

SPOT ORDER FOR THE PURCHASE OF ADULT SOCIAL CARE, CARE WITHIN THE HOME SERVICES



This agreement is for the purchase of Services from the Service Provider to support the Individual/ Service User specified below in accordance with the Overarching Contract for the Provision of Adult Care and Support Service, the Service Specification(s) and the Support plan between Surrey County Council (“the Council”) and the Service Provider.

Individual’s Details

| | |
|-------------------------------------|--|
| Surname | |
| Forenames | |
| Client number | |
| Client address for service delivery | |
| Start date of the Services | |
| End date (if applicable) | |
| Name and address of Provider | |
| CQC Location ID of provider | |

Care within the Home Services are to be delivered as outlined in the accompanying support Plan.

| Summary of Services to be provided: | | | | |
|---|------------------------|--|-----------------|-----------------|
| Home based care Use additional lines if applying different rates and provide additional information below. | Number of calls a week | Call length 15*/30/45/60min /Long Visit 4 hrs+ | Agreed rate (£) | Weekly Cost (£) |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Total weekly cost | | | | |

*15 minute call should not be commissioned **except when short visits for specific tasks or checks have been agreed as part of a wider package of support**

| Summary of Service to be provided | | |
|---|---|--|
| Waking nights | Number nights per week: | |
| | Agreed rate per night / per hour (please specify) (£): | |
| | Total weekly cost (£): | |
| Sleeping nights | Number of nights per week: | |
| | Agreed rate per night (£): | |
| | Total weekly cost (£): | |
| Live-in care | Number of days per week: | |
| | Agreed rate per 24 hours exclusive of replacement care worker break cover* (£): | |
| | Agreed rate per 24 hours inclusive of replacement care worker break cover* (£) *Complete whichever applies | |
| | Total weekly cost (£): | |
| Shared Live-in care To apply where one live-in care worker is meeting the needs of two people in the same home. Per person rate should be half the agreed total Live-in shared rate. | Number of days per week: | |
| | Agreed rate per 24 hours exclusive of replacement care worker break cover* (£ per person): | |
| | Agreed rate per 24 hours inclusive of replacement care worker break cover* (£ per person) | |
| | Total weekly cost (£ per person) | |

| | |
|--------------------------|--|
| TOTAL WEEKLY COST | |
| Additional Information: | |
| | |

Care timetable

| All | Mon | Tues | Wed | Thu | Fri | Sat | Sun | Start time | End time | Comments |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|------------|----------|----------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Social Care Contact

| | |
|----------------------------------|--|
| Name of Social Care Practitioner | |
| Telephone number | |
| Email Address | |

By signing this Spot Order, you agree to comply with the Terms and Conditions of the Overarching Contract for the Provision of Adult Care and Support Services, the Service Specification(s) and the Support plan which can be found at:

Signed for and on behalf of the Service Provider

| | |
|------------|--|
| Name: | |
| Role: | |
| Signature: | |
| Date: | |

Signed for and on behalf of Surrey County Council

| | |
|-------------------|--|
| Name: | |
| Role: | |
| Social Care Team: | |
| Signature: | |
| Date: | |

Every new placement must have an associated support/care plan and a copy must be retained by the Council with a copy of the Spot Order signed by both the Council and the Service Provider of the purchased Services.