THRUMS VETS

Response to the CMA consultation

Draft Veterinary Services Market Investigation Order and Undertakings 2026

The Directors of Thrums Vets | August 2026

1. Ownership information — online pharmacies

If clients are actively encouraged to purchase medicines online, they should be clearly informed who owns those pharmacies. Many major online pharmacies are owned by large veterinary groups (LVGs), meaning an apparently independent alternative may be part of a large, vertically integrated veterinary group. Ownership should therefore be displayed prominently at the point of comparison and purchase, rather than buried in website terms or privacy notices.

2. Price submission to the RCVS

We are concerned that Article 10 does not clearly allocate responsibility where a veterinary business has submitted accurate revised pricing information to the RCVS before introducing the new prices, but the RCVS delays publishing that information on Find a Vet. The RCVS Undertakings require publication only 'as soon as reasonably practicable', without a defined deadline. This could result in the practice's own website and charging systems showing the correct price while Find a Vet, and potentially third-party comparison services, continue to display an outdated price.

The Order should state expressly that a veterinary business has discharged its obligation once the revised information has been successfully submitted and acknowledged by the RCVS, and that it may charge the revised price from the effective date specified in its submission regardless of any subsequent publication delay. The RCVS should also be required to publish price changes by that effective date, subject to a reasonable minimum notice period, or within a specified number of working days.

The system should allow a practice to submit a future effective date. This would allow practices to upload a complete price change in advance while preserving the old public prices until the correct date. It is much clearer than relying on an undefined period of 'as soon as reasonably practicable'.

3. Written estimates

3.1 Estimates for lifelong medical conditions

The proposed estimate provisions are designed around discrete episodes of treatment and do not adequately accommodate lifelong medical conditions. For conditions such as Cushing's disease, diabetes and epilepsy, the medicine dose, monitoring requirements and overall treatment pathway depend upon the individual animal's response. Requiring a specific estimate covering all reasonably likely costs over 12 months risks producing either false precision or an excessively broad and alarming figure. Practices should be permitted to provide phased estimates and reasonable cost ranges, with clear assumptions, and to update these at clinically meaningful decision points.

3.2 Practical problems

The diagnosis may not yet be known

At the first consultation, the dog may have Cushing's disease, diabetes, liver disease or another condition. It is unclear whether the practice should estimate only the diagnostic work-up, the anticipated Cushing's disease pathway, or several possible pathways.

Medicine costs cannot be predicted accurately

In the example of Cushings Disease, Trilostane cost depends on body weight, initial dose, response and subsequent dose changes. An estimate based on the starting dose may become inaccurate quickly.

Monitoring is individual rather than fixed

A straightforward case may stabilise rapidly; another may require several additional consultations, tests and dose adjustments. Both are clinically normal possibilities.

The estimate could become misleadingly precise

A first-year figure of, say, £1,400 may appear to be a reliable forecast when it is actually built on multiple clinical assumptions. A very broad estimate, however, may frighten the client or be of little practical help.

Estimates may require repeated updating

If the projected total increases by 20% or £500, whichever is lower, a revised written estimate is required. Thus, if the original estimate were £1,200, a likely increase of £240 would apparently trigger a formal update. Several dose adjustments or additional tests could easily do that.

It is unclear what happens after the first 12 months

The Order defines the pathway by reference to the following 12 months but does not clearly explain whether a fresh annual estimate must then be produced for every ongoing condition. This needs explicit clarification.

3.3 A workable approach for practices

Rather than pretending to know the precise annual cost, an estimate might be structured in phases:

Phase	Estimate approach
Diagnosis	Fairly specific estimate for recommended tests
Initial treatment	Medicine based on current weight and starting dose
Stabilisation	Range based on likely number of tests and reviews
Maintenance	Expected annual cost if stable
Additional care	Clearly identified possible costs not yet clinically indicated

It would need prominent assumptions such as:

> *"This estimate is based on the currently anticipated pathway and assumes that your pet responds normally to treatment. The dose, medicine cost and number of monitoring tests may change according to clinical response. We will discuss material changes with you and provide an updated estimate where required."*

3.4 Estimates from referral centres

We support clients receiving timely information about the likely cost of referral, but it is unreasonable to make the first-opinion practice responsible for estimating charges set by an independent referral provider. At the point of referral, the specialist has usually not examined the animal and may substantially alter the proposed investigations or treatment following their assessment. Costs may also vary according to clinical findings, complications, length of hospitalisation and the referral centre's own pricing decisions, none of which is within the referring practice's control. First-opinion practices should be required to pass on any indicative costs supplied by the referral provider and advise clients to obtain a formal estimate directly from them. Legal responsibility for the accuracy, completeness and updating of that estimate must rest with the business providing and charging for the referral care.

4. Written prescription information

4.1 The cumulative requirements are grossly disproportionate

We fully support clients being made aware that written prescriptions are available. However, the Order requires the same essential message to be delivered at registration, on the website, in reception, in every consulting room, in appointment communications, verbally during consultations, on invoices and again through a flyer when medication becomes ongoing. The CMA has not demonstrated that each additional contact point delivers sufficient incremental benefit to justify its cost and intrusion. Beyond a certain point, repetition ceases to inform and instead creates message fatigue, administrative burden and visual clutter. A smaller number of well-designed, appropriately timed communications would be more effective and proportionate.

4.2 The CMA is requiring veterinary practices to advertise their competitors

These provisions go considerably beyond ensuring freedom of choice. They compel veterinary practices to use their own premises, consulting rooms, communications systems, staff time and invoices to promote purchasing from third-party retailers. No equivalent obligation appears to require online pharmacies to explain the benefits of immediate supply, the professional responsibility carried by the prescribing practice, delivery charges, delivery delays or the availability of ongoing clinical support. That is not competitively neutral. Consumer choice should be supported through balanced information, not through mandatory promotion of one particular sales channel at another provider's expense. This concern is particularly relevant where online pharmacies are owned by vertically integrated veterinary groups.

4.3 'Significantly cheaper online' is potentially misleading

The compulsory invoice wording says that clients may be able to buy medicines 'significantly cheaper online' and encourages them to compare the savings. That may be true for some ongoing medicines, but it will not be true in every case. The comparison depends upon the medicine, quantity, prescription fee, delivery charge, delivery time and whether the client needs treatment immediately. Requiring a practice to make a generalised price claim without reference to the actual product or transaction is inconsistent with the CMA's wider emphasis on accurate and transparent consumer information. Neutral wording such as 'Medicine prices can vary between suppliers. You may wish to compare the total cost, including any prescription fee and delivery charges' would be more balanced and defensible.

4.4 Acute and ongoing medication should not be treated alike

The potential benefit of shopping around is greatest for predictable, repeat medication. Acute medicines are fundamentally different: clients may need a small quantity immediately, and convenience and prompt commencement of treatment may matter more than a possible price difference. Yet the draft applies the posters, electronic messaging, invoice notification and verbal-offer requirements across both categories, with only a narrow clinical-urgency exception. The strongest prompts should be targeted at ongoing medication, where clients have time to compare meaningful like-for-like costs. Blanket messaging about online savings risks confusing clients and could inadvertently delay treatment.

4.5 Consulting rooms are clinical spaces, not advertising spaces

An A3 notice is a large and dominant presence in every consulting room. These rooms are used for difficult diagnoses, end-of-life discussions, euthanasia and conversations with distressed owners. A compulsory retail message about buying medicines elsewhere is neither sensitive nor appropriate in every clinical encounter. It also frames the relationship between owner and vet around suspicion and price at precisely the point where trust, clinical explanation and shared decision-making are most important. One prominent notice in the reception area, supported by targeted information at the appropriate point in the treatment pathway, should be sufficient.

4.6 The prescribed poster sizes and locations are arbitrary

The Order specifies A2 notices in every waiting or reception area and A3 notices in every consulting room, but provides no clear evidence that these exact sizes and locations are necessary. It makes inadequate allowance for small branches, shared consulting rooms, nurse rooms, bereavement rooms, multipurpose spaces or premises with little suitable wall space. Large print does not automatically produce understanding. The CMA should prescribe the desired outcome—information that is clearly accessible—while allowing practices to choose the most suitable physical or digital format for their premises.

4.7 Practices are being asked to accept an unseen legal obligation

The consultation cannot be meaningful when the actual Standard Written Prescription Notice and ongoing-medication flyer are absent from the draft Order and appear only as schedule headings. Their wording, tone, balance, accessibility and visual prominence are central to assessing the remedy. Practices cannot reasonably comment on the effect on clients or consulting environments without seeing what they will legally be required to display and distribute. The final materials should be published, consumer-tested and subjected to consultation before the obligation is made.

4.8 The compulsory verbal offer risks becoming an empty script

Requiring a veterinary professional to offer a written prescription whenever medication is prescribed turns an important consumer choice into a compliance phrase that may have to be repeated many times each day. In consultations involving several medicines, acute illness or complex clinical explanations, this risks distracting from the information most relevant to the animal's immediate care. It also creates uncertainty over how practices must prove that the words were spoken, encouraging additional record-keeping and defensive medicine. Veterinary professionals should be required to ensure that clients understand their options but should retain discretion over how and when that information is communicated.

4.9 The ongoing-medication flyer is badly targeted and unnecessarily wasteful

Targeted information when a medicine becomes ongoing is more defensible than blanket messaging. However, the Order defaults to a physical A5 flyer unless the client specifically requests email. This will generate printing, storage, stock control and waste across thousands of practices, even where the practice and client normally communicate digitally. Practices should be able to provide the information electronically by default, subject to client preference and accessibility needs. More fundamentally, if targeted information at the start of ongoing treatment is effective, that undermines the case for repeating the same message through every other mandated channel. The suggested leaflet with the exponential-looking graph is factually misleading.

4.10 The one-month replacement requirement creates unnecessary compliance risk

The CMA and RCVS may update the notices, literature and flyers, after which every practice must implement the changes within one month. For a multi-site practice, this means locating, replacing and checking posters in every waiting area and consulting room, updating websites and ensuring obsolete printed materials are withdrawn. The Order also requires businesses to self-report any non-compliance within 14 days of becoming aware of it. In principle, a missing or outdated poster in one consulting room could therefore become a reportable legal breach. That is a disproportionate enforcement framework for minor administrative failures that cause little or no consumer harm.

4.11 Online prices and local services

The proposed wording does not merely inform clients that they have a choice; it uses local practices' premises, staff and communications to encourage expenditure to leave those practices and, importantly, their local communities, without assessing whether the resulting loss of income could undermine the local services clients depend upon.

Online pharmacies may employ people and pay UK taxes, so we should avoid implying that all online spending disappears from the economy. However, money spent with a locally owned practice is more likely to support local wages, training, suppliers and community activity—the recognised 'local multiplier' effect. Local economic resilience is also a legitimate policy concern. An alternative version would be 'Medicines may be cheaper elsewhere', rather than specifying 'online'.

4.12 Summary of written prescription information

We support the principle that pet owners should understand their right to request a written prescription and should be able to make informed choices about where they purchase medicines. However, Article 14 replaces meaningful, proportionate communication with an excessive saturation campaign. It requires essentially the same message to be delivered through registration literature, websites, large notices in waiting areas and every consulting room, appointment communications, invoices, compulsory verbal offers and further flyers for ongoing medication. The CMA has not demonstrated the incremental benefit of each intervention, nor that the cumulative package is proportionate to the burden imposed. More troublingly, practices are being compelled to advertise third-party retailers using wording that may not be accurate for the particular medicine or transaction. We propose one prominent notice in each reception or waiting area, clear information on the practice website, and targeted information when medication becomes ongoing. Veterinary professionals should then retain discretion to discuss prescriptions when clinically and commercially relevant. This would protect consumer choice without overwhelming clients, disrupting consultations or turning clinical premises into advertising space for competing retailers.

5. Cremation options and prices

We support clear and transparent information about cremation services, but Article 20 does not adequately recognise the sensitive circumstances in which this information is provided. In cases of emergency euthanasia or unexpected death, its practical effect may be to require veterinary staff to present grieving owners with written prices for communal and individual cremation, external crematoria and separately charged urns, caskets and keepsakes immediately before or after their pet dies. At that moment, an owner may be distressed, shocked and poorly placed to absorb or compare detailed commercial information. A compassionate end-of-life consultation should not be converted into a prescribed sales and price-comparison exercise. Practices should be required to make comprehensive information available online and, wherever possible, provide it in advance of a planned euthanasia, but veterinary teams should retain professional discretion over the timing, manner and level of detail provided during an emergency or highly distressing consultation.

Article 20(3) allows an owner to refuse discussion of the end-of-life options, but Article 20(5) contains no corresponding exemption from the requirement to provide written prices and details of cremation add-ons. The Order should state explicitly that information need not be pressed upon an owner who declines it, and that the owner may nominate another person to receive the information or make the arrangements.

Where euthanasia is planned, practices should offer written information in advance. Following an unexpected death or emergency euthanasia, staff should provide a brief explanation of the principal options and offer written information, while retaining discretion to defer detailed price and add-on discussions until an appropriate time. A client's decision not to receive or discuss detailed information should be respected and briefly recorded.

8.3 Mixed-practice proportionality

Mixed practices will need to apply the Order to household-pet services while operating different systems for farm and equine work within the same business, and sometimes within the same premises, team or client account. The CMA should issue clear guidance and ensure that the resulting duplication does not disproportionately disadvantage rural mixed practices.

9. Conclusion

Thrums Vets supports the CMA's intention to improve transparency, choice and confidence in veterinary services. We believe these aims will be best achieved through information that is accurate, balanced and delivered when it is most useful to the client, supported by proportionate enforcement and realistic implementation.

We encourage the CMA to revise the draft so that it specifies clear consumer outcomes while allowing professional judgement and operational flexibility. In particular, we ask the CMA to reconsider the cumulative prescription campaign, the treatment of long-term-condition and referral estimates, the timing of end-of-life information and the allocation of responsibility for RCVS publication delays.

We would welcome continued engagement with the CMA, the RCVS and representatives of independent and mixed practices to test the revised requirements before they become legally enforceable.

The Directors

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