Regulatory Framework for Veterinary Professionals and Veterinary Services

Vets Market Investigation Working Paper

06 February 2025

Website: www.gov.uk/cma

The Competition and Markets Authority has excluded from this published version of the final report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [✂]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

Contents

Summary

1. The regulatory framework for veterinary services includes: the Veterinary Surgeons Act 1966 (**VSA**), the Royal College of Veterinary Surgeons (**RCVS**) as the regulator of the profession, and the RCVS' Supplemental Royal Charter of 2015 (the **Charter**), its Codes of Professional Conduct for Veterinary Surgeons (**RCVS Code**) and Veterinary Nurses (**RCVS Nurses Code**) and accompanying guidance; and its (voluntary) Practice Standards Scheme (**PSS**). It also includes mechanisms for regulating medicines: the Veterinary Medicines Directorate (**VMD**) and the Veterinary Medicines Regulations (**VMR**); and non-statutory structures such as the Veterinary Client Mediation Service (**VCMS**).

2. The industry has undergone substantial changes in the nearly 60 years since the legislation which underpins the regulatory framework, the VSA, came into force. Those changes include that non-vets now own large numbers of vet businesses, consolidation through acquisitions of first opinion practices (**FOP**s) by six large veterinary groups (**LVG**s), vertical integration as (most of these) LVGs own related services, an increase in pet ownership and the 'humanisation' of pets, and advances in treatment options. It has been put to us that the regulatory framework has not evolved with these developments and is no longer fit for purpose.

3. This working paper sets out our work so far, and our emerging thinking, on whether the current regulatory framework contains the right combination of substantive requirements and monitoring, enforcement and redress mechanisms to support the competitive processes and outcomes we would expect in a well-functioning market. We remain concerned that the framework does not do so.

4. A well-functioning market for veterinary services for household pets could be thought of as one in which:

   (a) animal welfare and public health and safety are protected;

   (b) there is a range of providers who each offer good quality services which serve the needs of animals and their owners at competitive prices; and

   (c) consumers are able to, and do, shop around between those providers and make informed decisions about the products and services they buy.

5. A market in which these conditions are present may be seen as one that protects important public interest concerns as well as consumers.

6. An effective system of regulation is likely to be needed to support such a well-functioning market. Veterinary services in the UK are provided mainly by commercial operators and their incentive and ability to make profits helps ensure those services are provided to meet consumer demand with the right level of

quality. However, commercial incentives alone may not be enough to protect the relevant public and consumer interests.

7. Commercial incentives may not always align with the public interest in animal welfare. Where consumers have less knowledge and experience than their vets, they will not necessarily be able effectively to shop around and make informed choices. Regulation in professional services markets such as veterinary services can, and should, protect relevant public and consumer interests by imposing requirements that aim to produce outcomes that an unregulated market on its own may not.

8. It is important that regulation as a component of a well-functioning market is set at the right level. Regulation can have an impact on the competitive process by shaping what products and services may be provided, by whom and how, as well as the information available to consumers.

9. Regulation that is too narrow risks insufficient protection for important public interests in animal welfare and public health and safety, and for consumers. Regulation that is too broad can unduly restrict what services may be provided and by whom, or increase the costs of provision, in ways that mean services that could benefit animals and their owners are limited, unavailable, or unaffordable for some consumers, and some animals go untreated.

10. In a well-functioning market, we might expect that the regulatory system (i) contains only the requirements and restrictions that are necessary to protect those important public interests; while (ii) giving consumers the ability to make informed choices and giving providers the freedom to innovate and offer a range of products, services, business models and practices to meet differing consumer needs. In that way, the system can help to fulfil relevant public and consumer interest objectives.

11. Our work to date has involved looking at the requirements imposed by the current regulatory framework, and the mechanisms for their monitoring and enforcement, as well as the redress mechanisms available to consumers if things go wrong. Our concern is that the framework may not contain the appropriate balance of requirements and restrictions because its focus on consumers and competition may be too limited, as:

    (a) Its scope is too narrow. It applies to individual vets but not to vet businesses and non-vets who own and work in them (to whom only the RCVS's voluntary PSS applies).

    (b) Its contents do not appear to result in consumers having good, relevant and timely information on price, quality and treatment options that would help

them make informed decisions and keep prices at the level we might expect if the market is working well.

(c) It does not contain sufficient and appropriate mechanisms for the monitoring and enforcement of vets' compliance with the RCVS Code and the supporting guidance to this code (**Supporting Guidance**) and, given its voluntary nature, no such mechanisms in relation to vet businesses under the PSS.

(d) Provisions for consumer redress are limited.

(e) The restrictions that apply to veterinary medicines may be narrowing consumers' access to medicines, reducing choice and increasing costs.

(f) Restrictions on the way in which, and by whom, services can be provided may be limiting the scope for innovation in how vet businesses operate.

12. We also have some concern that the current system of regulation may not allow for the most effective use of veterinary nurses. Clarifying or changing the legislation that currently applies to nurses could have a positive impact on the veterinary profession and on consumers.

1. Introduction and approach to regulation

1.1 In our **Overview** working paper, we set out: a summary of our current view of the market for veterinary services; our framework for assessing whether competition is working effectively in the supply of veterinary services; why we are publishing working papers at this stage of the investigation, and an outline of the evidence sources we have used to prepare our analysis and current thinking.

1.2 This working paper contains our current assessment of whether the regulatory framework for veterinary services contains the right combination of substantive requirements and monitoring, enforcement and redress mechanisms to support the competitive processes and outcomes we would expect in a well-functioning market. We consider:

(a) Why regulation might be expected to be part of a well-functioning market for professional services such as veterinary services and what role we might expect regulation to play in such a market. This is in the following paragraphs of this section.

(b) Whether the current regulatory framework for veterinary services contains the provisions and mechanisms we might expect of an effective system of regulation. This is in sections 2 to 6 of this paper.

1.3 Whether, in light of (a) and (b), we have concerns that the current regulatory framework does not contain the appropriate set of provisions and mechanisms and there may therefore be an adverse effect on competition. This is in section 7 of this paper.

What do we mean by 'regulatory framework'?

1.4 In this paper, we discuss the organisations, systems, legislation, regulatory codes and guidance which govern how veterinary professionals and veterinary services are regulated. These include:

(a) the VSA;

(b) the RCVS, as the regulator of the profession;

(c) the Charter;

(d) the RCVS Code and the Supporting Guidance;

(e) the RCVS Nurses Code and the supporting guidance to this code (**Supporting Guidance for Nurses**);

(f) the PSS;

(g) the mechanisms for regulating medicines: the VMD and the VMR; and

(h) non-statutory structures such as the VCMS.

1.5 Together with the practices the RCVS and the VMD follow (in, for example, applying and enforcing the RCVS Code and provisions relating to medicines), these comprise what we describe as the current regulatory framework in the market.

Why is regulation of veterinary services necessary?

1.6 Veterinary services for household pets in the UK are provided mainly by private operators. They have legitimate commercial incentives to make and maximise profits. Without those incentives, and the ability to make an adequate level of return, the capacity to meet demand would likely be insufficient and the quality of services likely poorer, harming animals and consumers. Successful and innovative commercial operators are a necessary though, for reasons explained in the following paragraphs, not sufficient, requirement to ensure animal welfare.

1.7 In some sectors, the market, by itself, may be able to deliver the competitive processes and outcomes for consumers that we might expect in a well-functioning market. That is, a combination of businesses' commercial incentives and the way consumers interact with the market may mean that consumers have the information and ability to make informed choices, and rival businesses compete to offer them a range of services meeting differing needs at competitive prices.

1.8 In other markets, and particularly those for professional services, the market alone may not deliver those processes and outcomes, and regulation may be necessary.[1] It appears to us that the market for veterinary services is one such market.[2]

1.9 One reason regulation may be necessary is that commercial incentives and the way consumers interact with these markets, by themselves, may be insufficient to deliver competitive processes and outcomes. The provision of professional services serves the public interest as well as commercial objectives. In the case of veterinary services, the services are provided in the interests of animal welfare and public health and safety.

1.10 Providers' commercial incentives may not always align with the public interest in animal welfare. Where consumers have less knowledge and experience than their

[1] Institute for Government report, What is regulation?, 1 August 2024.
[2] An example of such a market is that for higher education services. A 2017 report by the National Audit Office found that government had intended that competition in that market would improve quality and value for money for students. Market incentives were weak, however, so competition did not drive these improvements. The Office for Students was subsequently created as a regulatory body, with its statutory remit focusing on competition alongside student choice and outcomes.

vets, they will not necessarily be able effectively to shop around and make informed choices. Regulation in professional services markets like that for veterinary services can, and should, protect the relevant public and consumer interests by imposing requirements that aim to produce outcomes that an unregulated market on its own may not. We consider these matters further in the following paragraphs.

The public interest and externalities

1.11 The public interests (animal welfare and public health and safety) served by veterinary services involve externalities. Externalities are indirect impacts (costs or benefits) on third parties that occur when services are supplied. They can arise where an individual consumer accepts a level of service from a professional that may satisfy their needs but is not socially desirable – either an under-provision or an over-provision.[3] In medicine, for example, a patient's focus may be to alleviate their symptoms, whereas there may be wider public health impacts from the use of antibiotics or the transmission of disease.[4]

1.12 Similar considerations arise in the veterinary sector. In some cases, the commercial interests of vet businesses and the desires of a pet-owner may not necessarily reflect the wider public interest in animal welfare, leading in some cases to over- or under-treatment that harms an animal. In others, it might be socially optimal, or beneficial for overall animal health, for example, for pets with infectious diseases to be treated differently than would occur based only on the preferences of the individual pet owner. Likewise, it might be best for a vet to refrain from prescribing certain antibiotics, even if they might cure the animal's condition, where there are concerns about wider antimicrobial resistance.[5] Veterinary professionals are trained in matters such as dealing with infectious diseases and, for example, required by law to report cases of some such diseases if identified in an animal.[6]

1.13 The potential for these interests to be misaligned with service providers' commercial incentives seems clear. They may require providers to act in ways that may not maximise their commercial benefit. Regulation is used to ensure these wider societal interests, such as in animal welfare and public health, are protected. It can manage or address the costs of externalities, either directly through imposing conduct requirements or indirectly by maintaining adequate standards in educational settings.[7]

---

[3] Organisation for Economic Co-operation and Development (OECD), Competition and Regulation in Professions and Occupations (OECD report), 17 May 2024, page 14.
[4] OECD report, page 14, referring to OECD (2000), Competition in Professional Services, page 30.
[5] RCVS Knowledge AMR Hub (https://knowledge.rcvs.org.uk/amr/) (accessed 28 January 2025).
[6] RCVS, Supporting Guidance, Disclosures required by law, paragraph 14.45.
[7] OECD report, page 12.

Information asymmetries – how pet owners assess the quality of professional services

1.14 The purpose of a profession is to provide non-expert consumers with the benefits of a body of learning, expertise and experience. Where a consumer needs professional services, the consumer will almost always know far less about the transaction than the professional providing the services.

1.15 Many professional services involve the sale of credence goods, where the average consumer is unable to identify the quality of the good or service which best fits their needs. Instead, they rely on an expert who both diagnoses their needs and sells the goods or service to them.

1.16 Examples of markets for credence goods include healthcare, legal services and financial advice services. The informational asymmetries between the seller and the buyer in a credence goods market and the proximity of the seller to the financial rewards of the transaction create incentives for three types of inefficiencies: oversupply, undersupply and overcharging. These problems are exacerbated by the fact that often in markets for credence goods the consumer is unable to assess the quality of the product they have received even after trade has concluded.[8]

1.17 In these circumstances, the OECD has noted that professionals may: ‘have an incentive to reduce overall quality. Unable to judge quality differences well, consumers may make their decisions based on the average quality they expect. Knowing this, and knowing that most consumers will not detect below-average quality, sellers may offer substandard service while charging the “average” price. Lower quality service may then proliferate, and the market for high quality service may even fail.’[6] In veterinary services, 'substandard service' may mean that animals are not receiving adequate treatment or that they are being overtreated. In both cases this can lead to suffering for the animal and detriment to the consumer. Regulation can seek to guarantee the quality of services offered by regulating the access to, and the exercise of, the profession.[9]

1.18 In the veterinary services market, expert professionals provide clinical services to consumers who buy the services for their pets. The specialist nature of the services means consumers will always (or nearly always) be less knowledgeable about the services than those providing them. They will rely on those professionals to get the clinical care that their pets require at a fair price.

---

[8] Kerschbamer, R., & Sutter, M. (2017). The economics of credence goods – A survey of recent lab and field Experiments. CESifo Economic Studies 63: 1-23. Balafoutas, L., & Kerschbamer, R. (2020). Credence goods in the literature: What the past fifteen years have taught us about fraud, incentives, and the role of institutions. Journal of Behavioral and Experimental Finance, 26, 100285.
[9] OECD report, page 47.

1.19 This reliance is likely to be especially true for diagnostic tests, scans, and more complex surgeries, and other non-routine treatments (for example, oncology). In those cases, pet owners may be unable to assess independently the need for and quality of treatment and must follow vets' advice as to which treatment path to pursue.

1.20 We set out in our working paper on **How People Purchase Veterinary Services** our emerging view that the consumer response to competitive dynamics in the veterinary services market is weak. That is, our assessment based on the evidence so far is that consumers (i) are not price sensitive and do not shop around and/or switch providers in response to price differences or increases, and (ii) are not always given good, relevant and timely information to enable them to make reasonably informed choices about the treatments and services they buy, in the way they would in a well-functioning market.

1.21 The risk that vet businesses' commercial incentives alone may be insufficient is one that, as the OECD has recognised, an effective system of regulation can mitigate. Such a system can ensure that the imbalance that may exist if the market is left to itself is recognised and addressed.

1.22 More specifically, what an effective system of regulation can do, in circumstances where the operation of the market alone may not, is, first, require the quality of services to meet certain standards, and give consumers confidence that they do, particularly where they cannot readily assess that for themselves. Second, it can provide for consumers to be given information, and treated by professional service providers, in ways that mean they can make informed choices about the services they buy. This is an important competitive constraint on service providers, and a key part of a well-functioning market in which rival providers compete to offer consumers a range of services that might meet their needs at competitive prices.

Forms of regulation

1.23 Where regulation is required, it can take the form of rules and requirements in legislation and codes of conduct and regulatory structures, as well as mechanisms for enforcement and redress. Each of these can be important.

1.24 Regulation can have an impact on the competitive process by shaping what products and services may be provided, by whom and how, as well as the information available to consumers. There needs to be the right combination of substantive requirements and monitoring, enforcement and redress mechanisms to protect the relevant public interest concerns and to produce the competitive processes and outcomes we would expect in a well-functioning market.

Substantive requirements

1.25 As far as the substance is concerned, regulation that is too narrow risks insufficient protection for important public interests in animal welfare and public health and safety, and for consumers. Regulation that is too broad, which sets requirements that are too stringent or restrictive, or which is too focused on public interest considerations at the expense of consumer and competition ones, can unduly restrict what services may be provided and by whom, or increase the costs of provision.[10] That may mean that services that could benefit animals and their owners are limited, unavailable, or unaffordable for some consumers, and animals go untreated.

1.26 In a well-functioning market, we might expect that the regulatory system (i) contains only the requirements and restrictions that are necessary to protect those important public interests while (ii) helping consumers have the ability to make informed choices and (iii) giving providers the freedom to innovate and offer a range of products, services, business models and practices to meet differing consumer needs. In that way, the system can help to fulfil the relevant public and consumer interest objectives.

1.27 Substantive regulatory provisions can contribute to a well-functioning market by regulating access to a profession. They can do so by, for example, imposing entry qualification requirements on relevant professionals, requiring them to obtain a licence from an official authority before they are allowed to use certain titles or offer particular services,[11] or by keeping a publicly available register of qualified professionals and requiring them to maintain educational and professional standards as a condition of being registered to practise. Regulatory provisions may also limit the types of services different professionals can provide.

1.28 This sort of regulation occurs in the veterinary services market, where access to the profession is subject to minimum qualifications, the keeping of the register of veterinary surgeons and veterinary nurses by the RCVS, the imposition, setting and maintaining by the RCVS of educational standards (such as the continuous professional development (**CPD**) requirement), and by requiring veterinary surgeons and nurses to agree to the RCVS declaration on animal welfare.[12] There are also regulatory provisions which control the services different veterinary professionals, such as vet nurses or Specialists[13], can provide.

1.29 Rules that regulate access to a profession, or the services professionals can provide, can affect competition in the relevant market. They limit the number of

[10] In other words, lead to barriers to entry and higher prices – OECD report, page 6.
[11] OECD report, page 12.
[12] See 'Declaration on admission to the profession' in RCVS Code and 'Declaration on professional registration' in RCVS Nurses Code.
[13] Vets can apply for RCVS Specialist status in certain areas. See RCVS website, Specialist status.

professionals and so, if they are set more stringently than necessary, they may lead to shortages of supply and higher prices than we might expect in a well-functioning market. They may also stifle innovation and hinder the development of novel services that could compete with existing ones. We consider these points in the context of the veterinary services market in sections 2 (in relation to vets), 3 (in relation to vet nurses) and 6 (in the context of veterinary medicines) of this paper.

1.30 Substantive regulatory requirements can also help a market function well by imposing professional conduct rules. These can, for example, seek to mitigate the effects of the information asymmetry between professionals and consumers by setting quality standards and imposing information and transparency requirements.

1.31 These rules may be included in codes of conduct and may be accompanied by guidance and can cover not just the form and content of professional services, but also matters such as advertising, fees, business structures, and liability.[14] In some cases, such rules may apply both to individual professionals and those employing them, even if the latter are not themselves regulated professionals.

1.32 In the veterinary services market, some such provisions are contained in the RCVS Code and apply to individual vets and vet nurses (but not to vet businesses and non-vets who work in them). They cover matters such as the information to be given to consumers about treatments, prices and prescriptions, and conflicts of interest.[15] We consider in sections 2 (in relation to vets), 3 (for vet nurses) and 4 (in relation to vet businesses) of this paper the extent to which these provisions may be effective in helping consumers make informed choices and in facilitating competitive processes and outcomes.

1.33 Regulation can also address the kinds of externalities referred to in paragraphs 1.11 to 1.13 above. It may do so in, for example, rules that apply to the prescribing of antibiotics and other medicines or reporting requirements for infectious diseases. That is the case in the veterinary services market. We consider in section 6 of this paper, in particular, the extent to which such rules may be necessary to pursue public interest objectives or might be drawn in ways that unnecessarily limit innovation, choice and competition.

1.34 Other professional services in the UK are regulated in ways that seek to balance public interest concerns, quality assurance, consumer protection and competition considerations. For example:

(a) The regulatory objectives for the Legal Services Board (**LSB**), which oversees eight regulators for different legal professions, include 'protecting

[14] OECD report, pages 12-13.
[15] RCVS Code.

and promoting the public interest', 'protecting and promoting the interest of consumers', and 'promoting competition in the provision of services'.[16]

(b) The Financial Conduct Authority's (**FCA**) operational objectives include to 'protect consumers from bad conduct' and 'promote effective competition in the interests of consumers'.[17] The FCA has also published a Consumer Duty which 'sets high standards of consumer protection across financial services, and requires firms to put their customers' needs first'.[18]

(c) The General Pharmaceutical Council's (**GPhC**) quality-assurance powers help safeguard the public interest against pharmaceutical malpractice, but the GPhC also has powers to regulate consumer-focused behaviour, including by ensuring consumers are provided with 'all relevant information in a way they can understand, so they can make informed decisions and choices'.[19]

(d) 'Good medical practice' guidance developed by the General Medical Council (**GMC**) makes it clear that medical professionals, working in both public or private healthcare, 'must not exploit people's vulnerability or lack of medical knowledge'.[20]

1.35 We will consider whether there are lessons that may be learned from regulation in other sectors that could be applied in the veterinary services market.

Monitoring, enforcement and redress

1.36 Effective monitoring, enforcement and redress are the key counterparts to the appropriate set of substantive requirements and restrictions in a regulatory framework. Where providers know that their compliance with those provisions is monitored, and they face a realistic threat of enforcement action for non-compliance, they are more likely to be disciplined in terms of, for example, the quality of the goods and services they provide. The same applies where consumers have access to mechanisms that provide redress if things go wrong.

1.37 We consider in sections 2 and 5 of this paper the mechanisms in the regulatory framework for veterinary services relating to monitoring enforcement and redress. We may, as our investigation progresses, consider different forms of regulatory

[16] See Legal Services Act 2007, Part 1 - The regulatory objectives and LSB, The Regulatory Objectives, June 2017, pages 8-10.
[17] See About the FCA: How we operate (https://www.fca.org.uk/about/what-we-do/the-fca) (accessed 28 January 2025).
[18] See FCA: Consumer Duty (https://www.fca.org.uk/firms/consumer-duty) (accessed 28 January 2025).
[19] GPhC Standards for Pharmacy Professionals, page 8.
[20] GMC 'Good medical practice' guidance, 30 January 2024, paragraph 90(c).

structure – independent regulator[21] and self-regulation models[22] – and whether one or another is more likely to lead to better outcomes more closely aligned with those we might expect in a well-functioning market.

1.38 For now, we observe that the regulatory framework for veterinary services is based on the self-regulation model. That model was historically more common in professional services regulation in the UK.[23] However, the suitability of that model in modern professional markets has been called into question[24] and in some professions, such as architects and solicitors, as well as doctors, it has been replaced by an independent regulator.

Structure of this paper

1.39 Our assessment so far of whether the current regulatory framework is appropriate to support the competitive processes and outcomes we would expect in a well-functioning market is set out in the rest of this paper as follows:

(a) Section 2 outlines how vets are regulated and considers whether the current system is effective.

(b) Section 3 considers the regulation of vet nurses and whether it may or may not be helping the market work well and produce good outcomes for consumers.

(c) Section 4 assesses the extent to which vet businesses are effectively regulated and the possible consequences of any regulatory gap.

(d) Section 5 considers the extent to which there are effective mechanisms for pet owners to complain and seek redress in relation to poor quality service.

(e) Section 6 examines aspects of the framework that may be relevant to how competition works in the supply of Prescribed Veterinary Medicines.

(f) Section 7 assesses the possible impact of the current regulatory framework on competition and consumers, in light of the matters considered in sections 2 to 6.

---

[21] Where an independent body is responsible for regulating, licensing and disciplining members of a profession (OECD report, page 13).
[22] Where an association of the relevant professionals sets standards for entry into the profession, maintains standards for ongoing practice and regulates the conduct of members of the profession (in addition to a role as advocacy body for its members' interests). See OECD report, page 13.
[23] A self-regulation model for doctors, for example, existed for more than 150 years before it was reformed.
[24] An academic study of the self-regulation model for doctors, for example, suggested that while the majority of doctors were competent and trustworthy, the model was too weak to address the small number who were failing both their patients and their peers (Dixon-Woods, M., Yeung, K., & Bosk, C. L. (2011). 'Why is UK medicine no longer a self-regulating profession? The role of scandals involving "bad apple" doctors.' *Social Science & Medicine*, 73(10), 1452-1459).

2. Regulation of veterinary surgeons

2.1 In this section, we describe the role of vets and set out the framework for the regulation of their activities. We examine whether aspects of the regulatory framework may be leading to weak and ineffective oversight. These include the entry requirements for the profession, the extent to which regulation is focused on commercial and consumer-facing aspects of veterinary care, and monitoring and enforcement of regulatory compliance by the RCVS.

How are vets regulated?

The RCVS regulates vets

2.2 The RCVS was created by royal charter in 1844, and its powers are set out in the VSA and the Charter. The RCVS has a dual function as both a Royal College and a statutory regulator:

(a) **Royal College.** The RCVS holds a Royal Charter which gives it the power to carry out activities that 'set, uphold and advance veterinary standards, [and] promote, encourage and advance the study and practice of the art and science of veterinary medicine, in the interests of the health and welfare of animals and in the wider public interest'.[25] These activities include: exercising powers under the Charter to award Fellowships, Diplomas and Certificates to vets and vet nurses and to act as informed and impartial source of opinion on veterinary matters.[26] While some of these Charter responsibilities are similar to those, for example, held by the non-regulatory Royal Colleges serving as professional bodies in human healthcare, the RCVS has additionally used its Charter powers to expand its regulatory remit. Under the Charter, the RCVS has introduced regulation of veterinary nurses and established a Charter Case Committee (**CCC**) as part of its disciplinary process.

(b) **Statutory regulator**. The RCVS' responsibilities as a statutory regulator are established in the VSA, which requires the RCVS to keep a register of veterinary surgeons, supervise and recognise veterinary education and qualifications, and oversee the professional conduct of veterinary surgeons.[27] The RCVS is overseen by the Privy Council[28] and, as privy counsellor with policy responsibility, the Secretary of State for Environment, Food and Rural Affairs has a role in overseeing the RCVS's activities.

[25] RCVS Supplemental Royal Charter 2015, paragraph 3.
[26] For a fuller list of activities undertaken by the RCVS in its capacity as a Royal College, see the RCVS website About the RCVS (https://animalowners.rcvs.org.uk/about-us/about-the-rcvs/) (accessed 31 January 2025).
[27] VSA.
[28] VSA, section 22.

2.3 While other sectors have clear distinctions between their regulators and their Royal Colleges, the RCVS sees its combined roles as difficult to separate. It describes its unique structure as a 'Royal College that regulates'.[29] The RCVS has suggested, for example, that some initiatives such as its Mind Matters veterinary mental health support programme might have originally been considered a function of its 'Royal College' duties but have grown into a form of 'upstream regulatory activity'.[30]

2.4 Both 'regulator' and 'Royal College' duties are overseen by the RCVS Council and over 50 committees, subcommittees and working groups. Committee membership is drawn from Council members and other appointed individuals. Additionally, the RCVS employs over 100 staff with a range of operational, legal, and other specialist responsibilities.[31] The staff body comes from a mixture of veterinary and other professional backgrounds. In comparison, the GMC (which regulates over 300,000 doctors) employs over 1,600 staff, and in the pharmaceutical sector a total of over 450 employees work across its regulator and Royal Society.[32]

2.5 The RCVS is not the only regulatory body in the sector. Safe and effective use of veterinary drugs is managed by the VMD, an executive agency of the Department of Environment, Food and Rural Affairs (**Defra**). Voluntary mediation of consumer complaints is offered free-of-charge by the VCMS, which is funded by the RCVS.[33][34]

The RCVS maintains a register of vets who are entitled to practise

2.6 The RCVS regulates individual vets (and vet nurses).[35] Vets must register in order to practise. Under the VSA, it is the RCVS's responsibility to keep a register (the **Register**) of those who are entitled to practise.[36] Vets who meet the RCVS's educational requirements may register: they must have a veterinary degree from a recognised university[37] (a **recognised qualification**) or, for overseas vets without a recognised qualification, must pass the Statutory Membership Exam.[38]

---

[29] RCVS, Ensuring good governance: A consultation on recommendations to reform the governance structure of RCVS Council and VN Council RCVS, June 2024, page 4.
[30] See As a Royal College that regulates the RCVS is a unique organisation-shouldn't it also have a unique governance system? (https://www.rcvs.org.uk/faqs/as-a-royal-college-that-regulates-the-rcvs-is-a-unique/) (accessed 29 January 2025).
[31] The average full-time-equivalent number of employees in 2023 was 117 (figure taken from RCVS Annual Report 2023, page 42).
[32] General Medical Council Annual Report 2023, page 79, General Pharmaceutical Council Annual Report 2023, page 62, Royal Pharmaceutical Society Annual Report 2023, page 25.
[33] Parts of the wider veterinary profession are subject to other regulation. For example, farriery is regulated separately by the Farriers Regulation Council, as set out in the Farriers (Registration) Act 1975. Some veterinary professionals, such as animal physiotherapists, have also chosen to join voluntary registers of qualified practitioners.
[34] Veterinary practices, as private businesses, must also comply with general legislation such as the Consumer Rights Act 2015.
[35] Regulation of vet nurses is discussed in section 3 of this paper.
[36] VSA, section 9.
[37] VSA, section 3.
[38] VSA, section 6.

2.7 On admission to the profession, every vet makes a declaration that:

> 'I will pursue the work of my profession with integrity and accept my responsibilities to the public, my clients, the profession and the Royal College of Veterinary Surgeons, and that, ABOVE ALL, my constant endeavour will be to ensure the health and welfare of animals committed to my care.'[39]

2.8 Registration is renewed on an annual basis. The renewal process involves the vet confirming that their Register and contact details are up-to-date, declaring any criminal convictions, and paying a fee.[40] Vets must also undertake mandatory CPD.

Vets must adhere to a Code of Conduct

2.9 The RCVS operates a code of professional conduct for vets (the Code) which sets out their mandatory professional responsibilities. The Supporting Guidance provides more detailed information on the standards of practice expected. (The content of the RCVS Code and Supporting Guidance, in so far as it relates to consumer interests, is discussed below at paragraphs 2.31 to 2.39). The RCVS Code and Supporting Guidance, and any updates, are published on the RCVS website.

2.10 Under the RCVS Code, vets must maintain and develop the knowledge and skills relevant to their professional practice and competence, including completion of the Veterinary Graduate Development Programme (VetGDP) for newly qualified vets and a minimum of 35 hours of CPD per year.[41] Vets are required to plan, record and reflect on their CPD on the RCVS's digital platform (1CPD).[42] Anything relevant to a vet's role qualifies as CPD. The RCVS does not specify subjects or activities that must be covered.[43]

The RCVS provides assistance to vets

2.11 The RCVS provides a digital learning platform for vets (RCVS Academy). The platform has a short training course on informed consent and there is a course on complaints handling that was developed with the VCMS.[44] Other categories of

[39] RCVS Code, Declaration on admission to the profession.
[40] See Renew your registration (https://www.rcvs.org.uk/registration/renew-or-make-changes-to-your-registration/renew-your-registration/) (accessed 29 January 2025).
[41] RCVS Code, paragraph 3.3.
[42] See Continuing Professional Development (https://www.rcvs.org.uk/lifelong-learning/continuing-professional-development-cpd/) (RCVS CPD webpage) (accessed 29 January 2025).
[43] RCVS CPD webpage. We understand that the RCVS can monitor compliance with this requirement across the profession, and that it will write to non-compliant vets and may take disciplinary action where vets do not complete their CPD and this reaches the threshold for serious professional misconduct.
[44] RCVS meeting with the CMA on 16 October 2024, page 51. [✂]

training courses available include client engagement, leadership and coaching, culture and wellbeing.

2.12 The RCVS has a partner charity, RCVS Knowledge, which provides resources to veterinary professionals. Materials it makes available include a contextualised care hub, discussion guides for both vets and pet owners, quality improvement resources, peer reviewed journals, and free online CPD courses.[45]

2.13 The RCVS Advice team provides advice and guidance to vets on matters relating to professional conduct via telephone or email.

The RCVS complaints and disciplinary procedures

2.14 The RCVS has a duty to conduct a preliminary investigation into every disciplinary case (that is, a case in which it is alleged that a vet is liable to have their name removed from the Register or to have their registration suspended[46]), and to decide whether the case should be referred to the RCVS' Disciplinary Committee (**DC**).[47] A disciplinary case therefore includes a case in which a vet may be guilty of 'disgraceful conduct in a professional respect', affecting their fitness to practise, which, as set out below, is commonly referred to as serious professional misconduct.

2.15 The preliminary investigation is conducted by the RCVS' Preliminary Investigation Committee (**PIC**) which follows a two-stage process. At Stage 1,[48] the PIC must decide whether there is sufficient information to conclude there is no realistic prospect of establishing that a vet's conduct falls far short of that expected and could constitute serious professional misconduct. If it so concludes, it can close the case or issue advice. If it cannot reach that conclusion or, if it considers it appropriate to do so,[49] it will refer the case to Stage 2 for consideration.

2.16 At Stage 2, if the PIC agrees with the Stage 1 assessment, and considers it to be in the public interest to do so, it will refer cases to the DC for a hearing. The DC can remove or suspend vets from the Register if it finds them to have been convicted of a crime which renders them unfit to practise,[50] guilty of serious professional misconduct,[51] or to be fraudulently on the Register.[52] The hearings

[45] See RCVS Knowledge (https://knowledge.rcvs.org.uk/home/) (accessed 29 January 2025).
[46] VSA, section 16.
[47] VSA, section 15. Note, the process for disciplinary cases involving vet nurses is the same as the process for vets. See Serious professional misconduct and negligence explained - Professionals (https://www.rcvs.org.uk/concerns/reference-information/a-note-on-negligence/) (accessed 29 January 2025).
[48] Vet Preliminary Investigation Committee decision making guidance.
[49] For example, the PIC considers the case to be of wider significance to the profession.
[50] VSA, section 16(1)(a).
[51] VSA, section 16(1)(b).
[52] VSA, section 16(1)(c).

are generally conducted in public and apply the civil standard of proof. The DC may also issue a formal reprimand.

2.17 Where the PIC deems it not to be in the public interest to refer to the DC, it can instead refer a case to the CCC,[53] which was set up under the Charter in July 2023. There is no requirement for the CCC to hold a hearing and its decisions can be made by meeting, review of documents or by other means. The CCC can issue a confidential or public warning to vets or refer cases back to the PIC. Warnings issued to vets do not affect their registration status or right to practise.[54] Public warnings are published on the RCVS website and remain there for up to six months.[55] We also note that there is no reference on individual vets' RCVS 'find a vet' profile to their history of RCVS regulatory action.

How are medicines regulated?

2.18 While RCVS regulation applies to vets' use and prescription of veterinary medicines, the manufacture, sale and administration of those medicines is subject to a separate regulatory framework in the VMRs[56] and regulated by the VMD.[57] The VMD's activities include:[58]

(a) testing for residues of veterinary medicines or illegal substances in animals and animal products;

(b) assessing applications for and authorising companies to sell veterinary medicines (pharmaceutical and biological products);

(c) controlling how veterinary medicines are made and distributed;

(d) acting as policy lead for veterinary medicines, including on antimicrobial resistance;

(e) developing legislation and advising Ministers;

(f) being responsible for inspections and enforcement; and

(g) monitoring and researching equine anthelmintic resistance.

2.19 The VMD also noted that 'pharmacovigilance requires continual monitoring to ensure that authorised veterinary medicinal products have a continued positive

[53] RCVS Charter Case Committee Rules 2021.
[54] See Charter Case Committee decisions (https://www.rcvs.org.uk/concerns/charter-case-committee-decisions/) (accessed 29 January 2025).
[55] At the time of writing, there is one published public warning. See Charter Case Committee decisions (https://www.rcvs.org.uk/concerns/charter-case-committee-decisions/) (accessed 29 January 2025).
[56] The Veterinary Medicines Regulations 2013 (SI 2013/2033).
[57] See About us - Veterinary Medicines Directorate - GOV.UK (https://www.gov.uk/government/organisations/veterinary-medicines-directorate/about) (accessed 29 January 2025).
[58] VMD Teach-in, 10 September 2024 and response to email January 2024, [✂]

risk: benefit conclusion ensuring that the benefits of the product when used in the prescribed way outweigh the risks of use'.[59]

Aspects of the regulatory framework may be leading to weak and ineffective regulation of vets

2.20 In the following paragraphs we identify certain aspects of the regulatory framework that may not be contributing to the competitive processes and good consumer outcomes we might expect in a well-functioning market.[60] We consider:

(a) the entry requirements for the veterinary profession and how they may be affecting competition;

(b) whether the regulatory framework gives sufficient focus to the commercial and consumer-facing aspects of veterinary care; and

(c) the adequacy of the mechanisms for the monitoring and enforcement of veterinary regulation.[61]

2.21 In considering these factors, we take into account that the regulatory framework's primary focus is on animal welfare, but a wider set of concerns including competition and consumer protection are also relevant (and themselves contribute to animal welfare).

Entry requirements to register as a vet

2.22 The entry qualification requirements for veterinary surgeons (described in paragraph 2.6 above) pursue important public policy objectives: protecting animal welfare and public health by helping to ensure that those who provide services are competent to do so.

2.23 Requirements that restrict entry to a profession have the potential to affect competition in a market. If they are too onerous or otherwise inappropriate, they may mean that competent professionals are unable to practise. If that, in turn, means the supply of professionals does not meet demand, that can increase wage costs and prices to consumers (which outcomes can themselves be harmful to animals if they go untreated).

[59] Evidence submitted by the VMD, 24 January 2025.
[60] In section 5 below we consider whether the limited ability of pet owners to complain and seek redress in relation to poor quality service and resulting loss and damage may also be a feature of the regulatory framework which may contributing to competition and consumer outcomes that would not be expected in a well-functioning market.
[61] Another important aspect of the regulatory framework that may be contributing to weak and ineffective regulation is the lack of provision for the regulation of veterinary practices: the business entities supplying veterinary services as opposed to the vets employed by them. We assess the impact of this gap in the regulatory framework in section 4 of this paper.

2.24 We have seen some evidence that the entry requirements, especially for foreign-qualified vets, may be set inappropriately, contributing to a shortage of vets in the UK.[62] Changes to the RCVS Statutory Membership Examination for overseas vets were approved by government in December 2024 in an attempt to introduce more flexibility to the supply of vets.[63]

2.25 We recognise that the entry requirements into the profession must take account of the broad public policy interests described in paragraphs 2.22 above, and which are beyond the CMA's remit. However, in view of their potential to affect competition (and in ways that could harm animal welfare), it may be appropriate for the RCVS and government to assess whether those requirements appropriately take into account a balance of animal welfare, public health and consumer and competition interests.

The role of the consumer interest in veterinary regulation

2.26 In thinking about whether the regulatory framework gives sufficient focus to the commercial and consumer-facing aspects of veterinary care, we have considered:

(a) the framework's origins;

(b) the primacy given to animal welfare;

(c) the provisions of the RCVS Code and Supporting Guidance which relate to vets' interactions with consumers; and

(d) whether consumers appear to be able to make informed decisions about the services they receive from vets.

Origins

2.27 The existing regulatory framework is from the 1960s, when veterinary care was more focused on horses and farm animals than domestic pets. Veterinary services at that time were mainly provided by sole practitioners who owned their practices and were regulated by the RCVS, rather than larger more commercially focused businesses that are not regulated.[64]

2.28 A framework set up in that context may not have the degree of focus on protecting consumers' interests and promoting competition that is now appropriate in a much-changed market. That market now includes much larger non-vet owned

---

[62] Pets at Home has stated one way to help address this would be to amend the minimum salary requirements for Skilled Worker visas, Pets at Home Response to CMA consultation on the proposal to make a market investigation reference into veterinary services for household pets in the UK (the **Consultation**), page 6.
[63] The Veterinary Surgeons (Examination of Commonwealth and Foreign Candidates) Regulations Order of Council 2024.
[64] Bruce Vivash Jones, 'The emergence of small animal practice in the UK', (https://www.veterinary-practice.com/article/the-emergence-of-small-animal-practice-in-the-uk), 18 December 2017 (accessed 29 January 2025).

businesses employing a range of business models and placing a greater emphasis on the provision of veterinary services as a commercial proposition. In short, a concern arises that the framework may be out of date and no longer appropriate for the market it seeks to regulate. This concern is widespread throughout the vet sector and the RCVS has been raising the issue of regulatory reform for several years.[65]

The primacy of animal welfare

2.29 The RCVS regulates veterinary surgeons, in accordance with the VSA, to protect the public interest and to safeguard animal health and welfare.[66] To that end, its Code gives vets a range of responsibilities, but makes clear the primacy of animal welfare:

(a) The preamble to the RCVS Code says, 'the professional responsibilities in the Code may conflict with each other and veterinary surgeons may be presented with a dilemma. In such situations, veterinary surgeons should balance the professional responsibilities, having regard first to animal welfare'.[67]

(b) The first substantive provision of the RCVS Code – paragraph 1.1 – further provides that 'veterinary surgeons must make animal health and welfare their first consideration when attending to animals'.[68]

(c) We note that the RCVS declaration on admission (described in paragraph 2.7 above) commits vets to ensuring the health and welfare of animals committed to their care above all else.

2.30 However, our current view is that the interests of animal welfare, on the one hand, and consumer protection and promoting competition, on the other, are connected. If consumers have insufficient protection and competition does not function well, their access to good quality and reasonably priced veterinary services, in the interests of their pets, is likely to be reduced. The key question is whether the regulatory framework combines the protection of animal welfare and of consumers (and promotes competition) in an appropriate way. That brings into focus the specific provisions of the framework.

[65] The RCVS established a Legislation Working Party in 2017, made up of vet professionals, representatives of the BVA and BVNA and lay members, to examine regulation and make proposals for reform. It launched a public Legislative Reform Consultation in 2020 and a Report of its findings was published in June 2021. See also lifehaschanged.vet (accessed 29 January 2025).
[66] RCVS Code. These objectives are also reflected in the objects of the College as set out in paragraph 3 of the Charter.
[67] RCVS Code Preamble: About the Code of Professional Conduct.
[68] RCVS Code, paragraph 1.1.

The RCVS Code and Supporting Guidance address the consumer interests to some extent

2.31 The RCVS Code does contain provisions relating to the way vets must treat consumers. We first consider what these provisions say and then whether they are liable to be effective to protect consumers and to support the competitive processes and outcomes we might expect in a well-functioning market.

Information requirements

2.32 Vets are required by the RCVS Code to provide appropriate information to clients about the vet practice, including the costs of services and medicines.[69] They must communicate effectively with clients and ensure they obtain informed consent before treatments or procedures are carried out.[70]

2.33 The Guidance covers how to obtain informed consent,[71] including giving clients a range of reasonable treatment options to consider, and how to communicate estimates and fees.[72] It also says vets should communicate certain information on prescriptions, including displaying signs to tell consumers that they can purchase prescribed medicines elsewhere.

Conflicts of interest

2.34 Vets are required under the RCVS Code to provide independent and impartial advice and inform clients of any conflict of interest,[73] and to be open and honest with clients and respect their needs and requirements.[74] The Supporting Guidance states that vets should not allow any interest in a product or service, including any interest held by their employer or any organisation that they are associated with, to affect the way they prescribe or make recommendations.[75] Such interests should not affect their clinical decision making as animal health and welfare must be their first consideration.[76]

Referral requirements

2.35 Under the RCVS Code, vets must refer cases responsibly and in the best interests of the animal.[77] The Supporting Guidance amplifies this requirement by saying that:

---

[69] RCVS Code, paragraph 2.3.
[70] RCVS Code, paragraph 2.4.
[71] Supporting Guidance, Communication and consent.
[72] Supporting Guidance, Practice Information, fees and animal insurance and Consumer rights and freedom of choice.
[73] RCVS Code, paragraph 2.2.
[74] RCVS Code, paragraph 2.1.
[75] Supporting Guidance, Protection of title, advertising and endorsement, paragraph 23.39.
[76] Supporting Guidance, Maintaining clinical freedom, paragraph 23.41.
[77] RCVS Code, paragraph 1.2.

(a) When a case or treatment option is outside their area of competence, vets should refer to a colleague, organisation or institution who they are satisfied is competent to provide the required service.

(b) Vets should consider all relevant factors when considering referring, including the ability and experience of the referral vet, location, urgency, and the circumstances and financial situation of the owner.

(c) Vets have a responsibility to ensure that the consumer is made aware of the level of expertise and/or status of the referral vet and identify if they are an RCVS Specialist or Advanced Practitioner and, where relevant, explain the difference between the two.[78]

(d) When referring to a practice rather than an individual, vets should explain the experience of the vets working within the practice, so consumers can make an informed choice about what is best for their animal.[79]

(e) Vets should record the reasons for their referral decisions and be able to justify them. If they consider a real or perceived conflict of interest arises from any referral-based incentives or any links they have to a referral practice,[80] they should inform consumers.[81]

Contextualised Care

2.36 Under the RCVS Code, vets must make animal health and welfare their first consideration[82] and provide care that is appropriate and adequate.[83] Guidance on professional autonomy was updated in October 2024 and advises that, when providing care, vets should, '…. make decisions on treatment regimes based first and foremost on animal health and welfare considerations, whilst providing contextualised care and exercising professional judgement about what is best for the animal in each individual case, taking into account the needs and circumstances of the client.'[84] Contextualised care acknowledges that there are different ways to approach the diagnosis and treatment of an animal, depending on its and its owners' circumstances, and the context in which the care is delivered.[85]

2.37 The Guidance states that vets should ensure a range of reasonable treatment options are offered and explained, including cost, taking into account the needs

[78] Supporting Guidance, Referrals and second opinions, paragraph 1.6.
[79] Supporting Guidance, Referrals and second opinions, paragraph 1.6.
[80] For example, being part of the same corporate group.
[81] Supporting Guidance, Referrals and second opinions and Consumer rights and freedom of choice.
[82] RCVS Code, paragraph 1.1.
[83] RCVS Code, paragraph 1.3.
[84] Supporting Guidance, Veterinary Care, paragraph 2.2(c).
[85] See RCVS Knowledge Guidance on Contextualised Care.

and circumstances of the consumer.[86] It says that informed consent can only be given by a consumer who has had the opportunity to consider a range of reasonable treatment options, with associated fee estimates, and had the significance and main risks explained to them.[87] The Guidance also says that vets should, 'recognise the need, in some cases, to balance what treatment might be necessary, appropriate or possible against the circumstances, wishes and financial considerations of the client. Whatever the circumstances, the overriding priority is to ensure that animal health and welfare is the priority.'[88]

Guidance chapter 10: Consumer rights and freedom of choice

2.38 The RCVS has recently published an additional chapter[89] of the Guidance which consolidates its advice on the 'consumer-facing' aspects of regulation. The RCVS has told us that 'the purpose of this new chapter is to make it easier for veterinary professionals, and their employers, to see at a glance what is required in terms of supporting clients and delivering a fair service'.[90]

2.39 We are aware that the RCVS is also taking other steps to identify what support it might provide to veterinary practices and professionals on consumer-facing issues, such as establishing good complaints processes. It has told us that it assesses themes emerging from its 'enquiries and concerns data' and data from the VCMS to ensure that ongoing education can be provided by the RCVS Academy to address issues that matter to consumers.[91] There is currently a course available to veterinary professionals on complaints handling from the RCVS Academy, which was developed with the VCMS.[92]

Concerns

2.40 On the face of it, therefore, the RCVS Code and Supporting Guidance contain provisions that seek to protect consumers, or should have the effect of doing so, and which might help to promote competition for veterinary services. We remain concerned, nonetheless, that the regulatory framework may not give enough weight to these matters. There are three main reasons.

2.41 The first is the purpose and interpretation of the framework. The fundamental purpose of regulation by the RCVS, reflected in the VSA, is to regulate entry into the profession and oversee vets' conduct as professionals, with the aim of promoting animal welfare. These core purposes are based on a narrow interpretation of vets' professional responsibilities, which covers the clinical

[86] Supporting Guidance, Consumer rights and freedom of choice, paragraph 10.2(a)
[87] Supporting Guidance, Informed Consent, paragraph 11.2.
[88] Supporting Guidance, Consumer rights and freedom of choice, paragraph 10.2(b).
[89] Supporting Guidance, Chapter 10, 'Consumer rights and freedom of choice.'
[90] RCVS letter to CMA dated 25 October 2024. [✂]
[91] RCVS letter to CMA dated 25 October 2024. [✂]
[92] RCVS meeting with the CMA on 16 October 2024, page 51. [✂]

aspects of the RCVS Code and Supporting Guidance but not the consumer aspects, and of animal welfare, that is, without reference to the role that competitive markets play in advancing animal welfare. The RCVS has acknowledged to us that, in this context, one 'may not necessarily feel [that] the consumer interest is always at the fore [of the RCVS Code] because what we are looking at is professional responsibilities in [vets] discharging their duties'.[93] The RCVS has described its consumer work to us as involving 'an offering to make sure that they [consumers] have the right information so that their interactions with veterinarians, veterinary nurses and the practice as a whole is as productive as it possibly can be'[94]

2.42 The second reason, as set out below, is that there may be inadequate monitoring and enforcement of compliance with the provisions of the RCVS Code and Supporting Guidance, which includes requirements and guidance that seek to protect consumers as set out above.

2.43 The third is that, as we observe in our working paper on **How People Purchase Veterinary Services**, consumers are not able to make informed choices about the services they buy in the way we would expect in a well-functioning market. The evidence we have seen so far indicates, for example, that there is limited price information available for many services, that information on clinical options is not always communicated effectively, and that pet owners tend not to shop around for different treatments or options.

2.44 This appears to be the case notwithstanding the consumer-related provisions of the regulatory framework described above. That suggests those provisions may not be giving consumers enough help to make choices that protect their interests (and stimulate competition between providers), where what they are buying, in many cases, are credence goods.

2.45 It may be that the provisions themselves are poorly designed. We have noted their origins and their purpose, which may not take enough account of consumer protection and competition matters in a market where veterinary services are now offered by more commercial operators employing a range of business models.

2.46 It may also be that there are other weaknesses in the regulatory framework. One may be the lack of effective mechanisms for monitoring and enforcement (to which we turn in the following paragraphs). Another may be the lack of regulation of vet practices (which we consider in section 4 of this paper) and another may be weaknesses in the systems for consumer redress (covered in section 5).

[93] RCVS meeting with the CMA on 16 October 2024, pages 6-7. [✂]
[94] RCVS meeting with the CMA on 16 October 2024, pages 6-7. [✂]

Monitoring and enforcement of regulatory compliance

2.47 To be effective, regulatory rules need not only to contain appropriate substantive requirements but also to be accompanied by mechanisms that enable their effective monitoring and enforcement (so that those subject to the requirements are compelled to comply and deterred from non-compliance). It appears to us, however, that the RCVS's ability to take action against vets (and vet nurses) is significantly limited by a lack of compliance monitoring and the provisions of the VSA concerning disciplinary action and sanctions. We deal with these in turn.

Monitoring of compliance with veterinary regulation

2.48 The RCVS has told us that it operates a '*reactive, complaints-based system of investigation*'[95] under which its enforcement activities are driven by the complaints made to it by members of the public and the profession. It does not actively monitor the sector to identify non-compliance with regulation by veterinary professionals, and does not adopt any risk-based approach to identifying areas of potential concern. The RCVS has confirmed that it relies on complaints to highlight whether vets are not complying with good practices on contextualised care.[96]

2.49 The process of annual renewal of registration for vets and vet nurses, meanwhile, described in paragraph 2.8 above, does not enable the RCVS to assess professional competence or quality. This contrasts with the revalidation processes in other health professions, for example the GMC or Nursing and Midwifery Council (NMC), which are designed to confirm that professionals remain competent and fit to practise. While the requirement of 35 hours of CPD per annum should be reported by vets to the RCVS, the RCVS cannot take any automatic disciplinary action where vets do not complete their CPD and in this situation will only write to non-compliant vets to encourage their compliance.[97]

2.50 The RCVS has 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 enter and inspect premises.[98] The position again contrasts with that of other regulators. For example, the GPhC has powers to conduct unannounced visits, both routine and intelligence-led, to assess evidence as to whether professional

---

[95] RCVS Response to the Issues Statement, 30 July 2024 (**RCVS IS Response**), page 17. The RCVS also notes that it 'couple[s] this with a more proactive programme of education and culture change that promotes compliance.'
[96] RCVS meeting with the CMA on 16 October 2024, page 39. [✂]
[97] RCVS meeting with the CMA on 16 October 2024, page 50. [✂]
[98] The RCVS Legislative Reform Consultation Report 2021 recommended powers of entry for the RCVS and noted: 'The RCVS has no power of entry, meaning it does not have the right to enter a veterinary practice without consent. In most cases, this does not pose a problem in terms of investigating allegations of serious professional misconduct. However, where there are allegations that a veterinary surgeon has breached paragraph 4.3 of the RCVS Code of Professional Conduct, which states that 'veterinary surgeons must maintain minimum practice standards equivalent to the Core Standards of the RCVS PSS,' powers of entry would be useful. This is because, if a veterinary surgeon refuses entry, it is extremely difficult, if not impossible, for the RCVS to investigate allegations of this nature'. Recommendation 3.2, page 29, paragraph 65.

standards are being met.[99] The GPhC also has the power to conduct covert surveillance to help prevent criminal activity in pharmacies, such as the illegal selling of prescription medicines.[100] The VMD has powers of entry, powers of an inspector and powers to serve improvement notices.[101]

2.51 The RCVS therefore has limited visibility over conduct and outcomes within the veterinary sector, whether these relate to clinical standards or consumer outcomes. That has the potential, it seems to us, to significantly reduce its capacity to ensure compliance with regulatory requirements.

Enforcement of compliance with veterinary regulation

2.52 We are also concerned that limitations on the RCVS's statutory powers may lead to weaker enforcement of regulatory requirements against vets than we might expect in a market that works well. Our concerns relate to (i) the restrictions on formal disciplinary proceedings under the VSA; and (ii) the lack of effective sanctions at the regulator's disposal except in the most serious cases. It appears to us that the RCVS lacks a full regulatory toolkit enabling it to take action effectively against a range of misconduct, including in relation to consumer protection matters, and to impose a range of sanctions.

Restrictions on formal disciplinary proceedings

2.53 The VSA[102] requires the RCVS to investigate cases in which a vet is liable to be removed or suspended from the Register (and thus barred from practice). It defines those cases as involving:

(a) conviction of a criminal offence which, in the opinion of the RCVS's DC, renders a vet unfit to practise veterinary surgery;

(b) conduct judged by the DC to be disgraceful conduct in any professional respect; or

(c) fraudulent entry on to the Register.

2.54 The VSA enables the DC to remove from the Register or suspend registration of a vet found liable for one of these things.

2.55 The RCVS's statutory enforcement powers are therefore narrow. 'Disgraceful conduct in a professional respect', for example – more commonly referred to as

[99] GPhC webpage, Carrying out inspections (https://www.pharmacyregulation.org/pharmacies/inspections/carrying-out-inspections) (accessed 29 January 2025).
[100] The Investigatory Powers (Codes of Practice and Miscellaneous Amendments) Order 2018.
[101] Sections 34-35 and 38 of the VMRs. For more details on the VMDs inspection and enforcement policy, see: VMD Guidance, Enforcement policy for animal medicines.
[102] VSA, section 15.

'serious professional misconduct'[103] – is a small category including only the worst forms of behaviour. The courts have treated it as conduct that has fallen far short of the standard to be expected of a reasonably competent veterinary surgeon or veterinary nurse.[104] It is more than negligence[105] and could include: very poor professional performance where there are serious departures from the standards set out in the RCVS Code; fraud or dishonesty; criminal convictions or cautions.[106]

2.56 Recent cases in which the DC has found serious professional misconduct include:

(a) A vet who failed to euthanise a cat then performed a castration, removed the cat's microchip, and took it home without the consent of its owner. The vet also failed to make adequate clinical records.[107]

(b) A vet who was found to have made a number of dishonest and misleading failings relating to his certification of veterinary export health certificates, creating a risk of serious harm to animals and the public.[108]

(c) A vet who was found to have engaged in dishonest conduct, namely false insurance claims in the course of his employment.[109]

2.57 In addition to the requirements relating to the seriousness of a vet's misconduct, RCVS guidance says that, for a disciplinary case to be referred to the DC, reference must be in the public interest. That public interest is defined as having three elements, which are, it appears to us, defined principally by reference to considerations other than consumer protection and the promotion of competition:

(a) protection and promotion of the health and welfare of animals and the protection of public health;

(b) promotion and maintenance of public confidence in the veterinary profession; and

---

[103] RCVS, Serious professional misconduct and negligence explained.
[104] *Kirk v Royal College of Veterinary Surgeons* [2004] UKPC 4 and also RCVS, Serious professional misconduct and negligence explained.
[105] The test for serious professional misconduct is higher than the test for negligence, which is considered to be conduct that falls short (or below) the standard to be expected of a reasonable competent veterinary surgeon or veterinary nurse, but not far short of (or far below) that standard, such that it amounts to serious professional misconduct affecting fitness to practise. See RCVS, Serious professional misconduct and negligence explained.
[106] RCVS, Serious professional misconduct and negligence explained.
[107] This vet was reprimanded. See Herefordshire vet reprimanded for dishonesty over treatment of a cat. (https://www.rcvs.org.uk/news-and-views/news/herefordshire-vet-reprimanded-for-dishonesty-over-treatment-of/) (accessed 29 January 2025).
[108] This vet was removed from the register. See Staffs vet removed from Register for dishonest and misleading certification (https://www.rcvs.org.uk/news-and-views/news/staffs-vet-removed-from-register-for-dishonest-and-misleading/) (accessed 29 January 2025).
[109] This vet agreed to undertakings, including seeking assistance for a compulsive gambling disorder, and was given a reprimand and warning at the conclusion of such. See Vet issued reprimand and warning after admitting fraudulent insurance claims (https://www.rcvs.org.uk/news-and-views/news/vet-issued-reprimand-and-warning-after-admitting-fraudulent/) (accessed 29 January 2025).

(c) promotion and maintenance of proper professional standards and conduct in the veterinary profession.[110]

2.58 In an effective regulatory system, we might expect there to be a range of enforcement mechanisms that protect consumers and which, in turn, shape the conduct of vets (by having a deterrent effect). One of our concerns is that the limitations we have identified exclude from the scope of formal action many cases involving failure to comply with the consumer-facing requirements of the RCVS Code described above.[111] In that case, the extent to which those provisions discipline behaviour and effectively protect consumers may be diminished. Some conduct of a clinical nature will also be excluded from the scope of enforcement action, which may both impact animal welfare and affect the quality of services supplied.

2.59 We illustrate our concern in the following paragraphs by reference to issues relating to charges, informed consent, conflicts of interest and contextualised care. Likewise, we do so by reference to the number of cases handled by the RCVS's disciplinary processes.

Fee disputes

2.60 As to charges and fees, the Guidance says that:

(a) '… fee disputes where the charges levied by the vet are reasonable, or, even if the charges are high, they are not so extreme as to bring the profession into disrepute', are not likely to be referred to Stage 2 of the RCVS' disciplinary process;[112] and

(b) '… veterinary fees and charges [are unlikely to be referred to the DC] unless so extreme as to constitute serious misconduct'.[113]

2.61 Those provisions appear to limit the scope for formal disciplinary action in most if not all cases of disputed fees and possible overcharging. Only one case has been referred to the DC in relation to excessive fees alone and the DC concluded that the fees charged in that case did not amount to serious professional misconduct.[114] Our concern in this regard is amplified given that prices for veterinary services may not be as constrained by competition as we might expect in a well-functioning market (and there is evidence that consumers lack price

[110] RCVS, Disciplinary Committee Procedure Guidance, 26 August 2020.
[111] Based on a review of DC cases available on the RCVS website.
[112] RCVS, Vet Preliminary Investigation Committee decision-making guidance (Stage 1) - Areas not likely to result in referral to Stage two.
[113] RCVS, Vet PIC decision-making guidance (Stage 2) - Cases unlikely to result in referral.
[114] RCVS v [✂]. The RCVS told us it had not received any complaints in recent years where the fees have been so excessive that they could arguably amount to serious professional misconduct, but had received complaints that did not meet this threshold and where formal advice had been given to vets by the Preliminary Investigation Committee in relation to the provision of information relating to fees. RCVS response to RFI3, Question 6, 22 November 2024. [✂]

sensitivity), and where the VCMS has told us that complaints relating to reasonableness of fees have increased and are now in the 'top 5' complaint issues.[115]

Informed consent, conflicts of interest and contextualised care

2.62 Many failures to comply with the RCVS Code's requirements to obtain informed consent for treatments[116] and on conflicts of interest, or to follow good practice on contextualised care[117] also appear to us unlikely to result in formal RCVS disciplinary action. We have found only two cases where shortcomings in respect of informed consent were regarded as serious enough for formal action to be taken[118] and none in respect of conflicts of interest or contextualised care. We are also aware of two disciplinary cases during the last three years involving, amongst other things, charges that a vet failed to adequately communicate information to the pet owner and to obtain their fully informed consent, but in which no finding of serious professional misconduct was upheld by the DC.[119]

2.63 This is of particular concern given that the imbalance of knowledge between the vet and lay consumers means that consumers cannot be expected in many cases to know if good practice standards have been followed. One would therefore expect a professional services regulator to play an active role in monitoring and enforcing such standards.

Numbers of cases

2.64 We understand that, of the 3,540 enquiries[120] made to its Professional Conduct team between October 2023 and September 2024, 692 were 'registered concerns' deemed by the RCVS to relate to potential professional misconduct. The

---

[115] VCMS Teach-in, 2 October 2024. [✂]
[116] RCVS Code, paragraph 2.4 and Supporting Guidance, chapter 11.
[117] Supporting Guidance, Veterinary Care, paragraph 2.2(c), Consumer rights and freedom of choice, paragraph 10.2, Informed Consent, paragraph 11.2. See also RCVS Knowledge Guidance on Contextualised Care.
[118] See, for example, a vet who was found guilty of not obtaining informed consent and acting dishonestly after continuing treatment on a cat, removing his microchip, and taking him home after his owner believed he had been euthanised (Herefordshire vet reprimanded for dishonesty over treatment of a cat). This vet received a reprimand. This is the same case that is cited in paragraph 2.56(a) above. See also a vet who was removed from the register after carrying out total hip replacements on four dogs, which were not in the animals' best interests, and without consulting their owners about alternatives or gaining informed consent (Kent based veterinary surgeon removed from Register for carrying out surgeries which were not in animals' best interests).
[119] In the case of Katharine Power MRCVS, charges relating to inadequate communication of risks, complications and alternative options to surgery, as well as failure to obtain fully informed consent to surgery, were found by the Committee to be not proved. In the case of Paul Anderson Roger MRCVS, the Committee was satisfied that the failure to communicate adequately with the pet owner was conduct that fell below the standard to be expected of the reasonably competent vet but not far below the standard to be expected. It was accepted that failures to communicate mean the pet owner was not fully informed about the clinical picture and options for treatment, however the Committee did not consider that those failures amounted individually or cumulatively to disgraceful conduct in a professional respect. See: Disciplinary Committee hearings for disciplinary committee reports.
[120] The 'enquiry' stage includes all those who wish to raise a concern and who make contact with the RCVS Professional Conduct Department. After discussion, they will be provided with a link to raise their concerns formally if the matter relates to potential misconduct on the part of a Registrant. If that is not the case, they are encouraged to seek alternative means of resolving the issues. See RCVS letter to the CMA, dated 25 October 2024. [✂]

remainder were directed away from the RCVS for resolution, for example to the relevant vet practice or to the VCMS. The vast majority[121] of these related to 'veterinary care'.[122] We note that only 22 DC hearings are listed on the RCVS' website across the same period. It therefore appears that 670 of the disciplinary cases that were subject to preliminary investigation by the RCVS in the period stated did not meet the standard[123] for referral to Stage 3 of the RCVS disciplinary process, namely a public DC hearing. This would mean that only 22 out of more than 3500 complaints raised with the regulator went to a full disciplinary hearing. These figures appear to us to demonstrate the limited scope for formal enforcement by the RCVS, including in respect of matters that go to consumer protection and the promotion of competition.

Sanctions available to the RCVS

2.65 Our concerns extend not just to the scope of formal enforcement action but also to the sanctions available under the regulatory framework. We are interested in both the range and effectiveness of those sanctions.

2.66 The range of sanctions available to the RCVS includes the following:

(a) The 'formal sanctions for serious misconduct' found by the DC, some of which we have already referred to elsewhere in this paper: striking-off the Register or suspension from it for up to two years;[124] a formal reprimand or the case being held open for two years.

(b) For PIC Stage 1 and Stage 2 cases which fall short of the threshold for referral to the DC, the RCVS may issue 'formal advice' to the vet concerned. Where the PIC has concerns about the vet's conduct, advice could be issued, for example: to change practice protocols or procedures; to undertake additional CPD; or to remind the vet of relevant provisions of the RCVS Code or Supporting Guidance.[125] This advice is not binding, and so cannot be enforced, but it remains on the record for five years and it can be taken into account in any subsequent disciplinary proceedings during that period.

(c) Where a case has been referred to the CCC, rather than the DC, the CCC can impose a confidential or a public 'warning' or refer the case back to the

[121] 2,011 of the initial enquiries, and 508 of those which related to professional misconduct.
[122] The RCVS has confirmed that concerns and complaints data are recorded and categorised against the chapters of the Supporting Guidance. 'Chapter 2: Veterinary Care' covers a variety of topics, namely those covered in chapter 2 of the Supporting Guidance. [✂]
[123] To refer to Stage 3, the Stage 2 PIC Committee must find that there is a 'realistic prospect' that what the vet has done, or not done, could affect their fitness to practise (including whether any conviction renders them unfit) or amounts to serious professional misconduct (ie falls far short of the standard expected of a reasonably competent vet) **and**, if so, whether it is in the public interest to refer the case to the DC. See: RCVS, Preliminary Investigation Committee Manual.
[124] But no power of interim suspension pending a DC process.
[125] RCVS, Our terms explained.

PIC. Public warnings are published on the RCVS website for up for six months, but do not affect a vet's registration status or right to practise.

2.67 The sanctions the RCVS cannot impose also seem to us to be relevant. It cannot, for example, order vets to: carry out additional treatments; apologise to consumers; refund or cancel fees; give clinical advice about treatments; pay compensation; or resolve issues relating solely to negligence.[126] Nor can it impose conditions on vets' registrations or order them to undertake education or training (though it can advise) or undergo a period of supervision. The range of sanctions available to the RCVS is narrow.

2.68 The effectiveness of the sanctions is likely, it appears to us, to be limited by the circumstances in which they may be imposed. In particular, the formal sanctions described in paragraph 2.66(a) above, which might be supposed to carry the greatest deterrent effect and be most likely to influence the conduct of vets, apply only in the cases we have described in paragraphs 2.53 to 2.57 above. They are likely to be unavailable in many cases involving the consumer-facing requirements of the RCVS Code.

2.69 We are continuing to assess the effectiveness of formal advice issued by the RCVS as a form of sanction. It appears to us that, while it carries some weight because it may be taken into account in subsequent disciplinary cases,[127] its effectiveness may be undermined because it is not binding and the steps a vet takes to comply with it are not monitored.

2.70 We are accordingly concerned both that the range of sanctions available to the RCVS is too narrow and that the effectiveness of those sanctions is likely limited. Other professional regulators have different sanctions available to them. For example, optometrists, chartered surveyors, and lawyers in the UK can be fined for poor conduct. In Scotland, lawyers can be directed to compensate clients and directed to undertake education and training. Dentists and optometrists can face conditional registration, which is subject to compliance with certain conditions.

2.71 We also note that, despite reported low engagement by vets with the RCVS Code,[128] we have heard reports of them being 'afraid' of repercussions under the RCVS disciplinary process when it does apply:

---

[126] RCVS, Information for veterinary surgeons. Note, the RCVS provides that 'negligence is what might be considered to be conduct that falls short (or below) the standard to be expected of a reasonably competent veterinary surgeon or veterinary nurse, but not far short of (or far below) that standard, such that it amounts to serious professional misconduct, affecting fitness to practice. RCVS, Serious professional misconduct and negligence explained.

[127] *RCVS v Shah* (2020), a Disciplinary Committee case in which formal advice previously given was taken into account.

[128] From our qualitative research with veterinary professionals, we find that they are aware of the Code and generally acknowledge its importance. The Code is also viewed as a resource that can be consulted when needed, such as for dealing with a complaint. However, most respondents claimed to engage with it minimally as it did not affect the realities of day-to-day practice and was said to be somewhat out of touch with these. Instead, the research suggests that veterinary professionals rely on established practice norms and guidance from colleagues. See: Qualitative research with veterinary professionals, 'Regulation and sector challenges' section.

(a) Attendees at our roundtable with senior veterinary professionals from animal charities, 'agreed there was a fear of litigation in the sector and that fear of reprisals from the RCVS (being struck off)'.[129]

(b) This point was also raised at the roundtable with recently qualified vets, who 'discussed the fear of getting something wrong and being 'pulled up' in front of the RCVS'.[130]

(c) A vet who participated in our qualitative research said: 'RCVS complaint or anything like that, they're pretty terrifying and they come in pretty hard, and a lot of the time they're completely unfounded. And I think it's a really scary thing to have put on you…'.[131]

2.72 Those comments may support the idea that the RCVS lacks a range of regulatory tools to improve vets' conduct and protect consumers. We might expect an effective regulatory framework to contain a mixture of 'softer' approaches (for example, guidance, education, codes, and warning notices) and 'harder' actions such as fines, prosecutions and striking off the Register,[132] that can be targeted in a proportionate way for the benefit of both vets and consumers.

2.73 We observe in this connection that a disciplinary system based on proving and sanctioning serious professional misconduct differs significantly from that employed by some other regulators. Among human healthcare regulators, for example, 'fitness to practise' frameworks are seen as a more modern and effective way to protect patients, maintain public confidence in the profession, and uphold standards of conduct.[133] We note that, in 2021, the RCVS Council voted to accept the recommendations of the Legislative Reform Consultation (LRC),[134] including for new primary legislation introducing such a framework for the veterinary profession.[135]

Emerging views

2.74 Based on our assessment so far, we have concerns that:

(a) requirements to enter the profession and practise as a vet may be too restrictive;

---

[129] CMA, Summary of animal charity roundtable discussion, 19 September 2024, paragraph 14.
[130] CMA, Summary of vet student and new graduates roundtable discussion, 19 September 2024, paragraph 10.
[131] Qualitative research with veterinary professionals, 'Regulation and sector challenges' section.
[132] National Audit Office, Good practice guidance: Principles of effective regulation, May 2021, page 28.
[133] Professional Standards Authority, Right-touch reform, November 2017, Right-touch reform - a new framework for assurance of professions | PSA, page 39.
[134] See RCVS, Council agrees to adopt recommendations on future legislation following consultation with profession and public (https://www.rcvs.org.uk/news-and-views/news/council-agrees-to-adopt-recommendations-on-future-legislation/), 14 June 2021 (accessed 2 February 2025).
[135] RCVS, Report of the RCVS Legislative Reform Consultation, 11 June 2021, Part 4, Introducing a modern 'fitness to practice' regime.

(b) the substantive requirements of the regulatory framework may not ensure that vets give consumers enough or the right information to help them make choices that protect their interests and the welfare of their pets; and

(c) the mechanisms for monitoring vets' compliance with the requirements of the framework, and taking enforcement action and imposing sanctions for non-compliance, may be too limited.

2.75 Each of these points may arise because the regulatory framework does not take enough or appropriate account of consumers and competition, and each is liable to affect competitive processes and consumer outcomes.

2.76 Professional entry requirements which are too restrictive may affect competition because they may affect the supply of vets, the capacity to meet consumer demand and the prices consumers pay. Inadequate substantive provisions in, and limited monitoring and enforcement of, regulation may also affect competition and consumer outcomes. This is because effective regulatory requirements that result in consumers being able to make better choices should drive competition between providers and help ensure that consumers are offered a range of services that meet their needs at prices we would expect in a well-functioning market.

2.77 Our concerns do not arise only from a consumer or competition perspective. A system of regulation that is weak or ineffective for these reasons may also contribute to poor animal welfare outcomes, since a competitive market for veterinary services would reduce prices, improve quality and widen access to services and treatments.

2.78 We consider the impact of the regulatory framework on competition further in section 7 below.

3. Regulation of veterinary nurses

3.1 In this section we outline the role of vet nurses. We also explore whether the broad scope of activities currently reserved to vets could have implications for competition and consumers and consider the potential benefits of expanding the remit of vet nurses.

3.2 Like vets, registered veterinary nurses (RVNs) are regulated by the RCVS. They carry out a range of tasks, including some which can be performed only if they have been delegated to a nurse by a vet. This section will consider the implications of the lack of clarity as to the remit of the vet nurse role within the existing regulatory framework and explore the appetite across the veterinary profession for reform which would allow RVNs to carry out additional duties.[136]

3.3 The question of which type of veterinary professional should be permitted to carry out specific clinical tasks is rightly reserved to the RCVS and is not within the CMA's remit. However, it does appear to us that reducing the list of activities restricted to vets and extending the range of tasks that RVNs are permitted to undertake, with appropriate additional training and supervision, could offer positive impacts for veterinary professionals and pet owners and their pets. For example:

(a) enabling new ways of accessing services, and potentially more cost-effective forms of service delivery for consumers;

(b) freeing up vets' time in an under-staffed profession (see paragraphs 3.32 to 3.34) allowing more efficient use of resources and easing workforce-related pressures; and

(c) increased job satisfaction, career progression and earning potential for RVNs (potentially improving staff retention).

The role of veterinary nurses

3.4 Vet nurses work within veterinary teams, providing valuable supportive care to animals. They carry out technical work and are skilled in undertaking a range of

[136] For example, as expressed in IVC Evidensia Response to the Consultation, VetPartners Response to the Consultation, RCVS Response to the Consultation and Dog's Trust Response to the Consultation, and CVS Response to the Issues Statement, 26 July 2024 (**CVS IS Response**), Pets at Home Response to the Issues Statement, 30 July 2024 (**PAH IS Response**), Linnaeus Response to the Issues Statement, 30 July 2024 (**Linnaeus IS Response**), VetPartners Response to the Issues Statement, 30 July 2024 (**VetsPartners IS Response**), RCVS IS Response, BVNA Response to the Issues Statement (**BVNA IS Response**), and Dog's Trust Response to the Issues Statement (**Dog's Trust IS Response**).

diagnostic tests, medical treatments and minor surgical procedures under the direction of a vet.[137,138]

3.5 Nurses are trained to understand the basis of all common diseases of all animal body systems and how they present, as well as on the use of medications including routes of administration and recognition of adverse reactions. They are expected to refer cases to vets where appropriate and are not permitted to diagnose illness or health.[139]

3.6 Nurses are often involved in communication with clients regarding pricing and other relevant information. For example, we learned from site visits and our RVN roundtable that vet nurses play an essential role in providing information to consumers following a consultation and ensuring pet owners have understood the information provided by the vet.[140] They can also play an important role in the education of pet owners, including in relation to preventative healthcare.[141] The British Veterinary Nursing Association (the BVNA) has stated that:

> RVNs that consult at present are doing so from the preventative healthcare perspective, so often give a holistic consultation, addressing all areas of preventative treatment. This leads to improved animal welfare standards. Often clients will feel more at ease with an RVN and divulge more important information about their pet.[142]

3.7 We understand that nurses are sometimes used in practices as an alternative to recruiting to other roles, such as reception or admin support staff.

The current regulatory framework for veterinary nurses

3.8 As noted above, the RCVS regulates veterinary nurses. Although the VSA did not include reference to veterinary nurses when it was enacted in 1966, it was amended in 1991 where the role (but not the title) of veterinary nurse was formally recognised in law under Schedule 3 of the VSA (Schedule 3). Schedule 3 was amended in 2002 so that a veterinary nurse or a student veterinary nurse may

---

[137] See RCVS website, I want to be a veterinary nurse (https://animalowners.rcvs.org.uk/veterinary-careers/i-want-to-be-a-veterinary-nurse/ -:~:text=Veterinary%20nursing%20is%20the%20supportive%20care%20of%20animals%20receiving%20treatment) (accessed 29 January 2025).
[138] Examples of duties which may be delegated include but are not limited to: second vaccinations; maintenance & monitoring of anaesthesia; routine dental hygiene work; IV catheterisation and injections; IM injections; placing urinary catheters, and blood sampling (RCVS internal document, March 2020, submitted in response to RFI1 [✂]]
[139] Supporting Guidance, Treatment of animals by unqualified persons.
[140] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraphs 22 – 24.
[141] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 4.
[142] BVA response to RFI1. [✂]

carry out certain medical treatments and minor surgeries under the direction of a registered veterinary surgeon.[143]

3.9 The RCVS introduced a non-statutory register of veterinary nurses in 2007 and in 2011 a disciplinary system for RVNs was introduced, for which the RCVS is responsible.[144]

3.10 In 2015 the RCVS used its Charter powers to introduce formal regulation of RVNs. The Charter marked a change in the way the veterinary nursing profession was regulated and confirmed the RCVS as the regulator of veterinary nurses. The Charter made RVNs associates of the RCVS (this differs from vets, who are members). It also provided for the Veterinary Nurses' Council to continue as a committee of the RCVS and for it to set standards for pre-registration training and education, requirements for registration, and standards for conduct.[145]

3.11 Despite the amendments to legislation, the RCVS had to draw on its Charter powers to create the regulatory framework that currently exists, which does not include as wide a range of tasks as might benefit the profession and, as with vets, is not able to provide effective monitoring and enforcement of RVNs' compliance with regulation and guidance. This is another indicator that the VSA and the regulatory framework do not properly reflect the way in which the profession and industry currently operate.

3.12 The RCVS Nurses Code and the Supporting Guidance for Nurses largely mirror the vets' Code and Guidance and all RVNs are required to follow them. The RCVS' interpretation of Schedule 3 (which allows vets to delegate medical treatment and acts of minor surgery not involving entry into a body cavity) is provided in section 18 of the Supporting Guidance and the Supporting Guidance for Nurses.[146]

3.13 The regulation of vet nurses would appear to be vulnerable to similar regulatory weakness as those we have highlighted in section 2 above in respect of vets. These weaknesses include: inadequate mechanisms for the RCVS to monitor and enforce compliance with regulation that applies to vet nurses; insufficient focus within the regulatory framework on the commercial and consumer-facing aspects of veterinary care; and limited provision for consumers to obtain redress where problems occur.

3.14 We consider three aspects of the regulatory framework as it applies to veterinary nurses: the protection of the RVN title; uncertainty relating to the interpretation of

---

[143] The Veterinary Surgeons Act 1966 (Schedule 3 Amendment) Order 2002.
[144] RCVS Knowledge, Veterinary nursing timeline (https://knowledge.rcvs.org.uk/heritage-and-history/history-of-the-veterinary-profession/veterinary-nursing-timeline/) (accessed 29 January 2025).
[145] RCVS Knowledge, Veterinary legislation in the UK (https://knowledge.rcvs.org.uk/heritage-and-history/history-of-the-rcvs/veterinary-legislation-in-the-uk/) (accessed 29 January 2025).
[146] Supporting Guidance for Nurses, Delegation to Veterinary Nurses.

current regulation; and whether the range of tasks that nurses are permitted to carry out could be reformed.

Protection of the veterinary nurses' title

3.15 Despite recognition and regulation by the RCVS of the role of RVN, the title 'veterinary nurse' is not recognised in statute. Because vet practices employ many lay persons the RCVS is keen that only RVNs should be called veterinary nurses.[147] Nevertheless, a 2023 BVNA report suggested that 48% of veterinary professionals surveyed were aware of unqualified persons still using the 'veterinary nurse' title in practice.[148]

3.16 Protection of the veterinary nurse title is of high importance to the RVN profession and to the veterinary sector more widely. This was apparent from our qualitative research with veterinary professionals[149] and from our roundtable discussions with RVNs.[150] Stakeholders said that protection of the title was needed for the following reasons:

(a) To recognise the importance of the profession and the high level of training veterinary nurses complete. This could improve morale within a profession facing staffing challenges (see paragraphs 3.32 to 3.34).

(b) To ensure that clients can be confident that a qualified professional is caring for their pet, and that the fees charged reflect this. In the interests of pricing transparency, invoices should properly describe the person who is charging for their time.[151]

(c) Veterinary surgeons delegating tasks to RVNs under Schedule 3 could be more confident that the nurses they are working with have completed adequate training.[152]

3.17 Our emerging view is that protecting the veterinary nurses' title might enhance transparency and consumer confidence, improve consumers' ability to compare offerings between firms and therefore help stimulate competition between rivals.

[147] In particular, veterinary surgeons and veterinary nurses should not hold out a colleague as a 'veterinary nurse' unless that colleague is appropriately registered with the RCVS. See Supporting Guidance for Nurses, Treatment of animals by unqualified persons, paragraph 19.8.
[148] BVNA, Protect the Title Campaign, Survey results, May 2023, page 7.
[149] Qualitative research with veterinary professionals, 'Veterinary nurses' attitudes towards skill usage' section.
[150] CMA, Summary of vet nurses roundtable discussion, 23 September 2024.
[151] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, page 2.
[152] BVNA Protect the Title Campaign, Survey results, May 2023, page 6.

Interpretation of the existing framework

3.18 Uncertainty around what is permitted under current regulation may be leading to vet nurses being under-utilised across the sector. RVNs complete a high level of training and stakeholders including nurses, the British Veterinary Association (the BVA), the BVNA and the RCVS have suggested that a greater range of tasks could be undertaken by nurses within existing regulation.[153] This suggests that the under-utilisation may be due to a lack of understanding of the scope of Schedule 3 and the skillsets of RVNs.

3.19 Under Schedule 3, RVNs and student RVNs can perform certain procedures in veterinary practice, where delegated to them by a vet employed in the same practice, and where under the supervision of that vet.[154] This includes carrying out medical treatments or performing minor surgery so long as this does not involve entry into a body cavity.[155]

3.20 The responsibility is on the vet to decide whether it is appropriate to delegate, and to be available to answer any call for assistance.[156] Examples of what may be delegated under Schedule 3 include, but are not limited to: second vaccinations;[157] maintenance and monitoring of anaesthesia; routine dental hygiene work; IV catheterisation and injections; intramuscular injections; placing urinary catheters, and blood sampling.[158]

3.21 Veterinary nurses who participated in our RVN roundtable and qualitative research emphasised that the opportunities to use their skillset on a given day is subject to the discretion of the vet they are working with and will depend on their relationship with that vet and the level of trust the vet has in them. This appears to be driven by the fact the delegating vet faces the risk of being responsible for an inappropriate delegation made by them to an RVN. Whether a delegating vet would remain professionally responsible in situations where the decision to delegate itself was appropriate, but something then goes wrong in the execution of the task itself by the RVN, would depend on the particular context.[159] The BVNA and BVA believe clarity is still needed around who is responsible when problems occur.[160]

3.22 Schedule 3 does not appear to have been well understood by many vets and RVNs for a number of years. A 2017 RCVS survey found that vet nurses rated

---

[153] RCVS response to RFI3 Q15 [✂], BVA Teach-in [✂], CMA Summary of vet nurses roundtable discussion (23 September 2024) eg paragraph 7, and BVNA Congress 2024, Visions of Future VN Regulation [✂].
[154] Paragraphs 6 and 7 of Schedule 3.
[155] The Veterinary Surgeons Act 1966 (Schedule 3 Amendment) Order 2002.
[156] Supporting Guidance for Nurses, Delegation to veterinary nurses.
[157] 'Second vaccination' refers to the second injection in a primary course (the first set of injections) given to a puppy or kitten. First injections in a primary course and annual booster vaccinations, by contrast, are currently reserved to vets.
[158] RCVS internal document, March 2020, submitted in response to RFI1 [✂]
[159] RCVS meeting with the CMA on 16 October 2024, page 83. [✂]
[160] BVNA guidance, For-veterinary-professionals-Maximising-RVN-role-11.12.24.pdf, BVA minutes, Regulatory reform – enhancing the VN role meeting, enhancing-the-vn-role-minutes-12-november-2020.pdf

their understanding of Schedule 3 at 6.7 out of 10 and vets rated theirs at 5.6 out of 10. Both RVNs and vets requested more clarity and guidance on Schedule 3.[161] Although advice and formal guidance has since been provided by the RCVS (including case studies and a checklist)[162] on what should be delegated and how, it appears that there are still concerns about the lack of clarity around what vet nurses can do. As recently as last year, the BVNA and BVA reiterated that clarity is still needed around what can be delegated under Schedule 3, how this should be done, and who is responsible when inappropriate delegation occurs.[163] We also understand from our RVN roundtable that getting clarification via a phone call with the RCVS on what is included within Schedule 3 in a timely manner can be very difficult and this can prevent RVNs from being able to act on occasions.[164] Associations such as the BVNA have attempted to fill this gap and developed guidance to support their members.[165] It remains the case that there is no defined list of activities which can be carried out under Schedule 3.

3.23 The RCVS has expressed reservations about providing a defined list of Schedule 3 tasks. However, it told us that there are certain procedures (such as 'internal expression of anal glands') which many vets and vet nurses mistakenly believe nurses cannot do and noted that it clarifies these points when responding to advice queries, in its resources published online and at conferences.[166]

3.24 It was also clear from our roundtable with RVNs that there is some confusion and inconsistency in practice around what exactly a nurse could do in relation to anaesthesia within the current framework.[167] This may therefore be an area where some clarification would benefit vets, RVNs and, by extension, purchasers of vet services.

3.25 Our emerging view is that vet nurses could be more fully and effectively utilised within the requirements of existing regulation and that greater clarity with respect to interpretation of the existing framework could help enable this. In turn, this could benefit animal welfare by providing greater depth within the offering provided by vet teams and releasing capacity to broaden access to clinical services. This may result in lower prices for some services and foster a more competitive market. It appears to us there is some merit in the proposal to create a clearer indicative list of routine procedures that nurses can carry out. There may also be scope for a more detailed framework, which might, for example, specify qualifications or CPD modules which, if completed by an RVN, may give vets confidence in delegating

[161] RCVS survey report on Schedule 3, 27 October 2017.
[162] RCVS, Advice on Schedule 3.
[163] BVNA guidance, Maximising the RVN Role under current legislation and BVA minutes, Regulatory reform – enhancing the VN role meeting, 12 November 2020.
[164] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 19.
[165] BVNA guidance, Maximising the RVN Role under current legislation.
[166] RCVS meeting with the CMA, 16 October 2024, page 86. [✂]
[167] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 18.

specified tasks. More regularly updated guidance, containing examples, to encourage consistency in the approach to delegation by vets may also be of value.

Reform

3.26 Concerns around the current capacity of the veterinary workforce (see paragraphs 3.32 to 3.34) have led to considerable attention being given to how best to utilise the veterinary workforce and associated allied professions, with government, the RCVS, and business considering the issues and proposing change.[168]

3.27 As outlined above, it may be possible to better utilise RVNs within existing legislation, but any expansion of the role may require legislative change. This is because the rules that allow veterinary nurses to carry out acts of veterinary surgery are contained within Schedule 3, and that schedule also underpins what farmers can do to their own animals. Therefore, we understand that any expansion of the definition of 'minor surgery', for example, to allow RVNs to perform more duties, would also extend to farmers. The RCVS is concerned to ensure animal health and welfare by appropriately limiting the scope of veterinary care that farmers can lawfully provide to their animals (for example, the RCVS does not want farmers carrying out anaesthesia on their own animals) and, as such, it takes the view that primary legislation is required to expand the role of RVNs without expanding what farmers can do.[169] We are continuing to assess these points.

3.28 There is appetite for legislative reform to expand the role of veterinary nurses so that they can provide additional forms of care that may presently be reserved to vets. This could lead to RVNs having more autonomy once they have received suitable training. A 2017 RCVS consultation suggests that 92% of RVNs and 71% of vets agreed that nurses should be able to undertake additional areas of work.[170] More recently, roundtable participants told us that nurses often refer cases to vets that they could deal with themselves due to the confines of the VSA, which leads to additional costs for clients.[171]

3.29 The BVNA has said that fully utilising vet nurses would improve job satisfaction, reduce the number of nurses leaving the profession, and free up vets 'to do what only a vet can do; diagnose, prescribe and perform surgery'.[172] Five of the LVGs told us that allowing veterinary nurses to do more in practice would lessen the burden on vets and allow for more career progression for nurses.[173]

---

[168] See, for example: EFRA Committee, 12 March 2024, How to tackle the UK's vet shortage and Duncan Phillips: The urgent need to overhaul government veterinary support and regulation, 1 February 2024, (https://ivcevidensia.co.uk/News/duncan-phillips-time-to-overhaul-vet-support) (accessed 29 January 2025).
[169] RCVS meeting with the CMA on 16 October 2024, page 85. [✂]
[170] RCVS internal document, March 2020, submitted in response to RFI1 [✂]
[171] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 7.
[172] BVNA IS Response.
[173] CVS, PAH, Linnaeus, VetPartners IS, IVC Responses to the Consultation.

3.30 We recognise that the scope of activities which should be reserved to vets is for the RCVS to determine in accordance with legislation. However, several areas have been highlighted by stakeholders as potential areas where reform to the role of the vet nurse – and consequently to the breadth of tasks reserved to vets – could be beneficial. We outline a few of these below.

(a) The RCVS has stated that delegation to RVNs in relation to the induction and maintenance of anaesthesia should go further than it does at present.[174] In 2015, following extensive consultation and discussion, RCVS Council approved a recommendation to increase the role of veterinary nurses in the induction and maintenance of anaesthesia via reform of Schedule 3. These proposals would allow the veterinary nurse to 'assist in all aspects of anaesthesia under supervision', meaning a vet must be on the premises. This recommendation would increase the utilisation of veterinary nurses while freeing up vets' time.[175] Attendees at our RVN roundtable suggested that current legislation did not clearly reflect the practical realities of anaesthesia.[176] Reform could therefore align regulation with practice. We heard from the members of the CMA's Veterinary Advisory Panel[177] who are vet nurses that, if a nurse were able to play a greater role in anaesthesia, they could fully prepare an animal for surgery while a vet continued with other work such as consults, allowing vets' time to be used more efficiently.[178]

(b) We understand there is an appetite for a nurse practitioner role and for it to be possible for nurses to take on advanced specialisms.[179] There may be scope, for example, for Emergency and Critical Care specialised RVNs to be able to prescribe oxygen therapy and intravenous fluids in order to begin to stabilise a patient.[180] The RCVS is also researching a vet nurse prescriber role whereby a suitably qualified nurse would be able to prescribe certain medications within their competence without delegation from a vet. This would require a change to the VMRs.[181] The development of such roles may increase opportunities for career progression for vet nurses who wish to advance clinically. Stakeholders suggest that a key driver of RVN

[174] RCVS response to RFI3, Question 15. [✂]
[175] RCVS Legislative Review Consultation Report 2021.
[176] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 18.
[177] To assist in the market investigation the CMA Inquiry Group have appointed two veterinary nurses and four veterinary surgeons to the CMA's Veterinary Advisory Panel. The purpose of the advisory panel is to provide the Group with insight and analysis on an ad hoc basis on matters relating to practising as a veterinary nurse and veterinary surgeon.
[178] Discussion with the CMA's Veterinary Advisory Panel 11 October 2024. We note that one panel member suggested that a greater role for vet nurses could be possible for more routine anaesthesia procedures given appropriate training however anything with a higher ASA grade or risk is still likely to require veterinary input. Another member noted that given the inherent risks of anaesthesia there does need to be a vet available should they need to intervene.
[179] CMA, Summary of vet nurses roundtable discussion, 23 September 2024, paragraph 14.
[180] BVA response to RFI, dated 7 June, [✂]
[181] RCVS response to RFI3, Question 15. [✂]

resignations is the lack of progression opportunities[182] and that there is a shortage of veterinary nurses, and that recruitment is very difficult.[183]

(c) The RCVS is considering whether community nursing would be possible under current legislation, but indicated this would be difficult without legislative reform.[184] If 'district nursing' style services could be offered within a domestic setting this could benefit consumers, particularly those who find it difficult to travel to their practice. District nursing could also be beneficial for household pets who can experience great amounts of stress when visiting vet practices.

3.31 We appreciate that any expansion would need to be supported by awareness campaigns and training provision.

Possible benefits of greater utilisation of RVNs

Staffing challenges in the veterinary profession

3.32 We have heard from a range of stakeholders including, for example, the LVGs, independent vets, the BVA and the RCVS that there are staffing shortages within the veterinary profession. This was also a common theme in responses from veterinary professionals to our call for information.[185] There have been reports of practices that have stopped taking new pets because of the shortage of veterinary staff.[186] The BVA has suggested this is due to a combination of increased pet ownership, the impact of Brexit,[187] and an increase in vets leaving the profession.[188]

3.33 We were informed during site visits and teach-ins that, because of the ongoing veterinary workforce shortage, there has been an increased reliance on locum vets as veterinary practices struggle to fill permanent positions. We also understand that productivity tends to be lower than with permanent staff due to the

[182] See, for example, CVS research Lack of career progression cited as the main factor linked with resignations of UK veterinary nurses and Summary of vet nurses roundtablediscussion, 23 September 2024, paragraph 8.
[183] BVNA Congress.Visions of Future VN Regulation [✂]
[184] RCVS meeting with the CMA on 16 October 2024, [✂]
[185] A summary of the responses to our Call for Information was provided in our Decision to make a market investigation reference into Veterinary services for household pets in the UK, 23 May 2024. See paragraph 2.4 which states "another main area raised by veterinary professionals was staffing, where they highlighted significant staff shortages."
[186] BBC News, Wolverhampton vets refusing new cases amid national vet shortage - BBC News, 18 April 2024. (https://www.bbc.co.uk/news/articles/cw8qeded082o) (Accessed 3 February 2025)
[187] We understand that since Brexit fewer EU vets are coming to the UK. The Vet Times also reported that migration rules, which came into force in April 2024, are raising the salary threshold for vets over 26 years old to £48,100/year. See Fears increase over impact of migration rules on profession | Vet Times, 22 March 2024. (https://www.vettimes.co.uk/news/fears-increase-over-impact-of-migration-rules-on-profession/) (Accessed 3 February 2025)
[188] BBC News, Wolverhampton vets refusing new cases amid national vet shortage - BBC News, 18 April 2024. (https://www.bbc.co.uk/news/articles/cw8qeded082o) (Accessed 3 February 2025)

short-tenure roles,[189] and that locum rates tend to be higher than costs for employed vets.[190]

3.34 At the same time, some figures might indicate that the number of vets has increased in recent years by more than the number of cats and dogs and we have heard of redundancies in some vet practices. These could be factors suggesting an easing of the pressure on vet practices caused by staffing shortages.

Greater utilisation of RVNs could ease staffing pressures

3.35 In circumstances where there is a shortage of veterinary surgeons, enabling vet nurses to more often support vets with their workload could ease workforce-related pressures on the sector as a whole. Legislative reform could permit suitably qualified veterinary nurses to do more, and in the meantime the current legislation could be further clarified to ensure RVNs are being fully utilised. Both these steps could improve cost-efficiency and free up vets' time to carry out other, more complex fee-earning work.

3.36 This may improve the local competitiveness of a practice compared with those who only retain vets to do the same work. This could also enable new ways of accessing services and potentially facilitate more cost-effective forms of service delivery for consumers to be offered by practices. This might include, for example, practices offering unique services within current legislation such as nurse consultations on wellness, nutrition, or chronic disease monitoring.[191] Following legislative reform, services such as district nursing could be offered.

Emerging views

3.37 Our emerging view is that more effective utilisation of vet nurses could have a positive impact on the veterinary profession, animal welfare and consumer choice. Job satisfaction, career progression and earning potential could improve for RVNs while vets' time could be used more efficiently. It may also enable new ways of accessing services to emerge and facilitate more cost-effective forms of service, as set out.

3.38 RVNs could be used more effectively under current regulation, and regularly updated frameworks and guidance may improve vets' and nurses' understanding and confidence when engaging with Schedule 3. We acknowledge that the RCVS has published guidance to this effect and has creatively used other tools such as its Charter to promote the role of RVNs. However, legislative reform would be

[189] CMA Meeting with [✂]
[190] CMA Meeting with Pets at Home, 17 October 2023. [✂]
[191] BVNA Congress 2024 'Why utilising your nursing team means a healthier business.' [✂]

required to take certain steps such as amending Schedule 3 and to protect the veterinary nurse’s title.

4. Regulation of veterinary businesses

4.1 In this section we discuss the absence of regulation applying directly to vet practices as business entities and assess the effectiveness of the PSS in seeking to close this regulatory gap. In section 7 we consider the impact of the current regulatory framework, including the absence of regulation of veterinary businesses, on competition and the consumer interest.

There is no regulation of vet practices

4.2 The RCVS' statutory remit extends to individual practitioners. It does not apply to the businesses which sell veterinary services or to non-vet owners of vet practices. This means that the regulator cannot, for example, compel a business to provide information, monitor or control their conduct, nor sanction businesses or practice managers who are not vets.

4.3 The absence of practice regulation can be explained by the evolution of the veterinary sector. The relevant primary legislation is from 1966, when there was a much narrower veterinary workforce, there were notably different attitudes towards the care and treatment of pets, and vet practices were usually owned by (regulated) vets.

4.4 Now, 60% of vet practices are owned by LVGs with shareholders, significant management layers and senior executives who are not (or not necessarily) vets and who may not be physically proximate to the vets practising in the FOPs owned by the groups. Many smaller vet businesses also now have practice owners or managers who are not vets but who may have influence over practices.

4.5 Non-vets are therefore now much more commonly in positions where they can make or influence significant decisions which can affect the range, quality, price and transparency of services sold to consumers. These decisions might include: setting or influencing prices; deciding which vets to employ (including levels of skill and experience); investing in equipment; setting and monitoring KPIs and targets; setting consultation times; creating protocols and practice guidance; managing the information given to consumers; and managing complaints. In doing so they are outside the scope of regulation.

4.6 We note that some industry stakeholders were apprehensive about the impact of non-vets owning and managing vet businesses.[192] That is indicated in one

[192] The advice traditionally given by the RCVS and until 1997 reflected in the then *Guide to Professional Conduct* was that corporations could not own veterinary practices. This was based on the logic that only individuals registered with the RCVS could hold professional qualifications relevant to operating a veterinary practice. However, the RCVS position changed in 1997 and it was acknowledged that the RCVS has no power to prevent either incorporation by veterinary surgeons to own practices or non-veterinary partners. As such, the restriction on veterinary practice ownership only being allowed by veterinary surgeons was removed from the 1998 version of the *Guide to Professional Conduct.*

contemporary article which stated, '…. it is likely that the control of the Royal College over the standards of veterinary practice and the ethical conduct of its membership will diminish as more practices come under the ownership of companies and non-veterinarians'.[193]

4.7 The current regulatory framework applies to individual vet practitioners but not to non-vet owners and managers. There may now at least in some cases be a disconnection between those with responsibilities under the regulatory framework and those with much of the power to ensure that this responsibility is met. Such a disconnection may be a less serious problem in the context of smaller vet practices, especially where they are vet owned. However, with larger veterinary groups it may become quite pronounced, both in terms of the number and seniority of unregulated persons taking or influencing strategic decisions about the business[194] and the distance between those persons and the regulated vets and vet nurses delivering veterinary care.

4.8 The lack of practice regulation may also have consequences for individual vets:

(a) It risks creating a conflict for individual vets between what they would like to do and what they may feel encouraged (or required) to do by their employer or through corporate incentives. Veterinary surgeons and other stakeholders who attended our roundtable discussion in Swansea spoke about whether 'an employer could put pressure on vets to act in certain ways (for example, to cut corners or do things outside of their skill set) without recourse.' Some said that 'an employer would always be in a position of power over employees.'[195] It appears to be sub-optimal, and to put significant pressure on individual vets, for the effectiveness of the regulatory regime to depend on regulated individuals having to reconcile their obligations as employees with their responsibilities under that regime.

(b) The absence of regulation for vet businesses may lead to the regulatory framework placing the onus for maintaining standards on regulated individuals rather than the businesses who are responsible for the level of service provided to consumers. For example, paragraph 4.3 of the RCVS Code requires that '*Veterinary surgeons must maintain minimum practice standards equivalent to the Core Standards of the RCVS Practice Standards Scheme',* even though achieving these standards may not be within the control of an individual vet and will depend on decisions being taken by the vet business.

4.9 The absence of practice regulation means that the RCVS is not able to monitor or control the conduct of vet businesses. Where the effective application of the

[193] Gripper, J, (1998) 'Incorporation and its implications for veterinary practice', *In Practice*, pages 154-155.
[194] For example, providing resources, setting procedures, engaging with customers.
[195] CMA, Summary of Swansea roundtable discussion, 31 July 2024, paragraph 10.

regulatory framework rests on it having an appropriate disciplining effect on conduct (because it deters or sanctions misconduct), this may be a significant flaw in the effectiveness of that framework.

Attempts to fill this gap

Practice Standards Scheme

4.10 The RCVS has sought to fill the regulatory gap with its PSS.[196] This is a voluntary accreditation scheme which aims to promote and maintain the highest standards of veterinary care.[197] It offers practices a framework of good practice standards. Eligible organisations are 'those running veterinary practices from premises that are open to members of the public to bring animals for veterinary treatment and care, or where the veterinary treatment and care of animals is provided to members of the public via ambulatory services'.[198] The RCVS Legislation Working Group has noted the PSS '…is a voluntary scheme and as a result there is no mechanism to ensure standards across all practices through assessments'.[199]

4.11 Around 69% of eligible practices have joined the PSS,[200] and it is funded by annual membership fees. We understand that either all or a majority of the practices owned by each of the LVGs are part of, or in the process of joining, the PSS.

4.12 The PSS operates in accordance with the RCVS Practice Standards Rules.[201] There are different levels of accreditation available, depending on the type of premises, services offered and species treated.[202] The accreditations available to practices carrying out veterinary services within the scope of this Market Investigation are: Core Standards; General Practice (GP); Emergency Service Clinic (Small Animal); and Veterinary Hospital. Some accreditations are cumulative.

4.13 The modules for each accreditation are contained in the PSS Small Animal Modules and Awards document.[203] Practices must meet the requirements in each module[204] to achieve accreditation. Practices can also separately apply for

---

[196] CMA meeting with the RCVS on 16 October 2024, page 61. [✂]
[197] RCVS, Practice Standards Scheme.
[198] RCVS, Practice Standards Rules, 1 January 2024, page 3.
[199] See LWP update 1: assuring practice regulation, July 2020 and Working Group established to develop mandatory vet practice regulation, 12 January 2024.
[200] RCVS, Practice Standards Scheme.
[201] RCVS, Practice Standards Rules, 1 January 2024.
[202] RCVS, Practice Standards Scheme.
[203] PSS Small Animal Modules and Awards.
[204] There are modules on Anaesthesia, Clinical Governance, Client Experience, Dentistry, Diagnostic Imaging, Infection Control and Biosecurity, In-patients, Laboratory and Clinical Pathology, Medicines, Medical Records, Nursing, Out-of-Hours, Out-Patients (First Opinion), Pain Management and Welfare, Practice Team, Premises, Surgery and Environmental Sustainability. There is a module on Emergency and Critical Care which is only applicable to the Emergency Service Clinic accreditation.

voluntary awards in areas where they may excel, such as Team and Professional Responsibility, Client Service, Patient Consultation Service, Diagnostic Service, In-patient Service, Emergency and Critical Care Service.[205]

4.14 Within the 'Find a vet' function of the RCVS' website consumers can search specifically for PSS accredited practices.

PSS Assessment Process

4.15 The RCVS currently employs 25 PSS assessors. They are current vets or vet nurses who have been registered with the RCVS for a minimum of 5 years.

4.16 Stanley, the online system used to facilitate the operation of the PSS, is the central point of communication between practices, assessors and the RCVS. There is guidance for practices on how to use this system.[206] Practices are required to upload documentation to Stanley in advance of their PSS assessment (and afterwards, if further evidence is required by the assessor).

4.17 An initial assessment of practices should take place within six months of their electing to take part in the scheme and practices must achieve accreditation of Core Standards within 12 months. Practices are thereafter assessed in person by an assessor every four years and must make an annual declaration to the RCVS that they are compliant with the standards of their accreditation (and any voluntary awards).

4.18 Interim 'spot checks' can also be carried out on practices that are part of the PSS, on a targeted or randomised basis. Under the PSS rules, this can be done without prior notice, although practices are normally given 24 to 48 hours' warning.

Emerging assessment of the Practice Standards Scheme

4.19 We have considered how far, and how effectively, the PSS fills the gap created by the absence of a statutory regime for practice regulation.

Stakeholder views

4.20 We understand that the PSS is regarded by some stakeholders as a useful framework and that it is often used by new practices as a blueprint of how practices should be run,[207] including by practices who are not part of the scheme. We have been informed that PSS accreditation may make practices more

[205] For such voluntary awards, practices are assessed on a point scoring basis and, if they accrue at least 60% of available points for each module, are awarded a rating for their award of either good (60% and above) or outstanding (80% and above). A separate fee is charged for awards based on assessors' time.
[206] See RCVS, Getting to know Stanley: A guide for veterinary practices.
[207] CMA meeting with RCVS on 16 October 2024, page 64. [✂]

attractive to prospective employees[208] and the RCVS told us that it encourages new vet graduates to seek employment with accredited practices.[209]

4.21 A data-gathering exercise conducted by the RCVS between May 2022 and October 2024 of practices participating in the PSS revealed that, on a scale of 0-5 (0=not relevant at all and 5=extremely relevant) 982 practices scored an average of 4 when asked how relevant are the standards set by the PSS to the work they do.[210]

4.22 The National Office for Animal Health (**NOAH**) has stated to us that the PSS, 'encourages best practice, including in areas such as how prices are communicated to consumers'.[211] The Dogs Trust has told us that a PSS accreditation is a 'better indicator of overall service quality' than other quality improvement measures produced by the RCVS.[212]

4.23 Medivet has put to us that, '…accreditation entails an enhanced degree of transparency (and practice standards more generally) as compared to the RCVS Code obligations'.[213]

4.24 Other commentary from some stakeholders has been more critical:

(a) The Federation of Independent Veterinary Practices (**FIVP**) has told us that, 'the RCVS Practice Standards Scheme (PSS) is a voluntary scheme and many practices have chosen to be assessed to 'core standards' only. However, 'core' standards represent the minimum legal operation of a veterinary business and should be in place regardless of the RCVS PSS'.[214]

(b) The BVNA has noted that, 'the PSS is voluntary at the moment and not enforceable. Allowing the RCVS to regulate practices as well as individuals would help to standardise levels of service including transparency of ownership, standard fees and qualifications of staff working at the practice.'[215]

Our assessment

4.25 We have taken account of the stakeholder views put to us. Our emerging assessment is that the PSS is unlikely effectively to regulate veterinary practices

[208] Discussion with the CMA's Veterinary Advisory Panel
[209] RCVS meeting with the CMA on 16 October 2024, page 65. [✂]
[210] RCVS response to RFI3, Q10. [✂]
[211] NOAH Response to the Consultation, 11 April 2024, page 2.
[212] For example, the National Audit for Small Animal Neutering and the Canine Cruciate Registry. See Dogs Trust IS Response, page 4.
[213] Medivet Response to the Consultation, 1 April 2024.
[214] FIVP Response to the Issues Statement, 26 July 2024 (**FIVP IS Response**), page 4.
[215] BVNA IS Response, page 5.

for reasons that relate to: its status; its objectives and scope; its monitoring and enforcement and its lack of visibility to consumers.

Status

4.26 The voluntary nature of the PSS is likely to operate as an important drawback. Almost a third of practices are not signed up to the PSS. There are no mechanisms to compel their membership nor to compel compliance by those which are members. In circumstances where a practice is not compliant with the required standards, it can simply choose not to enrol or (if it is a member) to leave the scheme.

Objectives and scope

4.27 The PSS aims 'to promote and maintain the highest standards of veterinary care'.[216] We observe that, in seeking to raise the standards of veterinary care provided by practices, the PSS has the potential to improve quality and that this would benefit consumers. The scheme includes a 'Client Experience' module as part of the Core Standards, General Practice and Veterinary Hospital accreditations. That module requires, among other things, that practices have: an effective means of communication with clients; systems to consider and respond to complaints; protocols for how treatment options are discussed; and a system for updating clients on fees.[217] In this the PSS does to some extent provide for practice standards which protect consumer interests.

4.28 Even so, it may still be the case that consumer issues are not the scheme's core focus, and we are considering both the design and implementation of the PSS to explore this point. In terms of design, we note that most of the modules and awards available under the PSS relate to clinical standards rather than interactions between vet practices and consumers, while the accreditation assessment process is viewed by vet practices as 'a full clinical and regulatory compliance audit'.[218]

4.29 We also understand that the rationale for introducing the PSS was to fill the gap in veterinary regulation caused by the lack of statutory powers for the RCVS to regulate practices. It sought to extend the application of existing regulatory standards from individuals to practices. We set out in section 2 above our emerging assessment that those standards may have too limited a focus on protecting consumers and promoting competition.

[216] RCVS, Practice Standards Scheme.
[217] RCVS, PSS Small Animal Modules and Awards.
[218] RCVS, Practice Standards Scheme.

Monitoring and enforcement

4.30 In terms of its monitoring and enforcement, the PSS' voluntary status is liable to produce certain weaknesses. While practices are reassessed for accreditation every four years and must annually declare their compliance with the scheme's standards, there is limited scrutiny between assessments. The RCVS does conduct interim spot checks, but these are rare: since October 2021, eight spot checks have been carried out.[219] The RCVS also has no powers to compel vet practices to provide information or submit to inspection.

4.31 Even where there is (periodic) assessment, there appear to be difficulties which might limit the improvements to clinical quality and outcomes for consumers that the scheme might otherwise provide:

(a) We have heard that the PSS assessment process can be very time consuming for vet practices.[220] In May 2022, the Lead Assessor of the PSS advised the RCVS Standards Committee:

> 'A common feeling is the general struggle to meet the demands to remain operational. This is taking its toll on the profession in terms of stress, anxiety, and their general ability to prioritise and prepare for their PSS assessments. As a result, we have seen a surge in delay requests for PSS assessments, and others that are just simply unprepared. The data collected supports the challenges we are seeing by demonstrating lower uptakes of awards, increases in overdue evidence, overdue invoices remain high, and the number of top ten deficiencies are still too high. Veterinary teams have expressed that the added pressure of preparing for these assessments are not currently sustainable. The PSS team is concerned about the effect that this will have on the PSS scheme to ensure that the scheme remains successful to push up standards and to support the profession during this difficult time. PSS must respond by considering the needs and impact for any agreed changes to the standards and must be mindful to balance this with the struggle and pressures that practices currently face. Our focus must be to provide more support to practices to ensure that they are ready and prepared for the assessment process.'[221]

(b) In May 2023, the RCVS Standards Committee noted:

> …. around 10% [of PSS practices] are 'stuck' 'in progress' at the post assessment stage for long periods of time, sometimes for the

[219] RCVS response to RFI3, Question 11. [✂]
[220] Discussion with the CMA's Veterinary Advisory Panel. [✂]
[221] RCVS response to RFI1, Question 17. [✂]

whole of the four-year cycle, with outstanding evidence to be submitted. As of 3rd Oct 2022, there were 463 practice premises with overdue evidence outstanding for more than a year, and of those, 101 had more than 5 pieces of evidence outstanding and overdue, most made up of areas of concern relating to VMR and health and safety standards. The figure has since risen to above 600 practice premises with outstanding evidence (as at 1 January 2023).[222] [223]

4.32 These figures, and the comments at paragraph 4.31(a), are historical and may reflect COVID-19 and EU-exit related challenges and resulting non-compliance when practices may have been struggling. We note that the RCVS made changes to address these issues and improve compliance, for example allowing justifiable delays where these could be accommodated. It also introduced a 12-month cap on the PSS process which was implemented on 1 January 2024.[224] We understand compliance since that point has improved.[225]

4.33 There are limited sanctions available under the PSS, given its voluntary nature. The RCVS' only sanction, should businesses fail voluntarily to meet the scheme's requirements, is expulsion from the scheme.

4.34 We discuss in the working paper on **Competition in the Supply of Veterinary Medicines** evidence we have observed to date suggesting that many vet clients, across practice types, are not aware that they can obtain a written prescription.[226] This is supported by the low issue rates for written prescriptions as shown in Table 5.1 of that working paper.[227] This suggests that compliance with the PSS requirement for practices to 'make clients aware that they can request a prescription'[228] may be low, supporting concerns about weak monitoring and enforcement under the scheme.

[222] RCVS RFI1 Response, Q17. [✂]
[223] A total of 106 re-start assessments were carried out in 2024. The total number of non-compliant practices (those not achieving core standards within 12 months from date of assessment) in 2024 is 116 and the remaining 10 will be assessed as re-starts in 2025. Evidence submitted by RCVS, January 2025. [✂]
[224] The RCVS made changes to the PSS Rules on 1 January 2024, including a 12-month time limit from assessment to achieve core standards accreditation, a restart of the process if this time limit is reached and an escalation process if the practice fails to obtain accreditation on the second attempt, or there are serious concerns with the practice's ability to achieve core standards. See Updated rules to ensure compliance with Core Standards.
[225] Evidence submitted by RCVS, January 2025. [✂]
[226] See 'Information made available to pet owners in a FOP' section of the working paper on **Competition in the Supply of Veterinary Medicines**, page 76.
[227] See 'Written prescriptions requested by and provided to pet owners' section of the working paper on **Competition in the Supply of Veterinary Medicines**, page 73.
[228] Point 10.1.22 of Module 10 (Medicines) of the RCVS PSS Small Animal Modules and Awards requires that 'Practices must make clients aware that they can request a prescription' and provides guidance on how practices might do this.

Consumer awareness

4.35 There is evidence of low consumer awareness of the PSS. In our pet owners survey, only 7% were familiar with the scheme.[229] Of that small proportion, 64% said that it never affected their choice of veterinary practice.[230] The RCVS has confirmed that its 'Find a vet' function is used on average 53,949 times per month, with 2399 users searching specifically for accredited practices.[231] In circumstances where consumer awareness of the PSS is low, its potential to discipline the conduct of vet businesses, either by joining the scheme in the first place or by meeting its standards, may be limited.

4.36 The RCVS has told us that it would like awareness of the PSS to be higher, but emphasised the budgetary constraints limiting its promotion of greater consumer knowledge of the scheme.[232] It also noted that RCVS research suggests most consumers in the sector assume that all practices are regulated anyway and, as such, are not looking for a 'kite mark' because they do not think they need to.[233] We observe that the latter point may itself be indicative of a serious gap between consumer assumptions and regulatory reality and be a reason for more rigorous promotion and enforcement of the PSS as the current best alternative to mandatory practice regulation.

Approach to practice regulation in other sectors

4.37 We note that there are different approaches to regulation in other professional services sectors, including in relation to how businesses supplying those services are regulated. For example:

(a) The Solicitors Regulation Authority (**SRA**) has the power to regulate legal firms in England and Wales, whether these are owned by lawyers or non-lawyers.[234]

(b) The Royal Institute of Chartered Surveyors (**RICS**) has the power to designate that firms offering surveying services, even if not the business' primary service, are 'Regulated by RICS' if 25% of the firm's principals are RICS members. Firms that offer surveying services must be regulated by RICS if at least 50% of its principals are RICS members. [235]

(c) The General Pharmaceutical Council's regulation of retail pharmacies places specific duties on pharmacy owners. Owners may be licensed pharmacy

[229] Pet owners survey, Q122.
[230] Pet owners survey, Q123.
[231] RCVS letter to the CMA dated 2 December 2024. [✂]
[232] CMA meeting with the RCVS on 16 October 2024, page 62. [✂]
[233] CMA meeting with the RCVS on 16 October 2024, page 62. [✂]
[234] Part 5 of the Legal Services Act (2007).
[235] RICS, Rules for the registration of firms, 2 February 2022, page 4.

professionals in their own right, or alternatively be a 'body corporate' with a designated 'superintendent pharmacist'.[236]

4.38 The General Optical Council (**GOC**) supervises roughly half of optical businesses, and in October 2024 launched a consultation on its proposals to change primary legislation and require all optical businesses to be regulated by it.[237]

Emerging view on absence of practice regulation

4.39 Based on our assessment to date, we remain concerned that the absence of practice regulation means:

(a) The RCVS has limited leverage over the commercial and consumer-facing aspects of the provision of veterinary services, as well as decisions which could have an impact on animal welfare or public health.

(b) Regulation does not apply directly to vet businesses and the non-vets who often own and run them, and who are able to influence the way services are provided to consumers, the choices those consumers make and the outcomes they experience.

(c) Attempts to fill the regulatory gap through the PSS do not appear to us to have been effective (or not as effective as they would need to be).

4.40 The lack of practice regulation may contribute to consumers not having adequate and timely information on issues such as pricing, services (including referral services), ownership of practices, where to purchase medicines and range of treatment options available. They may be unable to, and may not, make the choices they would in a well-functioning market. We assess this further in section 7 below.

[236] Part 3 of the Pharmacy Order (2010).
[237] General Optical Council, Business Regulation.

5. Consumer redress and complaints

5.1 In this section, we set out our emerging thinking on the ability of pet owners to complain and seek redress for poor service. The concerns we outline are that redress mechanisms are an important element of a well-functioning market but, in the veterinary sector:

(a) the in-house complaint processes operated by vet businesses may not provide for effective redress; and

(b) the external redress scheme available (the VCMS) may represent the weakest type of mechanism – a voluntary scheme – consumer engagement with it is low, and the most effective use is not made of complaints data to drive improvements in professional regulation or service standards.

Why might we need options for consumer redress?

5.2 Consumers who are dissatisfied with a product or service they have purchased will often want, and should be able to, seek appropriate redress. This could include an admission of wrongdoing, an apology or a compensation.

5.3 The first port of call for dissatisfied consumers is typically the supplier itself. Some businesses operate complaints procedures to address any issues that may arise. Where businesses fail to resolve complaints, consumers might wish to turn to an external scheme to seek redress, which is likely to be cheaper and quicker than taking a supplier to court.

5.4 Effective consumer redress mechanisms can play an important role in the operation of a competitive market because:

(a) Consumers' ability to complain effectively and have their complaints resolved can discipline businesses in terms of the quality of the goods and services they provide. Effective redress mechanisms can help to concentrate the minds of professionals on higher standards, improved behaviour, and more focused action to resolve complaints quickly when they arise.

(b) Knowing they are backed up by an effective system of redress can also give consumers confidence to spend their money and help create (and preserve) public trust in suppliers.

(c) Such mechanisms can play a role in ensuring that regulatory rules – in this case, those designed to protect animal welfare and support pet owners – are effectively applied.

(d) The schemes are often rich with complaints data that can be analysed and used to refine the regulatory framework and improve standards of professional conduct.

What might a good consumer redress system look like?

5.5 A good consumer complaints and redress system might have several elements:

(a) effective in-house processes run by the suppliers of products and services;

(b) where these in-house arrangements are not present or do not appear to deliver acceptable outcomes, an independent or third-party redress scheme, which should also include the ability to gather information to improve industry practice, and which schemes are complemented, in regulated sectors, by effective disciplinary action by the regulator in cases where complaints involve misconduct; and

(c) as a last resort, access to the courts.

5.6 It seems to us that the different elements of the system should be connected and co-ordinated. Consumers need to know their options for seeking redress and how to exercise them (and at what stages). Suppliers, the operators of independent or third-party schemes and any sectoral regulator need to promote the system, to provide information about it to consumers and to direct them to the most appropriate recipient of their complaint. Where in-house processes or independent or third-party schemes uphold complaints that involve misconduct, any regulator needs to be able to act on that misconduct (to improve outcomes for consumers, as well as being able to use complaints data to improve regulation and overall service standards).

5.7 We consider, for now, how each of the in-house processes and the relevant third-party redress scheme currently function in relation to veterinary services and whether they operate as we might expect in a well-functioning market. We intend to consider further whether the different elements of the consumer redress system are appropriately connected and co-ordinated (and welcome comments about whether and how we do that).

In-house complaints processes run by vet businesses

5.8 If a consumer's complaint can be effectively addressed by their veterinary practice, this is likely to be the best outcome. It should be the quickest, cheapest and least resource-intensive means of resolution. It might also enable the vet business to improve its services – if the substance and outcome of complaints are monitored and acted upon.

5.9 Many vet businesses do appear to have complaints handling policies and processes in place. We are assessing how effective these are at protecting consumers where they receive poor quality service. Our starting view, in the meantime, is that a good in-house complaints and redress system would likely include:[238]

(a) a comprehensive, clear and fair 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 and clarity over what would trigger referral to any external scheme;

(b) staff awareness of, and training in, the complaints process;

(c) one or more methods to promote awareness of the process to consumers, together with a choice of access routes for them;

(d) a process for identifying when a consumer is making a complaint, understanding their grievance and exploring its causes;

(e) effective communication to the consumer throughout the process, including timescales, likely outcomes and what are their options if they do not feel that their complaint has been resolved; and

(f) a feedback loop so that the business can learn from the substance of complaints and work to avoid future issues.

5.10 Subject to our ongoing review, we are concerned that vets' in-house processes may not be as effective as they could, or should, be. There are two reasons. The first is the lack of a clear and consistent set of regulatory requirements for those processes. The second is the evidence of consumers' reluctance or inability to make complaints.

Regulatory requirements

5.11 Under the RCVS Code, individual vets must respond promptly, fully and courteously to clients' complaints and criticism.[239] They must also have a means of recording and considering client complaints. [240] The Guidance says that vets should provide clients with their complaints handling policy in writing.[241] Training

---

[238] We have considered research commissioned by the Solicitors Regulation Authority and Legal Ombudsman into the experiences and effectiveness of solicitors' first tier complaints handling processes (SRA | Research into the experiences and effectiveness of solicitors' first tier complaints handling processes | Solicitors Regulation Authority), December 2017, and Office of Rail and Road, Guidance on complaints handling procedures, 2015.
[239] RCVS Code, paragraph 2.7.
[240] RCVS Code, paragraph 4.3 and RCVS PSS Small Animal Modules and Awards, Core Standards, point 3.1.3.
[241] Supporting Guidance, Practice Information, paragraph 9.2(c). The RCVS has also published a new chapter of the RCVS Code (discussed in paragraph 2.38 above) which pulls together the consumer-facing aspects of the existing RCVS Code. This chapter makes no mention of how vets should manage complaints, including which processes to have in place.

on mitigating and resolving complaints is available to vet professionals via the platform RCVS Academy.[242]

5.12 Vet practices, however, do not appear to be subject to effective stipulations. The PSS requires only that vet practices have a scheme in place for considering complaints, and does not set out elements that such a scheme must include. The Supporting Guidance also recommends that vet practices have a complaints procedure[243] but without stating what that might involve.

5.13 The position therefore seems to be that there is no formal, agreed and consistent complaints process in the sector which sets out the expectations on vet businesses (for example, on outcomes and timescales) and that would ensure that they all operate complaints procedures of a certain standard. In many other sectors, there is such an established process.[244]

Consumer willingness or ability to complain

5.14 8% of respondents to our pet owners survey had considered making a complaint about their vet practice in the past two years.[245] 3% had made a complaint (most of them complaining directly to their vet).

5.15 In other words, less than half of those who considered complaining to their practice went on to do so.[246] When asked why not, the most common answers were: 'Didn't think anything would come of it' (53% of relevant respondents), 'Worried about ongoing relationship with vet' (38%) and 'Didn't know who to complain to' (32%) (respondents could choose more than one response).[247]

Third-party redress schemes

5.16 Third-party schemes offer consumers a way to seek redress when a supplier has not resolved a complaint satisfactorily. These schemes often take the form of Alternative Dispute Resolution (**ADR**) mechanisms or, in some sectors, ombudsman schemes.

---

[242] See RCVS Academy, Client Engagement, 'Resolving complaints in practice' and 'Complaints: Communication, confidence and compassion.'
[243] Supporting Guidance, Clinical Governance, paragraph 6.3(c)(vii).
[244] Appendix A to the Royal Institution of Chartered Surveyors (RICS) professional standards Rules of Conduct, October 2021, for example, includes that firms must publish a complaints-handling procedure, which includes an alternative dispute resolution provider approved by RICS, and maintain a complaints log. RICS also provides firms with an example complaints handling procedure and example complaints log template: https://www.rics.org/regulation/regulatory-compliance/requirements-support/alternative-dispute-resolution.
The Legal Services Board (LSB), meanwhile, has imposed statutory requirements (LSB Rules and Guidance) on approved legal services regulators to put in place their own regulatory requirements for Complaints Procedures on First-Tier Complaints.
[245] Pet owners survey, Q116.
[246] Pet owners survey, Q117 (35% "Yes") and Q118 (75% "the vet or vet practice staff", 17% "the owner(s) of the vet practice).
[247] Pet owners survey, Q117.

5.17 Some schemes provide for the mediation of disputes by an independent third party in ways that seek to help businesses and consumers reach an agreed outcome between themselves. Others involve the third party adjudicating complaints and imposing binding outcomes. An example of the former is the Optical Consumer Complaints Service (**OCCS**). The latter is what happens, for example, in the private healthcare sector where the Independent Sector Complaints Adjudication Service (**ISCAS**) provides independent adjudication on complaints about ISCAS subscribers.

5.18 Where consumers are aware of them and know how to use them, such schemes can help address an asymmetry of information between businesses and consumers in relation to disputed transactions and offer an alternative to lengthy and expensive court proceedings. The availability of such schemes may also put pressure on businesses to improve their own in-house processes.[248] Which? in a 2019 report identified that:

> ….. well-functioning ADR is not only important to individual consumers, who risk losing money, wasting precious time and suffering stress and anxiety when things go wrong, but is also critical to building consumer trust and a successful, competitive economy.[249]

5.19 Redress schemes can also, and in regulated professional sectors often do, analyse and share learning from their complaints data. This can contribute to better professional regulation and standards of service. For example:

(a) The Legal Ombudsman has stated that its insight sharing '… promotes better complaint handling, prevents future complaints and helps drive higher standards in legal services'.[250]

(b) The 2019 Which? report acknowledges that in most markets there is a large amount of rich data about performance and complaints that should be shared widely with businesses, enforcement bodies and consumer advocacy groups, and used as a tool to educate, enforce and prevent future harm.[251] It says, 'ADR schemes, if working well, should also help to drive up compliance and be a source of intelligence for problems that are occurring in a particular sector for targeting of enforcement resources. This requires radical reform of the approach to ADR in many sectors.'

---

[248] A 2021 report by Which? states that third-party-aided consumer redress is important due to 'the asymmetry in information and resources in some transactions [and] may also become increasingly important in helping consumers address some of the complexity in modern transactions.' Are Alternative Dispute Resolution schemes working for consumers?, Which?, April 2021, page 3.
[249] Which? Creating a successful enforcement system for UK consumers, February 2019.
[250] Legal Ombudsman, Office for Legal Complaints, 2024-27 Strategy for the Legal Ombudsman, page 1.
[251] Which? Creating a successful enforcement system for UK consumers, February 2019.

5.20 Drawing these points together, an effective third-party redress scheme could be seen as one which: consumers are aware of and know how to use; operates to address the asymmetry between businesses and consumers; produces prompt and effective resolution of complaints, and has mechanisms to make valuable use of complaints data to drive improvements to regulation and services.

The Veterinary Client Mediation Scheme (VCMS)

How does the VCMS scheme work?

5.21 The veterinary sector's third-party redress system, the VCMS, is a voluntary ADR mediation scheme[252] funded by the RCVS. It uses mediation to support pet owners and vet practice teams to resolve complaints without the barriers of a formal legal process. It seeks to repair the relationship between animal owner and vet practice[253] and find a mutually acceptable resolution, but it does not investigate or adjudicate complaints. The process is conducted on an entirely voluntary basis; both parties must agree to take part and both must agree to the outcome.[254]

5.22 The scheme is administered by telephone by an independent firm of solicitors[255] and is free to users. It was established in 2017, following a pilot the previous year funded by the RCVS and run by the same solicitors, in order to deal with the large numbers of complaints from customers which fell outside the narrow scope of the RCVS's statutory disciplinary process.[256] Complaints to the VCMS are made by customers via its website and the RCVS' website, and by referrals from the Citizens Advice Bureau (**CAB**), vet practices, the RCVS and animal and consumer charities.[257]

5.23 The scheme has a wide remit. The VCMS can assist where the complaint involves an individual pet owner and a complaint relating to the veterinary care and services provided by a practice in the UK. It engages with consumer and communication issues as well as allegations of professional negligence but does not deal with allegations of serious professional misconduct (which, if made to the

---

[252] VCMS is an Approved ADR Body accredited by Chartered Trading Standards Institute.
[253] VCMS Response to the Issues Statement (**VCMS IS Response**), page 1.
[254] Consumers seeking redress sometimes contact the RCVS. As explored in this paper, the RCVS disciplinary process addresses complaints and concerns about professional conduct, applies regulatory remedies and is limited in scope. The RCVS has no mechanism for addressing consumer complaints that fall outside its disciplinary process and will pass them on to the VCMS.
[255] VCMS is provided by Nockolds Solicitors, who specialise in complaint mediation in regulated professions. In addition to the VCMS, Nockolds provide the Optical Consumer Complaints Service (OCCS) which supports the UK optical sector and is funded by the General Optical Council.
[256] The VCMS ran as an ADR pilot for veterinary complaints in 2016. Following a review of the Nockolds pilot, the VCMS has continued as an ongoing service from 1 November 2017. In 2014-2015 the RCVS trialled an ADR initiative with Ombudsman Services, who investigated and adjudicated on a sample of complaints relating to small animal veterinary care.
[257] In 2023, of the 3649 complaints received by the VCMS, 1492 were made on the VCMS' website and 166 on the RCVS' website. In the same year, 254 complaints were referred to the VCMS by CAB, 183 by the RCVS, 136 by vet practices and 20 by charities (the remaining complaints were received from other sources such as 'other', 'charity', 'referral' or the source was unknown) . VCMS response to RFI 1, Question 12. [✂]

VCMS, are referred by it to the RCVS for investigation).[258] There are a few other limited exceptions.[259]

5.24 The VCMS is supported by veterinary advisers who provide veterinary and clinical advice to it. That includes advice on which enquiries may amount to serious professional misconduct, for referral to the RCVS, and advice to the resolution managers who engage in mediation discussions.[260]

5.25 The scheme receives around 3600 complaints a year.[261] Complaints data provided by the VCMS shows that, in 2023, 57% of the complaints it received related to standards of care, 20% customer service and 13% clinical fees (the nature of the remaining 10% was 'unknown,' 'other' or 'products').[262]

5.26 There are three phases to the scheme:

(a) At **Phase A**, the VCMS supports local resolution by providing support and advice where the relevant vet practice's own complaint procedure has not been concluded. All complaint referrals pass through Phase A and are reviewed to ensure they fall within the VCMS' remit.[263]

(b) At **Phase B** (mediation coordination) the VCMS engages with the practice to invite it to mediate and seek a commitment to resolve the complaint. [264]

(c) **Phase C** (mediation) involves the full mediation process, which is available to consumers and veterinary practices when local resolution has been exhausted. 25% of VCMS enquires progress to this phase.[265] The VCMS aims to conclude mediation within 60 days of the parties agreeing to mediate.

5.27 In 2022-2023, according to its Insight Report, of the 3644 complaints the VCMS received, it concluded 3629 (over 99%) of them[266] and achieved its 60-day target for the conclusion of the complaint in 80% of cases.[267] Of the 3629 concluded complaints:

---

[258] Between November 2022 and October 2023, 7 complaints received by the VCMS concluded with the animal owner indicating they were referring their concerns to the RCVS for investigation as potential serious misconduct or their concerns were policy related issues which fell outside the VCMS remit. - VCMS response to RFI 1, Question 6. [✂]
[259] The VCMS does not deal with complaints from commercial animal owners, complaints raised by those who don't own the animal, complaints over 12 months old and circumstances outside the UK.
[260] There is also coordination to address complaints between the RCVS and VCMS under their Working Together Policy. This helps ensure that complaints of serious professional misconduct made to the VCMS can be passed to the RCVS for investigation pursuant to its statutory duty, and more broadly that complaints are dealt with efficiently and the public protected. Hybrid complaints that cut across the remit of both the RCVS and VCMS are initially investigated by the RCVS and, once it closes its investigation suitable complaints are then passed to the VCMS.
[261] See VCMS IS Response, 9 July 2024, page 6. See also VCMS Insight Report 2022-23, page 4, and VCMS Insight Report 2020-21, page 4. These report that the total number of enquiries received by the VCMS were: 3644 in 2022-23; 3605 in 2021-22; 3963 in 2020-21; and 3151 in 2019-20.
[262] VCMS Insight Report 2022-23, page 6.
[263] VCMS Annual Report 2022-23, page 10. [✂]
[264] VCMS Annual Report 2022-23, page 10. [✂]
[265] VCMS Annual Report 2022-23, page 10. [✂]
[266] 12.5% concluded within 61-90 days and 7.5% required more than 91 days. VCMS Insight Report 2022-23, page 5.
[267] VCMS Insight Report 2022-23, page 4.

(a) c.62% (2237) were dealt with at Phase A, meaning they were supported to resolve the concern locally within the relevant vet practice;[268]

(b) c.16% (597) concluded at Phase B, with the complainant deciding not to proceed with mediation in 271 cases and the practice declining to engage in 326 cases;[269] and

(c) c. 22% (795) concluded at Phase C. Of these, 668 were resolved in mediation, 49 concluded this phase without resolution, and in 78 cases the mediation process was brought to an end because formal action (such as legal proceedings) was required.[270]

Assessment of the VCMS

5.28 Our assessment of the VCMS so far is that, while it offers some benefits to consumers, its effectiveness may be limited because it is voluntary, consumer engagement with it is low and the most effective use is not made of complaints data to improve regulation or service standards.

Benefits

5.29 The VCMS has the potential to play an important role in the existing regulatory framework by offering consumers a means to pursue complaints they are unable to resolve with their vet practice.

5.30 The figures in paragraph 5.27 above show that almost all complaints to the scheme in 2022 to 2023 reached a conclusion. This suggests that, often, the scheme offers consumers the possibility of practical resolution of their complaints quicker than would be likely in, for example, expensive legal proceedings.

5.31 We note that many cases are resolved under the VCMS without going to the mediation stage (in 2022 to 2023, 60.5% of complaints were taken no further than Phase A). One benefit of the scheme may, therefore, be the role it plays in helping consumers to engage constructively with practices and to resolve their complaints without the need for escalation (giving consumers peace of mind and veterinary professionals more time to provide care to animals). (The figures also mean, however, that in 60.5% of cases vet practices did not operate complaints processes that were effective without third-party assistance.)

5.32 Some feedback on the scheme is positive (although only involving a limited sample size from which it is difficult to draw conclusions). The VCMS asks participants about their satisfaction with it. In 2022 to 2023, it received 128

[268] VCMS Insight Report 2022-23, page 19.
[269] VCMS Insight Report 2022-23, page 19.
[270] VCMS Insight Report 2022-23, page 19.

responses, amounting to 15.7% of mediations.[271] 97% of the vet practices who replied said they would use the scheme again, while 93% of the consumers who responded said the same. 9.5 out of 10 of the consumers felt the VCMS understood their concerns, with 9.3 out of 10 satisfied with the process and 7.6 out of 10 satisfied with the outcome.[272]

5.33 We also note that the VCMS has played a significant role in reducing the burden on the RCVS to deal with large volumes of consumer complaints. Minutes from an RCVS Finance and Resources Committee meeting in September 2019 noted that the:

> …. mediation service has had a significant impact on lowering the number of concerns that have come in to ProfCon, cutting the figure almost in half from just under 1,000 concerns a year to 550 concerns. It has enabled the department to focus on only those concerns that would potentially meet the threshold of serious professional misconduct and created a more robust method for resolving complaints between veterinary surgeons and clients that fell below this level.[273]

5.34 In addition to its complaint resolution work in individual cases, the VCMS does share some insight gathered from the mediation process with the RCVS and with the profession:[274]

(a) It produces an annual 'insight report' capturing key performance metrics from the scheme as well as insights on the nature of complaints being made to the VCMS.

(b) Its insight contributes to CPD developed by the RCVS as part of the RCVS Academy. For example, in 2022 VCMS insight and input contributed to the creation of the RCVS Academy course 'Resolving complaints in practice'.[275]

(c) It engages with a range of stakeholders including industry associations, major employers and independent practices, and on social media and by attending large industry events, to raise awareness of the scheme and share learning that may support the improvement of standards of veterinary care and the relationship between animal owner and vet practice.

[271] VCMS Annual Report 2022-23, page 16. [✂] The VCMS told us that this response rate is at the upper end of the average response rate for non-incentivised customer feedback surveys.
[272] VCMS, Insight Report 2022-23, Appendix 5, page 24.
[273] RCVS Response to RFI1, Question 24. [✂]
[274] See VCMS IS Response, page 1.
[275] VCMS response to RFI 1, Question 19. [✂]

Limitations of the VCMS scheme

5.35 The previous paragraphs notwithstanding, however, we are concerned that a voluntary mediation scheme is one of the weaker ways – possibly the weakest way – an industry can seek to provide consumer redress, compared to, for example, schemes providing for binding adjudication of complaints (particularly in the absence of regulatory provisions on how businesses should run their complaints processes or the ability to take robust action against professionals or businesses which do not operate effective processes). We are also concerned about the low levels of consumer engagement with the VCMS and the limited use that is made of complaints data.

5.36 For these reasons, the scheme may not be as effective as it could be, and may not contribute to the competitive operation of the market as much as it could. We set out each of our concerns in more detail below.

Voluntary nature of the VCMS

5.37 The VCMS is a voluntary scheme which requires both the consumer and the vet practice to opt-in to the process (and to act in good faith) to resolve complaints. There is no guarantee that vet practices will agree to participate – 1144 were invited to engage in mediation in 2022 to 2023, and in 326 cases they declined[276] – and they are able to walk away from the mediation process at any stage. The scheme does not adjudicate complaints nor determine outcomes which bind vet practices.

5.38 The voluntary nature of the scheme appears accordingly to be an important limit on the access some consumers will have to effective means of resolving complaints (particularly where they are reluctant or unable to incur the costs of taking their dispute to court). It may also limit the extent to which vet businesses' conduct is disciplined by the threat of consumers obtaining effective redress for complaints.

Lack of consumer awareness

5.39 For the VCMS scheme to be effective, consumers must be aware of it and know how to access it. Although we understand from the VCMS that the number of complaints referred to it is higher than in comparable schemes, such as the Optical Consumer Complaints Service and the dental mediation service,[277] approximately 3600 complaints a year appears to us to be low in a market

[276] VCMS, Insight Report 2022-23, pages 4, 19 and 20.
[277] Data provided in response to Question 5 of VCMS RFI 1 confirms that the total number of complaints referred to the VCMS, OCCS and dental mediation service between the period November 2019 and June 2024 were as follows: VCMS – 16668, OCCS – 7582, and dental mediation service – 6406. We note this comparison does not reflect differences in market size, nor in complaint frameworks or pathways such as NHS processes. [✂]

comprising 16 million pet owning households and given the scale of concerns expressed to us about the operation of the market.[278]

5.40 We are concerned that these low numbers may signal that a significant number of consumers have grounds for complaint but do not complain or are easily put off from doing so. We noted above that less than half of people in our pet owners survey who considered complaining to their vet went on to do so, citing scepticism about the outcome (in 53% of cases), the possible effect on their relationship with their vet (38%) or ignorance about how to complain (32%).[279]

5.41 We are also concerned that pet owners may have limited awareness of, or engagement with, the VCMS. As discussed in our working paper **How People Purchase Veterinary Services**, our pet owners survey also found that only 5% of participants were aware of the VCMS[280] and a low number had complained to it.[281]

5.42 There seem to be limited mechanisms in place to increase the levels of consumer awareness and engagement:

(a) The VCMS has engaged in consumer facing activities, including stakeholder engagement with Citizens Advice, Which? and charities, providing information on its and the RCVS' websites, social media posts and by providing guidance on key complaint subjects. The VCMS plans in 2025 to issue consumer facing resources in collaboration with the RCVS and to work with charities and representative groups to gain greater insight into improving accessibility of the service, particularly for vulnerable consumers.[282]

(b) However, vets and practices have no obligation to make consumers aware of the VCMS. This contrasts with the optical sector in the UK, where professionals must operate a complaints process and, at the appropriate stage of it, inform patients of their right to complain or to seek mediation through the Optical Consumer Complaints Service.[283]

(c) And, the VCMS does not hold any data tracking consumer awareness of the service over time. It has told us, when we asked about this, that, 'It was agreed that the strategic focus for profile raising would be on veterinary practice teams, and then to provide information to support communication

[278] CMA calculations based on Statista's 2023 estimate of the proportion of UK households owning a pet (57%) and the ONS figure for number of UK households in 2023 (28.4 million).
[279] Respondents could choose multiple options.
[280] Pet owners survey, Q120. Among those who were aware, 67% of respondents had heard of it but not used its services (pet owners survey, Q121). Only a minority of the small proportion who had heard of it reported having had direct engagement with the VCMS: 12% by accessing materials, 9% by contacting directly, and 9% by referring complaints (pet owners survey, Q121). Of the respondents who thought about complaining, the majority (65%) did not ultimately file the complaint (pet owners survey, Q117a).
[281] Pet owners survey, Q118.
[282] VCMS response to RFI 1, Question 14. [✂]
[283] General Optical Council, Standards of Practice for Optometrists and Dispensing Opticians, Standard 18.

between practices and clients, sharing the VCMS details when local resolution at practice level was exhausted.'[284]

Complaints insights do not appear to be impacting the regulatory approach

5.43 For complaints data to help improve standards and address harmful behaviour there must be a system in place to capture and learn from those complaints. Our review of the evidence so far suggests that such a system does not operate as well as it could in the veterinary sector.

5.44 We have noted above that the VCMS gives the RCVS reports and updates on the performance of the scheme and shares some learning from it (for example, the quarterly and annual reports, insights, complaints data and case studies referred to in paragraph 5.34 above). There do not, though, appear to be any structured or methodical processes for the RCVS to capture the lessons that may be learned from the substance of the complaints the VCMS handles. It also does not gather complaints data from vet practices directly (which may be explained at least in part by its lack of statutory powers to compel businesses to provide information to it).

5.45 We are concerned that these shortcomings limit the RCVS's ability to understand consumers' experiences of veterinary services outside of the most serious professional misconduct cases that the RCVS is obliged to consider. This may mean it cannot identify common or emerging harms caused by vets' conduct or vet firms' business practices, and cannot feed these insights into a positive feedback loop which increases the effectiveness of regulation (for example, targeted monitoring and enforcement, issuing guidance or creating training or CPD materials aimed at addressing the substantive issues and concerns identified through the complaints handling system). It also seems to us a missed opportunity that the new '*Consumer rights and freedom of choice'* chapter of the Supporting Guidance, which consolidates the consumer-facing aspects of the RCVS Code, failed to make any mention of complaints.

Emerging views

5.46 Effective consumer redress schemes play an important role in the operation of a competitive market. While our work is ongoing, our emerging view is that there may be some large gaps in the existing consumer redress mechanisms in the veterinary sector, for the following reasons:

(a) They depend on individual vet businesses having good in-house complaint handling processes. There are, however, no regulatory requirements in place

[284] VCMS response to RFI, Question 15. [✂]. See the VCMS Guide for Animal Owners and the VCMS Guide for Veterinary Professionals.

that set standards for these processes (and which could be monitored and enforced).

(b) The VCMS was put in place to deal with the large numbers of complaints unresolved by vet businesses' in-house complaints processes but which fall outside the narrow confines of RCVS statutory disciplinary action. That scheme, however, provides only for voluntary mediation. It has no powers to compel vet businesses to engage in its processes, does not adjudicate complaints and cannot require businesses to take any particular action.

(c) There is limited consumer awareness of and engagement with the VCMS in any event. Fewer of the consumers who might otherwise benefit from it are therefore likely to use its services.

(d) The RCVS does not appear to use, as effectively as it could, the insights and lessons available from complaints data (both from vet firms and the VCMS) to strengthen regulatory practice and drive standards up across the sector.

5.47 The possible shortcomings we have identified may also suggest that the different elements of the system for consumer redress in the veterinary sector are not appropriately connected and co-ordinated. We will continue to consider that.

6. Regulation of the supply of veterinary medicines and other restrictions on the provision of veterinary care

6.1 In this section we consider aspects of the regulatory framework that may be relevant to how competition works in the supply of Prescribed Veterinary Medicines for household pets in the UK, including:

(a) the VMRs and the 'cascade' system that governs the circumstances in which vets may prescribe a non-authorised medicine (such as a human generic product) to treat an animal;

(b) other restrictions on the sale of Prescribed Veterinary Medicines, such as the restriction on retailers supplying FOPs; and

(c) the RCVS' approach to remote prescribing, including its 'under care' guidance and how this might be impacting on both existing practice and potential innovation.

6.2 We outline the concerns we have encountered on whether the regulatory framework restricts access to certain products, or the way in which they can be prescribed, and therefore may increase prices for consumers, or negatively affect innovation. We also discuss our emerging views on how these issues might be addressed. The retailing of medicines and how the supply chain works are discussed in our working paper on **Competition in the Supply of Veterinary Medicines**.

Regulation of the sale of medicines

6.3 Concerns we have heard or considered about the regulation of Prescribed Veterinary Medicines include the following:

(a) Where Prescribed Veterinary Medicines with a marketing authorisation (**MA**) are available for a given condition in a particular animal, normally only those medicines may be administered (or prescribed). The VMRs allow the administering or prescribing of an alternative (such as a human generic with the same active ingredient) under the prescribing requirements set out in paragraph 1 of schedule 4 to the VMRs (the **'Cascade**'),[285] but only where no authorised product is available (paragraph 1(2) of the Cascade); we refer to this limitation as the 'Cascade Restriction'. The concern is that in certain cases, the Cascade Restriction results in:

[285] The prescribing requirements set out in paragraph 1 of schedule 4 to the VMRs.

(i) higher prices and less choice for clinicians and consumers, who are deprived of the opportunity to access a cheaper, potentially effective treatment option; and

(ii) the removal of a potential competitive constraint on the price of the authorised product(s).

(b) The VMRs require that an animal be 'under care' of the veterinary professional prescribing the medicine.[286] There is a concern that this requirement, and in particular recent changes in how the RCVS interprets this requirement, may be unduly restricting the ability of vets to prescribe certain categories of veterinary medicines, such as parasiticides (flea and worm treatments).

(c) The VMRs prohibit FOPs from buying Prescribed Veterinary Medicines from retailers including from online pharmacies, even if those outlets may offer medicines at lower cost than wholesale channels. The concern is that this unnecessarily limits the ability of FOPs (in particular, independent FOPs) to access Prescribed Veterinary Medicines at the lowest possible cost.

(d) Determination of the initial classification for a veterinary medicine, and decisions to reclassify those medicines are, in most cases, driven by the marketing authorisation holders (that is, manufacturers) who propose the (re)classification for which they wish to apply, though the decision on which distribution category to grant is made by the VMD.[287] The concern is the possibility some products might be classified at a more restrictive level than is necessary, in turn limiting choice and/or increasing costs for consumers. For example, if a product is classified as 'POM-V', it can only be administered after prescription by a veterinary surgeon, in contrast with a classification which permits 'over the counter' purchase (**POM-V**).[288]

(e) Regulation and/or guidance issued by regulators leading to written prescriptions that are narrower than necessary in turn limiting the choice of consumers to purchase the medicine most suited to their pet's needs. By 'narrower than necessary', we mean prescriptions that refer to a product name rather than active ingredient, where more than one product contains the same active ingredient.

6.4 We recognise that the specialised nature of veterinary medicines products means that an effective regulatory framework will be essential to animal welfare,

[286] VMRs, schedule 3, paragraph 4.
[287] VMD. [✂]
[288] VMRs, schedule 3, paragraphs 3(2) and 3(5).

consumer and environmental protection and necessarily form part of a well-functioning market.

6.5 In the context of veterinary medicines specifically, we expect a regulatory framework in a well-functioning market might include as aims (for example):

(a) safeguarding animal, human and environmental welfare;

(b) securing supply;

(c) ensuring transparency and mitigating information asymmetries (including as to the choices available to consumers); and

(d) ensuring clinical and consumer confidence in the regulated products.

6.6 We acknowledge that some of these, and other, policy factors may in certain instances outweigh possible impacts on competition. We would expect that in a well-functioning market the regulatory framework would take account where possible of the benefits of effective competition, including (for example) the wider benefits to animals resulting from competitive prices, improvements and innovation in services and/or increased consumer choice.

How Prescribed Veterinary Medicines are regulated

VMRs

6.7 The Veterinary Medicine Regulations 2013 (**VMR**) were made under section 2(2) of the European Communities Act 1972, which created the power to transpose EU law requirements by way of secondary legislation.[289]

6.8 The current version of the EU veterinary medicines regulation is Regulation (EU) 2019/6 (**EU VMPR**).

6.9 The Windsor Framework means that EU law on veterinary medicines continues to apply to Northern Ireland post-EU exit date.[290]

6.10 For the rest of the UK, Part 3 of the Medicines and Medical Devices Act 2021 (MMDA) empowers the Secretary of State to amend the VMRs by statutory instrument, but only where the overarching objective is one or more of:

(a) 'the health and welfare of animals;

(b) the health and safety of the public;

[289] See explanatory note to 2024 amendment.
[290] VMD Guidance: Veterinary medicines legislation (Legislation in NI).

(c) the protection of the environment'.[291]

6.11 Where the relevant regulations '…may have an impact on the safety of veterinary medicines, the appropriate authority may make the regulations only if the authority considers that the benefits of doing so outweigh the risks.'[292]

6.12 Further, in 'considering whether regulations…would contribute to this objective, the appropriate authority must have regard to—

(a) the safety of veterinary medicines;

(b) the availability of veterinary medicines;

(c) the likelihood of the relevant part of the United Kingdom being seen as a favourable place in which to—

(i) develop veterinary medicines, or

(ii) manufacture or supply veterinary medicines.'[293]

6.13 It is of course open to Government to amend the VMRs, as they affect Great Britain, outside of these parameters using primary legislation.

6.14 In Northern Ireland, under the Windsor Framework and Northern Ireland Protocol, aspects of EU law (including the EU VMPR [294]) on Prescribed Veterinary Medicines continue to apply.[295] At present, until 31 December 2025, a 'grace period' for veterinary medicines means that existing rules for moving veterinary medicines between the rest of the UK and Northern Ireland remain in effect.[296] We understand that work on finalising arrangements post-expiry of the 'grace period' is continuing.

6.15 At present, the requirements of the VMRs are (via the EU VMPR) largely reflected in Northern Ireland (including, for example, the Cascade).

6.16 We note:

(a) The VMD is responsible for ensuring compliance with the VMRs, including the registration and inspection of vet practices (noting that practice inspections for PSS FOPs are delegated to the RCVS as described below).[297] It also administers the approval and authorisation of veterinary

---

[291] MMDA, section 10(2).
[292] MMDA, section 10(4).
[293] MMDA, section 10(3).
[294] VMD Guidance: Veterinary medicines legislation (Legislation in NI).
[295] Veterinary medicines legislation - GOV.UK.
[296] See European Commission announces three-year extension to the grace period for veterinary medicines - GOV.UK, 19 December 2022.
[297] VMD Guidance: Registration and inspection of veterinary practice premises.

medicines, monitors adverse events from veterinary medicines and advises government on veterinary medicines policy (including updates to the VMRs);[298]

(b) Aspects of the VMRs discussed above reflect Government (including, historically, European Union) policy choices. An example of this is the requirements of the Medicines and Medical Devices Act 2021 discussed at paragraph 6.10 above; and

(c) While regulation can have an impact on competition,[299] at the same time, the regulatory framework which affects the supply of Prescribed Veterinary Medicines also affects the veterinary medicines market more widely, and it is possible that changes made in response to issues arising in the household pets sector could have consequences for the wider veterinary medicines market, at various levels of the supply chain.

RCVS Code and Guidance; the PSS

6.17 The RCVS Code states that 'Veterinary surgeons who prescribe, supply and administer medicines must do so responsibly'.[300] The Guidance contains more specific requirements regarding the prescription, administration and sale of veterinary medicines.

6.18 The PSS includes a module on medicines. Practices that participate in the PSS are exempt from VMD inspection as the VMD has delegated this function to the RCVS PSS Assessors.[301] The VMD reserves the right to attend any PSS assessment and to enter any vet practice at any time under its own powers of enforcement. [302]

Cascade Restriction: what medicines may be administered to a household pet?

6.19 Regulation 8 of the VMRs provides that no person may administer a veterinary medicine product to an animal unless it:

(a) has a marketing authorisation; or

(b) it is administered

[298] See About us - Veterinary Medicines Directorate - GOV.UK (https://www.gov.uk/government/organisations/veterinary-medicines-directorate/about) (Accessed 3 February 2025)
[299] CMA, Guidelines for market investigations, (CC3), paragraphs 223-226.
[300] RCVS Code, paragraph 1.5.
[301] See RCVS website, Inspection of practice premises (https://www.rcvs.org.uk/registration/veterinary-premises/) (accessed 4 February 2025).
[302] CMA, Practice Standards Rules, 1 January 2024, Rule 41.

(i) under Schedule 4 VMRs (the Cascade); or

(ii) under Schedule 6 VMRs (which sets out a simplified authorisation procedure for medicines intended for a closed list of 'small pet animals' for example, cage birds and small rodents).[303]

Cascade: Schedule 4 VMRs

6.20 The Cascade[304] operates as an exception to the requirement that only a Prescribed Veterinary Medicine with an MA can be administered to animal, by providing that if '…there is no authorised veterinary medicinal product in the United Kingdom for a condition the veterinary surgeon responsible for the animal may, in particular to avoid unacceptable suffering, treat the animal concerned with the following ("the cascade"), cascaded in the following order—

(a) a veterinary medicinal product authorised in the United Kingdom for use with another animal species, or for another condition in the same species; or

(b) if there is no such product that is suitable, either—

(i) a human medicinal product authorised in the United Kingdom; or

(ii) a veterinary medicinal product not authorised in the United Kingdom but authorised in another country for use with any animal species (in the case of a food-producing animal, it must be a food-producing species); or

(iii) if there is no such product that is suitable, a veterinary medicinal product prepared extemporaneously by a pharmacist, a veterinary surgeon or a person holding a manufacturing authorisation authorising the manufacture of that type of product.'

Cascade: VMD Guidance

6.21 The VMD publishes guidance on the use of the Cascade. Extracts relevant to the issues in this paper include:

(a) '**Misuse of the cascade**: You must not promote or facilitate any use of the cascade which is not in accordance with Schedule 4 of the VMRs. This does not prevent a vet from discussing treatment options with the owner or keeper of the animal under treatment.'

[303] The equivalent EU VMPR provision is Article 106(1).
[304] See VMRs, schedule 4, paragraph 2 and EU VMPR, Article 112.

(b) '**Human medicines**: You are not allowed to prescribe a human medicine simply because it is cheaper than using an authorised veterinary medicine. Human medicines and veterinary medicines containing the same active substance may not be interchangeable.'

(c) '**Unavailability of product**: If a product cannot be obtained despite a thorough search and in a reasonable time, you may conclude that in these circumstances it does not exist. You may follow the cascade to identify a suitable alternative. However, there may be cases where urgency dictates you use whatever is to hand, whether authorised or not. We publish details of supply issues which have the potential to cause animal welfare issues and provide information on alternative products, where possible. If you cannot obtain authorised products from your usual wholesaler, you may issue a written prescription for the animal owner to use with another supplier.'

(d) '**Animal owner considerations**: You may conclude that an animal owner, perhaps due to age or disability, would have difficulties in administering the authorised product. In the interest of animal welfare and treatment compliance you could consider an alternative treatment under the cascade.'

(e) '**Medicines commonly found around the home**: In exceptional emergency circumstances, you may judge there is a need to alleviate a pet's discomfort until a home visit can be made or the animal brought to the surgery. You could recommend that an animal owner use a human medicine that they already have in their possession, such as antihistamine tablets. This does not mean a pet owner should be encouraged to go into a pharmacy and ask for a human medicine for their pet.'

Cascade: Supporting Guidance on additional steps

6.22 The Supporting Guidance reiterates the VMRs' requirements and adds that a 'decision to use a medicine which is not authorised for the condition in the species being treated where one is available should not be taken lightly or without justification.'[305]

6.23 Clients are to be 'made aware of the intended use of unauthorised medicines and given a clear indication of potential side effects. Their consent should be obtained in writing'.[306]

[305] Supporting Guidance, Veterinary medicines, paragraph 4.25.
[306] Supporting Guidance, Veterinary medicines, paragraph 4.26.

Requirements relating to clinical examination and 'under care'

6.24 The VMRs require that to prescribe a POM-V medicine for an animal the vet 'must first carry out a clinical assessment of the animal, and the animal must be under that veterinary surgeon's care.'[307]

6.25 The terms 'clinical assessment' and 'under care' are not defined further in the VMRs, but the RCVS Guidance provides additional (professional) requirements on the interpretation of these concepts for practising vets. These include:

(a) a requirement that the vet, or another veterinary service provider on their behalf, must be able 'on a 24/7 basis' to physically examine the animal. They should be able to carry out 'any necessary investigation in the event that animals taken under their care do not improve, suffer an adverse reaction or deteriorate';[308] and

(b) confirmation that a 'clinical assessment is any assessment which provides the veterinary surgeon with enough information to diagnose and prescribe safely and effectively. A clinical assessment may include a physical examination; however, this may not be necessary in every case.'[309]

6.26 The RCVS Guidance explains the factors that may be relevant in determining whether a physical examination is necessary. Notably, a 'physical examination is required at the time of prescription in all but exceptional circumstances where a veterinary surgeon prescribes antibiotics, antifungals, anti-parasitics or antivirals' for, among others, household pets.

Wholesale supply restrictions

6.27 Except in cases of temporary supply shortages, the VMRs permit wholesale supply of veterinary medicine products (including Prescribed Veterinary Medicines) only by either:

(a) an MA holder (usually a manufacturer); or

(b) the holder of a Wholesale Dealer's Authorisation.[310]

6.28 Retailers (including, for example, online pharmacies) may therefore not supply other retailers, including FOPs.

---

[307] VMRs, Schedule 3, paragraph 4(1).
[308] Supporting Guidance, Veterinary medicines, paragraphs 4.13 and 4.14.
[309] Supporting Guidance, Veterinary medicines, paragraph 4.16.
[310] VMRs, Schedule 3, paragraph 2.

Retail supply restrictions

6.29 The VMRs stipulate that a POM-V Prescribed Veterinary Medicine may only be supplied in accordance with a valid prescription by a veterinary surgeon, while a POM-VPS product may be supplied in accordance with a prescription from any of a veterinary surgeon, pharmacist or Suitably Qualified Person (**SQP**).

6.30 An SQP is a person registered with a VMD-approved 'registration body', which sets a syllabus and requirements for registration of an individual practitioner (for example, a veterinary nurse) to enable that person to become an SQP.[311] A public list of SQPs is maintained on the VMD website.[312] Examples[313] of registration bodies include:

(a) The Animal Medicines Training Regulatory Authority (**AMTRA**)[314];

(b) VetSkill Ltd;[315] and

(c) Vetpol Ltd.[316]

Evidence and observations on the Cascade Restriction

Stakeholder views on the Cascade Restriction

6.31 We have received a number of views on the potential adverse impact of the Cascade Restriction, most of which tie to the cost implication of preventing the use of (cheaper) human generics. Specifically:

(a) Qualitative research reported a number of vets who identified the Cascade Restriction as problematic, in particular the inability to resort to cheaper human generic medicines where the cost difference might be significant (and the human medicine equivalent is, in the view of the vet, effective).[317]

(b) MA products have been introduced (with resultant price rises due to vets being required to use the MA product in place of existing Cascade alternatives[318]) in circumstances where the Cascade human medicine had been successfully used over a significant period of time.[319]

---

[311] See VMD Suitably Qualified Persons (SQPs) Code of Practice, Defra, May 2024 (retrieved 2 December 2024).
[312] VMD List of Registered Suitably Qualified Persons (https://vmd.defra.gov.uk/register/sqps) (accessed 31 January 2025).
[313] See VMD Guidance: Suitably Qualified Persons.
[314] AMTRA (https://www.amtra.org.uk/) (accessed 31 January 2025).
[315] VetSkill (https://www.vetskill.com/) (accessed 31 January 2025).
[316] Vetpol (https://vetpol.co.uk/) (accessed 31 January 2025).
[317] Qualitative research with veterinary professionals [✂].
[318] By which term we mean a medicine which could serve an animal's and a consumer's needs but which is not the medicine which the Cascade Restriction requires vets to prescribe.
[319] See BEVA Response to the Issues Statement, 29 July 2024 (albeit in relation to equines). See also Dog's Trust IS Response, and an independent vet's response to the Issues Statement [✂]

(c) In general, there may be cost benefits to consumers in allowing the use of human generic alternatives (VetPartners[320], Edinburgh roundtable[321], Swansea vets roundtable[322]).

(d) Concerns animals may go untreated due to the high costs of MA products, where cheaper products were available (Charities roundtable[323]). We note, however, the VMD's response addressing potential clinical choices available in the alternatives in the event an animal would go untreated: see paragraph 6.40 below.

(e) There is a lack of awareness among consumers, for example as to why MA products are more expensive than human products with the same active ingredient.[324]

(f) Disruptions in the supply of an authorised Prescribed Veterinary Medicine may mean vets must resort to temporary prescribing of a (potentially significantly less expensive) Cascade alternative; when the supply resumes, the resulting increase in cost can surprise and confuse consumers.[325]

(g) Perception that recent changes to the VMRs making it an offence to 'promote or facilitate any purported use of the cascade which is not in accordance with [schedule 4 of the VMRs]'[326] increase the risk to vets who suggest an alternative medicine where the pet owner's financial circumstances make the authorised Prescribed Veterinary Medicine unaffordable[327] (noting that prescribing outside the Cascade has long been an offence, as discussed at paragraph 6.32(f) below).

6.32 We also note stakeholders' views on why the Cascade Restriction may be necessary. These include:

(a) To ensure animal health and welfare, highlighting the safeguards present in the authorisation process, and noting that a human medicine with the same active ingredient as a veterinary medicine will not necessarily be equally safe or effective for veterinary use (NOAH[328], IVC[329], Swansea vets roundtable[330], VMD[331]).

---

[320] VetPartners IS Response, 30 July 2024.
[321] CMA, Summary of Edinburgh roundtable discussion, 4 September 2024, paragraph 15.
[322] CMA, Summary of Swansea roundtable discussion, 31 July 2024, paragraph 8.
[323] CMA, Summary of animal charity roundtable discussion, 19 September 2024, paragraph 15.
[324] See, for example, VetPartners IS Response, 30 July 2024. Also [✂]
[325] Discussions with Veterinary Advisory Panel. [✂]
[326] VMRs, Schedule 4, paragraphs 9A and 10(d).
[327] CMA, Summary of Manchester roundtable discussion, 28 August 2024, paragraph 11.
[328] NOAH Response to the Issues Statement (**NOAH IS Response**), 30 July 2024, page 3.
[329] IVC IS Response, paragraph 7.19.
[330] CMA, Summary of Swansea roundtable discussion, 31 July 2024, paragraph 8.
[331] VMD Guidance, The cascade: prescribing unauthorised medicines - GOV.UK.

(b) Concerns that allowing Cascade alternatives to MA products would negatively impact the business case for the development of veterinary medicines (NOAH[332], BVA[333], FIVP[334], IVC[335], VetPartners[336], Academics' roundtable[337]). For example, the BVA submitted that the 'relatively small veterinary market just could not support the cost of R&D if they were in competition with generic drugs'.

(c) Mitigating the risks that would otherwise arise from significant regulatory divergence on veterinary medicines between the UK and EU, particularly in the context of Northern Ireland (BVA).

(d) The fact that using Cascade alternatives increases risk due to the lack of evidence of safety and efficacy versus an authorised veterinary medicine (VMD).[338]

(e) Cost issues arising from Cascade use can be mitigated, for example by using payment plans, sourcing medicines from less expensive outlets such as online pharmacies (VMD).[339]

(f) That prescribing outside the Cascade Restriction and Cascade has long been an offence, and that the 2024 'promotion' offence was added to prevent medicine suppliers promoting the use of medicines by vets in a way that would circumvent proper application of the Cascade (the VMD notes it is not the intention to limit treatment options or prevent individual vets from using their own clinical judgement when prescribing in accordance with the cascade, nor is it intended to prevent the vet from discussing treatment options with the owner of the animal under treatment) (VMD).[340]

(g) The ability of the VMD to monitor and take action in response to adverse events arising from Cascade use of non-authorised medicines is limited, due to (for example) the limited jurisdiction of the VMD to take measures concerning human medicines and their use, and lack of equivalent pharmacovigilance responsibilities relating to human medicines used under the Cascade versus those applying to veterinary medicine MA holders (VMD).[341]

---

[332] NOAH IS Response, 30 July 2024, page 3.
[333] BVA IS Response, 30 July 2024, paragraph 75.
[334] FIVP IS Response, 26 July 2024, page 7.
[335] IVC response to CMA s174 request of 13 November 2024, paragraph 29.5.
[336] VetPartners IS Response, 30 July 2024, paragraph 7.6.
[337] Summary of academics roundtable discussion, 16 September 2024, paragraph 24.
[338] VMD, [✂]
[339] VMD, [✂]
[340] VMD. [✂] and evidence provided by the VMD, 24 January 2025. [✂]
[341] VMD. [✂].

(h) That with each step down the Cascade, there is an increased potential risk to the target species so the prescribing vet needs to make a clinically justified decision regarding the medicines they prescribe to patients under their care (VMD).[342]

Our observations on the Cascade

Previous reports on the Cascade Restriction

6.33 Concerns about the Cascade Restriction are not new. In its 2003 investigation of the supply of prescription-only veterinary medicines, the Competition Commission consulted on recommending changes to the Cascade to:

(a) 'remove the ranking of cascade options in respect of non-food-producing animals so that, where circumstances allow recourse to cascade, a veterinary surgeon may use whichever option he considers best'; and

(b) 'to allow recourse to the cascade in the case of non-food-producing animals where, notwithstanding the existence of an authorised medicine for the species and condition in question, the veterinary surgeon having the animal under his care considers this justified on grounds of animal welfare including cases where the cost of treatment would otherwise cause the animal to go untreated'.[343]

6.34 Following consultation, these recommendations were abandoned, on the basis that they 'proved the most controversial of all the areas on which we consulted, with arguments over the role of the cascade in ensuring the safe use of veterinary medicines and in promoting innovation and availability of future veterinary medicines. Our consideration of the responses led us to conclude that changes to the cascade would require a review going beyond the scope of our inquiry.'[344]

6.35 Earlier, in 2001, an independent review had been commissioned to 'review the procedures by which prescription only medicines (**POMs**) for veterinary use are classified and sold in the United Kingdom and the impact current practices may be having on availability and prices' and provide recommendations to Government.

6.36 Its report stated that: 'we recognise the need to encourage research and development of new medicines for companion animal species. However, the rule that, when an authorised medicine is available no unauthorised alternative may be prescribed has the effect of greatly increasing the cost of treatment for some chronic conditions. This may result in a loss of welfare for the animals concerned. We believe that animal owners should be able to discuss the alternative courses of

[342] Evidence provided by the VMD, 24 January 2025. [✂]
[343] 2003 CC Report, Appendix 1.3, paragraph 40 – recommendations 18 and 19.
[344] 2003 CC Report, page 51, paragraph 2.198.

treatment with their veterinarian and balance the advantages of the more up to date and effective treatment against the added cost of shifting from older drugs, including generic drugs developed for use in human medicine. Whilst this may result in some loss of market in the United Kingdom for new medicines, we believe this would be minor compared with the global market and of substantial benefit to pet owners living on low incomes.'[345]

6.37 The report went on to recommend that the Government encourage the European Commission to amend the cascade legislation 'to allow veterinarians to prescribe generic treatments for companion animals where, after consultation with the owner, they come to the conclusion that this is the best treatment for the animal concerned'. Ultimately, this recommendation was not adopted by Government.[346]

Emerging views on the Cascade Restriction

6.38 There appears to be evidence that, at least in certain instances, the Cascade Restriction may be acting as a barrier to entry or expansion for products which otherwise might serve the needs of consumers at a lower price than the authorised medicine which the Cascade Restriction requires vets to prescribe.

6.39 We also see force in the view that the Cascade Restriction could have an adverse impact on animal welfare in certain circumstances. That could occur if, for example, the restriction results in animals going untreated and/or euthanised in circumstances where its owner could afford a Cascade alternative, but not the authorised Prescribed Veterinary Medicine.

6.40 The VMD has told us that, while financial reasons alone are never justification to use a human medicine over an authorised veterinary medicine, each case must be dealt with by a vet on a case-by-case basis. The VMD submitted that the Cascade is a risk-based decision tree that the prescribing vet needs to review in line with the circumstances of an individual patient. Potential risks to the target species increase with each step down the Cascade. The VMD further noted that there may be situations where there is clinical justification for Cascade use of alternative medicines if 'all the options of using an authorised veterinary medicine have been explored and the benefit:risk balance have been appropriately weighed…informed consent has been obtained from the owner' and [the Cascade use] is 'in the interest of preventing animal suffering'.[347]

6.41 However (noting the published guidance referred to in paragraph 6.21 above), this VMD view does not appear to us to counter the evidence above of the Cascade

[345] Ministry of Agriculture, Fisheries and Food, Report of the Independent Review of Dispensing by Veterinary Surgeons of Prescription Only Medicines, May 2001, page 8.
[346] Defra, news release: The Government's Formal Response to the Independent Review of Dispensing by Veterinary Surgeons of Prescription Only Medicines, 10 December 2002.
[347] VMD. [✂]

Restriction potentially preventing consumers from accessing less expensive alternative medicines in certain circumstances.

6.42 We are mindful of the possibility there could be increased risks associated with widespread use of Cascade alternatives, and the potential costs which managing those risks could involve. We acknowledge that in a well-functioning market, regulation will reflect animal welfare, public health and safety considerations. We also recognise that incentives to research, develop and innovate in the field of medicines are important.

6.43 Regulation can affect competition and consumers too, though. Its impact on competition and consumers can be considerable where it restricts consumer choice or leads to consumers paying higher prices than they otherwise would (which impacts may also affect animal welfare and public health and safety if, for example, the Cascade Restriction leads to animals going untreated or suffering detriment in their treatment).

6.44 For those reasons, it seems to us important that the regulatory framework, including the Cascade Restriction, reflects the right balance of considerations – including animal welfare, public health and safety, and competition and consumer interests. We have concerns that this may not currently be the case for the Cascade Restriction.

6.45 We recognise that the CMA may not be best placed to draw conclusions on the most effective weighting of competition (including consumer cost and choice) factors against the wider public policy issues involved. In light of our competition concerns, though, we invite comments on whether and how we might consider these matters further.

6.46 Subject to any such comments, our emerging view is that, where competition may be affected because the regulatory framework does not reflect the right balance of considerations, the public bodies responsible for regulating the prescribing of medicines (Defra, VMD, RCVS) should consider whether animal welfare, public health and environmental protection are appropriately weighted against the need to ensure veterinary services in the UK can deliver competitive prices, innovation and growth in step with technological change and consumer demand. This could involve, for example, introducing more flexibility in the Cascade for specific circumstances, or requiring products that are displacing a widely-used Cascade alternative to demonstrate value-for-money.

Observations on the Cascade: lack of clarity

6.47 Our stakeholder engagement highlighted some of the difficulties veterinary professionals may experience implementing the Cascade Restriction in practice.

The VMD has stated in published guidance[348] that vets 'are not allowed to prescribe a human medicine simply because it is cheaper than using an authorised veterinary medicine' and the RCVS has stated that '…the cost of the medication cannot be taken as justification for prescribing under the cascade, and instead the decision should be made only to avoid unacceptable suffering.'[349]

6.48 However, in the course of our engagement with stakeholders in the investigation, it has not always been possible to clarify whether a clinical decision – for example to avoid unacceptable suffering – might be made to resort to the Cascade, where the circumstances giving rise to that clinical situation are linked with cost (for example, the unaffordability to the pet owner of the authorised medicine).

6.49 Taken together with the perceived increased risk to vets resulting from the new offence of promoting misuse of the Cascade[350], the evidence so far suggests this lack of clarity is likely to restrict veterinary professionals when making prescribing decisions in difficult circumstances, particularly in a context when, for many consumers, cost of living concerns are relevant.

6.50 The VMD and RCVS may wish to consider clarifying (for example, with case studies) the circumstances in which cost might, or might not, feature in circumstances that a VMRs-compliant clinical decision-making process might respond to.

Observations and evidence on 'under care' requirement for prescribers of parasiticides

6.51 Here we consider views on the 'under care' requirement as it relates to prescribing certain medicines, such as anti-parasitical medications. From paragraph 6.74 below, we consider the impact of these requirements on the ability to offer telemedicine.

Stakeholder views on 'under care' requirement for prescribers of parasiticides

6.52 The VMRs require that an animal be 'under care' of the veterinary professional who prescribes a Prescribed Veterinary Medicine. As set out in the following paragraphs, some stakeholders have informed us that recent changes to how the RCVS interprets the guidance on this,[351] particularly as it relates to parasiticides, has meant that vets are required to conduct a physical examination before

[348] VMD Guidance, The cascade: prescribing unauthorised medicines - GOV.UK.
[349] See RCVS website, Standards & advice update, November 2020 (https://www.rcvs.org.uk/news-and-views/features/standards-and-advice-update-november-2020/ - paracetamol) (accessed 31 January 2025).
[350] Note that prescribing in breach of the Cascade Restriction has long been an offence.
[351] RCVS website, 'Under care' - new guidance (https://www.rcvs.org.uk/setting-standards/advice-and-guidance/under-care-new-guidance/) (accessed 31 January 2025).

prescribing relatively routine parasiticides, with an impact on consumers in terms of cost and choice:

(a) Some vets who participated in our qualitative research reported that these changes were badly received by vets and pet owners; for example, one vet suggested animals are sometimes unnecessarily required to attend consultations when alternatives would be feasible (such as a phone call), while another said the changes left pet owners feeling as though vets were seeking financial gain by requiring additional consultations.[352]

(b) An independent FOP submitted that the new requirements for a consultation prior to prescribing such products increase administration times and professional fees to clients.[353]

(c) A large veterinary group noted the changes could frustrate pet owners given the increased cost and time required by the regulatory requirement of a vet's physical examination before prescribing parasiticides, therefore leading them to purchase lower-priced, alternative over-the-counter drugs. These non-prescription products would be less effective for the pet's condition, or be administered by the owner at an inappropriate dosage given the lack of clinical assessment and guidance from vets.[354]

6.53 At paragraphs 6.90 to 6.99 below, we discuss the implications of the 'under care' requirements for those service providers which are, or are seeking to, prescribe remotely.

Our observations on the 'under care' requirement for prescribers of parasiticides

6.54 The concerns caused by the 'under care' changes that require vets to physically re-examine pets when prescribing parasiticides appear to be widespread. To the extent these changes make certain business models – particularly those focused on lower-cost or less intensive treatments – less feasible, they may constrain consumer choice and adversely affect competition.

6.55 We recognise that there are potentially wider policy and clinical concerns in play, relating to animal welfare and public health and safety. In a well-functioning market, we would expect competitive impacts (including on costs for consumers) to be factors that are considered when weighing relevant policy choices and setting the regulatory framework. These factors could also affect animal welfare

[352] Qualitive research with veterinary professionals.
[353] [✂] response to RFI 3. [✂]
[354] [✂] response to RFI 3. [✂]

and public health and safety if, for example, restricted choice or high prices mean animals go untreated.

6.56 We are concerned that the regulatory framework in this area may not reflect the right balance of public interest considerations, including the impact of regulation on competition. This is another matter we may consider further, and we invite comments on whether and how we should do so. Our emerging view in the meantime is that, where that balance may not be right and competition may be affected, the public bodies responsible for regulating the prescribing of parasiticides (Defra, VMD, RCVS) should review the way the framework takes account of animal welfare and public health considerations and competition and consumer interests.

Observations and evidence on (re-) classification of Prescribed Veterinary Medicines

Stakeholder views on (re-) classification of Prescribed Veterinary Medicines

6.57 Some stakeholders suggested that some Prescribed Veterinary Medicines may be retaining their 'high' classification (eg POM-V) for longer than necessary, due in part to the way re-classification is driven by the MA holder (the manufacturer).[355] This may make it more difficult – and expensive – than necessary for consumers to access these products. This is because the restrictions around POM-Vs (for example, the need for a prescription from a vet) means the pet owner will likely have fewer options for purchasing the product, which in turn may mean additional cost: for example, the payment of a consultation fee, and/or prescription/dispensing fees. Specifically, we note:

(a) [✂].[356]

(b) The VMD also confirmed it 'does not routinely review the distribution category of individual medicines' (other than as a result of pharmacovigilance monitoring of adverse event signals) and that the decision to change the distribution category is for the MA holder.[357]

(c) The VMD informed us that for each of the re-classifications 'downwards' in the past five years, all were requested by the holder of the MA in order to increase access to these products.[358]

(d) We have also seen internal documents from manufacturers suggesting that, in certain instances, re-classifying to 'over the counter' status was explored

[355] AMTRA Response to the Issues Statement (**AMTRA IS Response**), 30 July 2024.
[356] [✂]
[357] VMD letter to CMA. 9 October 2024. [✂].
[358] VMD letter to CMA, 9 October 2024. [✂]

(even if as an isolated event) to drive sales of a medicine [✂],[359] [✂] [360] from which we infer there may be commercial incentives to seek such re-classification in specific cases.

Observations on (re-) classification of Prescribed Veterinary Medicines

First authorisation

6.58 We note that upon first authorisation, the VMD 'encourages' the MA holder to distribute through the lowest distribution category that it considers appropriate and in line with legislation, in order to facilitate availability and thereby improve animal health/welfare.[361] The VMRs also specify, for certain veterinary medicines, the initial distribution category: for example, products containing antimicrobials (except Northern Ireland) or those 'intended for administration following a diagnosis or clinical assessment by a veterinary surgeon' must be categorised as POM-V.[362]

6.59 If the product is a generic, it will be granted the same distribution category as that of the reference product. If the MA applicant requests a higher distribution category, they will be 'advised that a lower distribution category is available' after assessment of the application[363] It is unclear whether this sufficiently motivates MA holders to choose a lower distribution category for their generic and therefore widen the accessibility of certain medicines. Even when there is precedent for a lower distribution category for another generic of the same reference product, the new generic has to have the same distribution category as the reference product initially. The MA holder will then need to subsequently apply for a variation post-authorisation.[364] It is possible this involves additional cost and resources for the MA holder; if so, this might discourage the MA holder from pursuing a lower categorisation (and may therefore be a reason for revising the approach to permit a lower distribution category upon authorisation, if warranted from a safety perspective.).

Review / change of the distribution category

6.60 Though there is evidence manufacturers have sought lower classifications in a number of instances, there is the possibility that products could be retained at a higher distribution category than is required vis-à-vis their risk profiles. Although the VMD is legally permitted to require a compulsory variation to change the distribution category, this is only to raise the distribution category to mitigate risks (the VMD is also permitted to require the distribution category to be lowered, but

[359] Medicine manufacturer response to RFI of August 2024. [✂]
[360] Medicine manufacturer response to RFI of August 2024. [✂]
[361] VMD letter to CMA. 9 October 2024. [✂]
[362] VMRs, Schedule 3, paragraph 1.
[363] VMD letter to CMA. 9 October 2024[✂]
[364] VMD letter to CMA. 9 October 2024. [✂]

has told us it cannot envisage an example where this would be required or appropriate)[365]

6.61 Therefore, the only route to re-classification to a lower category and thus access to wider distribution channels appears to be through a decision by each MA holder to seek a variation to its licence for its specific product. AMTRA in its response to our Issues Statement submitted that although 'those best placed to make safety assessments on existing authorised medicines are the Marketing Authorisation Holder and the VMD…it is not clear to AMTRA that all existing POM-V medicines, having demonstrated a five-year period of safe use in the field, continue to justify a POM-V classification.'[366] We note that recent amendments to the VMRs removed the requirement to renew an MA five years following initial authorisation in England, Scotland and Wales.[367]

6.62 The distribution category is generally considered on a product specific basis. Once the first product in a class achieves a lower than initial distribution category, other MA holders may follow suit and submit a variation for their similar products. This is a decision for the MA holders as the VMD does not mandate that the distribution category of all similar products is changed.[368] It is therefore possible that very similar products sit at different distribution levels simply because certain MA holders are not sufficiently incentivised to go through the re-classification process.

6.63 In the 2003 CC Report, the Competition Commission had concerns that 'manufacturers can have a commercial interest in the choice of distribution classification (including deciding whether to seek reclassification), going beyond questions of safety, quality and efficacy'[369]

6.64 The 2003 CC Report recommended that the VMD automatically review classification at MA renewal, to address these concerns.[370] Though Government responded positively to this recommendation, it was noted that legislative amendment may be required to implement it.[371] We are not aware of any such legislative change, and the VMD does not routinely carry out such reviews at present (other than as a result of pharmacovigilance monitoring of adverse event signals).[372]

6.65 We are interested in views as to whether the existing approach to classification (and re-classification) is as effective as it could be to allow as a wide a distribution

[365] VMD letter to CMA. 9 October 2024 [✂]
[366] AMTRA IS Response, 30 July 2024, page 2.
[367] Explanatory Memorandum to The Veterinary Medicines (Amendment etc.) Regulations 2024, paragraph 7.6(e).
[368] VMD letter to CMA. 9 October 2024. [✂]
[369] 2003 CC report, page 53, paragraph 2.204.
[370] 2003 CC report, Recommendations on classification, page 53 onwards.
[371] House of Commons, Written Ministerial Statements, Veterinary Medicines, 9 July 2003.
[372] VMD letter to CMA. 9 October 2024. [✂]

category as possible (while ensuring proportional safety and efficacy safeguards remain in place).

6.66 Aspects we may consider further include, for example, whether there are specific examples of Prescribed Veterinary Medicines where re-classifying would have a beneficial impact on prices for consumers, the role distribution categories play in driving manufacturer's investment decisions, and whether increasing the number of Prescribed Veterinary Medicines classified at POM-VPS (which could then be prescribed by pharmacists and SQPs[373] as well as veterinary surgeons) could increase consumer choice.

Evidence and observations on the wholesale restriction

Stakeholder views on the wholesale restriction

6.67 We have heard from a number of FOPs that, in certain cases, medicines are available at retail prices via online pharmacies cheaper than the wholesale prices they can obtain.[374] Under the VMRs, FOPs are permitted to obtain supplies of Prescribed Veterinary Medicines only from businesses holding a 'wholesale dealer's authorisation'. The extent to which FOPs would in fact purchase supplies of medicines from online pharmacies in preference to their wholesalers, should they be permitted to do so, is less clear. We discuss our emerging views on the ability of FOPs to negotiate competitive prices with their suppliers, and how these prices compare to those of third-party retailers (such as online pharmacies), in the working paper **Competition in the Supply of Veterinary Medicines**. Here, however, we focus on a specific regulatory restriction that applies to wholesalers.

Observations on the wholesale restriction

6.68 The VMD told us that the requirement for wholesalers to possess a Wholesale Dealer's Authorisation is important as it safeguards the supply chain for Prescribed Veterinary Medicines: for example, the quantities that are involved in wholesale supply require a greater degree of control and scrutiny, which the requirement to hold a Wholesale Dealer's Authorisation involves.[375]

6.69 We note some pharmacy businesses (which are selling Prescribed Veterinary Medicines as retailers) operate at scale selling substantial quantities of veterinary medicines and, as pharmacies, do not require a Wholesale Dealer's Authorisation, which appears to challenge the quantity-related rationale for the wholesale restrictions above. However, we also recognise there are aspects where the

[373] [✂]
[374] See for example: **Competition in the Supply of Veterinary Medicines** working paper, section 3, and CMA Issues Statement, 9 July 2024, paragraph 89.
[375] VMD teach-in, 9 October 2024. [✂]

business models of pharmacy businesses and wholesalers may differ – for example, in terms of delivery mechanisms to customers.

6.70 We also query whether a FOP purchasing supplies of Prescribed Veterinary Medicines from an online pharmacy would pose a specific risk (at least, in comparison to an online pharmacy delivering medicines to a consumer).

6.71 However, we are also aware that the regulatory constraint may not be the primary factor that prevents such sales: in principle, we expect an online pharmacy business that wished to engage in equivalent wholesale to FOPs could obtain a Wholesale Dealer's Authorisation and do so – either as a wholesaler or by utilising an alternative business model that allows for both business-to-business and retail sales of medicines.[376]

6.72 We discuss the evidence and set out our emerging views on the ability of FOPs to negotiate competitive prices with their suppliers, and how these prices compare to those of third-party retailers (such as online pharmacies), in the working paper on **Competition in the Supply of Veterinary Medicines**. However, while we would welcome further views on this topic, our emerging view is that the regulatory restriction discussed above is unlikely to be a primary barrier to FOPs accessing wholesale supplies of Prescribed Veterinary Medicines at competitive prices.

Interpretation of veterinary medicines regulations may be unduly restricting innovation

6.73 This section of the paper explores whether the current regulatory requirements which govern the provision of veterinary care and the prescription of medicines may be inhibiting consumers from being offered a range of options when seeking to obtain veterinary services, including innovative new services. Examples of such services include the use of telemedicine for certain treatments or prescribing and additional routes for vets or consumers to obtain medicines.

Telemedicines and remote prescribing

6.74 The RCVS has defined telemedicine as the use of electronic communication and information techniques to provide clinical healthcare remotely. This includes the provision of veterinary services via video-link, text, instant messaging or telephone,[377] or by other remote means to carry out[378]:

[376] The form such a business might take may also be depend on the available terms of manufacturer rebates – see on **Competition in the Supply of Veterinary Medicines** working paper, section 2.
[377] See RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 2.
[378] See BVA Policy statement, BVA policy position on under care and the remote provision of veterinary services, January 2021, page 5.

(a) **Remote Veterinary Consultation**: where the vet has access to clinical notes and can perform activities such as check-ups following an initial appointment, ongoing management of chronic conditions and preventative care;

(b) **Remote Prescribing**: prescribing without veterinary clinical examination or direct observation at the time of prescribing or providing where any requisite clinical assessment is made remotely. This may include new or repeat prescriptions; and

(c) **Remote Triage**: a service offered to clients in which a member of the vet-led team uses technology to make an initial assessment which does not include veterinary clinical examination or veterinary inspection and does not involve a diagnosis or prescribing. This can occur without access to clinical notes and will often result in referral to a vet, RVN or appropriately regulated allied professional

(together, **Telemedicine**).

6.75 As discussed in our working paper on **How People Purchase Veterinary Services**, our pet owners survey indicates that the use of Telemedicine is currently very limited. 7% of respondents said that they had used 'remote consultations and/or telemedicine services' in the past two years, with only 3% saying that they still used them.[379] Additionally, the survey indicates that a majority of respondents (58%) were unaware of these services.[380]

6.76 Though current usage of Telemedicine is limited, even before the COVID-19 pandemic the RCVS noted that 'the industry is changing rapidly... [there] are increasing numbers of businesses seeking to develop telemedicine services such as video consultations and chat apps directly to clients'.[381]

6.77 This reflects both the development and improvement of the technology required to carry out these services as well as a growing demand for such services exacerbated by the onset of the COVID-19 pandemic.[382] The RCVS has acknowledged that human healthcare appears to be ahead of the veterinary

[379] Pet owners survey, Q124.
[380] Pet owners survey, Q124.
[381] See RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 2.
[382] As part of its Vet Futures initiative launched in 2015, the RCVS "recognised the need to review the regulatory framework for veterinary businesses to ensure a level playing field, enable a range of business models to coexist, ensure professionalism in commercial settings, and explore the implications for regulation of new technologies (eg telemedicine)". Vet Futures, Taking charge of our future: a vision for the veterinary profession for 2030, 20 November 2015. During the COVID-19 pandemic, the RCVS temporarily permitted vets to remotely prescribe veterinary medicines: RCVS Press Release, Coronavirus: RCVS Council temporarily permits vets to remotely prescribe veterinary medicines, March 2020. One professional online vet advice provider saw a 900% increase in demand due to the impact of COVID-19: Summary of Pet Parent research commissioned by Vets-AI and Joii Pet Care, 5 May 2021, page 3.

profession in terms of developing regulatory regimes that allow for the provision of Telemedicine services.[383]

6.78 Telemedicine provides an additional avenue for consumers to access veterinary services and therefore widens access to professional care and broadens choices available to pet owners. Compared to in-person examinations, Telemedicine can sometimes offer a quicker and less expensive solution.[384]

6.79 Telemedicine can be beneficial for vets, too, as another tool at their disposal[385] for them to reach existing and new patients (including those whose owners live in remote areas or have accessibility needs), prescribe certain medicines and communicate with pet owners where a visit to the consultation room may not be necessary, practical or may cause undue stress on the patient.[386] Maximising the appropriate use of Telemedicine can mean more pets can be seen by vets more often which comes with benefits to animal welfare, and efficient resource utilisation.[387]

6.80 Vet businesses would benefit from Telemedicine as an additional service that they are able to charge for, and being able to provide it may improve their ability to win or retain customers who value the option of remote care.[388] Submissions have also been made to the RCVS that Telemedicine offers a new way to deal with lower value items (particularly where there is no prescription or treatment needed) which means practices can concentrate on higher fee-earning consultations.[389]

6.81 There is therefore scope for the benefits of Telemedicine to be further realised within the context of veterinary services to help improve consumer choice, reduce the resource burden on vets and promote animal welfare in a greater number of settings.

6.82 Nevertheless, the offering of Telemedicines as separate services or adjuncts to traditional veterinary services requires appropriate legal and regulatory safeguards to protect the health and welfare of animals as well as maintaining public confidence in the veterinary profession.[390] A cornerstone to ensuring this

---

[383] See RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 3.
[384] Pet owners survey, Q125. 13% of respondents to our pet owners survey mentioned using remote consultations, telemedicine, or video vet services because they were cheaper than in-person services. As part of the RCVS Telemedicine Consultation, efficiency and convenience was identified as an advantage by vet professional respondents. Lower cost, convenience and speed of access to vet were identified as advantages by public respondents: See RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 15.
[385] RCVS Council Papers, January 2023, page 13.
[386] See RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 15.
[387] PDSA Response to RCVS survey, January 2023 RCVS Council Papers, 16 January 2023, page 63. The official policy position of the World Veterinary Association acknowledges that "telemedicine can provide benefits to animal welfare, in reduced costs and in ease of service where owners cannot travel, where there are shortages of veterinarians and in remote areas: WVA Position Statement on Veterinary Telehealth Services, 22 April 2021.
[388] 8 in 10 (82%) cat and dog owners believe online veterinary services and support should be available to those who wish to use them (JOII) Summary of Pet Parent research commissioned by Vets-AI and Joii Pet Care, 5 May 2021, page 2.
[389] RCVS response to RFI3, Question 12. [✂], which includes minutes from a presentation from [✂] made to the RCVS.
[390] RCVS review of the use of telemedicine within veterinary practice, Summary Analysis, March 2018, page 2.

protection remains in place across varying degrees of physical proximity between vet and animal is the doctrine of 'under care' and, related to that, the definition of 'clinical assessment'. Historically, 'under care' has been developed within the context of Remote Prescribing[391] and is now enshrined within the VMRs:

> 'A veterinary surgeon who prescribes a veterinary medicinal product classified as POM-V[392] or a veterinary medicinal product under the cascade[393] must first carry out a clinical assessment of the animal, and the animal must be under that veterinary surgeon's care.'[394]

6.83 As acknowledged at paragraph 6.25 above, 'Clinical assessment' and 'under care' are not defined within the VMRs[395] and the RCVS as the sector regulator has addressed them in its Guidance.[396] Whereas the previous section considered these terms within the context of certain medicines such as parasiticides, this section will look more broadly at how the current interpretation of these terms may be impeding the provision of Telemedicine.

Clinical assessment

6.84 The current definition of 'clinical assessment' is contained within the Guidance and stipulates that:

(a) A clinical assessment is any assessment which provides the veterinary surgeon with enough information to diagnose and prescribe safely and effectively. A clinical assessment may include a physical examination, however this may not be necessary in every case.

(b) Whether a physical examination is necessary for the prescription of POM-Vs is a matter for the veterinary surgeon's judgement depending on the circumstances of each individual case.

6.85 The definition of clinical assessment was recently amended to its current form to provide more flexibility around the requirement for vets to conduct a physical examination in every instance of prescribing. The Guidance states that it is up to the vet to decide whether the clinical assessment needs to include a physical examination, in all but a number of circumstances:

---

[391] The term 'under care' was introduced by the Medicines Act 1968 and the RCVS issued its interpretation of it within its Code shortly after.
[392] See paragraph 6.3(d) of this paper for the definition of POM-V.
[393] See paragraph 6.20 for the definition of cascade.
[394] VMRs, Schedule 3, paragraph 4(1).
[395] Supporting Guidance, Veterinary medicines, paragraph 4.9.
[396] Supporting Guidance, Veterinary medicines, paragraphs 4.9 to 4.19.

(a) Where a notifiable disease is present;[397]

(b) When prescribing controlled drugs (unless there are exceptional circumstances);[398]

(c) When prescribing antibiotics, antifungals, antiparasitic or antivirals (unless there are exceptional circumstances).[399]

6.86 The Guidance also provides a list of factors vets are to consider when exercising their clinical judgement when deciding whether a physical exam is necessary.[400]

6.87 The current guidance therefore indicates the potential for a vet to prescribe without a physical examination, however, these opportunities appear to remain limited.

Under care

6.88 The current definition of 'under care' contained in the Guidance stipulates that:

(a) An animal is under a veterinary surgeon's care when the veterinary surgeon is given, and accepts, responsibility for the health of an animal… whether generally, or by undertaking a specific procedure or test, or by prescribing a course of treatment….

(b) A veterinary surgeon who has an animal under their care must be able, on a 24/7 basis, to physically examine the animal… or another veterinary service provider may do so on their behalf.[401]

6.89 Therefore, although the requirement for a clinical assessment may not be required for Remote Prescribing POM-Vs, the vet must still *be able* to physically examine the animal or ensure another vet will be able to do so.

How the requirements around the continued requirement for physical examination may be hindering the development of Telemedicine

6.90 First, there is a lack of clarity on the exact meaning of 'telemedicine'.[402] There have been claims that this confusion has not been helped by a lack of

---

[397] Notifiable diseases are those named in the Animal Health Act 1981, section 88 or an Order made thereunder. It is one that must be reported to government authorities given its importance to public health eg Foot and mouth disease.
[398] Controlled Drugs (CDs) within the context of veterinary medicines are listed in The Misuse of Drug Regulations 2001, Schedule 2.
[399] Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without a physical examination and record this justification in the clinical notes. See Supporting Guidance, Veterinary medicines, paragraph 4.20(a).
[400] This includes, but is not limited to, the (potential) health conditions being treated; the nature of the medication being prescribed, including any possible risks and side effect; the practicality of physical examination for individual; and when the animal was last physically examined by a vet. See Supporting Guidance, Veterinary medicines, paragraphs 4.17(a)-(k).
[401] Supporting Guidance, Veterinary medicines, paragraphs 4.12-4.14.
[402] For example, BVA, Policy Position on Under Care and the Remote Provision of Veterinary Services, January 2021, page 4.

transparency over the RCVS Council's discussions on proposals for reform in this area.[403] The BVA argues that, as the term has been developed within the context of medicines, this limits the concept to a temporal relationship to the act of prescribing even though the practice of veterinary medicine is much more than examining and prescribing.[404]

6.91 Second, there is a lack of clarity on the applicability of 'under care' and 'clinical assessment' outside of Remote Prescribing.

(a) 'Clinical assessment' is not defined or contained in the VSA at all nor in the RCVS Code or Supporting Guidance outside of the context of Remote Prescribing.

(b) Whether an animal is under the care of a vet is referenced in Schedule 3 but is only in relation to delegation to nurses and student veterinary nurses when it comes to minor surgery.[405] The concept of care and the responsibilities that come with having an animal under one's care is referenced throughout the RCVS Code and Supporting Guidance[406] but the definition of when an animal is under the care of a vet is only used specifically in relation to the prescription of POM-Vs.

(c) Third, there is a lack of clarity on the definition of 'exceptional circumstances' – that is, under what conditions vets can Remote Prescribe antibiotics, antifungals, antiparasitic or antivirals without carrying out (or being able to provide) a physical examination. This is because, although the RCVS has issued case studies which include some examples of exceptional decisions (for example a dangerous animal),[407] the Guidance does not stipulate what 'exceptional circumstances' are.

6.92 Where there is uncertainty or confusion within the provision of regulated services, this can lead to a chilling effect on innovation as those looking to provide services within a regulatory 'grey area' do not have the required confidence they can operate in a different way to traditional practice. When regulation fails to keep up with developments in technology and changes in consumer demand, this arguably stifles innovation.[408]

---

[403] RCVS, RCVS provide reassurance over recent Council decision to review 'under care' and 24/7 cover, 19 June 2019.
[404] BVA, Policy Position on Under Care and the Remote Provision of Veterinary Services, January 2021.
[405] Treatment and operations which may be given or carried out by unqualified persons: See sections 6 and 7 of the VSA and Supporting Guidance, Schedule 3 exemption, paragraph 18.4.
[406] For example, the Supporting Guidance on Veterinary Care, states at paragraph 2.1, "The *Codes of Professional Conduct* state that veterinary surgeons and veterinary nurses must provide veterinary care and veterinary nursing care that is appropriate and adequate."
[407] The case study for what would constitute an "exceptional circumstance" in the case of a controlled drug does involve only a phone-call given the animal is distressed and unable to be transported to the practice. Nevertheless, although the vet suspects the animal will need antibiotics, the case study indicates this assessment will wait until the vet comes into the practice.
[408] CMA Competition Assessment Guidelines, Part 2: guidelines, page 25, paragraph 4.1.

6.93 The retention of the need to perform a physical examination, in all but limited circumstances, to adhere to the Guidance when Remote Prescribing restricts the provision of Telemedicine. We note that:

(a) While the temporary guidance which allowed for Remote Prescribing without a physical consultation was in place during the COVID-19 pandemic, no serious safety concerns were identified.[409]

(b) During this period the RCVS noted that clients were not making many complaints to it about remote consultations.[410]

(c) There has not been any disciplinary action brought against a vet for Remote Prescribing[411] which suggests the ongoing relaxation of the rules is not leading to an uptick in complaints for gross misconduct and therefore an increased risk to animals.

6.94 In addition to the concerns raised by pet owners and vets in paragraph 6.52, business models looking to offer an alternative to bricks and mortar premises are arguably constrained by this requirement. The RCVS has also considered that the 24/7 emergency care and pain relief requirement could be seen as anticompetitive in favouring larger groups with national coverage over smaller groups.[412]

6.95 Similar issues may arise here (in terms of the public policy goals to be weighed) as in the context of the 'under care' changes requiring physical examinations for specific categories of veterinary medicine prescriptions, as discussed at paragraphs 6.54 to 6.56 above.

6.96 We have received submissions from vets who underscore the importance of having 'hands on the animal' not only because this increases their confidence in accurately diagnosing[413] and prescribing the best treatment, but also to ensure other symptoms are identified which are outside the initial purpose of a consultation.[414] Other concerns and views that we have been made aware of during this investigation include:

(a) Leaving the need for a physical examination to the individual judgement of each vet has the potential to put undue pressure and challenge upon

---

[409] RCVS survey, January 2023 [✂]
[410] RCVS response to RFI1, Question 12 [✂] We note that the COVID-19 pandemic did have an impact on complaints made to the VCMS: VCMS Insight Report 2020-21 determined that Covid-19 may have contributed to and exacerbated complaints. [✂]
[411] RCVS response to RFI3, Question 23. [✂]
[412] RCVS response to RFI1, Question 12. [✂]
[413] While the temporary guidance which allowed for Remote Prescribing without a physical consultation was in place during the COVID-19 pandemic, data was collected which showed that respondents felt less confident in carrying out their services remotely when compared to conducting a physical assessment. See ies Report, RCVS Covid-19 Survey 2020, September 2020, page 107.
[414] For example, a pet could receive a Remote Veterinary Consultation for its long-term condition but the owner does not have enough knowledge to identify certain symptoms for another ailment which would be picked up in the physical presence of a vet. ies Report, RCVS COVID-19 Survey 2020, September 2020, page 107.

individuals and leaves scope for an increase in complaints. This pressure is said to be a greater cause of concern for less-experienced vets.[415]

(b) The reduction in the need for a physical examination between vets and pets erodes the unique and important relationship between vet, pet and owner.[416]

(c) There is a fear that telemedicine companies would be able to find a centralised/national out of hours provider and that this would disadvantage independent practices.[417]

(d) Because the costs for a FOP to function (to cover premises and equipment, for example) is greater than that required by Remote Prescribers, this will lead to 'cherry picking the bread-and-butter income' that FOPs are legally required to provide.[418]

(e) That vets based overseas would be able to Remote Prescribe without any regulatory oversight.[419]

6.97 Although competition may be improved by the relaxation of these regulations, we recognise that the need to foster effective competition in a market is one consideration within a broad range of public interest factors that must be weighed. The development of 'under care' and 'clinical assessment' is underpinned by the need to ensure that animal welfare and public health remain at the heart of veterinary care in whatever form that may take.

6.98 Our concern is that the regulatory framework may not balance the relevant public interest considerations, including that in effective competition, appropriately. We may consider that further and we invite comments on whether and how we should.

6.99 It appears to us that the relevant public bodies could consider that balance, too. That may include reconsidering the approach to the definitions of 'under care' and 'clinical assessment' as they relate to the prescription of POM-Vs – and we note that the RCVS plans to review updated guidance, including revisiting these definitions once again commencing in January 2025.[420] It might also include consideration of the classification of Prescribed Veterinary Medicines (as discussed in paragraphs 6.57 to 6.66), which could reduce the number of products categorised as POM-V and broaden the range of medicines available for

[415] RCVS response to RFI1, Question 12, which summarises a response from [✂] to the RCVS's under care survey [✂]
[416] BVA Policy statement, BVA policy position on under care and the remote provision of veterinary services, January 21, page 13.
[417] RCVS RFI3 response to Question 28, summarising SPVS views as expressed in October 2022 on under care/out of hours. [✂]
[418] RCVS, RFI1 response to Question 12, referencing SPVS views in response to the RCVS under care consultation. [✂]
[419] However, the RCVS is clear that a number of safeguards are in place to protect against this risk – including that Prescribed Veterinary Medicines can only be supplied by Registered Veterinary Practice Premises in the UK. See inspection requirements in VMRs summarised in Defra Guidance, Inspection Criteria for Veterinary Practice Premises (https://www.gov.uk/guidance/inspection-criteria-for-veterinary-practice-premises) (accessed 3 February 2025).
[420] RCVS narrative response to RFI3, Question 21 [✂]

prescription outside the Under Care restrictions. It could likewise include defining the concept of Veterinary Client Pet Relationship (VCPR)[421] in a way that might provide a clearer framework for developing Telemedicine.

Advice-only services

6.100 Currently, advice-only practices (a form of Remote Triage) do not prescribe medicines for animals nor provide a diagnosis and instead provide specific advice to the extent which is appropriate without a physical examination of the animal. These providers do not have to offer 24/7 emergency care coverage unlike full-service practices and Limited Service Providers (**LSPs**) (see 6.108 to 6.120 below). An LSP is a practice that offers no more than one service to its clients and includes, but is not limited to, vaccination clinics and neutering clinics.[422]

6.101 Where advice is given remotely and there is no ability to monitor the animal, vets should ensure that the client understands the limitations of this service and that animal welfare and/or subsequent veterinary care is not compromised.[423]

6.102 As part of the RCVS' conclusions on its under care consultation, it has clarified that the remit of advice-only services seems to have remained largely unchanged and the matter appears relatively uncontroversial.[424]

Mobile veterinary services

6.103 Mobile veterinary services are where a vet and/or vet nurse travels to perform veterinary services in a pet owner's home or at other locations (for example within the van itself or at another convenient location) which are capable of being performed outside of a bricks and mortar practice.

6.104 Mobile veterinary services are particularly valuable for those with accessibility needs and for whom coming into the practice may be difficult. It also enables services such as euthanasia to be performed at the owner's house should they prefer.

6.105 The RCVS, in its response to our Issues Statement, stated that it does not currently have any restrictions on mobile veterinary practices, providing they can offer, or take steps to offer, in-person emergency care out of hours.[425]

---

[421] Which, in response to RCVS consultations, some organisations put forward as vital for understanding how veterinary services are provided today. CVS Response to RCVS Review of "Under Care" and 24/7 Emergency Cover, pages 5-6.
[422] The Supporting Guidance also lists equine reproductive clinics but this is outside the scope of Household Pets.
[423] RCVS Code, paragraph 2.33.
[424] Notwithstanding some responses to the RCVS Under Care Consultation which suggested there is a clear conflict of interest where advice is provided by insurance companies (British association of veterinary emergency and critical care) and calls for the RCVS to consider additional guidance that differentiates between routine advice to healthy animals (eg nutrition) where a 24/7 service would not be expected and specific advice to animals that are unwell (IVC Evidensia). RCVS Council Papers, 16 January 2023, page 28.
[425] RCVS IS Response, page 18.

Nevertheless, a mobile unit (which includes an ambulatory unit) cannot be registered by itself as a Veterinary Practice Premises but must be linked to a registered physical premises where the unit is normally stored (even if no veterinary services or VMP supply takes place from the premises itself).[426]

6.106 As discussed in paragraph 3.29 we have received several submissions in relation to the provision of community nursing. However, our understanding is that the restrictions on community nursing originate from the requirement for a vet to delegate certain tasks to a nurse, and that the vet must be under the same employment rather than anything specifically related to the requirements around 24/7 emergency care.

6.107 The practical hurdles to obtain such in-person emergency care out of hours is explored further at paragraph 6.114. It therefore may be the case that mobile vets struggle to obtain this coverage, especially if they are working independently of a bricks and mortar practice. The CMA would be interested to hear from providers of mobile veterinary services as a standalone offering, rather than an extension to bricks and mortar practice services.

Limited services providers and 24/7 coverage of emergency care

The legal requirements

6.108 As explained in paragraph 6.89, there is an obligation contained in the VMRs for a vet to be able to physically examine an animal under their care on a 24/7 basis. In addition to this, there is an overarching requirement for vets 'in practice' to 'take steps' to provide 24/-hour emergency first aid and pain relief according to their skills and the specific situation.[427]

6.109 'In practice' means offering clinical services directly to the public or to other vets. This includes but is not limited to vets working in the more traditional settings such as FOPs and referral practices as well as more atypical business models such as LSPs.[428]

6.110 'Take steps' does not mean that vets must personally provide the service but where they are unable to do so, they are required to ensure that clients are directed to another appropriate service and that this handover is recorded in writing. The Guidance states that vets are encouraged to co-operate with each

[426] RCVS FAQs: Do mobile units and stalls at exhibitions/shows need to be registered? (https://www.rcvs.org.uk/faqs/do-mobile-units-and-stalls-at-exhibitionsshows-need-to-be/) (accessed 3 February 2025).
[427] RCVS Code, paragraph 1.4.
[428] Supporting Guidance, Professional and legal responsibilities, paragraph 3.2.

other in the provision of 24/7 emergency care for example in shared arrangements between local practices or using a dedicated emergency service clinic.[429]

Amendments to the Guidance for LSPs

6.111 Recent changes to the Guidance have resulted in LSPs only having to provide 24/7 coverage in proportion to the services they offer.[430] Given the nature of services provided at LSPs, this means this level of coverage is of a lower intensity than that required at a traditional bricks and mortar practices where a broader range and more invasive treatments are able to be offered. This was in response to:

(a) The RCVS Standards Committee considered that it was unfair to expect LSPs to provide 24/7 emergency cover that went beyond what was proportionate for the services they provided.[431] The RCVS' Standards Committee determined that, given the length of time these businesses have been operating, that increased requirement in respect of out-of-hours might fall foul of competition law requirements, especially because there was no evidence of a negative impact on welfare and no objective justification.[432]

(b) Submissions to the RCVS that the existence of LSPs was beneficial to animal welfare because the services were more accessible in terms of cost and this might be the only veterinary input those who use LSPs would otherwise seek.[433]

6.112 Nevertheless, several concerns have been raised about the role of LSPs in the veterinary services market as it is today and what risks would arise if the number of services they could provide were to be expanded. These include:

(a) Allowing LSPs to provide a lower level of 24/7 emergency cover allows them to 'cherry pick' which services they will cover and can leave animals without access to emergency care.[434]

(b) The role of LSPs could lead to owners electing to 'pick and mix' among providers which leads to a lack of oversight of household pets over time.[435]

(c) Because LSPs are able to 'cherry-pick' some of the less onerous and more lucrative work, this is detrimental to bricks and mortar practices who must

---

[429] Supporting Guidance, Professional and legal responsibilities, paragraph 3.5.
[430] Supporting Guidance, Limited service providers, paragraph 3.50. This means that veterinary surgeons working for Limited Service Providers should ensure that the 24-hour emergency cover provision covers any adverse reaction or complication that could be related to procedures or examinations carried out, or medicines prescribed or used.
[431] RCVS response to RFI1, Question 12. [✂]
[432] RCVS Council Papers, 16 January 2023, page 53.
[433] RCVS response to RFI 1, Question 12. [✂]
[434] RCVS response to RFI 1, Question 12. [✂]
[435] RAND Europe, RCVS Under Care and 24/7 Emergency Care Review, 7 July 2002. Page 79.

cover the costs associated with providing equipment and increased staffing to facilitate a fuller range of services.[436]

(d) Some vets feel this pressure to provide 24/7 emergency coverage to LSPs is felt even more keenly for practices in rural areas who already experience acute staffing issues.[437]

6.113 Despite this relaxation of the 24/7 coverage in respect of LSPs the concerns listed above are arguably contributing to a position where LSPs are still constrained in their ability to challenge the prevailing business model of bricks and mortar practices. This is largely due to the requirement for them to offer no more than one service, for example neutering or vaccination. There are business models currently in the market who would like to offer both neutering and flea/worming treatments but are unable to do so.[438] They argue this undermines consumer choice and competition.[439] The RCVS' Under Care Consultation Report also includes responses arguing that LSPs can provide more than one service.[440]

6.114 An additional concern held by LSPs is that, as explained in paragraph 6.109, the current Guidance merely 'encourages' other vets to provide coverage for other practitioners, including LSPs. LSPs and other atypical service providers argue that this should go further than encouragement as the withholding (whether intentional or out of necessity) of this coverage for LSPs renders it practically difficult if not impossible to provide the required level of coverage.[441]

6.115 The Guidance only explicitly references vaccination clinics or neutering clinics. However, there appears some support for the recognition of other services such as gait analysis, fertility clinics and mobile or telemedicine providers.[442] The PDSA[443] has historically suggested that the definition of LSP could relate to service category (for example, preventative clinic providing vaccination and neutering) rather than the procedure.[444]

---

[436] RCVS, Review of 'under care' and 24/7 emergency cover, consultation report, 20 January 2023, page 45.
[437] RCVS, response to RFI1, Question 12. [✂] in [✂] and [✂] in who also warn that an increase in LSPs would make the costs of accessing OOH care insurmountable for animal owners in rural areas as it would be invoiced as a discrete service rather than being part of a social contract which exists within rural communities.
[438] Jollyes Response to CMA consultation on the proposal to make a market investigation reference into veterinary services for household pets in the UK (Jollyes Consultation Response), paragraph 2.6.
[439] Jollyes Consultation Response, paragraph 2.6.
[440] 19% of the respondents who left additional comments: RCVS Council Papers, 16 January 2023, Review of 'under care' and 24/7 emergency cover, Consultation report, page 45.
[441] Jollyes Consultation Response, paragraph 4.2, and Vets-AI Consultation Response. The provision of out of hours coverage is noted as a challenge in the veterinary services market, particularly within the context of staff shortages. For example: RCVS Council Papers, 16 January 2023, pages 40 and 51.
[442] RCVS Council Papers, 16 January 2023, page 46. The current RCVS position is that the current drafting is "the most effective way of achieving consistency, clarity and appropriate care without resulting in a system of bespoke rules for different types of LSPs which would be difficult to manage and enforce: RCVS Council Papers, 16 January 2023, page 54.
[443] People's Dispensary for Sick Animals, a veterinary charity.
[444] RCVS response to RFI1, Question 12, annex to a Standards Committee agenda for a meeting held 24 October 2022 which cites the response from the PDSA to the RCVS consultation under care survey. [✂]

How the continued restrictions on LSPs could be hindering competition by restricting innovation and new entry

6.116 The continued restriction on LSPs could be having a negative impact on competition within the UK's veterinary sector. This is because the LSP business model is an alternative to the traditional multi-service practice structure that has long held an incumbent position within the market. This alternative also tends to come at a lower cost for consumers since LSPs tend to have lower start-up and operating costs because they provide specific services with leaner resources. Improving access to core services via a greater supply of lower priced options which are integral for animal welfare (such as vaccinations and neutering) could also have a positive impact on pet wellbeing.

6.117 The nature of LSPs means they are often lightly staffed and therefore reliant on external emergency care coverage which is already in high demand. The Guidance states that vets may charge higher fees for unregistered clients[445] and therefore this additional cost may either have to be shouldered by the LSP seeking to rely on the coverage or by the customer.

6.118 Consequently, the current regulatory framework could be seen as over-protective of traditional business models at the expense of market opening measures which could foster new entry and innovation. We invite views from those currently providing LSP services or those attempting to do so. We also invite views from practitioners who have experience receiving and/or complying with requests for 24/7 emergency care from LSPs.

6.119 As referenced in paragraph 6.82, there are important animal welfare considerations which need to be taken into account when considering how non-conventional business models should be regulated within this sector. However, justifications around animal welfare should not be used over-inclusively to shield incumbent providers from having to compete with new and innovative entrants.

6.120 The CMA also notes that whereas the requirements of under care are underpinned by legislation (the VMRs), the RCVS acknowledges that it has more freedom to review its current provisions around 24/7 emergency cover.[446] Our emerging view is that it might be beneficial if the RCVS were to review these provisions with the considerations above in mind.

[445] Supporting Guidance, The costs of providing the service, paragraph 3.54.
[446] RCVS response to RFI1, 18 July 2024, Question 12. [✂]

7. Impact of the regulatory framework on competition

7.1 In this section, we consider how the aspects of the regulatory framework examined in this paper might affect competition in the market for the supply of veterinary services.

Regulation of veterinary services and medicines

7.2 Regulation of veterinary services and medicines may be necessary in a well-functioning market to serve two broad purposes. The first is to protect and advance public interests in animal welfare and public safety. The second is to protect consumers where there is an asymmetry of knowledge and information between them and the professional supplier of the services and, in many cases, what they are buying are credence goods. Regulation can help consumers make informed decisions about what they buy in a way that encourages service providers to offer a range of services to meet their needs at competitive prices.

7.3 How a system of regulation seeks to achieve these two purposes is important. Regulation affects the competitive process by restricting the range and type of products and services that may be delivered, the manner in which they are delivered, the people or organisations that may deliver them and the information available to consumers.

7.4 For example, regulation may restrict the circumstances in which certain diagnostics or treatments may be available and the professionals who can provide them. It may also restrict the range of medicines available to consumers. These restrictions may seek to ensure that public interests – in say, treatment quality and the management of infectious diseases and of antibiotic resistance – are served, and to protect consumers who might otherwise choose inappropriate drugs or treatments.

7.5 If regulation is too narrow, the relevant public interests, and consumers, may be insufficiently protected. That may occur if, for example, regulatory restrictions and requirements do not effectively safeguard treatment quality and manage infectious diseases. Consumers may buy services that they mistakenly believe are appropriate for their needs and/or effectively regulated.

7.6 If regulation is too broad, sets requirements that are too stringent or restrictive, or is too focused on public interest considerations at the expense of consumer and competition ones, it can unduly restrict what services may be provided and by whom, or increase the costs of provision. It may mean, for example, that services or medicines that would benefit pets are unavailable or that pet owners cannot afford such services and animals are not treated.

7.7 In a well-functioning market, we might expect an effective system of regulation to balance the way it seeks to meet public interest and competition and consumer protection objectives. That is, to contain only the requirements and restrictions that are necessary to protect those important public interests while helping consumers have the ability (and confidence) to make informed choices (and obtain redress if things go wrong), as well as giving providers the freedom to innovate and offer a range products, services, business models and practices to meet differing consumer needs.

7.8 A system of regulation that achieves the balance described in the preceding paragraph is more likely to be one which (i) fulfils its public interest objectives and (ii) gives due weight to protecting consumers (and their pets) and to using competition to deliver good outcomes. This is the lens through which we have considered the current regulatory framework for veterinary services and medicines.

Our emerging views

7.9 Given our assessment so far, set out in sections 2 to 6 of this paper, we remain concerned that the current regulatory framework does not contain the right combination of substantive requirements and monitoring, enforcement and redress mechanisms to support the competitive processes and outcomes we would expect in a well-functioning market. Its focus on consumers and competition may be too limited. There are four reasons for this.

7.10 First, the scope of the framework is too narrow. It applies to individual vets but not to vet businesses[447] and non-vets who own and work in them. That means that, as the market has changed and vet businesses may be, and are increasingly, owned or managed by non-vets, there is a range of people (shareholders, investors and managers) who have significant influence over the decisions vet businesses make in relation to the range, quality and price of the services they provide, and over the conduct of the vets and vet nurses they employ, but who are outside the scope of regulation. This may be particularly the case for the LVGs which now account for the majority of the market.

7.11 Second, even where they do apply, the contents of the regulatory framework that go more directly to consumer protection and competition matters do not appear to result in consumers having good information on price, quality and treatment options[448] that should help them make informed decisions and drive competition.

7.12 We note in that latter regard that the RCVS Code, in particular, does require vets to give consumers 'appropriate information …. about the practice, including the

[447] Which may choose to join the voluntary PSS.
[448] Including referral services.

costs of services and medicines.'[449] They must communicate effectively with consumers and ensure they obtain their informed consent before treatments are carried out.[450] They must also provide independent and impartial advice and tell consumers about any conflict of interest,[451] and be open and honest with consumers and respect their needs and requirements.[452] The Supporting Guidance elaborates on these requirements. In other words, on its face the regulatory framework appears to require consumers to be given information of the kinds they need.

7.13 Even so, as we set out in our working paper on **How People Purchase Veterinary Services**, consumers are in many cases not given, or do not have or act on, information about the price and quality of services, options for treatment or referral services, or the ownership of FOPs. There is evidence, for example, suggesting that information on clinical options is not always communicated effectively to pet owners and that the nature and timing of the information they are given about pricing may limit their ability to make informed choices.

7.14 Third, the framework does not contain sufficient mechanisms for monitoring and enforcement. The RCVS relies on complaints being made to it, rather than monitoring compliance by vets and vet nurses with the RCVS Code and RCVS Nurses Code, respectively. That limits its scope to identify non-compliance with the requirements to provide consumers with information. The RCVS is also unable, in any event, to take enforcement action for breaches of the codes that fall short of serious professional misconduct.

7.15 Neither does the framework contain sufficient mechanisms for consumers to obtain redress where problems occur. The VCMS is a voluntary mediation scheme, rather than a binding enforcement mechanism. Consumers appear to have limited awareness of, and engagement with, the scheme. The numbers of complaints made to and resolved by the scheme appear to be low. The RCVS does not appear to use the insights and learning available from complaints processes in the sector (both from vet firms and the VCMS) as effectively as it could to strengthen regulatory practice and drive standards up.

7.16 The shortcomings in monitoring, enforcement and redress appear to us to be important. Effective regulation in a well-functioning market for veterinary services requires not just that appropriate substantive requirements are in place, but also that they effectively discipline the conduct of veterinary professionals and vet businesses who know they face the threat of effective monitoring, and of enforcement and/or redress mechanisms, if they fall short.

---

[449] RCVS Code, paragraph 2.3.
[450] RCVS Code, paragraph 2.4.
[451] RCVS Code, paragraph 2.2.
[452] RCVS Code, paragraph 2.1.

7.17 Fourth, regulatory provisions relating to veterinary medicines may have the effect of limiting access to medicines, and restrictions on the way, and by whom, services can be provided may be limiting the scope for innovation in the way vet businesses operate.

7.18 As to access to medicines, some regulatory requirements – for example, the Cascade Restriction, requirements for the physical examination of animals before prescribing certain medicines (such as the 'under care' restrictions), and the restriction on retailers supplying FOPs – could be narrowing the way in which consumers can obtain medicines that would benefit their pets. Where that is the case, it is likely to result in increased costs and less choice for consumers.

7.19 As to innovation, the 'under care' restrictions, for example, may hinder the development of alternative business models, such as mobile veterinary services and LSPs. These could offer a cheaper and more convenient way for some pet owners to access veterinary services, in competition with other providers.

7.20 It may be that such increased competition would contribute to animal welfare. More animals could have more contact with veterinary professionals more often, especially those whose owners do not have the time, resources or ability to visit a bricks and mortar practice and may otherwise go untreated. We note in that regard that the 2015 RCVS Vet Futures Report recommended that the Government 'review the regulatory framework for veterinary businesses to ensure a level playing field [and to] enable a range of business models to coexist.'[453]

7.21 We will continue to investigate our concerns. We will consider what action may be required to address those we ultimately decide may have an adverse effect on competition.

7.22 We observe in this connection that our role is to assess whether competition is distorted and to remedy any adverse effects we find. Some of our concerns about regulation go directly to competition issues and would fall to the CMA to resolve. We may, for example, find that shortcomings in the scope of regulation, in the regulatory provisions that provide for consumers to be given information, or in the mechanisms for monitoring, enforcement or redress, are a feature of the market adversely affecting competition. In those cases, we may exercise our order making powers or recommend that others take action.

7.23 In other cases, such as medicines regulation and the effects of regulation on innovation, our concerns may involve not just competition but also whether the regulatory framework reflects the right balance of public interest considerations (including animal welfare and public health and safety). In those cases, we may not be best placed to draw conclusions about that balance and it may be that

[453] Vet Futures, Taking charge of our future: a vision for the veterinary profession for 2030, 20 November 2015.

those are matters that should be considered by other public bodies, like Defra, the VMD and the RCVS. We welcome comments on the areas of regulation where it may, and may not, be appropriate for the CMA to focus its efforts.

8. Consideration of remedies

8.1 Should we identify an AEC, we are required to consider which, if any, action we should take to mitigate or remedy this, whether through direct action ourselves or recommendations to others.[454]

8.2 On 9 July 2024 we set out in our Issues Statement potential remedies we were considering and invited views on those early remedy proposals. We have considered submissions that were made to us in response to the Issues Statement and are at the early stages of further developing our thinking on possible remedies, and/or a possible remedies package. We intend to publish a working paper in Spring 2025, setting out our emerging views on possible remedies and inviting written comments.

[454] Enterprise Act 2002, section 134(4).

9. Responding to this working paper

9.1 Any submissions must be provided no later than **5:00pm on Thursday 27th February 2025** by emailing: **VetsMI@cma.gov.uk**.

9.2 We intend to publish all responses from businesses and other organisations on our case page except those marked as confidential. Please clearly highlight any confidential information in your submission and provide a non-confidential version of your submission for publication.

9.3 We may decide to publish anonymised submissions from individuals on our case page. Please clearly mark your submission as confidential if you do not want it to be published and let us know if you would prefer not to be named.

9.4 We will redact, summarise, or aggregate information in published reports where this is appropriate to ensure transparency whilst protecting legitimate consumer or business interest. While the information you provide will primarily be used for the purposes of this investigation, where appropriate, we may also use information provided as part of this consultation in relation to the CMA's other functions. For example, we may share your information with another enforcement agency (such as local Trading Standards Services) or with another regulator for them to consider whether action is necessary.

9.5 Personal data received in the course of this consultation will be processed in accordance with our obligations under the UK GDPR, the Data Protection Act 2018, and other legislation designed to protect individual privacy.