CMA Consultation Response – Perspective from a Rural Mixed Practice

Thrums Vets is an independent, mixed rural practice serving the communities of Angus and Perthshire. We employ 26 vets across four branches, delivering care 24 hours a day, 365 days a year for small animals, farm animals, and horses. Our practice is built on the core values of **integrity, community, excellence, happiness, and friendship** — principles that guide our commitment to clinical integrity, continuity, and deep-rooted community trust. These values are reflected in nearly 1,000 online reviews averaging 4.8 to 4.9 stars.

We feel compelled to respond to this CMA consultation because many of the proposed remedies — particularly those concerning medicines and prescribing — risk serious unintended consequences.

We strongly support transparency and fairness in the veterinary sector. However, many of the CMA's proposed remedies—especially around medicines and prescriptions—risk causing serious unintended harm to independent practices like ours. These remedies, if poorly implemented, could stifle new start-ups and drive established businesses into a new wave of corporate ownership. The result would be reduced competition, lessen community-based care, and diminished client choice.

We strongly recommend that new regulation is introduced which allows the RVCS to regulate veterinary businesses.

Question 1

From a viewpoint within a rural mixed practice, we support the CMA's aim to improve transparency and client understanding. However, the proposed remedies — particularly those relating to pricing and medicine — must be implemented with deep awareness of the operational realities of independent, non-corporate practices. We strongly recommend that implementation be approached in stages, prioritising guidance and support over penalties.

Flexibility in delivery method will be essential. Mixed practices deal with multiple species across wide geographies, often with minimal admin infrastructure. A centralised set of templates, sample language for disclosures, and guidance on publishing ranges would help level the playing field between corporate groups and independent practices. Most importantly, implementation must not assume a one-size-fits-all solution. What works in urban, SA-only settings will not translate directly to rural, field-based care.

We also caution **against** allowing these remedies, designed for SA practices, to inform the regulation of equine and farm work without a separate, species-specific assessment.

Question 2

We support the trialing of information remedies prior to any national rollout. Trialing should include a broad spectrum of practices, including rural and mixed models — not just urban, companion-only providers. This will allow the CMA to understand unintended effects in lower-density, lower-margin regions.

Suggested trial elements include:
- Standardised pricing templates
- Disclaimers and explanatory statements to manage expectations
- Alternative digital vs physical display formats

Criteria for assessing effectiveness should include:
- Actual client understanding and satisfaction (via feedback, not assumption)
- Impact on uptake of services (e.g. any reduction in consultations or procedures following publication)
- Admin burden (especially in small teams)
- Comparison of outcomes across practice types and regions

We caution that transparency alone is not a proxy for quality or fairness. Remedy trials must measure whether outcomes improve for both clients and practices — and whether trust and care continuity are preserved. In this sense, it is imperative that an impact assessment is done before a national roll out is enacted.

CMA Consultation Response – Remedy 1 (Published information for pet owners)

Question 3

Yes, the standardised price list appears to cover the core services most small animal pet owners would expect, such as consultations, vaccinations, neutering, and preventative medications. However, additional clarity on dental procedures, chronic medication reviews, and diagnostic investigations (e.g. X-rays, blood tests) would be beneficial. These

are common but often excluded due to variability. Acknowledging these as 'variable cost' categories with a minimum or range would enhance client understanding.

Question 4

The proposed information is broadly feasible, but practices will need time and resources to implement it accurately. Listing what is included in each service is helpful, but in a real clinical setting, cases evolve. A checklist-style format may help standardise this without being overly restrictive. We also recommend including average consultation length, whether follow-up is included, and clarity on sedation or post-op care.

Question 5

Size (or weight) of the pet is the most reasonable factor for price variation, as it influences medication and anaesthetic use. Age, breed, and health condition can also impact procedure complexity but are harder to standardise in pricing. Using broad categories like 'small/medium/large dog' or **'healthy vs complex case'** may help with client understanding without overcomplicating the list.

Question 6

'Starting from' prices should reflect a straightforward version of the service — e.g. neutering a healthy, young small-breed dog. Price ranges could be based on actual recent practice data, omitting outliers. A 'typical price for most cases' label could also help manage expectations. What's **essential** is the inclusion of disclaimers explaining how complexity can increase cost.

Question 7

Yes, provided the list is user-friendly, well-explained, and set in context. It has the potential to reduce anxiety and empower decision-making. However, the list must be accompanied by a clear message that veterinary care is individualised and that price is only one part of the decision. The price list on its own, without context, will do more harm than good.

Question 8

Publishing prices for core services is proportionate. However, requiring detailed pricing for every possible service is not. In a small rural practice, we often adapt care based on what's best for the pet and client circumstances i.e contextualized care— too much rigidity would create friction. We suggest focusing on the top 10 common services per species, plus guidance on when further costs may arise.

Question 9

Yes. Clients may misinterpret 'starting from' prices as fixed, leading to confusion or dissatisfaction when the final bill is higher. Alternatively, they may avoid seeking treatment altogether due to fear of cost. There is also the risk that clients compare on price alone, not understanding the value of continuity, experience, or time spent.

Question 10

Yes. Independent rural practices — especially those without dedicated admin or marketing teams — may struggle to keep lists accurate and updated. Some practices still do not have comprehensive websites, and those with limited internet access will be disproportionately affected. This risks widening the gap between corporates and independents, and may make small practices look less competitive, even when they offer more tailored or accessible care.

Question 11

Pet owners should be supported to choose on more than just cost. Quality indicators could include:
- Whether the practice is independently owned
- Availability of OOH services
- Continuity of care (named vet or lead clinician model)
- RCVS Practice Standards accreditation
- CPD hours per clinician
- Testimonials or client feedback scores

These metrics give pet owners a broader understanding of care quality and values.

CMA Consultation Response – Remedy 2 (Comparison websites)

Question 12

A comparison site should prioritise clarity, fairness, and real-world relevance. Key information should include: - Core consultation fees
- Vaccination and neutering prices

- Prescription fees (including written prescription cost)
- Standard medicine pricing (e.g. for common flea/wormer brands) This must also include delivery times for medications. Quick access to medications is often **more important** than price.

However, composite pricing measures (e.g. 'average annual cost') risk misrepresenting practices who work across diverse geographical regions or customise care. Rural Scotland has a very different price structure and cost base to central London. These should be optional or supplemented with disclaimers. Medicine pricing should be published only for common items, as product ranges and dosages vary widely across pets and seasons.

Question 13

To maximise use, the comparison website must be:

-It should be a price **guide** website, not a price comparison website
- Simple to use, with species and service filters
- Clear about what's included and what isn't

It should be promoted through veterinary associations such as RCVS. Crucially, it should direct users to contact practices for tailored quotes, reinforcing that it is a guide — not a guarantee.

Question 14

Option (a), a single comparison site managed by the RCVS would be most effective. It ensures consistency, accountability, and trustworthiness.

Option (b), open data, risks fragmentation, misrepresentation, and SEO-driven dominance by large corporate groups. Uniformity and neutrality are vital. If it's not neutral, it will make things worse, increasing the corporates dominance of online pharmacies.

Question 15

Key challenges include:
- Regular updating of prices without a dedicated admin team. Will this be updated annually monthly or weekly?
- Standardising descriptions across services. If procedures are not standardised, the site will become gamified and will easily mislead consumers.
- Technical integration for smaller practices with basic websites

Solutions might include: simplified CSV upload templates, annual update deadlines, and

centralised support for non-digital practices. Mixed practices will also need the option to exclude non-SA services to keep data relevant.

A more appropriate option would be to roll out an extended version of the CMA's own web page "Choosing a vet practice and treatments for your pet". Every practice could signpost clients to this before they join the practice and the CMA/RCVS would be in control of having appropriate information here. Suggested information could include,

1.average costs for treatments

2. Breed problems and costs

3. finding a vet,

4. asking for options,

5. access to prescriptions,

6.information on sensitive topics such as cremations

7. how to complain.

This could be easily incorporated into the RCVS Find A Vet website.

Question 16

Providing price info based on animal type and weight is feasible for small animals, but quickly becomes complex in mixed practice. Weight affects drug costs, but not always labour or facility use. Age and condition (e.g. brachycephalic dogs) add more variation. We recommend allowing practices to provide typical examples (e.g. 'spay, 10kg dog') rather than requiring price differentiation for every characteristic.

Question 17

Where variation is common, we suggest showing price ranges (e.g. 'Dog dental scale & polish: £220–£450') with clear notes about what's included and why prices may rise. Visual aids — like tooltips or info icons — can help users understand complexity without overwhelming them.

Question 18

Funding should come from a central authority (RCVS or CMA), potentially supplemented by a modest levy on practices proportionate to turnover. This ensures access regardless of practice size. Funding should explicitly cover ongoing support and infrastructure — not just the initial build.

CMA Consultation Response – Remedy 3 (Pet Health Plans)

Question 19

For a rural mixed practice like ours, the impact of this remedy is likely to be minimal. We already provide clear summaries of our pet health plan benefits, and cancellation is managed with straightforward notice. We support fair client choice and have no objection to publishing terms visibly.. The greater risk lies in assuming all plans are alike — corporates may bundle or present plans differently, creating comparison difficulties.

Question 20

We do not expect this remedy to change what a typical plan includes. Most pet health plans already focus on preventative care: vaccinations, flea/worm treatments, discounts on consultations or routine procedures. If anything, increased transparency could help clients see more value in the plan rather than prompt reduction. For practices offering robust, transparent plans, this is unlikely to trigger significant change.

Question 21

The administrative burden will be low for practices already using digital platforms for plan management. Challenges may arise for practices that manage plans manually or via third-party providers with restrictive cancellation terms. We do **not** support giving an annual bespoke breakdown of plan usage to each client. In our practice alone, this would take an administrator **350 hours** of work per annum. This is a prohibitive cost four our business and would need to be passed on to the consumer. To resolve this, we suggest the CMA encourage best practice templates, minimum notice period standards, and clearer web display expectations, rather than enforce overly prescriptive tech requirements.

CMA Consultation Response – Remedy 4 (Referral Information for FOPs)

Question 22

In principle, supporting FOP vets to give clients a genuine choice of referral provider is a positive step. However, the feasibility depends heavily on having up-to-date, comparable data on referral provider services, wait times, outcomes, and pricing. In practice, many referrals are guided by specialist expertise, case urgency, and geographic access, rather than price or ownership model. Meaningful choice is only possible if the system supports shared, verified, and unbiased referral information.

Question 23

A potential detrimental consequence is further fragmentation of care if clients are pushed to select based on cost or branding, without understanding the clinical nuances. There is also a risk of eroding trust in the vet-client relationship if clients perceive that referrals are being withheld or filtered unfairly. Administrative complexity may increase if FOPs are expected to source, compare, and explain differences across multiple referral options for each case.

Question 24

Referral providers may face significant burden in standardising and regularly updating information, especially in smaller or independent referral centres. Differences in specialisation, regional access, and internal pricing policies may make uniform comparisons difficult. To reduce this burden, a centralised, RCVS-backed referral directory with standardised fields (e.g. ownership, species, specialism, expected wait time, payment policy) would help.

Question 25

As a mixed rural FOP, our priority is continuity of care and timely access to trusted referral colleagues. We already refer across multiple providers based on need, and support transparency. However, we would be concerned about regulatory overreach that assumes FOPs are gatekeeping access. Time pressures, client anxiety, and case urgency often dictate decisions — especially in rural areas with limited referral access.

Question 26

For clients, the most useful information would include:
- Species and specialism covered
- Typical wait times and urgency handling
- Summary of expected costs or cost structure
- Continuity of follow-up (back to FOP vs internal)

- Ownership model and independence (if disclosed transparently)

Clients benefit most from reassurance about quality, accessibility, and communication — not just pricing. A single-page summary, digital or printable, could support this at the point of referral.

CMA Consultation Response – Remedy 5 (Written Treatment & Referral Information)

Question 27

A financial threshold may help target administrative effort where the cost implications for clients are most significant. We suggest **£1000** as a pragmatic minimum threshold for mandatory written treatment information, balancing client protection with operational feasibility. Below this, verbal consent and explanation remain suitable in most cases, especially in a busy mixed or rural practice setting.

Question 28

A 'cooling-off' or thinking period may be appropriate for elective or high-cost procedures (e.g. over £1,000), but should be flexible. Where time is not a limiting factor, 24 hours may be sufficient. However, pet owners should always have the right to waive this verbally where urgent or preferred treatment timing is important to them.

Question 29

Yes, any requirement must include an exemption for emergency cases or those requiring immediate intervention. Delays in these contexts could worsen outcomes, and client understanding of urgency should be documented where possible.

Question 30

The administrative burden of formally recording every treatment option for every client would be prohibitive, especially in smaller practices. We estimate that this would add

approximately 4 minutes to each and every consultation. Across our practice, the total time cost for the CMA's remedies equates to 2 full time vets and a full time administrator. The **CMA must be aware** that we are not able to absorb these costs without either cutting clinical care or increasing client costs. Neither of which is acceptable.

Question 31

Treatment consent forms can be helpful where used appropriately, but they should not become overly legalistic or reduce client-practice dialogue. Unintended consequences may include:
- Clients feeling overwhelmed by paperwork
- Reduced trust if forms are perceived as liability protection
Training should support how to use forms as a communication tool, not a formality.

Question 32

The impact would vary. Corporate practices with central systems may absorb this easily, but small independent practices would face disproportionate workload. Mitigation includes phased implementation aiming at LVG's first, financial thresholds, digital tools, and RCVS-issued templates to reduce variability and training demand. Again this appears to disproportionately affect smaller independent businesses who do not had the central administrative support of the LVGs.

Question 33

Barriers include:
- Time pressures in consultations
- Complexity in cost estimation across varied species and conditions
- Emotional state of clients in acute situations
These realities must be acknowledged in the design of any remedy.

Question 34

Training would help if it focuses on:
- Communicating uncertainty in pricing
- Explaining treatment options clearly without undermining clinical recommendations
- Handling sensitive conversations during emotionally charged moments
Training should be concise, practical, and supported by scenario-based examples.

Question 35

The number of options should be proportionate to the clinical context. Where more than one valid approach exists, it is reasonable to explain those. However, the expectation should not be that multiple options must always be manufactured. Documentation should reflect genuine clinical reasoning.

CMA Consultation Response – Remedy 6 (Business Practices Limiting Client Choice)

Question 36

Business practices that directly or indirectly limit client choice — such as prescribing only in-house brands or restricting referrals to corporate-owned centres — should be clearly prohibited. These often arise from internal commercial policies rather than clinical reasoning. The RCVS could be given a broader role in maintaining and reviewing a list of prohibited practices, in consultation with profession-wide stakeholders. This approach must include protections for independent practices and avoid unintended penalisation of those already operating with transparency.

Question 37

Self-auditing may be a starting point, but for meaningful enforcement, independent audit mechanisms must be available — especially for large, multi-site operators. The RCVS could coordinate oversight with support from sector specialists. Any auditing approach should scale according to practice size and be focused on risk and transparency, not punitive inspection. This could be included in a compulsory PSS.

Question 38

Yes, larger veterinary groups (LVGs) should be monitored more closely. Their business practices — once systematised — can have wide-reaching effects across hundreds of sites. Compliance reviews should reflect the scale and influence of LVGs and prioritise areas such as medicine sourcing, referral pathways, and pricing transparency. Failing to do so would perpetuate existing imbalances in client choice and sector competition.

Question 39

Yes, the definition of 'business practices' should include internal guidance, incentives, and cultural norms that influence client-facing decisions. Many constraints are informal or embedded within targets or staff expectations rather than codified systems. A broad but practical definition will help prevent the circumvention of regulations while ensuring fair competition and client empowerment.

CMA Consultation Response – Remedies 7–10 (Medicines and Prescriptions)

Question 40

Yes, medicines administered by the vet during a consultation or procedure should be excluded from the mandatory prescription requirement. It is not clinically or logistically appropriate to issue a prescription in such situations, particularly for injectable or immediate-use treatments. A clear exemption should be made for 'in-consultation or procedural use' medicines to avoid regulatory overreach and protect workflow.

Question 41

Yes. The proposed remedies underplay the time burden of generating, tracking, and securely transmitting written prescriptions. In rural practices, where administrative capacity is lean and clinical time already stretched, this will likely require new systems and staff training. Also, requiring prescriptions for every eligible medicine, even where the cost difference is marginal, could inadvertently delay treatment. We estimate that currently each prescription would take between 3 and 5 minutes per consultation. In our practice this would equate to 2 full time equivalent vets working on admin at the expense of patient

care. This cost would either be passed onto consumers in the form of higher fees, or we would need to restrict patient access to our practice.

Question 42

A digital, template-based prescription system would be ideal, ideally integrated with practice software and VMD-compliant. Security should include vet identification, prescription timestamps, and one-time-use markers. Simplicity and compatibility across platforms are key to avoiding barriers for small and mixed practices. This would need to work with the current mix of 20 different PMS systems present in the UK. Currently there is no system available which does this.

Question 43

At least 24 months is required for practices to adjust workflows, train staff, and update software. A phased implementation, starting with SA-only, and exempting farm/equine practices until further consultation, would be a prudent approach.

Question 44

Prescriptions should clearly state the name, strength, and quantity of the medicine. However, prices should **not** be listed on the prescription form itself, as this may rapidly become inaccurate or misleading and detract from clinical messaging. Price comparison should be left to supplementary materials.

Question 45

Clients should be informed that a prescription is available, and that they may choose to use it elsewhere. This should be accompanied by a standardised explanation that the vet's recommendation is based on clinical need and not tied to in-house product margins.

Question 46

Option 1 (manual prescriptions) is low-cost but burdensome on clinical staff. Option 2 (semi-automated within PMS) is the most viable however many PMS's have limited API ability and are not be able to cope. Option 3 (e-prescription registry) would require major investment but could future-proof the system. Any rollout must consider the administrative limitations of small practices. The CMA should publish estimated costs for this in advance of any roll out.

Question 47

Generic prescribing is **only** feasible where equivalence is proven and clinically appropriate. Prescriptions should then name the active ingredient, dosage, and formulation, with optional 'no substitution' instructions where needed. The VMD **must** provide definitive equivalence lists to assist with this. While generic prescribing might seem logical, veterinary medicines are not like-for-like with human generics. A veterinary medicine may come as a tablet, liquid, paste, chew, or injectable, with formulations tailored for species-specific dosing and palatability. For example, a liquid is often needed for cats, while other species may require a paste. Generic versions may use different carriers, coatings, or flavourings — which can affect both compliance and efficacy. Treating them as interchangeable without robust VMD oversight is not only clinically unsafe, it's logistically naïve.

Question 48

Few proposed changes could be made under existing rules, but a wider rollout of generic prescribing would require VMD oversight, and revised guidelines. Legal clarity on liability where substitutions are made would be essential. If an online pharmacy made a generic substitution, they must be legally liable for any sub optimal outcomes.

Question 49

A significant unintended consequence could be loss of cross-subsidy. Modest margins on SA medicine sales currently help support services like OOH care and large animal work in rural mixed practices, which are otherwise marginal. Undermining this structure may weaken the overall availability of veterinary services in large swathes of rural areas.

Another unintended consequence would be driving medicine sales to online pharmacies, which are predominantly owned by LVGs. This in turn increases their profits, with reducing independent practice incomes. Independent will then need to increase their fees to remain viable and at the same time corporates could use their increased profits to embark on a further round of acquisitions, ultimately reducing competition and further increasing the cost to the consumer. We need a vibrant independent sector to shine a light on corporate practices. Indeed, the CVS share price saw a 30% jump when the stock market saw these remedies. Big finance can see how this will play out.

Question 50

Only medicines which are on a VMD equivalence list could benefit from generic prescribing. Products for chronic disease management, vaccines, or narrow therapeutic index drugs should be exempt to protect continuity and safety.

Question 51

Yes. Exemptions should include vaccines, controlled drugs, injectables administered in-house, and medicines for complex or chronic cases where formulation differences matter. Vets must retain clinical autonomy to override generic substitution where clinically justified.

Question 52

Yes. To support mandatory generic prescribing, medicines must be certified with clear equivalence categories. Labeling, packaging, and formulation consistency must be addressed. This will require changes in how generics are authorised via the VMD's cascade system and presented to ensure functional substitutability.

Question 53

Manufacturers must be required to publish ingredient-level comparison tables and equivalence certificates. This should be hosted centrally, under VMD oversight, and updated in real-time. Practices must be able to access this easily before writing prescriptions.

Question 54

An e-prescription system should allow for either:
(i) a generic name with dosage form (e.g. 'carprofen 50mg tablets')
(ii) a dropdown list of equivalent branded options from a VMD equivalence list.

This must link with PMS software and allow for digital signatures and usage tracking.

Question 55

We do not support a rigid price control. A reasonable range or cap is acceptable, but it must reflect real staff time, admin cost, and risk assumed. A blanket cap (e.g. £5) would not reflect workload, prescription review needs, or liability. Clear client info is a better solution than tight regulation.

Question 56

Yes. A price cap could lead to practices ceasing to offer written prescriptions, increasing tension with clients and potentially reducing transparency. It could also encourage volume-focused corporates while penalising low-volume, high-service independents. Reduced

margins for independents while increasing profits for online pharmacies will harm competiton.

Question 57

A soft cap, reviewed periodically, or tiered by medicine category or service complexity would be fairer. Flexibility for rural and mixed practices must be retained. We recommend consultation with organisations like XL Vets and SPVS to define cost structures.

Question 58

This question does suggest that there is a lack of understanding in what is involved in this part of the veterinary profession. If it was “just a piece of paper” anyone could do it and it costs a couple of pennies. However, there is far more involved in developing the skills and knowledge to be able to do this safely and then be legally responsible for that prescription. Writing a prescription includes verifying dose, drug history, drug interactions, animal history withdrawal periods (in food animals), client records, and legal compliance. It also takes a significant amount of time and resource to qualify as a vet to prescribe a medicine. The average cost is around £25 when vet time and admin are included.

Question 59

Dispensing costs vary with drug type and packaging but typically include:
- Vet or nurse time to select/draw/label
- Admin for stock control and recording including legal compliance.
- Packaging/labelling
- Disposal/logging of any waste

Estimated cost per item: £8, rising for injectables or controlled drugs.

CMA Consultation Response – Remedy 11 & Implementation (Medicines Price Controls)

Question 60

As a rural independent practice, we do not support the implementation of any interim price controls for veterinary medicines. The market is already under pressure from online retailers and clients with rising cost awareness. Any further regulation risks destabilising the business models of independent and rural practices, who depend on modest medicine margins to help subsidise underfunded services such as out-of-hours care and large animal visits. Price restraint should be encouraged through transparency and client education — not enforced pricing limits.

We have seen no evidence that independent practices are making excessive profits and to reduce the practice income will only reduce clinical care.

We are **very** concerned that these proposals have been put forward before the CMA has published its profitability analysis for veterinary businesses. This omission makes it extremely difficult for stakeholders to assess whether the remedies are economically proportionate, particularly for independent practices. Without transparency on current operating margins across different business models, it is impossible to judge the potential financial strain that new regulatory burdens may impose.

Independents—especially those in mixed and rural settings—operate with thin and variable margins, often cross-subsidising OOH and farm work through medicine income. If these remedies are applied without a clear understanding of financial resilience, they risk accelerating the trend toward corporate consolidation, reducing client choice and further undermining local provision of veterinary services.

Question 61

We do not believe a mandated percentage reduction in medicine prices is appropriate or warranted. Practices operate in different regions with varying overheads, client needs, and case complexity. Artificially deflating prices could restrict access to timely treatment and disincentivise investment in stock, staff training, and client care. In a rural mixed practice, price flexibility is essential for financial viability.

Question 62

We do not support price controls, even for a subset of medicines. However, if a scope must be defined, the top 10 prescription medicines could form a discussion base, provided any such control remains voluntary, advisory, and accompanied by detailed impact analysis.

We remain opposed to forced capping, especially when it risks pushing clients away from local care in favour of lowest-cost online providers which are invariably owned but large corporate groups, who would then use their increased buying power to undermine local independent practices.

Question 63

Monitoring price control would impose a disproportionate administrative burden, particularly on smaller practices. Effective enforcement would require significant resourcing, likely leading to cost burdens that fall unequally across the sector. Moreover, surveillance of price compliance could erode trust between regulators and practices. Encouraging openness is preferable to punitive mechanisms.

Question 64

We favour a system design that promotes digital access, client empowerment, and consistency — without removing flexibility for clinical judgement or regional cost variance. A well-structured, RCVS-endorsed portal could host prescription tools and standardised price range guidance. However, this should be optional, not enforced, and must be designed in collaboration with mixed and rural practices who will bear the brunt of system limitations if not consulted early.

Question 65

We believe the cost of developing and maintaining any national e-prescription or comparison portal should be funded centrally, either by the CMA or through a public/private model involving government and regulatory stakeholders. In reality it should be funded by the LVG's who are the only stakeholder who will actually benefit from this. Independent practices should not be required to subsidise a system primarily aimed at client comparison, especially when larger corporates stand to benefit most from scale and automation. Equity of access and sustainability must guide funding decisions.

CMA Consultation Response – Remedy 12 (OOH Contract Flexibility)

Question 66

No tie-in or excessive notice period is appropriate when it comes to out-of-hours (OOH) care contracts. Independent practices must retain flexibility to adapt as clinical needs, geographical coverage, and service standards change. We recommend a maximum notice period of 3 months, which aligns with standard business norms and allows for continuity without creating an undue barrier to change. Longer periods risk locking practices into suboptimal arrangements that don't serve patient or client needs.

Question 67

Any early termination fees should be modest, transparent, and proportionate to actual incurred costs. A fixed cap — for example, no more than two month's average contract value — is appropriate. Early termination charges that penalise a practice for seeking better care for its clients or adjusting to local demand create unnecessary friction and undermine service responsiveness. OOH providers should compete on quality and accessibility — not enforce loyalty through contractual entrenchment.

CMA Consultation Response – Remedy 13 (Cremation Transparency)

Question 68

We are ambivalent about this remedy. In principle, increased transparency around cremation options and costs is welcome — particularly where it can ensure clients are making informed, timely, and respectful choices. That said, this area of care is highly sensitive and often delivered in emotionally charged moments. Over-standardisation or excessive emphasis on fee structures may feel inappropriate if not handled delicately.

Revisions to the RCVS Code and guidance could be helpful if they emphasise clarity, compassion, and consistency in how options are presented. However, rigid regulation should be avoided. The focus should be on tone and timing of communication — not just the mechanics of pricing.

Overall, we support guidance-led improvement, not prescriptive enforcement, in this area.

CMA Consultation Response – Remedy 14 (Cremation Price Control)

Question 69

We do not believe a price control on cremations is necessary or appropriate for most FOPs, especially not for independent rural practices. If any restriction is to be considered, it should apply only to vertically integrated businesses that both provide cremations and control pricing through their own supply chains. Independent practices typically outsource these services and have no influence over the base cremation fees. Applying a universal price control would be unjust and distort market dynamics unfairly against smaller providers.

Question 70

If any control were implemented, it should take the form of a guidance-based pricing framework or suggested upper thresholds, rather than a fixed cap. Practices need flexibility to reflect differing supplier costs, regional fuel charges, and level of service (e.g. collection, memorial options). Rigid controls risk oversimplifying a sensitive service and undercutting the dignity of end-of-life care.

Question 71

Any price control introduced should be strictly time-limited and reviewed after 12 months. The cremation market, like many others, is subject to fluctuating operational costs that are outside veterinary control. Long-term price fixing in such a variable market would not be sustainable or fair.

Question 72

If extended beyond a short-term intervention, any control mechanism should be monitored by the CMA, not the RCVS. RCVS should remain focused on clinical standards and professional conduct, whereas price controls are an economic regulatory function best overseen by a specialist body. Any future role for regulation must involve consultation with small and mixed practices to ensure fairness across the sector.

CMA Consultation Response – Remedy 15 (Regulation of Vet Businesses – Revised)

Question 73

Yes, we strongly support the introduction of a statutory regulatory framework for veterinary businesses. The current challenges facing the sector — including reducing client trust, inconsistent pricing, poor transparency, and commercial conflicts of interest — have emerged largely due to the rapid expansion of unregulated corporate ownership and consolidation within the profession.

Corporate structures now account for a significant proportion of UK veterinary provision, yet operate under limited regulatory oversight in contrast to individual veterinary professionals. This regulatory gap has allowed business decisions to override clinical priorities in some cases, creating pressure on pricing models, medicine dispensing practices, and the erosion of continuity of care.

Effective regulation of veterinary businesses would:
- Ensure consistency in transparency and client information
- Provide checks on conflicts of interest from vertically integrated models
- Protect the ethical foundation of the profession
- Ensure fairness for independent and mixed practices that already operate with integrity

We urge the CMA and government to pursue this reform as a necessary foundation for the future sustainability, fairness, and public accountability of the sector.

CMA Consultation Response – Remedy 16 (Developing New Quality Measures)

Question 74

One challenge is the complexity of defining quality across diverse practice types. What constitutes high quality in a rural mixed practice offering out-of-hours farm services will differ significantly from a corporate SA-only clinic in an urban area. Measures must also account for client expectations, case complexity, and continuity of care. If poorly designed, quality metrics risk rewarding branding and presentation over clinical substance.

Question 75

An enhanced Practice Standards Scheme (PSS), if appropriately reformed, could support client choice by highlighting meaningful differences in service quality. However, it must avoid becoming a marketing badge for corporates and instead offer transparency into real-world aspects of care, such as:

- Client communication and consent
- Emergency availability
- Ethical medicine use
- Continuity of care
- Post-treatment support

The scheme's success depends on credibility, regular auditing, and genuine professional buy-in.

Question 76

Enhancements should be modular, with different assessment categories reflecting species and service type. Rural and mixed practices should not be penalised for lacking advanced imaging or referral departments, for example. Accreditation should reflect the needs and expectations of the local population and the scope of services offered. Flexibility and context-specific metrics are essential to ensure fairness and comparability.

Question 77

The CMA should consider developing a national client satisfaction index or anonymous feedback platform — moderated by an independent body — to complement professional schemes. This would provide insight into the lived experience of clients, support reflective learning, and highlight practices that excel in communication and care.

CMA Consultation Response – Remedy 17 (Consumer and Competition Duty)

Question 78

We support a proportionate consumer and competition duty being considered as part of any wider statutory reform. However, it must be framed carefully to avoid undermining professional clinical judgment or reducing care quality in favour of price-driven metrics. The veterinary sector is fundamentally a healthcare profession, and while commercial awareness is important, a duty to consumers must be balanced with the duty to animal welfare and veterinary ethics.

Question 79

If introduced, a consumer and competition duty should be framed as a principle of enabling transparency, fairness, and access to care, rather than enforcing price uniformity or service commoditisation. The duty should:
- Promote clarity in service descriptions and pricing
- Safeguard client choice while respecting clinical autonomy
- Protect against anti-competitive behaviour, including vertical integration conflicts as seen with LVG's
- Apply proportionately across practice types and sizes, recognising the diversity of provision, especially in rural and mixed practice settings.

It should complement, not override, the existing regulatory focus on ethics, competence, and care quality.

CMA Consultation Response – Remedy 18 (Compliance Monitoring)

Question 80

Monitoring mechanisms can play a role in maintaining transparency and fairness, but they must be carefully calibrated. Broad, indiscriminate monitoring will likely create resentment

and administrative burden among smaller practices who already work with integrity. Monitoring will only be effective if it is intelligence-led, proportional to risk, and designed in partnership with the profession.

Question 81

Monitoring must account for the diversity in practice type, size, and location. Mixed and rural practices do not operate like urban SA-only corporates. A tiered model would be more proportionate, with basic reporting for small practices and targeted audits where there is clear cause. Self-declaration supported by occasional spot checks may strike the right balance between accountability and efficiency.

Question 82

The main benefits are improved consumer confidence and consistency. However, the costs include:
- Time diverted from clinical care
- Software and reporting upgrades
- Stress and morale impact on small teams

The burden will fall disproportionately on independent practices without central compliance infrastructure, unlike large corporate groups.

Question 83

To mitigate these burdens, regulators should:
- Provide templated compliance tools and auto-fill digital forms
- Focus on education and support, not penalties
- Offer grants or subsidies for small practice digital transition

Costs should be shared between regulators (funded publicly or through larger corporate levies) and FOPs, scaled to business size. One-size-fits-all enforcement must be avoided if fairness is the goal.

CMA Consultation Response – Remedy 19 (Enforcement)

Question 84

There may be value in giving the regulator powers to issue warning and improvement notices to both individuals and businesses, especially in cases of repeated non-compliance or deliberate misinformation. However, the extension of powers to impose fines, or to suspend or remove firms' rights to operate, should be approached with extreme caution. The veterinary sector includes a wide range of practice sizes, business models, and resource levels. Heavy enforcement powers risk chilling effects on smaller, independent practices and could create an atmosphere of fear rather than collaboration. Any such powers must be exercised transparently, fairly, and proportionately.

Question 85

There are several potential unintended consequences if these enforcement powers are granted without adequate safeguards:
- Risk of over-regulation and damage to small, community-based practices that lack corporate legal and compliance teams
- Disproportionate enforcement focus on paperwork and pricing, rather than care quality and client trust
- Erosion of morale in already overstretched teams, particularly in rural or mixed practices

To mitigate these risks, any enforcement powers must be accompanied by clear right-of-appeal processes, contextual risk assessment criteria, and mandatory consultation with the profession during development of enforcement frameworks. Enforcement should always be a last resort, following guidance and improvement measures.

CMA Consultation Response – Remedy 20 (In-House Complaints Handling)

Question 86

We support the introduction of a standardised framework for in-house complaints handling across veterinary businesses. A clear, consistent process would benefit both clients and practices by improving expectations, encouraging early resolution, and reducing escalation to external bodies. However, any requirement must be adaptable to the scale and context of each practice — particularly for rural and mixed providers who may have limited admin resources and diverse client groups.

Question 87

A proportional model should be adopted. At minimum, the process should include:
- Acknowledgement of complaint within a set time (e.g. 5 working days)
- Clear explanation of next steps and expected timeline for response
- A written outcome summary with escalation details (e.g. referral to RCVS or ombudsman)

The framework should allow practices to tailor communication style and team roles while still delivering transparency. It must be supportive, not punitive — designed to build trust and improve service quality, rather than create legalistic pressure.

CMA Consultation Response – Remedy 21 and 22 (VCMS Participation Requirement)

Question 88

Mandating participation in mediation, such as via the Veterinary Client Mediation Service (VCMS), is appropriate in principle, provided it is implemented proportionately and retains a spirit of collaboration. Mediation can be an effective way to de-escalate disputes, promote understanding, and avoid unnecessary regulatory escalation. However, it is essential that the process remains voluntary in tone, non-adversarial in practice, and properly resourced to meet the volume and diversity of cases.

Question 89

Mandatory participation could be structured as a formal requirement to engage in mediation after internal complaint procedures have been exhausted. However, some challenges may arise:
- Risk of increased burden on small and rural practices, especially where complaint volumes are low but administration is high
- Potential misuse by clients seeking compensation rather than genuine resolution
- Unequal footing if practices lack time or support to engage with the process fully
- Delays in outcomes if the VCMS becomes overwhelmed or proceduralised

There must also be clarity on whether mediation outcomes are binding or advisory, and how this aligns with other complaint or legal processes.

Question 90

To mitigate these risks:
- Ensure mediation remains flexible and accessible, with support for small practices
- Limit mandatory mediation to cases where it is clearly appropriate (e.g. service dissatisfaction, billing concerns)
- Provide template documents and guidance for responding to VCMS cases
- Monitor the administrative burden and review participation data regularly
In addition, practices should retain the right to request escalation to formal processes where mediation is not achieving resolution or is being misused.

CMA Consultation Response – Remedy 22 (Raising Awareness of the VCMS)

Question 91

Any requirement to publicise the VCMS should be practical, proportionate, and focused on accessibility. We recommend a multi-channel approach:
- Displaying a clear statement on the practice website (e.g. in complaints or client care sections)
- Including a short explanation in written complaints responses or treatment estimate forms
- Providing optional printed materials in reception areas

It is important that this requirement does not become overly bureaucratic. Templates, visual icons, or short-form wording provided by the VCMS or RCVS would support consistency. Practices should retain discretion in how they present the information, provided clients are made aware of the VCMS as a neutral, accessible option for resolving complaints.

CMA Consultation Response – Remedy 23 (Use of Complaints Insights)

Question 92

To make appropriate use of complaints data, the regulatory framework must shift from a reactive to a learning-focused model. This means collecting, analysing, and sharing anonymised complaints insights across the profession to identify common issues and promote quality improvement.

The regulator should:
- Aggregate complaints data centrally from the VCMS, RCVS, and direct practice reporting
- Identify patterns across referral, pricing, communication, and consent
- Feed these insights into training materials, professional standards, and CPD topics
- Avoid using data solely as a punitive tool — the focus must be on shared learning

It is also essential to ensure data is interpreted in context. Complaints must not be used as crude performance metrics, especially for practices in high-pressure or complex environments such as rural and mixed settings.

CMA Consultation Response – Remedy 24 (Binding Adjudication)

Question 93

Introducing binding adjudication could improve finality in complaint resolution and reduce escalation to litigation. However, challenges include:
- Risk of inconsistent decisions across practices and settings
- Possible undermining of professional discretion and clinical autonomy
- Increased administrative and financial burden on smaller practices, particularly those without legal support
- Risk of perceived bias if adjudicators lack strong veterinary sector knowledge

Question 94

A fair scheme should:
- Be limited to defined types of complaints (e.g. communication, billing, service delivery)
- Be staffed by panels with mixed expertise (legal, veterinary, and client advocacy)

- Offer written rationales and a route to appeal for both clients and practices
- Build on the existing VCMS infrastructure to avoid duplication, with clear transition rules between mediation and adjudication phases

Question 95

If introduced, the scheme would likely need to be statutory to ensure consistency, fairness, and widespread participation. A voluntary scheme could lead to patchy uptake and reduce trust in its legitimacy. However, participation should be framed as part of a broader framework of proportionate, supportive regulation — not as a punitive measure. Smaller and independent practices would need clear procedural guidance and support.

CMA Consultation Response – Remedy 25 (Veterinary Ombudsman)

Question 96

A veterinary ombudsman could offer clients an independent, final-tier resolution route, increasing trust and consistency across the sector. However, challenges include:
- Risk of duplication or confusion with existing bodies (e.g. RCVS, VCMS)
- Potential overreach into clinical matters that require veterinary expertise
- Risk of increased litigation-style approaches that damage the client-practice relationship
- Resourcing and cost, especially if the body becomes overloaded with minor or vexatious claims

Question 97

If introduced, a veterinary ombudsman scheme should:
- Focus on unresolved service and conduct complaints, not purely clinical decision-making
- Be the final step in a tiered complaints model (following in-house and mediation attempts)
- Include professionals from veterinary, legal, and public interest backgrounds
- Provide accessible, transparent decisions with consistent appeal mechanisms

Question 98

A statutory model is likely necessary to ensure authority, consistent standards, and fairness across all providers. A voluntary scheme risks uneven engagement and reduced

credibility. However, statutory oversight must be accompanied by strong guidance, clear remits, and robust consultation with small and independent practices to prevent disproportionate burdens and maintain sector confidence.

CMA Consultation Response – Remedies 26–28 (Veterinary Nurse Role & Regulation)

Question 99

The RCVS could provide clearer, more detailed guidance on the interpretation of Schedule 3 to the Veterinary Surgeons Act (VSA), including case studies or decision trees to help practices determine appropriate delegation. This would enhance confidence while reducing unnecessary variation. However, any clarification should reinforce that delegation requires supervision and is not a substitute for full training or experience.

Question 100

While more effective use of vet nurses can improve efficiency and patient care, there is a real risk that expanding clinical tasks under Schedule 3 may reduce opportunities for vet students and new graduates to gain essential hands-on experience. This is particularly concerning in rural and mixed settings where training breadth is crucial. If driven primarily by cost-saving motives — especially within corporate settings — such changes may erode clinical development and long-term care quality. If vet nurses would like to do more advanced procedures, there is already a route available, and this is to qualify as a veterinary surgeon.

Question 101

Any expansion of the veterinary nurse role under reformed legislation must balance accessibility, safety, and professional development. Potential benefits include improved access and service delivery, but the risks include:

- Fragmentation of care
- De-skilling of early-career vets
- Inappropriate cost-cutting by employers

This expansion must not become a vehicle for reducing staffing costs at the expense of training, continuity, or oversight.

CMA Consultation Response –Proportionality

Question 102

We are concerned that the outline assessment may fail to understand the complexity of rural and mixed practices. Increased regulation often brings disproportionate administrative burdens to small teams. Any reform should fully account for these differences, not just model outcomes on urban or corporate SA-only practices.

Question 103

To amend the assessment, we recommend disaggregating practice types by species coverage, region, and ownership structure. Costs and regulatory capacity vary dramatically, and reforms that seem neutral may unintentionally disadvantage independent or rural providers.

Question 104

Alternative reforms should be tested through stakeholder pilots and cost-impact modelling across different practice types. Mixed rural practices should be included in any impact assessments to avoid creating a regulatory system optimised only for high-volume and high profit corporates as many of these remedies appear to favour.

Question 105

A reformed system should be funded proportionately, with scale-appropriate levies. Separate streams for complaints handling, regulation, and clinical standards may be useful — but must not lead to unaffordable costs for small practices. Larger corporate providers should bear a greater share of the burden.