far as they are able. Veterinary surgeons are more mobile and able to take their skills and families elsewhere. RVNs are less so and bear the brunt of corporate behaviour.

I do not know who considered that LVGs had improved employment practices or how this conclusion was drawn. The more so because this report was prepared without speaking to any really successful FOP. This was inevitable when the decision was made to restrict the conversation to LVGs (at length and first) and independent FOPs to single branch practices only. This was asinine stupidity on behalf of whoever drew up the plan for this investigation.

[REDACTED]

Our analysis indicates that 89% of FOPs are in local areas where there are at least four competitors, and for most areas (81%) there are five or more competitors.

This conclusion fails to understand what is happening. In my area, there are several veterinary practices, most are part of LVGs and work with protocols which include selling to their clients. To quote the clients (repeatedly) 'You go in there, love, and come out with three things you did not want because you are too polite to say 'No' fast enough.' This is not about head line price. This is about attitude to making the clients spend money.

Considering that this equates to a good well functioning veterinary supply situation for the clients just because there are several practices is deluded.

Similarly, 87% of referral sites are in local areas with at least four referral providers, and for most areas (78%) there are five or more referral providers

A similar level of delusion applies to this part of the market. [REDACTED]

A number of vets working in vertically integrated LVGs⁵⁷⁰ reported that they were encouraged to refer to group-owned referral centres.⁵⁷¹ However, there were differences between vertically integrated LVGs, with vets working at some LVGs reporting that they received encouragement more than those working at others.

My fellow director over the past few months has been touring FOPs in the region (Lincolnshire, South Yorkshire, North Norfolk, Nottinghamshire) to promote affordable advanced veterinary services which the vast majority of local clients would be able to afford. He has been repeatedly told at LVG member practices that there is no point in promoting low cost complex services, as he was trying to do, for the clients who cannot afford referral at the current centres as they are only allowed to recommend the referral centre owned by the LVG for which they work. Linnaeus in particular was implicated in this anticompetitive tactic, yet there is no consideration by CMA in the report on why veterinary fees for referral services are what they are.

there are certain LVGs that have increased FOP prices, by more than independents, and that these price increases are in response to factors that are present across the whole sector

many reported that rising prices for customers were the most notable change following the takeover

the perception is that fee increases following some LVG acquisitions are centrally directed. These increases are not always locally responsive or clinically driven, but commonly linked to corporate financial targets

For at least three LVGs that acquired FOPs since 2015 [%],²⁴³ there is strong evidence that acquisitions caused an increase in either average prices or claim values

an LVG-owned practice were, on average, 16.6% higher than the prices charged by an independent practice

Overall, our provisional view is that this analysis shows that veterinary businesses (these were LVGs, again independents were not considered) covering a substantial part of the market earned profits materially exceeding the cost of capital over a sustained period

These statements are certainly true of LVGs, but the reason for this i.e. that venture capital was used to make inflated offers for veterinary practices and venture capitalists expect more return than veterinary surgeons who own their own practices is never explored.

The conclusion that LVGs are profit driven and that LVGs use protocols to generate excessive profit as well as increasing prices in a manner which poorer clients in the locality cannot

afford is correct. The remedy proposed panders to the LVGs and handicaps the independents who are innocent of these commercial wiles.

If LVGs are profiteering, why then impose sanctions on the independent sector which will force clients to use LVBG owned on line pharmacies for medications when we, the independents, are acting in patient interests and not in the interests of profit?

I feel a judicial review of these findings and how they were arrived out might be a fruitful experience.

we consider the scope for all types of veterinary business, both LVGs and independents, to raise prices due to a lack of effective competition.

This statement clarifies that without evidence of independents acting in this manner the CMA simply assumed that they might then acted as though this was actually occurring. This is further evidence of the unsuitability of this report as a fair and unbiased assessment of industry activity.

LVGs may incur lower operating costs at acquired FOPs, for example due to their greater negotiating power to obtain rebates from manufacturers of veterinary medicines.²⁴⁶ It appears that any such cost savings are not being passed on to pet owners.

All larger practices achieve economies of scale but no independent is on the scale of the LVGs so none achieve this degree of economy. This again is correct but should have led to the CMA better considering how to control the behaviour of the LVGs rather than applying its sanctions to the entire sector in a manner which will assist the online pharmacies to make even more profit for their LVG owners.

we would expect more of these profits to be competed away through lower prices or greater investment in quality.²⁴⁹ Our evidence of profitability is therefore consistent with our overall provisional finding that there is not strong competition between veterinary businesses.

I cannot see how this conclusion was reached. It is certainly not my experience, not of any other independent practice principal to whom I have ever spoken.

We are in direct local competition on price with at least five other FOPs. We all are acutely aware of the need to compete on the services which most clients need. Clients choose veterinary practices on two main criteria:

1. Location, the closer the better.
2. Cost for comparable services.

We recognise that veterinary businesses, including LVGs, have made investments in quality and expanded the range of their services over time.

This is certainly untrue in the real world. A normally cynical person or one with business experience in the real world would know exactly why the CMA struggled to acquire the following information:

We have not, despite seeking it, seen substantive or robust evidence from LVGs on how their post-acquisition investments in capital or staff compare to investments that these practices would have made had they not been acquired.

It would be interesting to conjecture what real life business experience the people conducting this inquiry had in any sector. One conclusion might be that they lacked the real world experience to be able to extrapolate from the facts they have received and ask the appropriate follow up questions to reveal the true state of both the LVG and independent sectors of the veterinary industry. In such a case, the selection of the chair of this inquiry and his staff was inappropriate to the task in hand.

The other interpretation is that this entire inquiry was one in which the conclusion was pre-ordained. The CMA had decided in advance, or were briefed to decide, that the veterinary industry needed to be sanctioned for profiteering whether this was, in fact, the case or not. Such consistent determination to exclude any factually based consideration of the independent 40% (or so) of veterinary practices must be based on one of these.

There is no evidence in this report that the latter supposition is incorrect, in which case, it will be for a judicial review to decide whether the method by which the information was gathered, including the decision to ignore large sections of the veterinary independent sector, truly reflected the whole of the veterinary sector in the UK and whether the methods for analysing such information as was gathered was sufficiently statistically robust to warrant any conclusions being drawn and whether that treatment was sufficiently robust to justify the conclusions reached.

In terms of on-going investment, the LVGs have, by and large, bought functioning businesses and then sought to make as much profit from them as the local situation allows. The evidence for this is all around, available for anyone who has the wit to find it.

All that is required is to ask the question: What is the average investment in each practice acquired by an LVG and what was this money spent on? These facts will be in the annual accounts. It is not hard to find.

There has been no real investment a great deal of price increasing combined with cutting staff and worsening working conditions. This is why an exodus of staff and a fall in the standard of care has followed LVG take over in all the cases in our locality.

The local practices which are investing are the two independents. In the past five years, we have expanded our premises, our theatres, our hospital care facilities and our Physiotherapy/ Hydrotherapy capabilities. The local LVGs have done nothing of a similar scale but they raise prices non the less. This is to satisfy the profit required to support the return on the venture capital with which these businesses were acquired.

the price increases that occur following LVG acquisitions of independent FOPs cannot be wholly explained by improvements in the quality of services provided

This is entirely true for the reasons described above.

it is difficult for pet owners to observe and measure some aspects of clinical quality (such as, for example, the range of back-of-house equipment or the clinical accuracy of treatment advice),

This is entirely incorrect. Anyone reading the websites of the local practice and their reviews would have little difficulty finding out what level of 'back of house equipment' (the correct term is 'diagnostic services') of each happened to be.

Nor is there much difficulty in finding out which practices are consistently being praised for their clinical accuracy, just read the reviews. There are some clients who are never pleased with whatever a veterinary practice does but that is not by any means all of them. A brief look at the number of 5 star reviews is a good way to assess clinical ability.

We find the greatest driver to our new client registrations is word of mouth e.g. on dog walks.

This often addresses the LVG versus the independent ethos directly, often covering the aspect of not selling stuff your pet does not need; proposing tests which actually find out the problem; employing vets with sufficient experience to make reasonable suggestions about how to achieve good quality care; being able to propose solutions across a range of budgets; not just flogging flea control and wormer or unnecessary restarts to vaccination programmes etc.

Quality measures facilities, online support, appointment availability, parking and customer service,

Availability of appointments is not a measure of competence, nor is 'on-line support' if what is meant in this report is the failure to see an animal and an attempt to make a diagnosis over Zoom. I have seen considerable and prolonged animal suffering occurring as a result of on-line 'veterinary care' where a good quality physical examination sorted the issue in minutes. That is another fertile area of investigation of fees for poor quality service e.g. by Jooi and others.

These are things which both LVGs and independents should be trying to provide but have absolutely nothing to do with quality of veterinary services provided.

We have not received well quantified evidence of other increases in costs

This is because the CMA did not ask the correct groups of people. Had they done so they would have received the answer to why costs have exceeded inflation as is made clear throughout this commentary. If one chooses not to ask the question, one cannot expect to

receive a useful answer. I have described the effect of government activity on costs in recent years and most especially in the last eighteen months when there has been a perfect storm of cost increases, wage increases and government NI increase to drive a spiral of veterinary cost inflation.

Worse is to come should VAT be increased in the budget. At that point, a quarter of every veterinary bill (hopefully not more) will go to the government. Removing VAT from veterinary medical expenses as our pets are, in the modern world, family members, would be the biggest step which any government could make to ensure that veterinary costs remain affordable for all.

Instead the CMA has refused to consider the role of the government in what is occurring just as it refused to consider the role of the RCVS, our regulator which much prefers large organisations to small ones, in encouraging LVGs in their activities.

There was variance across the large groups with results ranging between [%] [5%] and [%] [25%] higher: compared to the average independent practice, the average price charged [%]

Even when controlling for observable determinants of these variables (including pet characteristics, location, practice type (ie FOP or referral centre) and whether the customer had submitted a previous claim for the same condition), we found that LVGs had, on average, higher claim values and first-year treatment vet bills than independents over this time period.

Yet again, LVGs are found to be profiteering but the CMA recommendations apply to the whole industry. Why is this and how was this decision arrived at?

Again a review of the brief given for this inquiry and the way in which information has been so selectively used is definitely indicated.

The CMA is present to gather information from a wide range of sources, not just the ones which they find easiest to contact.

This may be over-optimistic but I am sure that its brief for this inquiry was not to exclude groups which would require genuine effort to contact, including large parts of the successful end of the independent sector, and then base findings on LVGs and very small often low functioning independents, ignoring the ones which can effectively compete in the market. Yet this is what has happened leading to a massively distorted report which does not represent the independent sector at all and seeks to apply sanctions evenly across a profession in which only the LVGs are behaving abysmally.

Pets at Home did not acquire any practices in the 2015-2024 period, therefore our analysis of the effect of corporate acquisitions does not apply to it.

Why was this allowed to be the case?

[REDACTED]

Our analytical approach has been to estimate the return on capital employed (ROCE) of the six LVGs and compare this to their weighted average cost of capital (WACC). These LVGs comprise around 60% of the market.

Even given that this 60% figure is true, previous figures put independents at 51% of the total so it would be interesting to see how this number was reached, why were independents not looked as a group when considering this subject.

I strongly suspect that just as prices of independents were lower, their return on capital was also lower. There seems to have been a determination to consider only the LVGs (or as we call them the Corporates) and then apply the findings to the whole market. This is manifestly unfair.

In order to obtain an understanding of the financial performance of independent veterinary firms, we took a sampling approach, which involved requesting and obtaining financial information from 56 firms. We decided not to undertake a full profitability analysis for each of these because of the substantial resource implications that this would entail both on the firms and on us.

Fifty six of the smallest independents! What sort of analysis is that?

CMA talked to 6 LVG corporates. They represented 60% (by CMA figures) of the market. CMA looked at 56 independents (having eliminated all the more successful multibranch independent practices from the start).

Using the CMA's own figures there are around 2,133 independent practices in the UK. The CMA therefore based their findings for independent practice on 21.6% of independent practices. That is to say around 1% of the total of UK practices. This alone represents a ridiculous level of bias in this inquiry and renders its conclusions statistically invalid never mind invalid for a host of other reasons based on the bias inherent in the sampling technique.

We only included within our analysis those independent firms in our sample who had been trading across the whole of the three year period.

So did the CMA exclude LVG branches which had not been open for three years? I completely understand why this might have been imposed as it is only after three years that banks consider business accounts to be truly representative of the situation in which the business is trading but it is yet another cause of bias in the conclusions which are drawn.

This is presumably why the only graphs and figures presented in section 7.52 to 7.6 are for LVGs. Once again any conclusions drawn are of dubious validity based on the massive lacunae in the investigation which was performed.

For the independent veterinary firms, we found a wide distribution of EBIT margins: from -9% to 34%

That basis of preparation differed from the approach we took to the LVGs.

We therefore do not intend to place weight on the relative EBIT margin of independents compared to the LVGs

With competent accountancy and statistical advice, it would have been possible to produce a method of analysis which was capable of comparing the profit-making tendencies of both the independents which are still a very significant part of the veterinary market and the LVGs. It would appear that the CMA chose not to seek out that advice and therefore once again to fail to consider the independent sector when drawing its conclusions and making regulatory proposals.

Some of the analysis we have generated 91 nonetheless suggests, in our provisional view, some independent firms are making profits that we would not expect in a well-functioning market

Really. Where is the evidence? Only a tiny % of independent practices were looked at in any way at all and of those the analysis does not appear to have been robust.

The CMA has determinedly ignored almost 40% of the veterinary sector and then drawn conclusions only applicable to LVGs. That is against any concept of natural justice and fairness.

Our pet owners survey indicates that pet owners at independent FOPs are more satisfied with the quality of vet services than pet owners at LVG-owned FOPs.

Yet the CMA is seeking to treat all veterinary practices alike. Why does it suppose clients of independent practices are happier than those of LVGs?

At no point, did it bother to ask, yet the answer is very much at the root of what the ideal of a well functioning veterinary market should look like. The aim of a well functioning market would be to provide all clients with access to good quality affordable veterinary care which met their needs and assisted in the maintenance of good animal welfare standards for the pet sector.

The most egregious CMA proposal is that we should have to write prescriptions for all long term medications. We always supply written prescriptions on request, even though, as already noted, quite a large number of clients have one written script only then revert to picking up their medication from the practice because it is much the same price as on-line, easier and a more quality controlled method of acquiring drugs whose source is known and can be trusted.

Written prescriptions are invariably associated with an increase in animal suffering because there is a lack of regular contact with professionals so the owners never get to express sometimes niggling, and sometimes more serious, doubts about the treatment until the time for a six month review and repeat prescription comes around.

This is in no way often enough if things are deteriorating.

Part of what our independent practice routinely provides is convenient access to long term medications with veterinary advice at the time of both ordering the prescription on the telephone and prescription collection. This advice is initially from a Veterinary Nurse whose first job when a prescription is requested is to inquire how the pet is doing and ensure that the client is happy and confident to continue the treatment. This is a very useful net to catch early on treatments which are not working at they once did and need to be reviewed.

When the prescription is collected, we also check again that the client has no niggling concerns. There is no charge for either of these conversations, which have, on occasion, saved a pet from suffering and even, from time to time, helped it to avoid an acute and fatal deterioration and continue to live a happy existence in its human family.

I have already highlighted the effect of forced prescription writing on the older clients, those less computer literate and those who are either disorganised or time-poor. I have also pointed out that this is just handing yet another opportunity for profit to the LVGs which own the online pharmacies which it is intended that RCVS recommend and which the clients can in any case find as sponsored links on-line.

(I could easily laugh at this recommendation, given the competence of our regulator, if I were not inclined to cry at the gross unfairness of the CMA staff throughout this report to the profession in which I have spent my life trying to treat pets as well as the circumstances allowed and at affordable prices.)

While it is difficult for pet owners to observe and measure some aspects of quality (such as, for example, clinical standards),

Clients are not as stupid as this report supposes. I see many who arrive saying, correctly, that unnecessary tests were done; that the vet was afraid or too incompetent to handle the large dog or the cross cat they own; that the vet did not know what was going on and had no diagnostic plan other than to repeat what had already been given and did not work; that the vet they previously saw did not know what to do/ did not speak sufficiently good English to communicate either the diagnosis or the treatment plan.

This last is another RCVS ProfCon competence issue. They keep including on the Register of Veterinary Surgeons people whose English language abilities are deplorable yet this is the gateway to working as a vet in the UK. It is also a government issue as we do not train enough veterinary surgeons and a university selection issue as we do not train a cohort with realistic expectations of the job so do not stay on the profession. All of these add to industry costs, but the CMA took no interest in the wider picture.

It is possible that these satisfaction rates could reflect consumer bias against LVGs, rather than actual quality levels.

Given the content of the whole of the preceding report this is clearly rubbish and represents the determination of the CMA to lump all vets into the same category as the LVGs. The LVGs

have poor scores because their client communication is often parlous. We have referral inquiries from LVG practices, when their clients either can't or won't use the preferred referral service (owned by the same corporate), where our poor nurses cannot understand the vet on the telephone and have to ask them to email instead only to receive a frankly illiterate email in non-English.

This is not to say that I have anything against non UK qualified vets. Many of my veterinary team fall into that category but their English has to be of a standard which I would accept were I a client. This is nor the standard required by the local LVGs in my experience, hence both poor value for money and bad for animal welfare.

An internal document from one LVG [%] regarding brand awareness indicated that independent practices rather than LVGs were [%].

This is a consultation yet sections are repeatedly redacted. If the LVGs found it too sensitive/critical to appear surely that is a very good reason to publish and properly consider what was found.

I don't see any redacted sections for the independent sector which is further evidence that this sector was unequally treated and ill-informed recommendation were therefore made.

Sections 7.75 to 7.88 concentrate exclusively on LVGs with no attempt at balance. Investment by the independent sector should also have been considered just as much even if that was more time consuming and difficult to acquire the data.

There was also comment about PSS membership being higher among LVGs with no attempt to understand the drivers which lead to this difference. i.e. that this is one thing an LVG practice can stick on their website which is accomplished centrally as a paper exercise which has little resonance with the general public.

Independent practice principals, who are invariably clinicians whose primary role is to treat patients, have to waste clinical time making onerous applications and on RCVS inspections. Bear in mind we are already inspected by each nursing college and by the Radiation Protection Adviser, the Veterinary Medicine Directorate and the external body which advises us on Health and Safety and Employment Law.

We note that the remuneration per FTE worker figures submitted to us by LVGs did not include pay for locums, as discussed in detail at Appendix E.291 However, we consider that the exclusion of locum salaries is unlikely to have a significant effect on LVG remuneration per FTE worker data.

This is another area in which the CMA were markedly in error.

LVGs and independents have submitted that difficulties in recruiting and retaining staff have in part driven increases in staff remuneration.

Some independent FOPs have also increased their wages considerably. For example, one independent FOP [%] submitted that total salary expenditure as a proportion of its turnover had increased from 39% in 2009 to 50% in 2024.³⁰⁰ Another independent FOP [%] submitted that costs per vet had increased by 60.2% between 2016 and 2023 (an average increase of 6.9% annually).³⁰¹

One of the drivers of wage inflation was the extensive use of experienced locum veterinary surgeons in recent years at wages which eventually rose to £500 per day.

This was because the LVGs in general were having grave difficulty in attracting and retaining the services of permanent experienced staff. This warped the whole veterinary market for several years in that, unsurprisingly, vets with 5 years or so experience were leaving the independent practices which had trained them from being new graduates to earn large amounts as locums in LVGs .

The money was sufficient to outweigh the conditions (bossy managers with no clue about the industry, limited drug supplies and prescribing protocols inflexible to the needs of the patient. I have examples of this available should you wish to know about them, but, given the thoroughness of this inquiry report, I doubt that is likely.). In the last eighteen months the LVGs have capped locum wages and the situation has started to resolve.

Employment of veterinary surgeons especially in the less fashionable areas of the country is still difficult. We train our own nurses, usually, at least until this year due to government policy on employment costs. We employ our veterinary surgeons who qualify elsewhere.

Several independent practices mentioned Brexit reducing the supply of European vets available

Brexit is not currently the issue. HMG most certainly is. This summer, the policies of the government have made employing even new graduate vets from overseas to fill the gaps in the UK market more or less economically unfeasible. As one problem improves, another rears its head.

Increases may also reflect LVGs offering increasingly high salaries and increasingly generous benefits compared to independents. This is consistent with evidence submitted by independents that they find it difficult to compete with LVGs on salary or benefits

This alone should have informed an alert team at CMA that working for LVGs can be trying to say the least. The reason they are offering high pay and peripheral benefits is because the level of nursing at least in our immediate area is 'boring'. The patient care is limited due to limited procedures being performed and no overnight hospitalisation. The level of veterinary medicine on offer is simplistic and insufficient to meet the clients needs. RVNs are a caring profession but the allure of extra money means that independents have to match the RVN salaries on offer locally.

It is noted that there was a 5.6% rise in RVN salaries. This was very much driven, at least here, by the government's inflationary increase in minimum wage. That rose by 6.9% in 2024 and

6.7% in 2025. RVN wages have risen far less by comparison. This has led qualified staff to find themselves earning very little more than the minimum wage.

Additional drivers of higher employment costs mentioned by independents included the national minimum wage, the minimum salary for skilled worker visas, national insurance and pension contributions

A student nurse over 21 years old now earns £25,396.80 (yes, we do all work a 40 hour week). A newly qualified RVN was earning, in our practice, £25,000 p.a. prior to the rise in 2024. This was above the local rate for the job in Grimsby at the time. That salary was clearly neither fair nor sustainable with student nurses earning more than the qualified nurses who were teaching them, so it had to change.

The more the government racks up the minimum wage the less we will employ new student nurses who do not do a job but are trained by senior nurses, so cost both their salary and the senior nurse training time, and the more we will need to pay RVNs to make their qualification worthwhile holding. I suppose until we have Treasury staff and a Chancellor who has run a business and can do basic arithmetic, we will not see a change to this. Inflation and unemployment, here we come. This is not due to veterinary profiteering, even among the LVGs. This is due to brainless idiocy by the government.

This 50% pass through rate indicates that price growth would be roughly half the growth in remuneration, absent any other (non-wage) increases in costs.

This statement is truly without the slightest relevance as in a society where the pressure on veterinary wages is up the cost of everything else is also rising.

For example, in this period (2022-2025), when we were trying to open a new consulting area, the wages of the skilled labourers went from £600 per week to £700 per week. This is a 16% rise.

The building materials increased in cost by up to 33%.

If all the other people we have to employ from the people who service the diagnostic equipment to the cleaner all need the same pay increases the fixed costs increase astronomically. In consequence, the idea that in such an environment a 50% pass through rate with no other increases has any meaning is farcical and represents the level of stupidity present when these figures were analysed.

In case you are wondering, I did not increase prices by these silly amounts. We had a 3% rise last year and the same again early this year, having held still for long periods during the financial crisis as it was clear that the clients were suffering financial stresses of their own which were considerable. I have just had to contemplate a reluctant further 3% as we really cannot keep up with fixed costs but have kept the essentials (vaccination and neutering) the same as they were to help the locals as best I can. The government inflation figures do not represent local reality. They are an act of fiction.

How did I pay for this? By borrowing £750,000 unsecured and by taking £100,000 from my pension, not by charging the clients. Is this sensible? No, on a personal level. Is it kind? Yes. Perhaps, the CMA should take lessons.

We did not ask independents about investments in quality explicitly, as we did with LVGs

So yet again, the CMA not only chose to take evidence only from to the less successful end of the independent sector but also failed to treat them fairly and equally with the LVGs, then drew general conclusions for both LVGs and independents in spite of this exclusionary behaviour.

It was often unclear how the capital investments set out in the documents submitted related to total spending on capital by an individual LVG over a particular time period, and therefore how average treatment prices might be affected.

It was often difficult to tell from LVG internal planning documents which investments had been approved and completed (and therefore might warrant price rises) and which had not.

I am very concerned that the people taking this evidence did not have sufficient knowledge to read and analyse annual accounts nor sufficient humility to realise this and seek appropriate skilled help.

For example, LVGs provided no internal documents that clearly linked price setting decisions to investments in quality. In particular, for those LVGs that set prices centrally, such as [%], there appeared to be no direct link between local investment and prices.

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

[REDACTED]

The LVGs have also bought up the veterinary on-line pharmacies, so the plan to reduce their stranglehold on veterinary profits by making the independent vets write prescriptions is muddleheaded and foolish. It also reduces the standard of on-going patient care as described above. Had CMA bothered to consult the independent sector properly rather than accepting information from a minuscule number of the less successful independents they would have easily discovered these facts. Ownership of these entities is easily visible in an on-line search to anyone who cares to look.

new equipment in a local practice would be priced according to its cost per use, the price of that service in other group practices and local prices for the same service

This is a supposition created by someone who has never run a business. When I invest in equipment and staff training, we never know how much we will use the equipment, so 'cost per use' is meaningless.

Clearly, the more we use equipment the lower the cost of each individual procedure should be, because each procedure bears less of the fixed costs associated with having that piece of equipment. This is largely true.

Cheap equipment used all the time (Xray generators and ultrasound units) are less expensive for us to perform and less expensive to the client than complex procedures with high fixed costs associated with them e.g. MRI and particularly CT, however, to try to claim a direct mathematical relationship between cost per procedure and charge per procedure is incorrect as nobody in any veterinary practice ever knows how many of each procedure they will perform. Even the average varies widely month on month and year on year.

It also completely ignores the very high costs of training from external providers. Once you have a piece of equipment, on-going training to use it well is essential. This often does not happen in reality in the veterinary industry as a whole, leading to clients paying for services which, even when the equipment is available, the ability to use it is too poor for the examination to reach a useful conclusion.

We spend around £60,000 per year to train a group of fifty vets and nurses to improve their skills [REDACTED]

Please forget the 'Dragons' Den' scenario where they sit there predicting a % growth in year one, 2 and 5. These predictions are fantasy made merely to satisfy the banks if you are borrowing money to buy something really expensive (I am now on my second MRI scanner so can speak with considerable experience on this).

The cost is whatever the business needs it to be to attract clients, so highly dependent on what whichever practice has the next nearest one is charging and upon the location (were we to charge London prices, we would treat no animals as the local clients do not have that sort of money available for their pets) and the cost of repaying the loan.

[REDACTED] the organisation also factors in the % profit per annum which [REDACTED] feels it should make by having the equipment on site.

I am afraid that this has never, and will never, enter into my calculations when buying equipment. We have become the largest practice in our area over the last 20 years by making decisions consistently based solely on '*Will this be useful to help the animals under our care? Will we be able to make a diagnosis to help them and will we be able to provide better treatment as a result of this diagnosis?*'

By excluding the more successful and larger FOPs, the CMA failed to speak to the cohort of successful independent veterinary surgeons running their practices in this way and, therefore, gained an inordinately distorted vision of the veterinary market. Better communication with the whole veterinary market from the start of this inquiry might well have resulted in a very different view of this profession.

This means that expanding the range of treatment (such as purchasing the equipment needed to perform a laparoscopic spay) would not explain these price increases (even if a more traditional type of neutering was previously available).

This statement is nonsense. All small animal practices are still performing traditional spay procedures. Some are also offering laparoscopic spaying at extra cost. Both forms are still available in all practices everywhere as far as I am aware and I after all have far more experience of this industry than the denizens of the CMA who have taken such a brief, biased and superficial view of what the veterinary profession is and how it functions.

We charge £200 more for each laparoscopic spay to cover the increased time spent on each procedure (lap spays are slower to perform and involve more anaesthetic and staff costs than traditional spays performed by a competent practitioner). This covers our costs, but the other local practices both independent and corporate charge far for their procedures.

In the CMA view of the world, this would mean that we would do far more procedures as the clients became aware of this differential but, in fact, this is not the case, clients stick to the practices they know because there is a vet/ client bond of trust. In seeking to make the LVGs more worthy of that trust, the CMA report and the publicity surrounding it, which seeks to rubbish all of us as profiteers, is doing untold, and often unjustifiable, damage to the bond with all the clients of any veterinary practice anywhere purely for political purposes.


Overall, we have not received well-quantified evidence of the rise in non-staff costs in the veterinary sector, though we did receive some submissions from independents regarding general cost increases such as the cost of medicines, medical products, energy and rent

The CMA did not receive this evidence because it made no attempt to go out and find it. I can provide evidence of considerable increase in costs for everything from insuring our practice vans to electricity and gas to repairs and renewals and servicing costs. The CMA simply did not bother to look so did not find any evidence.

This is merely another indication of the incompetence and political bias with which this report was compiled. And adds more weight to the legal case for challenge of these findings through the mechanism of a judicial review of the conduct of the entire proceedings.

Please note, I would be more than happy to proceed down this route with the same lack of interest in personal cost which I have always shown in matters connected to the well being of my patients and the health of my profession.

These price increases cannot be fully explained by increases in costs and quality of service and a substantial part of the market earned profits that materially exceeded the cost of capital over a sustained period.

 The reputation of my and other independent practices is currently being traduced by this flawed report which did not bother to look with the same attention at the independent sector, still a large proportion of the veterinary market, because it would require effort to do so. We are now being libelled in the national press.

CMA and its directors are responsible for this and should be held to account. A rapid retraction of this report and a proper review of the market by people who are competent and prepared to do so is the only solution to this travesty of justice.

We also consider whether insurers are able to constrain veterinary businesses, for example by negotiating prices with certain vet practices in return for the insurance provider directing its customers to them.

As previously noted, some insurers act to distort the market and this elevates costs to the consumer.



In some cases, where the clients are insured because they know they cannot afford veterinary fees this can mean the difference between getting an animal treated and euthanasia, so the depict the insurers as somehow not involved in fee elevation is incorrect.

When pet owners are choosing between FOPs (either when they first need to register with a practice, or when they are considering switching vets), evidence indicates that they most often consider location, followed by recommendations from friends and family. Pet owners less often place weight on prices, which they consider alongside a wide range of other factors such as services offered and online reviews. There are no clear, measurable and reliable direct indicators of quality, although recommendation from friends and family may be based on an assessment of some aspects of quality.

This conclusion is entirely correct.

I do not quite see how one produces *reliable and transparent indicators of price and quality* as there is no way for the CMA to regulate poor quality providers e.g. people who perform an ultrasound examination with poor quality imaging equipment (Think grey cat in a coal cellar) or too little training (the 'no free fluid' issue); LVG protocols which demand the booking in of a certain % of dental procedures and which results in unnecessary dentistry etc.

Higher price does not represent better service or more experienced personnel in many cases. Only Google reviews and personal recommendation can help reveal this. No amount of publishing fees

is going to help this.

The CMA seems to be feel we live in a Panglossian perfect world and that the mere publication of figures is sufficient to ensure that all clients get the sort of veterinary care we

would wish for their pets at a sensible price. This is not the case. Publish figures if you like, it will just add to the administrative burden and to those non-staff cost rises which the CMA so singly failed to properly examine in this report.

The last time the CMA looked at the profession, their insane suggestion was a list of most prescribed drugs in every consulting room. To quote the clients again ' *Well, that's no good. We don't know we need them until you tell us we do.*' The current proposal, which I have no objection to apart from the time it will take, the cost this will incur and the on-going need to keep it updated whenever out drug costs change, is just another administrative burden which is frankly meaningless.

Our analysis of prices (set out in part A, section 7) shows that the average price charged by an LVG-owned practice was on average 16.6% higher than the average price charged by an independent practice,

I would agree with this statement. [REDACTED]

[REDACTED] It is however clear evidence that one part of the veterinary sector is profiteering and the other is not yet the CMA has made no distinction between these two sectors in its findings.

In addition, the CMA discriminated in favour of the LVGs by showing them the findings, or so I see on-line, before they released them on the profession. This was despicable behaviour and further evidence of bias.

Many FOPs do not supply information on prices that would enable pet owners to make an informed choice of practice. FOPs do not consistently publish comparable price information.

We regularly supply price information just not perhaps in the on-line format which the CMA has in mind. I could attach, were attachments permitted, our latest leaflet, which is very clear as to the price of our services and due to be released in the local area this month.

Why a leaflet?

This is because of the preponderance of older clients with low computer literacy and restricted internet access. If you send out a leaflet, everyone whose letter box it falls through knows your prices. If you publish on line, especially on the 'Find a Vet' site which almost no clients are aware of and use regularly, then only a few of the more internet savvy will know.

That is what proper pricing transparency looks like, not the false performative version which the CMA seems to feel is a good thing. I suppose that this is what one gets from London based governmental organisations with no idea of the client base North of Watford gap.

Some veterinary businesses do not make it sufficiently clear when a FOP is part of a larger group. 53% of those pet owners that attended an LVG practice did not know that their vet practice was part of a large group

This is correct especially of CVs which does not change the name of the practice and whose ownership of it can usually only be seen in the email address. [REDACTED]

I hope that the CMA will be able to see from what is written here that the system of interlinked ownership and profit making by the LVGs goes far beyond what was considered in their inquiry.

The lack of consideration of the veterinary market as a whole has led to a report which is skewed in favour of the LVGs which were after all what the CMA spent time communicating with, rather than the independents who are not the ones making excessive profits (see the 16% plus price differential in the report).

While veterinary businesses typically provide some information regarding the services they offer, LVG marketing of quality is typically left to local practices and generally light touch, making it difficult for pet owners to compare FOPs on the basis of quality.

The CMA ought really to have looked into why exactly it is so difficult to compare quality. The answer is the RCVS Code of Conduct Section 3.5 which prevents those who are competent from stating that they are better at what they do than any other veterinary surgeon either locally or more generally. RCVS also disapproves of us even implying this by including the additional qualifications of our veterinary surgeons on the web site.

We do so nevertheless, see our staff at <https://www.abbeyvetcentregirmsby.co.uk/our-staff/>. Clients who wish to know what we are qualified to do should read the website of the practice which they intend to consult. It is clear, from our site, that we are very invested in providing high quality care and in funding vets to gain the additional skills which this requires. Of course, the additional qualification does not mean that the veterinary surgeon involved can do the job. It just vastly increases the likelihood, but we can never say so explicitly.

RCVS is another issue here in that they ignore non European Diplomate qualifications. These are restricted to studying at certain locations so are a closed shop. Non European Diplomates doing specialist procedures at cheaper prices constantly have to state that they are not specialists.

If you consider that, at the moment, I am probably the veterinary surgeon who has been accurately producing and reporting MRI and treating animals based on that diagnostic modality for the longest periods in the UK, the others of my cohort having retired, you will see why the possession of a European Diploma and 'RCVS specialist' status is not more a guarantee of quality of service than anything else in the market.,

Yet again, the CMA also appears to have focused its inquiry in to referral veterinary services on the expensive, LVG owned part of the market rather than looking more broadly at what

was available and the impediments to clients accessing more cost effective advanced care when their pets need it.

Once they have found a FOP, pet owners rarely switch practices.

Really? How is it them that our practice has expanded from 5 to 13 veterinary surgeons in the last 15 years. This was not achieved by clients failing to change vets, if they felt the service which they received was poor.

This is another piece of incompetent research by the CMA. I can produce new pet register requests from our website which consistently give the lie to this assertion. Whatever sample the CMS chose to discover this 'fact', it was clearly as poorly chosen as the veterinary surgeons sampled to look into independent practice. We see many new pet register requests coming through our site. The majority are not for newly acquired pets. Many are from clients who are getting nowhere with the veterinary help being currently provided wherever they went before coming to us.

I see many new clients with older pets who have also come on personal recommendation from their friends. I also have an email in the practice inbox at the moment asking to come and see me because the lady involved saw me some years ago with a cocker spaniel with a Hansen type 1 disc extrusion and is now having orthopaedic issues with her new puppy which her vets are unable to advise about. This is how practices, which are good, expand and how those, which are not, lose clients.

Many clients never feel the desire to change vets if the service which they receive is good. We have clients with whom I am treating their fourth dog, with all four living happy lives and the clients receiving good service throughout all those dog life times, but those clients who receive poor quality service or incompetent advice do and are easily able to do so if you compare to other health care (Try changing NHS GP because they are talking rubbish and see how far you get).

As you will understand from the above, price is not the driver to changing practices. Competent and effective veterinary treatment is, so the following statement is complete misreading of the true situation:

low propensity to switch practices is likely to be, in part, because pet owners lack awareness of the significant price differences that exist between FOPs.

This is not to say we do not aim to be cost effective.



And yet the CMA is seeking to increase our administrative costs and reduce our revenue. Shame on you when we are providing such a good, low cost service.

Given all of the above, clients who can read web sites and listen to neighbours, never mind read our leaflets are easily able to inform themselves about services, prices and quality. The following statement is simply further evidence of inherent CMA bias and a failure to look at the whole industry in reaching its conclusions:

Some pet owners might prefer a value proposition (that still meets a basic level of professional standards), whereas others might wish to pay higher prices for the best available services. However, because pet owners cannot readily access comparable information on prices, ownership and quality, they are less able to make such informed choices.

we provisionally find that the most important factor for pet owners is location

If you have ever done a journey of any length with a howling cat or a barking dog, it is very obvious why this is the case, and no legislation will change it. This is in part why poor quality practices flourish, but the clients find a solution. For example, we see quite a lot of clients who use their own local vets for routine issues and come to this practice when they have a serious problem, This is not approved of by the RCVS, which again acts as an impediment to competition by the content of the Code of Conduct addressing these points.

Nobody should want a 'free market' where animals see multiple vets and receive possibly conflicting treatments e.g. ns aids and steroids which should never be administered together. Clinical histories should be easily and freely transferred. [REDACTED]

The current situation is frankly anti competitive. The government's privacy regulations which do not really apply to pets in any case, [REDACTED]

Reasons listed in our pet owners survey are set out in Table 8.1 below and summarised in detail at Appendix F, which also considers and summarises evidence from LVGs and independent vets, including through submissions and internal documents.

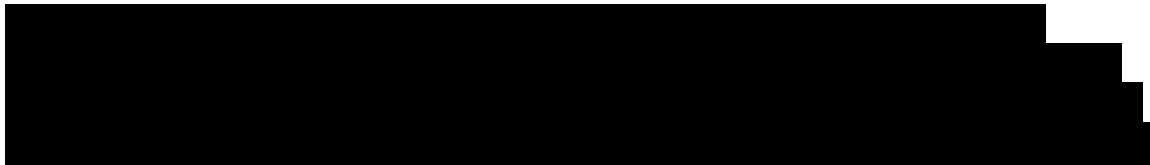
By their own admission, the sample of independent responses elicited was tiny. The sample of LVG responses elicited was large. Appendix F is, therefore, unscientific nonsense whose information which would not survive statistical analysis of the sampling technique. There are many articles available as to how this should be achieved in a mixed population such as the veterinary market.

I know at least one statistician at Imperial who is more than capable of designing proper survey size and selection criteria to draw valid conclusions about a diverse group such as the veterinary market, yet it is quite clear that the CMA simply decided to consult who it decided to consult and did not robustly sample the market as a whole in order to reach its

recommendations. This is an atrocious level of incompetence from the very first day of the inquiry.

Practice ownership may also be an important consideration for some pet owners in their choice of FOP. 21% of respondents reported considering practice ownership when choosing a FOP. Of these respondents, 68% preferred independent practices, with the remaining 32% preferring LVG practices.

Thanks to the furore stimulated by the unfounded allegations from the CMA about how independent veterinary surgeons practice and the libellous nature of the CMA press statements which fail to distinguish to distinguish in the press releases between independent and LVGs behaviour (never mind the CMA's disinterest in properly considering this in the first place), we are now writing 'proud to be independent' on any promotional material which we put out.



Most practices only publish prices for the most basic, simple treatments, and these are not published consistently.

This is again a fundamental misunderstanding of veterinary medicine. We cannot publish easily price comparisons for even relatively simple surgeries. The various submissions received that tis was not a practical possibility were correct e.g.

The BVA submitted that quality and outcome related measures are rarely available from clinical practice and that variability in case complexity, treatment protocols and patients makes it challenging to standardise quality measures

To take a common example:
Skin tumour removal:

- Tumours arise on patients of different sizes (think Chihuahua to Great Dane) with different anaesthetic and medication costs;
- Tumours are of different complexities when excising then (so different levels of surgical time, anaesthetic monitoring and post surgical care).
- The number of post operative appointments are very variable depending on whether there has been a large amount of tissue removed necessitating the insertion of a surgical drain, whether than drain is active or passive.

We always include post surgical check ups in our estimates so as to be as transparent as possible but this is very case dependent.

- whether post operative care in the immediate aftermath of surgery needs to occur in hospital (active drainage and opioid pain relief with intravenous fluid support) or at home (passive with non opioid pain relief and normal feeding)
- Histopathology to determine the margin of excision (whether the whole tumour has been removed) and the cell type or not. Whether this is indicated, at least in our independent practice, is determined by the gross appearance of the lump. Lipomata (fatty lumps) rarely merit the cost of histopathology by an (expensive) external specialist pathologist. Suspected mast cell tumours always do.

Dental disease is if anything even more difficult to publish costs for. A rapid dental descale under anaesthesia can be completed by the RVN in charge of theatre in around 30 minutes. A multiple multirooted tooth removal may take a veterinary surgeon more than two hours.

It is almost impossible in many cases to see exactly what dental work a pet may need when conscious and resisting examination. I always give a range of prices for this procedure depending on what I can see in the clinical examination, but on-line publication would produce a range so wide as to be meaningless.

In contrast, more complex problems e.g. imaging and hemilaminectomy in a paralysed patient is actually quite cost-predictable as there are a series of events which have to occur to help the animal recover so these are much easier to accurately publish. This explains why the referral centres publish prices and compete (although what is published on line is often quite a long way from what is charged in reality).

Like builders who find new problems with every wall they knock down, some referral centres seem to find ways to inflate their charges with every moment the patient is under their care e.g. charging massively for every extra day a poorly pet needs to stay in their hospital or repeating investigations which should not have been needed had the procedure been competently completed the first time.

Nobody can guarantee to do this, but I keep hearing of referral centres performing second spinal procedures because insufficient decompression was achieved with the first (two in the last fortnight alone) and then essentially doubling the cost to the client at a point where they cannot easily go elsewhere. I cannot remember the last time I had to reopen such a case and, in any case, this would be covered by our post surgical guarantee so at no extra cost to the client.

The 'not publishing prices apart from for basic procedures' issue is yet further evidence that the CMA has not managed to reveal any of the subtleties of how clients can be poorly treated and overcharged

The CMA will now consult on the Provisional Decision. All interested parties are welcome to respond to the provisional conclusions by the deadline of Wednesday 12 November 2025

The CMA is clearly fond of comedy. I am only able to respond because I worked either consulting or on call from 9am on Friday 17th to 7pm on Monday 20th and have time off in consequence.

(This leads me to wonder what the typical CMA working week is and how much of that is of the 'shirking from home' variety. Is the CMA professional in its approach and offering good value for money to tax-payers.? This report would indicate the contrary.)

At any other time, I would miss this window for response just as I did previously, due to doing my job. There are comments I could make about the constitution of the CMA and their failure to recognise that, normally, vets like me who would very much like to comment would be too busy doing the day job to do so in the short window of opportunity.

The CMA may well, as happens in such government inspired inquiries, to put it about that very few vets responded to their consultation as an indication that their findings were non controversial. If such a statement is made, I will most certainly be consulting my legal team.

The short statement put out by the person who ran this inquiry not only fails to address the findings in any sensible manner but also fails to mention the way in which this has been conducted and the consequent lack of validity of the conclusions by any objective assessment of the paucity of evidence gained from a significant part of the veterinary market.

it may make it difficult for pet owners to compare prices of specific treatments between FOPs and discover the price differences that may exist. Second, it may make it difficult for pet owners to estimate and compare expected future costs over a pet's lifetime

The solution to this is to require all veterinary surgeons to give a cost estimate which is binding on both parties at the time of proposing a procedure for all non-urgent veterinary care. This is what we currently do. The client then has the ability to take that estimate home and consider the situation.

The only problem is that to gain another accurate estimate from another practice , as explained above, would usually require a visit to that practice, a veterinary examination and an additional consultation fee for a veterinary surgeon to accurately estimate their costs. In theory, this estimate could be made from the clinical records, but, especially with the time constraints on LVG consulting, these are often sparse and insufficient for a good estimation of cost to be made from someone who did not examine the patient.

We often receive requests for our price for some procedure or other particularly dentals but, for the reasons explained above, this is really impossible to provide with accuracy. I am amazed that nobody at the CMA decided to look into why transparent pricing of other procedures was not available when the entire veterinary market is very transparent about those procedures which we can be transparent about.

We cheerfully put this information in our advertising leaflets and tell anyone who asks either by email or phone exactly what our prices are for those procedures which are sufficiently predictable for us to do so.

It seems that, yet again, the CMA assumed that the failure to publish prices for the less predictable procedures was due to a desire to cheat the public. Shame on you. This is a recurring theme and the CMA should take this criticism on board, applying it not only to this inquiry but to others both on-going and which it may undertake in the future.

Table 8.2

All independents 49% 462 42% 17% 179

'Small' independents 43% 395 40% 18% 169

'Mid-tier' independents 70% 84 (all websites) 61% 0% 18

The contents of this table has been specifically designed to mislead.

There are no figures in this report for 'all independents' as the CMA did not consider those multibranch independent practices in the sector which are most successful at any point. We have three branches in the local towns. This ruled us, and our ilk, out from the CMA's consideration.

As previously noted, we are the successful end of the independent sector and we were deliberately excluded by the CMA's decision making. Then the CMA has constructed its data deliberately to appear as if we were included. Possibly someone along the way has realised the sample was incorrectly and indefensibly selected and, instead of addressing the issue, has then sought to conceal this fact. Shame on you, yet again!

Poor selection of your sample in the first place is indefensible but lying about it in a report where we, the veterinary profession, are being accused of an absence of transparency is deplorable.

The Veterinary Surgeons' Code of Conduct's first principal is Honesty. Where is the CMA's Code of Conduct? Honesty is clearly not the first principal or, if it is, the chairman of this report has clearly disregarded this and has failed in his duties in its preparation.

This inadequate report should be accompanied by a clear and transparent complaints procedure for those who are reading its persistent untruths to follow. If you would like to supply me with one it would be much appreciated and possibly avoid the organisation in an length judicial review.

Heaven alone knows the criteria on which it was decided how single branch practices were assigned to being 'small' or 'medium' as almost all of these were perforce small by the way in which the sample was selected. It is normal practice to publish the criteria for selection and the statistical analysis which was performed in deciding those criteria in any scientific report. This is unevenced and untruthful nonsense which is seeking by an incorrect choice of words to conceal the bias inherent in the CMA's behaviour during this inquiry.

We note that the almost complete lack of transparency and comparability of prices for more complex services could, in theory, give FOPs the opportunity to attract pet owners based on cheaper initial services

This conclusion is untenable based on the evidence of my own career and local environment. The CMA presents no evidence to support it. It is simply further evidence of the bias of the people who conducted this report.

Whoever wrote this is implying here that my practice's policy (and those of other caring independent practices) of keeping routine treatment cheap, so that it is affordable for all, is actually a trap to lure in clients and then hit them with high costs for simple procedures. This is completely untrue. No evidence of this exists and none is presented. We are trying to offer an inclusive service which helps all sections of our society to afford the care their pet needs.

This ethos is also why we have set up a referral arm this year to provide treatment for the clients who cannot afford the inflated fees of the large LVG owned referral sites. I do not suppose for a moment that the government employees at the CMA considered that veterinary practice principals, such as myself, exist in the independent sector, and act in these ways out of a desire to promote the best possible animal welfare. The CMA's concentration of evidence gathering from LVGs suggests not. I repeat, shame on you!

RCVS Knowledge, which aims to measure and improve the quality of veterinary care and is the charity partner of the RCVS,348 submitted that measuring quality in veterinary care is not impossible

I would agree with this, but submit that detailing of services on websites and encouraging the RCVS to promote the appearance of Advanced Qualifications on those sites rather than disapproving of them would help clients who had an interest in this to assess the likely quality of care. Sadly, the majority will continue to go on location alone when deciding which practice to consult. Nothing I, nor the CMA, can do will change this fact.

the veterinary sector does not have an equivalent of the National Institute for Health and Care Excellence

I seriously hope that the CMA is not regretting the absence of a NICE equivalent for our industry. NICE price fixes, often with poor clinical evidence and scientifically unsupportable data, and limits care in consequence.

When my colleague, Brian, proposes chemotherapy he wants to propose the one which is the most effective and which has with the least side effects, not the cheapest. This is on the grounds of animal welfare.

We put a 1.2 mark up on the chemotherapy (cheap but very toxic CHOPs protocol or expensive but far more likely not to induce organ failure e.g. Palladia) to include the annoying ordering process from Chemopet, delivery and safe storage of a cytotoxic agent.

often follow from a conversation about the range of choices that the pet owner could make

This is simply practising good veterinary medicine, but the report fails to address the issue of LVGs limiting which referral centre can be promoted to clients and forbidding the mention of more cost effective options even to those clients who clearly cannot afford what is proposed.

where multiple referral providers are available and clinically appropriate, we would expect pet owners to be made aware that they can choose a referral provider and to be able to access information about those providers including the nature of the treatment, the skills and experience of the referral vet, the availability of appointments, and, in many cases, the likely cost.

A requirement included in the Code of Conduct

to discuss all the available local options when suggesting referral would result in better animal welfare, as transporting ill animals long distances is never in their best interests, and more pets getting high quality treatment, as more clients would be able to finance the advanced techniques on offer if they were encouraged to 'shop around'.

For OOH treatment, as well as the treatment options described above, there may, in some situations, be an additional option of waiting until normal business hours to receive treatment from their regular FOP.

Dedicated OOH services have protocols which require the staff to offer to see the patient whether the issue is an emergency or not. Our OOH service does not do this because, apart from anything else, no client wants to pay emergency fees when it is not needed and no vet wants to see OOH a patient who could be seen the following day when they are on call (rather than working a night shift) and trying to have at least a little down time.

I have worked on call for 40 years now. The growth of dedicated emergency clinics has elevated the costs of emergency treatment as their staff have to be paid specifically to be present all night. If they were required to triage patients so as not to waste client money on unnecessary visits to the emergency vet, this would destroy the economic model on which they are built but be a great deal fairer on the public.

This is why earlier in this document I proposed a return to each clinic providing its own local out of hours service as we used to have to do. We would then stop wasting clients money and time and start giving good out of hours advice. Most out of hours telephone calls are not urgent. They are just from people worried about what their animal is doing or feeling. They do not require action, but they are getting unnecessary treatment at vast cost in the current market. This is another area into which the CMA could have looked much more effectively but did not.

However, the evidence indicates that there is a lack of consistency in the approach taken by vets to help pet owners make well informed choices

This is highly dependent on the competence of the veterinary surgeon. Looking at the referral histories we receive, there is a significant cohort in FOPs whose knowledge really is insufficient for them to describe treatment options accurately, never mind with a sensible and logical price attached.

This will always be inconsistent as a client might be seeing a new grad from overseas in a practice where support is poor (Yes, I know there is now VetGDP monitoring of progress but that is really insufficient to the challenge) or a very experienced vet who will be able to propose and perform the complex procedure for themselves without the need for external referral (This is always the most cost effective option for the client in my experience).

On referrals specifically, pet owners could more often be made aware when alternative providers are available.

This would be a great step forward in providing affordable advanced treatments.

The insurers should also be told to stop discriminating in favour of some referral services over other less expensive ones and open their referral networks to all or to do away with an approved network altogether as this is essentially a price fixing cartel which is against both the letter and the spirit of UK law.

even if there is under-reporting, the pet owners survey indicates that a substantial number of pet owners are not given alternative treatment options.

There is no recognition in this report that for some conditions there are several treatment options e.g. allergic skin disease which can be clearly presented with pros and cons but for others e.g. pyometra in the bitch, there are no, the condition can be immediately life threatening and presenting options is a waste of valuable time when surgical intervention is indicated.

The CMA does not seem to have gained the slightest comprehension of the difference between a condition where many options are possible and may work and others where essentially it may be 'Hobson's choice' so presenting options is a nonsense. The veterinary profession appears to be condemned for not offering options where there are none.

This is as a result of unqualified people who did not ask the appropriate questions to achieve knowledge and understanding deciding simplistically to condemn a profession when the real life situation is far more complex than they are capable of appreciating.

vets reported that whether a pet owner had insurance influenced the options they give pet owners and how they communicated those options.

This issue can be firmly laid at the door of the universities teaching veterinary degrees in the UK. New grads emerge with this idea firmly in their heads and have to be dissuaded from

using insurance as a criterion for what they propose. A firm word with the Deans of faculty would be very useful here.

Ethically we should discuss all treatment options (if several exist) with all clients and allow them to choose the one which most closely fits both their budget and their personal philosophy of animal care. This is what I encourage my veterinary team to do. They should then fit their proposal into what the clients can manage not only to afford but also to administer.

In contrast, the LVGs seem to put a big emphasis on not only selling insurance policies (which I refuse to do as it is not one size fits all) then also tailor their recommendations to the existence of insurance or not. Clients often have very poor understanding of their insurance, what it does and does not cover and what the limitations are.

More transparency on the part of the insurance companies would be another major area which requires improvement. Animal Friends, while they pay claims promptly, have a particularly Byzantine system of exclusions which seem utterly without logic to both the clients and myself.

Responses to our pet owners survey suggest that pet owners with insurance were statistically significantly more likely to be provided with fewer treatment options than pet owners without insurance

This again causes me to call into question the efficacy of sample design. In my experience, more options can be provided to clients with insurance as there is a greater chance that the gold standard care which RCVS exhorts us to offer will be accessible to this group. I am perplexed yet again by the way in which sampling was conducted and have grave doubts about the robust design of the survey methods used.

We have found that some pet owners are not routinely being given the information about prices for treatments which we would expect in a well-functioning market.

This is a Code of Conduct issue. All veterinary staff are expected to obtain informed consent for any procedure. This includes consent about what will be done to the patient and informed financial consent. The best way to enforce this would be to make the Code of Conduct more explicit and require a written estimate to be given before every procedure over a certain cost. I believe this is what has been recommended and it is certainly something which we routinely do at the moment for all procedures more extensive than can occur in a single consultation slot.

Price estimates, when provided, were often given only orally rather than in writing. We recognise that written estimates may not always be appropriate, for example in emergencies.

This is completely incorrect. Even in an emergency we are required to obtain informed consent. If we admit any patient, whether in an emergency or not, the owner needs to read and sign a consent form which is required to include an estimate of cost. A reminder that

this is a requirement and some publicity surrounding this requirement would go some way to sorting out those professional colleagues who appear not to be sticking to the rules if the CMA's research is to be believed.

The evidence we have gathered suggests that both LVGs and independent practices are not doing enough to ensure that their vets are routinely making pet owners aware of prices before the pet owner decides on treatment for their pet.

By its own admission, the CMA hardly asked any independent practices what they did on any subject but, here we are again, concluding that, if the LVGs are not properly behaved, neither are the independent sector. Shame on you! Yet again, the CMA did not ask, has no evidence and has drawn an unjustifiable conclusion.

Evidence from roundtable discussions with animal charities and vets indicates that lack of understanding of Specialist qualifications can lead to misunderstandings about the quality of care being provided.

The issue here is of what constitutes appropriate qualification and what is a good standard of care. Personally, I find home care from several of the larger referral centres to be often poor and badly explained which in my field leads to unnecessary contractures after spinal surgery and an inability to regain function in pets in circumstances where good quality teaching of owners at the time of discharge would have been preventative.

In consequence, unfortunately, the actual qualifications of the veterinary surgeons are not a perfect guide to the likely outcome. The strength of communication with clients is a better measure of this but is very staff dependent and can vary considerably even within one centre.

The encouragement of staff at referral centres to push for expensive treatments rather than discuss what the owner can manage and what outcome is likely leads to tragedy

I find it especially depressing to be receiving cases where the insurance money has run out and the pets have been essentially just left without help. LVG referral has some questions to answer which are not addressed in this report as far as I can see. This is what independent practice at high level, there to help clients and pets actually has to put up with. Nobody at the CMA even tried to develop an understanding of the way in which this market really functions. The report is a travesty and a missed opportunity to create something which works much better.

Information about the prices of referral-only providers is not consistently being made available on their websites.

This is untrue. A few minutes on Google will tell me the price of all comparable referral services in the surrounding counties in so far as such prices can be streamlined to a point where pricing can be accurately published.

The more pressing issue is the tendency to get people to referral then suddenly start doing more than was originally envisaged and elevating the cost accordingly. Sometimes this cannot be helped in a serious ill patient with a dynamic disease process but sometimes it very much can (see earlier commentary).

‘when referring cases, veterinary surgeons should explain any links to the referral practice that could be considered a conflict of interest... including where the practice being referred to is owned by the same group’

The problem with this worthy sentiment is that it is not enforced. [REDACTED] practices which appear locally to be the ones prohibited from mentioning other referral options almost certainly do not mention clearly that the referral is to another [REDACTED] practice as this tends to really annoy the local clients because they tend to think, possibly correctly, that this is just another way of generating additional profit at their expense.

In this subsection we set out the evidence indicating that there is a lack of regulatory pressure to ensure FOPs provide treatment and referral options (and information about these options), and that this means that FOPs and referral providers may act in ways they would not in a well-functioning market.

[REDACTED]

Even if the RCVS were to identify such a failure, it would have very limited ability to act because such a failure is likely in many cases to fall far short of the serious professional misconduct in respect of which the RCVS can take formal disciplinary action.

This is a gross misrepresentation of ProfCon’s behaviour.

[REDACTED]

RCVS pursues minor misdemeanours which have no chance of appearing before the Disciplinary Committee obsessively thus causing upset to both veterinary staff and complainants over very long periods and delaying any form of resolution often for years. This has a very wearing and depressing effect on the profession. The problem is not a lack of disciplinary sanction but a lack of professional behaviour on the part of the regulator.

Discussing treatment options and prices with pet owners, taking account of their circumstances and wishes, can be a complex matter for vets given the range of considerations involved. It is important that vets are given support and training. This will enable them to provide appropriate and timely information about treatment options.

This is already occurring. It is an integral part of EPA1 in the Vet GDP which all new grads need to complete.

The issue here is that some practices will happily allow their new grads to pass VetGDP even when they are not really year one competent (including able to discuss financial and treatment options for complex cases with clients). This is purely a on-line statement based system so it is very easy for a new grad to appear more competent in their VetGDP portfolio than they really are. Some form of quality control from RCVS on people, who submit portfolios, when they cannot in reality fulfil the demands of the scheme, would be useful but I am unsure how that might be managed.

Vets have told us that there is sometimes a gap between gold standard care as taught in vet school and the day-to-day experience of treating pets

This is a massive understatement. Vet degrees invariably teach one clinical problem at a time but particularly for geriatric patients several problems at once is the norm.

This is what VetGDP is really for, to bridge the gap between an academic consideration of disease and reality. Although this is a praiseworthy RCVS initiative, it is not really sufficient to create good competent communicators without committed senior vets helping them along. It is these which are lacking in many practices. The time to teach is also an issue especially in protocol driven LVGs.

I am unsure how well VetGDP is working country wide. I supervise new grads doing VetGDP and the standard seems to be very variable. For example, [REDACTED] qualified vet who can do less, and is less competent to discuss options for care, than a graduate which we trained but only qualified last year (her surgical and medical skills are similarly far behind).

The CMA might want to note at this point that training time, when a senior vet stands next to a junior one to teach procedures, is another practice cost of which there is no mention at all in their considerations and which we do not ask the clients to fund. They pay the same whether their pet was examined by one vet who did the procedure or two where one taught the other. I do not know whether one produces a superior result compared to the other, but the second costs more than twice as much to the practice compared to the first.

Only one LVG [%] has submitted any evidence of effective training or guidance given to vets on how to put customers at ease specifically when choosing less sophisticated (and cheaper) treatment options, when these are clinically appropriate

Why did CMA only discuss this matter with LVGs yet again?

There are sections here where they say there was no evidence obtained but in the independent sector there is plenty of evidence of in house training should the CMA staff have been sufficiently motivated to research this area rather than just accept what the LVGs reported as 'Gospel' for the whole industry.

Similarly, there is commentary on the CPD policies of LVGs but no consideration at all as to whether these are adequate to prepare vets for difficult discussions nor whether they are adequate to produce clinically competent practitioners. I have already cited above the stark contrast between Medivet's CPD policy and the policy of my practice.

Yet again this is a very one sided view of what is happening in the veterinary industry when any inquiry could have produced a much more rounded result with more defensible outcomes.

These standard business practices can help veterinary businesses run efficiently and help produce good outcomes for pet owners. However, they have the potential to put pressure on, or unduly influence, vets' decisions, including about the treatment and referral options they offer. A concern would arise if business practices conflicted with vets' obligations to provide appropriate and timely information about treatment and referral options

Submissions from LVGs indicate that they consider that their vets can exercise clinical freedom.

This is much more than a concern. To cite an example:

- A dog has superficial pyoderma (skin infection) which is not resolving
- The Vet takes skin swab for bacteriology
- The result returns showing Marbofloxacin to be the only effective antibiotic
- The vet asks the support staff to order Marbofloxacin.
- The staff refuse because it is not on their order list.
- The vet in question, who is a locum so has no permanent connection to that practice, demands to know why.
- A person from head office comes and explains that even though the drug is clinically indicated the vet is not permitted to order it for any for the pet.
- The vet in question tells this person that he is MRCVS and his clinical decision holds or he will report the manager to RCVS (even though, as an untrained person, RCVS has little jurisdiction, but the vet did not trouble to tell the manager this fact).
- The dog gets the treatment it needs.
- The locum is never hired by that practice again.

LVGs, don't you love them.

The locum in question [REDACTED], also a very experienced MRCVS. Only real rudeness and determination got that dog what it needed and, please note, there was no question of allowing him to prescribe what the practice did not have and was not willing to order.

Financial incentives based on clinical KPIs, such as treatments sold, do not seem to be a common practice

Really? The CMA have been completely hoodwinked by the LVGs on this point. Selling is what they do.

This information is based on many interviews. I have hired various vets from LVGs and one who I did not hire much to her surprise. I did not hire her because her USP, in her opinion, was that she was the highest performing vet on her current team and, therefore, the best at selling regardless of the needs of the patients. I am not going to work with someone who considers that to be a good thing.

Another real life example:

A new grad took a job at a large referral centre which I will not name but could easily do so. She had a review after her first month. They showed her financial performance for that first month to her and then informed her that, in the following month, she was expected to do 10% better.

How was that to be achieved without pushy selling of things which the patients may or may not actually need?

[REDACTED] In contrast, although we discuss flea control and worming especially for young patients, I could not give a hoot whether we sell parasite control or the owners get whatever they fancy elsewhere. We are therefore a 'breath of fresh air' to both the RVNs and the clients who arrive from other surrounding practices.

The CMA has been overly innocent in believing what they are told without speaking to enough others in the sector to hear some interesting, if anecdotal, information about what is really going on.

Our provisional view is that pet owners can make substantial savings when purchasing a prescribed medication from an online pharmacy rather than directly from their FOP

See earlier comments. This really only works well if an animal is on a stable dose of a long term medication with no treatment changes required in the foreseeable future.

It works poorly for acute conditions due to the delay in starting treatment while the owner accesses a supply of medication.

It works poorly in terms of client support and communication while collecting repeat supplies of medication.

It works poorly when a pet is unstable on medication so the medication prescribed has to be changed and then possibly changed again.

It does not work at all for dangerous drugs particularly chemotherapeutic agents as noted earlier.

Online prescriptions also hand money to the LVGs who own them. In consequence, any compulsion for independents to write prescriptions rather than supply medications directly to clients (even given that cost differential can be minimal as it is for our long term medications) hands the commercial advantage to the very group whose business practices have led to this inquiry.

That is in no way a fair outcome.

Our analysis of data obtained from LVGs that own and operate online pharmacies (CVS, IVC, and VetPartners) shows that the price of veterinary medicines at these online pharmacies can be between 50% and 60% less than the price of the same veterinary medicine at their FOPs.

That should just have indicated to the CMA that the LVGs are overcharging at source for the medication, not that buying on-line is inherently better. We have ensured as far as we can that it is not in this practice for long term medications. The failure of the CMA to consider any possible approach other than that of the LVGs for the vast majority of this report makes the recommendations inherently unsound.

Many pet owners could make substantial financial savings of [£200-300] on average annually when purchasing commonly prescribed veterinary medicines from an online pharmacy rather than a FOP

That is entirely dependent on the charging policy at the FOP. LVGs re carrying out daylight robbery. There is no reason to punish the rest of the sector for their misbehaviour.

All LVGs have told us differences in costs between 'bricks and mortar' FOPs and online pharmacies (such as the staffing costs needed to provide medication to pet owners, costs of complying with regulations on reporting 'adverse events' and storage and wastage costs) may explain the differences in prices.

Retail prices for veterinary medicines at both LVG-owned and independent FOPs appear to be between two and five times their purchase costs on average, which is equivalent to an average mark-up on purchase costs of between 100% and 400%.

That is arrant rubbish. As you will read above, somehow or other this practice achieves and internet style mark up (20%) on all long term drugs so the LVGs could do likewise. After all they have the advantage of economies of scale in a way which we do not.

Why did the CMA not seek the views of the independent sector in any meaningful way before drawing these conclusions?

We do not sell things where we cannot get close in price, for example, prescription diets cannot be purchased by practices at the price one sees on the internet so we advise the

clients to buy on line and only order them for those clients who do not wish to do so or cannot access the internet easily for whatever reason. There is no real animal welfare issue with this unlike many of the treatments which can be life threatening if the client has to stop for a day or two should their medication delivery not arrive.

Our estimates of the level of gross contribution from the sale of medicines shows that medicine profits account for a large proportion of the overall level of profitability of a FOP.

For a business to keep trading, the fixed costs have to be paid. That cost can be loaded onto medication charges or onto other charges. It does not go away.

The LVGs will not expect a lesser return if they are no longer selling any drugs so the costs of consultations and procedures will rise. This means that elderly owners of small animals will pay the same as people in work with large dogs when, at the moment they pay substantially less because the cost of medication is much lower (mark up notwithstanding, this is dose related).

The CMA suggests that a prescription for a single item for single use will retail at £16 plus VAT. This will be in addition to the consultation charge. We are already charging this amount.

For many cheaper medications, it would actually be much more cost effective for us simply to supply the medication.

For example:

Written single use prescription for a single item £16 plus VAT
Consultation £39.95 plus VAT

For a 10kg Westie with skin irritation and secondary superficial pyoderma
(This is a very common type of consultation especially in summer)

The current cost for consultation and medication (Prednisolone and Kesium for 2 weeks at an appropriate dose) is £71.95 plus VAT = £86.34

The cost of consultation and a prescription would be £55.95 plus VAT = £67.14
The cost of the medication would be (source VetUK) £14.09
Total cost £81.23

Thus the client has spent around £5 less but their dog is still untreated, itchy and scabby until the medication arrives.

To order on line medication, the client has to scan and upload the prescription which many do not have the facilities or ability to do.

If they post their prescription, the on-line pharmacies will take their money but not send the medication until the paper prescription is received (around 2 days to get it posted and delivered to the pharmacy).

The time delays quoted by on-line pharmacies are 2 days to process the prescription and then (with express delivery) 2-3 days to deliver it.

The dog therefore suffers and its bacterial infection worsens for around a week after the diagnosis is made at the vet practice.

Is that a good thing? What ever happened to animal welfare?

Thankfully the CMA appears to have reluctantly recognised this time delay is a therapeutic disaster. We are not the NHS. No pet waits a week for an appointment. Let us get them treated promptly and reduce animal suffering.

What are the effects of prescribing for short term treatments for medication delivery from on-line sources:

- The cost to the client is a small amount less.
- The onset of treatment is delayed so their pet's problem goes untreated for around a week after diagnosis.

This represents an increase in animal suffering in this instance but could represent the difference between living and dying were we to consider a pet with more serious systemic disease.

- The practice incurs lower costs as we do not have to stock medication and pots/ labels or spend time explaining how to give meds and what they do to help treat the issue to the client, but we do spend time prescription writing, which is time consuming to do correctly. That additional time is included in the cost of the prescription.

The practice saves in the cost of carrying stock. The stock used here costs (assuming a x2 (100%) mark up on both drugs as this is our standard mark up for short term medications) including pots and labels £16.00, because we do not benefit from the same bulk discounts as online pharmacies do.

Therefore, the money charged for this consultation if we supply medication is £5 more, but by writing a prescription our costs become £16.00 less.

In theory, we should wish to follow this model, but the animal welfare impact is considerable and I would never do so unless I am forced by the muddle-headed behaviour of this government egged on by the CMA.

- The LVGs make more profit as the medication is purchased from them.

The motivating factor for the CMA inquiry was to address the excessive profits of LVGs.

Once the LVGs are receiving an effective monopoly on veterinary prescribing as a result of the CMA's action they will hike online prices so they are being favoured and encouraged to profit even more by the market model which the CMA is recommending.

This outcome makes medication less accessible and relief for the animal less immediately available, for a small saving in cost to the client.

The CMA has not concentrated its attention on this sort of consultation and one off supply of medication because there is at least some slight recognition that veterinary practices play a useful role in making acute illness better.

The focus instead has been on long term treatment where the CMA imagines that veterinary practices make most profit, so here is a second example.

A more long term example:

A 25kg dog with arthritis on on-going Carprieve, Gabapentin and Pardale

(This is a very common combination of medication used to help old, stiff dogs to remain comfortable when they have moderate to severe arthritis.)

Medication cost from our veterinary practice

The cost for the 6 monthly consultation required by the 'under care' rules and for us to supply medication for the six months until the next check is £279.08 plus VAT = £334.87

This is supplied at 2 monthly intervals as we are allowed to do so (but no more) by the VMD's rules for responsible prescribing.

Medication cost by prescription from on-line pharmacy

The cost of the 6 monthly consultation required by the 'under care' rules and for on-line prescriptions to supply medication for the whole of the six months until the next check is £167.95 plus VAT = £201.54

This is the cost of 6 individual prescriptions for Gabapentin and 3 prescriptions of 2 months duration for each of the other medications. The reason for the difference in prescribing between the three medications is government legislation. We can only supply monthly scripts for any prescription containing a controlled drug. Gabapentin falls into that category so repeated short term prescriptions would be required.

Note this assumes that we do not charge £16 plus VAT for every prescription for a single item (the CMA requirement) but charge for the script and put two items on each as we do now.

The cost of Carprieve from VetUK would be £19.73 for 2 months = £59.19 for six months
The cost of Pardale (currently on 'special offer') is £66.38(2 months) = £199.14 for 6 months.
The Gabapentin cannot be ordered from the same place because it is from the human market so would need to be sourced elsewhere and the prescriptions sent to a different retailer.

The cost of Gabapentin and delivery = £31.94 per month = £191.64 for 6 months
Medication costs from the on-line retailer = £449.97

The total cost to the client for online prescriptions and the medication themselves would be £651.51.

The client would pay £316.64 more for their pet's medication and have far more hassle with ordering supplies on time to maintain treatment from the on-line retailers as these state on their sites that there is around a week's wait from their receiving each prescription to its delivery. This requires better organisation than many of our clients seem to possess, which is why we write few prescriptions and many clients, having had one written prescription, never ask for another.

The practice would lose revenue to the tune of £55.79. Part of this is staff costs (veterinary time reviewing prescriptions; nursing time talking to clients on the phone where most request a prescription and when the client collects the medication; the labels and pots into which we dispense), some is medication costs.

Prescribing costs:

Supplying Medication

We use child resistant pots so the cost for all of these for each pot of medication is £2.00 including VAT. Over six months this would come to £18. The drug costs are somewhat dependent on the rebate from the buying group of which we are a member to try to control drug costs to us and to the clients, but our mark up is 20% so it is reasonable to assume that the cost to the practice for medication is £217.57.

So each similar 6 month course of treatment (and this is a very common combination of treatments for arthritis control) costs the practice £236.57 to supply.

Producing written Prescriptions for Medication

Each prescription takes around 5 minutes of veterinary time to produce. That is to review the clinical history to ensure that nothing has changed since the last prescription; write a new in-date prescription; sign and date it and apply the practice stamp (this is to prevent fraudulent use by the client at the request of the VMD).

These are prepared by the consulting vets so each costs around 5 minutes of consulting time. Our consultations are £39.95 plus VAT for 15 minutes (or as long as it takes!), so 5 minutes should earn £13.32 + VAT plus a little for printer ink, paper, nurse time to hand over the script or to scan and email it. In consequence a cost of £16 plus VAT per prescription is a justifiable charge in our environment. In the South where building costs are higher, it might well not be.

To write scripts instead of prescribe, the cost to the practice is £119.88 (excluding VAT as that is tax paid quarterly to the government).

In consequence, the current proposals mean that

- the client would pay £316.64 more every 6 months.

- The practice would earn £55.79 less but would spend £236.57 less.

It would actually be a financial advantage for the practice not to supply long term prescriptions such as this one, but the level of client cost would be much higher and the level of animal welfare would be much lower.

Please can the CMA explain the logic behind their prescribing proposals?

Their conclusion can only be based on speaking exclusively to the LVGs which this report reveals as generally charging more than the independents while offering a service with which the clients are less satisfied.

No financial analysis has been done of the effect on the clients or on their pets, as I have done, using my practice management system, in the production of these figures.

The only possible explanation is that in seeking to punish vets for imaginary profiteering their proposals are likely to cause clients increased cost, inconvenience and stress.

I am very happy to write veterinary prescriptions for those who want them or for those products where we cannot get near the on-line price, but this is a free market economy (or so I heard at the last count). The government should be dedicated to allowing consumer choice as to where the clients choose to acquire their medications.

The CMA should not be making life more expensive for the poorer and older sections of the animal owning population who are less likely to have online access and be able to scan prescriptions for the on-line pharmacies to receive promptly.

We are offering an excellent and competitively priced service so why is the compulsion to write prescriptions being forced upon us.

The CMA's incompetence and bias, either conscious or unconscious, has a great deal to answer for.

we have provisionally found that veterinary businesses covering a substantial part of the market earned profits materially exceeding the cost of capital over a sustained period

Given the analysis above, this conclusion is unsustainable and is yet another indication that the whole of the veterinary market was not considered in making these recommendations. Defensible sampling strategies were not adopted to select what size of sample should be contacted to obtain accurate results (100% of LVGs versus 21% of practices which are independent), so, as they say, it is 'garbage in, garbage out'.

Despite the potentially significant financial savings available to pet owners when purchasing medication from third-party retailers, pet owners purchase most of their veterinary medicines from FOPs.

The mathematics above indicate why so few clients want written prescriptions even though these are on offer. Their costs for common long term medications are much lower if they use the practice to supply them rather than have prescriptions and the service they receive is much better as we supply medications the same day if clients have let themselves run out. This happens a lot.

We have sought to understand the reasons why most pet owners do not purchase medication from third-party retailers despite the substantial savings that are available to them when doing so.

Could it be because these ‘substantial savings’ are a figment of the CMA’s imagination or an indication of conscious bias in the face of facts which they did not seek to learn? A cynical person might be drawn to conclude that this was the case.

This is not to suggest that all vets and veterinary businesses act only on their commercial incentives. Our qualitative research with veterinary professionals shows that many vets do support pet owners to choose the best option for them when purchasing medication that has been prescribed. This includes discussing the option of written prescriptions for pet owners to purchase on-going medication online where it might be cheaper for them to do so.

And not doing so when the cost on-line will be greater?

In any case a simple requirement for a sign on display on all consulting rooms would be enough to ensure that all are well informed about both our ability to provide prescriptions. This sign should also include the cost of both single use and multiuse prescriptions. In the interests of fairness, it should also include the likely delay which the client can expect before they receive treatment should they order online.

I do not think the possibility of medication being cheaper if supplied in the veterinary practice ever crossed the minds of the staff at the CMA making their analysis of this issue inherently unfair and open to challenge.

Pet owners may not be able to effectively assess the quality of medicine sold by third-party retailers without the support of their vet

This is certainly true. I have seen clients with ‘knock off’ pots of Apoquel with Cyrillic script on them whose efficacy was zero (which is why we were seeing them back at the practice with a red and sore looking pet). This is evidence which contradicts the CMA’s assertion:

there is no difference in the quality of medication sold by FOPs and authorised third-party retailers

That is not the real world experience.

Buying prescription medication at the moment is very much the ‘wild West’ so quality assurance is a problem.

The buying and selling of prescription medication on Facebook with no prescription is also absolutely rife leading to inappropriate treatments being traded on line between people with neither a veterinary diagnosis nor a prescription to support their use. The VMD is somewhat depressed about this, as I learn from our local inspector, but can do nothing about it. This is an area where government action would improve animal safety.

The answer is not, however, to hand even more capacity for profit to the LVGs by making RCVS approve their on-line pharmacies.

vets may not provide a written prescription for injectable medicines and medication with other administrative forms in all circumstances

And there is very good reason for this (see earlier example relating to chemotherapeutic agents). Does anyone want cytotoxic agents capable of doing harm particularly to small humans and other pets stored in their fridge at home?

Even when pet owners know that they can obtain a written prescription, few are aware of the potential savings available when purchasing medication from a thirdparty retailer rather than their FOP

Given the examples above, the only possible response is ‘Don’t make me laugh’.

The CMA’s inquiry is hopelessly biased as a result of not troubling to communicate with the more successful independent practices such as ours which are working for the benefit of their patients.

Our survey indicates that comparing prices for veterinary medicines made it much more likely that pet owners would purchase medication from a third-party retailer compared with those who had not compared prices

Those who compare prices on-line usually fail to take into account the regulatory requirements of the ‘under care’ rules and the requirement for prescriptions to purchase POM medication.

We get a scattering of irate phone calls from people, who have purchased a written prescription then discovered, when they finally do the maths properly, that they have just cost themselves money (see the example above).

Current prescription fees range widely, with a quarter of prescriptions priced below £15 and a quarter above £25.703 We also see that some of the higher fees are charged by LVGs

Well, there’s a surprise. Perhaps the CMA should have looked at prescription charges over a wider range of practices without lazily focussing solely on LVGs for the majority of its conclusions, but applying them to all.

our evidence and analysis suggest that the sale of veterinary medicines by FOPs appears to be highly profitable

Just another error based on poor quality data.
(See the analysis above)

We received representations that there was not a level playing field in relation to the purchase costs of medicines that are paid by FOPs and third-party retailers.

This is certainly true. There are some medications which we as a veterinary practice even as members of a buying group in an attempt to achieve better economies of scale cannot buy for the prices they are soled for on line.

This is in part a drug company issue. For example

The clients are allowed to buy drugs from anywhere. This means that those able to do so access cheaper German versions of the same drug.

The vets have to buy from UK registered sources, so we are denied access to the same supplies even though they would be more cost effective both for the practice and for the clients.

This is another source of inequality of treatment of veterinary practices which elevates veterinary costs, it is entirely attributable to government controls. The CMA did not trouble itself to investigate any aspect of the effect of this differential pricing and restriction to market access on UK veterinary practices' drug costs.

There is scope for independent FOPs to lower their purchase costs for medicines by joining a buying group or by switching to a buying group that offers a Preferred Product membership scheme

Preferred product schemes are a whole new area for ethical debate about prescribing.

We are Platinum Buysure members but there are some preferred products which we refuse to stock. The reason that we do so is that the Platinum products are sometimes not the most cost effective or user friendly for the client (monthly flea and tick control for a country dog versus three monthly for the same cost – which would you choose?)

We can do this because I have a hard nosed attitude to negotiation and Buysure buys a large amount of medication for us so I have negotiating power with their representatives. Not all independent FOPs are this fortunate.

We get far less discount on the alternative product but we stock what we consider to be best for our clients and their pets. The CMA does not even start to try to understand the ethics of

proper prescribing behaviour and its influence on veterinary medication costs at any point in their report.

The main options available to pet owners looking to purchase veterinary medicines are FOPs and online pharmacies.⁸²³ Although we understand that it may be possible to purchase some medication for animals from 'bricks and mortar' pharmacies, we have not seen evidence to suggest that this is a material sales channel for veterinary medicines.

This is the case. There is no incentive for local pharmacies to carry veterinary stock as the chances of their turning over sufficient volumes to justify the additional stocking and storage costs are slight.

Administration and injection fees appear to relate to the same basic activities (such as calculating and correctly drawing the dose, preparing and administering the medicine to a pet, and checking whether the medication is appropriate for the pet under care), but these fees may be more common for clinical procedures or hospitalised pets.

The CMA completely ignores some of the major costs of medication administration by injection.

These are the cost of

- the sterile supplies (needles and syringes)
- the stocking costs of holding a wide range of these to suit all drug types and animal sizes;
- the cost of disposal of used vials (DOOP) and of sharps which is a significant cost in our practice. We pay around £1,000 per month for this service.

Dispensing and prescription fees may also cover the cost of anticipated follow-on activities that are not separately charged for, including, for example, answering queries from pet owners or third-party retailers (such as requests to change the prescribed medicine to a different brand), responding to side-effects experienced by a pet, and on-going responsibility for the use of medication to treat the pet under care. ⁸⁵⁵ These activities are typically carried out by a vet after the initial consultation with the pet owner and do not necessarily require a pet owner to return to their FOP for another consultation with a vet.

I would be very surprised if these were included in any fee by any organisation involved in veterinary prescribing.

Our prescription charges are for veterinary time in writing the initial prescription and nursing time in supplying it to the client. They do not include any of this stuff. We do it for free when we need to.

Three online pharmacies in the UK are owned and operated by LVGs: CVS is in the same group as Animed Direct, IVC is in the same group as Pet Drugs Online (PDOL), and VetPartners is in the same group as VetUK.⁸⁵⁸ There are several other online pharmacies that offer POM-Vs in the UK which are not part of groups that own FOPs

So despite being aware of this, the CMA is proposing to hand more profit to these LVGs and preventing the independent practises from competing on service and price with them.

As I have previously written:

Shame on you, CMA, for a lazily constructed and biased report with recommendations which favour the very groups making most profit from veterinary clients.

Not the outcome which the government had in mind, I feel.

Table 11.3 shows that pet owners can potentially make substantial savings by purchasing medication prescribed by a vet from an online pharmacy rather than their FOP.

No it does not. The table refers to LVG FOP prices and LVG online prices. It does not even bother to address independent veterinary practice pricing.

Yet another potentially deliberate misrepresentation by the CMA.

This unevidenced conclusion cannot be seen simply as a distortion resulting from ignorance, unless the people preparing this report are either very stupid or very incompetent.

It shows that LVG FOPs are more expensive when supplying medications than their clients would be if they bought them on line.

It shows nothing at all about their independent sector as the inquiry essentially excluded almost all of those practices from their considerations.

Our analysis shows that pet owners could save [£200-300] [%] on average each year when purchasing commonly prescribed veterinary medicines from an online pharmacy rather than a FOP

This is arrant nonsense as evidenced from the examples of commonly prescribed medications described above.

The CVA considered only LVG pricing and supply strategies in any detail and nor with any wide spread examination of the market. Their conclusions are consequently meaningless and entirely incorrect.

***Some examples of commonly prescribed medicines included in our case study analysis are:
(a) Apoquel 16mg for allergic dermatitis***

This is currently on 'special offer' at the online pharmacies which I reviewed.

At its normal price, the saving over a year for online prescriptions is £11.

At the offer price, the annual saving, as long as the whole year was at that price, is £363.

(b) Vetmedin 5mg for heart failure

We do not stock Vetmedin, as it is more expensive for us, and for the clients, than Cardisure an equivalent medication with the same active ingredient.

We are really unlikely to write long prescriptions for this product as failure to adequately monitor cardiac failure patients would attract the attention of the RCVS.

If we supplied a written prescription for single use for a duration of two months at a time, the saving from buying on-line over a year would be £72.75.

These savings assume that a patient in cardiac failure lives to take all its tablets for the whole year without the need for changes in medication (so the medication the owner has at home goes to waste or gets sold on Facebook!) or additional prescriptions of alternative medications

(c) Bravecto 1000mg as a preventative parasiticide.

Our cost for a year's Bravecto for a 10-20kg dog, which is the most common one we supply, is £155.52. The cost for under care check ups and prescriptions and an equivalent annual supply is £154.32.

Once again, although there are some savings to be made on certain selected examples of the more expensive medications, these have been grossly exaggerated.

The CMA did not choose to highlight these particular products by accident. They have been chosen simply because the prices at which veterinary practices can buy them do not allow us to compete easily with internet prices.

The example of long term medication highlighted above is a far more typical situation in which prescribing in the practice is significantly cheaper than prescribing for supply on-line.

For example, if most pet owners were aware that they could save [£200-300] [%] on average a year by purchasing commonly prescribed veterinary medicines from online pharmacies, we would expect that this would lead to significantly fewer sales of such medication at a FOP

As is evidenced above, this untruth is one being pedalled by the CMA both in its report and in its press releases. This is frankly libellous to independent practices such as the one which I represent.

Really I should be taking legal advice as to the possibility of suing the CMA for the reputational damage which they and by extension the government are inflicting on my business, myself and my professional colleagues as a result of the dilatory manner in which this report was prepared and the implication that conclusions reached as a result of examining LVG pricing are generally applicable.

Instead, I am spending my (limited) time off in trying to correct the enormous libels which this report contains, however, the other option remains available.

Why should we be libelled in this manner by the CMA? At no moment, do they make clear that these are just estimates of savings made having consulted only the owners of the most expensive practices.

Evidence we have obtained shows that retail prices for veterinary medicines at LVG-owned and independent FOPs are typically well above the manufacturer list prices.

The whole of the section preceding this statement presents only evidence from LVGs, but then the CMA decides that this extends also to independents without any evidence being presented. This is manifestly not the case as the figures presented above demonstrate.

I feel an apology and a retraction are in order.

Independent FOPs set retail prices equivalent to applying an average markup on manufacturer list prices of between 50% and 60%, with this mark-up also varying depending on the type of medication

As can be seen from the previous sections relating to price, this is not universally the case and certainly not the case for my practice. Only 1% of practices, which were independent, approached by the CMA and, in consequence, this is libellous nonsense and should be recognised as such.

The working paper on Competition in the supply of veterinary medicines set out our intention to better understand the magnitude of these costs and gather information from veterinary businesses that we could include in our assessment of the profitability of medicine sales to FOPs

Even the CMA admit they failed to do so, but not the reason why their conclusions are warped by the failure to include a significant input from the independent sector as a result of their indefensible sampling decisions made right at the start of the inquiry.

I would strongly suggest that to avoid wasting tax payer money in future, all CMA inquiries should first consult a competent statistician to design a robust sampling strategy in order to avoid the repeated flaws and falsehoods included in this report and to avoid, in consequence, recommendations which favour the very groups whose profiteering led to the CMA inquiry in the first place.

We are therefore unable to verify with quantifiable evidence from multiple veterinary businesses the extent to which the costs identified in the submissions from stakeholders are able to explain the substantial mark-ups applied by FOPs on the purchase costs of veterinary medicines.

Try asking the question and you will get the answer.

The CMA did not seek to acquire this quantifiable evidence, for example, by the relatively easy strategy of asking all independent practices by email for their financial details relating

to this subject. These contact details can be found through the Find a Vet site or could have been supplied by RCVS on request.

Not all would have replied, but a significant number more than was ever considered in the production of the report would have been likely to do so, given the importance of this to the veterinary practices which are independent.

The inquiry, due to its conduct and sampling strategies, was an iniquitous waste of money led by people whose qualifications made them unable to understand robust sampling strategies and relevant statistical methods to create defensible conclusions.

These suggest the sale of medicines is a highly profitable activity for LVGs

No independent evidence considered here, either.

Over a quarter of responses highlighted the challenges of providing OOH care, particularly in rural areas. Some respondents stated that the market was increasingly fragile.¹¹⁴² Others noted the increasing difficulty in finding staff willing to work unsociable hours, stating that even if it were easier for FOPs to terminate outsourced OOH contracts, there might still not be significant entry into the market by alternative providers due mainly to the difficulty in recruiting vets to work outside normal working hours

This issue is about the selection methods used when recruiting students for veterinary courses and the lack of frank discussion that this job is not 9-5 Monday to Friday. A commitment to animal welfare, which is more than just sanctimonious words, is required to work OOH. Unfortunately, the selection processes employed have led to a steady decline in such people entering the profession in recent years.

Work life balance is something to be applauded and to be maintained, but selfish behaviour and the wish not to be there in an emergency, when one of your patients needs you most, is not at all the same as this concept. The universities and the RCVS need to consider the cohort which is currently being recruited and whether the recruitment strategies for students are creating this difficulty.

The average costs that FOPs incur to sell an individual cremation (excluding the wholesale price they pay to crematoria) are significantly smaller than these average mark-ups, for each of the four LVGs for whom we could estimate markups (which together own over half of the FOPs in the UK). This means that consumers may be paying in the order of an extra £100 for individual cremations at a substantial number of FOPs, compared to the prices they would pay if FOPs faced strong price competition.

Yet another section where LVGs supplied the data but general conclusions about independent practices alongside LVGs are drawn.

Cremations can represent a significant cost to pet owners – they can cost £300 or more, with extras such as urns and paw prints sold as add-ons to this base price

In fact, the most expensive cremation option which is available to our clients (individual cremation of a large dog, returned in a wooden casket with fur clippings and paw prints taken before cremation) cost £250.85 plus VAT.

Yet again, the CMA did not properly inquire into costs apart from at the LVGs who are already the cause of this inquiry due to their relentless pursuit of profit.

The distressing circumstances in which decisions about cremations are made mean that most pet owners would be unlikely, at the point at which a cremation service is purchased, to wish to spend time looking for alternative cremation providers or making price comparisons. Despite this, we currently consider that in a well-functioning market, the prices and options of cremation services would be made clear to pet owners in an appropriately sensitive manner

What is an appropriately sensitive manner when a sobbing family is having their beloved pet put to sleep?

Our provisional assessment is that veterinary businesses (both LVGs and independents) do not provide sufficient information for pet owners to make informed decisions, which is likely to dampen the competitive constraints faced by FOPs in the supply of cremations, including from specialist crematoria.

I would strongly recommend that the people responsible for writing this nonsense should attend a few euthanasias of dearly beloved pets who have lived with their families throughout the lifetime of the children to understand what is being asked here.

We write our cremation prices on the euthanasia consent form, but to do more is simply to intensify distress.

Independent practices also report having preferred cremation partners. 60% of independent practices that responded to our request for information stated that they had an exclusive contract with a crematorium

Did CMA think to ask why that might be? Apparently not.

Our Pets Cremation service is not hired in response to a desire to make profit. They are hired because they do the job properly and with respect and we can have complete confidence in the fact that, for example, ashes which are returned come from the patient who was sent for individual cremation.

A professional colleague running another practice once had the horrible experience of animals which she thought were being cremated turning up on the local tip and being identified as clients' beloved pets. This happened as a result of a rogue provider of animal cremation services.

There is no way we would ever risk that. Our service invites us to inspect their facilities and provides support to help the younger vets to perform this emotionally draining task in a manner which helps the clients to come to terms with their loss.

The CMA seems to want a cheap as chip service (although our prices seem cheap compared to the LVGs who were exclusively spoken to in the construction of this section of the report) with no client confidence in what is being done. I do not think this is how I would like to hand my pets over to be cremated once they had passed away and really doubt that the other local people would either.

Requiring FOPs to offer the services of different crematoria would place a significant additional logistical, administrative and operational burden on them.1175 It submitted that an unintended upward pressure on prices could result, as well as potentially delays in returning ashes and an increased risk of human error in dealing with multiple crematoria.1

One independent practice [%] spoke to the importance of developing a relationship and building trust with a preferred crematorium and noted that this relationship was important in enabling them to reassure clients at a difficult time in their lives.
(Oh look, finally a comment from a single independent practice...)

I completely agree that, firstly, offering several alternative cremation services is likely to be very insensitive at a critical time and prone to human error and, secondly, that a relationship of trust is essential for us to send pets for cremation with confidence that the procedure will all be handled as their owners would wish.

In this service price is a secondary consideration to quality and this defined the service which we choose to use. Only the really insensitive or those who had not been in the situation of having a pet euthanased would fail to appreciate this self evident fact.

ranging from £50 for a communal cremation of a small pet to over £300 for an individual cremation of a large pet

This ridiculously inflated price range tells me that:

1. this was a London centric survey where the pricing strategies in the North went unconsidered.

We in North Lincolnshire are well used to this from successive governments, but it always comes as a disappointment that people cannot hit the road to get accurate country-wide data before making decisions which affect the country as a whole.

2. This was a LVG based survey where the majority of independents went without being consulted.

3. The prices cited are uniformly ridiculous and selected purely to make the veterinary market appear as corrupt as possible, with no respect for accuracy.

For complete clarity, communal cremation at my practice costs £28.96 plus VAT which is nowhere near the £50 which is the bottom of the range cited here.

Shame on you, CMA, for this misrepresentation of my profession. The chair of this inquiry should not work in this field again as he has shown no ability to ensure quality control in his staff and, in consequence, is clearly unfit to do lead such an inquiry.

This is followed by another section dedicated to LVG pricing practices with no independent data presented but the conclusions drawn are again for the veterinary market as a whole. This is a disgrace.

Putting together these two estimates, we estimate that the 'average' total cost incurred by LVGs is around £60-65 per individual cremation and around £45-50 per communal cremation.

Based on my own costs these are likely to be an over estimate by around 100-150% at least as far as communal cremations are concerned. This again indicates the London centric nature of this inquiry as costs are considerably higher for all services in the South East. So not just an inquiry biased by incompetent sample selection practices but also biased by a failure to consider the whole of the UK.

Most pet owners choose individual (rather than communal) cremations

Overall, evidence suggests that the majority of pet owners choose individual cremations

Yet another unsustainable statement which is inadequately evidenced, or possibly a sign that, in the more economically favoured South, where wages are higher, there is more cash available for cremation.

We do not send the majority of our deceased patients for individual cremation as, firstly, people do not tend to request this ('being scattered at the crem' with other deceased pets which the clients have owned and which have been previously cremated through this practice is a popular option 'He's gone to join Dolly, to be scattered with her and all the other pets' (Dolly = the cat who passed away last year)) and, secondly, we do not hard sell this option.

If the LVGs are achieving 50% individual cremation, [REDACTED]

There is no evidence presented in this section from any independent practice source.

there is no easily comparable information about independent FOPs' retail prices (for cremation)

That is complete rubbish. Independent Crematoria are licensed. They have web sites. If you call them, they will tell you the retail price for these services and the discounts which they offer to veterinary surgeons in their area.

This is an untruthful statement which is designed to conceal the fact that nobody at the CMA bothered to acquire any independent data whatsoever, either by asking the independent practices or by asking the cremation services themselves. Half an hour on the phone to licensed providers would have clarified retail costs for independent veterinary practices.

Shame on you, CMA for the utter lack of honesty on these points and the lazy inaccuracy with which this inquiry was conducted.

Finally, we have seen evidence that some FOP providers may be providing euthanasia and cremation as a single service.

The only source of this suspicion is [REDACTED] yet the statement is made to apply to the veterinary market as a whole. This is accepting and drawing unjustifiable conclusions on the scantest evidence.

Evidence from veterinary businesses indicates that most FOPs have policies to provide pet owners with a choice of type of cremation service, such as individual or communal cremation, alongside home burial. However, around half of the respondents to our pet owners survey could not recall receiving these options.

This is entirely because whatever we say during euthanasia consultations is barely registered due to the emotion of the moment.

When I can, I discuss the options for what happens when a pet has gone before the day of a pet's death, but this requires that the client comes regularly to the practice and we can see that such a situation might be arising.

If we follow the CMA's model of as little veterinary/ client contact as possible, such opportunities will become ever more rare.

Thanks a lot CMA for proposals to make everybody's existence more difficult, at a terrible moment for most of the clients and a less than wonderful one for the vets and nurses who have to officiate.

Pet owners are often not made aware of their choices regarding alternative cremation providers

How much intensification of distress are we expected to inflict on the poor clients and a result of people with a determination to make the profession look bad and with no apparently personal experience of the situation in which most clients find themselves.

If I get to discuss this beforehand, I give printed estimates and let people have time to think, but, at the time, it is impossible in most cases to have a logical and reasoned conversation and that is, in fact, exactly what the clients do not want you to do.

Some independent crematoria publish pricing and the range of options on their websites while others present prices individually to clients over the phone, via email, or face-to-face

So with this knowledge the CMA could certainly have found out the retail prices of cremation (which was claimed to be impossible earlier in the report), had the will and commonsense existed to do so.

Yet more laziness and biased information gathering.

Our provisional assessment is that the current regulatory framework does not contain appropriate substantive requirements, or monitoring, enforcement and redress mechanisms, to support the competitive processes and outcomes we would expect in a well-functioning market for the retail supply of veterinary services for household pets by FOPs.

This results in an imbalance of knowledge and power between vets and pet owners.

These statements are an utter misrepresentation of how the disciplinary inquiries in the profession are conducted by RCVS. The relentless pursuit by ProfCon of the profession as whole, inquiring about anything which the general public report to RCVS, with no sense of filtration about whether the report might be deluded and with the consistent threat through all of this of strike off, job loss and inability to earn a living in the UK puts all the power in the hands of the public.

Many complaints are utterly baseless. Some are very serious. No ability is shown by ProfCon for RCVS to recognise. This is due to the staffing policies at RCVS, which favour solicitors over experienced practising veterinary surgeons. RCVS 'scatter gun' activity results in torment, particularly for the younger and less hardy members of the profession. They are subjected to repeated communications on subjects which have no chance of progression to the Disciplinary Committee, never mind having any chance of resulting in strike off, but result in the afflicted arriving crying in my presence should this happen to one of the vets or nurses in my team. Thankfully, this is rare.

The vets are not oversensitive. [REDACTED] It should not be in charge of the profession without considerable reform, should a new Veterinary Surgeons Act come into being.

The RCVS should certainly not enjoy any increase in its powers as it is unable to regulate the behaviour of the people it employs and make them work in a timely manner and behave as investigators of professional misdemeanours should (no conflicts of interest, no bullying students, no reducing veterinary surgeons to tears when they are innocent of misconduct (these are real examples)).

Until this happy state and a usefully functioning Professional Conduct department is established, I would strongly advise against putting any further powers in the hands of the RCVS.

the regulatory framework does not, it appears to us, result in pet owners having good, relevant and timely information on price, quality and treatment options that would help them make informed decisions about the services they buy and from whom.

So what other regulatory framework does this?

The private doctors?

The dentists?

The opticians?

Why single the veterinary profession out for this treatment when it is glaringly obvious that there is gross profiteering particularly in the private medical sector. I am well placed to judge this as I know what the provision of health care equipment and infrastructure costs in my own industry. Our equipment is from the medical field. Our procedures are modifications of human procedures. In many respects what we provide is not so different.

So why the vets?

Could it be just because we are a small group which it is momentarily fashionable to malign and persecute without adequate evidence or any sense of natural justice?

Could it be because the government and CMA are too afraid of the private sectors of the larger health care professions, whose behaviour is in every way as bad as that of the LVGs, but who contribute, however, slightly to NHS care and to dentistry provision?

Is this inquiry, which appears, by its conduct, to have been arranged to support one conclusion only, the equivalent of 'kicking the cat' just because you cannot go after the major offenders? A cynic might draw that conclusion.

The only example of similar regulation which the CMA could rake up is that of:

The provision of legal services, for example, also serves the public interest in access to, and the administration of, justice. Regulation is used to ensure such public interests are protected

Its cost regulation is very largely because the government funds prosecutions and on Legal Aid also funds the defence so it is important that value for money should be seen to be provided.

There is no analogous requirement of regulators in other health care fields in consequence this inquiry could be seen as mischievous, politically motivated interference

Successful and innovative commercial operators are a necessary

Given than this is accepted to be the case, why did the CMA not ask the successful multibranch independent operators for their in-put?

Sorry to be repetitive but the evidence in this report repeatedly illustrates that, if you look at an inadequate and biased sample, your conclusions will inevitably be biased and inadequate.

businesses obtain patients' valid consents to treatments, establish 'a clear complaints protocol' and make 'patients aware of their channels of complaint'

This report presents this as if veterinary surgeons do not have these obligations. This is again untrue and a misrepresentation of our profession.

Section 11 of the Code of Conduct described what is required in detail including examples of appropriate paperwork to ensure that consent is acquired. Again, a short period of reading what the profession has to do to avoid the clutches of ProfCon would have made this part of the report considerably less ill-informed.

We set out in both our Regulatory Framework and Remedies Working Papers the view that regulation of the market for the supply of veterinary services by FOPs is justified on the bases identified above. 1263 That appears to be uncontroversial.

This is because they were not released into the public domain with sufficient time for a response to be composed by people who have a demanding day job to do.

As I suspected earlier, the aim of the CMA will be to make the same sort of claim about this report. I would imagine that responses will be few.

I am doing this because, by chance, I have days off in, lieu after a prolonged period of working and if I do not do this I suspect that almost nobody else who works as an independent veterinary surgeon will have time to do so. It has taken me three days so far to the annoyance of the others with whom I live. Only a considerable commitment to tell the truth to counter this farrago of half truths and misrepresentations about my profession has kept me at the task.

We concur with the CMA's findings that current regulatory frameworks inadequately address non-veterinary business ownership. We fully support that this must be addressed.

I wholeheartedly agree with this statement. Any new legal framework should reflect the Code of Conduct adopted by the Royal College of Ophthalmology, which binds all people associated with their institutions, whether these are professionally qualified or not, to obeying their Code.

I would support this not only for all those owning, working in or otherwise associated with veterinary practices but also for all other veterinary structures including the RCVS itself, as a method of ensuring that all were behaving to the same ethical standard and could be effectively held to account.

An independent vet practice which has participated in the PSS since its inception told us that the administrative burden involved has increased significantly in recent years, placing considerable pressure on veterinary practices, particularly smaller, independent ones

I could be rude and say, finally, an independent voice in all of this, but they are correct.

PSS is burdensome costly and does not raise quality of care significantly which is why we are not a member, despite offering referral level 24 hour care. In addition, the public care not in the slightest about either the PSS or the RCVS awards. It has little effect in clients choosing veterinary care.

If it did, we would be part of the PSS, annoying and time consuming though that might be. It is just an additional drain on experience veterinary and nursing time which could be better spent promoting the standard of patient care and helping the less experienced in our practices.

The CMA presents the veterinary and nursing professions as being unregulated. The following statement represents the following as things which medics have to do with the implication that the same is untrue of veterinary surgeons. This is incorrect and is an utter misrepresentation of the true situation:

an annual appraisal, a recommendation from a responsible officer or suitable person,1394 a declaration of fitness to practise, undertaking hours of CPD and submitting written reflective accounts of their professional experiences.1

While we do not have an annual appraisal and, at least, in the independent part of the sector, this would be difficult to establish as we work in so many different environment using so many different skills, it would be very easy to introduce a statement of fitness to practice.

We already state that we have no undeclared convictions, have completed the requirement for CPD and provide written reflection relating to that CPD.

The RCVS has recently tried to introduce 'voluntary' revalidation but their idea should chill the blood of any authority interested in keeping veterinary costs under control,

The RCVS wanted to split the profession between very basic FOPs and very expensive referral centres and to do away with the ability for veterinary surgeons, except in a very limited number of places, to hone their skills sufficiently to offer high level services to the local clientele. This is the very opposite of a well functioning market, which provides for the needs of clients at a reasonable cost, without the need to drag very poorly animals long distances to access the care which they require to make them well. The RCVS have now rolled back on that, for the moment, but who can say what other restrictions will be introduced in the future to prevent us from offering a proper standard of care to the local pets.

At this moment, the CMA looks more like a problem rather than a solution. Even though we already do most of what has been recommended, the 'facts' on which it has based its conclusions have been shown to be unreliable and incomplete.

The RCVS also told us that its ability to monitor and assess compliance with regulation is limited by its lack of statutory powers, including to gather information and to enter and inspect premises

RCVS should not receive these powers without first root and branch systemic reform of its procedures and protocols to eliminate unfairness and conflicts of interest

There is, accordingly, only a limited range of sanctions available to the RCVS.¹⁴³⁴ It cannot do things like ordering vets to: carry out additional treatments; apologise to consumers; refund or cancel fees; give clinical advice about treatments; pay compensation or financial penalties; or resolve issues relating solely to negligence

No other professional body has these powers. Neither should the RCVS, especially given its long history of behaving unfairly to the most vulnerable members of the profession.

I also cannot see any client who has complained to RCVS having sufficient faith in the practice about which they have complained to wish that group of people to 'carry out additional treatments' or 'give professional advice'. The CMA is not living in the real world in promoting these possible future powers.

The legal frameworks which exist at the moment enable clients to reclaim inappropriate fees. The Veterinary Defence Society, the insurers of professional indemnity for almost all UK vets will advise when this might be appropriate with provision of the necessary paperwork to allow it to occur. They also negotiate and pay compensation where appropriate. The CMA does not seem to have realised that this is the case.

The CMA behaves as though compliant handling is poor. I do not know what the situation is like outside my own practice but we have a defined complaints protocol which is also available on our website, which meets the requirements which they appear to have in mind.

a comprehensive, clear and fair written complaints process based on minimum industry-wide standards, with set timescales for each part of the process, a commitment to uphold and resolve complaints that are found to be justified

I feel that this is again an example of CMA failing to ask the appropriate questions of the correct groups of people within the veterinary profession and then drawing unjustified, broad brush conclusions without presenting evidence.

Summary:

- **The groups spoken to in the preparation of this report were poorly chosen and excluded key stake holders.**

The preference given to consulting with the LVGs rather than the large independent sector makes the whole report highly biased. 60% of practices were represented by the LVGs. 1% of practices were represented by the independent practices which were consulted.

No statistically valid sampling methodology was employed to ensure fairness and accuracy.

An even handed look at the veterinary market should not have favoured only speak with the groups who are the reason that this report was commissioned, but instead have consulted with those who survive in the economic conditions which exist in the veterinary industry as successful independents. It is this group who are most suited to advise what a veterinary market, which is not profit driven should look like, and so are essential if the CMA were to construct what a well functioning market might look like and practical reality.

A lack of effort to find key financial information across the whole sector is present throughout this report. Opportunities to find the retail cost of cremation were ignored. The financial savings quoted in this report emanating from online acquisition of medication are almost universally removed from reality, as the examples which I have provided from my own practice management system demonstrate.

The biased sampling strategy which excluded significant segments of the veterinary market while unduly favouring other segments of it, which was instituted from the very outset, opens these findings to the threat of judicial review if their deficiencies are not recognised and corrected at this late stage.

- **The failure to consider the ownership of the on-line veterinary pharmacies in producing the conclusions arrived at by the CMA is farcical.**

The idea that the CMA takes the ability to prescribe and supply long term drugs from veterinary practices and hands that right to the very groups who have been profiteering in the first place is just a recipe for a sharp rise in on line drug prices as soon as this regulation is imposed.

The assumption that all on-line prescriptions are cheaper or that vets make massive profits from supplying medication are erroneous as the examples cited above indicate.

This appears to have been a major thrust of this inquiry but the skewed sample examined has led to an unsupportable conclusion about the supply and cost of veterinary medications across the sector.

- **There is an alarming absence of focus on animal welfare in delaying treatment of non urgent cases and the risking critical ones dying as a result of running out of medication** if it all has to be purchased on-line and received in time.

The director in his statement which was meant to appease veterinary professionals decided to highlight as evidence of his benevolent feelings towards the veterinary profession that he owns a 'Sprocker'. Nice dog though his may be, this in on way makes up for the bias in his report and for its selective use of those facts which the CMA staff did manage to glean.

His statement is simply window dressing in a report which did not speak to the more successful FOPs (Commercially successful independent practices often have more than one branch), and did not consider the ownership of the on-line pharmacies was important, even though his own document high lighted that these are owned by the same LVGs which are so keen on excessive profits.

- **The failure to given adequate time in the middle of this consultation for independent practices to respond** illustrates the complete ignorance of the CMA officials.

The independents have senior staff who are MsRCVS and whose first duty is patient care. They do not have in-house lawyers and legal departments whose entire job is to consider such responses. This was another step which was fundamentally unfair and biased against the very people who are not profiteering from veterinary practice and who are here to treat patients as far as can possibly be achieved within the financial constraints of their owners.

- **The consideration of the ability of FOPs to change OOH provider in no way addresses the issue with external OOH provision which shuts its doors during the day.**

It does not matter to the clients which OOH provider they are sent to.

What matters is the cost of OOH provision by the LVG owned providers, which is often prohibitive for those on low incomes. This is not about cost of medication.

It is about cost of the service as a whole and the selling tendency of the LVGs who own many OOH services (see above [REDACTED])

There is another debate about the dereliction of duty shown by RCVS in allowing this sector to develop in the first place. The usual activity of an OOH provider is to receive patients from their FOP clients when those close in the evening or at weekends.

This means the owners coming out of their work or pausing home life to collect a pet and take it to the OOH provider then to return the following day to collect the seriously ill patient and return it to the FOP from which it came only to potentially have to repeat the suffering required by these unnecessary transfers daily for as long as the pet needs hospital care.

The CMA completely missed the issue with OOH provision. Animal suffering and human anguish are caused by these providers, especially in rural areas where they are situated miles from the FOP from which the patient comes. This needs to be addressed by RCVS but never has been.

Going back to a situation where each veterinary practice had to provide its own out of hours emergency care for their own clients would get rid of the low level LVG branches sprouting like weeds and rid the sector of the LVG venture capitalists who are there purely for profit, as there is no profit in emergency services run by individual practices. It would clean up the market considerably if this were done.

- **The recommendations about informed financial consent are inherent in the activities of the veterinary profession and, rightly, have been ethical requirements for years.**

The CMA appears to have failed dismally to understand this, to ever read a consent form or listen to a veterinary surgeon in the process of acquiring informed consent.

As far as offering other providers for complex services is concerned, we always do and this is even on the consent form which all owners have to read (left alone with it in a consulting room with nothing to do but read for five minutes to ensure that they actually get on with the task.

The decision to instruct the CMA to produce this report was clearly politically motivated and based on the assumption that vets are there primarily to make a profit. This is evidenced by the choice of groups it decided to speak to and the choice of those it did not.

The CMA considers only the idea that price increases equal increased profit. This, at least in our case, is definitely not the case. We raise prices reluctantly because we know that in doing so some of our elderly and less well off long term clients will become unable to afford necessary care.

- **There is no proper consideration of the government interventions and regulatory activities which have driven the rise in costs.**
 - Elevated employer NI contributions introduced with no treasury consideration of the effect on employment and business costs.
 - Elevated minimum wage driving nursing wage inflation.
 - Elevated costs for employing overseas veterinary surgeons, driving increased veterinary costs and veterinary surgeon wage inflation.
 - The benighted Cascade system by which UK vets are not allowed to seek the most cost effective supply of medication although UK clients are allowed to do so.

[REDACTED]

The idea that RCVS does not have sufficient disciplinary powers is laughable [REDACTED]
[REDACTED]

The CMA claims not to be able to quantify the reasons for non-staff-related rises in cost, but this I have detailed without difficulty. That I am able to easily do so in my response and could have produced accounts to further evidence this question is an indication of the absence of rigour with which this report was produced and which dooms its conclusions to inaccuracy.

- **Throughout the period of this being inquired into the press releases which have emanated from the CMA have been untrue and libellous to professionals such a myself, to my practice and to the many other independent practices which function as we do.**

Were an organisation to libel an individual in this way, there would be the opportunity for legal redress and compensation. There is a potential for a similar action against the CMA from that group of independent practices which are so routinely libelled in this report. Evidence only from LVGs has been used to draw universal conclusion in many sections of this document. This evidence has then been extrapolated and used to denigrate the profession as a whole.

[REDACTED]

Abbey Veterinary Centre (Grimsby) Limited and Lincolnshire Veterinary Referrals