

## Comments on Provisional Decision Report 14/11/2025

### PART A

4.15 - no consideration of vertical market in relation to external labs

5.15 (g) (i) and 5.17 (c)- acknowledges cross-subsidy expected as part of WFM and yet the remedies discussed in Part B dismiss this as being key to keeping vet services prices accessible.

7.62/7.63 - discussion of profits in Independent FOPs, unclear if notional salaries and personal finance have been taken into account. Elsewhere it is stated that a profitability analysis has not been undertaken in the same way as it has for LVGs. If single site/very small practice groups are owned by one or two directors/partners who are taking below market rate salaries and paying back personal loans used to invest in their practices then this would need to be taken into account as not reflected in eg Companies House figures. Should profit in many Independents have been underestimated then loss of revenue from sale of POM-Vs could put businesses at significant risk (which is unlikely to be significantly mitigated by a 6mth period to "adapt" to change in business model).

7.107 - likewise it appears only LVGs have been taken into account in this analysis.

8.18 (a) - "Price does not feature as a criterion for most pet owners when choosing a FOP due to the current lack of consumer awareness that there are significant price differences between FOPs". That is supposition, it may be the case but equally it could be attributed to price not being as high a selection criteria for consumers as assumed.

8.82 - reflects comments above in that customers did not feel the need to compare prices and only the minority found it difficult to find information on prices.

9.18 - correlation vs causation concern - could it instead be that customers subscribing to pet health plans are inherently more likely to be the type of pet owner more likely to invest in healthcare for their pet, I suggest this is certainly the case.

Costs calculated in Appendix B 1.7 - the larger increase in veterinary prices (54%) vs in other services (32%) presumably is overall prices not prices for comparable services? As noted elsewhere the type of services (and the level of expertise and equipment required) have substantially developed between 2016-2023, for example use of CT being more commonplace, and this will have inflated prices faster than in other services where there has been less innovation.

## PART B

3.17 - not specifying the names/branding used risks confusion for customers where LVGs/other larger groups use terms such as "Independent Vet Care", "family vets" etc. so some sort of approval of words used may need to be incorporated in this measure.

3.37 - here, and in other remedies, a large amount of prescriptive information is being required to be added to leaflets as well as posters and websites. Is it proposed that this information will go on all leaflets (used for a variety of purposes) produced by a practice or only certain ones such as those provided to newly registering customers? There will not be room for everything! Also information overload for clients and risk of missing other vital messages due to this. Will, for example, QR codes suffice for some elements?

3.54 - care with wording of Category 6 in the Price List, although unless capitalised the word "Specialist" is not protected, in this context it may cause confusion as these procedures are also carried out by non-Specialists and that may discourage vets with other levels of qualification/experience from filling in prices. For Category 5 "Individual cremation" would this be the price without the price of a container or with the lowest price container (such as a cardboard scatter box), and would it be acceptable in the free type area to add a link to the crematorium website from when customers can check prices of urns etc? In Category 3 would the length of anaesthesia not be required to give a comparable price? And the "initial examination of mouth" is not appropriate to be placed in the Routine dentistry category as this will often take place in an unrelated consult (such as at routine vaccination, a nurse check etc), instead "examination of mouth while under anaesthetic" may be more appropriate. Where services are provided by a peripatetic vet presumably the FOP can (must?) fill in prices for the procedures they are undertaking in the FOP's building, regardless of the type of business relationship they hold? General note on price comparisons, since announcement of the CMA investigation we have had increased incidents of members of the public calling the clinic asking (and in some cases demanding!) prices for procedures and they have struggled to grasp that asking for the price of "an ultrasound" is not useful as (i) we'd need to see the pet first - with the associated consult fee, (ii) we might determine an ultrasound is not necessary or appropriate, (iii) the type of ultrasound has not been specified by the client (it is good that your list does go some way to differentiating), (iv) whether their pet would require sedation/anaesthesia to allow the scan, and (v) whether ancillary items such as pre-op bloods, intravenous fluids etc would be necessary. These queries come to the vet team via reception colleagues and are quite time consuming to answer (probably 15 minutes to pick up the message, check contact details and compose an email explaining all the above) and it is likely that the increased awareness of pricing brought about by the CMA will see these queries increase over time. As you can see just one query per day will take up the equivalent time of a

consulting slot with a vet. In time, with template emails and staff training this may be able to be handed over to lay team members.

General question on Remedy 2b defined services in price list - some components of services may sit in a grey area as to whether they are or are not included in a procedure, how are these to be communicated? Example: Neutering price includes pain relief and a buster collar; Optional extras (to be included in free type) include pre-op bloods and bodysuit; Other elements less clear - compulsory lungworm testing for any patient not on regular lungworm control (as lungworm increases bleed risk), compulsory extra fee for brachycephalic dogs (these receive extra medications/oxygen/higher level nursing care), compulsory extra fee for giant breeds (due to additional manpower and space requirements).

3.65 (c) digital comms with clients re appointments to contain price of consult and standard treatment - this could cause more complaints and confusion and would certainly need to contain a caveat. Example: consult for ear issue - would message include just consult fee, consult and cytology fee (though may not require cytology), consult+cytology+possible meds? Here, and in other remedies, a lot of info required to be placed in text messages which are not designed to be lengthy. This has a cost element, as well as possible technical issues, as will be spread across more than one text (for example our PMS limits to 160 letters per text message). More importantly clients may not absorb the key component of messages or, more likely, will ignore or be confused by additional info. Example: we currently send flea treatment reminders with one key element which is that pet is due meds and a secondary element that if customer has run out to order more; regularly clients will only absorb the second element and order meds when they in fact still have some at home; they feedback that that was the only part they "took in" from the text message. Example: Booster reminders key element is that pet is due booster, secondary element is to bring vaccine card; feedback from customers failing to bring vaccine card is that they didn't notice this part of message.

**KEY POINT** - If we are to impart large amounts of information in multiple formats to customers (as is being proposed in multiple areas of the recommendations) there will need to be prioritisation over what is displayed and when to avoid key messages being lost, diluting the purpose of the remedies.

Remedy 4 - is it possible that a lack of this information as relates to Independent FOPs could in any way be detrimental to Independents? An explanation for clients as to how the independents have been represented when they are a very heterogenous group should be provided alongside the results of the survey.

3.89 (a) - not currently aware of any PMS that can deliver a "pull through" to websites and without this the process of updating parasiticide prices would in fact be time consuming and expensive. This could be mitigated by having a reasonable time frame for price updates. In this and other parts of the remedies there is mention of

“as soon as reasonably possible” - can this be clarified? Most wholesaler prices of medications change frequently, even daily. We update our prices on our PMS monthly as daily would be too time consuming. Manually adjusting website prices, and info submitted to RCVS, would place an undue administrative burden on our small team if it were required to keep up with changes in real time (ie monthly). From a practice perspective annual updates would be ideal. From the perspective of what the remedies are trying to achieve monthly would presumably be preferred. A quarterly or biannual update would be a reasonable compromise - would this be deemed to be “as soon as reasonably possible”?

Question re pet healthcare plans - would the information supplied need to encompass historical plans? This would increase administration costs to FOP and provide less “clean” data for RCVS to process. Example: We phased out our older plans some years ago but some customers, when given the choice, preferred to stay on our older plans. Proposal - only plans currently being offered by a FOP to be included in the remedies. If historical plans are to be included it is likely we would cancel them to reduce administrative burden, this would negatively impact those clients still on these plans.

3.135 - has any data been collected as to the current level of customer engagement with Find-A-Vet? This will be necessary in order to monitor the effect of efforts to increase public engagement but it is unclear whether the RCVS has been requested to provide and monitor this information.

4.2 - contingent elements depending on results of diagnostic tests - how would this work in practice? Until the results are received there could be a very large number of possible treatment options, owing to there likely being a number of treatment options per possible diagnosis and, at the early stage, multiple possible diagnoses. Example: cat with weight loss, initial diagnostic test = blood sample, possible diagnoses include kidney disease, thyroid disease, diabetes, IBD, neoplasia, endoparasites etc etc. Each possible diagnosis will have several further diagnostic/treatment options. In practice how could an itemised written estimate possibly be provided? It would require a textbook to be written and explained to the customer. Unintended consequence of offering euthanasia as an option too early in course of diagnosis - (i) causing distress to owner, (ii) owner feeling overwhelmed and opting for euthanasia when disease may turn out to be readily treatable at a relatively low cost but they have been presented with multiple more complex/serious diseases in detail too early in proceedings. A possible solution would be to inform the owner that the initial blood test may lead on to further tests and/or a number of treatments of varying costs and that prognosis not yet known (ie all the things that the majority of vets would routinely communicate to clients currently) and that the total cost of tests and treatment may well exceed £500 (though this would be a very

arbitrary figure to mention at this point and likely to increase consumer confusion). This area definitely needs further consideration and consultation. The whole way the issue of estimates has been looked at is as though only surgical procedures, with fairly predictable costs and outcomes, have been considered. Medical cases will be poorly served by these blunt one-size-fits-all proposals and is not likely to support customer choice, just cause confusion and waste large amounts of time.

4.3 - unclear as to on whom it is incumbent to produce written estimates in the case of external referrals. Seems to be the FOP colleagues. This would need to be a very basic estimate, giving a ballpark figure for the preferred (and others as appropriate) option as it would not be possible to provide a detailed/itemised estimate for work to be undertaken at an external referral practice.

General question regarding peripatetics - how will the remedies apply to them (if at all)/ How will this be monitored? Are they considered an internal or an external referral when working out of a number of, unrelated, FOPs?

4.4 - estimate increases, presumably an email is accepted as being "written", however owners may not view/respond to emails in a timely fashion so in practice phone calls will be the most likely form of communication and emails sent in addition. It may be difficult to give itemised information in such an email as often the care of the patient takes place before billing is undertaken (both in cases of anaesthetised and hospitalised patients) - do you envisage the updated estimate to be itemised as this will pose considerable difficulty in practice? Can a range be given in the initial estimate, as is common practice currently, such that, as long as the estimate remains in the range initially discussed with the owner and provided in writing, a further updated estimate is not required? If yes then how would this be achieved - would the bottom and top of the range both require full itemisation or could one of these (or a central figure) be itemised and a range from there be provided?

4.18 - see comments on 4.2 above

4.26 - what does "knowledge of market" mean in this context?

4.44 (b) "estimate the reasonably foreseeable period that the Treatment Option will be relevant for the particular pet, having regard to its age and condition". Treatment for chronic illnesses will stretch over months/years, is it suggested that veterinary staff try to ascertain at what point in the future medication/check ups/diagnostic tests for monitoring a condition will exceed £500? How often will estimates be required? Once a condition is diagnosed and management of it becomes ongoing, such that the owner is aware of costs in the form of itemised invoices/receipts, is it still necessary to provide estimates and if so with what frequency? This seems impractical and of little use to consumers beyond conversations that are already routinely had in practice..

4.45 - "more limited information, and therefore time, would be required to comply in cases involving external referrals" - this is not reflected in practice as FOP staff have to contact multiple referral centres to check for availability, obtain pricing information etc.

Remedy 6 - SOPs and what actually takes place in reality are well known to substantially differ. This requirement may very well prove not be robust, specific or monitorable enough to protect consumers' interests.

5.18 (b) can this information be provided via a link from FOPs' general T&Cs? eg the two clicks would be 1) click on T&Cs from homepage, 2) click on link in T&Cs

5.22 - see comments on 3.65(c) above

Remedy 7 - time frames for provision of written prescriptions. Please confirm that the suggested timeframes (immediate for written, by end of day for digital) do NOT apply for customers requesting repeat prescriptions remotely and that these can be dealt with within the normal timeframes of the practice (for example we have a 48hr notice period required for collecting medication and would propose the same for written prescriptions such that there is no disadvantage to either group; we will potentially extend this to eg 72hrs if there is an increased amount of administration associated with the production of written prescriptions). It should be noted that currently, and in contrast to the view put forward in your remedies, it takes longer to produce written prescriptions than to dispense medicines in house (unfortunately I've had neither the time, nor access to specific enough data, to provide a quantitative estimate of the time involved). This is because our PMS (and i imagine most others) is set up to know what stock we have available so we are able to select the item rapidly without having to double check the strength of medication etc and also key information and warnings are automatically added to labels. In our practice the physical dispensing is then carried out by trained laystaff so does not impinge on vet time. This is in contrast to written prescriptions where vets need to either recall key details about a product (strength, number of tablets/mls in different pack sizes, warnings, storage requirements etc) and write this into a template prescription; there is often discussion with the owner on exactly what amount they want to collect at any one time etc, then printing and signing. As yet I am unaware of any systems that produce scripts similar to those provided by human GPs. Pet owners whose animals are on regular meds for chronic conditions, and who will rely on delivery from online pharmacies, will need to arrange vet appointments well in advance of running out of medications, as do patients of human GPs, and thus whether the written prescriptions (if digital), are provided the same day or within a few days should not significantly disadvantage them. In reality in clinical practice there are many times that vets stay late past closing time to finish writing up notes, deal with emergencies etc. To apply pressure to also produce all the written prescriptions from the day at

that stage (if for some reason they haven't had the opportunity to do so during consultations or their PMS is better suited to batching) then it seems reasonable to give at least 48hrs to provide these scripts (and significantly longer on the weekends) as, by the very nature of them being for chronic longterm meds, there should be no marked urgency.

Remedy 7 - comments on charging for written prescriptions and "one charge per consult". Producing prescriptions for more than one medication on one physical prescription is not currently possible from our (and likely other FOPs') PMS. As each medication is going to have different instructions with regards to dosing, other administration/storage instructions, warnings and, arguably more critically, duration of use/expiry date/number of repeats, this would be difficult to organise onto one script. Also each medication needs appropriate review and this takes time. A possible (likely) unintended consequence of stipulating only one prescription charge per consult is that vets will decline to authorise medication for more than one condition (and even potentially for more than one medication) per consult in order to ensure they are adequately assessing the patient and prescribing appropriately; customers will then need to book two consults for a pet with two conditions whereas currently they may be able to discuss both conditions in one consult. A (very) likely consequence is that practices who currently see more than one pet belonging to the same owner in a consult will no longer offer this (cheaper) option and will require customers to book (and pay for) separate appointments for each pet. To mitigate this I would suggest reconsidering the "one prescription fee per consult" and (i) specify one fee per pet (ii) give consideration to one fee per condition if not per medication (although this could be complicated by the fact some medication will overlap in treating more than one condition). Alternatively a reduced fee for additional items could be specified (as is commonly charged currently by practices).

Remedy 7 - comment on prescription fraud. This, in my opinion, has been massively underestimated in terms of the likely increase in issues as written prescriptions become the norm. Firstly, even if the % of fraudulent use of written prescriptions does not increase the actual numbers will and I have seen no evidence in the reports that monitoring and enforcement capabilities are ready to upscale sufficiently. Secondly, as more people become aware of written prescriptions and how they work I believe there to be a very real risk of an increase in % of fraud. This may go beyond the level of individual owners seeking to source further medication for their own pets and become interesting to criminal gangs attempting to gain access to medications to sell on. Many practices, very sensibly, opt to send prescriptions direct to pharmacies. This should be encouraged. Currently our practice does not, and I can see that administration would be complicated, especially in the initial stages, by having to send prescriptions to a variety of online pharmacies rather than to clients. I

also note CMA has looked at whether a central portal would be possible and concluded it is (currently) not.

Remedy 7 - time spent discussing written prescriptions and online pharmacies in consults. It is appreciated CMA no longer takes a view that a remedy requiring vets to "price shop" online meds for customers would be proportionate or workable. However, especially initially, and especially with clients who are less confident in purchasing online meds (which will be over represented in the next cohort as those already confident are already purchasing online), there will be considerable discussion in consult rooms about what the changes mean, how much can be saved online, how much will the written prescription charge contribute to the relative costs of different amounts of medicines purchased etc etc - clients like to talk to vets, they do not like to read emails! In the first year after remedies come into effect this, plus the time taken writing prescriptions could amount to an additional one hour per day of vet time (3 minutes every 3rd consult, assuming 20 consults per day, to explain to clients; 3 minutes added to 5 out of 20 consults to produce written prescriptions in person; plus around 20-30 minutes to produce written prescriptions at the end of the day), which is far from inconsiderable given the fee earning potential of a vet. This is a cost FOPs will inevitably look to pass on, albeit indirectly, to clients.

Remedy 10 - **\*\*\*Key Concern!\*\*\*** The default proposal, I feel, will be a disaster in practice. Firstly client engagement with any written material requesting an action from the client will be likely be low (do you have any evidence that this is not the case? Lots of data shows that customers only respond in very small numbers to such requests). Thus each client will still need to be verbally asked to confirm their default choice (as to write a prescription that is subsequently declined by an owner, in part because they have no idea why we have assumed a default position, would clearly be nonsensical). Even once confirmed that written prescriptions are in fact a client's preference this may then not apply because (i) it is an urgent med or a short trial course, (ii) a client may have different preferences for different longterm meds, (iii) the med, though longterm, may be inappropriate to provide online due to being specially formulated (eg Summit/BOVA products) or a controlled drug. This will cause frustration for consumers if they feel their default is not being respected. If it is decided to go ahead with this remedy then at least remove the default setting, it would be preferable for nothing to be added to a PMS with regards to customer preference until such time as this has been properly ascertained - this could be done in person the first time medication is prescribed or requested, until then a blank or a "written prescription preference - unverified" (the other two options being "written prescription preference - verified" and "in-house medications preference") should be recorded on the PMS (if anything).

5.85 - "In offering this choice, veterinary businesses operating FOPs would need to inform pet owners that it is often significantly more expensive to buy repeat

medication from a FOP." Unnecessarily inflammatory language and out of keeping with the rest of the report which specifies that conversations and literature should include information that "online medication can be significantly cheaper".

5.87 - "If a pet owner chooses that their default option for repeat prescriptions should be purchasing in clinic [...] the vet would still need to offer them a written prescription." I refer back to my key concern with defaults as detailed above. As a customer it would be annoying to have gone to the trouble of informing a practice of my default and to keep being asked. There either needs to be a default and the requirement in 5.87 scrapped or the default is scrapped (my preference!).

5.88 - "Remedy 7 would increase pet owners' awareness of their ability to request a written prescription, irrespective of whether they require chronic or acute Medication." Is this saying that vets still need to discuss written prescriptions even in circumstances where they could not be provided (ie where only acute meds are required)?

5.99 - would require software update which may not be forthcoming in the case of some PMS providers/would involve a cost.

5.102 - tick boxes/notes in records/pop-ups will be ignored by vets! Firstly because there is already a lot of info coming at vets (bite risk warnings, allergies, bad debt etc) and secondly because they are going to have to check with the client each and every time anyway due to the reasons discussed above. However in a non-consulting situation (ie when clients have requested repeat meds through the reception team and do not require a physical review) I concede that defaults may be helpful but client preference can also be readily inferred by checking the record to see how that specific medication has been prescribed to the pet in the past (this allows nuance such as the owner preferring to obtain some meds online and some in-house).

5.105 - covered above, would have to discuss written prescription and then on top explain why the default has been chosen without owner requesting it, why they can't have more than one preference recorded for different meds, and why certain meds aren't suitable for a written prescription.

6.6 - assume a typo here (6months and 6 months)

Written prescription unintended consequences - the CMA has made clear its position on the fact that service prices will inevitably rise when FOP income drops as a result of the loss of a substantial proportion of medication sales\*, in that competition should exert pressure to keep service prices low. This is notwithstanding the comments expressed above that some lower profit Independents may no longer be viable and/or have to reduce staffing levels/hold off on investing in training/equipment etc to make the books balance. However has any part of the background work undertaken by the CMA looked at all at specific risk groups and any unintended greater impact on particular consumers? While this may only be a hypothetical concern I introduce the possibility that vulnerable pet owners, such as the elderly, disabled, and those from a more deprived socioeconomic demographic,

may be more negatively impacted by some of the proposed remedies. It is also possible they may benefit from the remedies to the same, or a greater degree, than other consumers. In reality consult prices will go up as a result of the remedies, as will procedure prices (perhaps less so those in the Defined Services Price List). Practices will keep a smaller stock of POM-Vs on their shelves and charge a premium for them (in part because wholesaler prices will likely rise\*\* and rebates fall), in part to compensate for reduced sales income and in part as they would likely be requested in urgent situations (when online supplies have not reached a client in time) which adds additional pressure to staff. So those customers who may not wish to/feel able to shop for medicines online and who come in for the bare minimum for their beloved pet to be checked over by a vet and given medicine from a one-stop shop, will inevitably find that what they have to pay has gone up.

\*I was hoping to provide an estimate from my own practice's figures on the impact of lost revenue but have unfortunately not had time, please let me know if it would be helpful for this to be provided at a later date.

\*\*Engagement with wholesalers - apologies if this is in an appendix somewhere but have wholesalers given a view on how their operations will be affected by the proposed remedies? By FOPs buying less POM-Vs from wholesalers are they likely to (i) increase list prices, (ii) reduce discounts (this goes for manufactures and buying groups also), (iii) add charges such as for next day delivery or returns, (iv) no longer provide next day deliveries (with an obvious knock on to the supply of urgently needed meds for treatment of both FOP inpatients and for FOPs to supply to customers who have run low on critical meds), (iv) reduce stock portfolio, (v) make redundancies etc.

6.31 - "we propose to put in place other remedies that would help constrain the prices of other services towards the levels that would be expected in a well-functioning market." Is this just referring to the Price List of Services and other remedies set out in your proposals or are you considering other constraints specific to service pricing?

6.39 - number of meds on a prescription has been discussed elsewhere but would welcome input from VMD on this matter as well as RCVS guidance/templates. A scenario where vets prescribe for shorter periods when writing prescriptions vs dispensing meds from practice may well arise, and be justified, as there is less oversight and control when third parties are involved. For example when a pet owner contacts a FOP reception team to request further medication (within the time period an existing prescription is still valid) there will still be conversation around how that pet is doing clinically and how they are managing with the meds. When the request reaches the vet these important snippets, along with the vet's direct knowledge of the patient and client, plus indicators in the PMS that the client is requesting meds

unexpectedly early or late (indicating meds not being given at correct dose/frequency) can all help protect patient wellbeing. Without these "unofficial safeguards" vets may, understandably, be reluctant to give long validity periods on written prescriptions. We also cannot guarantee that clients are getting the meds from one of the VMD accredited sites (much as we can recommend they do so), that any changes (for example in dispensing syringe format etc) have been correctly understood by client such that dosing remains consistent, and that fraud has been correctly identified and prevented. And, concerningly, it is noted in Appendix J at 3.91 (a) that online pharmacies do not have to comply with the stringent controls on supply chain that the WDA imposes on wholesalers.

Extra question - presumably non-prescription meds can continue to be sold as now, with no requirement to inform owners that these may be available cheaper elsewhere?

Extra question - has the possibility of a FOP (or veterinary business) forming a relationship with one or more trusted online pharmacies been considered in order to streamline the transfer and fulfilment of written prescriptions? Would this be considered anti-competition (FOP here would be acting, in part, as a consumer and therefore exerting pressure on online pharmacies in terms of quality of service and possibly price)? Could clients opting to use the FOP's "preferred" pharmacy be offered lower price written prescriptions?

Remedy 13 - are there actual figures on the "likely significant customer detriment" of possible overselling/upselling of individual cremations/related products & services? Question being asked as (i) this is a one-off cost so does not materially affect consumers as much as ongoing costs, and (ii) this is a luxury item in the sense it has no bearing on animal welfare (which is likely the public's perception as to why vet fees should be lower). Is it possible it is being singled out (over and above say external lab fees) due to it being an emotive subject? It was surprising that you found some FOPs not offering a communal cremation option, we do and do not charge extra for it on top of our standard euthanasia fee. Could it be clarified whether a pet can go for same day cremation (for example if euthanised on the day of pick up by the crematorium) if client is clear on the option they would like (it appears the two day hold is not required if a client overrides it but less clear if the 1 day cooling off period will still apply)? Fees charged by practices are not just in respect of those listed in the report (handling, storage etc), the main one in terms of individual cremation is the liability, - if you've ever had to call an owner and say there has been a mix up and their beloved pet has gone for communal rather than the desired individual cremation then you will understand the responsibility that comes with processing a body at this very sensitive time. For that reason (amongst others) it is justifiable to charge a premium on individual over communal cremation.

9.52 - my limited (n-1!) experience of mediation was that the client wanted a large amount of money, we offered a small goodwill gesture as (in our, and our professional indemnity insurer's opinion) we had done nothing wrong (though of course there were learning opportunities from the case) which was declined. We have heard nothing many months on. My concern is, without specific veterinary mediators (ie with a clinical background) it would be very easy for a lack of understanding of the clinical picture to allow spurious claims (which can actually be very difficult to distinguish from genuine ones on occasion) to move through the process and for mediation to recommend a payment be made to a client which, while not legally binding, "refusal to agree to settlement may amount to a breach". Can it be made clear that, if both parties do not come to an agreement, that having engaged in mediation will not leave vets or veterinary businesses at risk of such a "breach" as this undermines the spirit of mediation. There are other means for compensation to be enforced which are listed elsewhere (courts, a future binding redress scheme). In my experience the complaint itself gave rise to reflection but the mediation process did not, however it may be that the mediators provide more feedback on practice quality/procedures/complaint handling in other situations.

9.54 - while VDS are broadly supportive of mediation, have they indicated (i) if they would settle claims when they have been recommended via the mediation process - if they disagree with the outcome of mediation where does that leave practices?, and (ii) if they would be supportive of a binding redress scheme and again would they agree to settle such claims? I would assume that in both cases they would want early involvement and the ability to defend their client.

9.60 (c) this is a very complex area and it is difficult to see how mediation could be successful, or even undertaken, if someone were involved who was not the primary person in the vet-client-patient relationship, ie the person who presented the animal/gave consent for treatment. Clarification on this element may be required by relevant stakeholders to ensure veterinary professionals will have trust in the process.

9.61 - please clarify if this is court proceedings brought by the customer against the vet or vice versa (or both)? One usually being to get compensation, one to get an unpaid bill settled in small claims.

COSTS - it is proposed mediation is paid for by FOPs, presumably this means directly rather than via RCVS fees (as is currently the case)? Is it proposed that that will be a set amount per complaint or an hourly rate?

9.113 - anonymised complaints, is this anonymous in terms of the veterinary personnel/business or just in terms of the client? Anonymity for businesses may help in collecting lower level complaint data (the higher level complaints being accessible to RCVS via other means such as the mediation service or professional conduct department).

