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# CMA Consultation – May 2025
# PDSA Response to potential remedies

## Introduction to PDSA

*As the UK's largest veterinary charity, PDSA is dedicated to supporting people and their pets during difficult times. We believe that every pet deserves a happy and healthy life.*

*By providing free and low-cost vet care through our 49 Pet Hospitals across the UK we prevent suffering, help to relieve poverty and keep people together with their much-loved pets.*

*Every year, we provide over 2 million veterinary treatments, and support over 6 million people with our expert pet care advice. We receive no government funding, relying entirely on generous public support to fund our vital services.*

## Consultation questions

### Implementation of remedies

**Question 1:** We welcome comments regarding our current thinking on the routes to implementing the potential remedies set out in this working paper.

This PDSA response is based on a number of considerations:

1. Recognition that whilst the principal target businesses were initially the LVG's, the veterinary profession and veterinary service provision is a complex ecosystem with multiple interdependencies, any remedies have the potential to have a collateral impact on independent or charity veterinary practices as well as the LVG's and should be approached with caution.
2. There may be unintended impact on animal welfare through the potential for proposed remedies to impact on the structure of services, decision making of clinicians, or impacts on the behaviour of clients. It should not be forgotten that the veterinary surgeon's oath states:
   *" I PROMISE AND SOLEMNLY DECLARE that I will pursue the work of my profession with integrity and accept my responsibilities to the public, my clients, the profession and the Royal College of Veterinary Surgeons, and that, ABOVE ALL, my constant endeavour will be to ensure the health and welfare of animals committed to my care."*
3. Potential impact on clients, or response of clients, to the remedies in an ideal world versus the real world; recognising that every client's situation and capacity for understanding of information provided to them is different. That many clients are

highly dependent upon their pets and that remedies which impact upon their decision making, service availability or cost may improve the lot of veterinary clients – but equally has the potential to create confusion, stress, uncertainty and impact upon their wellbeing.

4. That the provision of veterinary care is a complex and dynamic process with decisions being influenced by veterinary surgeon factors, regulatory and legislative factors, veterinary practice factors, client factors, patient factors, supply chain factors and disease or condition factors – to name but a few. The veterinary service sector is not a financial services or insurance sector where relatively predictable decision-making criteria and risk factors can be approached in a standardised fashion across multiple service providers to create one size fits all processes, frameworks or platforms.

PDSA would be concerned that each new requirement for compliance, additional administration or need to change approaches or processes comes at a cost to the charity, PDSA receives no government funding and is entirely reliant upon funds received from the public, we are immensely grateful to all of our donors, supporters and legators for the funds that they provide to use. We strive constantly to spend those funds in the best way we can to deliver our vision and mission, any requirement placed on the charity which diverts that focus or which represents an increased regulatory, compliance or administrative cost has an ultimate impact upon the charity – through a need to either raise additional funds or to change our ways of working or service delivery to mitigate the impact.

PDSA would encourage CMA to consider these broader impacts at every stage of their consideration of the remedies they may take forward, particularly if the element of competition under consideration has no, or reduced, relevance in the provision of charitable care. The impacts of any additional requirements should be considered in terms of its impact on those practices and organisations that are not the target of the remedies, but that would be captured by the method used to introduce or enforce those requirements.

**Trialling of information remedies**

**Question 2:** We invite comments on whether these (or others) are appropriate information remedies whose implementation should be the subject of trials. We also invite comments on the criteria we might employ to assess the effects of trialled measures. Please explain your views

PDSA would refer to the considerations outlined in its answer to question 1, particularly the fact that there are many interdependencies and complexities to take into account when considering the proposed remedies. PDSA feels it would be prudent to trial any element of the remedies which may impact upon our ability to deliver charitable care to our beneficiaries across a broad range of stakeholder practices to ascertain the impact, before making decisions as to their suitability.

**Remedy 1: Require FOPs and referral providers to publish information for pet owners**

**Question 3:** Does the standardised price list cover the main services that a pet owner is likely to need? Are there other routine or referral services or treatments which should be covered on the list? Please explain your views.

The proposed price list does cover a reasonable range of products, procedures and services, however PDSA has significant concerns that the aim of producing a price list that is meaningful, comparable and sustainable will not be possible under the current proposals. PDSA always supported the stated desire to promote contextualised care as a means to providing options to access quality veterinary care in an affordable manner, PDSA also supports greater transparency as a principle for the profession to work towards: however, PDSA believes that the publishing of price lists is not the entire solution to either issue. Price lists are a static source of information, whereas clinical decision making is a dynamic process and so, therefore are the costs associated with those decisions.

**Question 4:** Do you think that the 'information to be provided' for each service set out in Appendix A: Proposal for information to be provided in standardised price list is feasible to provide? Are there other types of information that would be helpful to include? Please explain your views.

Appendix A, Section 1
Hospitalisation charges do not appear to be included on the list. The degree to which hospitalisation fees influence a final invoice is linked to the delivery of contextualised dare and can be a significant influencer on costs borne by the client - a £500-600 operation can turn into thousands over just a few days once these fees are added.
Decision to admit, decision to keep in overnight., daytime hospitalisation charges, overnight hospitalisation charges, intensive care hospitalisation charges - these decisions add up significantly over just a few days.

Some of the prices on the price list would be relatively simple to produce, others far more complex as they incorporate multiple variables.

Whilst consultation fees are important, how often a first consult is charged, for example, may also influence client invoices significantly, this could be after a set period of not being seen, if a consult includes the vet looking at something new, anything which isn't a chronic consult, is a consult charged on top of other elements of the price list e.g. if an appointment is made for a microchip as a stand-alone? - these variations in charging practice over and above the price alone could make a big difference to the client over time.

Defining the circumstances in which a nurse consult may be charged, and when it is included in other charges e.g. post op check, again it's not about the price entirely, but also how often the charge is applied.

Appendix A, Section 3
Includes the phrase 'standard' when referring to preventive parasiticides, it is important to state what the practice deems as 'standard' and what the options are - POM-V/NFA-VPS/GSL products. There is a contextualised care element here - to include or not include parasite testing to aid decision making on whether to treat or decide which is the most appropriate treatment - these can add significant costs.

Costs of managing certain conditions:
Grouping all of these conditions together in this way is a major concern with regards to making clients aware of the contextualised care options that may be available to manage such conditions. There are significant cost differences that a client may be exposed to, not just related to the cost of products but the more general management of these conditions - the main route to establishing effective contextualised care conversations to give clients the choices it presents, is to either raise awareness of the clients that these choices exist within practices and/or across practices and empower them to ask the questions, or to create a culture within the profession where these choices are presented to the client in a way that empowers them to make the best choice for them and their pet. I understand that you can't entirely achieve that with price lists, but it has to be a key component.

Example – Diabetes costs can vary enormously.
Initial stabilisation method (e.g. outpatient or in-patient), monitoring with nadir blood tests, glucose curves, urine tests, weight gain or loss, water intake, wearable tech; administration of insulin via syringes or injection pens
Frequency of the monitoring tests and check-ups, recommendation to neuter entire bitches
All of these in whatever combinations a practice offers them add up to give the cost of diagnosis and management of this condition that a price list cannot necessarily articulate.

It may be the use of the term 'treatment' that creates the issue - perhaps the term 'medications' would simplify the comparison and then it does become a price comparator based on an indicator of cost, but there would need to be a warning to the client to discuss the cost of other elements of care involved in management of these conditions.

Appendix A, section 7
Use of the term 'Specialist' to describe section 7, PDSA would suggest a different descriptor here as this term has specific meaning in the veterinary profession, some of these procedures are not specialist. PDSA would suggest that there needs to be more structure to the list - some of these examples are so broad ranging and cover so many components that maintaining the price list by building the cost up will be time consuming. costly and of limited value as the price presented will not be made up of standardised components across practices.

The list in section 7 does not help with promoting contextualised care - some items are:

a. Items that are not chargeable in their own right:

Heart murmur, Patellar luxation and lens luxation are clinical findings that may be addressed in a number of ways depending on the diagnosis of condition causing the signs e.g. patellar luxation may be treated via conservative management or a range of surgical techniques according to grading of the luxation and impact on animal welfare

b. Single procedures listed that do not provide information on other (contextualised) options that may be available:
    a. Tumour staging – by CT only, or may other methods be employed.
    b. TPLO - contextualised care options may include (in appropriate cases) conservative treatment, or other techniques such as the Lateral suture which can give good results in many cases for a much lower cost.

    c. Hip replacement – contextualised care options may include Femoral Head and Neck Excision (FHNE)
c. Catch-all phrases that may have multiple options underpinning and decision making.
    a. BOAS surgery - This isn't a single 'thing' but is potentially a combination of a number of procedures - nares widening, Sacculectomy, Soft palate shortening.

As a basis for standardising how prices are presented it should be clear which procedures should be included and which should not.
PDSA would suggest that the price list presented in Appendix A is not fit for purpose.

**Question 5:** Do you agree with the factors by which we propose FOPs and referral providers should be required to publish separate prices for? Which categories of animal characteristics would be most appropriate to aid comparability and reflect variation in costs? Please explain your views.

The animal factors would appear to be a sensible approach to presenting a price list in some instances. There are a number of procedures commonly provided by veterinary practices that can readily be differentiated by price according to predictable 'bands' of animal categories – these are most often species and size e.g. preventive procedures such as Bitch Spey are often categorised by weight or in a small/medium/large fashion, product costs for a large dog to manage arthritis will be greater than those for an average cat.
However, this does not hold true in all cases some more appropriate to present on a procedure basis e.g. time cost, surgical cost/minute.

**Question 6:** How should price ranges or 'starting from' prices be calculated to balance covering the full range of prices that could be charged with what many or most pet owners might reasonably pay? Please explain your views.

This approach may be of value where elements of care are standardised e.g. Bitch spays from small to extra-large but would still then need an explanation as to how their pet may fall into the range.

**Question 7:** Do you think that the standardised price list described in Appendix A: Proposal for information to be provided in standardised price list would be valuable to pet owners? Please explain your views.

PDSA would suggest that the price list presented as Appendix A is not fit for purpose for the reasons stated above. As a top line it may help differentiate the expensive from the more economic practices if the list is kept simple and it is made clear what the limitations of relying on a price list are.

**Question 8:** Do you think that it is proportionate for FOPs and referral providers to provide prices for each service in the standardised price list? Please explain your views.

As stated, many of the elements are broad ranging and cover so many components that maintaining the price list by building the cost up will be time consuming.

**Question 9:** Could the standardised price list have any detrimental consequences for pet owners and if so, what are they? Please explain your views.

A price list can provide a false sense of security to end users as it is clinical decision making that ultimately impacts the bill that a client is presented with.
A practice with a mid-range pricing structure may not be a mid-range costing practice, if contextualised care is not employed effectively i.e. if many of the components of the price list are included in the care provided then the cumulative bill is likely to be similar to a high priced practice that employs a pragmatic approach and carefully tailors care to the means and needs of the owner,
PDSA believes that price lists may be a valuable tool as part of a broader engagement and information sharing exercise, but without that broader approach to ensure understanding there are inherent risks to clients, and practices, in the potential misunderstandings that may arise.

**Question 10:** Could the standardised price list have any detrimental consequences for FOPs and referral providers? Are you aware of many practices which do not have a website? Would any impacts vary across different types or sizes of FOP or referral provider? Please explain your views.

Impact on demand for those practices that appear to be more expensive through this one-dimensional view of potential costs. The true differentiator should be the lifetime costs of pet ownership rather than what individual prices are, decision making made on a few indicative prices may not be the best decisions, whereas managing expectations of the level of service to be expected and the likely care outcomes for their pats may be more valuable to clients.

It may be useful to have further clarity on the primary purpose of a price list – would it be to give an indicator of the price that clients can expect to pay, or a tool to provide clients an overview of whether a practice can be considered expensive or more economic?

**Question 11:** What quality measures could be published in order to support pet owners to make choices? Please explain your views.

PDSA notes that CMA have already recognised the challenges associated with this:
*"We currently consider that requirements relating to standardised customer feedback or publishing complaints may not be effective in addressing our concerns and could pose considerable practical challenges that may outweigh the potential benefits to consumers. As such, we are not currently proposing these measures as part of any requirement on FOPs and referral providers to publish information for pet owners. However, we consider in Section 6: A regulatory framework which protects consumers and promote competition the potential for complaints data to be incorporated into a new measure of quality and how complaints data and insights may be used to drive sector-wide improvements, and we welcome views on this topic"*

PDSA would agree with the assessment that there is no single measure of quality, when assessing clinical and service quality a range of measures are referred to and are judged in context:

- Customer service reviews
- Net Promoter Score
- Telephone contact statistics.
- Waiting times – for an appointment and once the client has entered the practice.
- Complaints – volumes and numbers upheld as indicating that something different could have been done i.e. learnings.
- Clinical incidents
- Employee, client and patient safety
- Treatment outcomes
- Survival/mortality/average age at death
- Number of animals on different treatments

This range of quality measures is not necessarily exhaustive but demonstrates that a balanced scorecard approach is necessary when considering quality.

Quality measures are invaluable in assessing a service, however they can lead to false conclusions regarding the quality of service being delivered unless the reader (including clients) has a deep understanding of what each component means and the context in which the service is being delivered – publication of quality measure results and patient outcomes in the NHS and other public sectors should be referred to in order to fully understand the benefits and risks of implementing such an approach.

**Remedy 2: Create a comparison website supporting pet owners to compare the offerings of different FOPs and referral providers**

**Question 12:** What information should be displayed on a price comparison site and how? We are particularly interested in views in relation to composite price measures and medicine prices.

PDSA would suggest that any issues and concerns raised by PDSA and other respondents regarding the creation of a price list in response to Remedy 1 would need to be considered and satisfactorily addressed prior to considering the next step, which would be creation of a dedicated site.

Additional thoughts
Customer reviews – practices have to put effort in to promote clients to leave reviews, those that do not will often find that only those clients with an issue are posting and therefore perfectly good practices may get poor ratings – not because they are providing a poor service, because they haven't focused on that element.
Practices would need to decide which comparison site to direct their clients to - Trust Pilot, Google reviews or A.N.other - this means they may be risking have poor ratings on ones that they don't focus upon.
The issues with the Pricing list above would need resolving.

Composite price measures would need to be created that are standardised and understood by users.

**Question 13:** How could a price comparison website be designed and publicised to maximise use and usefulness to pet owners? Please explain your views.

**Question 14:** What do you think would be more effective in addressing our concerns - (a) a single price comparison website operated by the RCVS or a commissioned third party or (b) an open data solution whereby third parties could access the information and offer alternative tools and websites? Why?

**Question 15:** What are the main administrative and technical challenges on FOPs and referral providers in these remedy options? How could they be resolved or reduced?

**Question 16:** Please comment on the feasibility of FOPs and referral centres providing price info for different animal characteristics (such as type, age, and weight). Please explain any specific challenges you consider may arise.

As per response to remedy 1
Whether practices mandated to supply information for presenting on their own websites or a centralised one, this represents and increased administrative burden.

**Question 17:** Where it is appropriate for prices to vary (e.g. due to bundling or complexity), how should the price information be presented? Please explain your views.

These marketing tools add additional complexity to the presenting of any price list, there may be bundles on offer from time to time, or short-term discounts and promotions that may require the site to be updated regularly. These kinds of promotions can also lead to confusion in perception of value for clients, they may offer low-cost consultations as a loss leader but then have high-cost treatment if any condition should be diagnosed.

**Question 18:** What do you consider to be the best means of funding the design, creation and ongoing maintenance of a comparison website? Please explain your views.

The concept of any potential site needs considerably more consideration in terms of structure, content, hosting, maintenance and inputs to ascertain cost feasibility before potential funding sources can be considered.

**Remedy 3: Require FOPs to publish information about pet care plans and minimise friction to cancel or switch**

**Question 19:** What would be the impact on vet business of this remedy option? Would the impact change across different types or sizes of business? Please explain your views.

PDSA does not currently offer pet care plans and is therefore not necessarily best placed to comment upon the impact of the remedy, structure of plans, or potential friction that clients

may experience when wishing to switch. However, there are some considerations PDSA would suggest may need to be taken into account:

1. Many pet care plans contain elements of preventive care, namely flea, tick and worm products, current and emerging guidelines concerning responsible use of parasiticides are suggesting that decisions on parasiticide supply should be based on assessment of a range of risks and factors (local parasite prevalence, lifestyle, diet, environment, affordability, client compliance e.g. ability to apply a spot on versus tableting) rather than being a blanket cover all approach – this may mean that in the future pet care plans are more diverse and rather than being fixed products, will be tailored to the individual animal and will therefore be difficult to compare like with like, or provide simple costs for comparison.
2. PDSA questions the need for publishing, or even gathering, of the information relating to uptake and usage of the plans (although some may already do it to ensure the financial viability of the plans) – provided a clear explanation and resources relating to the potential benefits of the plan are provided then clients should be able to judge whether they are getting value from the plans in the way they envisaged. Some clients will be determined to uptake every possible element to get a sense of value, others may be content to have the reassurance that they could if they wanted or needed to e.g. free consultations.
3. It appears to be the case that some businesses have calculated the % saving of these plans over the pay-as-you-go model (if all elements are accessed) and incorporated them into their sales and marketing materials – that does not seem like a difficult request and would help to inform owners what level of uptake they needed to achieve as a minimum value for themselves e.g. if they at least wanted to 'break even'.
4. Clients should be free to come to their own personal conclusions as to whether they are gaining the value they wanted from the plans and be free to cancel them if not, in much the same way that they will make value decisions regarding the many other subscription models that exist e.g. Gym membership or TV streaming services.
5. The CMA stance that *"If a pet owner cancels a pet plan within the same year, they would not be charged for any services they have not used. However, the pet owner would be required to pay the difference between the cost of the services used up to that point at the original price (outside of a pet plan) and the payments already made for the pet care plan so that the PO will have paid full price for the services used."* feels like a reasonable and fair approach.

**Question 20:** How could this remedy affect the coverage of a typical pet plan? Please explain your views.

**Question 21**: What are the main administrative and technical challenges on FOPs and referral providers with these remedy options? How could they be resolved or reduced?

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

**Question 22:** What is the feasibility and value of remedies that would support FOP vets to give pet owners a meaningful choice of referral provider? Please explain your views.

PDSA agrees with the CMA conclusion that to create a standardised and linked system would likely pose many challenges and could result in substantial costs.
RCVS 'Find a vet' web resource already has filters that allow users to filter for practices with specialists or advanced practitioners working in them by location and also discipline, and links through to their websites. The basic information is already available and in the public domain.
PDSA would suggest that a simple requirement for Referral and specialist practices to publish on their websites indicative case costs for their most frequently provided care episodes across the disciplines they cover, would provide a good overview for decision making. This approach may be possible as referral practices accept cases from FOPs for management of a particular condition and generally for a limited time until the patient is discharged from the care of the referral practice back to the FOP. This means that the level of billing of these 'referral periods' is easier to interpret i.e. the overall costs of dealing with any particular condition (including consultations, investigation/diagnostics, procedures and aftercare) is not mixed up with other services and products provided as is the case with FOP billing records.

**Question 23:** Are there any consequences which may be detrimental and if so, what are they?

If the issue at hand is the referral of clients within LVG business structures and a concern that such recommendations are not providing sufficient information to allow clients to make informed choices of the referral service they wish to attend, the following considerations may be taken into account.

1. Independent FOP and charities have no such business relationships with referral providers, their choices and recommendations are more often based upon reputation, location and cost as well as professional respect and relationships that may have been built up over many years.
2. It is not always possible to access a wide range of referral or specialist practices within any given location, therefore the options available may be limited by clients' ability to travel.

CMA should be cautious that their recommendations do not disproportionately impact many practices that are not subject to the concerns being addressed and that already have good and reliable networks in place.

PDSA has concerns that the onus to discuss, in detail, different treatment options and associated costs with clients will fall upon the FOP vets and this could be challenging, time consuming and open the FOP vets to criticism if the case management is not ultimately as discussed – when the entire purpose of referral is that the practice referred to is best placed to manage the condition of the patient, have the meaningful conversations regarding treatment options and costs for that particular patient.

PDSA feels that FOP veterinary surgeons should be required to have appropriate and unbiased conversations about the broad treatment options available with indicative costs of the different options – however, detailed conversations on referral level options and associated costs should be the remit of the referral practice.

In many cases the discussion around potential benefits for the pet over what the FOP is able to offer, travel distance, likely frequency of visits and indicative overall costs (it will cost about £X thousand) is enough to help owners decide whether they would be in a position to access the referral service. PDSA would suggest that any more detailed discussion beyond that should be between the referral practice and the client.

**Question 24**: What do you consider are likely to be the main administrative, technical and administrative challenges on referral providers in this remedy? Would it apply equally to different practices? How could these challenges be reduced?

These expectations should not be overall more onerous or difficult to comply with than those imposed on FOP, the content of the information required should be the only difference.

**Question 25:** If you are replying as a FOP owner or referral provider, it would be helpful to have responses specific to your business as well as any general replies you would like to make.

As an independent charity PDSA does not have any business connection with referral or specialist providers.

**Question 26**: What information on referral providers that is directly provided to pet owners would effectively support their choice of referral options? Please explain your views.

As stated above - In many cases the discussion around benefits for the pet over what the FOP is able to offer, travel distance, likely frequency of visits and indicative overall costs (it will cost about £X thousand) is enough to help owners decide whether they would be in a position to access the referral service.

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

**Question 27:** If a mandatory requirement is introduced on vet businesses to ensure that pet owners are given a greater degree of information in some circumstances, should there be a minimum threshold for it to apply (for example, where any of the treatments exceed: £250, £500, or £1,000)? Please explain your views.

To distil down the level of discussion required, and information made available to clients to an arbitrary financial figure would appear to be doing the profession, professional judgement and effective gaining of informed consent a disservice. There may be some circumstances of low-cost care where significant discussions and information sharing is necessary and some circumstances of high-cost care where decisions can be made with minimal discussion and information sharing.
Cost is just one element of the gaining of informed consent from clients which all veterinary surgeons are required to effectively gain under the Codes of Professional Conduct, meaningful informed consent cannot be gained by addressing just one of the factors involved and PDSA would suggest that to focus on just one element could have unintended consequences for animal welfare and may cloud client and clinician decision making.

There is already a requirement to provide an estimate for treatment plans discussed with the client – these take time to create as the veterinary surgeon often has to essentially cost up a service as though that service has been delivered.
The production of estimates for agreed treatment plans is already a time-consuming matter, any requirement to undertake the same process for multiple options in order to facilitate discussions to arrive at an agreed treatment plan would likely have a significant impact upon consultation times.
This remedy could detract from the time available, and ability, to hold focused and quality discussions on a decision once it has been made and would increase the time (and cost) involved in coming to that decision.

**Question 28**: If a requirement is introduced on vet businesses to ensure that pet owners are offered a period of 'thinking time' before deciding on the purchase of certain treatments or services, how long should it be, should it vary depending on certain factors (and if so, what are those factors), and should pet owners be able to waive it? Please explain your views.

PDSA believes that this approach is already widely applied across the profession, it is not unusual for veterinary surgeons to provide palliative or symptomatic treatment to protect the welfare of patients and allow clients 'thinking time' to digest discussions and consider the best options for themselves and their pets. Allowing for sufficient and appropriate 'Thinking time' is just one element of the gaining of informed consent from clients which all veterinary surgeons are required to effectively gain under the Codes of Professional Conduct, meaningful informed consent cannot be gained by addressing just one of the factors involved and PDSA would suggest that to focus on just one element could have unintended consequences for animal welfare and cloud client and clinician decision making.

**Question 29:** Should this remedy not apply in some circumstances, such as where immediate treatment is necessary to protect the health of the pet and the time taken to provide written information would adversely affect this? Please explain your views.

In alignment with the considerations outlined in Question 1 and the answer to question 28, PDSA would suggest that the concept of what is appropriate 'thinking time' looks different according to the condition being attended to, the treatment options available, the pet's immediate and longer term welfare needs, client decision making capacity and wellbeing, as well as practice factors such as the range of services available, capacity and waiting times. In order to take all of these variables into account PDSA would suggest that appropriate thinking time does look different for every case, the requirement to consider an appropriate and justifiable length of 'thinking time' seems sensible and should be informed by the clinical judgement of the attending veterinary surgeon through discussion with the client, the mandating of an arbitrary length of time would not seem appropriate.
PDSA would agree with the CMA conclusion that *'vets should be able to exercise their professional discretion over the number of potential treatment options which are provided to pet owners'* and would suggest that the method of sharing that information should also be left to the judgement of the veterinary surgeon.

**Question 30**: What is the scale of the potential burden on vets of having to keep a record of treatment options offered to each pet owner? How could any burden be minimised?

It should be remembered that veterinary surgeons have a limited and defined time available to attend to each case, any remedy which would add administration, or discussions that do not necessarily change the ultimate decision making (for the sake of ticking a box) can have significant consequences.
If the remedies consistently add time to consults then charges for those consultations would need to reflect the time spent – this would then potentially impact on clients' propensity to visit the vets, and impact pet welfare.
Longer consultations could also impact accessibility to veterinary care through reducing their availability, veterinary practices have a set amount of resource and therefore have a set amount of time to deliver consultations, if each consultation is longer then this will inevitably either:

a. Increase pressure on veterinary surgeons through increasing the likelihood of them running late with their consult lists, or
b. Extend appointment waiting times meaning that pets deteriorating and needing to be attended as urgent cases on top of existing lists becomes more likely.

**Question 31**: What are the advantages and disadvantages of using treatment consent forms to obtain the pet owner's acknowledgement that they have been provided with a range of suitable treatment options or an explanation why only one option is feasible or appropriate? Could there be any unintended consequences?

There is already a requirement for veterinary surgeons to record the decision making and rationale in the case notes (clinical history) of their patients, a consent form is a confirmation of the final decision reached. Caution should be taken to not blur the purpose of the consent form, whilst they may be used as a confirmation that the client is satisfied with the discussions and options presented to reach the point of giving consent, PDSA would suggest that to mandate significant additional detail being added to consent forms (which may be duplicating that recorded in the clinical history) would be unnecessary and would again add to the administrative burden on veterinary surgeons.

**Question 32**: What would be the impact on vet businesses of this remedy option? Would any impacts vary across different types or sizes of business? What are the options for mitigating against negative impacts to deliver an effective but proportionate remedy?

Any remedy which increases consultation time means that practices would either have to absorb the additional workload within their existing resources available i.e. make them work harder, reduce the number of consultations available through the practice, or increase resource available through recruiting additional clinicians (which is not easy in the current climate). Additional printing, postage costs or time spent emailing bespoke materials to individual clients all add costs to practices which would presumably need to be recouped from clients.

**Question 33**: Are there any barriers to, or challenges around, the provision of written information including prices in advance which have not been outlined above? Please explain your views.

As outlined in the answers above, plus the fact that not all clients have the same abilities to receive such information (digital access and capabilities vs hard copy), or absorb and

understand it – there is a danger that considerable time and resource would be spent on providing such information and little benefit would be gained.
Experience would suggest that clients and customers (not just of veterinary practices) do not read T&C's and service provider information shared with them, practice leaflets and other information resources are often taken but never read.
Is there any experience of the impacts and benefits of such information sharing methods, in the NHS perhaps, that could provide some insight into the effectiveness of such methods that could provide some reassurance that it would not be largely wasted effort and cost.

**Question 34:** How would training on any specific topics help to address our concerns? If so, what topics should be covered and in what form to be as impactful as possible?

Training on meaningful, effective and efficient yet pragmatic approaches to gaining and recording informed consent would cover all of the elements discussed above. This should result in effective conversations, the sharing of appropriate information at a level the clients can understand, effective and concise recording and robust decision making – all of which has the potential to increase client satisfaction, improve care and welfare and reduce conflict.

**Question 35**: What criteria should be used to determine the number of different treatment, service or referral options which should be given to pet owners in advance and in writing? Please explain your views.

See answers above.

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

**Question 36:** Are there any specific business activities which should be prohibited which would not be covered by a prohibition of business practices which limit or constrain choice? If so, should a body, such as the RCVS, be given a greater role in identifying business practices which are prohibited and updating them over time? Please explain your views.

Anything that enforces practices that are anti-competitive, unethical, unjustifiable or at odds with regulations or legislation should be prohibited; otherwise, businesses should be able to require their clinicians and teams to practice or behave in ways that are specified by them.

**Question 37**: How should compliance with this potential remedy be monitored and enforced? In particular, would it be sufficient for FOPs to carry out internal audits of their business practices and self-certify their compliance? Should the audits be carried out by an independent firm? Should a body, such as the RCVS, be given responsibility for monitoring compliance? Please explain your views.

**Question 38**: Should there be greater monitoring of LVGs' compliance with this potential remedy due to the likelihood of their business practices which are rolled-out across their sites having an impact on the choices offered to a greater number of pet owners compared with other FOPs' business practices? Please explain your views.

**Question 39:** Should business practices be defined broadly to include any internal guidance which may have an influence on the choices offered to pet owners, even if it is not established in a business system or process? Please explain your views.

There are a number of clinical governance activities which fall under the remit of the appointed senior veterinary surgeon, these should be ethical, justifiable and compliant with regulations. They are elements that are present in many practices, however, they have particular importance in the charity setting.
Defined Scope of service, there is an acceptance that each veterinary practice defines its own range of services, according to the skills, equipment, capacity, and in the case of charities – funding that is available. In order to provide reassurance to its funders and donors PDSA strives to have a similar Scope of Service available from all of its 49 Pet Hospitals and Clinics, and must therefore have those expectations documented in the form of Clinical Guidance and treatment protocols.
PDSA needs to ensure that its funds contribute to helping as many clients and their animals as possible and therefore has a defined list of medicines which are stocked and clinical guidelines and protocols that define how certain conditions are treated within the charitable activity. PDSA clients are however informed of other treatments that may be available at FOP's and referral practices, and those clients have a choice as to whether to access those alternatives.

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

**Question 40:** We would welcome views as to whether medicines administered by the vet should be excluded from mandatory prescriptions and, if so, how this should be framed.

PDSA believes that veterinary medicines administered by the veterinary surgeon or under the direction of the veterinary surgeon should not be subject to mandatory prescription requirements, these are most often administered in the consultation room with the client present, to in-patients as part of a procedure or hospitalisation or are in a form where it would be inappropriate for a prescription to be written e.g. injection. However, please see PDSA response to Q41 for the more general view on mandating prescriptions.

**Question 41**: Do these written prescription remedies present challenges that we have not considered? If so, how might they be best addressed?

PDSA is entirely opposed to the mandating of prescription writing, the introduction of a blanket approach which will mean the creation of a prescription whether a client wants one or not would represent a significant amount of wasted time and effort, the constrained resources of the veterinary profession should not be utilised performing tasks that, in a proportion of instances may not be required. The costs of doing so for those not taken up would need to be recouped by the practices.

PDSA supplies all of its medications, via our free, low cost or preventive services at zero or much reduced prices, it would be a waste of charitable resources creating prescriptions for the majority of our medication supply as the client is accessing medications for free.

If PDSA were to have to comply with mandatory prescription writing or a mandatory offer, this could be interpreted as encouraging clients to go and purchase those medications elsewhere (rather than the treatment being provided by the charity) and undermine perceptions of PDSA as a charity, this could have reputational ramifications for PDSA through accusations of cost avoidance.

If a client wishes to do so they are at liberty to request a prescription, as PDSA complies with current guidelines, but very few do make that request. PDSA would however be supportive of Option B raising awareness and a price cap on prescriptions.

PDSA would be concerned that the mandatory issuing of prescriptions could have an impact on pet welfare, whilst there may be a cost saving for clients, it should be remembered that the process having a consultation, receiving the prescription, submitting the prescription and receiving the medication can be lengthy and this timescale may not always be in the best interests of the pet. There should be clinical judgement as to whether the time delay is appropriate. Where a prescription is taken up and a time delay is likely some veterinary surgeons may feel that they need to protect the pet's welfare by starting medication with an injection, for example, which could negate cost savings of the prescription.

When issuing a prescription this may be recorded on the clinical system, but there is no record of supply of the medication or reassurance that the client has used the prescription and sourced the medication for their pet until the next time they visit the vets, at the very least the in-house supply provides reassurance that the client has that medication in their possession and the best chance that it will be used.

**Question 42**: How might the written prescription process be best improved so that it is secure, low cost, and fast? Please explain your views.

Whilst improvements in technological, or other, solutions to improve speed and efficiency of prescription writing would be welcomed, this would not change PDSA stance regarding mandatory prescription writing.

**Question 43**: What transitional period is needed to deliver the written prescription remedies we have outlined? Please explain your views.

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

**Question 44**: What price information should be communicated on a prescription form? Please explain your views.

PDSA is supportive of any initiative that may ease the cost burden of care for the pets of people who are financially constrained, which could make the difference between them making a decision to access charitable care or not. However, PDSA would also be concerned at any remedy that may impact the financial viability of practices and reduce accessibility to veterinary care. It is possible that those smaller practices that cannot source

medications at low prices compared to LVG's may be disproportionately impacted by this recommendation as they will not be able to compete with LVG's or internet sources.

PDSA would ask the question in what other industry are businesses required to tell their customers the prices of their competitors and effectively encourage them to go make purchases elsewhere. It may be reasonable to raise awareness that medications may be purchased more cheaply elsewhere, but actively providing those prices feels like a disproportionate step.

**Question 45:** What should be included in what the vet tells the customer when giving them a prescription form? Please explain your views.

PDSA believes that clients should be informed of the ability to request a prescription, that the fee for a prescription should be reasonable and justifiable compared to the cost of producing one, and that they should be given information on where they may be able to find alternate prices if they should wish to do so.

**Question 46:** Do you have views on the feasibility and implementation cost of each of the three options? Please explain your views.

The cost of this remedy should not fall on practices who will already be risking income through compliance.

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

**Question 47:** How could generic prescribing be delivered and what information would be needed on a prescription? Please explain your views.

PDSA already largely operates Generic prescribing (assuming the term generic in this case is referring to prescribing by active ingredient, rather than the more general understanding which would relate to prescribing of human medication) and would be supportive of raising awareness and application of this already permitted practice.

**Question 48:** Can the remedies proposed be achieved under the VMD prescription options currently available to vets or would changes to prescribing rules be required? Please explain your views.

**Question 49**: Are there any potential unintended consequences which we should consider? Please explain your views.

**Question 50**: Are there specific veterinary medicine types or categories which could particularly benefit from generic prescribing (for example, where there is a high degree of clinical equivalence between existing medicines)? Please explain your views.

Where the active ingredient and excipients are equivalent there would appear to be minimal risk.

There may be some minor data sheet differences, but these tend to be more down to whether the manufacturer has included specific information or data in their license applications than being real world significant differences.

**Question 51:** Would any exemptions be needed to mandatory generic prescribing? Please explain your views.

This should be left to the clinical judgement of the veterinary surgeon, who may decide that it is not appropriate in circumstances such as an immediate need to treat a pet already in their presence where a delay in treatment would have a deleterious effect on the welfare of that patient.

**Question 52:** Would any changes to medicine certification/the approval processes be required? Please explain your views.

**Question 53**: How should medicine manufacturers be required to make information available to easily identify functionally equivalent substitutes? If so, how could such a requirement be implemented?

VMD could do that on their Product Information Database - Home through the search/filter functionality, and NOAH could potentially indicate in their compendium.

**Question 54**: How could any e-prescription solution best facilitate either (i) generic prescribing or (ii) the referencing of multiple branded/named medicines. Please explain your views.

That platform could have the equivalences built in and populate them automatically.

There may be a concern with an e-prescription function that an animal's clinical history may not even have a record of a prescription being generated unless it communicates with practice management systems.

**Remedy 10: Prescription price controls**

**Question 55:** Do you agree that a prescription price control would be required to help ensure that customers are not discouraged from acquiring their medicines from alternative providers? Please explain why you do or do not agree.

PDSA agrees that a price cap at a level likely to cover costs of production in the vast majority of instances would be appropriate.

**Question 56**: Are there any unintended consequences which we should take into consideration? Please explain your views.

If a maximum value were to be stated in the form of a price cap, this might encourage some practices to raise fees up to that level (through interpreting it as being acceptable and wanting to compensate for potential loss of medication income), meaning that some clients may end up paying more for their prescription than previously.

**Question 57:** What approach to setting a prescription fee price cap would be least burdensome while being effective in achieving its aim of facilitating competition in the provision of medicines? If we were to decide to impose a cost based price control for prescriptions, we need to fully understand the costs involved with prescribing and dispensing activities. We are seeking to understand:

**Question 58:** What are the costs of writing a prescription, once the vet has decided on the appropriate medicine?

**Question 59**: What are the costs of dispensing a medicine in FOP, once the medicine has been selected by the vet (i.e. in effect after they have made their prescribing decision)?

**Remedy 11: Interim medicines price controls**

**Question 60:** What is the most appropriate price control option for limiting further price increases and how long should any restrictions apply for? Please explain your views.

PDSA supplies the majority of its medications to our charitable clients free of charge, where clients access our paid for services the prices charged for medications, and all other aspects of care, are set at a low-cost level which is below those charged by private veterinary practice. It is highly unlikely that a price cap would impact PDSA.

PDSA would be concerned that a price cap could impact smaller business far more than LVG's who are more likely to be sourcing their products at a lower price, this will leave smaller businesses more exposed to cost base fluctuations and limit their ability to respond to them.

PDSA would be concerned that a price cap on medications would potentially lead to the raising of the prices of other aspects of care which may have significant pet welfare implications. If the lost revenue from the high volumes of medication sales were to be loaded onto much lower volume surgical prices for example, this could raise procedure prices significantly and put lifesaving and essential surgery prices further beyond the reach of many pet owners, ultimately leading to higher euthanasia rates in potential surgical patients.

**Question 61:** If we aim to use a price control to reduce overall medicine prices, what would be an appropriate percentage price reduction? Please explain your views.

PDSA would be concerned that a price freeze, if prolonged, and particularly a price reduction, would impact upon our ability to flex our low cost service prices with the cost to PDSA of providing them, this could result in the charity needing to find funding to fill the shortfall.

**Question 62**: What should be the scope of any price control? Is it appropriate to limit the price control to the top 100 prescription medicines? Please explain your views.

**Question 63:** How should any price control be monitored and enforced in an effective and proportionate manner? Please explain your views.

Implementation of remedies 7 – 11

**Question 64:** We welcome any views on our preferred system design, or details of an alternative that might effectively meet our objectives. Please explain your views.

**Question 65:** What do you consider to be the best means of funding the design, creation and ongoing maintenance of an e-prescription portal and price comparison tool? Please explain your views.

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

**Question 66:** What would be an appropriate restriction on notice periods for the termination of an out of hours contract by a FOP to help address barriers to FOPs switching out of hours providers? Please explain your views.

PDSA would suggest that the availability of multiple OOH providers in many areas is restricted and that whilst the ability to switch in a friction free manner is important, it is also important to recognise that there can also be a significant impact of termination by an OOH provider where there are limited other options for user practices.

The veterinary profession has been changed significantly by the emergence of OOH providers and many veterinary surgeons and practice teams do not want to provide out of hours services themselves nowadays, if an OOH provider terminates in an area where there are no alternatives (as CMA have found, this is common) then the choices for a practice are to provide it themselves or close if they cannot do so (the RCVS Codes of Professional Conduct preclude practicing veterinary surgery without a 24/7 means of cover). To consult and change contracts, or recruit in to provide 24/7 cover themselves for most practices would not be a quick undertaking, PDSA would suggest that termination notice periods need to be balanced to protect both parties sufficiently.

PDSA would suggest that an increase in OOH provider options in many areas would be a better remedy and would provide the competition necessary to normalise the contractual relationships, and pricing, and would provide end-user practices with better negotiating power.

**Question 67:** What would be an appropriate limit on any early termination fee (including basis of calculation) in circumstances where a FOP seeks to terminate a contract with an out of hours provider? Please explain your views.

Not sure

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

**Question 68:** Do you agree that the additional transparency on the difference in fees between fees for communal and individual cremations could helpfully be supplemented with revisions to the RCVS Code and its associated guidance? Please explain your views.

PDSA agrees that price transparency between different forms of cremation would be appropriate to allow clients to choose the best options for themselves. However, there are many independent crematoria that will provide a private service to clients and collect the remains from veterinary practices for private cremation, this solution would only allow price comparison between veterinary practices unless CMA were to bring these crematoria into the scope of their proposed remedy.

**Remedy 14: A price control on cremations**

**Question 69:** If a price control on cremations is required, should this apply to all FOPs or only a subset? What factors should inform which FOPs any such price control should apply to?

PDSA feels that this element of veterinary service is different to other elements in that prescription medicines or surgery can only be accessed through veterinary practices, whereas cremation services are also available direct to client through private arrangements. Veterinary practices are often acting as an introducer of these services rather than a provider which are accessed by the clients for convenience at a difficult time.

**Question 70:** What is the optimal form, level and scope of any price control to address the concerns we have identified? Please explain your views.

It may be appropriate to state an average price that would be charged and make it clear to clients that they can access cremations via routes other than veterinary practices. However, as the pricing for cremations is dependent upon third party charges this approach to control prices may lead to this activity being loss making and should be approached with caution. It may be levels of mark-up rather than prices per se that is the issue.

Question 71: For how long should a price control on cremations be in place? Please explain your views.

Question 72: If a longer-term price control is deemed necessary, which regulatory body would be best placed to review and revise such a longer-term price control? Please explain your views.

**Remedy 15: Regulatory requirements on vet businesses**

Question 73: Would regulating vet businesses as we have described, and for the reasons we have outlined, be an effective and proportionate way to address our emerging concerns? Please explain your views.

PDSA would agree that the only existing mechanism for RCVS to regulate businesses is through Supporting Guidance 17 of the Codes of Professional Conduct which requires appointment of a senior veterinary surgeon (SVS) responsible for professional matters within an organisation. However, this means that the Appointed SVS in large and complex organisations may be held accountable for areas over which they have no direct control and may be very difficult to monitor effectively.

PDSA had agreed in the RCVS legislative review consultation (2021) that to regulate practices or businesses would seem like a rational way forward, however, it is still not clear the mechanism by which that may be enforced, would the RCVS gain powers to regulate lay persons within businesses or be able to take action against businesses as an entity.

**Remedy 16: Developing new quality measures**

Question 74: Are there any opportunities or challenges relating to defining and measuring quality which we have not identified but should take account of? Please explain your views.

PDSA would refer to its response to Question 11, as the response suggests, this is an area that requires significant assessment of both benefits and risks. In addition, PDSA would suggest that perceptions of quality and value will vary according to the audience and their individual needs, so would suggest that further assessment of the needs of the various audiences should be undertaken.

Question 75: Would an enhanced PSS or similar scheme of the kind we have described support consumers' decision-making and drive competition between vet businesses on the basis of quality? Please explain your views.

The PSS is perhaps more an indicator of compliance and having business processes in place, which may give reassurance, but is not a direct indicator of service quality.

PDSA would refer to the response given to this matter during the 2021 legislative reform consultation - *PDSA would agree that the regulator should mandate minimum acceptable standards that provide for acceptable welfare outcomes, but that it should not be in the form of an accreditation scheme such as PSS, which is designed for different purposes. PDSA could not agree to a recommendation that simply makes the PSS mandatory in its current form; despite a number of historical attempts to engage with RCVS (jointly undertaken by the major charities and aimed at making the PSS accessible to us at the level we wish to join), the joint charity proposals to overcome the barriers have not been taken forward*

Question 76: How could any enhancements be designed so that the scheme reflects the quality of services offered by different types of vet businesses and does not unduly discriminate between them? Please explain your views.

PDSA agrees that consideration of any enhanced scheme should not discriminate on a number of grounds such as those stated – cost, administrative burden, type of practice, pitch and scope of service.

Question 77: Are there any other options which we should consider?

PDSA has internally implemented a quality assessment system similar in nature to that employed by the CQC in the medical world.
This approach by our team of auditors means that each of our Pet Hospitals and clinics is audited and scored four times a year (minimum), with the reviews focused on 5 key criteria – Clinically effective, Safe, Well-led, Financially effective and Compliant.
Underneath those broad categories there are over 60 broad areas of compliance. risk or quality assessed, relating to over 100 identified specific risks, and the team asks over 300 questions over the course of their reviews in order to provide the quality scores. The audit team will work with the site leaders in between reviews to improve their scores and ensure ongoing focus in the most appropriate areas.
This system provides an over-arching rating for PDSA as a whole, by location, by broad category, and by individual question if necessary.
Whilst this system has provided valuable internal insight and has driven significant improvements within PDSA, it has involved significant engagement at all levels of the organisation and significant investment and resources.

**Remedy 17: A consumer and competition duty**

Question 78: Should any recommendations we make to government include that a reformed statutory regulatory framework include a consumer and competition duty on the regulator? Please explain your views.

PDSA agrees that a regulatory framework that includes consumer and competition elements has the potential to protect or improve animal welfare. Indeed, there are already elements of these matters within the RCVS Codes of Professional conduct.
However, PDSA would also re-iterate the statement made in response to Question 1 - that each new requirement for compliance, additional administration or need to change approaches or processes comes at a financial and time cost, the impacts of any additional requirements should be considered in terms of its impact on those practices and organisations that are not the target of the remedies, but that would be captured by the method used to introduce or enforce those requirements.

Question 79: If so, how should that duty be framed? Please explain your views.

**Remedy 18: Effective and proportionate compliance monitoring**

Question 80: Would the monitoring mechanisms we have described be effective in helping to protect consumers and promote competition? Please explain your views.

PDSA would agree that such mechanisms would be a consideration, but only if the deficiencies in the regulatory system are found to be contributing to the matter with which the CMA are engaged, proportionately to the degree to which these additional bureaucratic requirements would impact the spectrum of practices across the profession. Indeed, many LVG's (and charities who are required to provide such assurances to their donors, supporters and trustees) would find these requirements easier to comply with as they have

the structures, processes, monitoring, and quality assurance frameworks that may be required by such a remedy. As stated previously, any remedy which disproportionately impacts independent, or charity practice should be considered very carefully.

Question 81: How should the monitoring mechanisms be designed in order to be proportionate? Please explain your views.

If this remedy is found to be proportionate to the degree to which it contributes to the issues, then the existing RCVS proposals for legislative reform (which have already been consulted upon) should be closely examined to ascertain whether they would provide the reassurances required – rather than creation of an additional platform. The proposed detail of this remedy and others related to this one should be consulted upon separately with the profession, and veterinary customers should be consulted upon what matters to them the most.

Question 82: What are the likely benefits, costs and burdens of these monitoring mechanisms? Please explain your views.

Any practice that has the above-mentioned frameworks in place already and that would be able to comply with the requirements, such as the LVG's may have a competitive advantage in this area.

Any increase in monitoring or compliance requirements has the potential to drive costs into the profession, direct costs to the practices of compliance, direct or indirect costs to practices to fund the monitoring body and their internal administration. The overall costs of such a system versus the benefits to veterinary clients should be carefully considered.

Question 83: How could any costs and burdens you identify in your response be mitigated and who should bear them? Please explain your views.

**Remedy 19: Effective and proportionate enforcement**

Question 84: Should the regulator have powers to issue warning and improvement notices to individuals and firms, and to impose fines on them, and to impose conditions on, or suspend or remove, firms' rights to operate (as well as individuals' rights to practise)? Please explain your views.

PDSA would refer to its response to the RCVS legislative reform consultation:

*PDSA agrees that the concept of remedial action prior to sanction is a reasonable and sensible way forward, provides for a system that could be beneficial for the wellbeing of those concerned by offering an agreed route to resolution, and would align the process with the approach taken by other regulators.*

*However, PDSA feels that a tiered system for approach should be applied:*

- *Warning issued – opportunity for remedial action.*
- *Notification of intent to serve Improvement notice – opportunity for remedial action*

- *Improvement notice*
- *Sanction*

*At each stage an approach to remedy the issues that is agreed, realistic and achievable should be documented so that the process can be as robust as possible; thus, removing extended periods of mental anguish and costly misalignment of understanding that leads to disagreement.*
*RCVS should be clear on the thresholds for such action to be taken at each of the stages. Progression of this recommendation should come with assurance that the process is designed to avoid damage to reputation and commercial viability.*

Question 85: Are there any benefits or challenges, or unintended consequences, that we have not identified if the regulator was given these powers? Please explain your views.

PDSA would again refer to its response to the RCVS legislative reform consultation:

*If serving of an improvement notice results in loss of public faith and trust unfairly, as a result of lack of understanding of the issues and process, which leads to reduced practice, or reduced charity, income or support; then that is tantamount to an immediate sanction. PDSA would therefore recommend that the process should not be within the public domain.*

**Remedy 20: Requirements on businesses for effective in-house complaints handling**

Question 86: Should we impose a mandatory process for in-house complaints handling? Please explain your views.

PDSA would suggest that all businesses and practices have different structures and capabilities for handling of client complaints. There is already a requirement to have procedures for addressing client complaints within the Codes of Professional conduct. PDSA would therefore suggest that the important factor here is the outputs of those processes rather than the detail of the processes involved being mandated.

Question 87: If so, what form should it take? Please explain your views.

**Remedy 21: Requirement for vet businesses to participate in the VCMS**

Question 88: Would it be appropriate to mandate vet businesses to participate in mediation (which could be the VCMS)? Please explain your views.

PDSA already utilises the valuable services of VCMS and regularly signposts the service to complainants as a further option that they could pursue and which we are comfortable to participate in good faith. This signposting only occurs once a complaint or dispute has been through the full process within PDSA, on occasion PDSA itself will invite a client to participate.

PDSA would have no issue with mandating use of this service as described as it believes that it is already compliant in that manner.

Question 89: How might mandatory participation in the VCMS operate in practice and are there any adverse or undesirable consequences to which such a requirement could lead?

A simple requirement for practices to signpost the availability of the service at the point the practice believes they have reached a conclusion to a complaint.

Question 90: How might any adverse or undesirable consequences be mitigated?

Clarity for clients as to the limitations of the service.
Clarity that the service is not equivalent to a small claims court and clarification of the differences.
At present VCMS is funded by RCVS – however, if this remedy drives significantly increased traffic through the services there is potential for it to become unaffordable, there will have to be longer term consideration of the funding model for this service. If RCVS attempt to fund via increases in individuals' subscription fees or levying an increased practice registration charge (for this and other proposed remedies), then this could drive significant dissatisfaction within the profession.

**Remedy 22: Requirement for vet businesses to raise awareness of the VCMS**

Question 91: What form should any requirements to publicise and promote the VCMS (or a scheme of mediation) take?

As above – at the point when existing efforts to come to an agreement or establish a way forward with a complainant have been exhausted.

**Remedy 23: Use of complains insights and data to improve standards**

Question 92: How should the regulatory framework be reformed so that appropriate use is made of complaints data to improve the quality of services provided?

PDSA already internally gathers its complaints data, establishes themes, identifies learnings and refines its service offering, guidelines and processes to take into account these learnings.
A similar approach could be taken at profession level, however, this would involve the collation of large amounts of data, and context for the complaints – for example PDSA finds that only a proportion of complaints are upheld, in that the organisation would have expected a different outcome or that things could have been done differently – it would be important to distinguish upheld from non-upheld complaints data.

VCMS or the RCVS Disciplinary process data could be used, but as they are the unresolved or most serious complaints, they wouldn't necessarily give a view of the types of complaints that impact practices on a more routine basis.

**Remedy 24: Supplementing mediation with a form of binding adjudication**

Question 93: What are the potential benefits and challenges of introducing a form of adjudication into the sector?

PDSA feels that there is much to be gained and learnings to be gathered through increased awareness and utilisation (for the right reasons) of the existing frameworks. PDSA would question the need without sufficient information being shared on the proportion of current mediation recommendations that are not followed, and the reasons why, is there a problem here that needs to be fixed?

Question 94: How could such a scheme be designed? How might it build upon the existing VCMS?

PDSA would recommend assessing the impact of remedy 23 before making further changes or introducing an element of compunction.

Question 95: Could it work on a voluntary basis or would it need to be statutory? Please explain your views.
As above

**Remedy 25: The establishment of a veterinary ombudsman**

Question 96: What are the potential benefits and challenges of establishing a veterinary ombudsman?

PDSA recognises that CMA have acknowledged that this would be a 'longer term possibility' and would suggest that, in line with our response to Remedy 24, that it remains so if all other attempts to normalise mediation have failed.

Question 97: How could a veterinary ombudsman scheme be designed?

This would be a complex and potentially highly costly undertaking and PDSA would suggest that a full consultation on this matter alone, with significant exploration of the possible benefits, risks, methods and impacts of implementation be undertaken if the decision were taken to move forward.

Question 98: Could such a scheme work on a voluntary basis or would it need to be statutory? Please explain your views.

Refer to question 97.

**Remedies 26 – 28: Effective use of veterinary nurses**

Question 99: What could be done now, under existing legislation, by the RCVS or others, to clarify the scope of Schedule 3 to the VSA?

There have been many attempts to clarify the potential for delegation to veterinary nurses under the existing legislation, as a consequence of this the information required is already available. It is the operationalisation of that capability across the profession which seems to be the main issue. There are likely circumstances or practices where taking full advantage of

even the existing potential may be difficult e.g. practices with limited consulting space or surgical capacity may not be able to dedicate the physical space to take full advantage.

Question 100: What benefits could arise from more effective utilisation of vet nurses under Schedule 3 to the VSA, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

Benefits such as more effective utilisation of skills and resource, job satisfaction, client satisfaction, efficiency gains and potential reduced costs are well documented.

Question 101: What benefits could arise from expansion of the vet nurse's role under reformed legislation, in particular for the veterinary profession, vet businesses, pet owners, and animal welfare? Might this result in any unintended consequences?

PDSA would refer to its comments in response to the RCVS legislative reform consultation, summarised below:

PDSA was supportive of the recommendation for protection of the title Veterinary nurse and would welcome resolution of this long-standing matter.

PDSA is supportive of calls for nurse practitioners and nurse prescribers to be considered under the proposed legislative reform.

PDSA felt that the proposed flexible delegation powers of RCVS would be beneficial and that it would mean that RCVS could make decisions on matters that could be delegated to Veterinary nurses without recourse to legislative change.

However, PDSA felt that this did not go far enough (the examples given of RCVS extending VN's role in anaesthesia and cat castrations were uninspiring) and that such flexible delegation should likewise be extended to veterinary surgeons; responsibility and accountability for delegation should primarily lie at veterinary surgeon level on a case-by-case basis according to case risk, and the skills and competency of the veterinary nurse. This would remove the uncertainty as to what is and isn't encompassed by Schedule 3 and would preclude the need for 'lists' of individual procedures which are often called for. In these cases, the veterinary surgeon may already be held accountable for the decision as delegator and the regulated delegee may already be held accountable for their actions in choosing to discharge that delegation.

**Proportionality**

Question 102: Do you agree with our outline assessment of the costs and benefits of a reformed system of regulation? Please explain your views.

PDSA is concerned that the cumulative impact of the proposed remedies would add significant cost, administrative burden and operational inefficiencies into the veterinary sector, the ultimate impact of some of the remedies may well be detrimental to animal welfare as an unintended consequence due to their impacts on the profession. The remedies

will impact upon LVG's, independent practices and charities alike in their current form and will have disproportionate impacts on those without significant corporate backing.

PDSA would suggest that the remedies working paper provides no insight into the costs of the remedies and provides little reassurance that they are able to be borne by the profession without consequence. PDSA would suggest that these costs and the mitigations or means to fund them are explored further before any decisions are made.

Question 103: How should we develop or amend that assessment?

Question 104: How could we assess the costs and benefits of alternative reforms to the regulatory framework?

Question 105: How should any reformed system of regulation be funded (and should there be separate forms of funding for, for example, different matters such as general regulatory functions, the PSS (or an enhanced scheme) and complaints-handling)