

ANALYSIS OF LOCAL COMPETITION

Vets Market Investigation Working Paper

06 February 2025

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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 Some numbers have been replaced by a range.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.

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Summary

1. Veterinary services for household pets are most often provided in the UK from veterinary practices with a fixed address. In order to receive care, a customer must take their animal to the relevant site to see a vet. A customer's choice of veterinary practice will be limited to those located within the geographic area where the customer is willing (and able) to travel. This is shown by 68% of respondents to our pet owners survey noting that location was a relevant factor when choosing a veterinary practice, with the highest proportion (34%) noting location was the main reason for their choice.
2. Before 1999 veterinary practices were all owned by vets, with acquisitions and consolidation beginning in the early 2000s and accelerating through the 2010s. By 2024, large veterinary groups (**LVGs**) owned around 60% of first opinion practices (**FOPs**), in the UK. This change in market structure has led to an increase in the degree of local concentration in the UK, with concerns raised by some parties during our [consultation on a market investigation reference](#) that there was now an insufficient number of competitors in some areas.
3. The CMA has reviewed a number of veterinary mergers since 2022. The CMA's merger control function assesses, on a prospective basis, whether the acquisition by one firm of another gives rise to competition issues. A market investigation also enables us to look at local markets, but it is a broader tool that allows us to assess a range of market situations including those which fall outside of merger control.
4. We have analysed the degree of local competition in first opinion practices, out of hours (**OOH**) care and referral centres. We do this in order to determine the number of sites which face a limited number of competitors such that they might be able to increase prices (or decrease quality) as a result of insufficient local competition. In order to evaluate the scope of any potential concentration issues, we have focused on sites that face three or fewer competitors.
5. Our analysis suggests that the supply of FOPs is not generally concentrated, with 85% of FOPs competing with at least three local rivals. However, there are some areas that are more concentrated, in particular:
 - (a) we identified 49 FOP sites which may not face competition from any other local providers, accounting for 1% of total sites;
 - (b) we identified 183 FOP sites that may face only one competing local provider, accounting for 5% of total sites; and
 - (c) we identified 292 FOP sites that may face two competing local providers (so these are areas with three providers in total), accounting for 8% of total sites.

6. FOPs are required to provide OOH cover to their clients, and this can either be done in-house, or outsourced to a third party. Our analysis of OOH care focuses on outsourced OOH provision and accordingly we have viewed FOPs as the customers and outsourced OOH providers as the suppliers.
7. Our analysis suggests that the provision of outsourced OOH care is more concentrated than the supply of FOPs, possibly because there is less demand and fewer suppliers which may be because OOH care is typically only accessed in emergencies. We identified 356 providers of outsourced OOH services, and of these, 69 (19%) face no local competitors and a further 88 (25%) face only one local competitor. In total this represents 44% of OOH sites.
8. Our analysis suggests that the vast majority (79%) of referral sites may compete with at least five other local suppliers. When we included referral centres that also do first opinion work as relevant sites, we observed that there were no monopoly areas and only five duopoly areas (out of 242), with 80% of areas having five, or more, competitors. Our analysis thus far has considered all referral centres as competitors, irrespective of the services they offer. Since a referral centre that specialises, for example, solely in oncology is unlikely to be a substitute for one that specialises solely in orthopaedics, this result could differ if we were to analyse each specialism individually, and there may be more areas with fewer competitors.
9. We are considering our next steps for this area of work and whether we should do further work to refine our assessments of local competitive conditions. We welcome views on the analysis in this paper.
10. We will set out our emerging views on possible remedies, including those that might look to address possible adverse effects on competition (**AEC(s)**) relating to the supply of veterinary services in local areas, in a working paper in Spring 2025. We will invite written comments on remedies at that time.

1. Introduction

- 1.1 In this working paper, we set out our approach to analysing the extent of local competition for FOPs, outsourced OOH providers and referral centres.¹ We then present our emerging views.
- 1.2 In each of these sectors, suppliers can choose the price, range of services offered and quality of service for an individual site, subject to meeting regulatory requirements, and there is scope for these to be varied across different geographic areas. Such variations may be in response to differences in demographic or demand factors, such as average salaries or income levels in the area, or supply side factors such as the number and strength of competitors or the ability to recruit and retain staff.
- 1.3 Since consumers must physically travel to a site to receive its services, the set of sites that consumers consider as substitutes will be limited by their willingness to travel. Accordingly, we are interested in both the size of local markets and the number of competitors operating in them.
- 1.4 FOPs and referral centres directly serve individual consumers who are responsible for choosing, sometimes with guidance from a vet, where they will receive care. Therefore, for these markets we are interested primarily in how far the substantial majority of consumers are willing to travel to visit a site. Since customer data is available, we are able to use this to estimate the size of the area from which a site draws most of its customers – the catchment area.
- 1.5 FOPs are required to provide OOH cover to their clients and this can either be done in-house, or outsourced to a third party. Where a FOP chooses to outsource OOH provision, it will enter into an arrangement with a third-party provider and direct its clients there when it is closed, commonly through an automated telephone message. Since FOPs choose to whom they outsource their OOH services, and sometimes pay a fee for this service, and we consider that consumers in most instances would follow the directions of their FOP, we have analysed the availability of outsourced OOH to FOPs. Accordingly, from the consumer perspective, we have viewed FOPs as the customers and outsourced OOH providers as the suppliers.²

¹ A veterinary practice or animal hospital that offers services accessed via a referral from one qualified vet to another and where such referral work forms a substantial part of the site's offering (ie they have Veterinary Hospital accreditation by RCVS or equivalent). Vets at a referral centre may have a particular specialism, and referral centres may, for example, offer specialist imaging, dentistry or complicated surgery.

² We recognise that individual consumers will have an independent relationship with an OOH if the consumer chooses to use the OOH's services.

1.6 In this paper we set out the methodology we have followed to analyse the extent of local competition for FOPs, OOH and referral centres. For each, we then present our emerging views.

2. First Opinion Practices

Introduction

- 2.1 In this section of the paper, we set out our analysis of local competitive conditions for FOPs in the UK.
- 2.2 We first set out how we have identified who offers first opinion services for small companion animals. We then set out our methodology for analysing the size of the local market, which gives us the area over which to calculate a measure of concentration. We follow by discussing which concentration metrics we have available and which we have used.
- 2.3 After setting out our methodology, we go on to present our emerging views, before then discussing further analysis which we may undertake. We set out our methodology in more detail in Appendix B.

Identifying small animal FOPs

- 2.4 We are interested in who the competitors are for a given FOP in each local market. This means we need to identify the competitor set. In this case, we are interested in the effective competitors for local FOPs providing veterinary care to small companion animals.
- 2.5 In the market for first opinion services, the competitor set comprises all commercial FOPs providing care to small companion animals during standard daytime hours. This includes small FOPs offering basic services, as well as veterinary hospitals and hubs which may provide other services alongside small animal first opinion services.
- 2.6 We excluded from the competitor set:
- (a) sites that provide other small animal veterinary services (such as OOH, referral, or telemedicine) where these sites do not also provide FOP services to small animals;
 - (b) charitable providers of veterinary services, as these are not commercial FOPs and they only serve particular customer groups (and hence are not an alternative provider for most consumers); and
 - (c) specialist sites that offer only a limited range of services (such as vaccination only centres, sites specialising in providing Animal Health Certificates for pet

travel, and sites focusing on small animal physiotherapy and pain management).³

- 2.7 These types of sites are unlikely to be substitutes for a FOP due to significant differences in the nature and scope of their services compared to a FOP. We explain in more detail in Appendix B why we have excluded these other providers.

Identifying the list of effective competitors

- 2.8 We were provided with a list of practices by the Royal College of Veterinary Surgeons (**RCVS**) at the start of the investigation,⁴ which included several different types of businesses, including (but not limited to) FOPs, referral centres, animal hospitals, farm and large animal practices and providers of complementary treatments.⁵
- 2.9 To identify the list of currently active small animal FOPs, we contacted each provider on the list with a request for information (**RFI**).⁶ We collected comprehensive information from the LVGs and larger independent groups. For the long tail of smaller practices (single site as well as smaller groups), we sent a voluntary request for information (**cross-market RFI**) and followed up with non-responders on multiple occasions.
- 2.10 We attained an overall response rate of just under 80% (as shown in Table 2.1 below), but there were around 1,000 independent practices which did not respond. This could be for a variety of reasons, including that the practice had closed, it did not treat small companion animals, or they chose not to engage with our information request.

³ For example, Jollyes, Pet Setters and Active Pet.

⁴ Vets need to register as individuals with the RCVS and in doing so often provide some information about the practice where they work. We understand that there is currently no reporting obligation on practices to supply information to the RCVS and as a result the information on practices is partial and may not be accurate.

⁵ To gather contact details we web scraped the RCVS website, which resulted in some additional practices being added to the original list.

⁶ We contacted all 5,425 veterinary sites on the RCVS Register, not solely those where the description includes that they treat small animals (3,318 sites) as this information is provided voluntarily by vet practices and may not be up-to-date.

Table 2.1 Response rate by type of FOPs

| <i>Party type</i> | <i>Number of sites in RCVS dataset¹</i> | <i>Number of sites for which we have received data</i> |
|--|--|--|
| Large Veterinary Groups | 2,829 ² | 2,782 |
| Independent chains and single-site practices | 2,401 | 1,433 (60%) ³ |
| Charities | 80 | 65 |
| Total | 5,425 | 4,280 (79%) |

Source: CMA analysis of data collected from RCVS and FOPs.

Notes: ¹This list includes some sites that do not provide FOP services, or treat small animals, as well as sites that have closed recently, while it may not include recently opened sites. ²The LVGs have provided lists of all of their sites, and therefore there are no sites missing for LVGs. ³The response rate for small animal FOPs is likely to be higher, as some non-respondents likely do not provide FOP services or treat small animals.

2.11 Of the 4,280 veterinary sites that provided data in response to our request for information, 3,704 sites (87%) provide commercial FOP services to small animals. We refer to these sites as ‘confirmed practices’. The remaining 13% are a mixture of sites that specialise in providing small animal specialist referral, farm or equine only services, other small animal veterinary services and/or other veterinary services, sites that do not offer FOP services, and sites that we removed as part of data processing.⁷ We present some descriptive statistics for the FOPs in our dataset in Appendix A (including opening times, size of practice and treatments offered). Our data processing methodology is outlined in Appendix B.

Unconfirmed and duplicate sites

2.12 We marked any sites that did not respond to our information gathering as ‘unconfirmed sites’. We note that the RCVS list omitted some sites which we confirmed were active through our information requests, and included some which we were told were not active and/or small animal FOPs.

2.13 We requested data from two insurance companies [X] on insurance claims made by their customers which includes information on the practice in which the animal was treated. This data includes the name and address of the practice that treated a given animal. There is significant duplication within each of the insurance datasets, which means that in total there are around 2,000 ‘sites’ in the combined insurance data set that do not appear in the RCVS dataset in the same form. We believe that some of these will be omissions from the RCVS list, but the majority

⁷ A small number of sites (6) told us that they do not offer any veterinary services.

will be duplicates with the name, or postcode, for a given practice being slightly different in different datasets.

- 2.14 Based on these two datasets, we currently have a total of 2,605 unconfirmed and / or duplicate sites (we refer to these as unconfirmed sites):
- (a) 1,025 from RCVS; and
 - (b) 1,580 from the insurance data.
- 2.15 We are in the process of identifying and removing duplicates from these lists. For the insurance data, we are also seeking to identify whether any of the sites are already present in our confirmed practice list in a different form (for example, where there is an error in name or postcode).

Conclusion on list of small animal FOPs

- 2.16 Our practice list contains details of all confirmed practices (3,704) as well as a list of 2,605 unconfirmed sites (1,025 from RCVS and 1,580 from the insurance data). In our initial analysis we included only the 3,704 confirmed sites.
- 2.17 We are considering what further analysis we could undertake to assess local concentration that includes unconfirmed sites. This could include:
- (a) adding any unconfirmed sites to catchment areas where our initial analysis, based on confirmed sites, indicates that there could be high concentration and taking measures to solicit information from these practices to determine whether they are active FOPs offering small companion animal veterinary services (through a combination of desk research and contacting the sites);
 - (b) conducting an additional check on whether any of the areas centred around unconfirmed sites raise potential competition concerns. This could involve assessing whether these unconfirmed sites are active FOPs offering small companion animal veterinary services if the unconfirmed site is at the centre of any catchment areas that appear highly concentrated. Where this is the case, we could add any additional unconfirmed sites in the catchment area and gather information on these; and
 - (c) verifying whether each unconfirmed site is an active FOP, such that all sites are either confirmed or excluded.

Geographic market

- 2.18 The first step in our local analysis was to work out the geographic area over which a FOP competes for customers. We refer to this as the geographic market.

- 2.19 A properly defined local geographic market would encompass the area over which a hypothetical monopolist could profitably raise prices by a small but significant amount.⁸ This is often defined as encompassing the area from which a site draws the majority of its customers.
- 2.20 Since customers must travel to visit a FOP (and transport their pet), the further a consumer is located from a focal site, the greater the travel cost a consumer will incur to visit that site. At a certain distance from the focal site, the customer will view alternative sites as substitute sites and a hypothetical monopolist would not be able to increase prices to them without the customer switching away.
- 2.21 The CMA has used catchment areas as a pragmatic approximation of the geographic market in many previous markets and mergers cases.⁹ A catchment area is calculated based on the location of a supplier's customers. In the past five years the CMA has conducted a number of phase 1 merger reviews into veterinary practice acquisitions, including:
- (a) CVS / The Vet, the CMA calculated site-specific drive time catchment areas that captured 80% of customers for each site, it then calculated a simple average for each party.¹⁰
 - (b) VetPartners / Goddards, the CMA calculated site-specific drive time catchment areas that captured 80% of revenue for each site, it then calculated a simple average for each party.¹¹
 - (c) IVC / multiple independent practices, the CMA calculated site-specific drive time catchment areas that captured 80% of revenue for each site, it then calculated a simple average for each party.¹²
 - (d) Medivet Group Limited / multiple independent veterinary businesses, the CMA calculated site-specific drive time catchment areas that captured 80% of customers for each site, it then calculated a simple average for each party.¹³
- 2.22 We present the results of our catchment area analysis as the drive time that encompasses 80% of the closest customers (based on drive times) for different

⁸ The test involves asking if a hypothetical monopolist could profitably increase prices by a small but significant amount and keep that increase in place for a significant period of time. This is known as a small but significant and non-transitory price increase (SSNIP). For more information see [Market Definition Guidelines](#), OFT 403, paragraph 4.2

⁹ See, for example, [Retail Mergers Commentary \(CMA62\)](#), 10 April 2017, paragraph 2.1. Also see [IVC/Multiple independent practices](#), [VetPartners/Goddard](#), and [CVS/The Vet](#).

¹⁰ CVS/The Vet, paragraph 110.

¹¹ VetPartners/Goddards, paragraph 130.

¹² IVC/Multiple independent practices, paragraph 144.

¹³ [Medivet Group Limited / multiple independent veterinary businesses](#), paragraph 153.

types of urban and rural locations (80% drive time catchment area).¹⁴ See Appendix B for a fuller description of our methodology.

Sources of customer location data

2.23 We have two sources of customer data, both of which have certain limitations:

- (a) We requested site level customer data from the LVGs. This covers all customers within each practice and is available for almost all LVG owned or co-owned sites. However, we did not consider it practical to attempt to collect site level data from the several thousand independent practices.¹⁵ Thus site level data gives good coverage for LVGs but does not cover any independent practices; and
- (b) We obtained insurance claims data from two insurers [X] which covers insured customers who have made claims at different types of vet practice including both LVG and independent practices, and thus covers most vet practices. However, it only includes a limited number of observations (that is, claims) from each site. Comparing the insurance data with data from LVGs we can observe that the insurance data captures around [X]% of total LVG turnover.¹⁶

2.24 We used the insurance data to estimate catchment areas as this captures both LVG and independent practices.

Methodology for calculating catchment areas

2.25 We provide a brief summary of our methodology here. More detail is provided in Appendix B.

2.26 We used insurance data, which contained information on the name and location of both the customer and the practice where the pet was treated. We combined this with data from the ONS, which classifies areas as (different types of) Urban or Rural depending on their population density. This allowed us to assign each FOP to one of the 10 urban/rural classifications.¹⁷

2.27 We aggregated some of the ONS classifications for urban and rural as the data shows that catchment areas are similar for a number of different categories, and in

¹⁴ See, for example, Retail Mergers Commentary (CMA62), 10 April 2017, paragraph 2.20 and VetPartners/Goddards paragraph 126.

¹⁵ To collect customer data from independent practices we would need to send over 1,000 s174 notices and collate and process the data, which may be presented in different ways.

¹⁶ [X]

¹⁷ There are slightly different classifications in England and Wales from those in Scotland and Northern Ireland, with 10 different classifications in England and Wales (ONS Postcode Directory User Guide August 2024 p18) and 8 in Scotland and Northern Ireland (ONS Postcode Directory User Guide August 2024 p15).

some of the rural categories there were only a limited number of observations. Therefore, we aggregated the categories as follows, separately for each of England & Wales, Scotland and Northern Ireland:

- (a) urban: settlements of 10,000 people and over.
- (b) small town and accessible rural: settlements of up to 9,999 people, and within a 30-minute drive time of a Settlement of 10,000 people or more.
- (c) rural: settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes – but less than or equal to 60 minutes – to a Settlement of 10,000 people or more.
- (d) very rural: settlements with a population of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 people or more; and areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a Settlement of 10,000 people or more.

2.28 Since this data included only a limited number of observations for each practice, we were not able to calculate the 80% drive time catchment area for each individual site and then average these across each urban/rural classification. Instead, we pooled the insurance data, assigned each practice/customer pair to an urban/rural classification, based on the location of the practice, and calculated the 80% drive time based catchment area for each classification.¹⁸ We consider that the sample of insurance data is large enough that the average catchment area for each classification will be analogous to those calculated using site specific data. We are considering using a sample of site level customer data provided by the LVGs to test this.

2.29 Catchment area drive times, rounded to the nearest minute, are given in Table 2.2 below.

¹⁸ Catchment areas were calculated using drive times (using ArcGIS software), rather than straight-line distances. A drive time measures how long it takes a person to drive from an origin point to a destination point. Unlike straight-line distances, they can account for natural features that limit travel, such as rivers or mountains (which would have specific crossing points).

Table 2.2: Catchment areas based on drive times for 80% of customers (to nearest minute)

| | England & Wales | Scotland | Northern Ireland* |
|---------------------------------|-----------------|----------|-------------------|
| Urban | 17 | 17 | 19 |
| Small Town and Accessible Rural | 20 | 19 | 19 |
| Rural | 29 | 25 | |
| Very Rural | 30 | 45 | |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

Notes: *A very small number of areas in NI fall into the Rural or Very Rural categories. As the number of observations we had for these areas was too low to obtain reliable estimates of drive times, we have included these areas in the Small Town and Accessible Rural category for NI. We note that the drive time calculated for the Small Town and Accessible Rural category is of a comparable magnitude to those in England & Wales and Scotland.

Other evidence on catchment areas

2.30 We also analysed internal documents, to identify whether there was any evidence that suggested how large catchment areas are, particularly in the context of entry, exit, or acquisition. This evidence is consistent with our analysis of the insurance data, described in more detail in Appendix B paragraph 7.2961, in particular:

- (a) internal documents provided by LVGs relating to acquisitions and closures of FOPs look at the presence of competitors and local demographics within a distance of 12 to 40min and/or 5 to 15 miles of a focal site.
- (b) employment contracts and/or Joint Venture Agreements contain restrictive covenants, commonly non-compete and non-solicitation clauses, which apply for a set period of time and a radius around a site (or multiple sites). Across the documents we have seen, the period ranges from 6 months to 5 years and the radius ranges from 6 to 25 miles, though this varies between LVGs.

Concentration metrics

2.31 A concentration metric is a measure that gives an indication of the number of competitors in a local market and can also indicate their relative strength. Concentration metrics include the number of different providers competing with each other ('fascia counts') and market shares, which can be based on capacity (for example share of sites or share of vets), revenue or another variable.

2.32 When assessing the degree of competition in each local market across the UK, the concentration metric needs to have broad coverage and ideally be readily measurable for all areas. This creates a trade-off between the quality of the concentration measure and the coverage, as the highest quality measures often have the lowest coverage.

2.33 In this investigation we have access to information on ownership for all sites and gathered more detailed information for a large proportion of the market, but we do not have universal coverage. Therefore, we have considered which core

concentration metrics we can use – these are measures which we can observe for all sites – and which additional metrics we might also use.

2.34 We note that in recent merger investigations in the veterinary sector the CMA has calculated a share of capacity measure such as the share of full time equivalent (FTE) vets in the area.¹⁹ This required gathering information from the majority of sites and making an assumption about those for whom data was not available. We have gathered information on the number of FTE vets from around 80% of practices (see paragraph 2.10), since we do not have as broad coverage with this measure as with a fascia or a site count, we may consider using it only as a secondary filter (as described in paragraph 2.48).

Core concentration measures

2.35 The CMA often uses a count of the number of providers competing in a local market to measure concentration. Such fascia counts have been used in numerous markets and mergers investigations across a wide range of sectors.²⁰

2.36 Although fascia counts may be most appropriate in cases where consumers can observe site ownership and choose between different owners, they are also informative where brand is either not important to, or not observable by, consumers. This is because we would expect competition to be more intense in markets with a greater number of independent suppliers as there are more parties to instigate or amplify a competitive response, even if ownership is not observable by consumers.

2.37 Market shares based on the ownership of stores, or sites, are an alternative readily observable measure that has been used in a number of merger investigations. Using a share of sites measure has some advantages over a fascia count, as it can give an indication of the relative size of each fascia (that is, of the different players in a market). However, there are two principal weaknesses of using share of sites measures in this context:

(a) the capacity of a vet clinic will be related to factors such as the number of consultation rooms and FTE vets the practice has at its disposal. We know that FOPs differ markedly in size from small clinics to large veterinary hospitals. Since share of sites measures are unable to account for site capacity, it does not necessarily add much to a fascia count.

(b) in a merger review, a share of sites measure can easily be calculated as the aim is to establish the merging parties' share of total sites in an area. In a market investigation, we are interested in whether there is sufficient

¹⁹ See VetPartners / Goddards paragraph 135.

²⁰ See, for example, Retail Mergers Commentary (CMA62), 10 April 2017, paragraph 3.22.

competition in any area; hence we are interested in the share of each party present in an area. For instance, an area where there are three parties with 33% each is likely to be more concerning than an area where there is one party with 33% and many with shares under 20%. Therefore, in order for a share of sites measure to add value, we would need to calculate a concentration metric such as HHI²¹ or CR4.²²

- 2.38 We have used a fascia count as this gives a metric that is appropriate for assessing market-wide concentration and is easy to interpret. We are considering what other concentration metrics we could feasibly use in addition to this metric, and which would significantly improve our assessment (discussed further in paragraph 2.46).

Interpretation of fascia count

- 2.39 When analysing local concentration, we have two related aims. First, we want to gain insight into the competitive conditions in different parts of the UK. Second, we want to identify whether there are any areas within the UK where there is insufficient competition.
- 2.40 In interpreting a fascia count, in general the more fasciae present in an area, the more competitive it is likely to be. This is because there will be more firms to both initiate a competitive process and, once initiated, continue to exert competitive pressure and drive down price or improve quality. In order to gain a broad overview of competitive conditions across the UK, we have counted the number of fasciae in each catchment area around a focal site.
- 2.41 In some areas there will be fewer fasciae, which could be for a variety of reasons. This could either be because there are few FOPs overall (for example there may be insufficient demand to sustain more than one FOP) or because, while there may be sufficient demand to support multiple FOPs, they are all operated by the same provider.
- 2.42 When assessing a large number of local areas, it is common practice for the CMA to focus on a sub-set of these areas, for example by applying a preliminary filter. This screening filter is used to identify the areas where there are sufficient competitors that there is no prospect of competition concerns arising from concentration levels. The CMA can then rule out further analysis in these areas. In

²¹ The Herfindahl–Hirschman Index (HHI) is a common measure of market concentration of an industry - the size of firms in relation to the industry they are in - and is used to determine market competitiveness. It is calculated by squaring the market share of each competing firm in the industry and then summing the resulting numbers.

²² The four-firm concentration ratio (CR4) is an economic metric that measures the market share of the four largest companies in an industry by summing their market shares.

the remaining areas, the CMA will commonly conduct further analysis to determine whether competition concerns arise.

- 2.43 In market investigations the CMA has followed different practices depending on the specifics of the market in question. For instance:
- (a) in the Grocery Market Investigation, the Competition Commission focused on those local markets with three or fewer fasciae in total, where one of those fasciae had a share of local grocery sales area that was greater than 60% within a 10- or 15-minute drive-time.²³
 - (b) in the Private Healthcare Market Investigation, the CMA identified a hospital as being of potential concern if either of the following conditions was met: (a) the weighted average market share of patients and/or the weighted average market share of revenue was below 0.6; or (b) fascia count (set of 16 specialties) and/or fascia count (oncology) was equal to or below 1, that is there were one or zero competitors within the hospital's catchment area.²⁴
 - (c) in the Funerals Market Investigation,²⁵ the CMA carried out a filtering exercise to determine whether there might be significant local concentration concerns. It found that:
 - (i) the vast majority (93%) of funeral director branches were in catchment areas with four or more fasciae;
 - (ii) the funeral director branches in areas with three or fewer fasciae were disproportionately in rural areas compared with the total funeral director branch population in the dataset; and
 - (iii) for those funeral director branches in catchment areas with three fasciae, 74% of the funeral director branches had a nearest rival fascia within a 5-minute drive time (increasing to 86% within 10 minutes).
- 2.44 The CMA has conducted a relatively greater number of merger investigations involving local markets, from which we can draw more generalised views. The CMA has typically either used a four to three fascia count or a five to four fascia count as a preliminary filter depending on the specifics of the case in question.²⁶ Therefore, the most cautious fascia count filter commonly applied in merger cases has identified areas as potentially problematic when there are four or fewer fasciae remaining.

²³ [Competition Commission, Grocery Market Investigation, 2008](#) - see para 6.13).

²⁴ See [Private Healthcare Market Investigation](#) paragraph 6.154 – 6.157.

²⁵ See [Final report](#) – see paragraph 4.49.

²⁶ See [Retail Mergers Commentary](#) paragraph 3.35.

- 2.45 We focused our assessment on areas with four or fewer fasciae, this meant identifying areas where the focal site only faces zero, one, two or three competing providers.

Additional concentration metrics

- 2.46 We may review additional metrics at a later stage of our analysis. We have some data derived from our cross-market RFI, which collected information on various characteristics of each site. Due to a lower response rate among independent practices, we may need to gather additional data.
- 2.47 We collected data which relates to the services provided and capacity of each site, including: opening hours, the number of consulting rooms, operating theatres, number of FTE vets, veterinary services provided at the site, and type of in-clinic diagnostic equipment. Calculating concentration measures based on these metrics would enable us to better consider the strength of competitive constraint that is imposed on a focal site in areas with fewer fasciae. For example, sites with more FTE vets might exert a stronger competitive constraint.
- 2.48 We are considering using share of FTE vets or share of consultation rooms to further assess competition in areas that do not pass our initial filter, or a subset of them where concentration appears to be particularly high. We may use additional metrics for further analysis in areas where potential competition concerns remain once we have taken account of capacity.

Emerging findings

Initial results for confirmed practices

- 2.49 We outline below our initial results when analysing the number of fasciae in each local area. As set out in paragraph 2.11, these initial results are based on the 3,704 sites we have confirmed are operating as FOPs supplying services to small companion animals.²⁷ These initial results do not include (as either focal sites or competitors) any unconfirmed or duplicate sites.
- 2.50 Since our initial results do not yet include any unconfirmed sites, there are likely to be additional fasciae present in some areas which will increase the fascia counts – if this occurs some areas will be less concentrated than our analysis suggests. Conversely, there may also be some additional concentrated areas captured by our secondary filter (centred on unconfirmed sites), if the unconfirmed site is an active FOP and the area is concentrated (see paragraph 2.71).

²⁷ We note that a small number of sites would not geocode in ArcGIS (the mapping software) so are currently omitted from the analysis

2.51 A count of the total number of fasciae in the area around each focal FOP is shown in Table 2.3 below. Overall, the majority of FOPs face competition from multiple fasciae, with 85% of areas containing at least four fasciae. There are some areas that are more concentrated; in particular:

- (a) We identified 49 FOP sites which may not face competition from any other providers within their catchment area ('monopoly sites'). This accounts for 1% of total sites;
- (b) We identified 183 FOP sites that may face only one competing fascia (the 'duopoly areas') accounting for 5% of total sites; and
- (c) We identified 292 FOP sites that may face two competing fasciae (so these are areas with three providers in total), accounting for 8% of total sites.

Table 2.3: Count of total number of fasciae in the catchment area

| <i>Number of fasciae</i> | <i>Count of focal FOP sites</i> | <i>Percentage of FOP sites</i> |
|--------------------------|---------------------------------|--------------------------------|
| 1 | 49 | 1% |
| 2 | 183 | 5% |
| 3 | 292 | 8% |
| 4 | 334 | 9% |
| 5 | 496 | 14% |
| 6 | 627 | 17% |
| 7+ | 1668 | 46% |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS.

Possible monopoly areas

2.52 Our initial analysis has identified a total of 49 areas that may be monopolies. Figure 3.1 below shows the 49 possible monopoly areas (with each focal FOP site represented by a red or blue dot) on a map of the UK. As shown in the figure, these areas are spread across the UK, though it is worth noting that the majority of monopoly areas appear to be in coastal areas or on islands. It is possible that FOPs in such locations may draw customers from further away than average and may face competition from other fascia that lie outside of the average catchment areas we have used.

Figure 2.1: Areas in the UK where there is a count of one fascia



Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS.

2.53 An area may be a monopoly because there is only a single site in the area (shown as red dots in Figure 2.1), or because there are multiple sites, but they are under common ownership (shown as blue dots).

2.54 Of the 49 monopoly areas, there are 24 where the owner of the focal site owns at least one additional site in the focal site's catchment area. However, we note that since our analysis is centred on sites these areas may either overlap with, or be

adjacent to, each other. For instance, if there are three branches of company A in a town that all lie within each other's catchment area, when we centre on each, we may find that each is a monopoly with two other branches of company A in the catchment area. However, if we were to define our geographic market as the town and centre on that rather than individual sites, we would only find a single monopoly. This means that site-based measures can overstate the number of problematic areas.

2.55 Table 2.4 below shows the breakdown of these 24 areas: in 14 areas the owner of the focal FOP site owns one additional FOP site, in six areas the owner of the focal site owns two additional sites, and in four areas the owner of the focal sites owns four or more additional sites.

Table 2.4 Multi-site ownership in monopoly areas, by number of FOP sites owned

| <i>Additional FOP sites with same ownership</i> | <i>Number of focal FOP sites</i> |
|---|----------------------------------|
| 0 | 25 |
| 1 | 14 |
| 2 | 6 |
| 3 | 1 |
| 4 | 2 |
| 5 | 0 |
| 6 | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

2.56 Table 2.5 below shows the ownership of the 24 focal FOP sites where the owner of the focal site owns at least one additional FOP site in the focal site's catchment area. Most of these focal sites (17) are owned by LVGs (12 are owned by [redacted], four are owned by [redacted] and one by [redacted]). Seven of these focal sites are owned by four different independent vet groups with multiple sites.

Table 2.5 Multi-site ownership in monopoly areas, by owner

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| LVG [redacted] | 12 |
| LVG [redacted] | 4 |
| LVG [redacted] | 1 |
| INDEP [redacted] | 3 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 1 |
| INDEP [redacted] | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

Possible duopoly areas

2.57 We have identified a total of 183 areas that may be duopolies. Figure 2.2 below shows the 183 possible duopoly areas on a map of the UK, with each focal FOP site which faces one other competitor in its catchment area represented by a red or blue dot. As shown in the figure, these areas are spread across the UK, with few in London and its surrounding counties.

Figure 2.2: Areas in the UK where there is a count of two fascia



Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

- 2.58 An area may be a duopoly because there are two sites in the area (shown as red dots in Figure 2.2), or because there are multiple sites, but they are under the ownership of two parties (shown as blue dots).
- 2.59 Of the 183 duopoly areas, there are 106 where the owner of the focal FOP site owns at least one additional FOP site in the focal site's catchment area, as shown in Table 2.6 below. In 46 areas the owner of the focal site owns one additional site, in 27 areas the owner of the focal site owns two additional sites, in 16 areas the owner of the focal site owns three additional sites and in 17 areas the owner of the focal site owns four or more additional sites.

Table 2.6 Multi-site ownership in duopoly areas, by number of sites owned

| <i>Additional FOP sites with same ownership</i> | <i>Number of focal FOP sites</i> |
|---|----------------------------------|
| 0 | 77 |
| 1 | 46 |
| 2 | 27 |
| 3 | 16 |
| 4 | 9 |
| 5 | 7 |
| 6 | 0 |
| 7 | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

- 2.60 Table 2.7 below shows the ownership of the 106 focal sites where the owner of the focal site owns at least one additional site in the focal site's catchment area. Most of the sites (92) are owned by LVGs: 55 sites are owned by [redacted]; 18 are owned by [redacted]; eight are owned by [redacted]; [redacted] and [redacted] own five each, and [redacted] owns one. There are 14 focal sites owned by nine different independent vet practices.

Table 2.7 Multi-site ownership in duopoly areas, by owner

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| LVG [redacted] | 55 |
| LVG [redacted] | 18 |
| LVG [redacted] | 8 |
| LVG [redacted] | 5 |
| LVG [redacted] | 5 |
| LVG [redacted] | 1 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 2 |
| INDEP [redacted] | 1 |
| INDEP [redacted] | 1 |
| INDEP [redacted] | 1 |
| INDEP [redacted] | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

Areas with three fasciae

2.61 Our analysis has also identified 292 areas where there is a count of three fasciae. Figure 2.3 below shows these areas on a map of the UK, with each focal FOP site that faces two other brands in its catchment area represented by a red or blue dot. As expected with a higher fascia count, the figure shows that these are spread evenly across the UK.

Figure 2.3 Areas in the UK where there is a count of three fasciae



Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

2.62 An area may have three competitors because there are only three sites in the area (shown as red dots in Figure 2.3), or because there are multiple (more than three) sites, but they are under the ownership of three parties (shown as blue dots).

2.63 Of the 292 areas with three fasciae, there are 185 where the owner of the focal FOP site owns at least one additional FOP site in the focal site's catchment area. Table 2.8 below shows the breakdown of the 185 areas: in 82 areas, the owner of the focal site owns one additional site. In these areas, and all others in the table, there is scope, in principle, to increase the number of fasciae in the area from three to four.

Table 2.8 Multi-site ownership in areas with three fasciae, by number of sites owned

| <i>Additional FOP sites with same ownership</i> | <i>Number of focal FOP sites</i> |
|---|----------------------------------|
| 1 | 82 |
| 2 | 41 |
| 3 | 24 |
| 4 | 15 |
| 5 | 7 |
| 6 | 5 |
| 7 | 2 |
| 8 | 7 |
| 9 | 1 |
| 10 | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

2.64 Table 2.9 below shows the ownership of the 185 focal FOP sites where the owner of the focal site owns at least one additional FOP site in the focal site's catchment area. Most of the sites (163) are owned by LVGs: 97 sites are owned by [redacted]; 20 are owned by [redacted]; 16 are owned by [redacted]; 14 are owned by [redacted]; 12 are owned by [redacted], and three are owned by [redacted]. 22 sites are owned by 15 different independent vet practices.

Table 2.9 Multi-site ownership in areas with three fasciae, by owner

| Ownership | Number of focal sites where the owner has additional sites in the catchment area |
|--------------|--|
| LVG [X] | 97 |
| LVG [X] | 20 |
| LVG [X] | 16 |
| LVG [X] | 14 |
| LVG [X] | 12 |
| LVG [X] | 4 |
| Independents | 22 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [X], Insurer 2 [X], ArcGIS and ONS

Areas with four fasciae

2.65 We have identified a further 334 areas where there is a count of four fasciae. Figure 2.4 below shows the focal FOP sites which face three competing fasciae in their catchment areas on a map of the UK, with each focal site represented by a red or blue dot. As the figure shows, these focal sites are spread evenly across England, Wales and Northern Ireland with grouping around larger cities in Scotland.

Figure 2.4 Areas in the UK where there is a count of four fascia



Source: CMA analysis of data collected from FOPs, Insurer 1 [X], Insurer 2 [X], ArcGIS and ONS

2.66 An area may have four competitors because there are only four sites in the area (shown as red dots in Figure 2.4), or because there are multiple sites, but they are under the ownership of four parties (shown as blue dots).

2.67 Of the 334 areas with four fasciae, there are 206 where the owner of the focal FOP site owns at least one additional FOP site in the focal site's catchment area. Table 2.10 below shows the breakdown of the 206 areas: in 66 areas, the owner of the focal site owns one additional site, and in 60 areas the owner owns two additional sites. In these areas, and all others in the table, there is scope, in principle, to increase the number of fasciae in the area from four to five.

Table 2.10 Multi-site ownership in areas with four fasciae, by number of sites owned

| Additional FOP sites with same ownership | Number of focal FOP sites |
|--|---------------------------|
| 1 | 66 |
| 2 | 60 |
| 3 | 39 |
| 4 | 12 |
| 5 | 11 |
| 6 | 8 |
| 7 | 6 |
| 8 | 2 |
| 9 | 1 |
| 10 | 1 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [X], Insurer 2 [X], ArcGIS and ONS

2.68 Table 2.11 below shows the ownership of the 206 focal FOP sites where the owner of the focal site owns at least one additional site in the focal site's

catchment area. Most of the focal sites (185) are owned by LVGs: 83 sites are owned by [redacted]; 26 sites are owned by [redacted]; 22 sites are owned by [redacted]; 22 sites are owned by [redacted]; 20 sites are owned by [redacted], and 12 are owned by [redacted]. There are 21 focal sites that are owned by 17 different independent vet practices.

Table 2.11 Multi-site ownership in areas with four fasciae, by owner

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| LVG [redacted] | 83 |
| LVG [redacted] | 26 |
| LVG [redacted] | 22 |
| LVG [redacted] | 22 |
| LVG [redacted] | 20 |
| LVG [redacted] | 12 |
| Independents | 21 |

Source: CMA analysis of data collected from FOPs, Insurer 1 [redacted], Insurer 2 [redacted], ArcGIS and ONS

Summary of initial analysis and next steps

- 2.69 Our initial analysis of confirmed sites has therefore identified a total of 858 focal sites (22% of confirmed practices) which face three or fewer rival fasciae in their catchment areas (so there are four or fewer fasciae in the catchment areas when including the firm that owns the focal site). 49 of these are potential monopoly areas where there may be no competition.
- 2.70 We are considering the following further steps to identify whether these areas are in fact highly concentrated and the strength of any out of (geographic) market constraint.
- (a) Verify the location of sites in concentrated areas and correct for any geocoding errors.
 - (b) Identify whether there are any additional unconfirmed sites (that is, ones which were not in our initial data set because they did not respond to our information request) within these catchment areas.²⁸
 - (c) Explore whether there are any FOPs just outside the calculated catchment areas which may exert a competitive constraint.
 - (d) Analyse area-specific data on customer location to see how far customers in that area travel in order to assess to what extent FOPs in this area compete over a wider area than the average catchment area we have currently used. For this analysis we could use insurer data from [redacted] and [redacted] and LVG customer data which we already have, and we could also request customer lists from independent FOPs in the area.

²⁸ We have received locations of all corporate-owned sites, and therefore only independent sites could be missing from our dataset.

Further analysis of unconfirmed and duplicate sites

- 2.71 As set out in paragraph 2.12 there is a large number of unconfirmed and duplicate sites, comprising sites which are included in the RCVS dataset but which have not responded to our cross-market RFI, as well as significant duplication between the insurer datasets. Some of these unconfirmed and duplicate sites will be active small companion animal FOPs, while others may offer other types of veterinary care and/or treat different types of animals, may be closed or will simply be duplicates or errors in the data.
- 2.72 We intend to conduct further work to verify whether these unconfirmed sites are active FOPs supplying services to small companion animals, and if so, we will include them in our confirmed practice list. We will then update our filtering to include these sites. We are considering using the following resources to identify whether a practice is active:
- (a) Desk research looking to see if there is an active website that has been updated in the last year (or similar evidence);
 - (b) Interrogation of insurance data to see if the site is submitting insurance claims in the last year;
 - (c) RFIs or s174 notices.
- 2.73 We would welcome further information on any unconfirmed sites in areas with four or fewer fasciae.

Effect of local concentration on outcomes

- 2.74 We are currently considering what, if any, analysis we may undertake in to order to determine if local concentration has an effect on price or other outcomes.

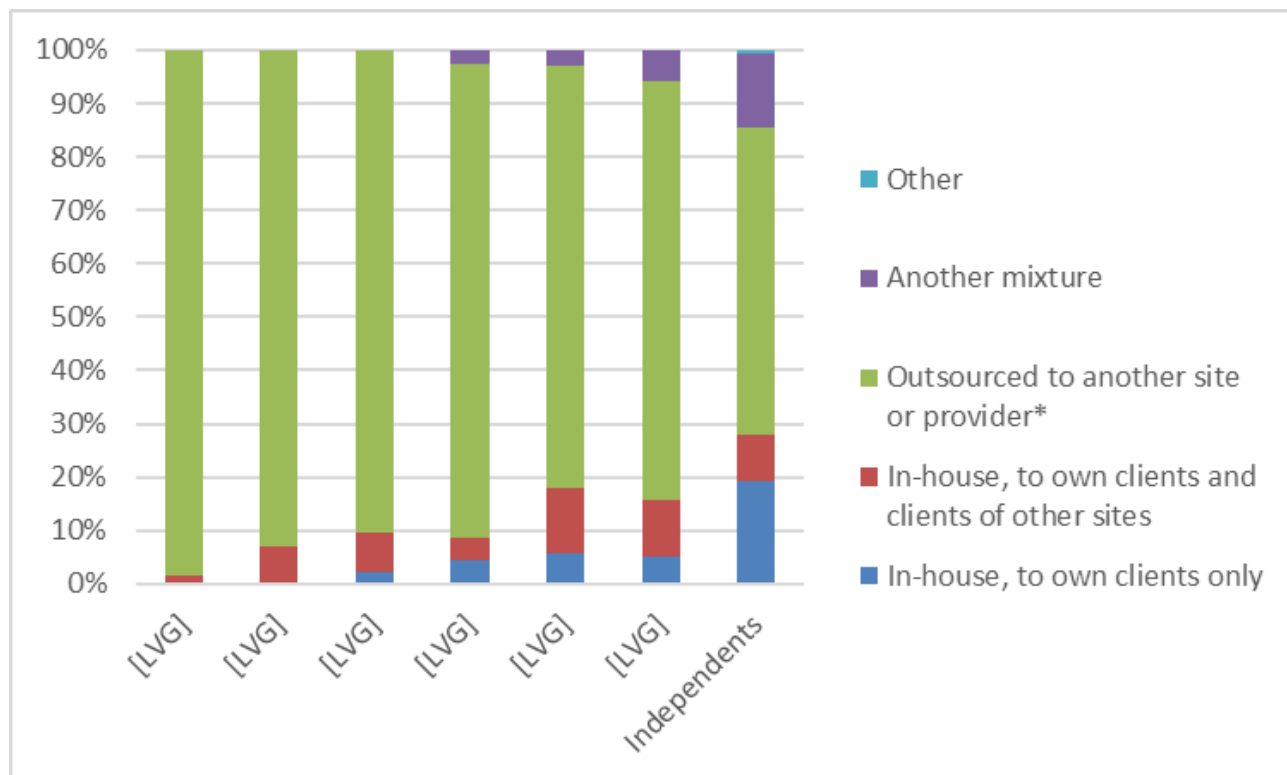
3. Out of Hours sites (OOH)

Introduction

- 3.1 All veterinary sites which treat animals during standard opening hours are required to have arrangements for 24-hour emergency cover. In particular, under the RCVS Code of Professional Conduct, veterinary surgeons have professional responsibilities relating to the provision of 24-hour emergency cover to pets under their care.²⁹ This requirement applies to all practising vets, including those working in FOPs, charitable veterinary practices, neutering and vaccination clinics, teaching sites and referral centres.
- 3.2 Veterinary sites can arrange their OOH provision in a number of ways, including:
- (a) Providing OOH care at their site, by existing staff that do a mix of standard hours and OOH shifts;
 - (b) Providing OOH care at their site using specific OOH staff; and
 - (c) Outsourcing OOH care to another provider.
- 3.3 As set out in paragraphs 2.8 to 2.11, we have obtained data from 3,704 FOPs in the UK, which includes information on how they provide their OOH services. As shown in Figure 3.1, the majority of FOPs (80%) outsource OOH provision to another site (either a specialist OOH provider, or another FOP), this includes sites which outsource to other sites within the same group. The percentage of FOPs that outsource OOH provision to another site or provider is higher for LVGs (78% to 98%) than for independent FOPs (58%).

²⁹ [RCVS code of professional conduct for veterinary surgeons.](#)

Figure 3.1 OOH arrangements, separately for each LVG and aggregated for independents



Source: CMA analysis of data responses collated through RFIs.

Note:

*Includes sites which outsource to other sites within the same group.

¹The LVGs are ordered from highest to lowest percentage of outsourcing.

²FOPs were asked the following question:

Which of the following best describes your veterinary site's approach to providing Out of Hours (OOH) emergency cover?

- Provided in-house (i.e. at the site by your own staff), for clients of this site only
- Provided in-house, to clients of this site and clients of other sites or providers (through formal arrangement)
- Outsourced to another site or provider
- A mixture whereby the site generally covers its own OOH work for most hours / days / animals and uses another site or provider for the remaining emergency cover
- Another mixture
- None of the above (displayed as 'Another arrangement').

182 respondents did not provide a response to this question and are thus not included in the chart. 68 respondents selected more than one response and are counted more than once in the chart.

3.4 In Table 3.1, we removed any LVG sites that outsource to another LVG site within the same group (for instance, any IVC site that outsources its OOH to another IVC practice or Vets Now). The majority 60-70% [X] of those outsourcing to a third-party use an LVG [X] as their OOH care provider. Another 8% use another LVG [X] and 10% of FOPs use independent OOH providers.

Table 3.1: Number of FOPs outsourcing OOH provision, by OOH provider, excluding self-supply

| OOH Provider | Number of FOPs | Percentage of FOPs |
|------------------|--------------------|--------------------|
| [LVG] [REDACTED] | 50-100 [REDACTED] | 5-10% [REDACTED] |
| [LVG] [REDACTED] | 700-800 [REDACTED] | 60-70% [REDACTED] |
| [LVG] [REDACTED] | 50-100 [REDACTED] | 5-10% [REDACTED] |
| [LVG] [REDACTED] | 0-50 [REDACTED] | 0-5% [REDACTED] |
| [LVG] [REDACTED] | 50-100 [REDACTED] | 5-10% [REDACTED] |
| [IND] [REDACTED] | 0-50 [REDACTED] | 0-5% [REDACTED] |
| [IND] [REDACTED] | 100-200 [REDACTED] | 10-20% [REDACTED] |

Source: CMA analysis of data responses collated through RFIs.

Notes:

1. The table contains analysis based on responses received from small animal FOPs and mixed practices.
2. The table includes FOPs that provide OOH care offsite to another OOH care provider that is not part of the same group.

3.5 Where a FOP chooses to outsource OOH provision, it will enter into an arrangement with a third-party provider and direct its clients there when it is closed, commonly through an automated telephone message and/or information on its website. Our [pet owners survey](#) found that over 70% of consumers follow the directions of their FOP when seeking OOH care, whereas only 19% found an OOH provider ‘through their own search’.³⁰ We found that FOPs:

- (a) choose to whom they outsource their OOH services; and,
- (b) sometimes pay a fee for this service.

3.6 Therefore, we have analysed the availability of outsourced OOH to FOPs and have viewed FOPs as the customers and outsourced OOH providers as the suppliers.

How FOPs contract with OOH providers

3.7 When a FOP chooses to outsource its OOH obligation to a third party it will typically enter into a contract with the third party. Although some OOH providers do not charge a fee and instead generate all their revenue directly from the provision of care to customers, many charge FOPs a monthly fee.

3.8 We have seen that there is significant variation in the level of fees paid by FOPs to OOH providers, with monthly fees ranging from £100 to over £1,100 (excluding VAT). In some cases, contracts had additional fees in, for instance for providing cover on a bank holiday. The contracts did not include information which explained the variation in fees, which could be driven by a number of demand or supply side factors. In particular:

- (a) [REDACTED]³¹

³⁰ Pet owners survey, question 88c.

³¹ LVG response to RFI 3 [REDACTED]

(b) [REDACTED]^{32 33}

(c) [REDACTED]³⁴

(d) [REDACTED]³⁵

(e) [REDACTED]³⁶

(f) [REDACTED]³⁷

(g) [REDACTED]³⁸

3.9 We have seen evidence that some independent OOH providers do not charge any fees to FOPs and make all their OOH revenues from fees charged to pet owners. Additionally, we have seen a contract between an LVG OOH provider and a referral specialist that did not include any fees. For example:

(a) [REDACTED]³⁹

(b) [REDACTED]⁴⁰

(c) [REDACTED]⁴¹ and

(d) [REDACTED]⁴²

3.10 Outsourced OOH providers may be integrated within FOPs, such that some or all staff may be shared with the standard hours first opinion service, or they can employ entirely different staff. In either case, the outsourced OOH provider does not have customers independently of the referring FOP, as customers will only use it if they require care outside normal working hours. OOH providers enter into medium term contracts with FOPs that can include exclusivity clauses. In the contracts we have reviewed, we have seen that:

(a) Contract duration is typically 12 to 24 months, although contracts often have automatic extensions.⁴³ In addition, an LVG [REDACTED] told us that [REDACTED] of its [REDACTED] practices contract their OOH cover to an external provider and that [REDACTED] provides OOH cover for around [REDACTED] of its practices. Further, most [REDACTED] of its

³²LVG response to RFI 3 [REDACTED]

³³ LVG response to RFI 3 [REDACTED]

³⁴ LVG response to RFI 3 [REDACTED]

³⁵ LVG response to RFI 3 [REDACTED]

³⁶ Independent response to RFI1 [REDACTED]

³⁷ Independent response to RFI1 [REDACTED]

³⁸LVG response to RFI 3 [REDACTED]

³⁹ Independent response to RFI1 [REDACTED]

⁴⁰ Independent response to RFI1 [REDACTED]

⁴¹ Independent response to RFI1 [REDACTED]

⁴²Independent response to RFI1 [REDACTED]

⁴³ For example, [REDACTED].

existing contracts with [REDACTED] are based on either [REDACTED]-month notice periods, and the remaining contracts have a notice period of [REDACTED] months.^{44 45}

- (b) [REDACTED]^{46, 47, 48, 49, 50, 51} However, we have seen a template rolling contract with a [REDACTED] notice period.⁵²
- (c) [REDACTED] All of the contracts we have reviewed for the provision of OOH emergency services include an exclusivity clause, whereby the OOH contracts specify that the relevant practice undertakes to use the specified OOH provider unless the OOH provider consents to the practice using another OOH provider.⁵³ In some instances the FOP is able to direct its customers to two different sites operated by the OOH provider.^{54, 55, 56}

Geographic Market

- 3.11 As explained above, a properly defined local geographic market encompasses the area over which a hypothetical monopolist could profitably raise prices by a small but significant amount,⁵⁷ this is often defined as encompassing the area from which a site draws the majority of its customers.
- 3.12 Since FOPs choose an OOH provider who will serve their customers, they are likely to prefer a provider located nearby as opposed to one located further away. Therefore, OOH providers located closer to a FOP practice are likely to represent better alternatives to that practice (and its customers). This means that to the extent that OOH providers compete for FOP practices, their closest competitors are likely to be geographically those closer to them.
- 3.13 We asked FOPs that told us that they outsource their OOH to provide details of who their OOH supplier is and their address. We used this data to calculate the drive time from each FOP to the OOH provider they used.
- 3.14 Table 3.2 provides summary statistics on the drive time from FOPs to their OOH provider, both for the UK as a whole and separately for each devolved nation. The

⁴⁴ LVG response to RFI 3 [REDACTED]

⁴⁵ Agreements based on [REDACTED]-month notice periods are [REDACTED].

⁴⁶ LVG response to RFI 3 [REDACTED]

⁴⁷ LVG response to RFI 3 [REDACTED]

⁴⁸ LVG response to RFI 3 [REDACTED]

⁴⁹ LVG response to RFI 3 [REDACTED]

⁵⁰ LVG response to RFI 3 [REDACTED]

⁵¹ LVG response to RFI 3 [REDACTED]

⁵² LVG response to RFI 3 [REDACTED]

⁵³ For example, LVG responses to RFI3 [REDACTED], [REDACTED], [REDACTED], [REDACTED], [REDACTED]

⁵⁴ LVG response to RFI3 [REDACTED]

⁵⁵ LVG response to RFI3 [REDACTED]

⁵⁶ LVG response to RFI3 [REDACTED]

⁵⁷ The test involves asking if a hypothetical monopolist could profitably increase prices by a small but significant amount and keep that increase in place for a significant period of time. This is known as a small but significant and non-transitory price increase (SSNIP). For more information see Market Definition Guidelines, OFT 403, paragraph 4.2.

average travel time is around 20 minutes, the minimum is one minute and the maximum is 81 minutes.

Table 3.2: Drive time (rounded to nearest minute) from FOPs to their OOH providers, by nation and the UK

| Country | Number of FOPs | Average drive time (mins) | Minimum drive time (mins) | Maximum drive time (max) |
|------------------|----------------|---------------------------|---------------------------|--------------------------|
| England | 1,782 | 18 | 1 | 81 |
| Northern Ireland | 26 | 22 | 2 | 56 |
| Scotland | 158 | 20 | 2 | 68 |
| Wales | 102 | 22 | 3 | 59 |
| UK | 2,068 | 18 | 1 | 81 |

Source: CMA analysis of data responses collated through RFIs and ArcGIS.

Notes:

1. The table contains analysis based on responses received from small animal FOPs and mixed practices.
2. ArcGIS Pro (version 3.3.2) was used to generate the travel times from FOPs to their OOH providers. Travel times have been generated using the following assumptions: (a) Day of the week: Wednesday, and (b) Time: 10 pm.

3.15 In order to calculate the average catchment area from which a FOP will typically choose an OOH provider, we assigned each FOP to an ONS urban/rural classification.⁵⁸ We then calculated the catchment area from which 80% of FOPs select an OOH provider; this is shown in Table 3.3. In urban areas 80% percent of FOPs outsource OOH care to a site within around 25-minute drive time, while the drive time is longer in more rural areas.

Table 3.3: Drive time (rounded to nearest minute) from FOPs to their OOH providers, by urbanicity

| Area | Number of FOPs | 80th Percentile drive time (mins) |
|---------------------------------|----------------|-----------------------------------|
| Urban | 1,596 | 25 |
| Small Town and Accessible Rural | 424 | 28 |
| Rural/Very Rural | 48 | 45 |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

Notes:

1. The table contains analysis based on responses received from small animal FOPs and mixed practices.
2. ArcGIS Pro (version 3.3.2) was used to generate drive times from FOPs to their OOH providers. Travel times have been generated using the following assumptions: (a) Day of the week: Wednesday, and (b) Time: 10 pm.
3. Urbanicity definitions – see Appendix B, paragraph 4.59. 'Rural' and 'Very Rural' areas have been grouped together due to limited number of observations (12 observations) for 'Very Rural' areas.

3.16 We also asked LVGs over what area they believe OOH providers compete. They told us:

⁵⁸ See Appendix B for the urbanicity definitions. The 'Rural' and 'Very Rural' categories have been grouped together to form one group due to limited number of observations for 'Very Rural' areas (12 observations).

- (a) an LVG [X] told us that OOH providers are chosen based on the location of each individual [X] practice and that it aims to join the most suitable and sustainable OOH service available within a reasonable drive time of that clinic's client base. [X] further told us that it considers 'reasonable' to be within a 40 to 45-minute drive time in the majority of locations, though this could increase in very rural locations.⁵⁹
- (b) an LVG [X] told us that competition for OOH services takes place locally. It estimates that consumers typically travel up to 45 minutes to an OOH provider, although this figure varies significantly depending on the OOH site.⁶⁰
- (c) an LVG [X] told us that competition for OOH services is local and that, based on its approximate estimate, clients may be willing to travel up to 45 minutes to 1 hour to an OOH provider.⁶¹

3.17 We note that these distances are larger than the 80% catchment areas based on FOP location. However, this may partially reflect that the responses refer to customers rather than FOPs.

3.18 A FOP is likely to be a good proxy for the average customer of a site, as customers are likely to be fairly evenly distributed around a FOP, such that analysing the travel time from a FOP to its OOH provider should also proxy customers' willingness to travel. Additionally, OOH services are also often accessed in an emergency where a longer travel time may lead to worse outcomes. Therefore, we have used the 80% catchment areas set out in Table 3.3.

Concentration

3.19 The nature of outsourced OOH means that its provision is likely to be more highly concentrated than for FOPs. Since the service is often used in emergencies there is less demand in each local area, so each area is able to support a smaller number of OOH vets. OOH care is also more expensive to provide, per veterinary professional required, as it depends on staff working unsocial hours. Therefore, it may be the case that concentration is high in a number of local areas, with no likely scope to increase the number of competitors due to insufficient demand.

3.20 Based on the catchment areas outlined in paragraph 3.15 we have calculated how many providers of outsourced OOH services lie within the catchment areas of each outsourced OOH focal site. In total we have found that there are 356 providers of outsourced OOH services (as shown in Table 3.4 below), of which 69

⁵⁹ LVG response to RFI 3 [X]

⁶⁰ LVG response to RFI 2 [X]

⁶¹ LVG response to RFI 2 [X]

face no competitors within their catchment area (possible monopoly areas) and a further 88 face one competitor (possible duopoly areas). The possible monopoly and duopoly areas together represent 44% of areas.

Table 3.4: Fascia counts for OOH providers that provide care to offsite pet owners

| <i>Number of Fascia</i> | <i>Count of Focal OOH Sites</i> | <i>Per cent</i> |
|-------------------------|---------------------------------|-----------------|
| 1 | 69 | 19% |
| 2 | 89 | 25% |
| 3 | 105 | 29% |
| 4 | 75 | 21% |
| 5 | 11 | 3% |
| 6+ | 7 | 2% |
| Total | 356 | 100% |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

Notes:

1. Table contains analysis restricted to sites that provide OOH care to offsite pet owners. It excludes sites that provide OOH care to in-house clients only.
2. ArcGIS Pro (version 3.3.2) used to generate the travel times from each focal OOH site to other OOH sites. No assumptions were used to generate the travel times.
3. The catchment areas are based on the focal OOH site's urbanity. The drive time applied to each focal site are shown by the 80th percentile in Table 3.3 In order to test whether concentration, particularly in possible monopoly areas, is due to insufficient demand to sustain multiple sites, we have counted the number of sites in these areas. If monopoly areas arise not through common operation of multiple sites, but through the presence of only one site in an area, this would be consistent with there being insufficient demand to sustain multiple sites.

Possible monopoly areas

3.21 We identified 69 sites where there may be only one provider of outsourced OOH services within the catchment area. These are distributed fairly uniformly throughout the UK, as shown in Figure 3.2 below.

Figure 3.2: Areas in the UK where there is a count of one fascia



Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

Notes:

1. Figure contains analysis restricted to sites that provide OOH care to offsite pet owners. It excludes sites that provide OOH care to in-house clients only.
2. ArcGIS Pro (version 3.3.2) used to generate the map.

3.22 Of the 69 potential monopoly areas, in 42 there is only a single site providing OOH services. In the remaining 27 areas there are multiple sites which are under common ownership, as shown in Table 3.5 below.

Table 3.5: Multi-site ownership in monopoly areas by number of OOH sites owned

| <i>Additional OOH sites with same ownership</i> | <i>Number of focal OOH sites</i> |
|---|----------------------------------|
| 0 | 42 |
| 1 | 16 |
| 2 | 4 |
| 3 | 3 |
| 4 | 4 |
| Total | 69 |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

3.23 Table 3.6 below shows the ownership of the 27 focal OOH sites where the owner of the focal site owns at least one additional OOH site in the focal site’s catchment area. 11 sites are owned by LVG [✂]; LVG [✂] owns five; LVG [✂] owns four and independents own the remaining seven sites.

Table 3.6: Multi-site ownership in monopoly areas by owner

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| [LVG] [✂] | 11 |
| [LVG] [✂] | 5 |
| [LVG] [✂] | 4 |
| [IND] [✂] | 3 |
| [IND] [✂] | 2 |
| [IND] [✂] | 1 |
| [IND] [✂] | 1 |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

3.24 This data suggests that in around 40% of the monopoly areas there may be sufficient demand to sustain multiple operators, as there is more than one provider of outsourced OOH services, but that they are under common ownership. We would welcome submissions on whether there are any other factors we should consider when assessing whether there is sufficient demand to sustain multiple competitors in such types of area, and whether common ownership of multiple OOH sites in an area could be a problem.

Possible duopoly areas

3.25 We identified 88 areas where there may only be two independent providers of outsourced OOH services. Similarly to the monopoly areas, these are distributed throughout the UK, as shown in Figure 3.3.

Figure 3.3: Areas in the UK where there is a count of two fascia



Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

Notes:

1. Figure contains analysis restricted to sites that provide OOH care to offsite pet owners. It excludes sites that provide OOH care to in-house clients only.
2. ArcGIS Pro (version 3.3.2) used to generate the map.

3.26 Of the 89 possible duopoly areas, in 59 there are only two OOH sites providing outsourced OOH services. In the remaining 30 areas, at least one of the two providers operates two or more sites, as shown in Table 3.7 below.

Table 3.7: Multi-site ownership in duopoly areas by number of OOH sites owned

| <i>Additional OOH sites with same ownership</i> | <i>Number of focal OOH sites</i> |
|---|----------------------------------|
| 0 | 59 |
| 1 | 16 |
| 2 | 7 |
| 3 | 1 |
| 4 | 3 |
| 5 | 2 |
| 6 | 1 |
| Total | 89 |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

3.27 Table 3.8, below shows the ownership of the 30 focal OOH sites where the owner of the focal site owns at least one additional OOH site in the focal site’s catchment area. 11 sites are owned by an LVG [⌘], another LVG [⌘] owns five, and independents and one other LVGs own the remainder.

Table 3.8: Multi-site ownership in duopoly areas by owner

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| [LVG] [⌘] | 11 |
| [LVG] [⌘] | 5 |
| [LVG] [⌘] | 2 |
| [IND] [⌘] | 2 |
| [IND] [⌘] | 2 |
| [IND] [⌘] | 2 |
| [IND] [⌘] | 2 |
| [IND] [⌘] | 2 |
| [LVG] [⌘] | 1 |
| [LVG] [⌘] | 1 |

Source: CMA analysis of data responses collated through RFIs, ArcGIS and ONS.

3.28 This data suggests that, in around a third of duopoly areas, there may be sufficient demand to sustain additional operators, as there are two providers of outsourced OOH services, but three or more sites. We would welcome submissions on whether there are any other factors we should consider when assessing whether there is sufficient demand to sustain multiple competitors in such types of area, and whether common ownership of multiple OOH sites in an area could be a problem.

3.29 We also note that the RCVS requires that, where a FOP outsources its OOH provision, it does it to a provider who meets at least the same standards. This means that:

- (a) Practices accredited at Core Standards can outsource OOH services to any premises.
- (b) General Practice accredited practices must outsource to a practice at General Practice, Veterinary Hospital or Emergency Service Clinic level.

General practice accredited practices cannot outsource to a core or non-practice standards scheme practice.

- (c) Veterinary Hospital accredited practices can only outsource to a Veterinary Hospital or Emergency Service Clinics.

3.30 We are considering what, if any, effect this might have on local concentration in OOH provision. We are also considering what work to undertake to assess further our initial results and the next steps in our analysis.

4. Referral Centres

Introduction

- 4.1 When an animal presents with a more complicated condition, a vet in a FOP may decide to refer the case to a more experienced vet who may be a specialist in a particular field. A Specialist vet, as defined by the RCVS, will have at least a postgraduate diploma level qualification.⁶²
- 4.2 Specialist vets can work in a number of different types of practice. These can be referral-only sites, such as multidisciplinary referral-only centres, where Specialists with expertise in a range of different areas work together in a single practice, or single speciality referral-only sites, for instance a site that specialises in oncology. Alternatively, FOPs can choose to employ full time Specialist vets to work from individual sites, to give a practice that offers both FOP and referral services. Lastly, some FOPs employ peripatetic specialist vets who travel to different practices to deliver services within those practices, such that a FOP site may occasionally have a Specialist working there on referral cases. We have not captured this last class of sites in our analysis of referral centres.
- 4.3 Since consumers must physically travel to the referral site to receive its services, the set of sites that they consider as substitutes will be limited by their willingness to travel. Accordingly, we are interested in both the size of local markets and the number of competitors operating in them.
- 4.4 In order to give an overview of competitive conditions we have initially focused our analysis at a site, rather than specialism level. Accordingly, we have estimated catchment areas and counted the number of fasciae, for (i) referral-only centres and (ii) referral-only centres and FOPs/animal hospitals employing Specialist vets. This approach will give an indication of the competitive conditions in different local areas within the UK but suffers from two issues:
- (a) the boundaries of the product market are not clearly defined with the potential for some substitution to peripatetic vets operating from FOPs.
 - (b) the set of substitutes for a site will depend on the specialisms offered within that site. For instance, if a referral centre specialises only in oncology, then a site offering orthopaedics will not be a substitute for its customers.

⁶² <https://www.rcvs.org.uk/lifelong-learning/professional-accreditation/specialists-status/?&&type=rfst&set=true#cookie-widget>.

4.5 We present the results of our analysis at the site level in this paper. We are considering whether to conduct further work analysing the level of concentration at a specialty level and, if we were to do this, how we would treat peripatetic vets.

Identifying the list of effective competitors

4.6 We are interested in who are the competitors for a given vet practice that offers small animal specialist referral services. We note there is not always a clear-cut distinction between first opinion and referral services – some first opinion vets may provide certain types of referral services depending on their specific areas of focus.

4.7 We used information from our confirmed practice list to categorise practices as:

- (a) 'referral-only' if it offers small animal specialist referral services only
- (b) 'referral/FOP' if it offers small animal specialist referral services and FOP services⁶³

4.8 In total there were 241 practices offering referral services – 99 referral-only and 142 referral/FOP. We have not considered in this analysis FOPs to which peripatetic vets travel to conduct occasional work.

Geographic Market

4.9 As noted above, a properly defined local geographic market would encompass the area over which a hypothetical monopolist could profitably raise prices by a small but significant amount,⁶⁴ this is often defined as encompassing the area from which a site draws the majority of its customers.

4.10 Since customers must travel to visit a referral site (and transport their pet), the further a consumer is located from a focal site, the greater the travel cost a consumer will incur to visit that site. At a certain distance from the focal site, the customer will view alternative sites as substitute sites and a hypothetical monopolist would not be able to increase prices to them without the customer switching.

4.11 We have used site level data from LVGs to calculate the area from which they draw the majority of their customers. Since some sites offer both FOP and referral services, we have restricted the set of sites we use to calculate catchment areas

⁶³ Where practices provide a mix of first opinion and referral services, we do not hold information on how their work is divided between the two types of services.

⁶⁴ The test involves asking if a hypothetical monopolist could profitably increase prices by a small but significant amount and keep that increase in place for a significant period of time. This is known as a small but significant and non-transitory price increase (SSNIP). For more information see Market Definition Guidelines, OFT 403, paragraph 4.2.

to those that offer only referral services. This is because FOP customers are likely to travel a shorter distance than referral customers. This left us with 41 sites.

4.12 We calculated the straight-line distance from the site to each customer in order to calculate the 80% catchment area. We chose this approach as there were computational challenges estimating drive times given the large number of customers and for an initial analysis we consider distances are reasonable in these circumstances. We noted that the majority of the sites had catchment areas of around 30 miles, but a small number had much narrower catchment areas. These were located in, or around, major conurbations. In order to reflect this, we grouped sites into two categories based on the ONS urban/rural classification:

- (a) major conurbation – included ‘urban major conurbation’ for England and Wales, ‘large urban area’ for Scotland and, for Northern Ireland, ‘Belfast metropolitan urban area’ and ‘Derry urban area’.
- (b) other – included all other categories.

4.13 Based on the 41 LVG referral-only sites, we found that the average 80% catchment areas were:

- (a) major conurbation – 18 miles
- (b) other – 37 miles

Concentration

4.14 We calculated the number of fasciae that lie within the catchment area around each site offering referral services. Since there may be a difference between the competitive strength exerted by a referral-only site and a referral/FOP site, we centred on each separately:

- (a) first, we centred on referral-only sites and included only other referral-only sites as competitors. These results are shown in Table 4.1.
- (b) second, we again centred on the 99 referral-only sites but included both referral-only and referral/FOP practices as competitors. These results are shown in Table 4.2.
- (c) third, we centred on referral/FOP sites and included both referral-only and referral/FOP practices as competitors. These results are shown in Table 4.3.

Referral-only fascia counts

4.15 First, we centred on referral-only sites and included only other referral-only sites as competitors. These results are shown in Table 4.1. There are 99 sites that only

offer referral services: these include both LVG and independently owned sites. There are six sites that face no competition from other referral-only sites within their catchment area, and a further 12 that face only one competitor.

Table 4.1: Fascia count referral-only practices

| <i>Referral-only fascia Count</i> | <i>Number of referral-only focal sites</i> | <i>Percentage</i> |
|-----------------------------------|--|-------------------|
| 1 | 6 | 6% |
| 2 | 12 | 12% |
| 3 | 11 | 11% |
| 4 | 8 | 8% |
| 5 | 19 | 19% |
| 6 | 12 | 12% |
| 7+ | 31 | 31% |

Source: CMA analysis of data collected from RFIs and ONS

Possible monopoly areas

4.16 When centring on referral-only practices and considering referral-only practices in the competitor set, we found that there are six potential monopoly areas. These are shown in Figure 4.1 below.

Figure 4.1 Referral-only: Areas in the UK where there is a count of one fascia



Source: CMA analysis of data collected from RFIs and ONS

4.17 Of the six possible monopoly areas, there are three referral-only sites where the owner of the focal site owns at least one additional site in the focal site's catchment area. All three of these focal sites are owned by one LVG [✂].

Possible duopoly areas

4.18 When centring on referral-only practices and considering referral-only practices in the competitor set, we find that there are 12 potential duopoly areas. These are shown in Figure 4.2 below.

Figure 4.2 Referral-only: Areas in the UK where there is a count of two fasciae



Source: CMA analysis of data collected from RFIs and ONS

4.19 Of the 12 potential duopoly areas, there are five referral-only sites where the owner of the focal site owns one additional site in the focal site's catchment area. The remaining seven focal sites are the only site within the catchment area.

4.20 Table 4.2 shows the ownership of the five referral-only focal sites where the owner of the focal site owns at least one additional referral-only practice in its catchment area. An LVG [✂] owns two sites, and independents [✂].

Table 4.2 Multisite ownership in areas with two fasciae

| <i>Ownership</i> | <i>Number of focal sites where the owner has additional sites in the catchment area</i> |
|------------------|---|
| [LVG] [X] | 2 |
| [IND] [X] | 2 |
| [IND] [X] | 1 |

Source: CMA analysis of data collected from RFIs and ONS

4.21 In the second stage, we again centred on the 99 referral-only sites but included both referral-only and referral/FOP practices as competitors. These results are shown in Table 4.3. As can be seen there are no sites that face no competitors within their catchment area and only three that face a single competitor. 80% of areas have four or more competitors within their catchment areas.

Table 4.3: Fascia count when centring on referral-only sites and including both referral-only and referral/FOP in competitor set

| <i>Fascia Count</i> | <i>Number of referral-only focal sites</i> | <i>Percentage</i> |
|---------------------|--|-------------------|
| 1 | 0 | 0% |
| 2 | 3 | 3% |
| 3 | 7 | 7% |
| 4 | 10 | 10% |
| 5 | 5 | 5% |
| 6 | 7 | 7% |
| 7+ | 67 | 68% |

Source: CMA analysis of data collected from RFIs and ONS

Referral/FOP fascia counts

4.22 Third, we centred on referral/FOP sites and included both referral-only and referral/FOP practices as competitors. These results are shown in Table 4.4 . As can be seen there are no sites that face no competitors within their catchment areas and only two sites that face only one competitor. Over 75% of sites face four or more competitors.

Table 4.4 Fascia count including all referral options

| <i>Fascia Count</i> | <i>Number of referral/FOP focal sites</i> | <i>Percentage</i> |
|---------------------|---|-------------------|
| 1 | 0 | 0% |
| 2 | 2 | 1% |
| 3 | 19 | 13% |
| 4 | 10 | 7% |
| 5 | 16 | 11% |
| 6 | 10 | 7% |
| 7+ | 85 | 60% |

Source: CMA analysis of data collected from RFIs and ONS

Possible duopoly areas (no monopoly areas)

4.23 When centring on referral/FOP practices and considering all practices that offer referral services in the competitor set, we find that there are no potential monopoly

areas. There are only two duopoly areas, which are shown in Figure 4.3 below. In both possible duopoly areas, there are only two sites within each catchment area.

Figure 4.3 Referral-only and referral/FOP: Areas in the UK where there is a count of two fasciae



Source: CMA analysis of data collected from RFIs and ONS

Further analysis

- 4.24 We are considering what work to undertake to assess further our initial results and the next steps in our analysis. We are also considering whether to conduct further analysis at a specialism level. Analysis at a specialism level may be appropriate as there are significant differences between the number of specialisms that referral sites undertake. Some specialise in a single type of service, such as orthopaedics, while others are multidisciplinary.
- 4.25 As shown in Table 4.5, 40 of the 99 referral-only sites specialise in a particular service and a further 13 offer only two types of services.⁶⁵ This suggests that under half of referral centres offer more than three services.

Table 4.5 Number of specialisms offered by referral-only sites

| Number of referral services offered at each site | Sites offering this number of services |
|--|--|
| 1 | 40 |
| 2 | 13 |
| 3 | 5 |
| 4 | 5 |
| 5 | 4 |
| 6 | 6 |
| 7 | 7 |
| 8 | 7 |
| 9 | 3 |
| 10 | 3 |

Source: CMA analysis of data responses collated through RFIs.

- 4.26 We would welcome submissions on our analysis of concentration in referral centres and whether we should extend this analysis to specialism level. Linked to this we would be interested in views as to whether competition concerns could arise at a specialism level.

⁶⁵ Note that six sites indicated that they are referral sites but did not state the number of specialisms that they offered.

5. Responding to this working paper

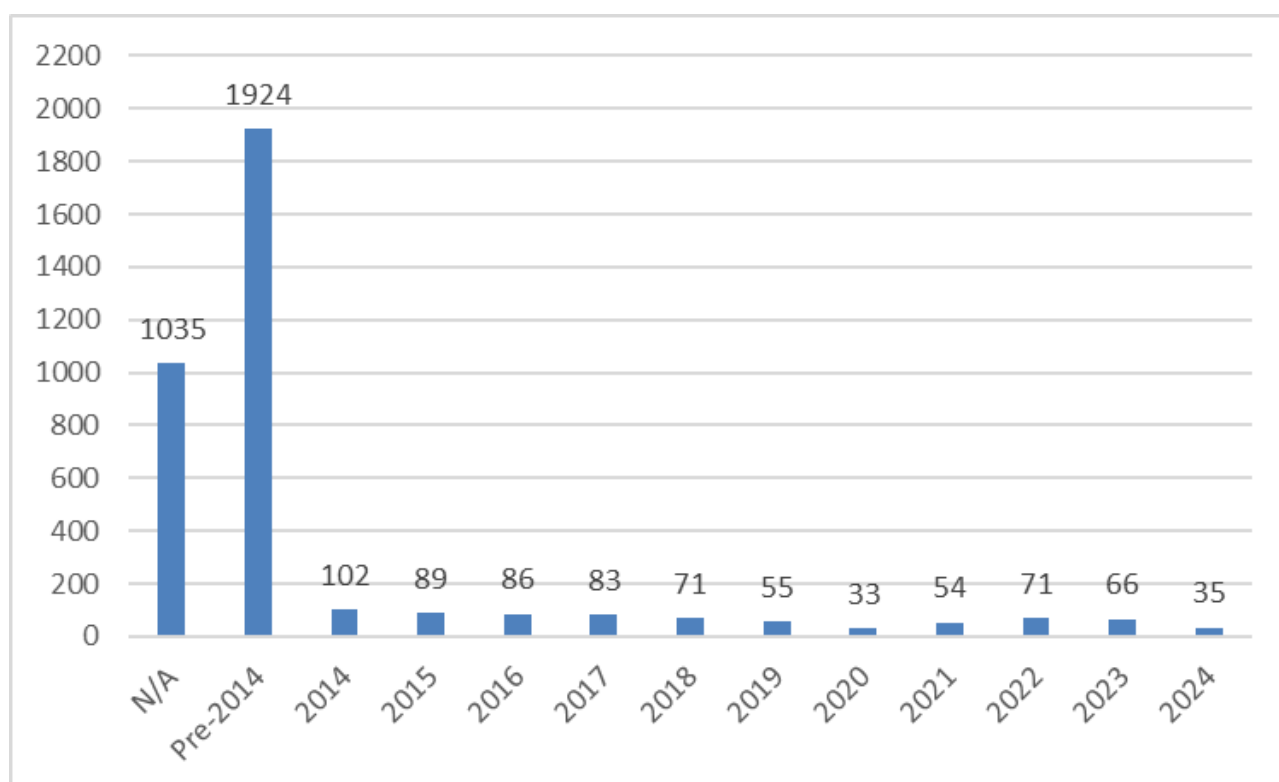
- 5.1 Any submissions must be provided no later than **5:00pm on Thursday 27th February 2025** by emailing: VetsMI@cma.gov.uk.
- 5.2 We intend to publish all responses from businesses and other organisations on our case page except those marked as confidential. Please clearly highlight any confidential information in your submission and provide a non-confidential version of your submission for publication.
- 5.3 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.
- 5.4 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 market 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.
- 5.5 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.

6. Appendix A: Descriptive statistics

Descriptive statistics on confirmed practices offering small animal FOP commercial services

- 6.1 In this appendix we set out a summary of the data we have received for the 3,704 confirmed sites. Of the 3,704 small animal FOPs in our dataset, 2,648 (71%) are owned by LVGs and 1,056 (29%) are independent.
- 6.2 The majority of confirmed sites (52%) were opened before 2014, as shown in Figure 6.1 below. Over a quarter of sites (28%) did not provide a year of opening, and the vast majority of these (95%) are LVG-owned and were previously acquired by the LVGs. A small number of sites have opened in each year in the period 2014 to 24.

Figure 6.1: Number of FOPs by year of opening

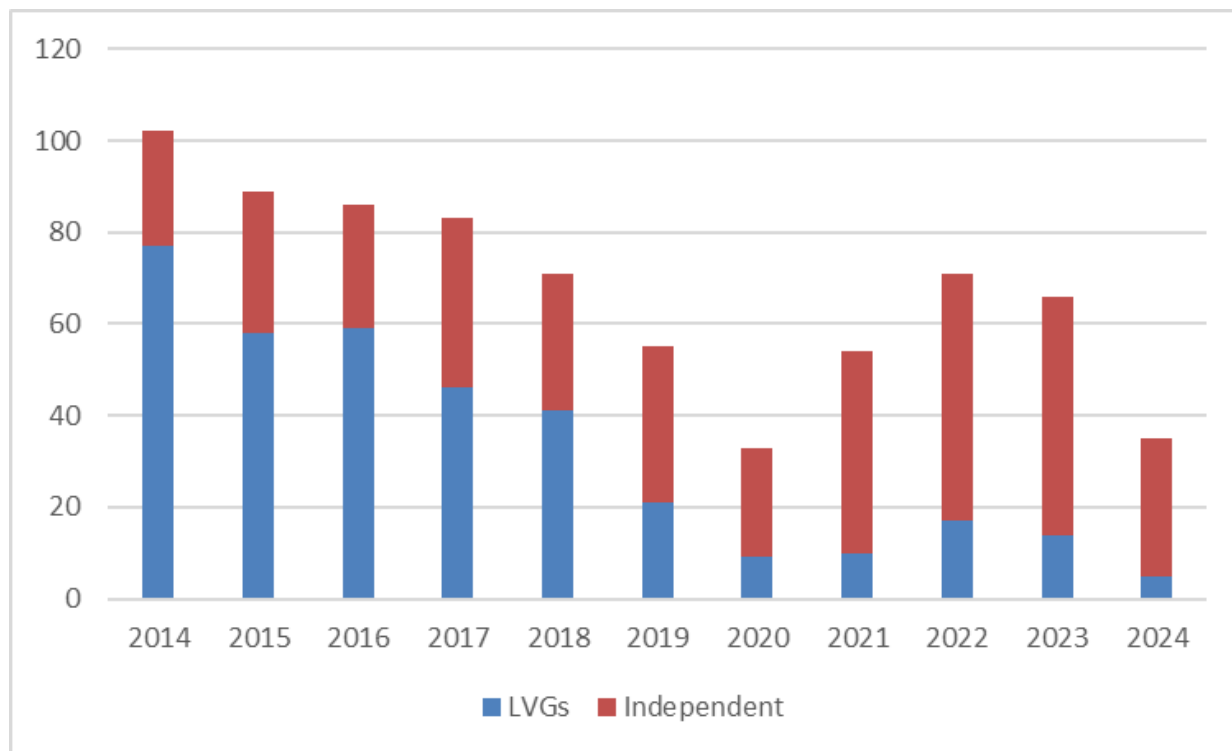


Source: CMA analysis of data responses collated through RFIs.

Note: 2024 is not a full year, and covers the period January – September. FOPs were asked the following question: Please select the month and year when the veterinary site was first opened. (Where the month is not known, you may specify only the year).

- 6.3 We looked at site openings in the period 2014 to 2024, as shown in Figure 6.2 below. It shows that the number of sites opened each year appears to be reducing over time. This seems to be driven by a reduction in number of new sites opened by LVGs. On the other hand, there has been an increase in the number of new sites opened by independents.

Figure 6.2 Number of FOPs opened in each year since 2014, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

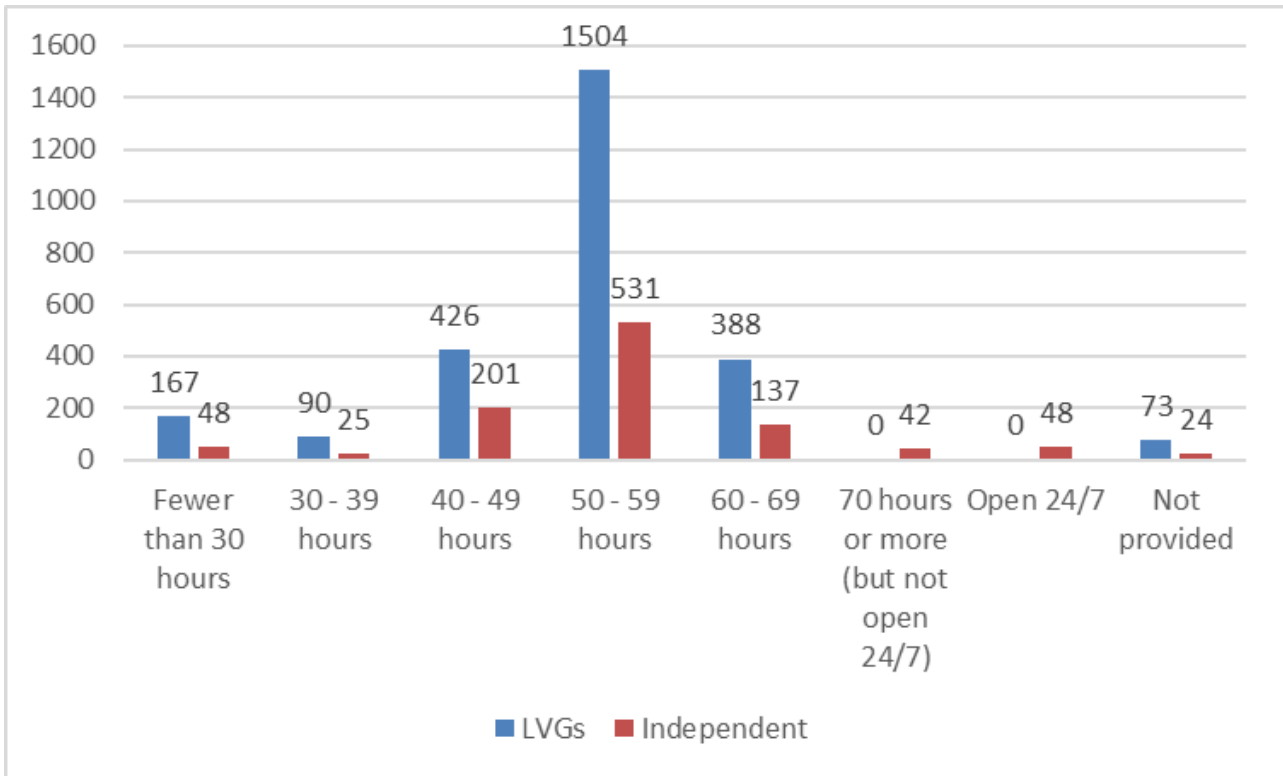
Note: FOPs were asked the following question:

Please select the month and year when the veterinary site was first opened. (Where the month is not known, you may specify only the year).

6.4 There is some variation between FOPs in terms of opening hours as shown in Figure 6.3 below. The majority of FOPs (86%) are open 40 to 69 hours per week:

- (a) 55% are open 50 to 59 hours per week;
- (b) 17% are open 40 to 49 hours per week; and
- (c) 14% are open 60 to 69 hours per week.

Figure 6.3: Breakdown of FOP opening hours, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

Note: FOPs were asked the following question:

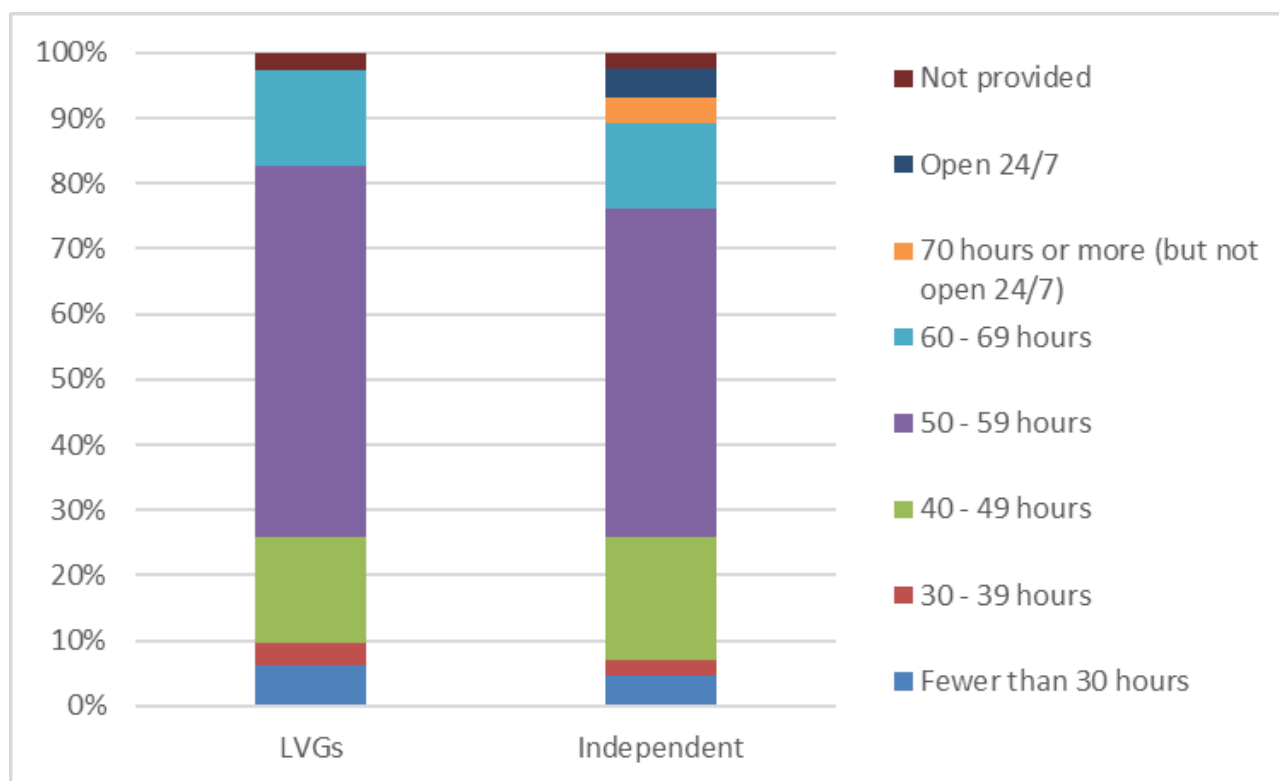
What are your standard opening hours in a typical week?

(Please provide the total number of hours that the veterinary site is open, excluding any Out of Hours provision.)

- o Fewer than 30 hours
- o 30 - 39 hours
- o 40 - 49 hours
- o 50 - 59 hours
- o 60 - 69 hours
- o 70 hours or more (but not open 24/7)
- o Open 24/7.

6.5 There is some variation between LVGs and independent FOPs. LVGs are more likely to be open 50 to 59 hrs and 60 to 69 hours per week, while only independents are open 70+ hours.

Figure 6.4: Comparison of Independent and LVG FOP opening hours



Source: CMA analysis of data responses collated through RFIs.

Note: FOPs were asked the following question:

What are your standard opening hours in a typical week?

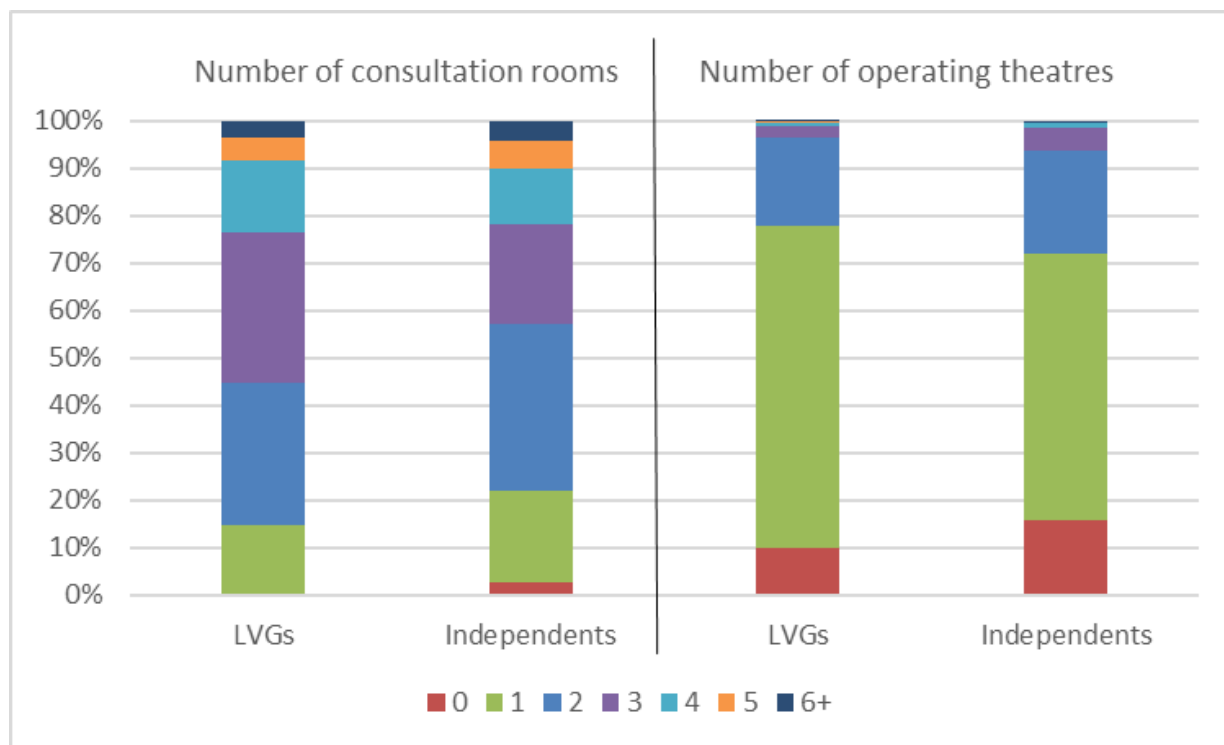
(Please provide the total number of hours that the veterinary site is open, excluding any Out of Hours provision.)

- Fewer than 30 hours
- 30 - 39 hours
- 40 - 49 hours
- 50 - 59 hours
- 60 - 69 hours
- 70 hours or more (but not open 24/7)
- Open 24/7

6.6 The majority of FOPs (60%) have two or three consulting rooms, as shown in Figure 6.5 below. This is higher (62%) for LVGs than for independent FOPs (55%). A higher percentage of independent FOPs (10%) than LVGs (8%) have five or more consulting rooms.

6.7 The majority of FOPs (64%) have one operating theatre. This is higher (68%) for LVGs than for independent FOPs (54%). A higher percentage of independent FOPs (27%) than LVGs (22%) have 2 or more operating theatres.

Figure 6.5: Breakdown of number of consultation rooms and operating theatres, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

Notes: FOPs were asked the following question:

How many consultation rooms and operating theatres does the premises have?

| | Consultation rooms | Operating theatres |
|------|--------------------------|--------------------------|
| None | <input type="checkbox"/> | <input type="checkbox"/> |
| 1 | <input type="checkbox"/> | <input type="checkbox"/> |
| 2 | <input type="checkbox"/> | <input type="checkbox"/> |
| 3 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4 | <input type="checkbox"/> | <input type="checkbox"/> |
| 5 | <input type="checkbox"/> | <input type="checkbox"/> |
| 6+ | <input type="checkbox"/> | <input type="checkbox"/> |

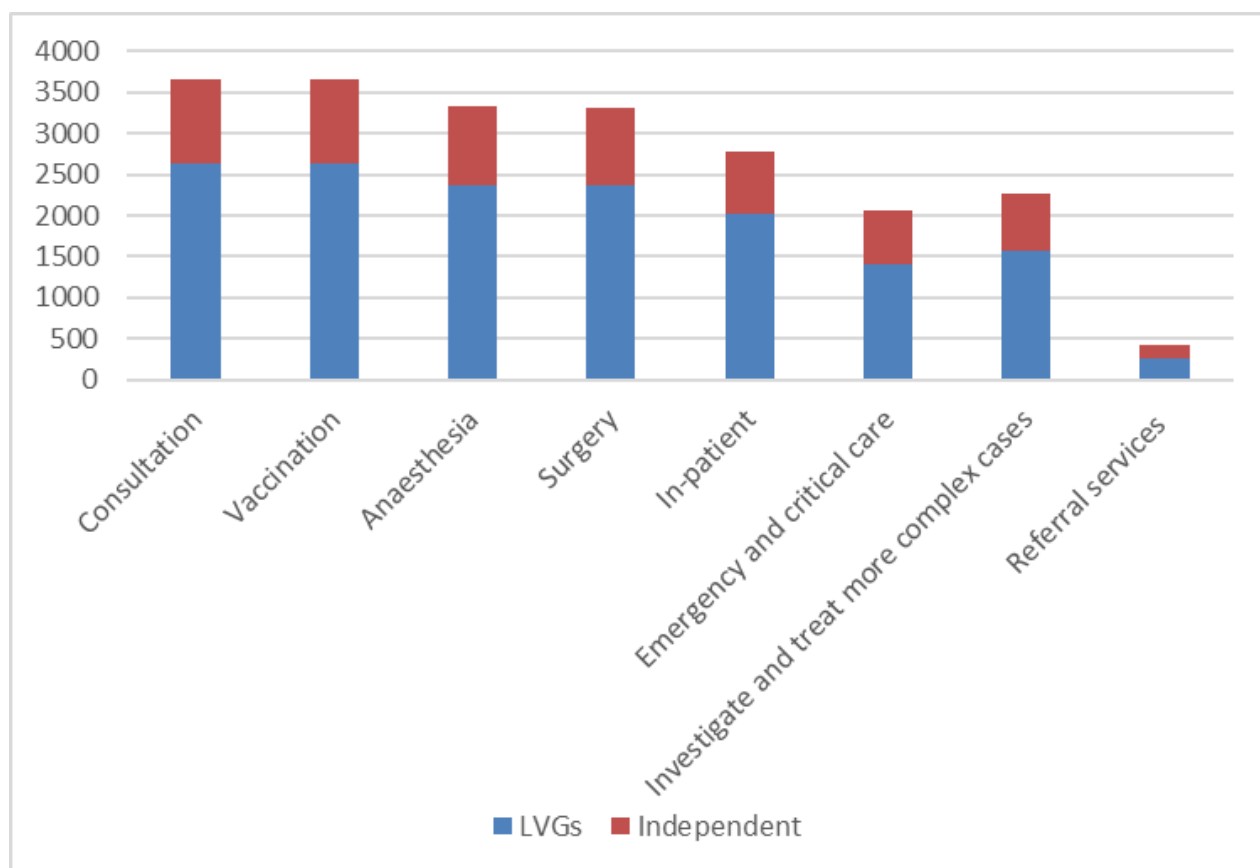
21 FOPs did not provide data on number of consultation rooms, and 45 FOPs did not provide data on number of operating theatres.

6.8 Figure 6.6 below shows the veterinary services offered at FOPs. The vast majority of FOPs offer consultations (99%) and vaccinations (98%), as well as anaesthesia (90%) and surgery (89%). This is similar for LVGs and independent FOPs.

6.9 A large majority of FOPs offer in-patient services (75%). This is slightly higher for LVGs (77%) than independent FOPs (73%). 60% of FOPs can investigate and treat more complex cases. This is slightly higher for independent FOPs (63%) than LVGs (59%). 56% of FOPs offer emergency and critical care. This is higher for independent FOPs (63%) than LVGs (53%).

6.10 11% of FOPs offer referral services on site. This is higher for independent FOPs (16%) than LVGs (10%).

Figure 6.6: Breakdown of services provided at FOPs, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

Note: FOPs were asked the following question:

Which of the following services are provided at the veterinary site? Please tick all that apply

- Consultation
- Vaccination
- Anaesthesia
- Surgery
- In-patient
- Emergency and critical care
- Investigate and treat more complex cases
- Referral services (ie offers services at the site when a request for veterinary services is made via a referral from a first opinion vet)
- None of the above.

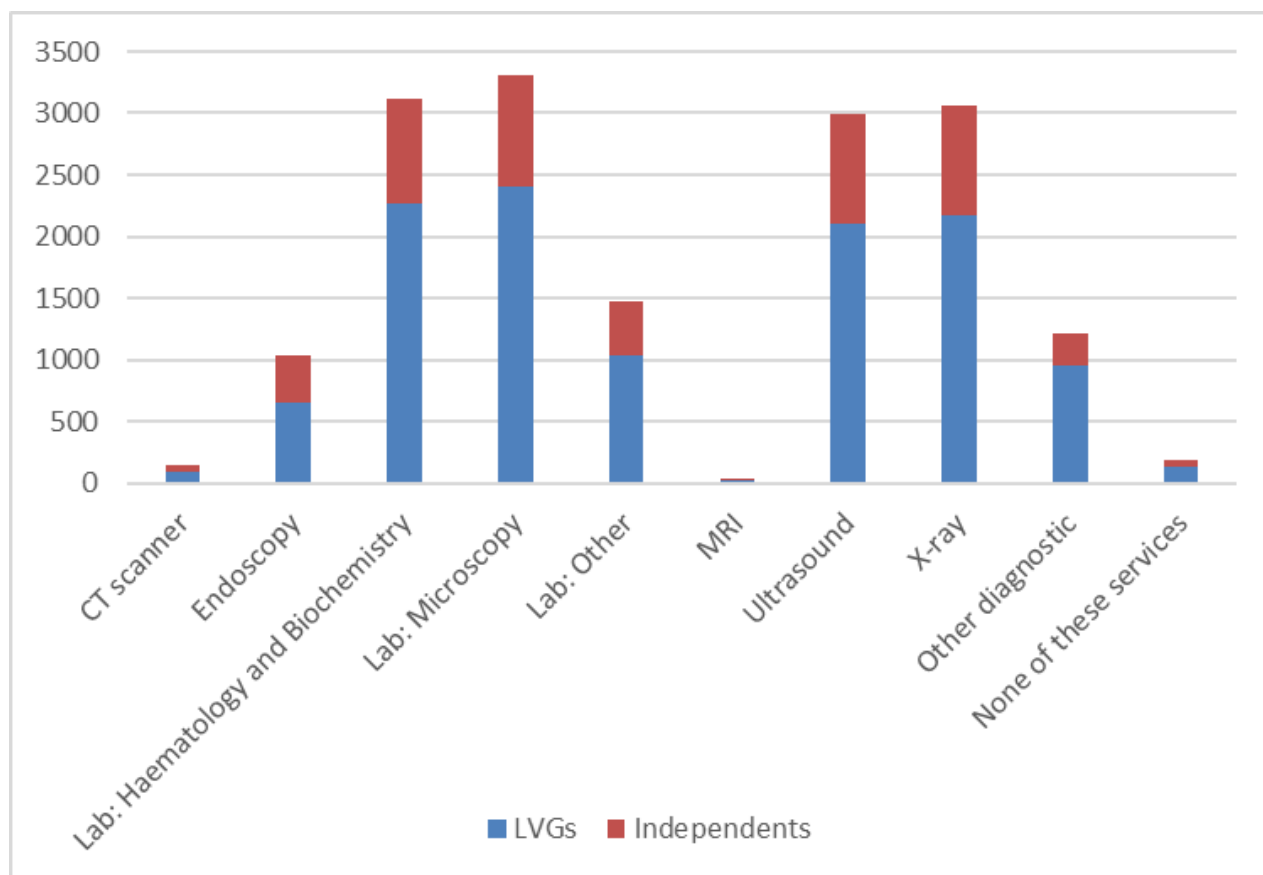
5 independent sites selected 'None of the above'. These sites told us that they are small animal FOPs in response to another question, and provided the number of FTE vets employed, so the sites are included in the competitor set.

6.11 There is significant variation between FOPs in terms of in-clinic diagnostic equipment available at the site, as shown in Figure 6.7 below. Some equipment is more common in FOPs: in particular:

- (a) lab: Microscopy is available in 89% of sites;
- (b) lab: Haematology and Biochemistry is available in 84% of sites;
- (c) x-ray is available in 82% of sites; and
- (d) ultrasound is available in 81% of sites.

6.12 A very small minority of FOPs have either a CT scanner (4%) and/or an MRI machine (1%).

Figure 6.7: Breakdown of in-clinic diagnostic equipment at FOPs, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

Note: FOPs were asked the following question:

Which of the following in-clinic diagnostic equipment does the veterinary site have? (Please select all that apply)

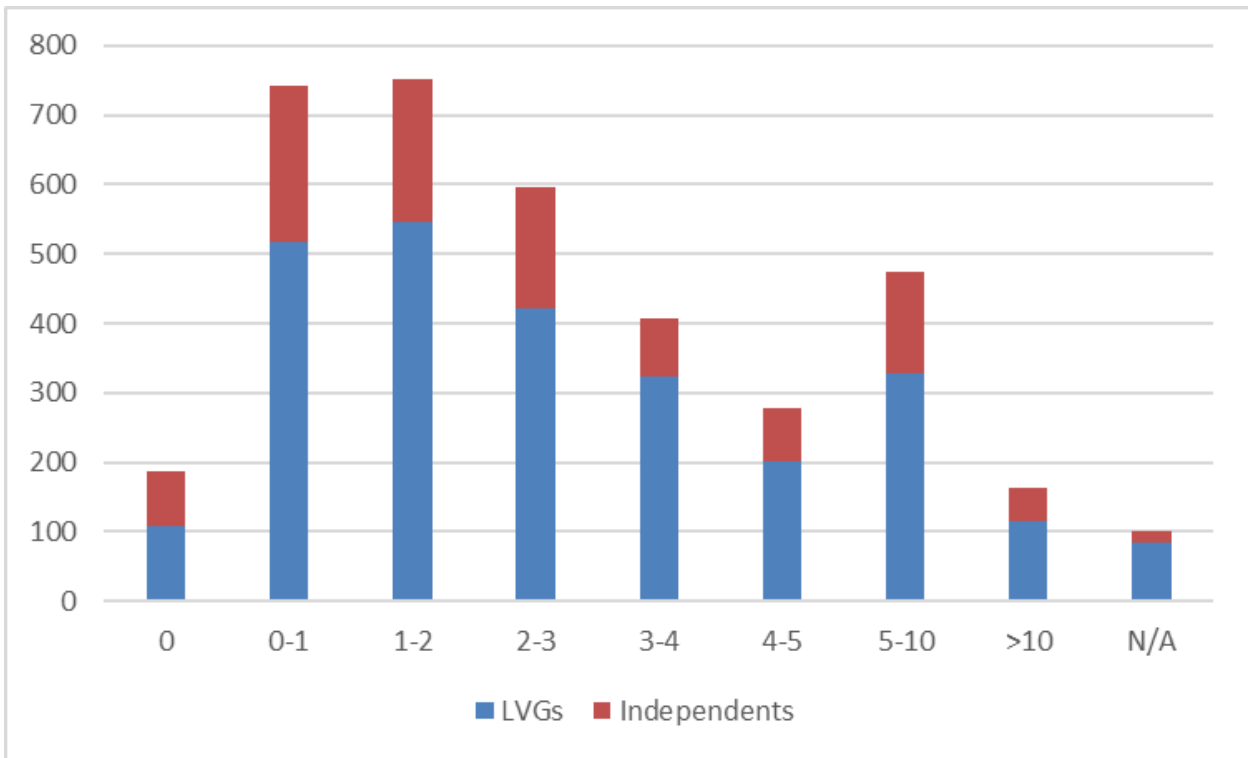
- CT scanner
- Endoscopy
- Lab: Haematology and Biochemistry
- Lab: Microscopy
- Lab: Other
- MRI
- Ultrasound
- X-ray
- Other diagnostic
- None of the above.

6.13 Figure 6.8 below shows a breakdown of the number of FTE vets working at FOPs. In particular:

- (a) 20% of FOPs have up to one FTE vet working on-site. This is similar for independent FOPs and LVGs;
- (b) 55% of FOPs have between one and five FTE vets. This is higher for LVGs (56%) than independent FOPs (51%); and

(c) 17% of FOPs have more than five FTE vets. This is similar for independent FOPs and LVGs.

Figure 6.8: Breakdown of number of FTE vets employed at FOPs, by LVGs and independent FOPs



Source: CMA analysis of data responses collated through RFIs.

Note: FOPs were asked the following question:

Please provide the number of FTE Vet surgeons (excluding any locums) employed at the veterinary site as of 1st June 2024, and, where known, by years of experience. FTE is Full-Time Equivalent (e.g. 0.2 FTE for a member of staff working 1 day per week).

- _____ Total number of FTE vets
- _____ Number of newly qualified vets (<1 year's experience)
- _____ Number of vets with 1-2 years' experience
- _____ Number of vets with 3-5 years' experience
- _____ Number of vets with 5 or more years' experience.

7. Appendix B: Methodology

7.1 In this appendix we set out the methodology we have followed in conducting our analysis of local competition.

Catchment area methodology

Insurer or LVG data

7.2 The CMA has used catchment areas as a pragmatic approximation of the geographic market in many previous markets and mergers cases.⁶⁶ A catchment area is calculated based on the location the customers for a store or site.

7.3 In considering the data which may be available to analyse customer location, we identified two broad categories of sites and two types of customers:

- (a) sites – are either owned (or part owned) by LVGs or by independents.
- (b) customers – are either insured or uninsured.

7.4 We have access to two sources of data on the location of a site's customers:

- (a) site level data is available from LVGs, for almost all owned and co-owned sites, but not for independents.
- (b) insurance data, from Insurer 2 [X] and Insurer 1 [X], covers insured customers who have made claims at different types of vet practice including both LVG and independent practices, but not uninsured customers [see paragraph 7.9].

7.5 Therefore, we do not have data available that has coverage across both different types of sites and different types of customers.

7.6 Site level data is only available for LVG owned and co-owned sites, so a catchment area calculated on this basis excludes the 40% of sites owned by independent operators. Some LVGs operate hub and spoke business models, where several smaller satellite practices will be located around a single large hub site. Most independent practices cannot operate this business model as they are operating from one or two sites. Therefore, using LVG data risks incorrectly estimating the catchment area of the average site due to the differences in business models.

⁶⁶ See, for example, Retail Mergers Commentary (CMA62), 10 April 2017, paragraph 2.1. Also see IVC/Multiple, VetPartners/Goddard, and CVS/The Vet.

- 7.7 Insurance data covers both LVG and independent sites, but only insured customers. If insured and uninsured customers have a different willingness to travel to access FOP services, then this data risks inaccurately estimating the catchment area. As set out in our working paper on **How consumers purchase veterinary services** there is currently little information available to consumers on factors such as price and quality, so we would not expect significant differences in the choices made by insured and uninsured customers.
- 7.8 We consider that insurer data is more likely to provide a robust market-wide estimate of catchment areas across the largest range of sites, so have used this data in our analysis. This is more likely to give an accurate representation of the catchment area for the average type of practice in each type of area.

Description of insurance data

- 7.9 We collected data on insurance claims from Insurer 1 [redacted] and Insurer 2 [redacted]. [redacted].
- 7.10 The data includes the practice name and address as well as the customer's address. Coverage is not universal, with 3,126 practices in Insurer 1's [redacted] data set and 4,977 in Insurer 2's [redacted] data set, in 2023/24. We compared how many LVG owned or co-owned practices are in this data set with how many the LVGs told us they own – Insurer 1's [redacted] data includes 75% and Insurer 2's [redacted] data 92% of LVG sites. This indicates that the datasets have broad but not complete coverage.
- 7.11 Table 4.6 below shows the distribution of the data by practice owner and practice type for the period 2023-2024. The data included approximately 2 million claims, with on average [redacted] for independents and [redacted] for LVGs claims per practice in Insurer 1 and insurers 2's data sets respectively.

Table 7.1: Sample Distribution by Practice Type

| | Insurer 2 [REDACTED] | Insurer 1 [REDACTED] |
|----------------------------|----------------------|----------------------|
| Number of claims | | |
| All practices | [REDACTED] | [REDACTED] |
| Independents | [REDACTED] | [REDACTED] |
| LVGs | [REDACTED] | [REDACTED] |
| Unique practices | | [REDACTED] |
| All practices | [REDACTED] | [REDACTED] |
| Independents | [REDACTED] | [REDACTED] |
| LVGs | [REDACTED] | [REDACTED] |
| Claims per practice | | [REDACTED] |
| All practices | [REDACTED] | [REDACTED] |
| Independents | [REDACTED] | [REDACTED] |
| LVGs | [REDACTED] | [REDACTED] |

Source: CMA analysis using both Insurer 2 [REDACTED] and Insurer 1 [REDACTED] data

Note: The sum of unique practices for independents and LVGs does not always match the total number of practices. This discrepancy arises because, during the 2023-2024 period, some independent practices were acquired by LVGs, resulting in the same practice being included in both groups.

Data processing and identification of type of site

- 7.12 The insurance customer data contains information on the name and location of the practice where the pet was treated, and the postcode of the customer filing the claim. This data, consistent with the scope of our investigation, covers only small companion animals and not equine or farm animals.
- 7.13 The data was requested primarily for the purpose of econometric analysis, so covered the last 10 years. Since we are concerned with how far people currently travel to visit a vet, we restricted the dataset to observations dated between July 2023 and August 2024. In principle, if there were no significant events to disrupt consumer behaviour one could use a longer period. However, travel patterns are likely to have been different during Covid. Additionally, we are interested in the travel patterns for current sites, and using data from the last year reduces the likelihood of including sites that have ceased trading.
- 7.14 In order to identify which practices were FOPs, as opposed to referral centres, or other types of clinic, which are out of scope (around 7% of clinics responding to our questionnaire were not FOPs), we utilised the responses to our information request to LVGs and independent practices. As set out in paragraph 2.10 we attained full coverage for LVGs and nearly full coverage for larger independent groups, but had some information missing for smaller independents. We assigned an ‘unknown’ marker to practices who had not responded, as we were not able to

confirm either that the practice was active or that it offered FOP services. This left us with:

- (a) a set of known FOP clinics, which matched to sites in the insurance data and therefore used to calculate catchment areas;⁶⁷ and
- (b) a set of unknown FOP clinics, where we did not have a return to our information request, so we did not include these when calculating catchment areas.

7.15 The datasets lacked a common unique identifier, so matching was conducted using site postcodes and practice name. Since different sites can share a common postcode, and there were instances of this within the datasets, matching could not be conducted on postcode alone.

7.16 We encountered two related but slightly different issues. First, some postcodes only appeared in the insurance data once but appeared in the cross-market RFI more than once. Second, some postcodes appeared in both the insurance data and the cross-market RFI more than once. To choose the correct match, a string similarity metric was calculated between the practice name in the insurance data and the practice name in the data from the cross-market RFI. The correct match was chosen based on the lowest string similarity metric (for instance the practice names were the most similar), below a certain threshold.⁶⁸

7.17 We note that since some sites did not respond to our information requests, the coverage of the cross-market RFI dataset is limited. As a result, there may be some postcodes where two practices exist, but we only have one in the cross-market RFI dataset. This means that it is possible that some referral-only sites or OOH only providers⁶⁹ in the insurance data were incorrectly assigned a FOP label, if they shared a postcode with a FOP from the cross-market RFI data and the referral site or OOH provider did not respond. Since customers are likely to travel further to visit such sites, this may increase the size of our catchment areas, although this is likely to be largely mitigated by our approach of excluding the 20% of customers who travel the furthest (set out in more detail in paragraph 7.22).

Urbanicity

7.18 We grouped sites based on a measure of the population density in the area in which they are located. This is because travel patterns are typically different in densely populated urban areas to those in sparsely populated rural areas.

⁶⁷ There were additional known FOP sites which had not had not submitted insurance claims in the last year.

⁶⁸ A Jaro-Winkler similarity was used for the string similarity metric. A threshold of 0.4 was used and was selected based on manual checks of the score assigned to the correct matching observation.

⁶⁹ We did not assign a FOP variable to any practices with 'Vets Now' in the name, as it is a known OOH service provider.

- 7.19 The ONS produces a rural/urban classification of output areas,⁷⁰ which classifies each output area as Urban or Rural, with four urban subcategories and six rural subcategories. We assigned each site to a rural/urban classification, which allowed us to group them by urbanicity. To do this, we used the ONS Postcode Directory from August 2024 for England, Scotland and Wales. We used the ONS Postcode Directory from August 2011 for sites with Northern Irish postcodes, as this was the most recent year with a classification variable for this region.
- 7.20 We matched each output area to the corresponding postcode and used this to associate the ONS classifications of urban or rural with each FOP in our data set. We calculated catchment areas for each of these ONS classifications. However, we did not consider that it was appropriate to use up to 10 different urban/rural classifications in our analysis. This is because the sample size in some of the subcategories was small, such that the results were unlikely to be robust, and customers' willingness to travel is likely to be similar across some of the subcategories.
- 7.21 Based on a combination of our analysis of the definitions of each subcategory and the drive times produced when we estimate catchment areas for all subcategories, we aggregated into four categories as follows:
- (a) Urban: Settlements of 10,000 people and over.
 - (b) Small Town and Accessible Rural: Settlements of less than 10,000 people, and within a 30-minute drive time of a settlement of 10,000 people or more.
 - (c) Rural: Settlements of 3,000 to 9,999 people, and with a drive time of 30 minutes – but less than or equal to 60 minutes – to a settlement of 10,000 people or more.
 - (d) Very Rural: Settlements with a population of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a settlement of 10,000 people or more; and areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a settlement of 10,000 people or more.

Methodology to calculate catchment area

- 7.22 As set out in paragraph 7.2, we are using insurance data, rather than site specific data, to calculate catchment areas. When calculating catchment areas using site specific data, the catchment area for each individual site is calculated by estimating the drive time in which the closest 80% of customers travel from (closest in order of drive time). These '80% drive times' for each site can then be

⁷⁰ 2011 Urban Rural classification of output areas England, Wales and Scotland; 2001 Urban Rural classification of output areas Northern Ireland.

used to estimate an average drive time across sites in different urban/rural classifications in which the closest 80% of customers travel from.

- 7.23 The insurance data allows us to include customers of both LVGs and independents when calculating catchment areas, but since it does not include all customers of each, in general there are not enough customers at each site to estimate catchment areas for each site. To calculate the catchment area for different urban/rural classifications, we pooled data for all sites within each urban/rural classification and calculated the drive time in each pooled dataset from which the closest 80% of customers travelled to their FOP. This gives an analogous result to calculating site specific catchment areas and then averaging across them.
- 7.24 We filtered out any observations where the practice type, or rural indicator was 'NA', indicating that the practice was not in the cross-market RFI dataset or in either ONS Postcode Directory. We collated both insurance datasets, pooling customers for sites with the same postcode together. We note that there is a possibility that the same customer had an insurance policy, and submitted a claim, with both insurance companies. Using data for only one year reduces the risk of this and we do not consider it poses a material risk to our analysis.
- 7.25 We used ArcGIS, mapping software, to calculate the drive time between each site and customer in our insurance data. A drive time measures how long it takes a person to drive from an origin point to a destination point. Unlike straight-line distances, they can account for natural features that limit travel, such as rivers or mountains (which would have specific crossing points).
- 7.26 ArcGIS maps the distance between map grid references, but since we only have postcodes for sites rather than exact coordinates, the postcode was converted to a coordinate. Since a postcode area refers to a small geographic area, rather than an exact point, ArcGIS takes the centre of the postcode area as the coordinate. This coordinate may not precisely identify the location of a FOP or its customers but gives a sufficiently precise one for estimating catchment areas. We used the ArcGIS online network of average road speeds to estimate the drive times.
- 7.27 We did not weight catchment areas by revenue. Revenue weighted catchment areas are normally used when a store or site may derive higher revenue from customers who are closer. This mostly occurs when consumers make repeated purchases and can therefore split these purchases between different providers over time. This is not generally the case for trips to the vet where customers typically use the vet practice they are registered with and how much they spend at a practice will be based on clinical need rather than how close they are to the practice.

Evidence from internal documents and past cases on the catchment areas

- 7.28 We have also analysed internal documents, to identify if there is any evidence that suggests how large catchment areas are, particularly in the context of entry, exit, or acquisition and whether any such evidence is consistent with our analysis of the insurance data.
- 7.29 Internal documents provided by LVGs, related to acquisitions and closures of FOPs, look at the presence of competitors and local demographics within a distance of 12 to 40min and/or 5 to 15 miles of a focal site, with some variation between LVGs and also by type of site. There are also a few documents where LVGs have calculated catchment area (based on customer locations) for a target site. In particular:
- (a) Several documents from an LVG [REDACTED] which set out the rationale for the acquisition of FOPs, contain analysis of competitors within a five- to 15-mile radius around the target site or within 12- to 30-minute drive time. In particular, one document contains competitor analysis based on a five- to 15-mile radius around a proposed acquisition site, and it also considers the presence of [REDACTED] sites within a 15-mile radius.⁷¹ Some documents contain competitor analysis within five- and 15-mile radii around proposed acquisitions.⁷² ⁷³ A financial due diligence document looks at competition within a 15-mile radius of a proposed acquisition.⁷⁴ Another document contains competitor analysis within 30-min drive time (map) and 20-min drive time (table) of a proposed acquisition.⁷⁵ A further document contains competitor analysis within a 5-mile radius as well as analysis of vet saturation within a 12-minute isochrone, and it also considers presence of [REDACTED] sites within 15-mile radius.⁷⁶ A document contains competitor analysis within 20-minute drive time or 8.1 mile radius of a proposed acquisition and analysis of vet saturation within a 12-minute isochrone, as well as stating that the LVG's nearest site (17 minutes away) is outside the catchment area.⁷⁷ Another document includes competitor analysis within 12-minute drive time of a target site, considers presence of [REDACTED] sites within 15-mile radius, and contains implied market size analysis using a 16-minute isochrone (based on 80th percentile of clients).⁷⁸ A further document contains competitor analysis within a 30 minute radius, calculates catchment area of 18.3 minutes and also flexes the catchment area by 1.5x (27.5 minutes).⁷⁹

⁷¹ LVG Response to RFI3 [REDACTED]

⁷² LVG Response to RFI3 [REDACTED]

⁷³ LVG Response to RFI3 [REDACTED]

⁷⁴ LVG Response to RFI3 [REDACTED]

⁷⁵ LVG Response to RFI3 [REDACTED]

⁷⁶ LVG Response to RFI3 [REDACTED]

⁷⁷ LVG Response to RFI3 [REDACTED]

⁷⁸ LVG Response to RFI3 [REDACTED]

⁷⁹ LVG Response to RFI3 [REDACTED]

- (b) A document outlining the background and rationale for closure of 14 FOPs states that where an LVG [REDACTED] is closing a FOP, it transfers customers to the nearest alternative LVG FOP which has been up to either 17-miles or 29-minutes, drive time from the closing site. The LVG’s own analysis indicated that it expected to retain at least half, and for many sites over 75%, of the customers of the closing FOP.⁸⁰
- (c) According to documents, an LVG [REDACTED] indicates that it considers the local area is within [REDACTED] minutes’ drive time or [REDACTED] miles of a FOP. In particular, a document setting out the strategy for the opening of new greenfield sites states that ‘*catchment set at [REDACTED] min drive time to align with the LVGs [REDACTED] existing estate capturing 80% active clients (Jan-23)*’.⁸¹ Another document setting out a recommendation for the acquisition of a veterinary practice includes consideration of the number of competitors within a [REDACTED]-mile catchment.⁸²
- (d) An LVG’s [REDACTED] documents make a distinction between [REDACTED] sites and [REDACTED] with [REDACTED] considered to have a wider catchment area ([REDACTED] minute) than [REDACTED] [spokes] ([REDACTED]-minute). In particular, a document setting out the rationale for the acquisition of a veterinary practice includes consideration of the number of competitors within [REDACTED]-minutes’ drive time;⁸³ another document shows [REDACTED] -minute and [REDACTED]-minute drive time catchment areas around a [REDACTED];⁸⁴ a further document considering opening of new sites within existing gardening retail sites maps ‘potential reach’ within a [REDACTED] to [REDACTED]-minute drive time;⁸⁵ an additional document setting out strategy for addition of new greenfield [REDACTED] states that any new greenfield [REDACTED] need to be at least [REDACTED]-minute drive time from an existing practice or new [REDACTED].⁸⁶
- (e) An LVG’s [REDACTED] document containing a third-party valuation of an independent practice shows ‘nearby competitors’ on a map, with the furthest one shown located [REDACTED]-miles away;⁸⁷ another document which sets out rationale for purchase of a new CT scanner states ‘*Intensity of competition: 7 practices within a [REDACTED]-minute drive*’;⁸⁸ and a further document containing advertising strategy ahead of opening of a new site outlines plans for digital advertising, door drop and digivan within [REDACTED]-minutes’ drive time, and advertising in ‘traditional OOH’ within [REDACTED]-minutes’ drive time.⁸⁹

⁸⁰ LVG Response to RFI3 [REDACTED]

⁸¹ LVG Response to RFI3 [REDACTED]

⁸² LVG Response to RFI3 [REDACTED]

⁸³ LVG Response to RFI3 [REDACTED]

⁸⁴ LVG Response to RFI3 [REDACTED]

⁸⁵ LVG Response to RFI3 [REDACTED]

⁸⁶ LVG Response to RFI3 [REDACTED]

⁸⁷ LVG Response to RFI3 [REDACTED]

⁸⁸ LVG Response to RFI3 [REDACTED]

⁸⁹ LVG Response to RFI3 [REDACTED]

- (f) Some investment case summaries from an LVG [REDACTED] which set out [REDACTED]. These same documents also include [REDACTED].^{90 91 92}
- (g) Several documents from an LVG [REDACTED] which set out the rationale for the acquisition of FOPs plot a map of the local area around the target site without specifying the distance used.^{93 94}

7.30 We have also reviewed many documents containing employment contracts and/or Joint Venture Agreements. The contracts include restrictive covenants, which set out a duration and a radius around a site (or multiple sites), preventing veterinary surgeons from opening a competing site. Across the documents we have seen, the period ranges from 6 months to 5 years and the radius ranges from 6 to 25 miles, though this varies between LVGs. In particular:

- (a) Restrictive covenants we have seen within an LVG's [REDACTED] internal documents include radii of [REDACTED] to [REDACTED] miles with durations of [REDACTED] to [REDACTED] years.^{95 96 97 98 99 100}
- (b) Restrictive covenants within an LVG's [REDACTED] documents contain a [REDACTED]-mile radius around any veterinary surgeries operated by the LVG [REDACTED] for a duration of [REDACTED] months (depending on tenure).^{101 102 103}
- (c) Restrictive covenants on the sellers of a practice, within an LVG's [REDACTED] documents apply within a [REDACTED] mile radii from the practice address (with the [REDACTED] mile radius being driven by the [REDACTED] for a duration of months to [REDACTED] years, all agreed within the context of sale and purchase agreements.^{104 105}

7.31 We also commissioned a quantitative survey of consumers who had visited a vet practice in the last 24 months. Although the main aim of the survey was not to investigate the size of the geographic market, it included some questions that give useful insights into consumer behaviour with regard to geography.

7.32 We found that 68% of respondents who have been at their vet practice for less than 10 years told us that they considered location when choosing their vet

⁹⁰ LVG Response to RF13 [REDACTED]
⁹¹ LVG Response to RF13 [REDACTED]
⁹² LVG Response to RF13 [REDACTED]
⁹³ LVG Response to RF13 [REDACTED]
⁹⁴ LVG Response to RF13 [REDACTED]
⁹⁵ LVG Response to RF13 [REDACTED]
⁹⁶ LVG Response to RF13 [REDACTED]
⁹⁷ LVG Response to RF13 [REDACTED]
⁹⁸ LVG Response to RF13 [REDACTED]
⁹⁹ LVG Response to RF13 [REDACTED]
¹⁰⁰ LVG Response to RF13 [REDACTED]
¹⁰¹ LVG Response to RF13 [REDACTED]
¹⁰² LVG Response to RF13 [REDACTED]
¹⁰³ LVG Response to RF13 [REDACTED]
¹⁰⁴ LVG Response to RF13 [REDACTED]
¹⁰⁵ LVG Response to RF13 [REDACTED]

practice.¹⁰⁶ Location was stated as the main reason for the choice of vet practice by 34% of respondents who have been with their vet practice for less than 10 years.¹⁰⁷ This was the most common main reason for choice of vet practice, followed by recommendation (23%). Of the respondents who moved to their current practice from another practice, 7% stated that 'For a better location - nearer home/easier to access/park etc' was one of the reasons for their choice of vet practice.¹⁰⁸

7.33 We consider that the internal documents and survey evidence are broadly consistent with the catchment areas that we have defined using insurance data.

Defining the competitor set

7.34 After defining the catchment area, we then defined the competitor set to allow us to calculate the number of rival fasciae in each area. In the market for first opinion services, the competitor set comprises of all commercial FOPs providing care to small companion animals during standard daytime hours. This includes GP style FOPs as well as veterinary hospitals and hubs which may provide other services alongside small companion animal first opinion services.

7.35 We were provided with a list of practices by the RCVS, but this did not include information on the range of services offered by each practice. We sent an information request to all practices on the RCVS list, asking them what services they offer. We have included in the competitor set all sites that told us that they provide FOP services for small companion animals or a mix of small animals and other types of animal.

7.36 We exclude from the competitor set:

- (a) sites that do not provide veterinary services to small animals (eg equine practices);
- (b) sites that only provide other types of veterinary services to small animals (such as OOH services, referral services, or telemedicine);
- (c) charitable providers of veterinary services, as these are not commercial FOPs and they only serve particular customer groups (and hence are not an alternative provider for most pet owners); and

¹⁰⁶ CMA quantitative survey, Q13. Still thinking about your current vet practice ([Q9]), thinking back to when you registered with them, why did you [VTEXT]? Please select all that you considered when making your decision. Base: Those who have been with vet practice for less than 10 years (1,757).

¹⁰⁷ CMA quantitative survey, Q14. And what was the main reason? Base: Those who have been with vet practice for less than 10 years and who had more than 1 reason (1,757).

¹⁰⁸ CMA quantitative survey, Q33. You said earlier that you had moved to your current practice from another practice. Why did you decide to leave your previous vet practice? Base: Those who moved from another practice (740).

- (d) specialist sites that only offer a limited range of services (such as vaccination only centres, sites specialising in providing Animal Health Certificates for pet travel, and sites focusing on small animal physiotherapy and pain management).¹⁰⁹

Sites that only provide other types of veterinary services

7.37 Sites that only provide other services of veterinary services to small animals, such as OOH services, referral services, or telemedicine, are complementary to FOP services rather than substitutes for FOP services. In particular:

- (a) Referral-only centres are unlikely to be an alternative for consumers wishing to use a first opinion veterinary service, as by their nature, referral-only centres for specialist care can only be used after visiting a FOP and obtaining a referral;
- (b) we do not consider that there can be material demand-side substitution between veterinary services provided during standard daytime hours and those provided outside of these hours, as:
 - (i) OOH is usually in response to a veterinary emergency, outside of standard small animal veterinary service hours;
 - (ii) OOH consultations and treatments generally incur premium pricing for consultations and any callout charges, and
 - (iii) the services offered can differ between the two types of facilities (for example, FOPs may typically offer vaccinations and neutering, which would not typically be conducted in OOH sites). Based on this, we consider that OOH forms a distinct product market from standard hours small animal services, and have assessed this separately; and
- (c) Other services such as telemedicine do not provide the breadth of services offered in FOP practices and are offered by some providers as a complementary service to their FOPs.

Charitable providers of veterinary services

7.38 Only customers who are eligible for particular income assistance are eligible to access the service of most charitable providers, which means they generally do not compete with commercial FOPs for most pet owners. Charitable providers include the People's Dispensary for Sick Animals (PDSA), the Royal Society for the Prevention of Cruelty to Animals (RSPCA), and Animal Trust.

¹⁰⁹ For example, Jollyes, Pet Setters, and Active Pet.

7.39 There are differences between the business models of charities and commercial sites which limits any competitive constraint from charitable providers on commercial FOPs. Charities typically offer a narrower range of veterinary services, focusing on cost-effectiveness (or ‘pragmatic care’), in order to ensure that their funds and provision can extend to as many pets as possible.

Specialist sites that only offer a limited range of veterinary services

7.40 Specialist sites offer a limited range of services. The largest chain of specialist sites is Jollyes – The Pet People (**Jollyes**), a specialist pet retailer operating 103 retail stores across the UK, of which 75 also include Community Pet Clinics (‘CPC’) which offer a limited range of non-invasive treatments, primarily vaccinations and microchipping services for cats and dogs.¹¹⁰ CPCs typically operate for 3 to 4 hours, one day per week; however, in a few locations, they may trade for longer periods. Therefore, these sites are not an alternative provider for most pet owners.

7.41 We have not sought to exclude FOP sites that have chosen to focus on the treatment of a certain type of small animal (for example, cat- or dog-only sites), though we note that these will only be an option to a subset of customers.

Methodology

7.42 Our initial data gathering is based on a list of UK veterinary practices provided by RCVS. Basic information such as site name, address, and contact details were available for most of the listed practices. This allowed us to contact 98% of all possible sites, based on this list. RCVS also provided additional information for certain sites, including type of animals treated, accreditation level, the number of veterinary surgeons employed, and opening hours.

7.43 For LVGs and large independent groups (ie small and medium chains), we requested information through issuing s174 notices.¹¹¹ For smaller practices (single site as well as smaller groups), we sent a cross-market voluntary RFI.¹¹² We received responses from all six LVGs and 20 out of 23 small and medium independent chains. While response rates were notably lower among very small independent practices compared to corporate groups, an overall response rate of just under 80% provided a robust data set for identifying the competitor set.

7.44 For each vet practice we contacted, we requested the following information:

(a) Site name and address;

¹¹⁰ Independent response to RFI 1 [§]

¹¹¹ LVGs: RFI4, July 2024; Small and medium chains: RFI2, July 2024.

¹¹² CMA data request from all first opinion practices, [Factual_data_request_from_all_FOPs.docx](#)

- (b) Type of practice (eg, small animal FOP, mixed animal);
- (c) Year and month the site opened;
- (d) Whether the site is part of a group (and if so, which group) or a single site;
- (e) Opening hours;
- (f) Number of consultation rooms and operating theatres;
- (g) Number of Full-Time Equivalent (FTE) Vet surgeons;
- (h) Practice Standards Scheme accreditation level, either actual or the level the site would aspire to if it had not applied for accreditation;
- (i) Services provided at the site;
- (j) Referral services (where offered on site);
- (k) In-clinic diagnostic equipment;
- (l) OOH arrangements (including external OOH provision); and
- (m) Cremation arrangements.

Data processing

7.45 Variation in both form and completeness of responses necessitated a thorough process of data cleaning and standardisation to ensure consistency in our dataset. We assume all information provided is accurate, but also acknowledge the potential for residual errors or inconsistencies inherent in self-reported information. Steps were taken to mitigate for these factors. For example:

- (a) For cases where a FOP appeared to have submitted multiple responses to our information request, only the most recent response was retained, as indicated by the latest completion date in the raw data. A total of 44 duplicates were dropped.
- (b) Where necessary, responses were also cross-checked against publicly available information on the relevant practice's website. This was done to verify accuracy, clarify potential ambiguities, and include missing information, ensuring the data accurately reflected a given FOP's operations.¹¹³

¹¹³ In total, these changes affected 65 sites.

- (c) Other relevant changes, for example site closures¹¹⁴ or changes to the type of services provided by a FOP, were implemented as and when this information became available to us.

7.46 Given the importance of understanding ownership distribution among FOPs, we constructed an ownership variable to provide clearer visibility of each site's ownership status. Due to data limitations, our approach varied between group-owned and independently operated sites:

- (a) For practices owned by LVGs or that indicated they were part of another group, we used information on group ownership, specifically the group name provided in their response.
- (b) For small independents that indicated they were part of a group but gave no group name or other similar cases where the group affiliation was not clear, ownership was instead inferred based on site name and in some cases required further cross-checks. Where a multi-site independent failed to reflect that they operate more than one site (that is, group name showed as 'NA' or where this information was only provided for some of their owned sites), or where there were minor discrepancies between site names (eg, [⌘] and [⌘]), we employed a similarity metric,¹¹⁵ which allowed us to extract pairs of site names that exceeded a defined similarity threshold. For practices flagged by this metric, we cross-checked our data with publicly available information, primarily through veterinary practice websites. Where we identified discrepancies, site ownership was adjusted accordingly.

7.47 By establishing a variable that accurately reflected ownership status at each FOP, we were able to construct a competitor set that provides a clear indication of the number of competitors in each local area.

Local area competitor set methodology for known sites

7.48 In constructing the competitor set, we adopted a two-stage approach. We did so to reduce the number of areas requiring further analysis and to prioritise those that might give rise to prima facie competition concerns.

7.49 In carrying out our initial analysis, we considered a catchment area for each FOP in our data set to assess the competition it faces. In order to calculate the number of competitors that lie within the catchment area of a given FOP, we needed to first calculate the relative proximity of each site to other sites in the area. This meant

¹¹⁴ For example, Valley Vets (owned by VetPartners) has closed 4 of its sites in Wales since responding to our questionnaire.

¹¹⁵ A Jaro-Winkler similarity metric measures the similarity between two strings, accounting for the number of matching characters and their order. The resulting similarity score ranges from 0 (completely dissimilar) to 1 (exact match). Here, we set a similarity threshold of 0.9. This is the minimum level of site name similarity required to consider two site names as potentially similar.

estimating drive times between all vet practices in the UK. In order to minimise the computational load of this calculation we restricted our estimates for a given focal site¹¹⁶ so we only calculate the drive time to other sites lying within:

- (a) a 50-mile radius of the focal site in England, Wales, and Northern Ireland; and
- (b) a 100-mile radius of the focal site in Scotland. This is to reflect larger catchments in sparsely populated areas in Scotland where there are generally fewer FOPs.

7.50 Using ArcGIS, we calculated drive times based on average speeds between each focal FOP and all other FOPs within the specified radial distance.¹¹⁷ We then applied the relevant catchment area measures, as shown in Table 2.2, to identify which FOPs fell within the focal FOP's catchment area.

7.51 This enabled us to produce a unique local area competitor set for every FOP in our data set.

7.52 We note that, in our initial analysis, we assume all FOPs that fall outside a given local area competitor set impose no competitive constraint on the centroid FOP and have initially only included known sites as competitors.

Local area competitor set methodology for unknown sites

7.53 We marked any sites that have not responded to our information gathering as 'unconfirmed sites'. We note that the RCVS list omitted some sites which we confirmed were active through our information requests, and included some which we were told were not active and/or did not provide small animal FOP services.

7.54 We intend to conduct further work to verify whether these unconfirmed sites are active FOPs, and if so, we will include them in our confirmed practice list. We will then update our filtering to include these sites. We are considering using the following resources to identify whether a practice is active.

- (a) Desk research looking to see if there is an active website that has been updated in the last year (or similar evidence).
- (b) Interrogation of insurance data to see if the site has submitted insurance claims in the last year.
- (c) RFI and/ or s174 notices.

¹¹⁶ A focal site being the vet practice on which a catchment area is calculated.

Referral Methodology

7.55 We followed a similar process in analysing FOPs and referrals. In this section we highlight some particular differences.

LVG Customer data

7.56 We gathered information from LVGs to better understand the geographic distribution of their customer base.¹¹⁸ For each of their individual sites, we requested the full address and postcode of each customer who had made at least one purchase from that site in the 12-month period commencing 1 July 2023. There was no indication of the type of services provided at each site, which is why we then matched this data to our existing list of referral practices.

7.57 As an initial step, we collapsed the customer data so that each site had one unique entry. We then merged the data sets using matching criteria based on identical postcode and ownership entries. Since multiple sites can share the same postcode, we also assessed similarity of site names and addresses using a Jaro-Winkler string similarity score. In the case of multiple matches for the same postcode, similarity was used to choose the correct match, selecting the entry with the lowest similarity score as the best match and dropping any other matches. Where required, reference site's 'site number' was used to further verify matches.¹¹⁹

Data limitations

7.58 In a previous data submission from an LVG, we noted several cases where more than one site number was combined to reflect multiple cost centres that operate out of the same premises.¹²⁰ These cost centres were presented separately in a more recent data submission.¹²¹ As a result, such sites required a more nuanced approach to matching. Instead of using a similarity score to decide on the correct match, manual spot checks were carried out (primarily against practice websites) on a case-by-case basis to ensure we captured the customer data associated with the correct referral cost centre.

Missing customer data for referral-only sites

7.59 Where relevant, each LVG set out a list of sites for which they were unable to provide customer data, as well as cases where a site had been closed for part of

¹¹⁸ LVGs' [REDACTED] RF15 Response, Question 1. [REDACTED]

¹¹⁹ In our correspondence with LVGs, we requested that a unique 'site number' be attached to each site they submitted information on.

¹²⁰ LVG Response to RF14 [REDACTED]

¹²¹ LVG Response to RF15 [REDACTED]

the specified period and thus where customer data was limited. This affected six sites in total.

Excluding [REDACTED] sites from catchment calculation

- 7.60 An LVG [REDACTED] submitted that, as well as providing OOH services, two sites belonging to its dedicated OOH business [REDACTED], provide small animal specialist referral services as well as OOH services.¹²² The customer mix at these sites will thus capture those using OOH services and / or referral services.¹²³ Both serve separate purposes and cater for different types of customer needs. Therefore, the geographic distribution of customers using these services will also differ. We thus excluded the OOH Operations [REDACTED] from our catchment area calculation for referral-only sites but included both in the competitor set.

¹²² LVG Response to RF15 [REDACTED]

¹²³ LVG Response to RF15 [REDACTED]