Response to the CMA Consultation on the Draft Veterinary Services Market Investigation Order 2026 and Draft Undertakings

[redacted]

Date: 4 August 2026

To:
Veterinary Services Market Investigation Team
Competition and Markets Authority

1. Introduction

I am a veterinary surgeon currently working as a locum. I was previously the owner and operator of an independent group of veterinary practices employing veterinary surgeons, veterinary nurses and support staff.

My previous experience as the owner of an independent veterinary group gave me direct responsibility for clinical standards, staffing, pricing, medicines, client communication, complaints, investment in practice-management systems and regulatory compliance. My current work as a locum veterinary surgeon also gives me practical insight into the different systems and procedures used by individual veterinary practices.

I therefore consider the proposed requirements from both perspectives: as a practising veterinary surgeon who will be expected to implement many of the requirements during day-to-day consultations; and as a former independent veterinary business owner familiar with the operational, financial and administrative demands placed upon veterinary practices.

I support the broad objectives of improving price transparency, helping clients make informed decisions, protecting clinical independence and ensuring that veterinary complaints are dealt with fairly.

Independent veterinary practices depend heavily on the trust of their clients. Clear communication about treatment options, likely costs, medicines, referrals and complaints is an important part of maintaining that trust.

My representations relate principally to whether particular provisions of the draft Veterinary Services Market Investigation Order 2026, the draft Undertakings and the supporting documents are sufficiently clear, proportionate and operationally workable, particularly for small and independently owned veterinary businesses.

Unlike a large veterinary corporate group, a small independent practice does not generally have dedicated legal, compliance, information-technology, marketing, procurement or human-resources departments. The veterinary surgeons, veterinary nurses and reception staff responsible for treating

animals and supporting clients will frequently also be responsible for implementing, operating and documenting the proposed requirements.

My experience as a locum has also shown me that practices use a wide range of practice-management systems, pricing structures, dispensing procedures and administrative processes. Requirements that appear straightforward in principle may therefore require significant changes to software, staff training and established clinical workflows.

I ask the CMA to consider the following drafting clarifications and practical safeguards before making the final Order and accepting the final Undertakings.

2. Proportionality for small independent practices

From my previous experience owning and operating an independent group of veterinary practices, I recognise that regulatory requirements must ultimately be translated into workable procedures for veterinary surgeons, nurses, reception staff and practice managers.

My present work as a locum also allows me to observe how significantly staffing levels, premises, software systems and administrative resources vary between practices.

The draft Order appropriately recognises small veterinary businesses by providing longer implementation periods for certain obligations. However, a longer implementation period does not, by itself, address the disproportionate ongoing administrative burden that may fall upon a small or single-site practice.

Many of the proposed requirements involve maintaining public information documents, updating websites and practice-management systems, monitoring estimates, recording prescription offers, distributing notices and flyers, maintaining complaints records, monitoring deadlines, retaining evidence of compliance and responding to monitoring requests.

For a large group, these functions may be centralised. For a small practice, they will commonly be carried out by clinical and reception staff alongside patient care.

The final Order and Explanatory Note should expressly recognise that compliance systems may be proportionate to the size, resources and organisational complexity of the veterinary business, provided that the required consumer outcome is achieved.

The CMA and RCVS should publish a single small-practice compliance package containing approved templates, notices, policies, registers, examples and guidance.

3. Parasiticide price-list requirements

I support giving clients clear information about the prices of commonly dispensed parasiticides and their ability to obtain prescribed medicines from other authorised suppliers.

However, the proposed requirement to publish the ten most commonly sold products where fewer than ten products exceed the specified sales-volume threshold may be impractical for practices but especially a small practice.

Many corporate and certainly single-site practices may carry a deliberately limited formulary. Requiring ten entries could result in publication of products sold only occasionally and which are not representative of routine pricing.

The requirement is also technically complex because products vary by species, weight, active ingredient, formulation, strength, pack size, treatment duration, prescription status and whether supplied through a pet care plan.

I request that a veterinary business be required to publish a smaller minimum number, such as the five most frequently supplied products.

The final guidance should clarify whether different weight bands are separate products, whether individual doses and manufacturer packs are counted separately, how care-plan supplies are treated, how branding changes are handled, whether seasonal variation matters and how often rankings must be recalculated.

A standard CMA spreadsheet or electronic template should be provided.

4. Standard price-list definitions and maintenance

I support publication of standard prices for commonly purchased veterinary services. However, veterinary treatment is not always a standardised product.

Costs may vary materially by species, weight, age, clinical condition, anaesthetic risk, procedure complexity, medicines, diagnostic findings, complications, timing and postoperative care.

The prescribed descriptions should permit meaningful price ranges or 'from' prices where a single fixed price would risk misleading clients.

The final drafting should distinguish between a genuinely standard service, a service with predictable species or weight bands and a clinical procedure whose likely cost cannot reasonably be determined without examining the animal.

The requirement to update a published price before a revised price is charged may create accidental technical breaches where the practice-management system, printed price list and website are maintained separately.

There should be a correction provision for isolated, non-deliberate discrepancies that cause no material disadvantage and are corrected promptly.

5. Written estimates and the definition of a treatment pathway

I support written estimates before clients commit to significant expenditure. However, the concept of a treatment pathway requires greater clarification.

Veterinary cases evolve. At the outset, a clinician may not know the final diagnosis, all tests required, response to treatment, need for hospitalisation, surgery, complications or referral.

An estimate covering every possible intervention could be too broad to assist the client, while one confined to the immediate step may later be criticised as incomplete.

The final Order should distinguish between the currently recommended and reasonably foreseeable stage, contingent future stages dependent on findings and remote or speculative possibilities.

Guidance should include worked examples involving undiagnosed gastrointestinal disease, stabilisation and diagnostics, cases that may later need surgery, emergency treatment where the owner cannot be contacted, chronic sequential investigations and possible referral.

The £500 threshold should be reviewed periodically and indexed to an appropriate measure of veterinary-sector cost inflation.

6. Updating estimates when costs change

The proposed requirement to update an estimate when expected cost increases by 20% or £500, whichever is lower, may be difficult during surgery, hospitalisation or emergency treatment.

The drafting should make clear that necessary treatment must not be delayed where immediate action is required for animal welfare, the client cannot be contacted, further treatment becomes necessary during anaesthesia or surgery, or stopping would expose the animal to additional risk.

The final Order should contain a clear animal-welfare exception, with an obligation to contact the client and provide updated information as soon as reasonably practicable.

It should also clarify how the increase is calculated where the original estimate was a range and where several small increases cumulatively exceed the threshold.

7. Third-party and referral costs

A first-opinion practice does not control fees charged by referral hospitals, external laboratories, crematoria, imaging providers or other independent third parties.

The final Order should state that a practice must communicate third-party information reasonably available to it but is not responsible for prices controlled by an independent provider.

Where appropriate, clients should be advised to obtain a definitive estimate directly from the third party.

A practice should not be treated as non-compliant because an independent provider changes a price after accurate information was communicated.

8. Written-prescription notices

I support ensuring that clients understand their right to request a written prescription and obtain medicines elsewhere.

However, mandatory A2 notices in reception and A3 notices in every consulting room may be excessive and impractical for small premises and may detract from the décor and professional appearance of the surgery.

The objective could be achieved through a clearly visible but proportionately sized notice, supported by the website, invoices and client communications.

The final Order should adopt an outcome-based prominence standard or leave it to the vets' discretion as to the size of notices and where they should be displayed.

The prescribed wording should be balanced and should mention delivery times, urgency, storage, supplier authorisation and the need to obtain the correct product, formulation and strength.

9. Mandatory oral offer of a written prescription

The proposed obligation to make an oral offer whenever a medicine is prescribed could create repetitive administrative burden and lengthen consultations.

Clients may already have been informed through registration documents, the website, notices, appointment communications, invoices and previous consultations.

The final drafting should permit practices to record a standing client preference to buy from the practice, receive a written prescription or decide each time.

The choice should be revisited where treatment is prolonged, medicines materially change, the financial difference may be significant or the client asks to reconsider.

10. Written-prescription turnaround times

The proposed deadline should account for part-time working, weekends, bank holidays, record review, re-examination requirements, incomplete information, pharmacy queries, controlled-drug restrictions, exceptional absence and system failures.

The final Order should define when a request is complete. The period should begin only once the practice has the information reasonably necessary to prepare and send the prescription.

There should be an exception where the prescribing veterinary surgeon reasonably considers that examination, review or monitoring is required before prescribing safely.

11. Prescription-fee caps

I understand the objective of preventing prescription fees from obstructing client choice.

Nevertheless, preparing a prescription involves professional and administrative work and continuing professional responsibility, including review of records, examinations, laboratory results, weight, dosage, contraindications, concurrent medicines, repeat suitability, preparation, checking, secure transmission, pharmacy queries and record retention.

The final Order should clarify whether the cap applies per document or per medicine, how different strengths are treated, whether repeat authorisations covering several dispensings count as one prescription, whether replacements or amendments can attract further charges and how the cap will be reviewed.

Any cap should be indexed automatically and reviewed periodically against the actual cost of providing the service.

12. Ongoing-medication flyer

I support providing clear information when long-term medication begins.

However, small-practice systems may not identify automatically the first or second occasion on which a medicine becomes ongoing.

Guidance should define when short-term treatment becomes ongoing, whether dose changes or brand changes restart the requirement, whether separate flyers are required for concurrent medicines, how intermittent medicines and care-plan supplies are treated and what evidence proves supply.

A single flyer should be capable of covering the client's general right to request prescriptions for all ongoing medicines.

13. Own-brand medicines

The own-brand medicine provisions should be supported by a definitive and regularly updated list of relevant products and corresponding reference products.

It would be unsafe and inconsistent to leave each practice to determine equivalence without an authoritative source.

Apparently similar products may differ in authorised indications, species, excipients, formulation, pack sizes, dosage and licensing status.

The VMD, CMA or RCVS should maintain an authoritative mapping on which practices may rely.

14. Itemised invoices

I support meaningful itemised billing, but excessive disaggregation may make invoices longer and less comprehensible, particularly for hospitalised or surgical cases involving many low-value consumables.

The final Order should allow sensible clinical bundles where the bundle is clearly described, principal components are identified, the client was informed of the overall price and bundling does not conceal a material charge.

Guidance should provide examples for neutering, dentistry, inpatient care, imaging, laboratory profiles, emergency consultations, vaccination courses and euthanasia and cremation.

Practices should not be required to list every syringe, needle, swab, dressing or minor consumable separately unless it carries a distinct material charge.

15. Cremation and end-of-life information

I support clear and compassionate information about end-of-life choices.

The final drafting should recognise that these discussions often occur when clients are distressed and rigid presentation or billing rules may cause additional distress.

Staff should retain sensitive professional judgement about timing and method while ensuring clients are not steered unfairly.

Practices should be entitled to rely on current information supplied by crematoria and should not be responsible for unnotified third-party price changes.

Practices should be permitted to provide general home-burial information and direct clients to authoritative government or local-authority guidance.

16. Complaints procedure and complaint log

I support clear complaint procedures and access to independent mediation.

However, the definition of an actionable complaint and the point at which the formal timetable begins should be unambiguous.

The final Order should distinguish between an informal concern, service query, invoice correction, clinical discussion, formal complaint and actionable complaint.

The practice should be permitted to ask whether the client wishes the matter to be treated formally.

The timetable should begin only when sufficient information has been received to identify the client, animal, episode of care and substance of the complaint.

The complaint log should follow data-minimisation principles and should not duplicate extensive clinical records.

17. Alternative dispute resolution and mediation

I support access to mediation where a complaint cannot be resolved internally.

The final arrangements should clarify qualifying providers, eligibility, costs, insurer participation, interaction with RCVS complaints and civil proceedings, limitation periods, confidentiality and data sharing.

A practice should not be regarded as failing to mediate in good faith merely because it disputes liability or declines a settlement it reasonably considers unjustified.

The process must allow compliance with reasonable professional-indemnity insurer requirements and should permit mediation to be declined in exceptional cases such as fraud, abuse, vexatious repetition, staff-safety risk or advanced litigation.

18. Clinical independence policy

I strongly support protection of independent clinical judgement.

The requirements should distinguish legitimate clinical governance from inappropriate commercial interference.

Clinical protocols, antimicrobial stewardship, controlled-drug procedures, health and safety, formulary decisions and peer review may properly guide conduct.

Monitoring clinical outcomes, estimate compliance, record quality, medicines, infection control and client communication should not automatically be treated as pressure on clinical judgement.

For a small owner-operated practice, a concise policy proportionate to its structure should be sufficient.

19. Practice-management software and implementation dependency

Many proposed measures depend on functionality controlled by third-party practice-management software providers.

A small practice cannot independently program estimate alerts, automated revisions, prescription-offer fields, turnaround tracking, invoice formats, website synchronisation, flyer prompts, own-brand warnings, complaint registers or structured exports.

The CMA should engage with principal software providers and publish technical specifications sufficiently early for development and testing.

A practice should not be penalised solely because a required feature is unavailable where it has made reasonable efforts, introduced a proportionate interim process, informed the provider, retained evidence and acted in good faith.

20. Safe-harbour and corrective-action period

The draft Order introduces many detailed procedural, publication, record-keeping and communication requirements. Even a conscientious practice may make an isolated administrative or technical error while adapting.

Examples include timing discrepancies between a website and practice-management system, a damaged or incorrectly sized notice, an unrecorded prescription offer, an omitted estimate field, an unrecorded flyer, a short complaint delay due to exceptional absence or a software fault.

Such errors should be distinguished from deliberate non-compliance, repeated failure, concealment, obstruction or conduct causing material consumer harm.

I request a proportionate corrective-action process. Written notice should identify the alleged breach, evidence, required action, time allowed and evidence needed to demonstrate correction.

Formal enforcement should not normally follow where the breach is minor, technical, isolated, non-deliberate, causes no material harm, is corrected promptly and the practice cooperates and takes steps to prevent recurrence.

The correction period should ordinarily be at least 30 working days, subject to shorter periods where inaccurate information could immediately mislead clients.

Additional time should be allowed where correction depends on a software provider, website developer or external supplier and the practice has acted promptly and introduced an interim process where practicable.

The corrective process should not apply to deliberate or fraudulent conduct, repeated non-compliance, refusal to cooperate, falsification, material consumer detriment, serious interference with informed choice or significant animal-welfare risk.

During the first 12 to 18 months, monitoring should primarily support implementation and improvement, except in serious cases.

A proportionate escalation process should comprise informal advice, written improvement notice, agreed action plan, follow-up review and formal enforcement only where correction fails or the breach is serious.

Assessment should take account of practice size, seriousness, duration, self-reporting, speed of correction, actual or potential harm, systems and training, third-party causes and previous compliance history.

The practice should have an opportunity to explain the circumstances and correct factual inaccuracies before an adverse finding is finalised or published.

21. Implementation timetable

Small independent practices require sufficient time after publication of the final Order, not merely after publication of drafts, to understand requirements, obtain advice, secure software updates, revise websites and printed materials, renegotiate third-party arrangements, prepare documents, train staff, test processes and correct problems.

Implementation periods should run from the date on which the final Order, Explanatory Note, prescribed notices, templates and necessary technical specifications are all available.

Where the CMA or RCVS later makes a material change, an appropriate additional implementation period should apply.

A phased timetable with a clear checklist for each phase would be more likely to produce accurate and sustainable compliance.

22. Small-practice implementation package

I ask the CMA and RCVS to publish a consolidated implementation package specifically for small and single-site practices.

It should include a plain-English guide, definitive timetable, article-by-article checklist, editable price-list and parasiticide templates, model estimates, treatment-pathway examples, compliant invoice examples, proportionate prescription notices, a clinical-independence policy, complaints procedure and log, end-of-life information sheet, authoritative own-brand mapping, training materials, a self-audit form and a clear implementation contact point.

The package should be available in editable electronic formats so that small practices do not have to commission legal drafting, graphic design or software work merely to reproduce standard regulatory material.

23. Summary of requested amendments and clarifications

I ask the CMA to ensure that the final Order and guidance permit proportionate compliance for small businesses; reduce the minimum parasiticide publication requirement; clarify price ranges and 'from' prices; define treatment pathways; provide an animal-welfare exception; clarify estimate-increase calculations; protect practices regarding independent third-party prices; replace rigid notice sizes with an outcome-based standard; permit documented prescription preferences; clarify prescription turnaround and fee caps; provide definitive guidance on ongoing and own-brand medicines; permit meaningful invoice grouping; preserve sensitivity in end-of-life discussions; define actionable complaints; clarify mediation; distinguish governance from commercial interference; recognise software dependency; introduce corrective action for minor breaches; and provide a complete small-practice implementation package.

24. Conclusion

I support the CMA's objectives of improving transparency, informed client choice, clinical independence and accountability within the veterinary sector.

My representations are informed by my previous experience owning and operating an independent group of veterinary practices and by my current work as a locum veterinary surgeon.

As a former practice owner, I understand the responsibility of translating regulatory requirements into policies, software processes, staff training and day-to-day procedures. As a locum, I also see how those procedures affect consultations and how widely systems, staffing and resources differ between practices.

The effectiveness of the reforms will depend not only on their objectives but on whether the final requirements are clear, proportionate and capable of implementation in day-to-day practice.

Unnecessarily prescriptive requirements risk diverting clinical and support staff from patient care without a corresponding consumer benefit and may disproportionately affect independent practices compared with large groups with centralised departments.

The final Order should focus on clear consumer outcomes while allowing reasonable flexibility in delivery. It should contain clinically workable definitions, preserve animal welfare in urgent and evolving cases, recognise small-practice constraints, account for reliance on third parties and software, provide approved templates, allow minor errors to be corrected proportionately and provide sufficient implementation time.

These amendments would not undermine the remedies. They would make the requirements more likely to be understood, adopted consistently and complied with effectively.

Thank you for considering this response. I would be pleased to provide further information about the practical operation of independent veterinary practices and the day-to-day implications for locum clinicians should that assist the CMA in finalising the Order, Undertakings and supporting guidance.

Yours faithfully,