

CMA response

All I can see is extra admin work and ultimately needing to increase prices of services to cover this admin time. The remedies proposed disproportionately affect small independent practices who have less admin staff and middle management while also forcing us to send our clients to go spend their money at the big corporates online pharmacies. And then we might have to pay for extra inspections and regulation. If this isn't done carefully my practice and other small independents like it are gone and the corporates remain.

1. I'm concerned about how the implementation of many proposed remedies would affect small independent practices. Without scaling requirements to business size, this will be hugely burdensome. Clearer, simpler approaches are needed to avoid pushing independents out of the market.
2. Trialling information remedies could be useful, but they must include a wide range of practice types—including small independents. The key criterion should be whether the remedy improves client understanding without overwhelming the practice with admin.
3. The standardised list may include core procedures but misses the reality of clinical variation. Case complexity, species differences, and patient needs mean very few services are truly "standard." It risks misleading clients.
4. The information in Appendix A is not feasible for small practices. Trying to assign fixed fees or even structured ranges is extremely difficult when costs depend on so many individual factors. Adding more info won't help—it adds to the confusion and workload.
5. While separating prices by species, size, or age seems helpful, the practical reality is that there are too many variables. Every patient is unique. Trying to break this down systematically adds admin with minimal value for pet owners.
6. "Starting from" prices are reasonable, but calculating meaningful ranges is a challenge. A narrow range excludes genuine variation; a wide range confuses clients. A better alternative is to give typical examples with an explanation that costs may vary.
7. A standardised price list may seem useful but is likely to mislead clients into thinking procedures are directly comparable across practices when they're not. It could lead clients to choose based on price alone, not quality or scope.
8. No, it's not proportionate. Small businesses don't have admin teams or time to constantly update online lists. Larger practices might cope—but for us, it's unrealistic.
9. Yes, if clients are misled by "cheap" options that don't include key elements of care, patient welfare could suffer. It could also create tension or mistrust when estimates differ from what's listed online.
10. The time taken to create and the constantly update such as extensive price list is completely unfeasible. I have no issue with displaying prices on my website and already do so (vaccs, consults, neutering and dentistry) but your list is excessive. The sorts of things you

want pricing for is influenced by more than what prices we set, our own suppliers and constantly updated their prices (drugs, consumables, labs, cremation etc etc), this would be an unreasonable admin burden.

11. In theory, quality measures sound helpful, but it's incredibly difficult to define or compare "quality" in veterinary practice. Clients value trust, continuity, and communication—not metrics like number of procedures or clinical audits.

I don't agree PSS is helpful in this regard, its all paperwork and box ticking. Having worked in practices with accreditation and without I see no difference in day to day standards. I have made sure we abide by the core standards but have no intention of paying a high sum of money to have someone inspect us and stress the team out at the same time.

Remedy 2: Create a comparison website

12. What information should be displayed on a price comparison site and how?

- If done at all, it must compare like-for-like services—e.g. neutering **with or without fluids, bloods, pain relief**, etc.
- The site must clearly explain that not all services or practices are directly comparable.

13. How could a price comparison website be designed and publicised to maximise use and usefulness to pet owners?

- Simple layout. Plain language. Focus on **core services** only.
- Include filters (e.g. distance, species seen, emergency cover).
- Publicise through RCVS, practice websites, and social media—but it must be kept up to date and accurate to avoid misleading clients.

14. Which is more effective: (a) a single comparison site run by RCVS/third party, or (b) an open data model?

- **Option (a)** – A single site run by the RCVS or a commissioned neutral third party.
- Open data (option b) risks inconsistent tools, misuse of data, or bias. A central, controlled platform would build more trust.

15. What are the main administrative and technical challenges for FOPs and referral providers, and how could they be reduced?

- Huge admin burden for small practices: inputting, updating, checking pricing data.
- Realistically, this would need financial or admin support to be workable.

16. Please comment on the feasibility of providing price info for different animal characteristics (type, age, weight).

- Not feasible. Too many variables and permutations.

- Price varies based on age, weight, behaviour, pre-existing conditions—not just species.
- Could be simplified with broad ranges (e.g. “dog under 10kg”, “cat over 8 years”) but still not very meaningful.

17. Where prices vary (e.g. bundling or complexity), how should price info be presented?

- Use **real-life examples**: “This price includes fluids, pain relief, and follow-up; additional charges may apply if...”
- Avoid misleading ranges or hidden extras—just explain clearly what’s included and why.
- Comparison tools must include the **context**, not just the numbers.

18. Best means of funding a comparison site?

- Must be **publicly funded** (government or regulator).
- Asking small practices to fund this is unfair and unsustainable.

Remedy 3: Publish information about pet care plans

19. What would be the impact on vet business of this remedy? Would it vary across business types?

- Very negative for small practices. The **admin time** required to provide breakdowns of individual savings per client is unworkable.
- Corporates might automate this centrally, but for a team of 4–5 people, it’s unrealistic.
- Could force some practices to **stop offering care plans** altogether.

20. How could this remedy affect coverage of a typical pet plan?

- Plans may become more generic and less tailored—fewer optional services, more rigid terms.
- If too hard to manage or explain, clients may **lose interest** or practices may **discontinue** the offering.
- The focus should be on transparency at the time of sign-up—not ongoing individualised reporting.

21. The biggest challenge is the time and admin required to gather, present, and communicate all this information. In a small practice without a management team, these tasks fall to clinical staff. That time is taken away from patient care. Automation via PMS systems could help, but the setup and ongoing checking would still be a burden.

Remedy 4: Provide FOP vets with information relating to referral providers

22. It's feasible to offer a choice when appropriate, but in most cases we already refer to trusted specialists based on experience, communication, and continuity of care. Adding formal "choice" measures risks undermining this and confusing clients who just want our clinical recommendation.

23. Yes. Presenting a list of referral options could delay urgent cases, erode trust in professional advice, and overwhelm pet owners. It could also risk clients choosing suboptimal referrals based purely on price or convenience.

24. Referral centres would face more enquiries and admin from clients and unfamiliar referring vets. Smaller or specialist centres might be overlooked in favour of more visible generalist ones. It might also damage existing collaborative relationships.

25. As an FOP owner, I already provide appropriate referral options when needed. I refer based on the individual case and client circumstances. A mandated list of options would be unhelpful and unrealistic, especially in urgent situations.

26. The most useful information for clients is: location, opening hours, services offered, and how to get there. Too much data (like complex price comparisons) won't help—what they want is reassurance that their pet will be in safe hands.

Remedy 5: Provision of clear and accurate information about different treatments, services and referral options in advance and in writing

27. I feel it is pretty standard to provide an estimate for anything over around £200. At my practice all costs are constantly discussed and no one is met with an unexpected bill. I'd have thought the same is true at most practices?

28. This one seems bizarre – of course we always give owners thinking time. Most procedures are booked for a later date and the owner has plenty of "thinking time". We always provide estimates well ahead of the procedure. Even in an emergency we would stabilise the patient and then return to the owner to discuss estimates and obtain informed consent. What are you implying here???

29. Yes—if you had something as strange as mandated "thinking time" this should clearly not apply when delays would harm the pet or where clinical urgency requires immediate action. Common sense and clinical judgment must be allowed.

30. It depends what you mean? We generally record what options are offered in the clinical notes (to cover ourselves if someone turns around and claims they weren't offered x y z) but this would be a line of text listing the procedure etc not a detailed breakdown involving costs. When people do ask for detailed estimates for different options we would happily provide them and there would be a record of them in the "estimates" section of their file on our PMS. I'm not wasting time working out 10 estimates unless the client actually wants them though. Again another remedy adding masses of unnecessary admin work.

31. Consent forms are useful, but overcomplicating them with lists of rejected options risks confusing clients and making forms unreadable. It may reduce engagement with genuine consent and increase legal defensiveness.

32. The admin load would be significant. Larger practices might absorb it through admin teams; small practices cannot.

33. Yes—pricing varies depending on diagnostics, complications, and evolving plans. Requiring detailed cost info in advance can create false expectations or confusion when real cases don't follow a standard script.

34. Training could help in explaining treatment options and managing expectations, but it must be short, practice-relevant, and ideally subsidised.

35. The number of options should be clinically appropriate. For simple cases, one or two options may be plenty. For complex cases, clients can feel overwhelmed if presented with too many choices. Quality over quantity is key. Also, I would like to think the vet is able to choose and recommend the option best suited for that animal without stressing an anxious client out with a range of options which they don't have to clinical knowledge to choose between. My clients know me and trust me to help them at these times, if I had to provide them with a range of alternatives to tick some mandated box it is harmful to that relationship.

Remedy 6: Prohibition of business practices which limit or constrain the choices offered to pet owners

36. One example is corporate practices tying vets to internal referrals or their own online pharmacy—even when cheaper or better options exist. Yes, the RCVS should monitor and prohibit practices that clearly restrict client choice.

37. Internal audits may help, but there's a risk of box-ticking. Independent audits could be expensive. RCVS oversight might be most appropriate, but only if they have the resources and neutrality to manage it fairly.

38. Yes—LVGs should be closely monitored. They affect a much larger number of clients and can roll out restrictive practices across hundreds of sites quickly. Oversight here is essential.

39. Yes—business practices should include any internal guidance or software defaults that affect options offered to clients. For example, drop-down menus in PMSs or pre-set estimate templates can limit choice just as much as formal policies.

Remedy 7: Changes to how consumers are informed about and offered prescriptions

40. Yes, medicines administered by the vet (e.g. injections at the time of consult or procedure) should be exempt from prescription rules. These are part of treatment—not products. Trying to offer a written prescription for every injection is nonsensical. They can't

even access most of these medicines with a WP anyway?? The fact this is even a question deeply concerns me about your understanding of how a vet practice works??

41. Yes, there are several challenges. Writing and managing prescriptions for every medication creates a significant admin load—especially when many are short-term or administered on-site. It also risks confusion and duplication if clients misunderstand how to use or fill prescriptions. How would we complete this in a standard consult time? Increase consult length and so then need to increase prices!!

42. The best way to improve written prescriptions is to integrate them seamlessly into PMS systems—allowing vets to click a button and generate, sign, and send securely. It needs to be simple, digital, and compatible across systems and pharmacies. To prevent fraud we currently email prescriptions direct to pharmacies and this can be difficult enough to get the pharmacy to match it up with the order. A centralised system would be welcome.

43. A transition period of at least 12–18 months would be needed, particularly for small practices. This would allow time to update software, train staff, and change workflows. Anything less would be unfair and chaotic.

Remedy 8: Transparency of medicine prices so pet owners can compare between FOPs and other suppliers

44. Price comparison info should not be included—it varies by supplier and would go out of date quickly. Also the clients are grown adults surely they can work this out for themselves! Why should the burden be on us?

45. Vets should tell clients: (a) that they have the right to a prescription, (b) that they can buy it elsewhere, and (c) what the prescription fee is. This should be verbal and backed up with signage or written policy—not something we have to say every single time unless relevant.

If the client needs the medication urgently enough to have to decide where to get it from during their visit at the FOP they don't have the time to wait for it to be posted anyway so will get it from the FOP. If its long term ongoing medication they have all the time in the world to go home sit on google and choose where they want to get it from and the process needs zero input from me other than providing the WP if requested. This seems a massive overcomplication that is going to negatively affect the practice, will most likely need us to increase prices to cover this extra admin time and then ultimately cost the client more too!

46. The cost of implementing any of these options is significant, especially for independents. Corporates may cope, but smaller practices will struggle with setup, ongoing admin, and staff time. That burden must be recognised and funded.

Remedy 9: Requirement for generic prescribing (with limited exceptions) to increase inter brand competition for medicine sales

47. Generic prescribing could work for some meds, but it needs to be flexible. Prescriptions should include the active ingredient, but also allow the vet to specify a brand when clinically justified. Client safety and clarity must come first.

48. Some changes to VMD rules may be needed, especially if generic prescribing becomes mandatory. Current forms don't always make space for both generic and brand options. The VMD must provide clear, user-friendly guidance.

49. One big risk is confusion—some clients may end up with different-looking drugs from different suppliers and assume there's been a mistake. There's also a risk of supply issues or brand changes causing unexpected reactions or compliance problems.

50. Yes—non-critical, long-term medications like NSAIDs, heart meds, or parasite treatments could benefit from generic prescribing where clinical equivalence is well established. But for complex cases (e.g., epilepsy, skin disease), brand consistency is important.

51. Yes—exemptions should be allowed where (a) clinical judgment deems a specific brand necessary or (b) there's a known reaction or tolerance issue. Vets must retain discretion to protect patient safety.

52. Possibly—if we're going to rely more on generic equivalence, we need more rigorous and transparent certification that generics are truly equivalent in absorption, bioavailability, and efficacy. That's currently lacking in some areas.

53. Manufacturers should be required to provide clear equivalence data, ideally summarised in a central, independent database maintained by the VMD.

54. An e-prescription portal should allow drop-down lists for both generic and branded options. It must flag clinical warnings, allow vet notes, and ensure pharmacy access. It should not assume that one version fits all.

Remedy 10: Prescription price controls

55. I do not support a blanket prescription price cap. Most independents already charge low fees to remain competitive. A cap risks forcing us to work at a loss on prescriptions—while large corporates could offset it elsewhere. It could backfire.

56. Yes—prescription fees help cover time, record-keeping, liability, and follow-up. A cap may make it unviable to offer prescriptions or result in rushed, unsafe processing. It could also create pricing pressure elsewhere.

57.

58. Writing a prescription typically takes 5–10 minutes when done properly, including reviewing clinical records, calculating dose, updating the PMS, and signing off. The cost is roughly £10–£15 in staff time alone.

59. Dispensing costs vary by medicine but include staff time (5–10 minutes), label printing, packaging, stock management (sometimes there is expensive wastage regarding broach dates), and client advice. All dispensed medicines are countersigned by two members of staff. It's more straightforward when it's medication dispensed during a consult but can get more time consuming when its medication people order remotely. We then have to constantly chase people up to collect their medication and then return it to stock when they don't. It's not just handing over a box—it can easily cost £10–£20 per item dispensed.

Remedy 11: Interim medicines price controls

60. Some sort of cap on mark up % from list price. We already have lower mark ups than the corporates I've worked at (while having much lower rebates I might add!!!!) so I feel this would stop them without having as much of an impact on us.

62. Yes—limiting controls to the top 100 most-prescribed medicines makes sense. This keeps things manageable and targets the areas with the most potential impact on clients without overregulating the entire system.

63. Enforcement must be proportionate—small one-off price discrepancies shouldn't trigger penalties. Education and warnings should come before punishment.

Implementation of remedies 7 – 11

64. A simple, integrated portal that links with existing PMS software would be best. It must be fast, secure, and not require separate logins or re-entry of data. Practices are overwhelmed with portals already—this must streamline, not add complexity.

65. It should be centrally funded by government or the regulator. Expecting small practices to bear the cost of development or maintenance is unreasonable—particularly when they are already under financial pressure.

Remedy 12: Restrictions on certain clauses in contracts with third-party out of hours care providers

66. A fair notice period might be 3 months. Anything longer risks trapping practices in unsuitable or costly contracts. Shorter periods would allow flexibility and encourage OOH providers to maintain standards to keep custom.

67. Early termination fees should be capped—perhaps at 1 month of average billing or a fixed £500 maximum. This prevents extortionate fees and lets small practices adjust OOH provision as needed.

Remedy 13: Transparency on the differences between fees for communal and individual cremations

68. Yes—more transparency about cremation options is good, especially at a time when emotions run high. Many clients don't understand the difference between communal and individual cremations. Clear, sensitive language is key.

Remedy 14: A price control on cremations

69. A price cap should only apply to practices where cremation services are not itemised clearly or where clients are not given choice. Many practices already use third-party cremation services transparently.

70. A fair cap would reflect average third-party charges plus a reasonable handling/admin fee. It should allow for regional cost variations and inflation. Personally I have very little mark up on cremation fees, I think we only just cover costs. I don't agree with profiting from peoples grief.

71. If a price control is introduced, it should be reviewed every 2–3 years to ensure it stays fair and relevant. Too long without review risks mismatched costs and unintended business impacts.

72. The RCVS would be a logical body to oversee cremation price reviews, provided they work with the profession and cremation service providers. Their oversight must be informed and collaborative—not top-down.

Remedy 15: Regulatory requirements on vet businesses

73. Regulating vet businesses could help with transparency, but any new system must be proportionate. Right now, regulatory burden already feels excessive, especially from the PSS. New rules must focus on outcomes, not just tick boxes.

Remedy 16: Developing new quality measures

74. Defining “quality” is complex. Metrics must account for client communication, continuity of care, and patient outcomes—not just audit compliance or paperwork. One challenge is how to reflect the value of personalised, empathetic care.

75. I do not believe the PSS in its current form drives meaningful consumer decision-making. It's seen as a time-consuming, expensive accreditation with little client awareness. Enhancing it may help, but only if reformed substantially.

76. Any enhanced PSS must scale by business size and model. What's realistic for a 2-vet practice is very different from a 20-site corporate. It must also recognise diverse strengths—e.g., community integration or innovation—not just paperwork and branding.

77. Instead of expanding bureaucracy, consider supporting practices to deliver core client-centred services—like continuity of care, end-of-life support, or accessible payment options. These are often more meaningful to clients than accreditations.

Remedy 17: A consumer and competition duty

78. A consumer and competition duty for the regulator might help tackle anti-competitive practices—especially those of large groups. But it must be balanced carefully to avoid overburdening small practices that are already client-focused.

79. The duty should be framed as a responsibility to protect and promote fair access, choice, and transparency—while recognising the diversity of the veterinary sector. It should encourage proportionate oversight, not catch-all rules.

Remedy 18: Effective and proportionate compliance monitoring

80. Monitoring mechanisms must balance effectiveness and fairness. They should focus on trends and outliers, not punish occasional errors. Self-assessment can work for smaller practices, but large groups need more robust, external oversight.

81. Monitoring could be effective if proportionate. Large corporates should be scrutinised more heavily, but for small practices, it must be light-touch. Over-regulation will just increase costs and reduce availability of independent services.

82. Monitoring must be simple, limited in scope, and not a significant time burden. Use online self-declaration forms with minimal admin required for small practices.

83. The biggest burdens are time and financial cost for independent practices. These could be mitigated by exempting very small businesses or offering central support tools/templates.

Remedy 19: Effective and proportionate enforcement

84. I disagree with giving the regulator sweeping powers to suspend or fine vets or businesses—this would create a climate of fear and make recruitment even harder. Warnings and improvement notices seem reasonable, but beyond that it's disproportionate.

85. Yes—disproportionate enforcement could lead to small practices closing, which reduces competition. It could also deter people from entering the profession.

Remedy 20: Requirements on businesses for effective inhouse complaints handling

86. I support effective in-house complaints handling, but it must be simple. Mandatory processes should not involve excessive documentation or timescales.

87. A simple complaints log, standard response timeframe (e.g., 7–14 days), and escalation protocol to the VCMS if unresolved would be appropriate.

Question 88

Yes—mandating participation in the VCMS is appropriate. It protects both clients and practices by providing a structured, fair mechanism.

Question 89

There is a risk that this could be used vexatiously. Any mediation process must be free for practices, and frivolous complaints should be filtered early.

Question 90

Clear guidance on what issues are suitable for VCMS and a triage system to dismiss unfounded cases would help mitigate risks.

Question 91

Practices should be required to display VCMS information on websites.

Question 92

Use aggregated, anonymised complaint data to identify trends and improve standards across the profession. This should be led by the RCVS.

Question 99

The RCVS could publish clearer guidance and case examples to help practices understand and confidently utilise Schedule 3.

Question 100

Better nurse utilisation could free up vets for complex tasks, improve job satisfaction for nurses, and reduce costs. Risks include training gaps or role confusion if not managed well.

Question 101

Expanding the role under new legislation could help improve efficiency and access to care. But it must include safeguards, proper training, and clarity on accountability.

Question 103

It should give greater consideration to the pressures on small independent practices. Implementation support must be factored in.

Question 104

Trial periods and feedback mechanisms could be used to compare the impact of different options, especially for pricing and care plan transparency.

Question 105

I can't fathom facing any of the costs of this, it could destroy my practice. Increase admin work, loss of income, plus then to top it off I have to pay for the whole process?? Goodbye small independents.