

**HEALTH SERVICE EXECUTIVE**

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| **HSE**  **Community Healthcare Organisation**  **Or**  **National Office** | CLICK OR TAP HERE TO ENTER TEXT. |

**and**

**[INSERT NAME OF THE PROVIDER]**

**Care Group: MENTAL HEALTH**

**Service Arrangement**

**Section 39 Health Act 2004**

**Part II**

**Healthcare Provider Specific Requirements 2024**

*To be populated, executed and returned to the Executive by Mental Health Voluntary Providers as part of Section 39 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 33 (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 37.10 (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 CHO, Hospital Group, 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, where applicable, Funding CHO, Hospital Group or national office of the Executive) together with the Part II for each Funding CHO, Hospital Group, national office of the Executive or Funding Health Region together will comprise the Arrangement for a Multi-Funded Provider.
   4. The provisions of Clause 37.12 (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* | |
| **Community Healthcare Organisation or Health Region Name & Number**  *(or National Office Name)* |  |
| **Community Healthcare Organisation or Health Region Address**  *(or equivalent)* |  |
| 1. Executive Contacts | |
| *The purpose of this section is to set out details of the Executive Key Contact Person* | |
| **Chief Officer’s or Regional Executive Officer’s Name** *(or 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 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** |  |
| **Charity Status**  Is the Provider a Charity?  If yes is ticked above, the Provider must be registered with the Revenue Commissioners and the Charities Regulator.  Provide the following information:-  **Revenue Commissioners CHY Number**  **Registered Charity Number**  *If the Provider is not yet registered, the actions being taken to obtain registration must be outlined.* | Yes No   |  |  |  | | --- | --- | --- | |  |  |  |  |  | | --- | |  |  |  | | --- | |  | |
| **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: |  |

# SECTION 2 – FUNDING particulars

**Funding Particulars**

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| 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 €XXXXXXX.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. |

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

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| Schedule Of Payments To Provider |

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| --- | --- | --- |
| ACCOUNT NUMBER |  |  |
| VENDOR NUMBER |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **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. |
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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 Generic Excel Template has been developed by the Executive and made available to Providers which can be used to detail the Services being provided. This can be used as required. | |
| **Detailed description of Services to be provided** |  |
| **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)* |  |
| **Premises at which Services are to be delivered** |  |
| **Activity Details**  *(The detail of volume of Services proposed where the Generic Excel Template is not being used)* |  |
| **No. of Service Users**  *(availing of Services)* |  |
| **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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| 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 19** **of Part I (Third Party Contracting).**  List all third party arrangements entered into by the Provider for the purpose of engaging an agent, sub-contractor 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. Third party arrangements in respect of services such as cleaning or catering do not require to be listed below. |
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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 37.10 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 4.2 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 |
| Business Plan or equivalent document as agreed by Executive |
| Service Specification Template if used |
| Access, Referral, Admissions & Discharge Policies and Procedures |
| Financial Reports / Management Accounts for local services |
| Activity Data |
| Senior Staffing Template  Senior Staffing - Details of Direct Provider Personnel involved in provision of or associated with the Services (as defined at Clause 1.1 of Part I of this Arrangement) who are in receipt of salaries equivalent to current Grade 8 or above on the consolidated salary scales should be set out on the Senior Staffing template available on the **Non-Statutory Section** of the Executive’s website. This template must be submitted to the Executive Key Contact Person in the highest funding CHO, Hospital Group (or, following the Executive Restructuring, Health Region or national office). In this regard, where the Provider is part of a Group, any employee of any other member of the Group who participates in the management/administration of the Services and is funded from the Funding received by the Provider under this Arrangement should also be included.  *(For this purpose, “****Group****” means the Provider and any holding company or subsidiary of the Provider and any subsidiary of any such holding company, holding company and subsidiary having the meaning ascribed to such terms at Sections 7 and 8 of the Companies Act 2014).* |

| Performance Indicators |
| Measures of the improvement in performing an activity. These include relevant national and local standards as required by the appropriate Care Group.  ***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) |
| Any additional requirements to be listed here: |
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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:** |  |  |  |

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