STATUTORY INSTRUMENTS

2013 No. 1617

The National Health Service (Direct Payments) Regulations 2013

PART 2

Direct Payments

Monitoring and review of direct payments

14.—(1) A health body must monitor—

(a) the making of direct payments to or in respect of a patient; and

(b) the health conditions of the patient in respect of which direct payments are made.

(2) A health body must review the making of direct payments to or in respect of the patient at appropriate intervals and—

(a) at least once within the first three months of the direct payments being made; and

(b) subsequently, at intervals not exceeding twelve months.

(3) Where a health body is notified, or becomes aware, that the state of health of the patient has changed significantly, the health body must consider whether a review is appropriate.

(4) Where a health body becomes aware that direct payments have not been sufficient to secure the services specified in a care plan, the health body must carry out a review.

(5) When carrying out a review a health body must—

(a) review the care plan to establish whether it continues to provide appropriately for the health needs of the patient;

(b) consider whether the direct payments have been used effectively;

(c) consider whether the amount of the direct payments paid to or in respect of the patient is sufficient to provide for the full cost of each of the services specified in the care plan; and

(d) consider whether the patient, representative or nominee has complied with the obligations imposed on them by or under regulation 11.

(6) When carrying out a review a health body may—

(a) re-assess the health needs of the patient for services to be secured by way of direct payments;

(b) consult any of the persons mentioned in regulation 7(2)(a) or (3)(a) to (c) or, where relevant, (e) (consultation by a health body in relation to a decision to make a direct payment to or in respect of a patient);

(c) review receipts, bank statements or other information relating to the use of the direct payments;

(d) consider whether the direct payments have been effectively managed, including whether any provider of services secured by means of the direct payments—

(i) if carrying on a regulated activity, is registered as a service provider in respect of that activity with the Care Quality Commission,

(ii) has complied with any obligation that the provider has to be registered as a member of a profession regulated by a body mentioned in section 25(3) of the 2002 Act, or

(iii) operates under insurance or indemnity cover which is proportionate to the risks involved in providing the service and otherwise appropriate in relation to the services provided to the patient.

(7) If a patient, representative or nominee requests a health body to review the making of direct payments—

(a) the health body must decide whether to carry out a review, taking into account relevant local practices and circumstances; and

(b) if the health body decides to carry out a review, they must carry out the review in accordance with this regulation.

(8) Following a review, a health body may, having regard to the purposes of the care plan and the consultations and enquiries under regulation 7—

(a) amend the care plan;

(b) substitute the patient for the nominee or representative of the patient, or substitute a representative or nominee for the patient, as the person to whom the direct payments are made;

(c) increase, maintain or reduce the amount of the direct payments;

(d) impose on the patient, representative or nominee either or both of the following conditions in connection with the making of direct payments—

(i) the recipient, whether the patient, their representative or their nominee, must not secure a service from a particular person, or

(ii) the patient, their representative or their nominee must provide information that the health body considers necessary other than as described at regulation 7(2)(b), (4)(a) or (6)(c) (information that can be required in relation to a decision to make a direct payment) or regulation 11(4), (7) or (8)(b) (conditions relating to information that are to be complied with by the patient, representative or nominee); or

(e) take other action that the health body considers appropriate.

(9) Where, following a review, a health body decides to reduce the amount of, or stop making, the direct payments the health body must give reasonable notice in writing to the patient and any representative or nominee, stating the reasons for the decision.

(10) On receipt of a notice under paragraph (9), a patient, representative or nominee may require a health body to undertake a further review and may provide evidence or information for the health body to consider as part of that review.

(11) A health body must give written notice to the patient and any representative or nominee of the decision in any further review, stating the reasons for the decision.

(12) A health body may not be required to undertake more than one further review following a decision under paragraph (9).