27 May 2025

Competition & Markets Authority
Veterinary Market Investigation Team
8th Floor
25 Cabot Square
London E14 4QZ

Dear Investigation Team,

Re: Consultation on Possible Remedies — Veterinary Services Market Investigation

I am writing on behalf of Animal Trust Vets CIC, the UK's largest community interest veterinary provider. Animal Trust Vets has grown from a startup to a sector disruptor, now treating over 100,000 pets annually, and as a CIC, our business model was specifically designed to support consumers access care in the light of difficult to justify sector price inflation.

We welcome the CMA's attention to the sector and support several elements of the proposed remedies. However, in our view, some of the proposals risk hindering innovation and may inadvertently reduce competition. In other cases, we believe the CMA's approach does not fully address the underlying competition issues or is disproportional. In fact some proposed remedies seem likely to distort the market in favour of large Veterinary Groups (LVG's), reinforce their dominance and raise barriers to market entry. We therefore urge the CMA to revisit and refine the proposed remedies to better target the identified concerns.

We submit the following observations.

Standard Price List and Comparison Site
Animal Trust fully supports the introduction of mandatory, standardised price lists and a centralised comparison website. Transparent and comparable pricing is essential to support informed decision-making, enhance consumer confidence, and promote effective market competition. However, for these tools to be meaningful and proportionate, they must be underpinned by safeguards that ensure genuinely like-for-like comparisons, represent what the patient needs and are accompanied by quality indicators.

Based on our experience as a long term published price provider, owners only benefit from transparency when headline fees are clear, inclusive, and consistent. Price lists that exclude key elements such as anaesthesia, consumables or VAT are neither fair nor informative. Similarly, procedures, (e.g dental work) must include all components that are commonly needed in the treatment so that the cost of care can be compared across providers, and mitigate the risk of low headline prices (e.g. dental descale) with expensive none regulated, but essential, add-ons (e.g. extractions).

The proposed categorisation across referral and other categories is misleading as some 'referral' procedures are common in FOP, the list is poorly representative of common procedures in practices and in the current form will be of limited value to clients. Out-of-hours (OOH) fees and emergency procedures, which are often a major and unexpected cost, are not featured on the list and must be clearly disclosed. If OOH is contracted to a third party practice, the providers prices should be disclosed as they are a material consideration for clients selecting a first opinion provider.

To prevent distortion and maintain fairness we believe the price list must:

- Deliver a single, all-inclusive price for what should be required for each treatment, covering all standard elements from admission to discharge.

- Differential pricing by weight or breed should be avoided to prevent complexity and selection bias.
- Headline prices must not be artificially lowered by shifting costs into unregulated add-ons.
- Chronic care packages must be standardised to product level e.g. specified pharmaceuticals and durations

To improve comparability, highlight value, and maintain relative consumer benefit, we recommend the inclusion of the following practical quality metrics:

- Volume of procedures performed annually (experience indicator)
- RCVS Practice Standards Scheme status and inspection outcomes
- Antibiotic usage per 1,000 registered patients (stewardship indicator)

Longer-term, once technology allows, metrics such as complication and outcome rates for defined procedures, using a national classification system, should be introduced. Piloting this with LVG's would support early implementation and system development.

In parallel, a central comparison website would improve market visibility for pet owners. To be effective and fair we believe this site must offer:

- Service and geographic filters (e.g., by region, practices with on site 24/7 inpatient care)
- Clear ownership disclosure
- Filtering by quality metrics
- Limited representative patient examples (e.g., a 15kg dog and 4kg cat) to aid comparison without overcomplicating pricing.

The most neutral and trusted approach would be a single RCVS-hosted platform. This would avoid commercial bias, ensure consistent presentation, and reduce conflicts of interest. The platform could be sustained via advertising from related industries, such as insurers or pet food companies, given the likely high web traffic.

However, delivery of both the standard price list and comparison tool is dependent on Practice Management System (PMS) capability. Current systems may not support standardised exports or API integration. To ensure participation from all provider types, especially smaller practices, the CMA should mandate PMS providers to develop and maintain the required functionality.

Require FOPs to publish information about pet care plans and minimise friction to cancel or switch

We believe this proposed remedy appears to be based primarily on concerns related to the preventative care structure commonly seen in many LVG plans. It does not appear to adequately consider the broader range of pet care plans currently in operation—particularly those that resemble membership models. These plans often include benefits such as complimentary consultations, diagnostic tests, or treatments. Their primary purpose is not to deliver significant cost savings, but rather to enable clients to budget for veterinary care by spreading cost and risk.

We are concerned that the proposed remedies would disproportionately affect more innovative health plans, especially those designed to offer clients reassurance that care is available when needed, as opposed to plans delivering regular, monthly preventative care. Without appropriate safeguards, such remedies may inadvertently lead to the removal of valuable plan features that require long-term cost averaging—such as complimentary lab work or consultations—or benefits that rely on broader risk pooling across a client base.

Furthermore, the administrative burden associated with the proposed client reporting requirements would be significant and may be disproportionate to the actual benefit to consumers. As currently proposed, this remedy would advantage LVGs, which typically operate bespoke, well-resourced health plan systems and can automate reporting. There are also technical constraints to consider. Many PMS's do not currently support the kind of data reporting being proposed, and compliance would therefore depend on future development by third-party providers. Without a mandate from the CMA many practices may find it unfeasible to deliver this information in a proportionate and consistent manner.

We would support a more balanced and proportionate approach to improving transparency and flexibility in health plans. Specifically, we propose:

- A 14-day cooling-off period.
- The ability for clients to cancel at any time without penalty, provided no benefits have been claimed in that year.
- Any claims of financial savings in marketing materials to be based on actual average client savings, rather than theoretical maximums.

Improving choice with referrals

The CMA's investigation has highlighted that vertically integrated large veterinary groups (LVGs) often direct referrals internally, thereby limiting owner choice. We support the proposal that first-opinion practices (FOPs) should be required to inform owners of their right to choose a referral provider and direct them to a centralised comparison website.

However, it is important to acknowledge that, in some cases, identifying a referral centre with availability can be challenging. Delays while exploring alternatives could compromise the patient's best interests by risking the loss of a referral opportunity altogether. Clinical judgement and case urgency must therefore be considered with the remedies to ensure that a requirement to provide referral options does not trump clinical needs

As both a referral provider and FOP we believe that directing clients to price comparison information is feasible providing it is a centralised comparison website. We do not support a FOP having to obtain multiple prices on a clients behalf as the administrative cost would not be proportionate to the benefit.

We want to highlight that referral decisions involve cost and clinical expertise. To ensure owners can make informed choices, pricing information should be accompanied by key contextual indicators, such as:

- Level of expertise involved in the procedure (e.g., Specialist-led, Certificate holder)
- Post-operative care provision, including whether 24/7 vet and nurse cover is provided on site
- Warranty for post procedure complications
- Procedure-specific outcomes and complication rates, once a nationally standardised reporting methodology is developed and adopted

Providing this information alongside pricing would allow owners to assess value in a more meaningful way, balancing cost with the quality and comprehensiveness of care.

Provision of clear and accurate information about different treatments, services and referral options in advance and in writing

While we support the principle of ensuring clients are informed of treatment and referral options, we believe that mandating written information for all treatments would place a significant and disproportionate burden on veterinary practices—particularly in the case of non-standard treatments, for which templated documentation may not be feasible. This would likely lead to increased operational costs, which in turn could raise the cost of care for clients and reduce access to timely veterinary services. It would be particularly unfair to low-cost providers like Animal Trust who rely on efficient process to deliver a low price point.

We agree that clients should be made aware of available options, but we do not support a requirement for this information to be explicitly documented in writing for all treatments. Given these concerns, if this remedy is implemented (which we do not support) we believe that any formal threshold for such written documentation should not be set below £1,000 and indexed annually.

The introduction of a mandatory "thinking time" period to consider treatment options would also have a disproportionate operational impact and, in certain cases, could pose a serious risk to animal welfare and clinical outcomes—particularly where care is time-sensitive. The current RCVS Code of Conduct already requires 'informed consent', and we would suggest that strengthening the accompanying guidance to more

clearly define what constitutes the presentation of options would be a more proportionate and effective remedy.

At Animal Trust, we already utilise procedure-specific consent forms, which we find to be a practical and effective way of providing tailored information to clients. However, such a model is not suitable for all conditions where the clinical picture or treatment pathway may not be fully known at the time of admission. In high-throughput, low-cost care settings, requiring a written explanation of all possible options in such scenarios would be administratively burdensome and offer limited benefit to the client or patient.

In our view, the emphasis should be on ensuring impartial, well-communicated guidance from veterinary professionals, rather than imposing rigid procedural requirements that may undermine clinical flexibility, delay necessary care and inflate costs.

Prohibition of business practices which limit or constrain the choices offered to pet owners

At Animal Trust, we have adopted a Community Interest Company (CIC) model to ensure that the needs of pet owners and their animals are prioritised over shareholder profit. While we advocate for this model as the most effective means of embedding community and welfare interests into veterinary provision, an alternative approach would be to require all veterinary groups to adopt a formal decision-making framework that explicitly protects animal welfare and consumer benefit.

If there is a prohibition on commercial incentives is included, in order to make the remedy proportional we believe that these should be subject to a safe harbour so it does not apply to practices operating at a group EBITDA of below 18%. This is significantly above what many practices, including us, operate at . It would still allow practices to reinvest in services, support sustainable growth, and deliver reasonable shareholder returns—without encouraging excessive profit-seeking behaviours that could harm patients or clients.

There is a balance between supporting commercial sustainability and preventing policies that risk prioritising profit over the best interests of pets and their owners. We therefore suggest that the CMA, rather than prohibiting all commercial incentives implements a remedy which requires veterinary businesses to maintain a decision-making methodology, demonstrating alignment with pet welfare and client outcomes and deliver a sensible profit level. We also believe that vertically integrated (LVGs) present the highest risk in this context, as they are both the most incentivised to introduce financial rewards for specific behaviours and the most structurally disconnected from front-line clinical decision-making. It is therefore proportionate for greater regulatory focus and enforcement on incentives and business practice limitations to be directed towards LVGs. Compliance with any such business practice constraints could be monitored through a combination of self-certification, RCVS PSS audits, and whistleblowing mechanism.

Changes to how consumers are informed about and offered prescriptions

While we fully support greater transparency for pet owners, the requirement to issue a written or electronic prescription at every consultation would introduce unnecessary delays, additional administrative costs, and a redundant process that is unlikely to deliver meaningful benefit. This burden would fall disproportionately on low-margin models such as ours.

In line with the CMA's principle of adopting least-distortive remedies, we propose a more proportionate and effective alternative:

- Targeted prescription trigger points: A prescription should only be provided when:
  - (a) the treatment is not time-critical, and
  - (b) the owner expressly requests one, having been clearly informed of their options.
- Pre-consultation disclosure: Practices should be required to provide clear, standard-format information on prescription options as part of appointment booking confirmations, prominently on practice websites, and through in-practice signage in waiting and consult rooms.
- Cost transparency through comparison tables: These disclosures should include reference to independent cost comparisons, showing median online pharmacy prices, local competitor

pricing (within a 20-mile radius), and the practice's own prices, for a defined list of regulated medicines.

This approach achieves the objective of transparency without creating a perverse 'issue and immediately hand back 'loop for clients who still prefer to have their prescriptions filled by their FOP. It also preserves clinical flexibility in urgent cases and avoids wasting veterinary time on unnecessary documentation. We wish to highlight that urgent medicines—those required immediately to prevent suffering or clinical deterioration—must continue to be dispensed directly by the FOP. Allowing clients to obtain these elsewhere would compromise animal welfare, breach professional obligations, and contradict the CMA's own principles of effectiveness and proportionality. Mandatory prescription requirements should explicitly exclude any medicines that are:

(i) urgently required
(ii) administered or initiated in practice for welfare reasons.

If this prescription remedy is implemented we believe anything other than an efficient and scalable prescription process through a fully digitised, secure and cost-effective e-prescription system, would result in a disproportionate administrative burden, and significant cost rises to practices and consumers. Such a system would need

- API integration with practice management systems (PMS), feeding into a centralised, VMD-governed e-prescription database.
- The owner chooses a dispensing outlet, which then securely retrieves and locks the prescription for use.
- Full audit trail - Time-stamped usage ensures regulatory compliance, prevents duplicate dispensing, and satisfies record-keeping requirements.

Again, the viability of such a system relies entirely on Practice Management System (PMS) providers building the necessary infrastructure. In the absence of this, mandating prescription provision could become highly distortive, placing an undue burden on smaller and independent practices. To ensure fairness and avoid disproportionate impacts, it is essential that the CMA requires PMS vendors to develop and maintain the systems needed to meet these regulatory obligations.

Implementation of these prescription changes will require a significant lead-in period, with the primary constraint being PMS capability, particularly for non-LVG providers who rely on third-party vendors. A 24-month transition would be realistic:

- 12–18 months for PMS development,
- 6–12 months for phased onboarding, staff training, and client communication.

Transparency of medicine prices so pet owners can compare between FOPs and other suppliers

To enhance transparency and facilitate informed consumer choice, we recommend that all veterinary prescriptions include the following statement:

"Medicine prices vary. This prescription may be dispensed by the prescribing veterinary practice, another veterinary practice, or a veterinary pharmacy. Shopping around may significantly reduce the cost of medication."

If a centralised price comparison tool exists, a link to this resource should also be included on the prescription.

This wording explicitly informs clients that they have the option to obtain medication not only from online pharmacies but also from alternative local veterinary practices or physical pharmacies—a point that is currently underrepresented in the draft remedy proposals. Such clarification is also important to open up competition for medications that are too urgent to be delivered by post. As it stands, the current remedy appears to unfairly favour online providers over physical, local outlets, which we consider to be inconsistent with the CMA's own principles of neutrality and minimal market distortion.

Including our proposed statement would enhance consumer transparency and promote healthy competition across both online and local markets, without imposing significant administrative burden on practices.

We also strongly recommend that veterinary surgeons should not be required to provide any further explanation or information beyond what is already stated on the prescription form. Many prescriptions are either posted to clients or collected at a later time, making it impractical to rely on verbal briefings at the time of issue. Any additional requirement would significantly increase workload and reduce clinical efficiency without adding proportional value.

Animal Trust supports the principle of developing a real-time API-based feed into a centralised medicine price comparison tool.

This would offer several key benefits:

- Maximised transparency and lowest search cost for owners
- Incentivisation of price competition, exposing excessive pricing and supporting dynamic pricing strategies
- Creation of a comprehensive data set to inform future regulatory decisions
- Allow online and physical pharmacies /practices to compete
- High accuracy and low maintenance, once configured

However, again, for non-LVG providers like us, delivering such a solution will only be feasible if practice management system (PMS) providers develop the necessary integration tools. Without PMS-level functionality, smaller practices would face a disproportionate burden in complying with this requirement.

Requirement for generic prescribing (with limited exceptions) to increase inter brand competition for medicine sales

We support the introduction of a requirement for generic prescribing in veterinary medicine. In line with human healthcare practice, we believe that a prescribing veterinary surgeon or pharmacist should be permitted to substitute a therapeutically equivalent product where the active ingredient is the same. This measure would clearly encourage competition in the veterinary pharmaceutical market and, in our view, represents one of the least disruptive remedies to implement at the practice level.

To enable this approach, we believe minor amendments to the Veterinary Medicines Regulations 2013 may be necessary—specifically, to permit the automatic substitution of licensed generic products within the same cascade tier.

We would, however, highlight a potential unintended consequence: manufacturers may begin seeking niche product licences with unique carriers or excipients to avoid generic classification. To mitigate this, we recommend that the Veterinary Medicines Directorate (VMD) be mandated to develop and maintain a "functional equivalence" register, clearly listing which products may be safely substituted. This would pre-empt regulatory loopholes and ensure consistent guidance for both prescribers and dispensers.

While generic prescribing can benefit access to a broad range of medicines, the greatest consumer value is likely to come from high-volume product categories where clinical equivalence is well established—such as systemic NSAIDs, single-agent antibacterials, and long-term medications for chronic diseases.

We support the inclusion of appropriate exemptions such as formulations where excipients or preservatives affect safety or tolerability, such as preservative-free ocular preparations

We do not anticipate that prescription requirements would need to change significantly beyond requiring prescribers to specify:

- The active ingredient,
- The concentration, and
- The dosage, based on the amount of active substance (e.g. mg), rather than by volume (e.g. ml) or unit (e.g. per tablet).

Dispensing practices or pharmacies should then be able to supply any product that meets the stated specification, provided it is on the functional equivalence list.

We recommend a defined pathway to opt out of substitution in specific cases to ensure clinical safety. Where a prescriber chooses not to allow substitution, they could be required to provide a clinical justification—such as a known allergy or sensitivity to certain excipients. In the absence of such an opt-out, substitution should be permitted in line with the functional equivalence register.

Prescription price controls

We do not support the implementation of direct price controls on prescriptions. In our view, such measures would be disproportionate, potentially distort market dynamics, and inadvertently favour certain business models over others.

For providers like Animal Trust, which do not charge for consultations and rely on prescription fees as part of their service model, direct price controls could undermine our ability to continue offering free consultations. This would ultimately reduce consumer value and limit choice.

Introducing a blunt price cap risks creating several significant distortions:

- Upward pressure on consultation fees, disproportionately affecting low-income pet owners. As a provider committed to accessible care, we recognise that consultation costs can act as a barrier to seeking professional advice. Our model, for example, offers free consultations, precisely to lower this barrier.
- Curtailment of innovative pricing structures, including low- or no-fee consultation models such as our own.
- Incentivising unnecessary repeat consultations for prescription renewals, which could ultimately neutralise any intended consumer benefit.

As an alternative, we advocate for a transparency-led approach. Under this model, the prescription fee, dispensing fee, and cost of the medicine would be clearly communicated through publicly accessible price lists and itemised invoices. This enables consumers to make informed decisions and select pricing options that best suit their pet's needs.

We believe this approach promotes competitive outcomes, supports innovation in pricing strategies, and enhances consumer choice by providing clarity and comparability across providers.

If the CMA nevertheless determines that a price cap is necessary, it should be:

- Indexed to the cost of professional time,
- Reviewed annually to remain relevant and avoid stagnation, and
- Set at a level that reflects the true cost of issuing a prescription, ensuring that practices are not forced to cross-subsidise from other services, thereby impairing their ability to compete fairly in other areas. Our internal modelling estimates that the average prescription requires approximately 7.5 minutes of professional time, equating to a cost of £23.75 + VAT (based on a professional rate of £190 + VAT per hour).

For dispensing, we estimate an additional 20% markup on the net cost is required to cover operational factors such as wastage, packaging, and compliance (e.g. controlled-drug audits).

Interim Medicines Price Controls

We do not consider interim price control to be necessary. The broader remedies proposed should result in a more transparent and competitive marketplace, making additional pricing regulation redundant.

We also caution against blanket price reductions. As a practice operating on minimal margins, further constraint could jeopardise the sustainability of providers like ours. However, if a price regulation model is adopted, we recommend:

- A maximum permitted margin of 20% on wholesale list price.
- Application of this margin across all medicines, to prevent substitution that bypasses regulation.

While this proposed margin is higher than our typical pricing, we believe it strikes a balance—allowing for a range of pricing models to coexist and compete, while still protecting consumers from excessive charges.

In terms of regulation of pricing compliance a strengthened Practice Standards Scheme (PSS), would be suitable as it would avoid dealing with another regulator and keep the administrative burden proportional. Similarly we favour the development of a VMD-hosted e-prescription and price comparison portal, with funding provided via a levy on marketing authorisation holders.

Restrictions on certain clauses in contracts with third-party out of hours care providers

A maximum notice to change providers of two to three calendar months is proportionate and fully aligned with (i) typical veterinary employment notice and (ii) the CMA's guidance that switching frictions must not exceed what is objectively necessary.

- Effectiveness: three months gives FOP a reasonable time to make a decision and switch —thereby lowering barriers to new OOH providers and widening owner choice.
- Proportionality: it grants incumbent OOH centres a fair window to adjust rotas or redeploy staff, preventing undue operational shock.
- Minimal distortion: anything longer would entrench incumbents and perpetuate local monopolies;

Early-termination fees should be prohibited once the notice requirement is met. Allowing financial penalties would undermine the very purpose of the notice-period cap and deter challenger entrants. Where a practice terminates without the required notice, liability should be limited to pro-rata recovery of demonstrable staffing costs already incurred.

Other observations on OOH

The proposed contractual remedies alone will not restore competition in many catchments dominated by vertically-integrated LVGs. To meet the CMA's effectiveness test, we consider additional interventions are necessary:

- Enhanced customer information remedy. Require every FOP to inform clients with the standard OOH prices of every OOH providers within a 45-minute drive-time rather than just the one they contract with.
- Structural remedy for highly concentrated areas: In cases where a significant proportion of an OOH centre's caseload is sourced from FOPs owned by the same LVG, and no alternative non-LVG OOH provider is available, we believe a structural remedy is needed to restore competition. Specifically, the LVG should be required to divest either the OOH centre or a sufficient number of FOPs to reduce its market share to a level that enables the entry of a viable OOH competitor. Without such a remedy, it is challenging for new entrants to secure a sustainable OOH caseload, as FOPs owned by the incumbent LVG are not realistically available to switch providers. This creates a barrier to entry and limits competition in the local OOH market

Transparency on the differences between fees for communal and individual cremations and cremation pricing

We believe the existing RCVS Code of Conduct, which already obliges veterinary professionals to provide "clear and accurate information" on costs, could be proportionately expanded to specifically include cremation services. This would be a suitable and balanced approach to enhancing transparency.

In the event that a price control remedy is considered necessary, it must be applied uniformly across all practices, including both independent providers and large veterinary groups (LVGs). Where LVGs operate their own crematoria, pricing should be based on external market rates, not internal transfer pricing.

If a cap is imposed, we propose the following formula:

- Communal cremations: capped at the cost of 15 minutes of the median hourly veterinary charge-out rate (£47.50 + Vat if at £190/hr)
- Individual cremations: capped at 30 minutes, (£95 + vat if at £190/hr)
- Plus, in both cases, the invoiced crematorium cost to the practice.

This model strikes a balance between commercial viability and protection against excessive charges. Practices should also be permitted to offer single, weight-agnostic prices, reflecting averaged costs, to ensure owners receive clear, upfront pricing during a distressing time.

Importantly, if cremation fees are capped, safeguards must be in place to ensure these costs are not recouped through increased euthanasia fees, which could deter low-income owners from accessing timely and necessary end-of-life care—potentially prolonging animal suffering.

RCVS, through the PSS, would be well placed to oversee this regulation, adding only minimal regulatory burden to FOP's.

Regulatory requirements on vet businesses

We support more robust regulation of veterinary businesses. A flat-rate regulatory model would be disproportionate and could undermine the viability of low-margin and small providers. We support initially applying any new regulatory framework to practices with over 50 sites, given their greater resource capacity. Once tested and refined, a streamlined version could be rolled out to smaller businesses. This approach supports the CMA's remedy objectives while preserving choice and diversity in the market.

Developing new quality measures

We fully support the development of quality reporting, but metrics must be risk-adjusted and case-mix weighted to avoid penalising providers who serve higher risk cases or more cost-sensitive communities. This includes socioeconomic weighting, as clients in deprived areas are more likely to choose pragmatic care options.

We would support an enhanced PSS being made mandatory. Initially, reporting could mirror the Care Quality Commission (CQC) model, combining a star rating with a narrative summary. Ratings should be partitioned by service type, but kept simple for a consumer to understand—e.g, for FOP: Consulting service, Medical Investigations, Diagnostics, Surgery & Onsite Overnight Care. Each with a star rating and narrative.

Consumer and competition duty

We support embedding a statutory duty on regulators to consider consumer costs and competition, ensuring that frameworks accommodate both challenger brands and conventional models. It is vital however, that regulators maintain independence from LVGs, particularly given concerns over senior positions within RCVS being filled with a high number of LVG employees.

Compliance Monitoring and Enforcement

We support data-based compliance monitoring, using dashboards populated from data already held in PMS. This would meet the least-burdensome test. Manual data processing would be disproportionate and error-prone. However, to achieve this, PMS systems must develop capabilities for standardised data export. We request that the CMA mandate PMS providers to supply the required APIs at cost, enabling seamless compliance across the sector.

We believe it is proportional for a regulator to have more powers for enforcement, we advocate a graduated framework similar to that used by the CQC, for example:

1. Informal guidance
2. Formal warning
3. Improvement notice
4. Financial penalties
5. Removal of practice rights (in severe or persistent cases)

Penalties should be proportional to turnover (as in GDPR) and should consider the nature of the provider. For example, it would be inappropriate to hold a charity-based, low-cost clinic to identical financial penalties as a large referral group.

Consumer Complaints and Disputes
We support a standardised, internal complaints process across all practices, where clients can upload complaints via practice websites, as we already do. However, we caution against requiring complex public reporting, which is unlikely to be useful for consumers given differing case types and demographics between providers.

If reporting is mandated, we recommend:

- Yearly reporting of anonymised complaint themes via pie charts (e.g. Clinical, Pricing, Customer Service)
- A simple metric: number of complaints per 1,000 pets treated annually

We favour strengthening internal processes rather than increasing Veterinary Client Mediation Service or ombudsman involvement, which may impose disproportionate complaint management costs on small providers and encourage frivolous claims.

However, if the CMA mandates escalation pathways, we recommend:

1. Internal complaint process with right of appeal
2. Referral to VCMS if no resolution
3. Arbitration if VCMS fails to resolve the matter
4. A final step of low-cost arbitration (under £2,000 claims), with a nominal fee to discourage trivial claims

Expansion of the role of veterinary nurses
We support a series of post qualification training and certifications for RVN. For example, post certification they could be licensed to prescribe some medications like vaccines. To safeguard patient safety in the event of unexpected complications a veterinary surgeon should be on site at the time a RVN is administering treatment and the a RVN should be regularly re-accredited and undertake mandatory CPD in relation to their additional qualifications. We estimate these changes could free up 20 % of vet time, if RVN were licensed to manage common conditions, lowering our cost base and helping support price deflation.

Funding of reformed regulation
We believe the most equitable funding mechanism is a per-premises regulatory levy, as inspection and compliance workloads are closely tied to the number of physical locations. This approach aligns with an ability to pay principle and avoids overburdening smaller providers.

Final comments
We believe it is essential that remedies preserve the ability of innovative models to disrupt incumbents. Animal Trust's CIC, free-consult and published-price model is the very type of challenger the CMA wishes the market to nurture, yet had some of the proposed remedies been in place when Animal Trust started it couldn't have operated the effective challenger model it has

Remedies that fix prescription prices or limit the usefulness of health/ membership plans will reduce innovative models and long term reduce competition from challenger brands. In addition, we caution that remedies that raise fixed-cost compliance (e-prescriptions, expanded reporting) without supplier mandates on PMS vendors risk "freezing the market in today's structure" and locking in LVG advantage.

We urge the CMA to act fairly and proportionally to preserve a diversity of models in the sector while delivering consumer enhancements.

Yours sincerely

[redacted]

Dr Owen Monie MRCVS
CEO and Founder