

**HEALTH SERVICE EXECUTIVE**

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| **HSE**  **Health Region/**  **Integrated Healthcare Area**  **Or**  **National Office** |  |

**and**

**[INSERT NAME OF THE PROVIDER]**

**Care Group: DISABILITIES**

**For-Profit Service Arrangement**

**Part II**

**Healthcare Provider Specific Requirements 2025**

*To be populated, executed and returned to the Executive by Disabilities Providers as part of For-Profit Service Arrangement*

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STATUS OF PART ii (HEALTHCARE PROVIDER SPECIFIC REQUIREMENTS)

1. This document constitutes Part II of the Arrangement, being the Healthcare Provider Specific Requirements or HPSR, and is supplementary to the terms and conditions set out in Part I of the Arrangement.
2. Capitalised terms used in this HPSR have the meanings ascribed to them at Clause 1.1 of Part I of the Arrangement (or elsewhere in the Arrangement) unless otherwise expressly defined in this HPSR.
3. Part I (including its Schedules) and Part II (HPSR) of the Arrangement, together form the Arrangement and the provisions of Part I of the Arrangement apply to the HPSR.
4. For avoidance of doubt and without limiting the generality of the foregoing:
   1. Clause 1.4 (Conflict) of Part I applies to this HPSR.
   2. Clauses 1.5 and 1.6 (Interpretation) of Part I apply to this HPSR.
   3. Clause 30 (Dispute Resolution) of Part I applies to Disputes arising under or in connection with this HPSR.
   4. Variations to the HPSR are governed by and may only be made by the parties in accordance with Clause 34.10 (Variation) of Part I of the Arrangement.
5. In relation to completion, submission and execution of the HPSR:
   1. The HPSRis in standard format but, in respect of each Arrangement, the required information in respect of the specific Arrangement shall be populated by the Executive and the Provider (as applicable).
   2. The HPSRis completed and executed by the parties at the commencement of the Duration of the Arrangement and then on an annual basis throughout the Duration of the Arrangement.
   3. In the case of a Multi-Funded Provider, separate HPSRs shall be completed and executed by the parties in respect of each Funding IHA, national office of the Executive or Funding Health Region at the commencement of the Duration of the Arrangement and then annually throughout the Duration of the Arrangement. The Part I executed by the Provider and the Lead Health Region or national office of the Executive together with the Part II for each Funding IHA, national office of the Executive or Funding Health Region together will comprise the Arrangement for a Multi-Funded Provider.
   4. The provisions of Clause 34.12 (Counterparts) apply to the execution of the HPSR by the parties.

# SECTION 1 – CONTACT DETAILS

### Part A - Executive Particulars

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| 1. Executive Particulars | |
| *Set out the key Executive organisation details below* | |
| **Name of Health Region, IHA or National Office** |  |
| **Health Region, IHA or National Office Address** |  |
| 1. Executive Contacts | |
| **Name of Regional Executive Officer, IHA Manager or National Office equivalent** |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Key Contact Person Name**  *(This is the nominated key contact person who will have operational responsibility for the Arrangement)* |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Authorised Signatory Name**  *(This is the person who has been assigned responsibility for executing the Arrangement on behalf of the Executive. This should be in line with National Financial Regulations as appropriate)* |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Service Lead’s Name** |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |

### Part B - Provider Particulars

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| 1. Provider Particulars | |
| **Registered Name**  *(Legal Entity as per CRO)* |  |
| **Registered Address** |  |
| **Trading Name**  *(if applicable)* |  |
| **Legal Status** |  |
| **Registered Company Number** |  |
| **Tax Registration Number** |  |
| **Parent Organisation Name** |  |
| **Parent Organisation Address** |  |

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| 1. Provider Contacts | |
| *The purpose of this section is to set out the key Provider contact details* | |
| **Key Contact Person Name**  *(This should be the person who has overall responsibility for execution of the Arrangement on behalf of the Provider and will be the Provider’s key contact person with the Executive)* |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Chief Executive Officer, Director or appropriate Senior Official Name**  *(Enter correct title)* |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Authorised Signatory Name**  *(This should be the person authorised by the Board of the Provider to execute the Arrangement on behalf of the Provider CEO / Chairperson or Equivalent Senior Person delegated by the Board of the Provider)* |  |
| **Position Title** |  |
| Address: |  |
| Telephone Number |  |
| Email |  |
| **Service Lead’s Name** |  |
| Address |  |
| Telephone Number |  |
| E-mail |  |
| **Provider’s representative on the Community Healthcare Organisation’s Children’s Disability Network (CDN) Governance Group**  *(Point of Contact for CDNT Services)* |  |
| **Position Title** |  |
| Address |  |
| Telephone Number |  |
| Email |  |

# SECTION 2 – FUNDING particulars

**Funding Particulars**

|  |  |
| --- | --- |
| Funding Details | |
| *The purpose of this section is to specify details of the Funding to be paid to the Provider for the provision of Services in accordance with this Arrangement.*  **All** of the Funding provided to the Provider should be included below. This includes amounts paid by Electronic Fund Transfer (EFT), or other periodic payment process, invoiced amounts, payments made according to activity levels with an estimate of funding included if possible (unless this would give false assurance) and a description of the authorisation and payment methodology.  **This section must be completed by the Executive.** (Information should be updated on the SPG system)  The total amount of the Funding shall be applied by the Provider exclusively for provision of the Services by the Provider as further specified in **Section 3 of this HPSR** (Service Delivery Specification). | |
| **Total Payments** | Subject to Clause 4 and Schedule 1 of Part I of this Arrangement, the Funding to be paid by the Executive to the Provider in consideration for the provision of the Services in accordance with the terms of this Arrangement in the financial year commencing on 1st January XXXX and ending on 31st December XXXX (the “**Financial Year**”) shall not exceed EUR €XXXXXXXX.00.  The Executive will use its reasonable endeavours to notify the Provider of the level of Funding for the Services in advance of the start of the Financial Year. |

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| --- | --- | --- | --- |
| Payment of Funding | | | |
| **Description** | **Area** | **Amount €** | **Payment Method** |
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| **Total Funding for the Year** |  | **€** |  |

Non-Pay allocation should be included for Providers who are Lead Agencies for CDNT.

The Provider shall note that where HIQA Action Plans require additional funding to be sourced through the HSE, the HSE will not commit to providing any additional funding unless there is a discussion and agreement with the IHA Manager or nominated person with delegated authority from the relevant IHA in advance of submission to HIQA as is the process for any business case.

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| Schedule of Payments to Provider | | |
| PROVIDER BANK ACCOUNT NUMBER |  |  |
| HSE VENDOR NUMBER |  |  |

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| --- | --- | --- | --- |
| **Dates** | **Details** | **Amount €** | **Payment Method** |
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| Charging of Service Users |
| The criteria and procedures for charging Service Users and the applicable rates are to be set out in this section. |
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# SECTION 3 – Service Delivery Specification

**Service Particulars**

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| Service Overview |
| Below is a brief overview of the Services to be provided by the Provider and relevant to this Care Group. Additional documentation may be referenced to provide context.  Indicate where both ID and P&S services are provided. |
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| Details of the Services | |
| Where appropriate, the Statement of Purpose as required by HIQA shall be consistent with the Services as described and in respect of which Funding is received by the Provider under this Arrangement.  **Note:**  A National Standard Template composite (Excel) is in use for all disability services to ensure consistency of information management. This composite template provides information which links Key Performance Indicator data to the service quantum, with staffing information also linked to Section 3 HPSR. The template is available on the HSE Website and should be electronically appended to this HPSR. | |
| **Objectives of the Services to be provided**  *(to be completed by the Provider)* |  |
| **The Catchment Area covered by the Services**  *(to be completed by the Executive)* |  |
| **Number of Service Users** |  |
| **Detailed description of Services to be provided** |  |
| **Activity Details to include Scope & Quantum of Service.**  *(This should set out the level and type of Services where the Composite Excel Template is not being used)* |  |
| **Premises at which Services are to be delivered** |  |
| **Service capacity at premises**  *(This should indicate the number of service users that can receive a service in the location each day)* |  |
| **Associated Staffing Resource**  *A National Standard Excel Template is available where numbers are high and may be a required return (Employment Monitoring Template)* |  |

**Note:** Placements and Related Funding: Where vacancies arise during the year due to a Service User passing away or being transferred, the Funding linked to such vacancies will be identified and notified by the Provider to the Executive immediately.

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| Key Personnel | |
| If required by the Executive, this section should list the persons who are to be regarded as Key Personnel (within the meaning of the Service Arrangement) for the purposes of providing the Service. The role(s) which such persons perform should also be set out: | |
| Name | Role |
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| Service Outcomes |
| The expected outcomes that will occur over the longer term as a result of Services provided by the Provider under this Arrangement. |
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| Service User Engagement |
| If appropriate, please provide a description of the Provider’s Service User engagement and feedback structures / mechanisms. |
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| Third Party Contracts |
| Requirements in relation to third party contracting are listed in **Clause 16** **of Part I (Third Party Contracting).**  List all third party arrangements entered into by the Provider for the purpose of engaging an agent, subcontractor or third party to provide any of the Services or part thereof provided that such third party arrangement relates to health or personal social services provided as part of the Services. In this regard it should be understood that a third party arrangement in this context relates to a contract or arrangement where an agent, sub-contractor or other third party is engaged by or on behalf of the Provider to provide a substantial or significant element of the Services or part-thereof on behalf of the Provider. Third party arrangements in respect of ancillary services which are not health or personal social services such as cleaning or catering or property maintenance do not require to be listed below.  Detail any Pilot Personalised Budget Project entered into on a co-managed arrangement where you have purchased a service on the individual’s behalf from another Provider. Name each such Provider, give a description of the service and the costs associated. |
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| Additional Services |
| Where the scope of the Services provided pursuant to this Arrangement is increased, whether by developing existing Services or introducing new Services, the increase must be authorised in advance in writing by the Executive utilising the Contract Change Note procedure at Clause 34.10 of Part I of this Arrangement.  A detailed specification for any such Additional Services must be agreed in writing between the parties prior to any Additional Services being provided by the Provider, including the range, type, and volume of Services, together with the amount and timing of payments due in respect of the Additional Services utilising the Contract Change Note. Clause 4.3 of Part I of the Arrangement shall apply with regard to Additional Services. |

# section 4 – Further Information and governance Requirements

**The below are to be provided, where relevant, by the Provider*.***

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| General |
| Disability Composite Template |
| Children Disability Network Team (CDNT) Staffing template, as appropriate. |
| Lead Agencies - Children Disability Network Team (CDNT) Accommodation template, as appropriate |
| Register each service user on the National Ability Support Services (NASS) Database |
| Provide information as required, through the National Ability Support Services (NASS) Database |
| Register each day service user on the National Day Service Database |
| Provide information as required, through the National Day Service Database |
| Provide data on all service users in receipt of services for the purposes of equal access, monitoring and tracking. |
| Disability Act Compliance data through National Disability Office |
| EASI Annual Report *(Interim Standards for New Directions)* |
| Access, Referral, Admissions & Discharge Policies and Procedures  It is accepted by the Service Provider that should vacancies arise in congregated settings during the year for reasons of service user deaths or transfers, the funding linked to the vacancies will be utilised to address emergency residential needs presenting and/or, with the agreement of the HSE, enhance existing residential capacity. |
| Financial Reports / Management Accounts for local services |
| Activity Data |

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| Safeguarding Adults at Risk of Abuse eLearning Programme |
| Providers must comply with requirements as set out in the Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedure, 2014.  Safeguarding awareness training is a requirement for all staff working in older persons services and services for adults with disabilities.  Safeguarding awareness training is available on [HSeLanD](https://www.hseland.ie/dash/Account/Login). |
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| Performance Indicators |
| Measures of the improvement in performing an activity. These include relevant national and local standards as required by the appropriate Care Group.  Children Disability Network Team - IHA Specific KPIs (If Required)  Children Disability Network Team - Lead Agency KPIs (If Required)  ***Note:*** *HSE National Service Plan Targets/Metrics for the relevant Care Group and related services must be part of the Provider’s Performance Reporting System (data related to national key performance indicators to be submitted to Executive Key Contact Person as relevant).* |
| **Additional Local Performance Indicators / Local Activity Data** |
| 1. |
| 2. |
| 3. |
| 4. |

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| Quality |
| 1. In addition to Care Group contracting requirements included in Part I of the Arrangement and in Section 4 of this HPSR, additional Codes of Practice (as defined at Clause 1.1 of Part I of this Arrangement), Monitoring Tools being implemented / adhered to by the Provider in the provision of the Services should be listed here. |
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| 1. The Provider should describe the process for monitoring the quality and safety of the Services listed at Section 3 (Service Delivery Specification) of this HPSR. |
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| 1. The following should be included, if relevant  * External Accreditation system * Any major review of Service, governance or finances |
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| Performance Review Meetings | | | |
| This sub-section outlines the Schedule of Review Meetings appropriate to the level of Funding provided for the purpose of Clause 13 of Part I of this Arrangement. | | | |
| **Month** | **Description** | **Location** | **Attendees** |
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| Other Information Relevant to the Services (Optional) |
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# signature page to part II of ARRANGEMENT (healthcare provider specific requirements)

**IN WITNESS WHEREOF** this Arrangement, is executed by the parties as follows:-

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| Signed by  for and on behalf of **[PROVIDER]:** |  |  |  |

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| --- | --- | --- | --- | --- |
|  | |  | Name: |  |
|  | |  |  |  |
| Date: |  |  | Title: |  |

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| --- | --- | --- | --- |
| Signed by  for and on behalf the  **HEALTH SERVICE EXECUTIVE:** |  |  |  |

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| --- | --- | --- | --- | --- |
|  | |  | Name: |  |
|  | |  |  |  |
| Date: |  |  | Title: |  |