City of Westminster

APPENDIX B – SPECIFICATION WESTMINSTER HEALTHWORKS

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GLOSSARY

Term	Definition
Activities	These are general events or outreach sessions that help raise awareness, connect people, and encourage participation. Examples include community health fairs, group exercise classes, cooking classes, and information stalls at local events. The goal is to engage residents and give them opportunities to learn about health and wellbeing.
Co-design	A collaborative process where residents, community organisations, and stakeholders help shape the service model, interventions, and delivery approach.
Culturally responsive	Approaches that respect and reflect the cultural values, language, and needs of diverse communities.
Health inequalities	Differences in health outcomes between population groups, often linked to social, economic, or environmental factors.
Health interventions	These are structured, evidence-based actions designed to improve health for individuals or groups. Examples include one-to-one health coaching, programs to help people stop smoking, weight management plans, and mental health support sessions. The aim is to change behaviours and improve health indicators like heart, lung, and mental wellbeing.
Hub-and-spoke model	A delivery structure where the Lead Provider acts as the central hub, and subcontractors are the spokes delivering services locally.
KPI (Key Performance Indicator)	A measurable value used to track progress toward specific service objectives, such as resident reach or health outcomes.
Lead provider	The main organisation responsible for coordinating the HealthWorks service, managing subcontractors, and ensuring delivery meets the specification.
Social value	The wider benefits created by the service beyond health outcomes, such as employment opportunities, volunteering, and environmental sustainability.
Subcontractors	Community-based voluntary sector organisations that deliver culturally responsive health interventions and engagement activities under the Lead Provider’s oversight.
Warm referral	A referral process where residents are actively supported to connect with other services, reducing barriers and improving engagement.

1. SERVICE OVERVIEW

1.1. Westminster HealthWorks (The Service) is a borough-wide, community-led public health initiative commissioned by Westminster City Council as part of the #2035 commitment to improve population health. The Service aims to reduce health inequalities by delivering culturally responsive, preventative health interventions that improve heart, lung, and mental health outcomes for adults aged 16 and over.

1.2. Delivered through a hub-and-spoke model, HealthWorks will be led by a Lead Provider (the hub) that subcontracts with a network of at least 7 voluntary and community sector (VCS) organisations (the spokes). These Subcontractors will co-design and deliver tailored interventions such as blood pressure monitoring, smoking cessation support, health coaching, and culturally competent counselling.

1.3. This specification seeks to identify and commission a Lead Provider who will be responsible for establishing and managing the delivery network. During the initial six-month co-design phase, the Lead Provider will work collaboratively with the Council, residents, and community stakeholders to formalise subcontracts with smaller or grassroots VCS organisations. These subcontracts will be embedded into the service delivery model and supported throughout the contract period.

1.4. The Service will prioritise residents from Global Majority backgrounds, those with disabilities or learning needs, individuals experiencing poor mental health, and people living in deprivation or facing systemic barriers to care. HealthWorks will also strengthen referral pathways, build community capacity, and support integration with existing health, care, and council services.

1.5. With a total investment of £1.47 million over three years, HealthWorks will build on the legacy of the Healthy Communities Fund, embedding sustainable, community-driven approaches to prevention and early intervention. The Service will be evaluated against population-level health indicators and community-level outcomes, with a strong focus on equity, access, and impact.

1.6. The Service must be informed by evidence, such as public health data, Joint Strategic Needs Assessments (JSNAs), and community insight. Delivery must be evidence-based and shaped by what works in similar programmes. The Lead Provider must ensure that interventions are culturally sensitive and accessible.

1.7. By building strong relationships between community groups and health service providers, HealthWorks will enable locally driven solutions to common health challenges and ensure that services are accessible, acceptable, and equitable for all residents.

2. STRATEGIC CONTEXT

2.1. This specification aligns with the following strategic documents:

- Fairer Westminster 2022-2026
- Westminster Borough Stories
- Global Majority JSNA
- Health and Wellbeing Strategy
- Our Responsible Procurement and Commissioning Strategy

2.2. This specification also supports Westminster City Council's #2035 vision, which commits to creating a healthier, fairer borough by reducing health inequalities and embedding preventative, community-led approaches into the local health system. HealthWorks is a key delivery mechanism for achieving these ambitions, ensuring that culturally responsive interventions and strengthened referral pathways contribute to long-term population health improvement.

3. SERVICE AIMS

3.1. There are 2 overarching aims of the Service:

a) **Aim 1:** To improve pathways into existing public health, council, primary care, and voluntary sector services.

b) **Aim 2:** To support community-led public health delivery. This aim focuses on empowering local organisations and residents to lead health improvement interventions in their communities.

4. DELIVERY MODEL

4.1. The Service will be delivered via a hub-and-spoke model, where:

- A Lead Provider (the hub) provides strategic oversight, governance, and operational leadership.
- Community-based voluntary sector organisations, referred to as Subcontractors in this specification (the spokes) will a) deliver culturally responsive public health prevention activities directly to residents and b) improve pathways into existing public health, council, primary care and voluntary sector services.

4.2. The first six months of the service will be a co-design phase, which the Lead Provider will lead on, to establish partnerships with subcontractors and design services collaboratively with residents and system partners.

5. CONTRACT DURATION AND BUDGET

5.1. The total value for this contract is £1,470,000 for 3 years.

5.2. The Lead Provider will retain 20% of the total contract value to cover strategic partnerships coordination, six-month co-design period, and monitoring responsibilities.

5.3. The remaining 80% will be distributed to sub-contracted organisations to support service delivery and associated costs (e.g., staffing, venue hire and usage, equipment and training.)

6. SERVICE TARGETS

6.1. Target Groups

- The Service will provide targeted support to communities experiencing the greatest health inequalities, with a particular focus on residents, aged 16+, experiencing greatest health inequalities, including:
    - People from ethnically diverse and Global Majority backgrounds (e.g. Black African, Black Caribbean, Pakistani, Bangladeshi, and other).
    - Individuals with learning needs.
    - People with physical disabilities.
    - Those with poor mental health.
    - Residents living in deprivation.
    - Inclusion health groups[1] or communities with no fixed abode, such as those experiencing homelessness, rough sleeping, asylum seekers etc.

6.2. Focus areas and outcomes

a) **Preventable long-term health conditions to improve heart, lung and mental health outcomes**

- Cardiovascular disease (CVD)
- Hypertension
- Type 2 diabetes
- Stroke
- Obesity
- Chronic obstructive pulmonary disease (COPD)
- Dementia
- Mental health conditions

b) These conditions disproportionately affect residents from global majority backgrounds and those living in areas of deprivation. HealthWorks aims to reduce these inequalities by;

- Improving early detection,
- Providing access to care, and community-based support,
- Improving their heart, lung and mental health outcomes.

[1] Inclusion Health: applying All Our Health - GOV.UK

c) While HealthWorks will not deliver clinical services directly, it will play a critical role in delivering community-based health improvement interventions, increasing uptake of existing services by identifying at-risk residents, providing culturally competent engagement, and facilitating warm referrals. These activities will contribute to improvements in population-level indicators by enhancing access, early detection, and equity in service utilisation. Some examples of interventions include, but not limited to-

- Community-based blood Pressure checks and referrals to NHS Health Checks
- Smoking cessation advice
- Health coaching and behavioural change
- Culturally competent counselling support
- Type-2 Diabetes Risk awareness and referrals
- Weight management and goal setting

7. SERVICE OUTCOMES

7.1. Improved access and engagement

- Increased proportion of residents from priority groups (Global Majority, deprived areas, disabilities, mental health) accessing preventive health services.
- Improved understanding of the barriers to service access and enhanced engagement through culturally responsive and locally delivered interventions.

7.2. Improved preventative health outcomes

- Measurable improvement in heart, lung, and mental health indicators, e.g.:
  - Identification and management of blood pressure and hypertension among participants.
  - Increased smoking cessation rates or reduced smoking prevalence.
  - Improved Diabetes awareness and prevention with structured education.
  - Improved mental wellbeing scores (e.g., WEMWBS or ONS4)
  - Loneliness reduction (e.g., ONS scale)
  - Improved physical activity
  - Improved understanding of nutrition advice
- The HealthWorks service is designed to contribute to achieving key public health priorities as outlined in the national Public Health Outcomes Framework (PHOF), published by the Office for Health Improvement and Disparities. These priorities include reducing smoking prevalence, improving physical activity, tackling obesity, and enhancing mental health outcomes (refer to Appendix D).

- While the service will not report directly against PHOF indicators, its community-led interventions will support progress towards these outcomes locally, helping to reduce health inequalities and improve population health in Westminster.

7.3. Increased uptake of preventative care

a) Higher participation in vaccination programmes, cancer screening, and healthy lifestyle interventions among target communities compared to baseline.

7.4. Strengthened Referral Pathways

a) Improved completion rate of referrals into Public Health, council, primary care, community and specialist services.
b) Increased resident confidence and satisfaction with referral processes (measured via feedback).

7.5. Increased community capacity and resilience

a) VCS organisations demonstrate increased skills and capability to deliver culturally competent health interventions.
b) Stronger community networks supporting health and wellbeing, reducing isolation and improving trust in services.

8. SERVICE SCOPE

8.1. The following components are **within the scope** of the contract:

a) Lead Provider coordination
b) Direct delivery of culturally responsive Public Health prevention activities and interventions
c) Community engagement and co-design
d) Capacity building for subcontractors
e) Monitoring and evaluation
f) Strategic VCS leadership in the health and care system

8.2. The following components are **out of the scope** of the contract:

a) Clinical services: Diagnosis, treatment, or prescribing medication.
b) Emergency or acute care: Any urgent or hospital-based interventions.
c) Standalone commissioning of multiple providers: The contract is for a single lead provider, not multiple direct contracts.
d) Long-term social care provision: Beyond signposting and referral or community-led health interventions
e) Mental health therapy: Beyond basic wellbeing support and signposting.

9. ROLES AND RESPONSIBILITIES

9.1. As part of their coordination role, the Lead Provider is responsible for:

a) Establishing and managing partnerships with the subcontractors
b) Leading on the six-month co-design process at the start of the contract (refer to Sections 10.1-10.10)
c) Accountability of overall service delivery
d) Performance management of the subcontractors
e) Capacity building for subcontractors (e.g., through provision of training)
f) Collecting, monitoring and reporting KPIs to the Council
g) Financial management: manage budgets, invoicing, and payments to subcontractors.
h) Risk management: Identifying and mitigating risks across the service pathway.
    - The Lead Provider must maintain and update a programme risk register, including mitigation actions, to evidence proactive risk management.
i) Strategic visibility and collaboration with health and care system partners (e.g., Neighbourhood health teams, mental health services etc.)
j) Conducting a programme evaluation:
    - The Lead Provider will be responsible for ensuring a robust evaluation of the HealthWorks programme is carried out to assess effectiveness, impact, and alignment with service aims.
    - If the Lead Provider does not have the internal capacity or expertise to deliver this evaluation, they may commission an independent evaluator to undertake this work. The evaluation must include both qualitative and quantitative measures, incorporate community feedback, and inform continuous improvement throughout the contract period.

9.2. The Subcontractors are responsible for delivery of agreed service elements as per subcontract agreement with the Lead Provider, which will include:

a) Direct delivery of culturally responsive Public Health interventions (refer to Sections 10.20-10.28)
b) Enabling pathway improvement into existing services (refer to Sections 10.29-10.33)
c) Ongoing community engagement and co-design (this is for the duration of the contract, not the initial 6-month co-design process mentioned above)

9.3. The roles and responsibilities outlined above provide a summary of accountabilities. Detailed operational requirements, including processes for co-design, partnership development, delivery of interventions, engagement, and capacity building, are set out in Section 10: Service Requirements.

10. SERVICE REQUIREMENTS

The Service will deliver the aims set out in Section 2 by meeting the following objectives:

Co-design process

10.1. The co-design process and subcontractor development will take place within the first six months of the service.

10.2. The co-design phase is a critical foundation of the HealthWorks model. It ensures that service delivery is shaped by the lived experiences, priorities, and insights of local communities.

10.3. As part of this process, the Lead Provider will develop a co-design plan within the first month of mobilisation, outlining the timelines, engagement methods, and key milestones. An indicative timeline has been provided in Appendix A.

10.4. While the timelines in Appendix A may be subject to minor adjustments, the Lead Provider is expected to deliver all activities and key milestones included in the timeline within the 6-month timeframe to ensure timely mobilisation and service readiness.

10.5. The Lead Provider will facilitate inclusive engagement with residents with lived experience, grassroot organisations, community leaders, and key stakeholders listed in Section 11, "Key Relationships", ensuring representation from priority groups as covered in Section 5.1.

10.6. The Lead Provider will deliver at least 4-6 co-design workshops during this period, using a combination of in-person and digital formats – such as advisory panels, focus groups, and surveys to ensure broad accessibility.

10.7. The co-design workshops will focus on shaping the service model and delivery approach in collaboration with residents and community partners. At a high level, these workshops may cover:

a) **Designing interventions**: Identifying priority health improvement activities (e.g., blood pressure checks, smoking cessation support, culturally competent counselling) and tailoring them to local needs.

b) **Monitoring and evaluation**: Agreeing on practical, community-led approaches for measuring outcomes and impact, including qualitative and quantitative methods.

c) **Referral pathways**: Mapping and improving connections between HealthWorks, NHS, council services, and voluntary sector organisations.

d) **Accessibility and inclusion**: Exploring barriers to engagement and co-creating solutions (e.g., language support, trusted venues, flexible hours).

e) **Community engagement strategy**: Developing outreach plans and identifying roles for community champions or peer advocates.

f) **Capacity building needs**: Understanding training and support requirements for subcontractors to deliver culturally competent interventions.

g) **Social value opportunities**: Discussing how the service can contribute to wider community benefits, such as volunteering, skills development, and environmental sustainability.

10.8. The Lead Provider must ensure that participants such as residents and community organisations are appropriately remunerated for their time and contributions.

10.9. The Lead Provider will map existing services and gaps in preventative health provision, using community insights to identify priority areas for intervention.

10.10. The Lead Provider will be required to document and report on co-design outputs to the Council, and evidence how community feedback has shaped service design and delivery models.

10.11. The co-design process must be iterative, transparent, and embedded throughout the contract period to support continuous improvement and responsiveness to emerging needs.

Subcontractor development

10.12. During the six-month co-design period, the Lead Provider will also be responsible for identifying and developing formal subcontract arrangements with a minimum of 7 VCS organisations.

10.13. The Lead Provider may subcontract with as many organisations as necessary to achieve the aims of the Service, provided that a minimum of 7 VCS organisations are included as set out in 10.12. However, the Lead Provider retains full accountability for the performance and compliance of all subcontractors. To mitigate risks associated with scale, the Lead Provider must implement robust governance and oversight mechanisms that ensure equal and consistent performance management across all subcontractors, regardless of size or number.

10.14. The Lead Provider must demonstrate a clear and proactive approach to ensuring equity in the identification, engagement, and inclusion of smaller subcontracted organisations, particularly those that are grassroots, community-led, or represent seldom-heard groups. The Lead Provider must demonstrate ongoing commitment to equitable subcontracts throughout the contract.

10.15. To ensure equity in subcontractor development, the Lead Provider will provide:

a) Transparent and accessible processes for identifying and selecting subcontractors.

b) Evidence of outreach to a diverse range of organisations, including those with limited capacity or resources.

c) Support mechanisms to enable smaller organisations to participate meaningfully (e.g., capacity building, flexible funding, simplified reporting).
d) Regular monitoring and reporting on the diversity and size of subcontractor organisations involved in the service.

10.16. The Lead Provider will facilitate matchmaking between smaller organisations and potential subcontractors to support consortium bids. A database of interested organisations may be maintained to support collaboration.

10.17. The Lead Provider must apply the following subcontractor selection process:

- Apply transparent criteria and a scoring matrix.
- Establish an independent oversight panel (including Public Health, Primary Care, and community representatives).
- Ensure an inclusive application process with support for grassroots groups.
- Promote diversity in the provider mix (e.g. size, geography, specialism).

10.18. The Lead Provider will comply with the following requirements when procuring subcontracted services:

a) Advertisement of opportunity
   - The Lead Provider must formally advertise all opportunities to bid for subcontracted services. The advertisement shall provide a reasonable timeframe for responses and include full details of the assessment methodology, including whether award criteria will be assessed in stages.

b) Assessment of bids
   - The Lead Provider must assess all bids received in accordance with the published assessment process. The assessment shall cover, at a minimum, the following criteria:
     a) Quality and innovation
     b) Value, integration, collaboration, and service sustainability
     c) Improving access, reducing health inequalities, and facilitating choice
     d) Social value

c) The Subcontractor must have a mean average annual turnover in the past two years in excess of 1 x the value of the contract they are bidding for. For example, if they are bidding for an activity that will cost £20,000 per annum, the subcontractors mean average turnover in the past two years must be at least £20,000.

d) Record keeping
   - The Lead Provider must maintain robust and auditable records of the procurement procedure, including:
     a) How each bid was scored
     b) The rationale for selecting the successful provider(s)

e) Identification of successful provider(s)
    - The Lead Provider must identify the successful provider or group of providers in accordance with the published criteria.

f) Notification of outcome
    - The Lead Provider must notify the successful provider(s) in writing of its intention to award a contract. The Lead Provider must also notify each unsuccessful provider in writing that its bid has been unsuccessful.

10.19. The Lead Provider must include the following as part of the subcontracting terms:

a) Use standardised templates agreed by the Council with clauses on safeguarding, data sharing, data protection, EQIAs, and dispute resolution.
b) Implement performance-based payments, whilst also demonstrating a degree of flexibility and offering advance payments where needed.
c) Include equity and transparency clauses.
d) Conduct annual reviews of subcontracting arrangements.

Delivery of preventative public health interventions

10.20. The Lead Provider will be responsible for ensuring the Subcontractors deliver community-led preventative interventions to improve heart, lung, and mental health outcomes for residents aged 16+, with a focus on early detection, behaviour change, and culturally competent support.

10.21. All preventative public health interventions must be designed to address the priority target groups outlined in Section 6 (Service Targets) and contribute to achieving the outcomes specified in Section 7 (Service Outcomes). This includes ensuring interventions are culturally responsive, accessible, and focused on reducing health inequalities among residents most at risk.

10.22. Interventions may include but are not limited to community-led blood pressure monitoring, smoking cessation support, personalised health coaching, and culturally competent counselling.

10.23. The specific activities and the KPIs for the activities will be shaped through a co-design process with local communities to ensure relevance and impact.

10.24. Following the co-design process, the Lead Provider will set relevant KPIs, in addition to those set out in Appendix B, based on activities agreed during the co-design period.

10.25. The activities will be captured in the subcontracts, which the Council will review and approve before they are awarded.

10.26. The Lead Provider and Subcontractors shall ensure a proportionately higher take-up of the Service from local deprived communities and social housing, people experiencing poor mental health, people who have learning needs and physical disabilities, as they are at higher risk of developing

preventable long-term health conditions such as cardiovascular disease at an earlier age.

10.27. The Lead Provider and Subcontractors will provide targeted support to communities experiencing the greatest health inequalities, with a particular focus on the target groups highlighted in Section 5.1.

10.28. Services must be delivered in trusted community venues, particularly in areas of higher deprivation, and must include options for self-referral. Accessibility must be ensured through flexible hours, transport considerations, and language inclusivity, with a minimum percentage of services available in community languages. To support this, the Lead Provider shall:

a) Deliver interventions in trusted community venues, linking with the wider VCS sector and community hubs to foster familiarity and trust.
b) Provide materials in easy-read formats and community languages to ensure information is understandable and inclusive.
c) Offer flexible hours, including evenings and weekends, to accommodate working residents and those with caring or childcare responsibilities.
d) Conduct outreach to seldom-heard groups, ensuring their voices and needs are reflected in service design and delivery.
e) Establish inclusive referral pathways, including self-referral, GP referral, and signposting to reduce barriers to access.

Improving referral pathways into existing services

10.29. The Lead Provider and the Subcontractors must strengthen referral pathways between HealthWorks, NHS, council services, and voluntary sector organisations to ensure residents can access the right support promptly and effectively.

10.30. The Subcontractors will ensure residents are supported through referrals by facilitating warm handovers between the HealthWorks service and other service providers. This means helping individuals navigate the system and stay engaged with services.

10.31. The Subcontractors will build strong relationships with frontline staff across health, care, and community sectors to improve understanding of roles and referral processes.

10.32. The Subcontractors will work with communities to co-design improvements to services, ensuring they are culturally appropriate and meet local needs.

10.33. The Lead Provider will be responsible for ensuring the Subcontractors track and evaluate referral outcomes to understand what works well and where improvements are needed, using this data to inform ongoing service development.

Engagement, outreach and insights

10.34. The Lead Provider will work with the Subcontractors to establish a structured process for gathering insights from community members and frontline providers throughout the contract period.

10.35. This process must embed continuous feedback loops to ensure the Service remains responsive to local needs and system priorities.

10.36. Insights will be collected using a mix of qualitative and quantitative methods (e.g., focus groups, surveys, interviews, and feedback forms at service touchpoints).

10.37. The Lead Provider and Subcontractors will develop and implement a comprehensive engagement and outreach strategy prioritising residents from target groups identified in Section 5.1.

10.38. Quarterly insight sessions will be convened with the Subcontractors and system partners to review emerging themes, barriers, and opportunities for improvement.

10.39. All insights must be documented, analysed, and used to identify trends, gaps in provision, and areas for innovation.

10.40. Findings will inform iterative service design and delivery adjustments, with clear evidence of how feedback has shaped decisions.

10.41. A summary of insights and resulting actions must be included in quarterly reports to the Council and shared with stakeholders to maintain transparency and trust.

10.42. The Lead Provider will ensure compliance with data protection requirements and provide engagement tools in accessible formats (e.g., easy-read, community languages).

10.43. Outreach activities must include:

a) **Community-based engagement:** Sessions in trusted local venues (e.g., community centres, faith settings, housing estates).

b) **Digital engagement:** Accessible online platforms and social media to promote services and share health information.

c) **Peer-led outreach:** Recruitment and training of community champions or peer advocates to support engagement and act as connectors within their communities.

10.44. All engagement materials must be culturally appropriate, available in community languages, and provided in easy-read formats.

10.45. The Lead Provider will monitor engagement activities and report on reach, participation, and demographic breakdowns in quarterly reports.

10.46. Engagement must remain iterative and informed by community feedback to ensure relevance and effectiveness throughout the contract period.

Community capacity building

10.47. To strengthen the ability of subcontracted organisations to deliver high-quality, culturally competent public health interventions. The Lead Provider will provide Subcontractors with structured support and training to build skills, knowledge, and resilience within the voluntary and community sector (VCS) network.

10.48. The Lead Provider will develop and implement a capacity-building plan within the first two months of mobilisation, aligned with the co-design process.

10.49. The Lead Provider will deliver or source mandatory training for all Subcontractors on:

a) Safeguarding and data protection compliance.
b) Public health intervention basics (e.g., behaviour change, health coaching).
c) Cultural competence and anti-racism in health delivery.
d) Environmental sustainability in service delivery.

10.50. The Lead Provider will provide ongoing training and development opportunities throughout the contract period, including refresher sessions and advanced modules based on emerging needs.

10.51. The Lead Provider will offer practical support such as toolkits, templates, and guidance on monitoring, evaluation, and reporting requirements.

10.52. The Lead Provider will facilitate peer-learning opportunities through regular workshops and knowledge-sharing forums among subcontractors, at least 2 times per year.

10.53. The Lead Provider will ensure smaller or grassroots organisations receive tailored support to overcome capacity challenges, including flexible funding arrangements and simplified reporting processes.

10.54. The Lead Provider will monitor and evaluate the impact of capacity-building activities, reporting outcomes and improvements in subcontractor capability in quarterly reports to the Council.

10.55. The Council will undertake an annual subcontractor survey to verify that ≥ 80% of subcontractors feel supported and equipped to deliver culturally competent interventions.

11. KEY RELATIONSHIPS

11.1. To achieve the best outcomes for the service, the Lead Provider and Subcontractors shall develop and maintain effective working relationships with key stakeholders, including, but not limited to:

- Bi-borough Public Health Team
- Public Health Commissioned services:
    - Behaviour Change (such as Integrated Healthy Lifestyle, Smoking cessation)
    - Communities (such as Community Champions)
    - Families and Children (such as Change for Life)
    - Sexual Health (such as GUM, LARC)
    - Substance misuse (such as Club Drug Clinic and Build on Belief)
- Bi-Borough Place-based Partnership (PBP) and Neighbourhood Health Teams (formerly INT)
- Bi-borough NHS and primary care services, including GPs, pharmacists, talking therapies and other connector functions in Octopus.
- Relevant council directorates, departments and services including Housing, Environment, Communities, Adult Social Care, and programmes like North Paddington Programme.
- One Westminster
- Local VCS and faith organisations and other community support
- Healthwatch Westminster
- Sports and Leisure services and providers

12. PERFORMANCE TARGETS AND CONTRACT MANAGEMENT

12.1. The Lead Provider will attend quarterly meetings with the Authority Representative and produce quarterly reports for such meetings, 15 (fifteen) Business Days before each meeting).

12.2. All data handling and management shall follow information governance and data management best practice and the Law.

12.3. The Lead Provider shall meet all reporting requirements and demonstrate progress on achieving the objectives and outcomes as set out in Appendix B. The Lead Provider will complete this dashboard template and report on the specified deliverables, in addition to the following information on:

Activity targets

12.4. The Lead Provider must highlight the significant achievements, events and activities during the previous quarter.

12.5. The Lead Provider must maintain and update a programme risk register, including mitigation actions, to evidence proactive risk management.

12.6. In addition, the Lead Provider must flag any high or emerging risks to the Council immediately, providing details of potential impact, mitigation measures, and proposed actions. Risks that could affect service delivery,

compliance, or safeguarding must be escalated outside of routine reporting cycles.

12.7. The Lead Provider must flag any issues arising for the delivery of the Service including staffing and plans for remedial action.

12.8. The Lead Provider must highlight learning from the delivery of the Service in the previous quarter

12.9. The Lead Provider must update on forward planned programme of work.

Value for money and innovation

12.10. The Lead Provider must introduce and sustain innovative, evidence-based approaches that improve service quality, efficiency, and user outcomes.

12.11. The Lead Provider must demonstrate how insights from quarterly engagement sessions have informed service adjustments and improved outcomes.

12.12. Examples of innovations in service delivery could include, but are not limited to:

a) Accessibility enhancements, such as pop-up health clinics in housing estates
b) Culturally responsive approaches, such as faith-based health interventions delivered in trusted venues like mosques, churches, or temples.
c) Co-produced models, such as co-design of interventions with residents and grassroot organisations (e.g., culturally adapted smoking cessation programs).

Priority group reach

12.13. Providing a comprehensive service, representative of our local communities is a key priority.

12.14. The Lead Provider must ensure that all information is broken down by demographics, with a clear narrative around work undertaken to engage different sections of our communities. This will include an annual deep dive into activity and a plan for the year ahead about actions to be taken to ensure the service is responsive to emerging local need.

13. SOCIAL VALUE

13.1. Public Sector organisations have an obligation under the Public Services (Social Value) Act 2012 (SVA) to consider how the proposed procurement might improve the economic, social and environmental well-being of the relevant area. This links to the Council ambitions to proactively work with its suppliers to ensure that every pound spent can be maximised to bring wider benefit to the local community.

13.2. The Council have identified priority areas where they are seeking to work with suppliers to create social value – these areas are identified within the Responsible Procurement Delivery Plan and are summarised below:

- Reducing long term unemployment; increasing employment participation among the socially excluded and disadvantaged; and raising the skills level of the local workforce;
- Increasing opportunities for local SMEs and community groups;
- Promoting greater environmental sustainability.

13.3. The Lead Provider shall work with the Council to develop and deliver the social value offered by the Lead Provider in the Tender.

13.4. The Council would like the Lead Provider to demonstrate how it will work holistically to signpost and partner with organisations who can address the wider needs of clients through this contract, i.e. encourage individuals to take part in local physical community activities / volunteering, seek employment and skills advice if required etc.

14. DATA PROTECTION

14.1. General expectations

a) Proper protection of sensitive personal and confidential data in accordance with the terms and conditions of the Contract is of the utmost importance in the execution of the services.

b) The Lead Provider and Subcontractors must ensure that all staff involved in the execution of the services, including office-based staff, are made aware of their responsibilities for Data Protection and have received appropriate training in the handling and security of personal and sensitive personal information.

c) The Lead Provider will ensure that it has in place appropriate technical and organisational measures to ensure the security and safe disposal of all personal and confidential data (including a document control procedure to guard against unauthorised access, accidental loss, destruction or damage to, the personal data.) in accordance with all of the requirements of the Data Protection Act and the provisions of the UK General Data Protection Regulation or any other equivalent data legislation which may come into effect in the United Kingdom.

d) The Councils' reserve the right to inspect the arrangements for handling, security and disposal of personal and confidential data at its discretion.

e) Prior to Contract commencement the Councils will require the Provider to complete an Information Security assessment and input into a Data

Protection Impact Assessment as part of the Councils' risk management procedures surrounding personal data management and protection.

14.2. Compliance Visits, Spot Checks and Inspections

a) The Councils expect the Lead Provider to carry out spot checks to ensure that its staff are providing the Services required by the Council in accordance with the Service Specification and the Conditions of Contract. The Council reserve the right to request details of the frequency, content and outcome of these checks.

b) The Lead Provider is required to provide a full response to any observations made by the Council within 28 days, including details of any remedial action taken.

c) The Council reserve the right to carry out follow-up checks and audits where considered necessary, to increase the frequency of checks and audits, and to issue Contract improvement notices, where it considers that Lead Provider has failed to meet significant requirements of the Contract.

14.3. Record-keeping

a) The Lead Provider must keep records to enable delivery of the service and quarterly reporting against KPIs as agreed with Commissioners (refer to KPIs in Appendix B). This will include, but is not limited to, the following:

- Weekly activity logs, including:
    - Name of event/session
    - Date and delivery ward
    - Number of sessions delivered
    - Number of participants
    - Number of staff and volunteers involved
- Demographic data:
    - Ethnicity breakdown
    - Gender
    - Age group
    - Disability status
    - Sexual orientation
    - Employment status
    - Ward and postcode
- Outcome and impact data:
    - Physical activity participation
    - Healthy eating and nutrition engagement
    - Smoking, alcohol, and substance use reduction

- Mental health and emotional wellbeing improvements
  - Reduction in social isolation and loneliness
- Referral activity:
  - Number and type of onward referrals (e.g., GP, NHS Health Checks, Stop Smoking services, cancer screening, counselling)
- Associated health indicators and self-reported measures:
  - Blood pressure readings
  - Wellbeing scores (e.g., WEMWBS or ONS4)
  - No. of health coaching conversations
  - No. of mental health support sessions
- Qualitative feedback:
  - Testimonials, quotes, case studies
  - Observed barriers and enablers (e.g., childcare, transport, interpretation)
  - Emerging themes and gaps
- Training records:
  - Training attended by staff/volunteers
  - Implementation and impact of training
  - Additional training needs
- Peer learning and collaboration
  - Workshop logs, agendas, and participant lists for knowledge-sharing forums delivered to the VCS network.
- Risk management
  - A risk register updated regularly, with immediate escalation of high or emerging risks to the Council.
- Budget monitoring:
  - Spend by category (staff, venue, activities/materials, promotion, enablers, refreshments)
  - Variance tracking

APPENDIX A: CO-DESIGN AND MOBILISATION PLAN

Months	Phase	Activities/milestones
1–2	Initial engagement	• Confirm co-design period timelines with the Council • Engage community organisations, residents, Council, and NHS partners through workshops to ascertain delivery partners, activities, PH interventions and the spread of community organisations to deliver the Healthworks service • Confirm subcontracting approach and indicative allocations **Key milestone:** 1. The Lead Provider must submit a mobilisation plan with timelines, governance structure, and engagement strategy within the first month of the co-design period.
2–3	Subcontracting and compliance	• Formal subcontracting of organisations from the 80% allocation • Ensure robust due diligence is undertaken with respect to data protection and information security. • Deliver initial training (5% allocation) on safeguarding, data protection compliance, and public health intervention basics to ensure readiness for service delivery. • Training on anti-racism, health inequalities and environmental sustainability **Key milestones:** 1. The Lead Provider must implement a transparent subcontractor selection process with published criteria and scoring matrix; minimum 3 independent scorers. 2. The Lead Provider must allocate 80% of the total contract value (£1.47m) to subcontractors. 3. The Lead Provider must ensure 100% subcontractor compliance with minimum

<table>
<tr><td></td><td></td><td>standards (DBS, safeguarding, insurance, data protection) before delivery.</td></tr>
<tr><td>3–4</td><td>Co-design activities</td><td>Collaborative design sessions with residents and VCS partners to confirm activities to be delivered and the public health interventions that will be delivered
Integrate NHS, Council and resident's feedback</td></tr>
<tr><td>4–5</td><td>Draft activity plan</td><td>Lead provider consolidates co-design outputs into a draft activity plan
Lead provider to ascertain frequency of peer-learning opportunities that will be delivered through workshops and knowledge-sharing forums among subcontractors.
Design clinical governance in collaboration with NHS and Public Health
Confirm KPIs, monitoring reporting and evaluation framework
Key milestones:
The Lead Provider must adapt the monitoring form to reflect outcomes from the co-design period around activities and interventions outputs.
The Lead Provider must submit an annual training and peer learning programme.
The Lead Provider must provide a programme evaluation plan / framework.</td></tr>
<tr><td>5–6</td><td>Finalisation and mobilisation</td><td>Final activity plan and monitoring & evaluation framework approved by Council
Subcontractors confirm readiness and compliance
Mobilisation begins (marketing, engagement, scheduling activities)</td></tr>
</table>

APPENDIX B: KEY PERFORMANCE INDICATORS (KPIs)

Outcome 1: The service is responsive, well led, and able to demonstrate value for money

The Provider is required to meet a ‘Good’ target standard across all KPIs.

KPI	Title	Description	Measurement method	Frequency	Good	Approaching target	Requires improvement	Inadequate
1.1	Quarterly service delivery reporting	The Provider must submit a quarterly operational performance report (activities, outputs, demographics, risks, insights) to the Council within 15 business days before each quarterly meeting.	Report submission log	Quarterly	≤ 15 days	16 – 20 days	21 – 29 days	≥ 30 days
1.2	Value for money and innovation	The Provider must submit an annual improvement plan and at least three case studies demonstrating innovative approaches and added value in service delivery. Evidence should include: • Number of innovations implemented (minimum three per year for ‘Good’ performance).	Case studies, improvement plan	Annually	3+ innovations per year, jointly developed with stakeholders, aligned with best practice and implemented	At least 2 innovations per year, jointly developed with stakeholders, aligned with best practice and implemented	At least 1 innovation per year, jointly developed with stakeholders, aligned with best practice and implemented	No innovation

		• Demonstrate engagement/joint working with stakeholders in developing innovations. • Clear alignment with best practice and measurable impact on service delivery.						

Outcome 2: Staff and subcontractors are trained, supported, and culturally competent

KPI	Title	Description	Measurement method	Frequency	Good	Approaching target	Requires improvement	Inadequate
2.1	Mandatory training completion	The Provider must ensure that 95% of subcontractor staff attend mandatory training and any other training required to ensure organizations are able to deliver the health interventions (safeguarding, data protection, cultural competence, health coaching within the first 6 months).	Training compliance tracker, attendance logs	Quarterly	≥ 95% training completed by subcontracted organisations	94-85% training completed by subcontracted organisations	84-75% training completed by subcontracted organisations	< 74% training completed by subcontracted organisations

2.2	Subcontractor satisfaction	The Council will undertake an annual subcontractor survey to verify that ≥ 80% of subcontractors feel supported and equipped to deliver culturally competent interventions.	Subcontractor survey and feedback	Annually	≥ 80%	79 - 70%	69 - 60%	<59%
2.3	Peer learning and collaboration	The Provider must deliver 2 knowledge sharing forums per year to build resilience across the VCS network.	Workshop logs	Annually	100% delivered	99-75%	74-50%	< 49%

Outcome 3: Residents access personalised, culturally responsive preventative health interventions

KPI	Title	Description	Measurement method	Frequency	Good	Approaching Target	Requires Improvement	Inadequate
3.1	Resident reach	The Provider must evidence the number of residents reached through the service (e.g., attendance at community events and activities)	Attendance logs	Quarterly	≥ 750 residents per quarter	749 – 500 residents per quarter	499 – 300 residents per quarter	< 299 residents per quarter
3.2	Number of activities delivered	The Provider must evidence the number of activities delivered. Activities are general engagement or	Activity log	Quarterly	≥150 activities per quarter	149 – 100 activities per quarter	99 - 50 activities per quarter	<49 per quarter

		outreach events that aim to raise awareness, build community connections, or encourage participation such as community health fairs, group exercise sessions, cooking demonstrations, information stalls at local events.						
3.3	Number of people receiving preventative health interventions	The Provider must evidence the number of people receiving preventative health interventions to meet service commitments for measurable improvement in heart, lung, and mental health indicators. (Interventions are structured, evidence-based actions designed to improve specific health outcomes for individuals or groups. Examples of interventions are:	Preventative health interventions logs	Quarterly	≥60% of residents reached receive a preventative health interventions	59%-40% of residents reached receive a preventative health interventions	39%-20% of residents reached receive a preventative health interventions	< 19% of residents reached receive a preventative health interventions

		• One-to-one health coaching • Smoking cessation programs • Weight management plans • Mental health support sessions)						
3.4	Health outcomes	The Provider must measure and report the percentage of service users who indicate an improvement in physical and/or mental wellbeing following participation in preventative health activities, based on pre- and post-activity surveys (the Lead Provider can either develop a survey or use a validated tool, such as ONS).	Pre/post surveys	Quarterly	≥ Each subcontracted organisation achieves 75%	Each subcontracted organisation achieves 74–65%	Each subcontracted organisation achieves 64 - 50%	Each subcontracted organisation achieves < 49%

Outcome 4: Referral pathways are strengthened and equitable

KPI	Title	Description	Measurement method	Frequency	Good	Approaching target	Requires improvement	Inadequate
4.1	Referrals completed	The Provider must record and report the number of residents referred into public health, council, primary care, and VCS services. Referral numbers must be reported separately for each subcontractor.	Referral forms/ tracker	Quarterly	125 - 75 referrals in total	124 - 50 Referrals in total	49-25 Referrals in total	< 24 referrals in total
4.2	Priority group reach	The Provider must evidence that ≥ 80% of service users are from priority groups (Global Majority, deprived areas, disabilities, poor mental health).	Demographic data	Quarterly	≥ 80%	70–79%	60–69%	< 60%

Outcome 5: Social value is delivered

KPI	Title	Description	Measurement method	Frequency	Good	Approaching target	Requires improvement	Inadequate
5.1	Responsible procurement Commitments delivered	The Provider is expected to develop their social value delivery plan for the lifetime of the	Social value plan, monitoring reports	Annually	≥ 90%	75–89%	60–74%	< 60%

		contract which will be reviewed and revised annually. This will include tangible deliverables in line with the key service objectives, which may include but not be limited to: • Employment Opportunities • Careers Promotion in Health and Social Care • Volunteer Skills Development • Community Engagement Workshops or Training • Safeguarding Awareness Initiatives • Innovative and Impactful Initiatives						

APPENDIX C: DATA

- Westminster Ward Profiles
- Westminster Borough Stories
- Global Majority JSNA

APPENDIX D: PUBLIC HEALTH OUTCOMES FRAMEWORK (PHOF) INDICATORS

Domain	Indicator	Outcome / Why it matters	Data sources
Respiratory Health	Smoking prevalence – adults (18+) (*also impacts cardiovascular health)*	Reduced smoking rates → Lower CVD risk and improved population health.	PHE Fingertips – Smoking Profile
	Hospital admissions for COPD	Fewer admissions → Improved respiratory health and reduced healthcare burden.	Respiratory Disease Profile – GOV.UK
Cardiovascular & Metabolic Health	Smoking status at time of delivery	Improved maternal health and intergenerational prevention of smoking-related harm.	PHE Fingertips – Smoking Profile
	Excess weight in adults	Lower obesity prevalence → Reduced risk of diabetes, CVD, and related conditions.	PHE Fingertips – Obesity Profile
	Physically active and inactive adults	Increased physical activity → Better metabolic health and reduced chronic disease burden.	Sport England – Active Lives Survey
	Diabetes prevalence (QOF)	Early detection and management → Reduced complications and premature mortality.	NHS Digital – QOF Data
Mental health	Self-harm hospital admissions	Reduced crisis episodes → Improved mental wellbeing and access to early intervention.	PHE Fingertips - Self Harm Admissions
	Excess under-75 mortality in severe mental illness	Lower premature mortality → Better care coordination and health equity.	PHE Fingertips - Excess Mortality in SMI
	Social isolation and loneliness	Reduced isolation → Improved mental wellbeing and community resilience.	ONS – Community Life Survey

Preventive Care & Screening	NHS Health Check uptake	Increased uptake → Early detection of CVD risk factors and improved prevention.	NHS Digital – Health Check Data
	Cancer screening coverage (breast, cervical, bowel)	Higher coverage → Early diagnosis and improved survival rates.	Fingertips – Screening Programmes