Adult Services
Community Support Team

Strictly Confidential

Individual Progression Agreement

Paris ID	
Service User Name	
Service Provider Name	

Cyngor Abertawe
Swansea Council

To be completed prior to placement. To be completed on behalf of the Service Purchaser by the Service Users Care-Coordinator **in discussion with** the Service Provider, the Service User and their family and/or previous carer(s): and any other key persons e.g. an advocate, other professionals etc.

1. Service User Details

Paris ID			
Service User Name			
Date of Birth		**Case File Number**	
Previous Address			
		Post Code	
Telephone Number.			

Next of Kin			
Address			
		Post Code	
Telephone No.			

2. Details of Person Acting for Service User in respect of their Financial Affairs

(Please tick)

Appointee ☐ **Deputy** ☐ **None** ☐

Name			
Address			
		Post Code	
Telephone No.			

3. Details of other Professionals

Name & Job Title			
Email		**Telephone No.**	

Name & Job Title			
Email		**Telephone No.**	

Name & Job Title			
Email		**Telephone No.**	

4. Accommodation Details

(a) Service Users New Address

		Post Code	
Telephone No.			

(b) Service Providers Details

Name			
Address			
		Post Code	
Telephone No.			
Name of Team Leader/ Scheme Manager			

(c) Landlord of the Property Details

Name		
Address		
Telephone No.		

(d) Type of Accommodation

Unfurnished Assured Tenancy ☐

Furnished Assured Tenancy ☐

Other (Please state) ☐

(e) Number of other possible tenants ☐

4. Outcomes Required from the Supported Living Service

National Outcomes Framework	Broad Outcomes from Service Provision	Targeted Resources/Support Required to Deliver Outcomes	Timescales	Progress
Physical and mental health and emotional well-being				
Domestic, family and personal relationships				
Education, training and recreation				
Contribution made to society				
Social and economic well-being				
Suitability of living accommodation				
Control over day to day life				
Participation in work				
Securing rights and entitlements				
Protection from abuse and neglect				

Known Risks Associated with this and the plan to reduce risk: (please specify)

5. Support Hours

Number of 1:1 direct day support hours required each week: * hrs

Number of 1:1 Day Support Hours are to provide support to undertake:

☐	Personal Care	0 hours	☐	Socialisation	0 hours
☐	Access to the Community	0 hours	☐	General Support	0 hours
☐	Other as identified in Care Plan	0 hours	☐	Housing Related Support	0 hours

Number of 2:1 Day Support Hours required each week: * hrs

2:1 Support Hours are to provide support to undertake:

☐	Personal Care	0 hours	☐	Socialisation	0 hours
☐	Access to the Community	0 hours	☐	General Support	0 hours
☐	Other as identified in Care Plan	0 hours	☐	Housing Related Support	0 hours

Number of shared hours each week: * hrs

Number of Wakeful Night Support Hours each week: * hrs

Number of Sleep-In Hours required each week: * hrs

Safety and risk factor

(Please describe)

Manual Handling

(Please describe)

6. Date of Commencement

The Service Purchaser and Service Provider agree that the Service will be delivered in accordance with this IPA and the Framework Terms and Conditions for the service and the relevant Service Specification for the Service, and any other relevant care, education plans and health records as necessary.

By completing this IPA, the Service Provider and Service Purchaser acknowledge that they are entering into a binding Agreement to deliver the service to the Service User named in this IPA.

IPA shall commence upon:	
IPA shall end upon:	

7. Review Schedule

This IPA together with the Care Plan and any other relevant documentation shall be reviewed in accordance with the below review schedule.

Date of Initial Assessment:	
Date of Care Plan:	
Date of Contract:	
Date of One Month Review:	
Date of 6 Month Review:	
Date of 12 Month Review:	

8. Financial Information

Hourly Rates for Named Service User (as submitted by the Service Provider)

Day Support Hourly Rate: £

Wakeful Night Hourly Rate: £

Sleep-In Cost: £

Weekly Cost

Day Support Total Weekly Cost £

Wakeful Night Total Weekly Cost £

Sleep-In Total Weekly Cost £

Total Weekly Cost	**£**

SERVICES NOT INCLUDED IN THE ABOVE CANNOT BE PROVIDED WITHOUT PRIOR ASSESSMENT/RE-ASSESSMENT AND WRITTEN AGREEMENT OF THE SERVICE PURCHASER.

Funding Sources

The weekly cost will be funded by: (State N/A against non-applicable funding sources)

Funding Source	£
Social Services	
Local Education Authority	
Health Board	
Service User Contribution (if applicable)	
Benefits payable to Service User	

Payment Arrangements

As set out in Call-Off Conditions of Contract Schedule 7.

9. IPA Termination Arrangements

In accordance with clause 15.1 of the Call-Off Conditions of Contract, either party shall have the right to determine the Contract at any time by giving not less than one months' Notice. Please refer to the Call-Off Conditions of Contract for additional termination provisions.

10. Agreement:

The Service Provider agrees to provide the above services for the Service User in accordance with the Call-Off Conditions of Contract and the Schedules from the Framework Agreement for
the Provision Of Tenancy Based Care And Support (Supported Living)

This Individual Progression Agreement is signed and agreed by the following.

Signed:_____
(on behalf of the Service Provider)

Position:
_____

Date: _____

Signature of Service User:_____

Date: _____

Signature of Service User Relative/Carer: _____

Date:
_____

Signed:
_____
(on behalf of the Service Purchaser)

Position:
_____

Date:
_____

Copy of signed IPA to be sent to Team Leader and all participants.