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Performance Update - Adult Social Care, Public Health and Active Lifestyles

Date: 18th June 2024

Report of: Directors of Adults and Health, Public Health, City Development

Report to: Scrutiny Board (Adults, Health and Active Lifestyles)

Will the decision be open for call in? ☐ Yes ☒ No

Does the report contain confidential or exempt information? ☐ Yes ☒ No

Brief summary

- This report provides an overview of outcomes and service performance related to the Council and city priorities within the remit of the Adults, Health and Active Lifestyles Scrutiny Board, reflecting delivery of Best City Ambition and the Council's performance management framework relevant to this Scrutiny Board.

- This report focuses on the most recently available data locally and nationally at the end of the 2023/24 financial year. The report is for information, providing assurance that current performance is visible, understood and informs our priorities and our areas for development. It also serves as information to the Board when considering areas to undertake further scrutiny work.

Recommendations

a) It is recommended that the Board consider and comment on the performance information contained in the report and appendices, noting the assurance provided and considering if any additional information or further scrutiny work would be of benefit.

What is this report about?

1 This report provides an overview of outcomes and service performance related to the Council priorities and services within the remit of the Adults, Health and Active Lifestyles Scrutiny Board. It is intended as a succinct overview ensuring visibility, providing assurance and informing ongoing scrutiny work.

2 This report provides an update on progress in delivering the Council and city priorities in line with the Council's performance management framework and the Best City Ambition. It also relates to city and Council strategies including the Health and Well Being Strategy, the Leeds Health and Care Plan and the Better Lives Strategy.

3 Updates against city and Council priorities are brought to the Board to inform the start of the scrutiny year and the annual budget setting cycle. The report is presented in three distinct sections reflective of Council accountabilities. These are Public Health, Adult Social Care and Active Lifestyles - with the majority of the updates in the respective appendices. While there are commonalities in how these relate to the citizens of Leeds, the appendices are in effect distinct reports, with the covering report offering an introduction.

Public Health

4 Appendix 1a is a public health performance report providing an update on indicators that describe population health outcomes for Leeds and operational indicators, including the performance of Public Health services commissioned by the Leeds City Council Public Health team. It provides an explanatory narrative for those indicators that have been updated since the last report in January 2024. Appendix 1b sets out the data for the indicators and highlights those that have been updated since the last report. Where possible, the rate is also shown for the most and least deprived areas of Leeds (i.e. those in the 10% most/least deprived neighbourhoods in England) to be able to monitor health inequalities. Appendix 1c includes additional comparisons against the seven other major English cities ('Core Cities') for the indicators updated in this report.

5 Overall position

- The data included in this latest report shows that there has been a slight increase in life expectancy for both men and women in the most recent period. This will be monitored closely to assess whether this is the start of an upward trend. A significant gap in life expectancy remains between the poorest and wealthiest parts of the city - around a ten-year difference for men and nine years for women (when comparing all Leeds neighbourhoods in the poorest 10% nationally with those in the wealthiest 10% nationally. This difference is around 12 years for Leeds at individual ward level, which is an alternative method of measuring this gap).
- In line with the national picture, overall life expectancy in Leeds remained largely unchanged between 2011/13 and 2018/20. From this point onwards, life expectancy in the city declined slightly. The downward trend started before the onset of Covid-19 so it cannot be wholly attributed to the impact of the pandemic. However, it is likely that deaths from Covid-19 contributed to this trend.
- There is a mixed picture in terms of the impact of major disease(s) on the city's population. These include circulatory diseases such as heart disease and stroke; respiratory conditions like COPD; cancer, and alcoholic liver disease.
- Overall, however, there is a continued reduction in the rates of death for people under 75 years old from preventable causes. This may represent a genuinely positive trend - possibly

in part attributable to the impact of preventative services and interventions. It may also in part be due to the impact that Covid-19 had on vulnerable populations - with people dying from Covid-19 rather than from these preventable conditions.

6 Improvements

Despite the challenging and complex picture described above, there have been several improvements in key indicators. These include:

- The decrease in rates of obesity in primary school aged children - most notably in 10 – 11-year-olds (Year 6).
- Rates of deaths from preventable causes in people aged under 75 years old are falling most quickly in the most deprived parts of the city. Similarly, rates of deaths from respiratory disease, cancer, and alcoholic liver disease (all age and in under 75s) are following a similar pattern – with declines most rapid in poorest parts of the city.
- The number of people taking up an offer of an NHS Health Check. This indicator continues to recover after Covid (increasing from 53.4% to 71.4% over the last quarter) and Leeds rates remain above the regional and England average.
- The proportion of people successfully completing alcohol treatment has continued to increase and is significantly higher than the rate in Yorkshire and the Humber and for England.
- The overall trend for successfully completing drug treatment (opiate users), is positive and Leeds continues to have significantly higher success rates than across Yorkshire and the Humber and England.

7 Continued challenges

- There has been a small increase in the rate of deaths from circulatory disease in the most deprived parts of the city. This continues the worsening trend (in deprived areas) for this indicator and the gap continues to increase between the most and least deprived areas of Leeds.
- Excess weight in adults has also increased slightly in the most recent period. This indicator also shows a marked increase compared to pre-Covid rates.
- Entrenched inequalities between the most deprived and least deprived communities remain across a range of other indicators including those for alcohol, smoking status by occupation, serious mental illness, and physical inactivity in adults.

Adult Social Care

8 The national framework within which adult social care data is collected and reported nationally is set out within the Adult Social Care Outcomes Framework (ASCOF). The ASCOF has been refreshed with a revised indicator set published for 2023/24 onwards. The annual aggregate Short and Long Term Care (SALT) return has been replaced with a quarterly Client Level Data (CLD) return with the two ‘dual running’ in 2023/24. In addition, data forms a key part of the evidence base used to support the Care Quality Commission (CQC) Assurance regime. These changes are reflected in this report.

9 Appendix 2a presents the Adult Social Care Annual Performance Report. This includes the provisional ASCOF results for 2023/24. These metrics are informed by the results of mandatory national data collections and surveys. This report presents results alongside the most recent comparative data from 2022/23. The final ASCOF results will be published in October 2024 and as such the data contained within this report may be subject to change.

10 This is supplemented with additional information linked to the Best City Ambition, Better Lives Strategy and CQC Assurance Framework. This includes seven Adult Social Care measures that have been included by the Office for Local Government (OFLOG) in their Local Authority Data Explorer.

11 To contextualise the performance position in relation to capacity and demand - adult social care continues to experience significant pressure on its services and there remains a high volume of referrals into the system. In addition, people's needs are often more complex and as a result they need more support than they did previously. Their requirements being more complex means that social workers are having to spend more time on understanding needs, on undertaking Best Interests Decisions and in some cases seeking decisions through the Court of Protection at a higher volume than seen previously. Whilst the number of people receiving homecare has remained broadly consistent the average size and cost of the package received continues to increase.

12 Whilst there has been positive movement over recent months in staffing levels and a reduction in the number of vacancies, Adult Social Care continues to face pressures around staffing. We are now managing to recruit to vacant posts but the loss of experienced Social Workers and Wellbeing Workers who have been replaced by relatively new and recently trained staff means there continues to be pressures around workforce capacity. Benchmarking data shows Leeds ranks 6th of 8 English core cities for Social Workers per head of population and 7th for Wellbeing Workers per head of population. Leeds also has lower rates than the neighbouring authorities of Wakefield and Bradford. A new national workforce strategy for Adult Social Care will be launched in July 2024, outlining a new vision and long term workforce priorities linked to wider national government led reforms for the sector. Locally we continue to recruit and develop a social care workforce that is representative of the diverse communities within the city and building inclusive workplaces, focusing on productivity, skills, workloads and wellbeing.

13 Activity - As of 31st March 2024 Adult Social Care provided long term support to 8,795 people (3,826 aged 18-64, 4,969 aged 65 or over). These figures continue the trend of an increase in older people supported (up 2.6% on 2022/23 year-end figures), and in particular an increase in the numbers of older people in permanent nursing/residential placements which rose by 8.6%. These figures are now broadly in line with those seen pre-pandemic.

14 Improvements

The overall picture in relation to ACOF measures compared to the last available result is positive with 12 measures (out of 22) having improved whilst nine have declined, with the results for the remaining measure not yet available. Further details on each of these measures are contained within the appendices but areas of note are:

- Reablement – Leeds' performance on the two national measures relating to outcomes for people completing the service are positive with both improving to their highest levels. In addition, the volume of people receiving a reablement service has increased in 2023/24. These improvements are reflective of both the HomeFirst Programme and operational changes made at service level. The service is ambitious for further developments and improvements and has clarity, direction and continued support of the HomeFirst Programme to enable growth and expansion through further integrated working with our Alliance partners.
- Safety / Safeguarding – Measures looking at the safety of adults who may be vulnerable are positive. Data from the Safeguarding Adults Collection (SAC) shows an increase in the percentage of safeguarding concerns that resulted in an enquiry to a level more in line with national averages. This is in part due to working in partnership with other agencies to reduce

levels of inappropriate referrals. Results for a new ASCOF measure show an increase in the proportion of safeguarding enquiries where the risk was reduced or removed. In addition, the proportion of people who had their desired outcomes met improved slightly and the percentage of individuals who lack capacity provided support by an advocate, family or friend remained broadly consistent.

- Assessment waiting lists and timeliness – 2023/24 saw continued high numbers of people waiting and long waiting times for assessments. Whilst it is acknowledged that there is further work to be done and it remains a priority for improvement, throughout the year there has been substantial improvements as a result of a focus both on practice and improved recording. The waiting list has reduced, with a focus on those with the longest waits and as a result the mean wait time has also reduced. Processes are in place to ensure that people are 'waiting safely' through the screening of referrals, contacting people and families to manage risk and prioritise workloads.

15 Challenges

Challenges remain in terms of performance against several key measures and plans are in place to improve against these. These include:

- Direct Payments – The percentage of service users receiving a direct payment remains relatively consistent at a level that is low compared to other Local Authorities. This is recognised as an improvement area and a project is underway to increase the take up of direct payments. The service has developed an action plan which clearly sets out areas of improvement including a refresh of the information available to people requiring care and support services and carers, increased promotion of direct payments and simplifying the process of setting up a direct payment. In addition, targeted work is taking place in specialist services with regards to the implementation of Individual Service Funds and Personal Health Budgets providing Leeds with an opportunity to diversify in terms of it's personalisation offer and improve outcomes for individuals.
- Reviews - The percentage of people receiving long term service who have had a review in the last 12 months has fallen and stands at 41.9%. This is linked to demand elsewhere in the system impacting on the capacity to carry out annual reviews. The development of a new integrated reviewing team (IRT), made up of social workers and Occupational Therapists is starting to show progress with an increasing number of reviews carried out each month and a reduction in the number of outstanding reviews. This remains an area of service improvement and further work is underway to scope out the use of digital technologies in assisting the service to identify and prioritise cohorts for reviews. Across Specialist Services, the Reassessment Team has increased the numbers of reviews undertaken specifically in Learning Disability and has generated substantial financial efficiencies and ensured people's support is tailored to their needs. Recently the ICB has funded a mental health nurse to undertake joint reviews to ensure that there is the correct social work and clinical input into reviews and reassessments resulting in the potential for increased efficiencies and the promotion of dignity and independence.

Active lifestyles

16 Appendix 3 is an update on Active Lifestyles. This associated measure of 'Percentage of physically active adults', based on the national Active Lives Survey (ALS), carried out by Sport England. This KPI is now measured on an annual basis rather than biannual. The Inactive rate for Leeds has fallen from November 2021 to November 2022 (24.3%) to 23.9% for the period Nov 2022 to Nov 2023. Which now means less than 160,000 adults are inactive and over 443,000 are now classed as very active which is up by 0.8% to 66.4%. It is also lower than the National (25.7%), regional (27.7%) and core cities (25%) averages.

17 The levels of inactivity in the city remain highest in the most deprived areas of the city and whilst there is an improvement in people moving from inactive to active or fairly active, this shift

has been greater in the least deprived areas (1.8% change) compared with most deprived (0.7% change). This indicates there is a continued need to focus work with these communities to better understand the barriers to physical activity including environmental factors and identify the preferred type of activity.

18 The appendix provides further details on current work taking place in this area.

What impact will this proposal have?

19 This is an update paper on city outcomes and service performance there are no specific proposals.

How does this proposal impact the three pillars of the Best City Ambition?

☐ Health and Wellbeing ☐ Inclusive Growth ☐ Zero Carbon

20 Equality issues are implicit in the priorities presented in this report. As a broad headline report the detail is not necessarily provided, accepting that some of the outcomes and services included directly relate to user groups that match protected characteristics. The adult social care and many of the health outcomes relate to vulnerable adults and reflect how well their needs are being met and their vulnerabilities addressed. The purpose of the strategic and operational activity in this report is to ensure that the needs of people at risk of poor outcomes are identified and responded to at both individual and community levels. Protected equalities characteristics such as race and sexuality are considered in the design and operation of services.

21 The report provides an update on current progress against elements of the Best City Ambition pillar of Health and Wellbeing as relevant to the board. Where measures are included, they are highlighted as linked to the Best Council Ambition within the relevant update.

22 There are no specific inclusive growth or zero carbon implications from this report. However, in broad terms the promotion of healthy lifestyles and the maintenance of good health and independence is supportive of these ambitions for example through the promotion of walking and cycling as means of travel.

What consultation and engagement has taken place?

Wards affected:		
Have ward members been consulted?	☐ Yes	☒ No

23 This is an information report and as such does not need to be consulted on with the public. However, performance information is published on the council's website and is available to the public, locally and often through national publications and websites.

What are the resource implications?

24 There are no direct resource decisions involved in this report. How resources are best used to achieve priorities is relevant especially given our asset based and strengths based approach.

What are the key risks and how are they being managed?

25 In presenting performance against key priorities key risks and challenges are highlighted. This report forms part of a comprehensive risk and performance management process in the council

to monitor and manage key risks. The council's most significant risks are available and can be accessed via the council's website.

What are the legal implications?

26 All performance information is publicly available. This report is an information update providing Scrutiny with a summary of performance for the strategic priorities within its remit and as such is not subject to call in.

Options, timescales and measuring success

What other options were considered?

27 Not applicable

How will success be measured?

28 Not applicable

What is the timetable and who will be responsible for implementation?

29 Not applicable

Appendices

- Appendix 1a: Public Health update paper (summary of key issues)
- Appendix 1b: Public Health Performance Report
- Appendix 2a: Adults Social Care update paper (summary of key issues)
- Appendix 2b: Adult Social Care Datasets
- Appendix 3 More Adults are Active

Background papers

- None.

Appendix 1a: Public Health Bi-Annual Performance Report, Date: April 2024

Summary/Purpose

This report provides an update on:

- indicators that describe population health outcomes for Leeds
- operational indicators, including the performance of Public Health services commissioned by the Leeds City Council Public Health team.

It provides an explanatory narrative for those indicators that have been updated since the last report in January 2024.

Appendix 1b sets out the data for the indicators and highlights those that have been updated since the last report. Where possible, the rate is also shown for the most and least deprived areas of Leeds (i.e. those in the 10% most/least deprived neighbourhoods in England) to be able to monitor health inequalities.

Appendix 1c includes additional comparisons against the seven other major English cities ('Core Cities') for the indicators updated in this report.

Overall position

The data included in this latest report shows that there has been a slight *increase* in life expectancy for both men and women in the most recent period. This will be monitored closely to assess whether this is the start of an upward trend. A significant gap in life expectancy remains between the poorest and wealthiest parts of the city - around a ten-year difference for men and nine years for women (when comparing all Leeds neighbourhoods in the poorest 10% nationally with those in the wealthiest 10% nationally. This difference is around 12 years for Leeds at individual ward level, which is an alternative method of measuring this gap).

In line with the national picture, overall life expectancy in Leeds remained largely unchanged between 2011/13 and 2018/20. From this point onwards, life expectancy in the city declined slightly. The downward trend started before the onset of Covid-19 so it cannot be wholly attributed to the impact of the pandemic. However, it is likely that deaths from Covid-19 contributed to this trend.

There is a mixed picture in terms of the impact of major disease(s) on the city's population. These include circulatory diseases such as heart disease and stroke; respiratory conditions like COPD; cancer, and alcoholic liver disease.

Overall, however, there is a continued reduction in the rates of death for people under 75 years old from preventable causes. This may represent a genuinely positive trend - possibly in part attributable to the impact of preventative services and interventions. It may also in part be due to the impact that Covid-19 had on vulnerable populations - with people dying from Covid-19 rather than from these preventable conditions.

Improvements

Despite the challenging and complex picture described above, there have been several improvements in key indicators. These include:

- The decrease in rates of obesity in primary school aged children - most notably in 10 – 11-year-olds (Year 6).
- Rates of deaths from preventable causes in people aged under 75 years old are falling most quickly in the most deprived parts of the city. Similarly, rates of deaths from respiratory disease, cancer, and alcoholic liver disease (all age and in under 75s) are following a similar pattern – with declines most rapid in poorest parts of the city.
- The number of people taking up an offer of an NHS Health Check. This indicator continues to recover after Covid (increasing from 53.4% to 71.4% over the last quarter) and Leeds rates remain above the regional and England average.
- The proportion of people successfully completing alcohol treatment has continued to increase and is significantly higher than the rate in Yorkshire and the Humber and for England.
- The overall trend for successfully completing drug treatment (opiate users), is positive and Leeds continues to have significantly higher success rates than across Yorkshire and the Humber and England.

Challenges

There has been a small increase in the rate of deaths from circulatory disease in the most deprived parts of the city. This continues the worsening trend (in deprived areas) for this indicator and the gap continues to increase between the most and least deprived areas of Leeds.

Excess weight in adults has also increased slightly in the most recent period. This indicator also shows a marked increase compared to pre-Covid rates.

Entrenched inequalities between the most deprived and least deprived communities remain across a range of other indicators including those for alcohol, smoking status by occupation, serious mental illness, and physical inactivity in adults.

Commentary on indicators updated in this report.

Only indicators that have been refreshed are included in the commentary below.

Technical Background

A full set of indicators is available in Appendix 1b. This includes a dashboard and charts. This report was prepared using the latest available data at the time of writing. Updated indicators are highlighted in bold in these documents.

Trends over time between Leeds most and least deprived parts of the city are provided where possible.

The charts in appendix 1b include longer term trend data that uses 'Most' and 'Least deprived parts of the city as comparison groups. Most deprived refers to neighbourhoods in Leeds which are in the 10% most deprived Lower Super Output Areas (LSOAs) in England. This equates to around 24.3% of the Leeds population (n=199,594 people) based on ONS 2022 mid-year estimates[1]. Least deprived refers to neighbourhoods in the 10% least deprived LSOA's in England, this equates to around 6.7% (n=55,435 people) of the Leeds population[2].

LSOA level data is required to calculate inequalities and this level of data is not available for some indicators. Indicators without deprivation data are marked with a hashtag (#) in the Dashboard (Appendix 1b).

An additional appendix is included in this report (Appendix 1c) which sets out how Leeds is performing against key indicators compared to other Core Cities. The population baseline numbers (used by the Office for National Statistics) to develop the Core City analysis are slightly different to those used locally so there may be slight variation in reported rates.

Commentary on indicators updated in this report:

Life expectancy at birth - males
The average life expectancy of a baby boy born in Leeds between the period 2020 to 2022, is estimated to be 77.8 years. This has increased slightly from the previous period (77.7 years) but is not a statistically significant change. The overall Leeds trend has been flat, with life expectancy not significantly different than 2011-2013 (78.1 years). Life expectancy in least deprived parts of Leeds has increased slightly (from 82.9 years in 2019-21 to 83.0 years in 2020-22), but this is not statistically significant. Life expectancy in the most deprived areas has increased slightly (from 72.9 years in 2019-21 to 73.0 years in 2020-22), but this is not statistically significant.

Life expectancy at birth - females
The average life expectancy of a baby girl born in Leeds between the period 2020 to 2022, is estimated to be 82.0 years. This has increased slightly from the previous period (81.8 years) but is not a statistically significant change. The overall Leeds trend has been flat, with life expectancy not significantly different than 2011-2013 (81.9 years). Life expectancy in the least deprived areas of Leeds has decreased slightly (from 87.2 years in 2019-21 to 86.9 years in 2020-22), but this is not statistically significant. Life expectancy in the most deprived areas has increased slightly (from 77.4 years in 2019-21 to 77.6 years in 2020-22), but this is not statistically significant. Overall, there have been no significant changes in the Leeds average, or most and least deprived areas for life expectancy.

Reception (4-5 years): Prevalence of obesity (including severe obesity)
The prevalence of obesity in reception age children was 9.4% in 2022/23. This has decreased slightly from the previous period (9.9%) but is not a statistically significant change. The overall Leeds trend has been flat, with the prevalence not significantly different than 2013/14 (9.5%). Data on the least and most deprived parts of the city is not available at time of update.

[1] 24% of Leeds LSOAs (114 out of 482 LSOAs)
[2] 7% of Leeds LSOAs (33 out of 482 LSOAs)

Year 6 (10-11 years): Prevalence of obesity (including severe obesity)
The prevalence of obesity in Year 6 children was 23.3% in 2022/23. This has decreased from the previous period (25.0%) but is not a statistically significant change. The overall Leeds trend has been increasing, with the prevalence significantly higher than 2013/14 (19.3%). Data on the least and most deprived parts of the city is not available at time of update.

Excess weight (obesity) in adults % of adults who have a BMI of over 30
The percentage of obese adults (BMI > 30) in Q4 2023/24 was 24.6%. This increased slightly compared to previous quarter (24.5% in Q3) but was not a statistically significant change. However, compared to the pre-Covid rate there has been a statistically significant increase (23.6% in Q3 2019/2020). For people living in the most deprived areas the percentage was 29.4% and for the least deprived areas 19.8%. There are no significant changes compared to the previous quarter but compared to pre-Covid the rates in the most (28.3%) and least deprived (18.9%) areas have risen significantly.

Percentage of physically inactive adults
The percentage of physically inactive adults (aged 19+, <30 moderate intensity minutes per week) in Q4 2023/24 was 34.2%. This decreased slightly compared to previous quarter (34.4% in Q3) but was not a statistically significant change. However, compared to the pre-Covid rate there has been a statistically significant decrease (35.4% in Q3 2019/2020). For people living in the most deprived areas the percentage was 40.1% and for the least deprived 27.1%. Overall, there are no significant changes in the most and least deprived area rates.

Prevalence of severe mental illness (SMI) 18+ (per 100,000)
The rate for Leeds in Q4 2023/24 was 1,308.5 per 100,000. There were no significant changes from Q3 (1,307 per 100,000) and there is no statistically significant trend compared to five years ago (1,332 per 100,000 in Q4 2018/19). For people living in the most deprived areas the rate was 1,942.4 and for the least deprived areas 665.5. There are no statistically significant changes from the previous quarter and the overall trend is stable.

Circulatory disease mortality, all ages (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 235.7 per 100,000. This was a slight decrease on the previous period (236.6 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows statistically significant improvement compared to 2015-2017 (284.1 per 100,000). The rate was 344.9 per 100,000 for the most deprived parts of the city and 156.6 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Circulatory disease mortality, under 75 (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 77.2 per 100,000. This was a slight decrease on the previous period (77.9 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows statistically significant improvement compared to 2015-2017 (87.7 per 100,000). The rate was 132.8 per 100,000 for the most deprived and 40.2 for the least deprived areas. Overall, there are no significant changes in the most and least deprived rates.

Respiratory mortality, all ages (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 78.0 per 100,000. This was a slight decrease on the previous period (84.4 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows statistically significant improvement compared to 2015-2017 (82.0 per 100,000). The rate was 145.3 per 100,000 for the most deprived and 32.5 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Respiratory mortality, under 75 (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 28.2 per 100,000. This was a slight decrease on the previous period (30.9 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows no significant changes compared to 2015-2017 (30.4 per 100,000). The rate was 58.4 per 100,000 for the most deprived and 5.9 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Cancer mortality, all ages (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 270.0 per 100,000. This was a slight decrease on the previous period (277.0 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows a significant decrease compared to 2015-2017 (290.7 per 100,000). The rate was 374.9 per 100,000 for the most deprived and 221.7 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Cancer mortality, under 75 (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 132.6 per 100,000. This was a slight decrease on the previous period (138.2 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows a significant decrease compared to 2015-2017 (147.6 per 100,000). The rate was 190.2 per 100,000 for the most deprived parts of the city and 97.4 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Alcoholic liver disease mortality, under 75 (age standardised per 100,000)
The mortality rate for Leeds between 2020 and 2022 was 12.9 per 100,000. This was a slight increase on the previous period (12.4 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows no significant change compared to 2015-2017 (11.0 per 100,000). The rate was 17.6 per 100,000 for the most deprived parts of the city and 5.7 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Under 75 mortality rate from causes considered preventable
The mortality rate for Leeds between 2020 and 2022 was 178.8 per 100,000. This was a slight decrease on the previous period (186.8 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows a significant decrease compared to 2015-2017 (199.7 per 100,000). The rate was 290.5 per 100,000 for the most deprived parts of the city and 98.0 for the least deprived areas. Overall, there are no significant changes in the most and least deprived area rates.

Suicide Rate (persons) (DSR per 100,000)
The nationally reported mortality rate for Leeds between 2020 and 2022 was 12.1 per 100,000. This was a slight decrease on the previous period (13.7 per 100,000 in 2019-2021) but is not statistically significant. The overall trend shows no significant change compared to 2015-2017 (11.8 per 100,000). Local data enables further analysis of the gap between the most and least deprived areas of the city. This shows that for the most deprived areas the suicide rate is 14.1 per 100,000 and for the least deprived areas it is 6.4. Overall, there are no significant changes in the most and least deprived rates.

Operational indicators

Recorded diabetes type 1 and 2, all ages (age standardised per 100,000)
The rate of recorded diabetes type 1 and 2 in Leeds for Q4 2023/24 was 6,883 per 100,000. This was a slight increase on the previous quarter (6,851 per 100,000 in Q3) but is not statistically significant. The overall trend is slightly increasing. For people living in the most deprived areas the rate was 9,817 and 4,280 for the least deprived areas. There are no statistically significant changes from the previous quarter. The overall trend is stable in the least deprived parts of the city but slightly increasing in the most deprived areas.

Percentage of NHS Health Checks offered which were taken up in the quarter
The percentage of NHS Health Checks offered (people aged 40-74yrs) which were taken up in Q4 was 71.4%, this was a statistically significant improvement from Q3 which was 53.4%. There is no clear trend but there is large variation between quarters, this trend is seen nationally. As per latest national publications in Q3 Leeds was performing better than the Yorkshire and the Humber (46.7%) and England (39.7%) averages.

Successful completion of drug treatment - opiate users (%)
The percentage of opiate users that left drug treatment successfully who did not re-present to treatment again within 6 months was 7.3% in 2022. This was a slight decrease on the previous period (7.9%) but is not statistically significant. The overall trend shows significant improvement compared to 2016 (3.9%). The percentage is significantly better than the Yorkshire and Humber (4.5%) and England (5.0%).

Successful completion of alcohol treatment (%)
The percentage of alcohol users that left alcohol treatment successfully who did not re-present to treatment again within 6 months was 45.8% in 2022. This was a slight increase on the previous period (43.1%) but is not statistically significant. The overall trend shows significant improvement compared to 2016 (25.4%). The percentage is significantly better than the Yorkshire and Humber (36.4%) and England (35.1%).

Appendix 1b - Public Health Performance Report Dashboard Q4 2023/24

For the majority of these indicators a reduction represents an improvement. Notable exceptions are Life Expectancy at Birth, service / health intervention uptake and successful completion / continuation.
Indicators marked with an asterisk * and shown in bold have been updated.
Where deprived Leeds data is unavailable, this is marked with a hastag #

Due to a delay in the relase of ONS mid-year population estaimates for 2021 for lower super output areas, deprivation data is not available for the mortality indicators when ordinarily it would be.

Legend

Significance of change since previous period:

- Statistically significant, direction is postive
- Statistically significant, direction is negative
- Not statistically significant, direction is postive
- Not statistically significant, direction is negative
- Unable to test, direction is positive
- Unable to test, direction is negative
- Unable to test, data unavailable

Population Indicators

Updated April 2024

Overarching Indicator

	Leeds	Most Deprived	Least Deprived
* **Life Expectancy at Birth - Males**	**77.8**	**73.0**	**83.0**
* **Life Expectancy at Birth - Females**	**82.0**	**77.6**	**86.9**
1. Improving the health and wellbeing of children and young people:			
Infant mortality rate per 1000 births	5.0	5.7	5.8
* **Reception: Prevalence of obesity (including severe obesity)**	**9.4%**	**#**	**#**
* **Year 6: Prevalence of obesity (including severe obesity)**	**23.3%**	**#**	**#**
Under 18 conception rate/1,000	19.3	#	#
2. Improving the health and wellbeing of adults and preventing early death:			
Smoking Prevalence in adults (18+) - current smokers (APS)	12.4%	#	#
Likelihood of current smoking (self-reported) among adults aged 18-64 with a routine and manual occupation (APS)	1.8	#	#
* **Excess weight in adults % of Adults who have a BMI of over 30**	**24.6%**	**29.4%**	19.8%
* **Percentage of physically inactive adults (aged 19+, <30 moderate intensity minutes per week)**	**34.2%**	**40.1%**	27.1%
* **Prevalence of severe mental illness 18+**	**1,308.5**	**1942.4**	665.5
Gap in the employment rate for those in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (gap - percentage points)	69.2	#	#
Gap in the employment rate between those with a learning disability (aged 18 to 64) and the overall employment rate (gap - percentage points)	67.5	#	#
* **Circulatory disease mortality, all ages, DSR per 100,000**	**235.7**	**344.92**	**156.6**
* **Circulatory disease mortality, under 75, DSR per 100,000**	**77.2**	**132.8**	**40.2**
* **Respiratory mortality, all ages, DSR per 100,000**	**78.0**	**145.3**	**32.5**
* **Respiratory mortality, under 75, DSR per 100,000**	**28.2**	**58.4**	**5.9**
* **Cancer mortality, all ages, DSR per 100,000**	**270.0**	**374.9**	**221.7**
* **Cancer mortality, under 75, DSR per 100,000**	**132.6**	**190.2**	**97.4**
* **Alcoholic liver disease mortality, under 75, DSR per 100,000**	**12.9**	**17.6**	**5.7**
Excess under 75 mortality rate in adults with severe mental illness (SMI)	353.6%	#	#
* **Under 75 mortality rate from causes considered preventable**	**193.3**	**340.0**	**82.4**
3. Protecting health and wellbeing (*protect the health of the local population):			
* **Suicide Rate (persons) (DSR per 100,000)**	**12.1**	**14.1**	**6.4**

5. Developing community health capacity and the wider public health workforce:

- Training and development programmes
- Local community health development
- City wide health determinants

6. Improving the use of Public Health Intelligence in decision making by organisations and the public:

- Health profiling
- Needs assessment
- Social marketing and insight

Operational Indicators

Updated April 2024

		Leeds		Most Deprived		Least Deprived
1 Improving the health and wellbeing of children and young people:						
Breastfeeding maintenance at 6-8 weeks (%)	↓	46.0%	↑	41.7%	↓	59.5%
Best start - number of under 2s taken into care	↑	96	↓	47	↑	<6
2 Improving the health and wellbeing of adults and preventing early death:						
* **Recorded diabetes type 1 and 2 (per 100,000)**	↑	**6,883.4**	↑	**9,817.0**	↑	**4,280.3**
* **Percentage of NHS Health Checks offered which were taken up in the quarter**	↑	**71.4%**	→	**#**	→	**#**
* **Successful completion of drug treatment - opiate users (%)**	↓	**7.3%**	→	**#**	→	**#**
* **Successful completion of alcohol treatment (%)**	↑	**45.8%**	→	**#**	→	**#**
Admission episodes for alcohol-specific conditions - All Ages (Persons, DSR per 100,000)	↑	702.7	↓	1,240.6	↓	243.3
Admission episodes for alcohol-specific conditions - Under 18s (Persons)	↓	5.0	↑	5.7	↓	6.8
Emergency Admissions from Intentional Self-Harm (DSR per 100,000)	↓	107.1	↓	145.4	↓	65.7
Emergency admissions due to falls for aged 65 and over	↓	1,385.7	↓	1,829.5	↓	960.9
3 Protecting health and wellbeing (*protect the health of the local population):						
New HIV diagnosis rate per 100,000 (All ages)	↑	16.2	→	#	→	#
New STI diagnoses (excluding chlamydia aged under 25) per 100,000 (All ages)	↑	437.0	→	#	→	#
4 Support NHS to provide effective and equitable health care service:						
Public Health advice to NHS Commissioners						

5. Developing community health capacity and the wider public health workforce:

- Training and development programmes
- Local community health development
- City wide health determinants

6. Improving the use of Public Health Intelligence in decision making by organisations and the public:

- Health profiling
- Needs assessment
- Social marketing and insight

	Population Indicators	Leeds	Most Deprived	Least Deprived	Latest period	Previous period Leeds	Previous period Most Deprived	Previous period Least Deprived	Previous period	An improving direction is an
	Overarching Indicator									
*	**Life Expectancy at Birth - Males**	**77.8**	**73.0**	**83.0**	**2020-2022**	**77.7**	**72.9**	**82.9**	**2019-2021**	**increase**
*	**Life Expectancy at Birth - Females**	**82.0**	**77.6**	**86.9**	**2020-2022**	**81.8**	**77.4**	**87.2**	**2019-2021**	**increase**
1	**Improving the health and wellbeing of children and young people:**									
	Infant mortality rate per 1000 births	5.0	5.7	5.8	2020-2022	5.0	6.1	5.5	2019-2021	decrease
*	**Reception: Prevalence of Obesity (including severe obesity)**	**9.4%**	**#**	**#**	**2022/23**	**9.9%**	**12.6%**	**7.4%**	**2021/22**	**decrease**
*	**Year 6: Prevalence of Obesity (including severe obesity)**	**23.3%**	**#**	**#**	**2022/23**	**25.0%**	**31.0%**	**15.2%**	**2021/22**	**decrease**
	Under 18 conception rate/1,000	19.3	#	#	2021	19.8	#	#	2020	decrease
2	**Improving the health and wellbeing of adults and preventing early death:**									
	Smoking Prevalence in adults (18+) - current smokers (APS)	12.4%	#	#	2022	12.1%	#	#	2021	decrease
	Likelihood of current smoking (self-reported) among adults aged 18-64 with a routine and manual occupation (APS)	1.8	#	#	2022	1.9	#	#	2021	decrease
*	**Excess weight in adults % of Adults who have a BMI of over 30**	**24.6%**	**29.4%**	**19.8%**	**Q4 2023/24**	**24.5%**	**29.2%**	**19.6%**	**Q3 2023/24**	**decrease**
*	**Percentage of physically inactive adults (aged 19+, <30 moderate intensity minutes per week)**	**34.2%**	**40.1%**	**27.1%**	**Q4 2023/24**	**34.4%**	**40.5%**	**27.5%**	**Q3 2023/24**	**decrease**
*	**Prevalence of severe mental illness 18+**	**1,308.5**	**1942.4**	**665.5**	**Q4 2023/24**	**1,307.0**	**1937.9**	**681.9**	**Q3 2023/24**	**decrease**
	Gap in the employment rate for those in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (gap - percentage points)	69.2	#	#	2020/21	63.7	#	#	2019/20	decrease
	Gap in the employment rate between those with a learning disability (aged 18 to 64) and the overall employment rate (gap - percentage points)	67.5	#	#	2021/22	69.6	#	#	2020/21	decrease
*	**Circulatory disease mortality, all ages, DSR per 100,000**	**235.7**	**344.92**	**156.6**	**2020-2022**	**236.6**	**329.6**	**161.6**	**2019-2021**	**decrease**
*	**Circulatory disease mortality, under 75, DSR per 100,000**	**77.2**	**132.8**	**40.2**	**2020-2022**	**77.9**	**130.0**	**41.4**	**2019-2021**	**decrease**
*	**Respiratory mortality, all ages, DSR per 100,000**	**78.0**	**145.3**	**32.5**	**2020-2022**	**84.4**	**152.9**	**32.6**	**2019-2021**	**decrease**
*	**Respiratory mortality, under 75, DSR per 100,000**	**28.2**	**58.4**	**5.9**	**2020-2022**	**30.9**	**65.7**	**5.6**	**2019-2021**	**decrease**
*	**Cancer mortality, all ages, DSR per 100,000**	**270.0**	**374.9**	**221.73**	**2020-2022**	**277.0**	**394.0**	**212.8**	**2019-2021**	**decrease**
*	**Cancer mortality, under 75, DSR per 100,000**	**132.6**	**190.2**	**97.35**	**2020-2022**	**138.2**	**205.6**	**90.8**	**2019-2021**	**decrease**
*	**Alcoholic liver disease mortality, under 75, DSR per 100,000**	**12.9**	**17.6**	**5.7**	**2020-2022**	**12.4**	**19.6**	**5.2**	**2019-2021**	**decrease**
	Excess under 75 mortality rate in adults with severe mental illness (SMI)	354%	#	#	2018-20	380%	#	#	2017-19	decrease
*	**Under 75 mortality rate from causes considered preventable**	**193.3**	**340.0**	**82.4**	**2020-2022**	**198.2**	**353.5**	**79.6**	**2019-2021**	**decrease**
3	**Protecting health and wellbeing (*protect the health of the local population):**									
*	**Suicide Rate (persons) (DSR per 100,000)**	**12.1**	**14.1**	**6.4**	**2020-22**	**13.7**	**19.1**	**6.7**	**2019-21**	**decrease**

Operational Indicators		Leeds		Most Deprived		Least Deprived	Latest period	Previous period Leeds	Previous period Deprived	Previous period Least Deprived	Previous period	An improving direction is an
1	**Improving the health and wellbeing of children and young people:**											
	Breastfeeding maintenance at 6-8 weeks (%)	46.0%		41.7%		59.5%	2022/23	48.4%	41.3%	61.0%	2021/22	increase
	Best start - number of under 2s taken into care	96		47		<6	2021/22	94	55	0	2020/21	decrease
2	**Improving the health and wellbeing of adults and preventing early death:**											
*	**Recorded diabetes type 1 and 2 (per 100,000)**	**6,883.4**		**9,817.0**		**4,280.3**	**Q4 2023/24**	**6,851.3**	**9768.6**	**4,268.4**	**Q3 2023/24**	**increase**
*	**Percentage of NHS Health Checks offered which were taken up in the quarter**	**71.4%**		**#**		**#**	**2023/24 Q4**	**53.4%**	**#**	**#**	**2023/24 Q3**	**increase**
*	**Successful completion of drug treatment - opiate users (%)**	**7.3%**		**#**		**#**	**2022**	**7.9%**	**#**	**#**	**2021**	**increase**
*	**Successful completion of alcohol treatment (%)**	**45.8%**		**#**		**#**	**2022**	**43.1%**	**#**	**#**	**2021**	**increase**
	Admission episodes for alcohol-specific conditions - All Ages (Persons, DSR per 100,000)	702.7		1,240.6		243.3	2021-2022	687.5	1313.7	219.7	2020-2021	decrease
	Admission episodes for alcohol-specific conditions - Under 18s (Persons)	5.0		5.7		6.8	2019-2021	6.3	5.1	7.2	2018-2020	decrease
	Emergency Admissions from Intentional Self-Harm (DSR per 100,000)	107.1		145.4		65.7	2021-2022	150.0	236.5	68.5	2020-2021	decrease
	Emergency admissions due to falls for aged 65 and over	1,385.7		1,829.5		960.9	2021-2022	1,796.1	2405.6	1,303.3	2020-2021	decrease
3	**Protecting health and wellbeing (*protect the health of the local population):**											
	New HIV diagnosis rate per 100,000 (All ages)	16.2		#		#	2022	8.9	#	#	2021	decrease
	New STI diagnoses (excluding chlamydia aged under 25) per 100,000 (All ages)	437.0		#		#	2022	370.0	#	#	2021	decrease

Notes

* **Indicators marked with an asterisk have been updated April 2023.**

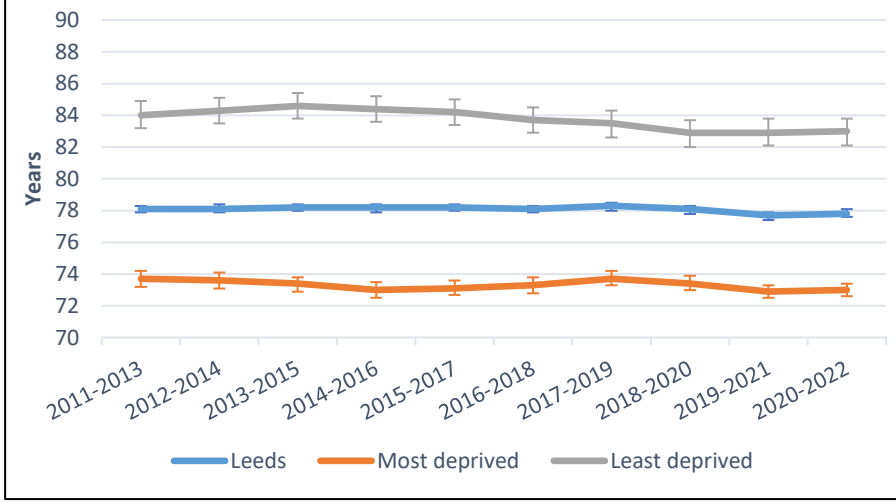
\# **Data at LSOA level is unavailable, Deprived data cannot be calculated.**

"Most Deprived" is the population of Leeds living in an area ranking in the 10% most deprived nationally, "Least Deprived" is the 10% least deprived nationally. There is an exception for child obesity indicators which use 20% most deprived and 20% least deprived to align with the ntaional Child Measurement Programme.

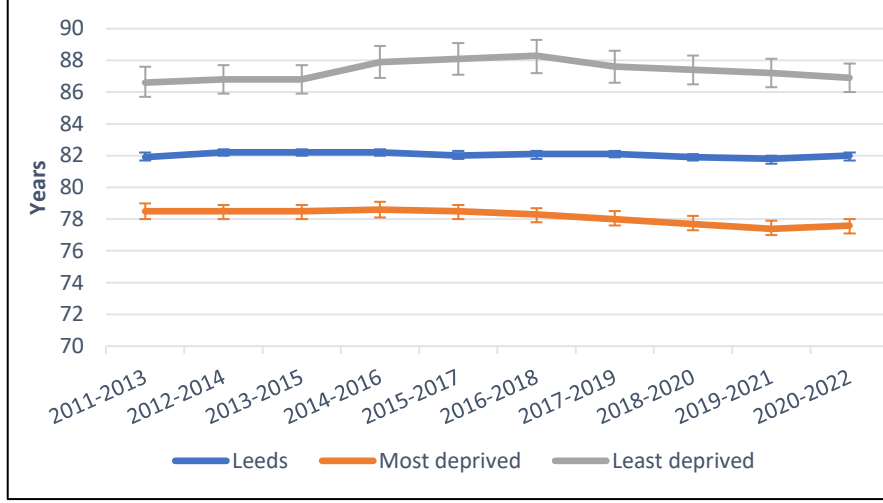
Population' and 'Operational' indicators are defined as follows. Population level indicators are health outcomes (i.e. Increased life expectancy, Reduced premature mortality, People living healthier lifestyles). Operational indicators are measures of service delivery or health intervention, and the outcome of that service delivery or health intervention (i.e. breast feeding initiation, and continuation at 6-8 wks, health checks and numbers on diabetes register, completion of alcohol dependency treatment and admission to hospital for alcohol harm). Please note that providing a Leeds Deprived split is not possible for all indicators.

Indicators marked with an asterisk * and with a blue heading have been updated in April 2024

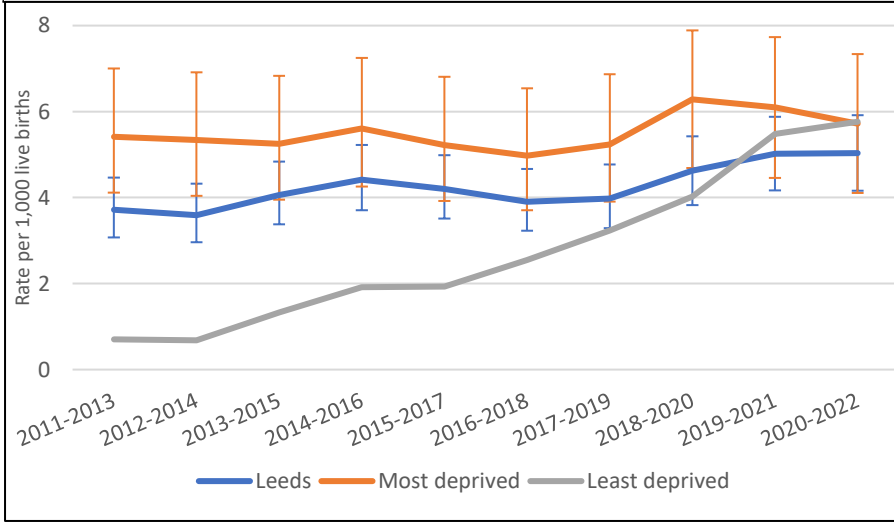
*Life Expectancy at Birth - Males



*Life Expectancy at Birth - Females

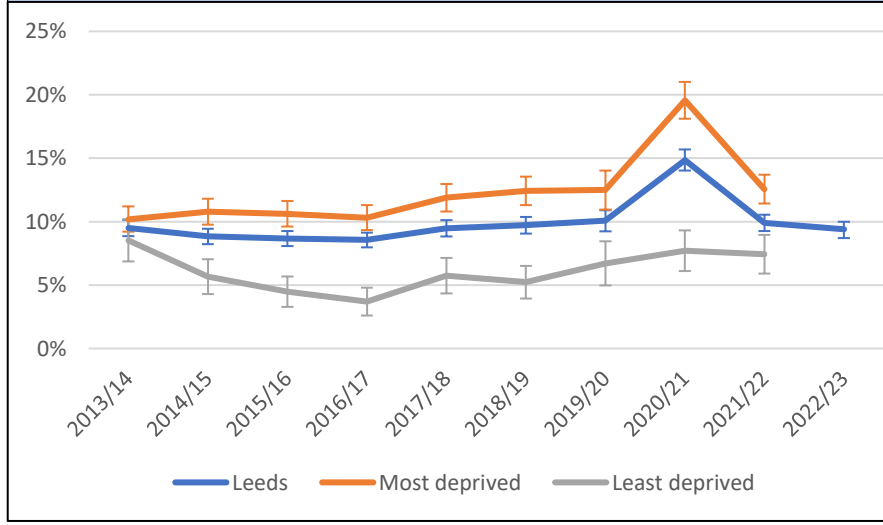


Infant mortality rate (per 1000 live births)



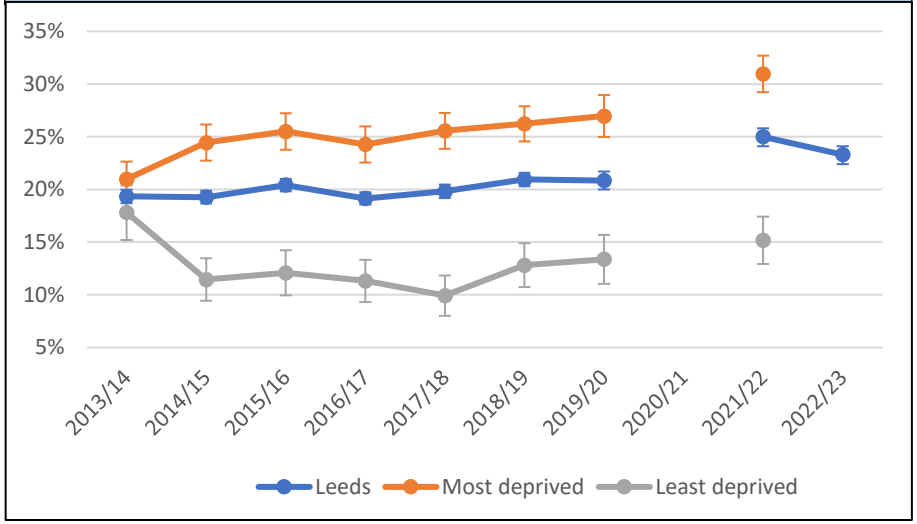
Number of deaths for 2019-2021 is under 8.

*Reception: Prevalence of Obesity (including severe obesity)



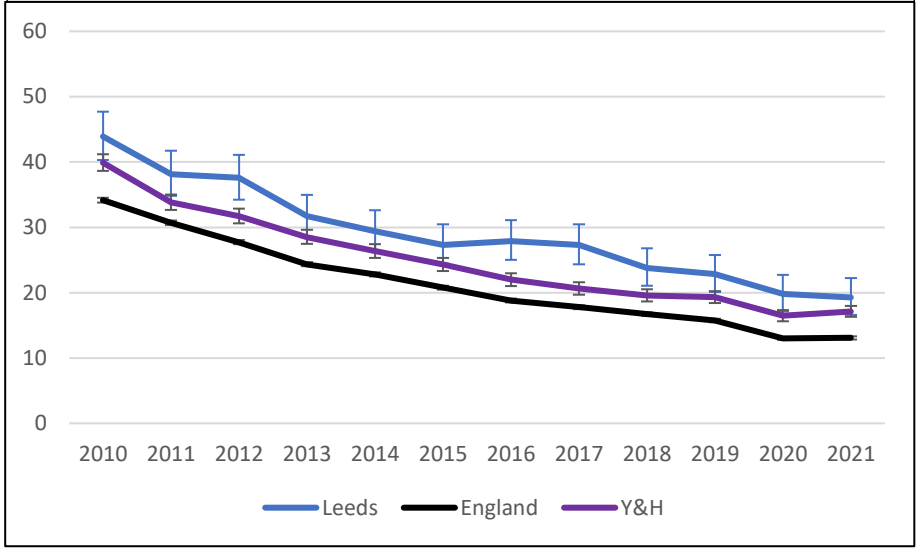
All locally calculated sub-Leeds level 22/23 data was under review and not available for circulation at time of update

*Year 6: Prevalence of Obesity (including severe obesity)



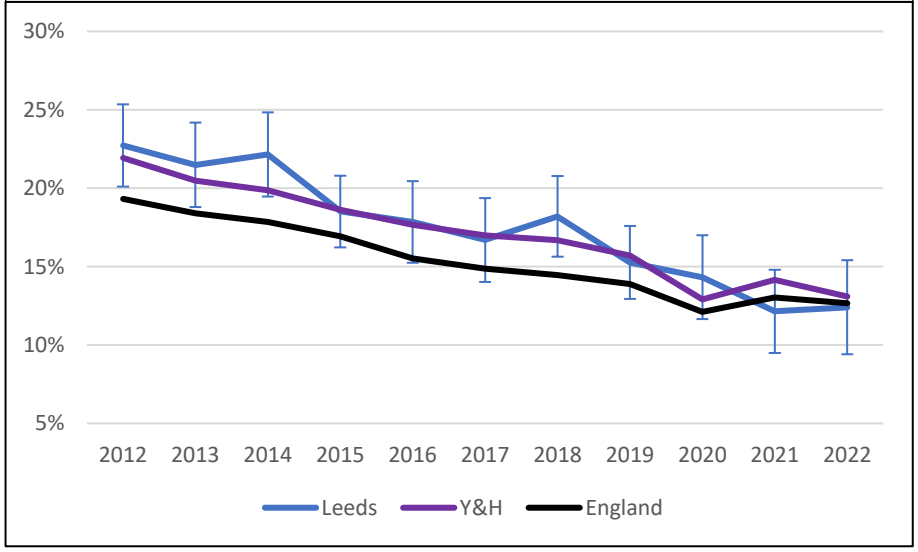
Data unavailable in 2020/21 due to school closures. All locally calculated sub-Leeds level 22/23 data was under review and not available for circulation at time of update

Under 18 conception rate (per 1,000)

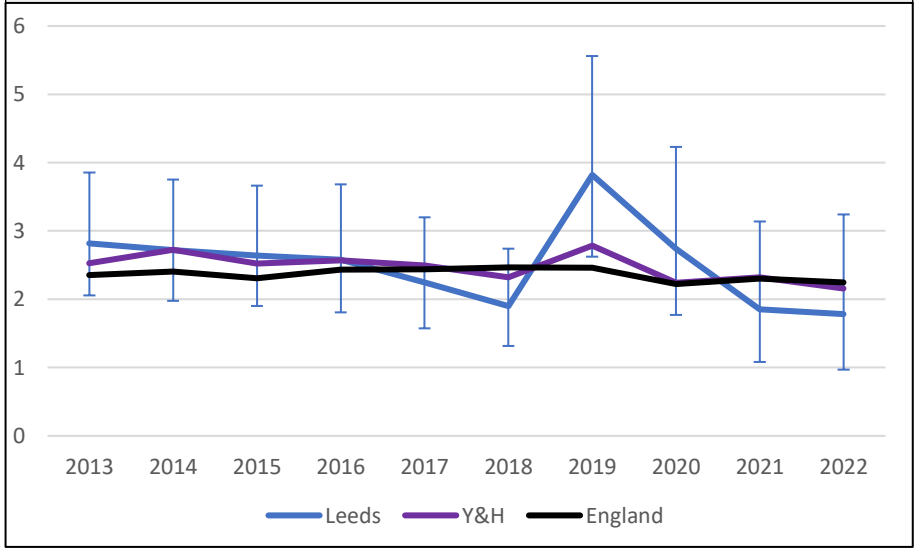


Where Leeds inequalities data not available, regional and national comparators presented.

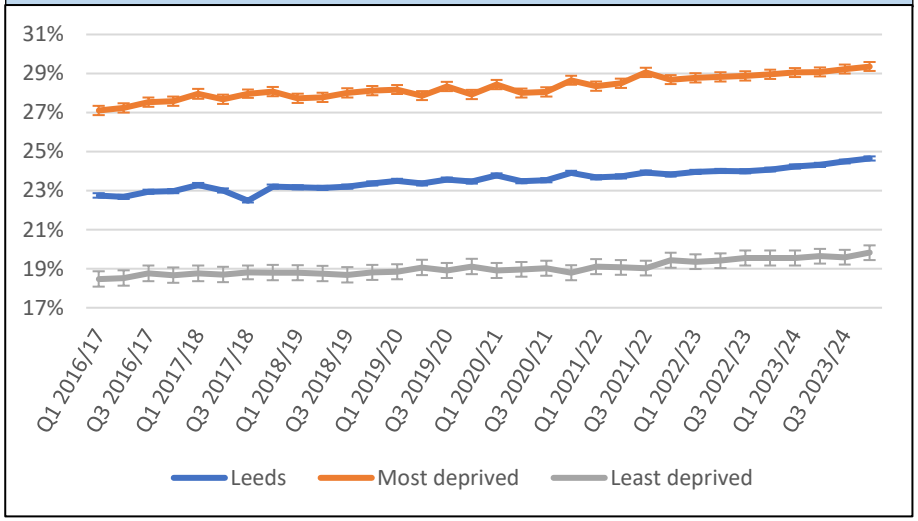
Smoking Prevalence in adults (18+) - current smokers (APS) (Proportion%)



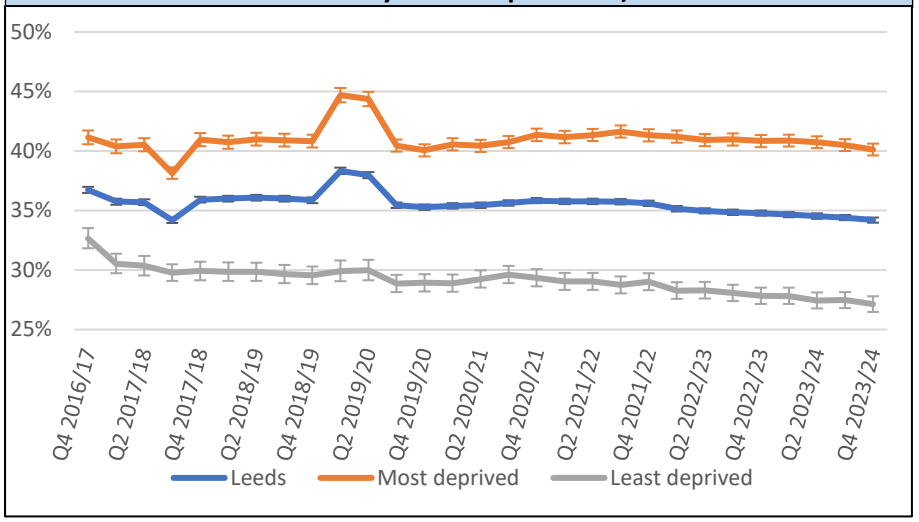
Likelihood of current smoking (self-reported) among adults aged 18-64 with a routine and manual occupation (APS)



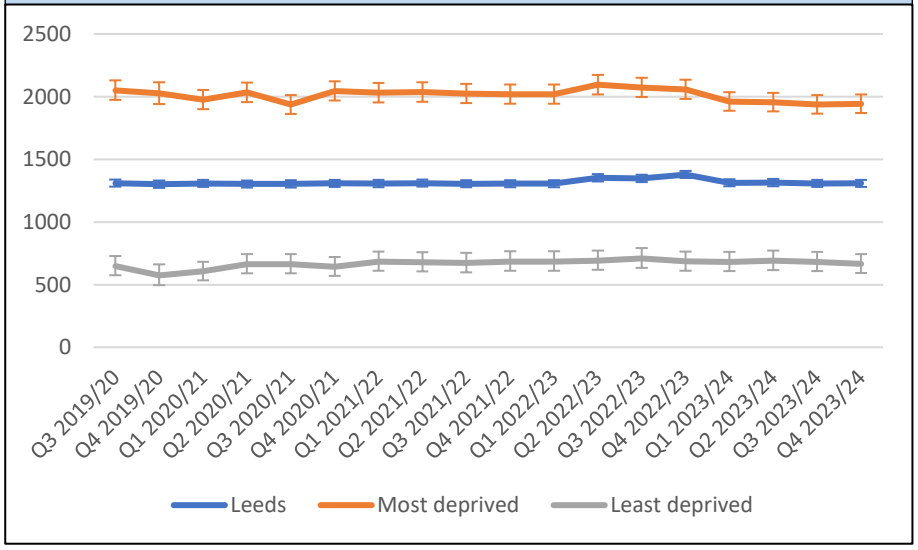
*Excess weight (obesity) in adults % of Adults who have a BMI of over 30



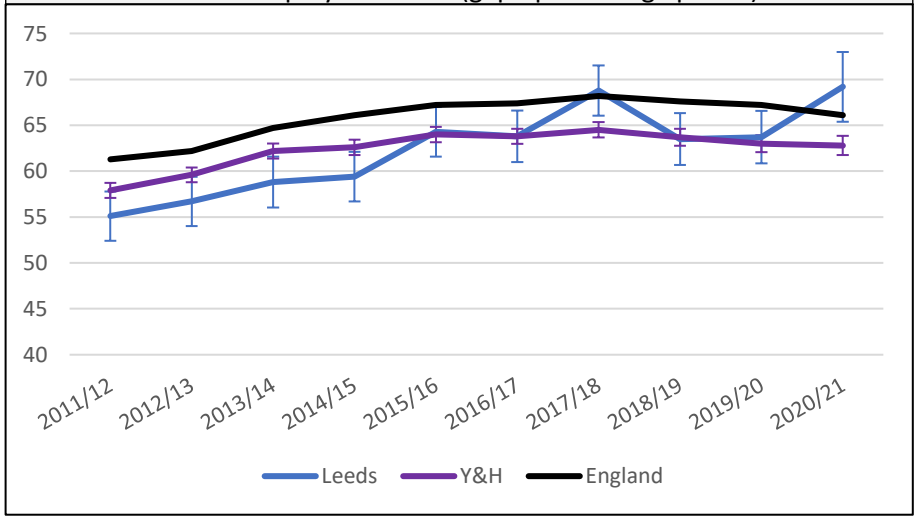
* Percentage of physically inactive adults (aged 19+, <30 moderate intensity minutes per week)



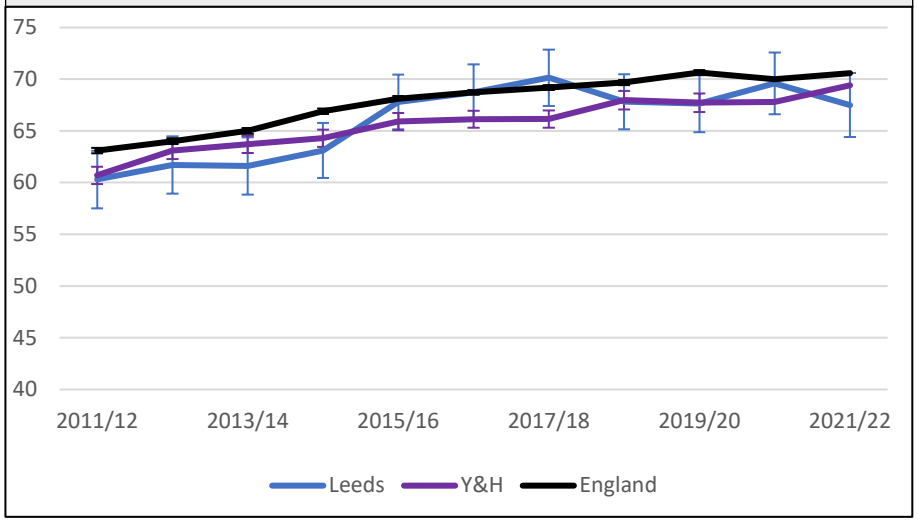
*Prevalence of Severe Mental Illness 18+ (DSR per 100,000)



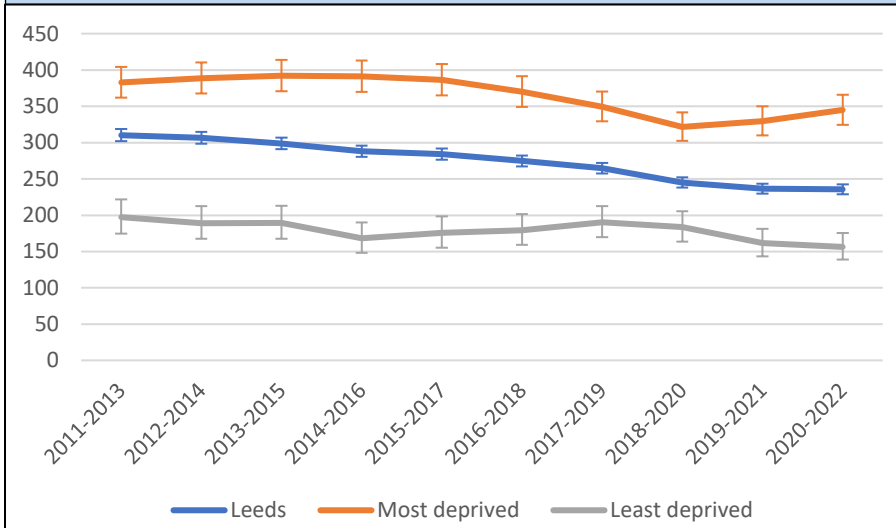
Gap in the employment rate for those in contact with secondary mental health services (aged 18 to 69) and on the Care Plan Approach, and the overall employment rate (gap - percentage points)



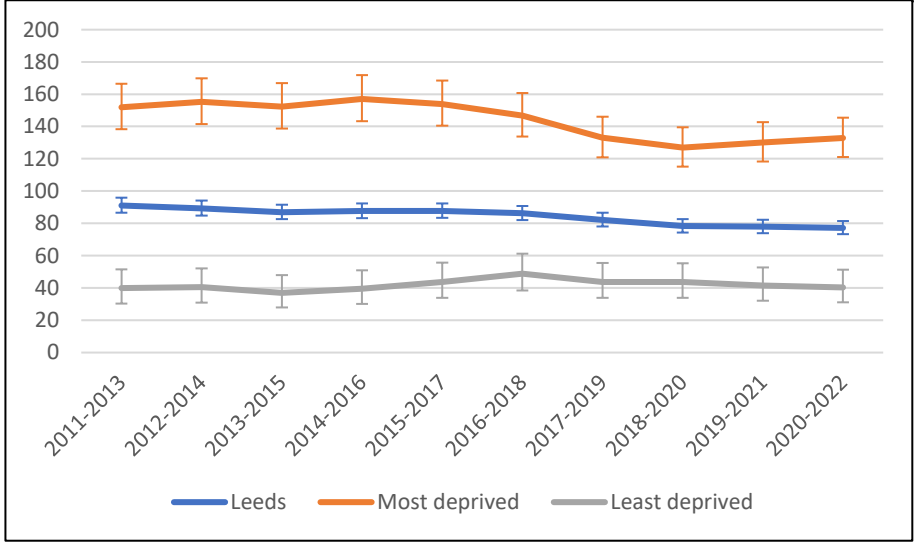
Gap in the employment rate between those with a learning disability (aged 18 to 64) and the overall employment rate (gap - percentage points)



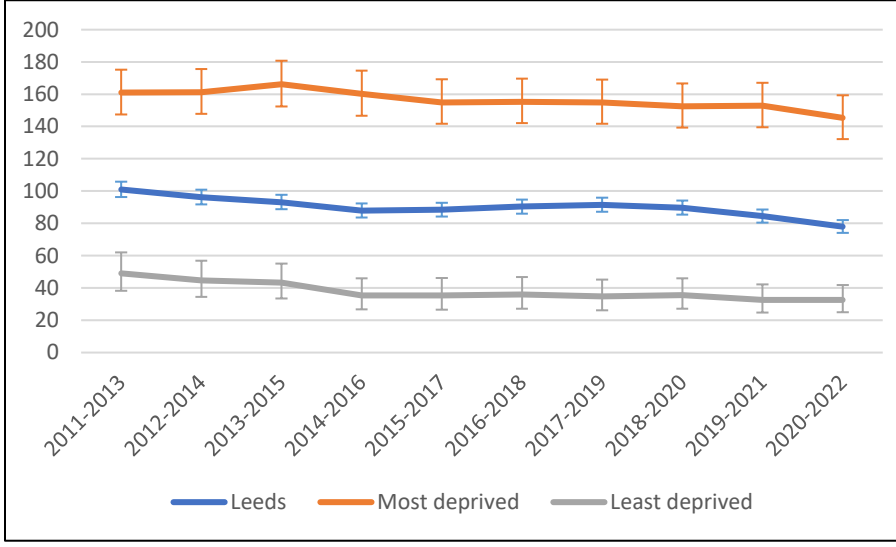
***Circulatory disease mortality, all ages (DSR per 100,000)**



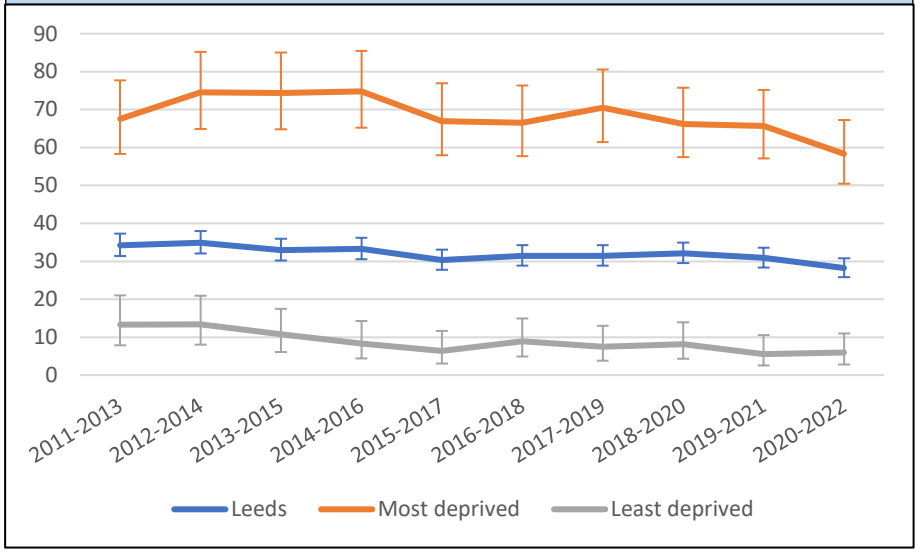
***Circulatory disease mortality, under 75 (DSR per 100,000)**



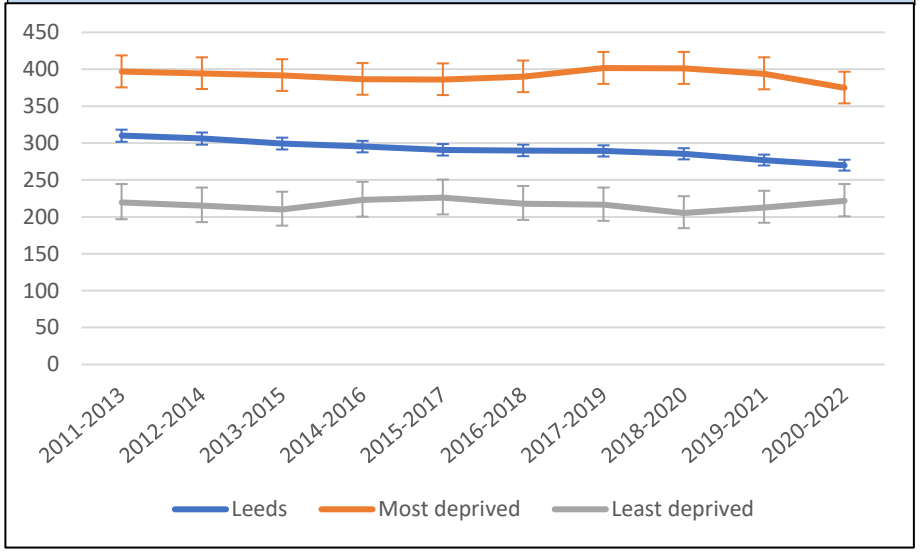
***Respiratory mortality, all ages (DSR per 100,000)**



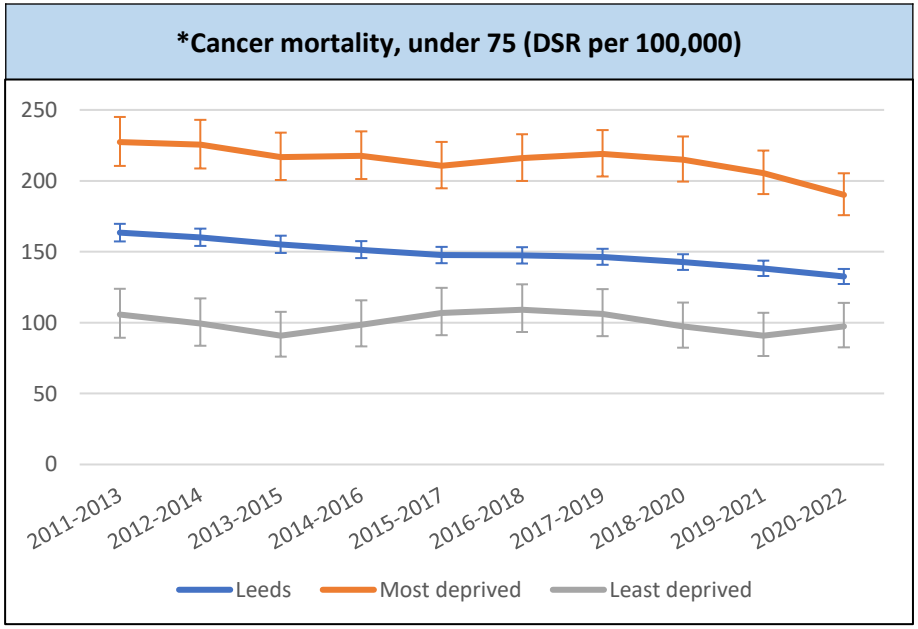
*Respiratory mortality, under 75 (DSR per 100,000)



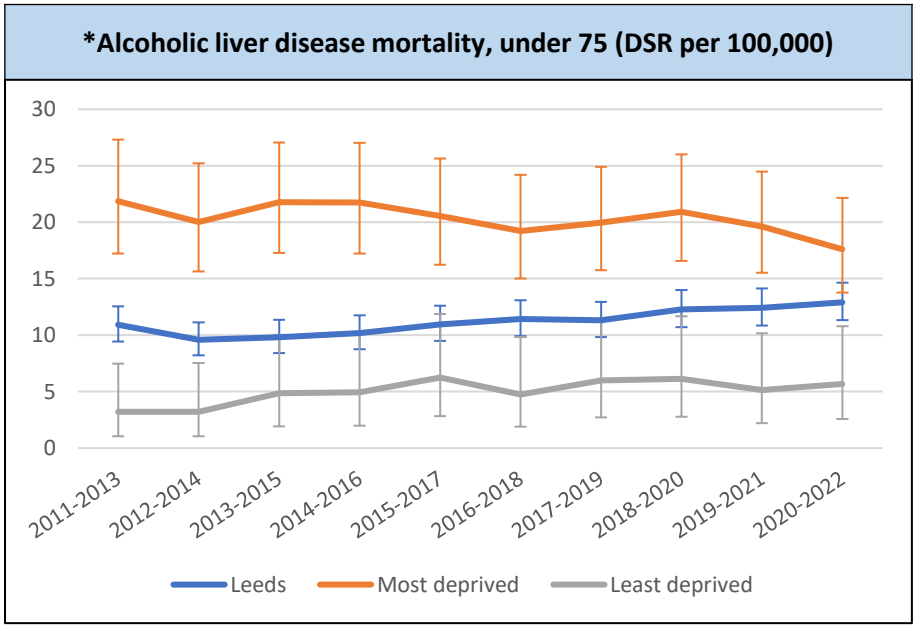
*Cancer mortality, all ages (DSR per 100,000)



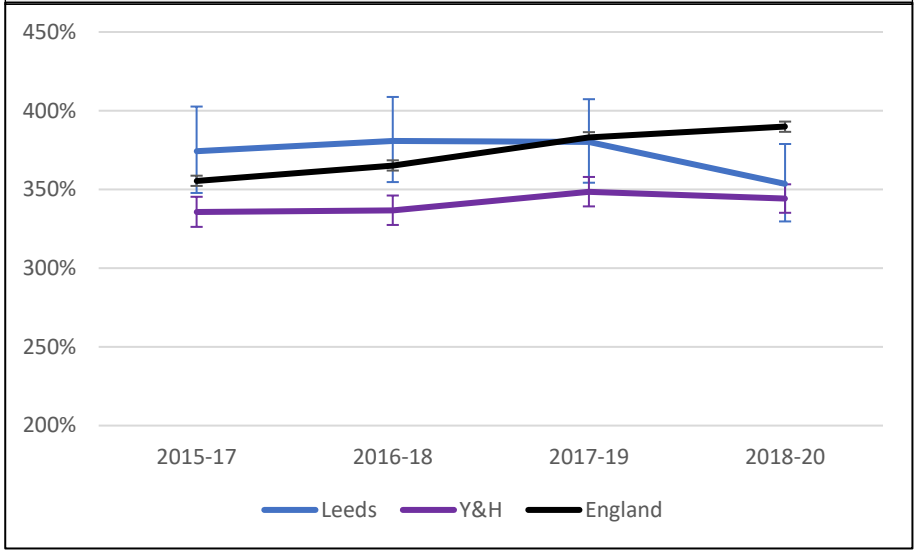
*Cancer mortality, under 75 (DSR per 100,000)



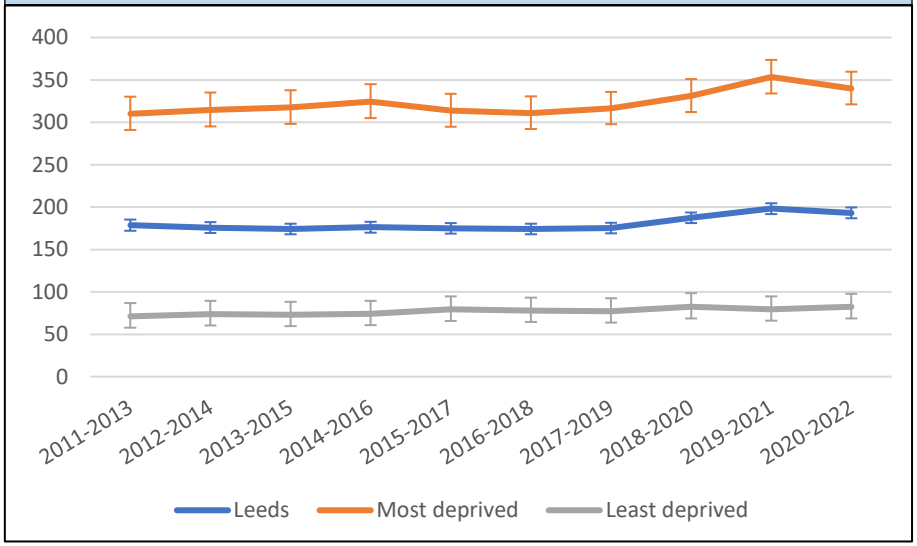
*Alcoholic liver disease mortality, under 75 (DSR per 100,000)



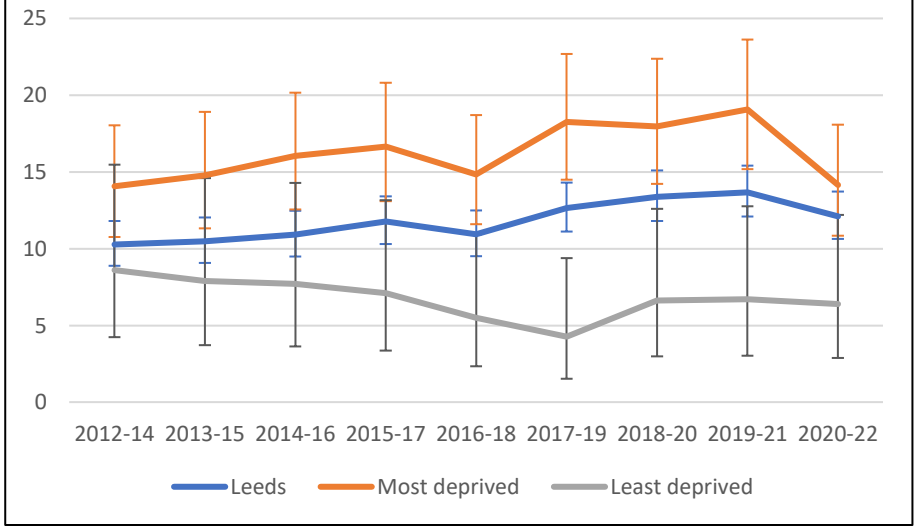
Excess under 75 mortality rate in adults with severe mental illness (SMI) (Excess risk %)



***Under 75 mortality rate (DSR per 100,000) from causes considered preventable**

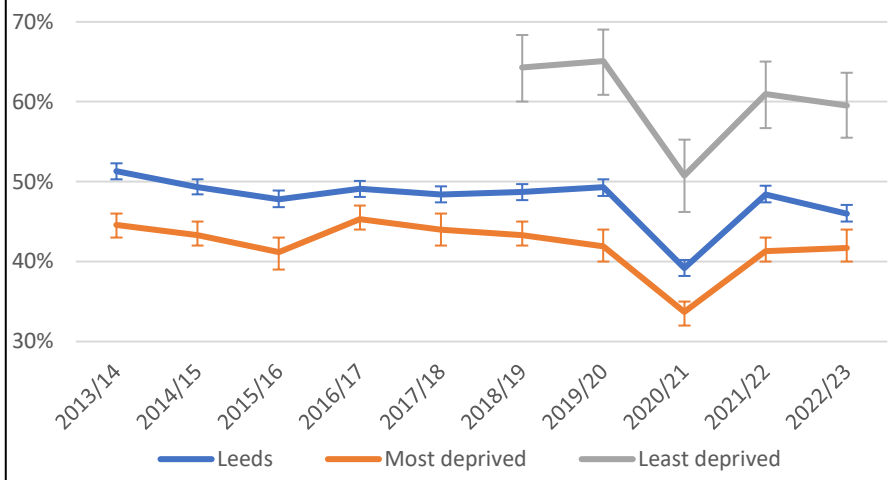


***Suicide, 3 year average rate (DSR per 100,000)**



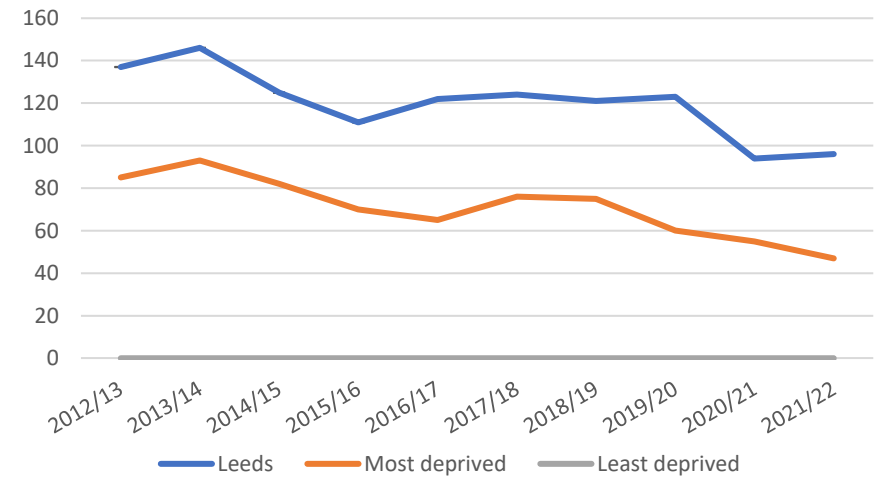
Operational Indicators

Breastfeeding maintenance at 6-8 weeks (%)



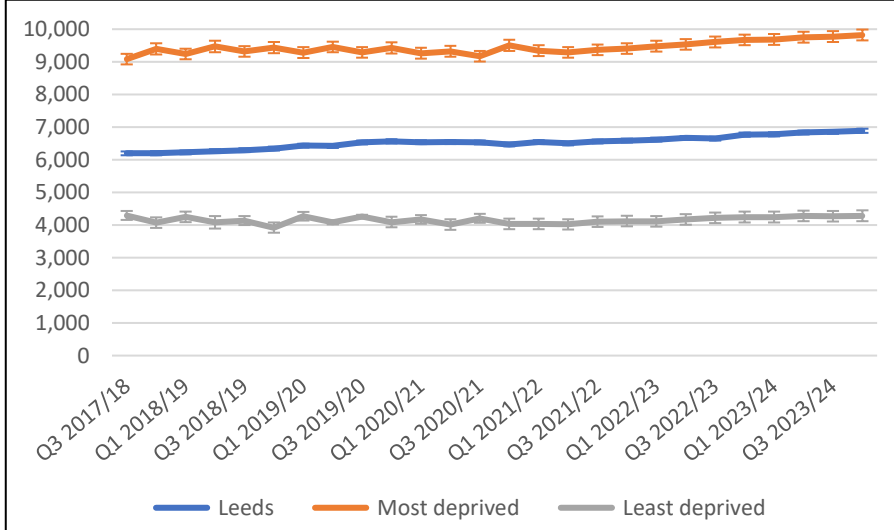
‡Data sourced from LCH and unavailable prior to 2018/19

Best start - number of under 2s taken into care‡

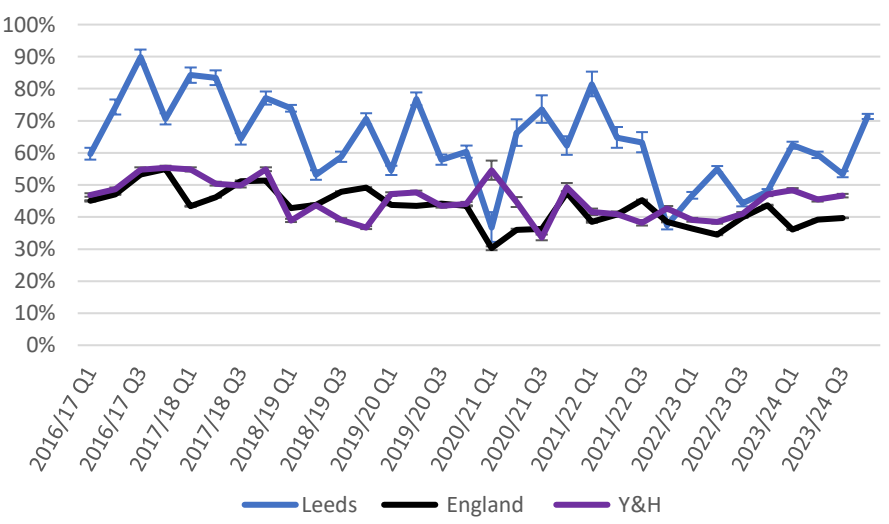


‡Care starts in the least deprived has remained under 5

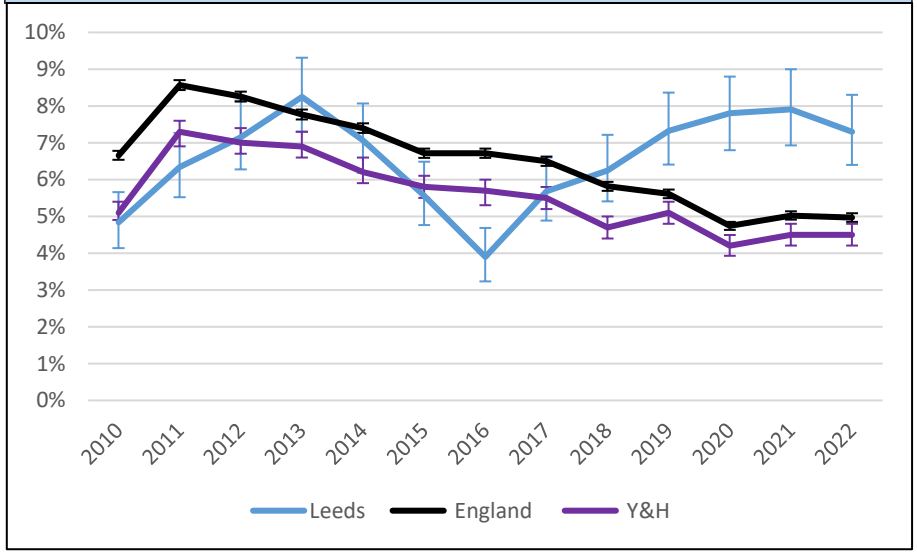
*Recorded diabetes type 1 and 2 (per 100,000)



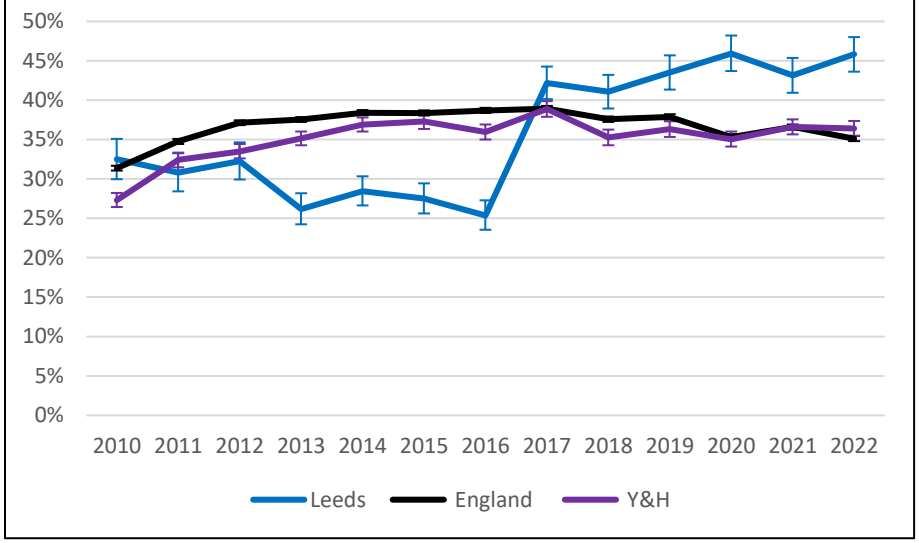
*Percentage of NHS Health Checks offered which were taken up in the quarter (%)



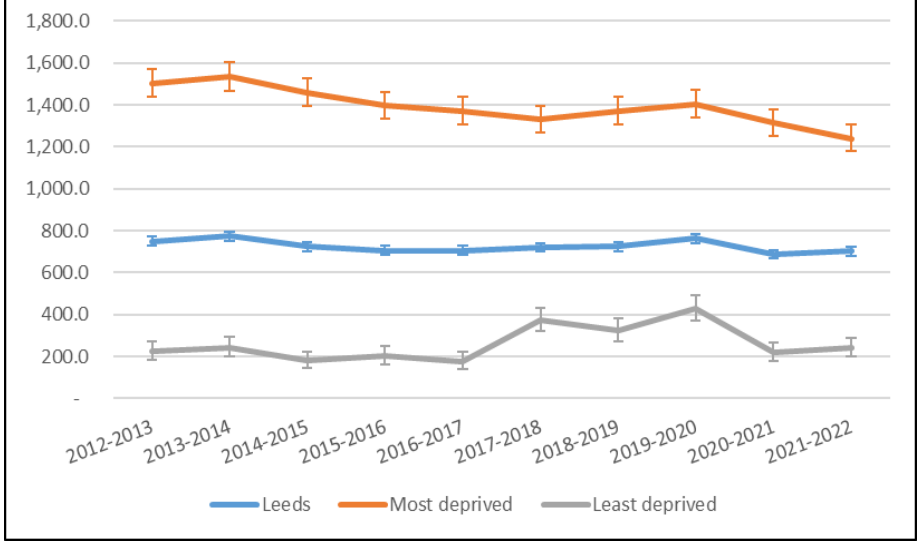
*Successful completion of drug treatment - opiate users (%)



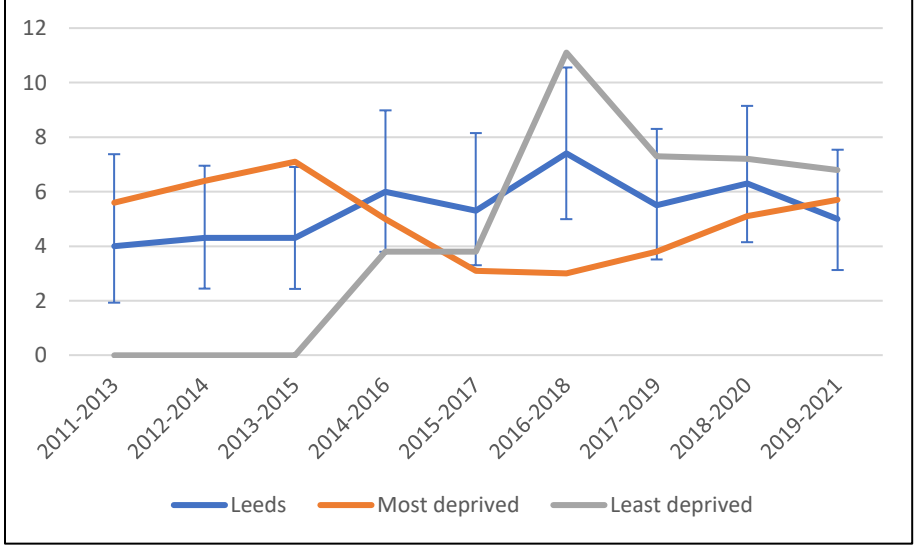
*Successful completion of alcohol treatment (%)



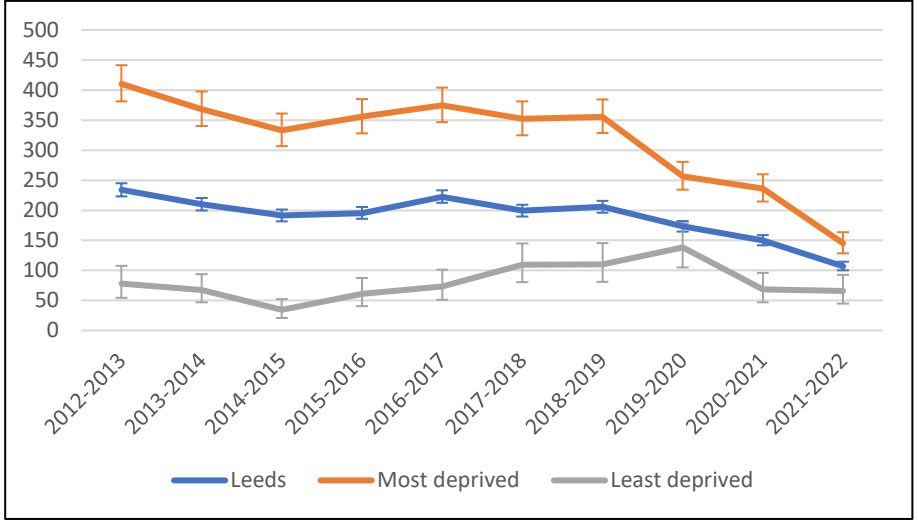
Admission episodes for alcohol-specific conditions - All Ages (Persons, DSR per 100,000)



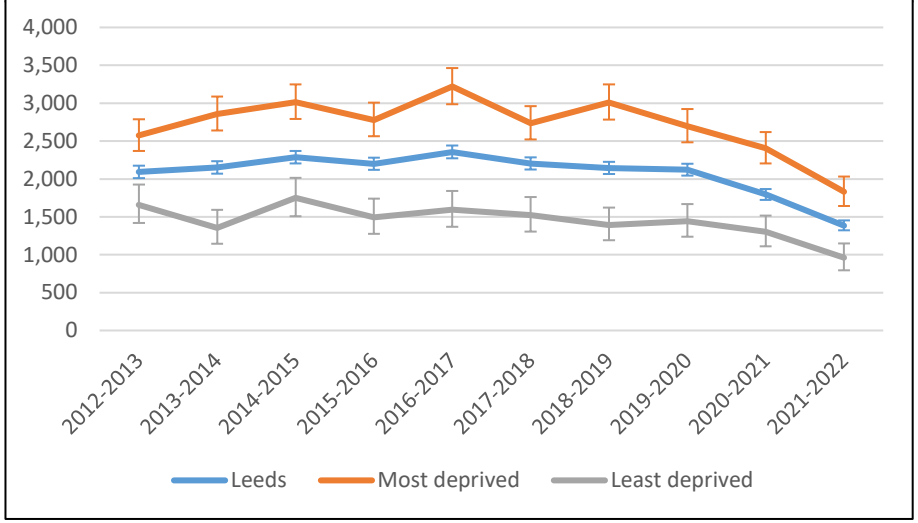
Admission episodes for alcohol-specific conditions - Under 18s (Persons)



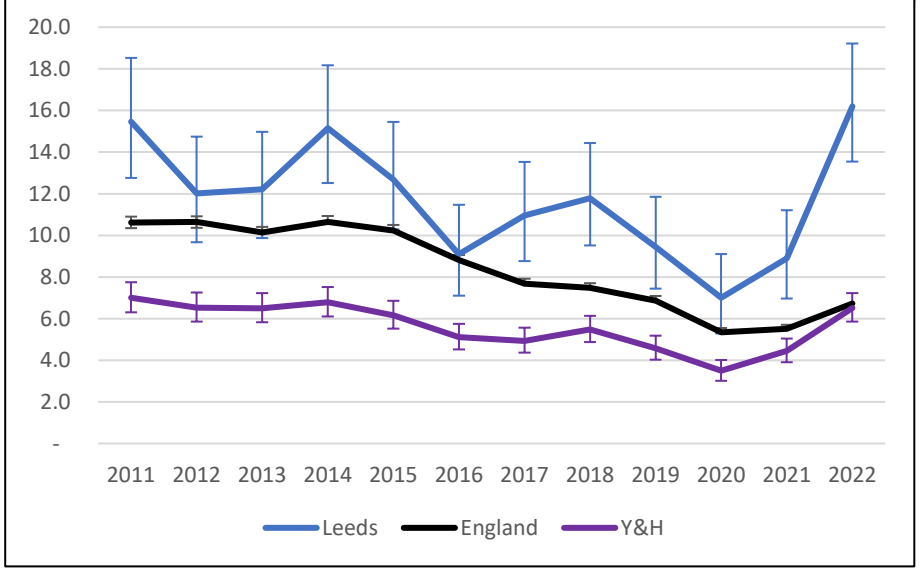
Emergency Admissions from Intentional Self-Harm (DSR per 100,000)



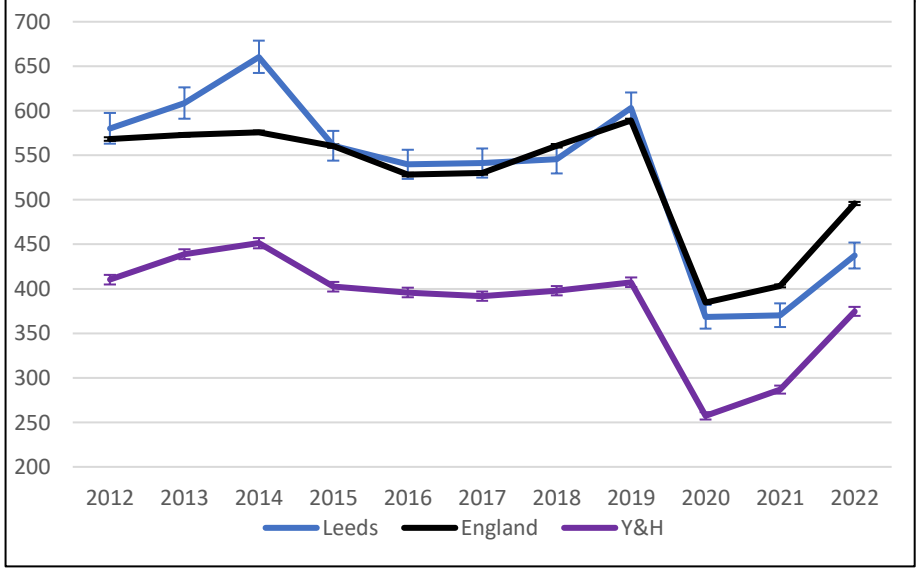
Emergency admissions due to falls for aged 65 and over (DSR per 100,000)



New HIV diagnosis (Crude rate per 100,000) (All ages)



New STI diagnoses (excluding chlamydia aged under 25) Crude rate per 100,000 (All ages)



Appendix 1c - Core Cities Comparison Report

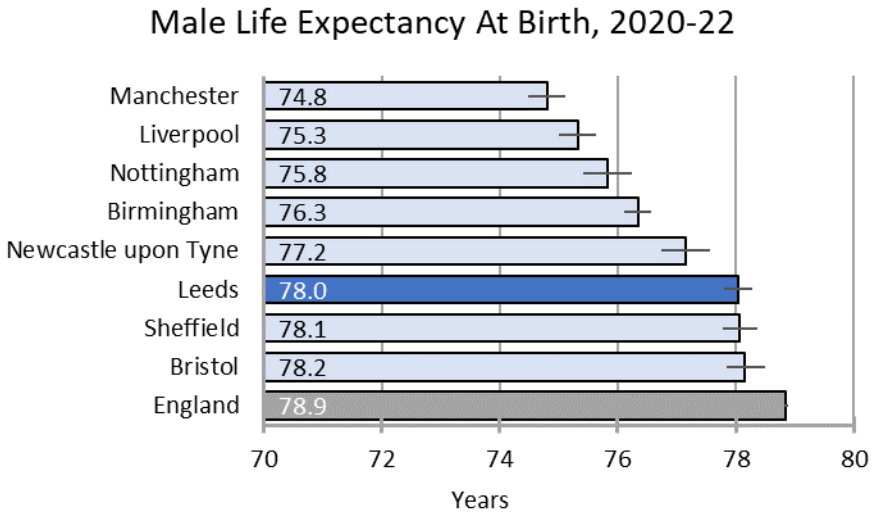
This report compares Leeds data against the seven other major English cities ('Core Cities'). It complements the Public Health performance report (June 2024) and therefore only includes analysis of indicators that were updated locally in Quarter 3 2023/24

The data contained in this appendix is sourced from the Office for Health Improvement & Disparities (OHID) Fingertips website [1]. *Nationally provided intelligence does not provide comparisons between populations within Leeds and alternate local data sources may provide more timely reporting.*

In some cases there may be a slight difference in the rates reported in this appendix and the main Public Health performance report due to:

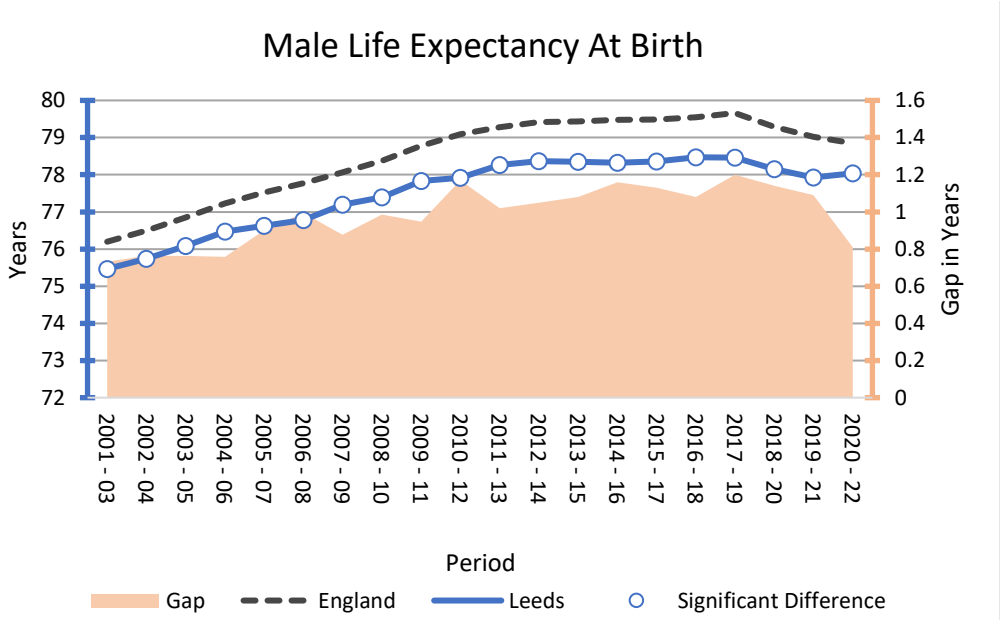
- The population baseline estimates used in the local reporting differing slightly (i.e. using LSOA level 2021 population estimates rather than 2022 Local Authority level) to be able to compare the rates for the most and least deprived neighbourhood in Leeds, and/or
- In some cases local data is reported on a quarterly basis whereas the Core Cities data is based on an annual figure, and/or
- In some cases a slightly different definition may be used for the indicator.

Figure 1: Life expectancy at birth (Male)



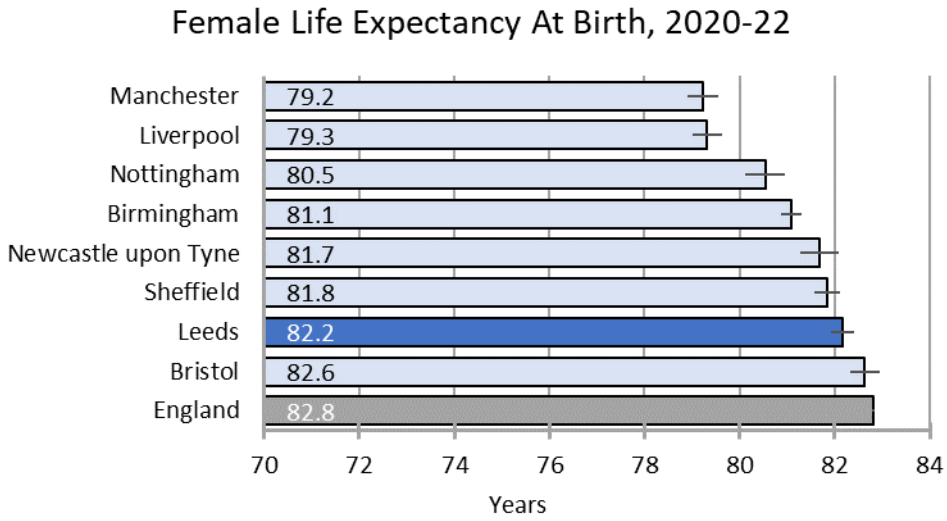
Male life expectancy at birth in Leeds is statistically significantly lower than in England. However, it is also statistically significantly higher than five other Core Cities.

Figure 2: Life expectancy at birth (Male) Trend



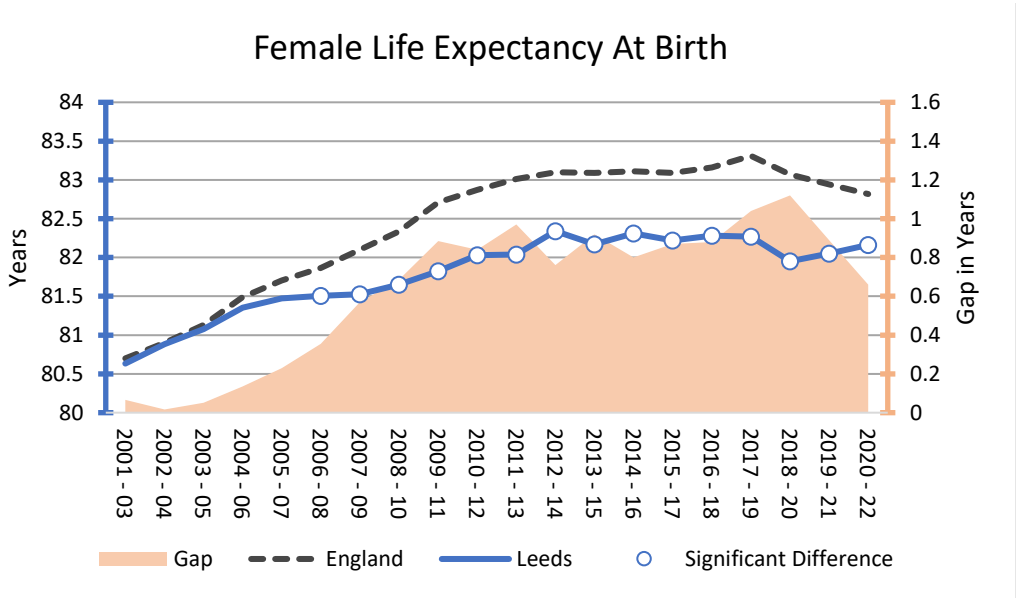
Male life expectancy at birth in Leeds has marginally increased in the latest period. Life expectancy in England has declined/worsened. The gap between Leeds and England has therefore reduced/improved.

Figure 3: Life expectancy at birth (Female)



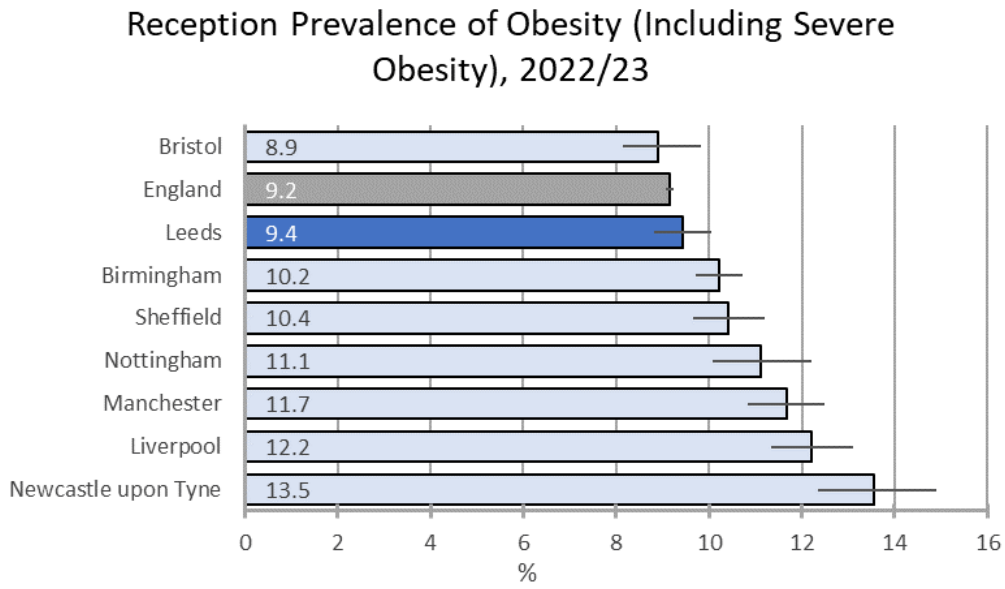
Female life expectancy at birth is statistically significantly lower in Leeds than in England. It is also statistically significantly higher/better than four other Core Cities.

Figure 4: Life expectancy at birth (Female) Trend



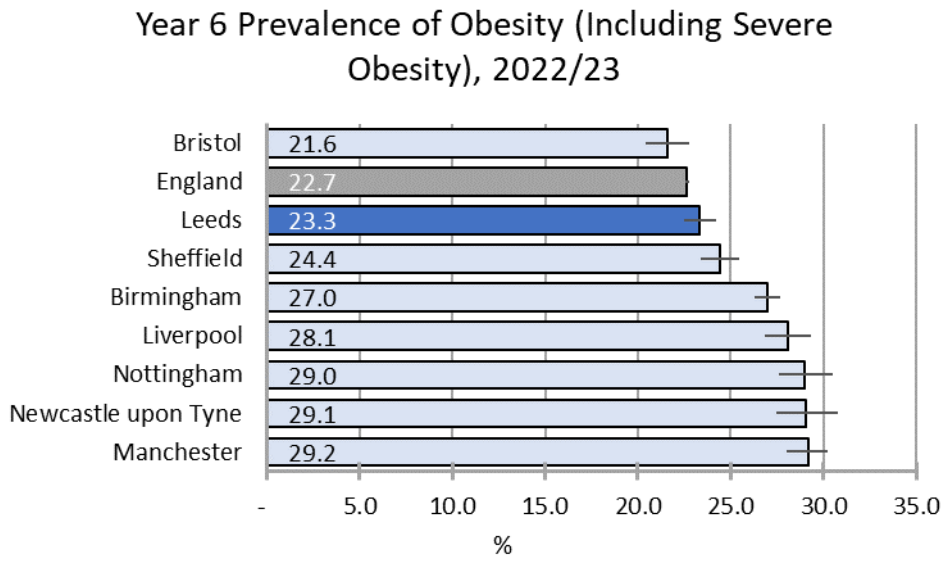
Female life expectancy at birth in Leeds has increased, while in England it has worsened/decreased in the latest period. The gap between Leeds and England has reduced/improved.

Figure 5: Reception: Prevalence of obesity (including severe obesity)



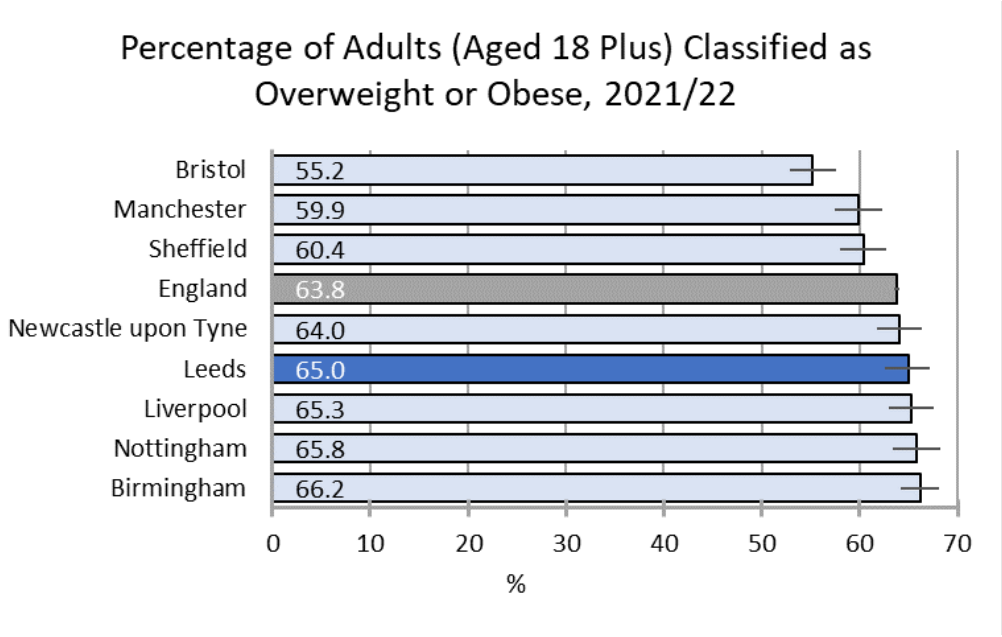
Reception obesity (including severe obesity) in Leeds is similar to England. Leeds has the second lowest / best Core Cities rates, with four Core Cities statistically significantly higher than Leeds.

Figure 6: Year 6: Prevalence of obesity (including severe obesity)



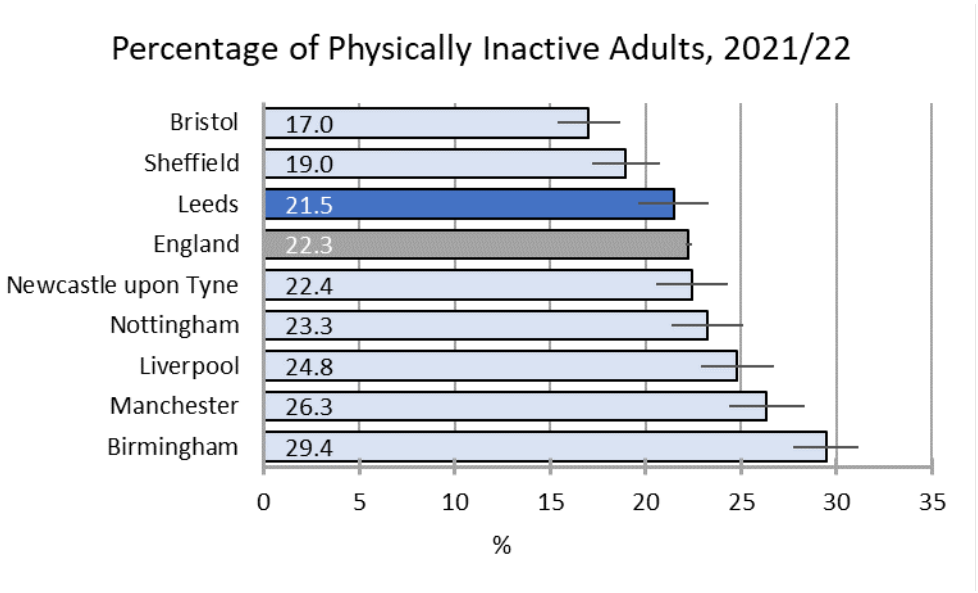
Year 6: Prevalence of obesity (including severe obesity) in Leeds is similar to England. Leeds has the second lowest / best Core Cities rates, with five Core Cities statistically significantly higher/worse than Leeds.

Figure 7: Percentage of Adults (Aged 18 Plus) Classified as Overweight or Obese



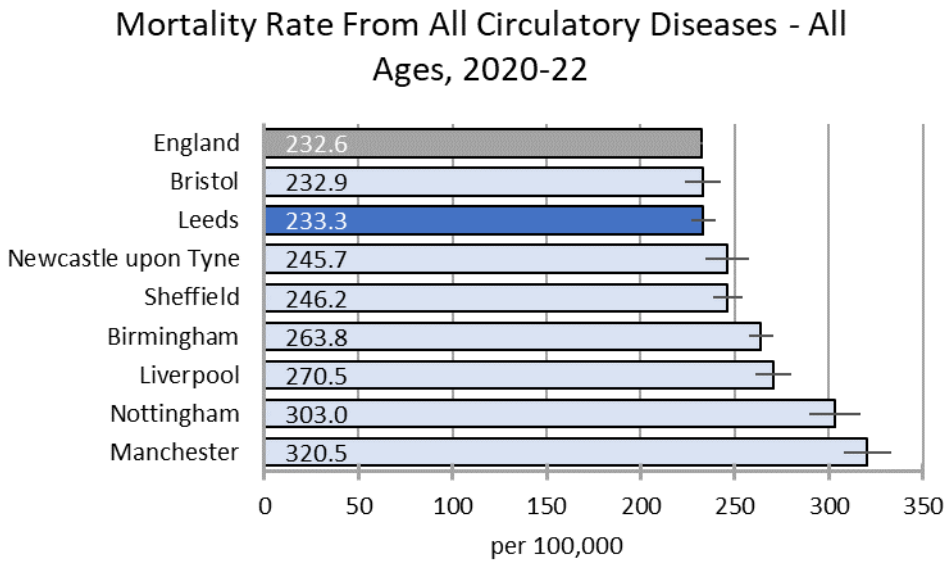
The percentage of Adults (Aged 18 Plus) classified as overweight or obese in Leeds is similar to England. It is only statistically significantly higher /worse than two other core cities, Manchester and Bristol.

Figure 8: Percentage of physically inactive adults (national survey data)



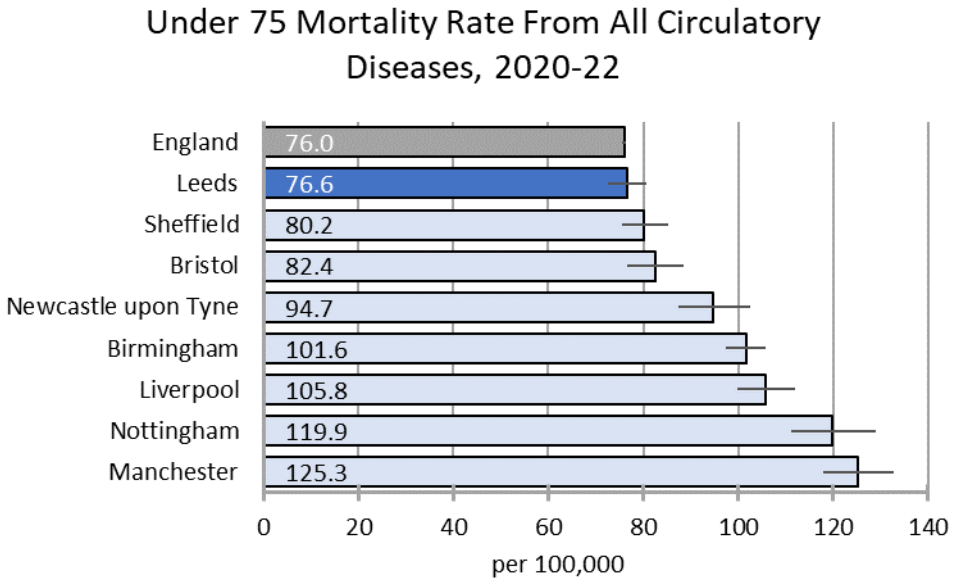
The percentage of physically inactive adults in Leeds is similar to England and the third lowest/best among Core cities.

Figure 9: Mortality rate from circulatory, all ages



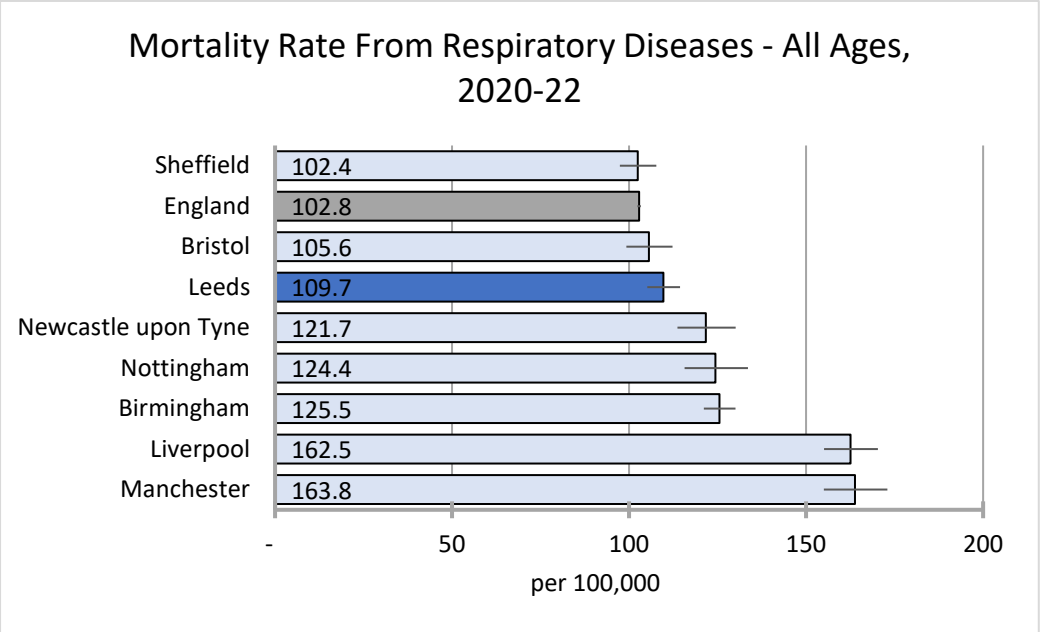
Mortality rates from all circulatory diseases in Leeds are similar to England overall. They are lower/better than five other core cities.

Figure 10: Under 75 mortality rate from all circulatory diseases



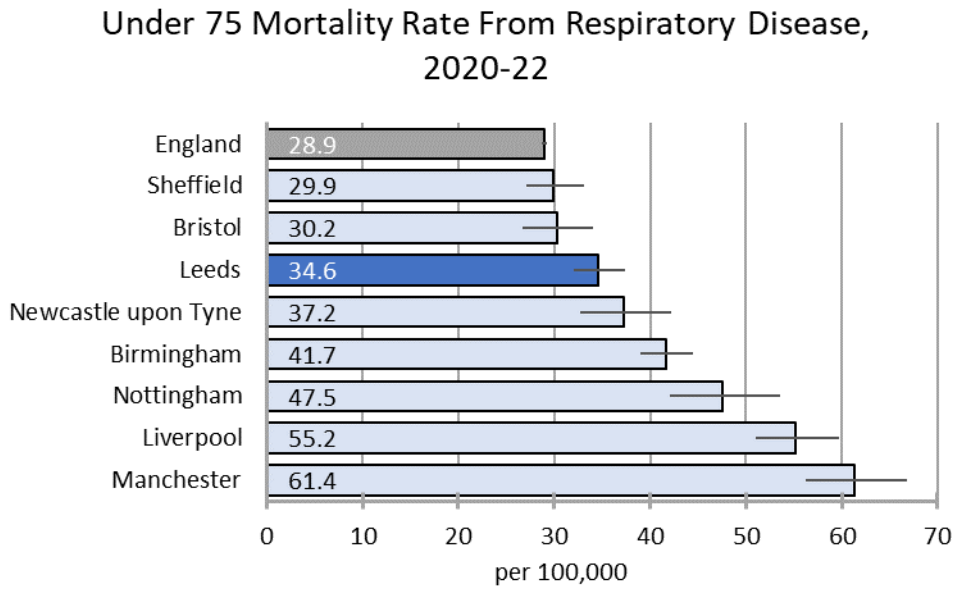
The under 75 mortality rate from all circulatory diseases in Leeds is the lowest / best among Core cities and similar to England.

Figure 11: Mortality rate from respiratory disease, all age (including influenza and pneumonia)



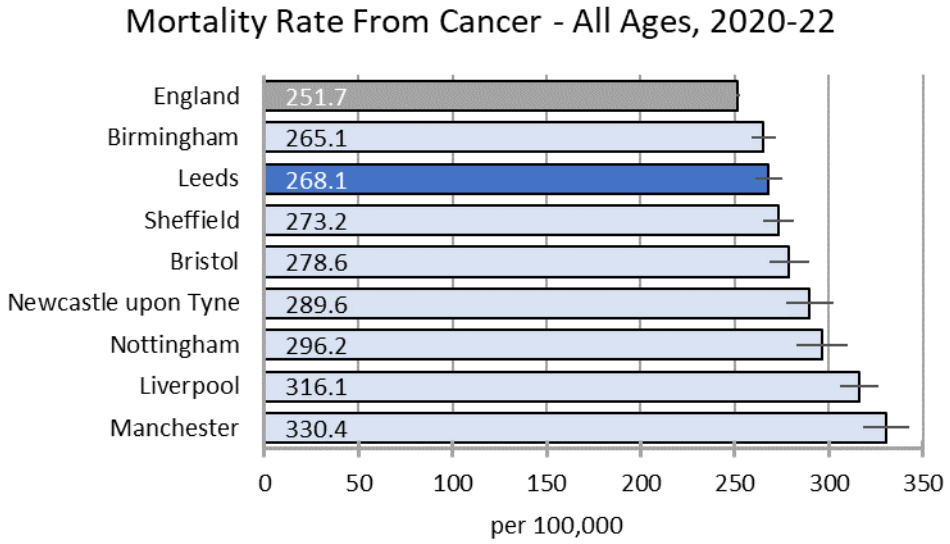
Mortality rates from all respiratory diseases in Leeds are higher than England overall. They are lower/better than five other core cities.

Figure 12: Under 75 mortality rate from respiratory disease



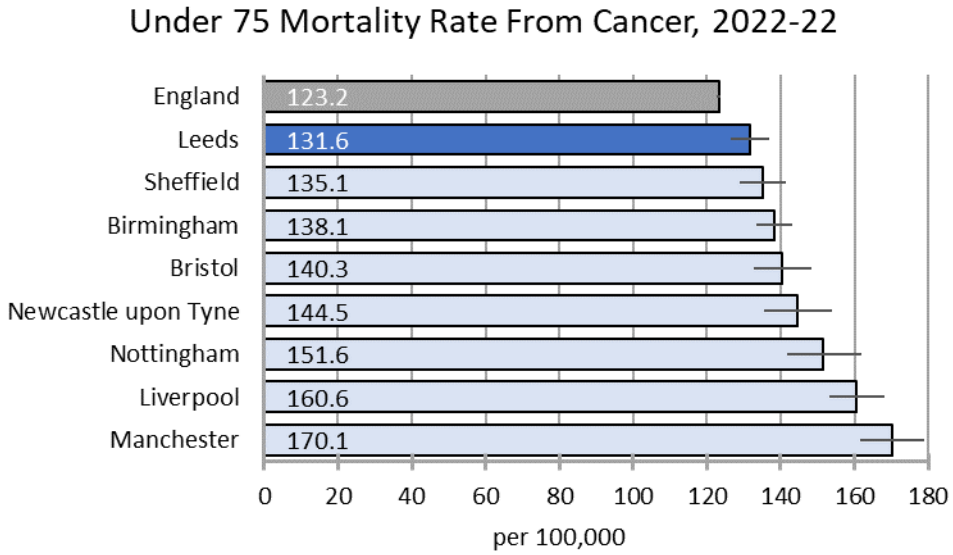
The under 75 mortality rate from respiratory disease is statistically significantly higher than England. However, it's also statistically significantly lower than four other core cities.

Figure 13: Mortality rate from Cancer - All Ages



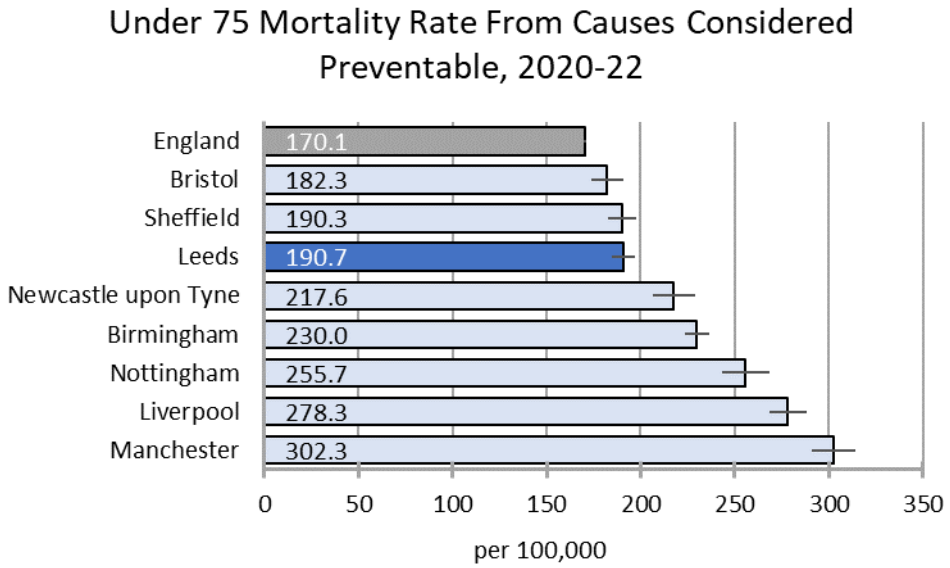
The mortality rate from cancer (all ages) in Leeds is statistically significantly higher than England. However, it is also the second lowest/best among core cities.

Figure 14: Under 75 mortality rate from cancer



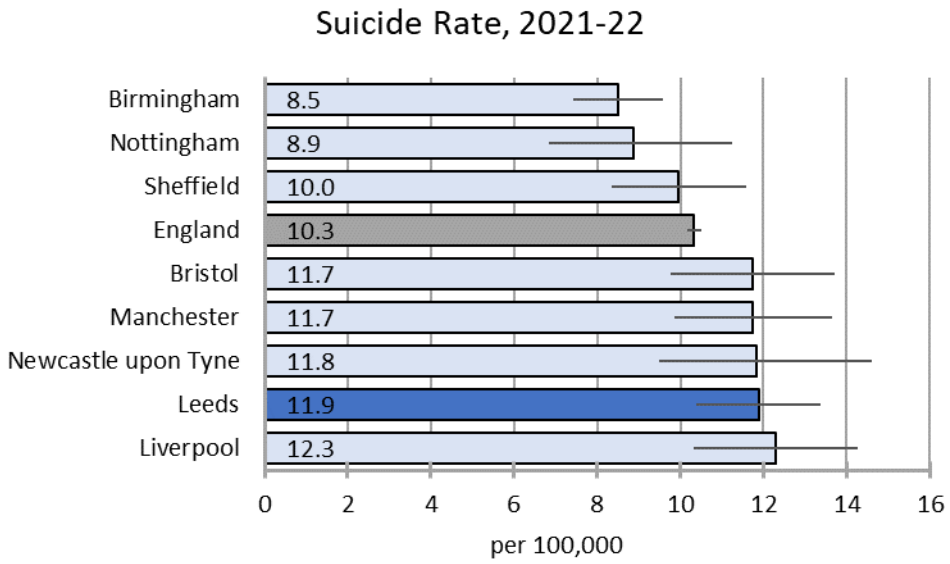
The mortality rate from cancer (all ages) in Leeds is statistically significantly higher than England. It is also the second lowest/best among core cities.

Figure 15: Under 75 mortality rates from causes considered preventable



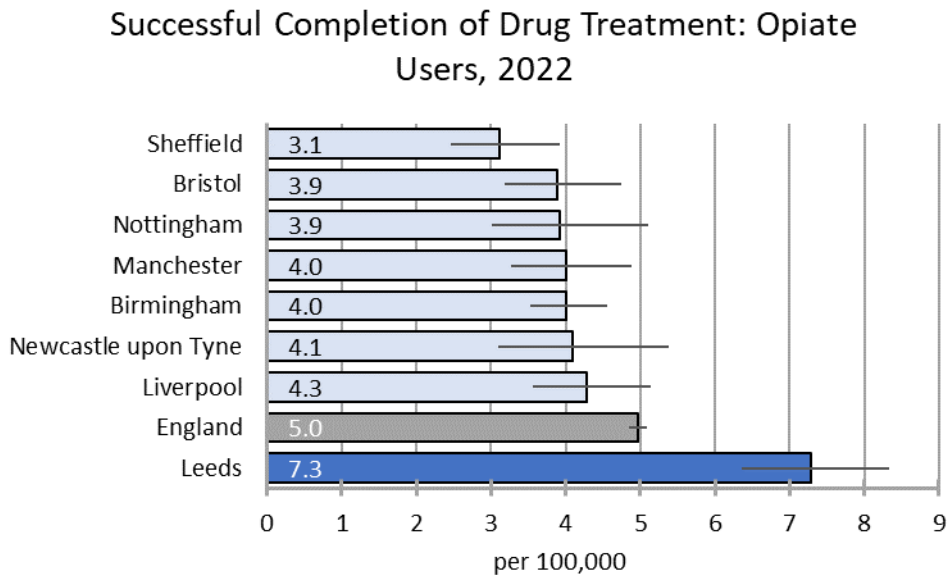
The under 75 mortality rate from causes considered preventable in Leeds is statistically significantly higher than England. However Leeds rates are also statistically significantly lower/better than 5 other core cities.

Figure 16: Suicide Rate



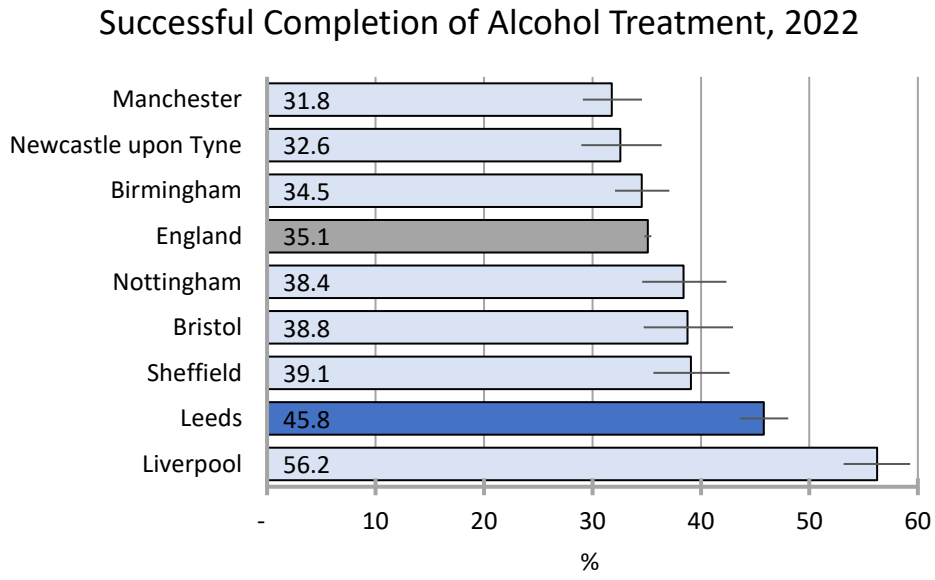
The suicide rate in Leeds is the second highest/worst of the Core Cities. It is only statistically significantly higher than Birmingham.

Figure 17 Successful completion of drug treatment - opiate users



Successful completion of drug treatment - opiate users' rate, is statistically significantly highest / better among core cities and England.

Figure 18 Successful Completion of Alcohol Treatment



Successful completion of alcohol treatment is higher/better than England and the second highest of the Core Cities.

Appendix 2a: ASC Annual Performance Report including national comparators.

Summary/Purpose

This report presents an update on the Adult Social Care Outcomes Framework (ASCOF) provisional measures for 2023/24. This is supplemented with additional information linked to the Best City Ambition, Better Lives Strategy and Care Quality Commission (CQC) Assurance Framework. This includes seven Adult Social Care measures that have been included by the Office for Local Government (OFLOG) in their Local Authority Data Explorer.

Background

- Social Care in Leeds provides a range of care and support services to help meet the needs of older people, people with a learning disability, those with mental health issues and people with a physical or sensory impairment. These services range from those available on a direct access basis for preventative support through to residential and nursing care when this is the right option. Services can be provided directly and through commissioning and funding arrangements.

- The ASCOF provides an outcomes-based national framework for measuring performance of all local authorities. The ASCOF has been refreshed with a revised indicator set published for 2023/24 onwards.
  The framework is now divided into six objectives:
  - Objective 1 - Quality of life: people's quality of life is maximised by the support and services which they access, given their needs and aspirations, while ensuring that public resources are allocated efficiently.
  - Objective 2 - Independence: people are enabled by adult social care to maintain their independence and, where appropriate, regain it.
  - Objective 3 – Empowerment, information and advice: individuals, their families and unpaid carers are empowered by access to good quality information and advice to have choice and control over the care they access.
  - Objective 4 - Safety: people have access to care and support that is safe, and which is appropriate to their needs.
  - Objective 5 - Social connections: people are enabled by adult social care to maintain and, where appropriate, regain their connections to their own home, family and community.
  - Objective 6 - Continuity and quality of care: people receive quality care, underpinned by a sustainable and high-quality care market and an adequate supply of appropriately qualified and trained staff.

  The metrics within the ASCOF are informed by the results of mandatory national data collections and surveys. This report presents 2023/24 provisional results alongside the most recent comparative data from 2022/23. The final ASCOF results will be published in October 2024 and as such the data contained within this report may be subject to change at that point.

- The CQC framework for local authority assurance has been published which sets out nine quality statements across four themes of:
  - How the local authority works with people.
  - How the local authority provides support.
  - How the local authority ensures safety within the system.
  - Leadership.

  The framework includes several process and outcome based performance measures. The latest results for these are included within this report.

- The Leeds approach to Adult Social Care is informed by the Better Lives Strategy and Best City Ambitions which include a range of performance measures. The latest results for these are included within this report.

- Activity - As of 31st March 2024 Adult Social Care provided long term support to 8,795 people (3,826 aged 18-64, 4,969 aged 65 or over). These figures continue the trend of an increase in older people supported (up 2.6% on 2022/23 year-end figures), and in particular an increase in the numbers of older people in permanent nursing/residential placements which rose by 8.6%. These figures are now broadly in line with those seen pre-pandemic.

- To contextualise the performance position in relation to capacity and demand, Adult social care continues to see high volumes of referrals into the system. In addition, people's needs are often more complex and as a result they need more support than they did previously, their requirements being more complex means that social workers are having to spend more time on understanding needs, on undertaking Best Interests Decisions and in some cases seeking decisions through the Court of Protection at a higher volume than seen previously. This is illustrated through the make-up of people in receipt of long term care in the community. Whilst the number of people receiving homecare has remained broadly consistent the average size and cost of the package received continues to increase. It is also evident in Occupational Therapy where the need to make return visits to ensure safety of people with equipment provided has increased since 2020.

- Capacity to meet this demand has improved with positive movement over recent months in staffing levels and a reduction in the number of vacancies within Adult Social Care. However, the loss of experienced Social Workers and Wellbeing Workers who have been replaced by relatively new and recently trained staff meaning there continues to be pressures around workforce capacity. Benchmarking data shows Leeds ranks 6th of 8 English core cities for Social Workers per head of population and 7th for Wellbeing Workers per head of population. Leeds also has lower rates than the neighbouring authorities of Wakefield and Bradford.

- Combined, these capacity and demand forces are impacting on the ability to respond to the numbers of referrals in a timely way, illustrated through continued high numbers of people waiting for assessment and long waiting times for services.

ASCOF framework

- Following the completion of the Client Level Dataset (CLD) return, Personal Social Services (PSS) Survey and Carers Survey, the draft results for the majority of ASCOF measures for 2023/24 are now available. Comparator data will not be available until October 2024. Overall, compared to the last available result, 12 measures have improved whilst nine have declined, with the results for the remaining measure not yet available. The measures can be broken down into five distinct groups by their source:
- Seven measures are obtained from the CLD return and are based on social care activity. Of these five have improved whilst two have declined compared to 2022/23. It should be noted that although these are existing measures the data source has changed from the Short and Long Term Return (SALT) to the CLD therefore the methodology for calculating measures differs, and in some instance not been fully confirmed therefore the results contained in this report are likely to change when published. In addition, comparisons to previous year's results should be treated with caution.

- Seven measures are obtained from the PSS survey. Performance has improved for two measures whilst it has declined for five measures compared to 2022/23.
- Five measures are obtained from the Carers survey. Three have improved and two declined compared to the last survey carried out in 2021/22.
- One measure is obtained from the Safeguarding Adults Collection (SAC) which has improved compared to 2022/23.
- Two further measures are obtained from external data. One of these has improved in 2022/23 whilst the result for the final measure is not yet available.

Objective 1 - Quality of life

- This objective contains five measures obtained from the PSS and Carers surveys.
- The reported quality of life scores remain broadly consistent to previous survey with the service user score 19 (out of 24) compared to 19.5 last year. The carers score was 7.1 (out of 12) compared to 7.4 in 2021/22.
- The second set of measures look at service users and carers satisfaction with the services they receive. The picture is mixed, the score for service users declined from 64.4% to 62.0% whilst that for carers improved from 32.5% to 39.7%.

Objective 2 – Independence

- This objective contains five activity based measures obtained from the CLD return.
- In relation to reablement activity, the percentage of people being independent following reablement has increased in 2023/24 to 75.3%. The percentage of older people at home 91 days after discharge into reablement has also increased compared to last year to 84.9% Both results are the highest recorded in Leeds. It should be noted that the '91 days' measure is due to broaden in scope to include all discharges from hospital into social care in the future though the methodology has yet to be confirmed. In addition, the local measure on the volume of people completing a reablement service shows that flows through the service have increased in 2023/24. These improvements are reflective of both the HomeFirst Programme and operational changes made at service level. At transformation level, building upon the Active Recovery principles in the pilot area, in recent months, the service has rolled out these new ways of working across the entire Reablement service. A new local performance framework with clear leadership escalation processes complement the Power BI and System Visibility dashboards, together with changes to management approaches and slow but increasing recruitment initiatives. The service is ambitious for further developments and improvements and has clarity, direction and continued support of the HomeFirst Programme to enable growth and expansion through further integrated working with our Alliance partners.
- The rate of care home admissions for people aged 18-64 is 18.2 per 100,000 population, which is 93 people. This is a significant increase compared to 2021/22 (13.3 per 100,000 population / 63 people). Investigations have shown that the increase relates to admissions to residential rather than nursing homes and is predominantly influence by people with a learning disability. A further factor is data cleansing work to correctly record where a temporary placement has become permanent. Once this factor is taken into account the result still represents an increase over the last three years but is broadly comparable with the pre-pandemic result from 2019/20 of 81 admissions. Work continues on examining other factors behind this increase and the forecasting of future admission rates.

- The rate of care home admissions for people aged 65+ is 519.0 per 100,000 population, which is 666 people. This is a small decrease compared to last year although it may increase over coming months before it is confirmed.
- A new measure has been introduced that looks at the percentage of long term social care users who live in settled accommodation. The Leeds result stands at 49.5%. This is heavily influenced by the fact that this data was not previously required to be captured for all clients. Where an individual's accommodation status is 'not known' they are recorded as 'not settled'. System developments and training have taken place to ensure this is now being captured for everyone via assessments and reviews and the result is expected to increase over time. The result for the previous measure focusing on 18-64 year olds with a learning disability is also provided which shows an improvement in performance.
- Leeds Indicators – The ratio of people who receive community-based support vs people who are supported in care homes is unchanged with 2.4 people receiving community based care for every one person in a care home. The number of telecare installations has increased in 2023/24 and is broadly inline with pre-covid activity levels.

Objective 3 – Empowerment, information and advice

- This objective contains 6 measures. Four are obtained from the PSS and Carers surveys and two are based on activity date from the CLD.
- The proportion of carers who report that they have been involved in discussions about the person they care for has increased compared to the last survey.
- The proportion of people who find it easy to find information about support compared to the previous surveys fell for slightly for service users to 71.4% but increased for carers to 58.1%.
- The result for the measure that looks at service users feeling of control over their lives continues to fall for the third consecutive survey and is 70.9%.
- The percentage of service users receiving a direct payment has reduced slightly compared to last year and stands at 14.6%. It should be noted that this is calculated using the new revised methodology and so is subject to change and not directly comparable. The actual number of people in receipt of a direct payment remains consistent. This is recognised as an improvement area and a project is underway to increase the take up of direct payments. The service has developed an action plan which clearly sets out the areas of service improvement which include a refresh of the leaflets and information to promote the use of direct payments and use of the P card which makes the direct payment process easier to manage in terms of financial oversight of how the budget is being used. There is also a proposal being explored to expand the role of the Direct Payment team. The focus of the expansion will mean the team will support more people and have direct conversations with people about the benefits of a direct payment. It is recognised that the current direct process is quite lengthy, so this would also release social work capacity if they take on these elements of the process. In addition to having a focus on Direct Payments we are exploring two pilot sites within the Learning Disability Service with regards to the implementation of Individual Service Funds (ISF), we have two providers on board who have a proven track record in delivering on creative ISF's. we will be looking to commence two pilots in June 2024, this provides Leeds with an opportunity to diversify in terms of it's personalisation offer which will be based upon improved outcomes for individuals. In relation to Personal Health Budgets the Council and the ICB continue to deliver on PHB's and specifically PHB's for

people who are eligible for Section 117 funding for aftercare in respect of the Mental Health Act. these numbers are steadily growing and achieving creative outcomes for people with complex mental health conditions. There may be a link between this activity measure and the previous survey measure. The future results of both will be monitored alongside each other to give a fuller picture of choice and control.

- The proportion of carers who receive a direct payment has increased as more 'time for carers' grants have been issued in 2023/24.
- Leeds indicators – 95.6% of service users have a record of if they have accessible information needs which is unchanged from last year. The usage of the Leeds Directory continues to grow with over 13,000 users in 2023/24 and increase of 28% on 2022/23.

Objective 4 – Safety

- This objective contains two measures. One is from the PSS survey and the second from the SAC return.
- The proportion of people who feel safe improved in 2023/24 from 70.4% to 71.5%.
- A new ASCOF measure for 2023/24 is obtained from the SAC return and relates to the proportion of safeguarding enquiries where the risk was reduced or removed. The result for 2023/24 is 88.7% which is an improvement compared to 2022/23.
- Leeds indicators: Whilst still high compared to historical levels 2023/24 saw a small fall in safeguarding concerns compared to 2022/23. This was alongside a noticeable rise in the number of safeguarding enquiries. As a result of this the percentage of concerns that resulted in an enquiry increased from 24.1% to 30.7% in 2023/24. This is in part due to working in partnership with other agencies to reduce levels of inappropriate referrals. The proportion of people who had their desired outcomes fully or partially met when being the subject of a safeguarding enquiry improved slightly in 2023/24 to 94.4% compared to last year whilst the percentage of those individuals who were determined to lack capacity who were provided support by an advocate, family or friend remained broadly consistent at 92.5%

Objective 5 – Social connections:

- This objective contains two measures which are obtained from the PSS and Carers surveys. The measures look at the proportion of service user/carers who report they have had as much social contact as they would like.
- For 2024/25 the results show that performance only changed to a small degree for both groups, increasing from 49% to 49.2% for service users and falling from 30.8% to 29.2% for carers.

Objective 6 - Continuity and quality of care:

- This objective includes two measures which are obtained from external data from Skills for Care and CQC Provider Data. These are both new additions to the ASCOF framework although both have been previously reported to the board as local measures.
- The result for the proportion of staff in the formal care workforce leaving their role in the past 12 months in 2023/24 is not yet available and will be published in October.

- The proportion of CQC registered care services rated good or outstanding in 2023/24 improved to 79.5%. This follows a previous trend of declining performance on this measure and is the highest result since 2020/21.

Other key measures

- 2023/24 saw continued high numbers of people waiting and long waiting times for assessments. However, throughout the year there has been substantial improvements in the area as a result of a focus both on practice and improved recording. The waiting list has reduced by approximately 200 people over 2023/24 and the mean wait time reduced from 29 to 22 days. Processes are in place to ensure that people are 'waiting safely' through the screening of referrals, contacting people and families to manage risk and prioritise workloads.
- The contact centre continues to experience a high volume of calls. 2023/24 has been broadly in line with 2022/23 with an average of over 4,000 contacts per month and average call wait times of 225 seconds.
- The percentage of referrals for social care resolved at initial point of contact or through accessing universal services increased in 2023/24 to 29.4%.
- The percentage of people receiving long term services who have had a review in the last 12 months has fallen year on year since 2019/20 and currently stands at 41.9% in 2023/24. This fall is linked to demand elsewhere in the system impacting on the capacity to carry out annual reviews. The development of a new integrated reviewing team (IRT), made up of social workers and Occupational Therapists is starting to show progress in this area with an increasing number of reviews carried out each month and a reduction in the number of outstanding reviews. An additional benefit of undertaking more reviews is also demonstrated in the associated savings achieved by undertaking timely reviews which ensure that care packages are right sized and appropriately reflect care and support needs. This remains an area of service improvement and further work is underway to scope out the use of digital technologies in assisting the service areas to identify cohorts of reviews that can be targeted e.g. low level telephone reviews, to support the improvement in review performance. For the past 5 years the Reassessment Team has been in operation across Specialist Services, the team has increased the numbers of reviews undertaken specifically in Learning Disability and has generated substantial financial efficiencies and income generation for the Council, people's support is now further tailored to their needs, this has been and continues to be a joint initiative across Specialist Services operations and Working Age Adult commissioning. Recently the ICB has funded a mental health nurse to undertake joint reviews in terms of high-cost packages to ensure that there is the correct social work and clinical input into reviews and reassessments. This additional investment has resulted in the potential for increased efficiencies and the promotion of dignity and independence. This data is again impacted upon by the change in national data collections.
- The number of carers assessments recorded as being completed per month in 2023/24 was 322 which is an increase of over 150% compared to 2022/23. This is largely due to changes in recording practice which have simplified the recording process where a joint assessment of both a service user and a carer has taken place.

Capacity

Capacity to meet this demand has improved with positive movement over recent months in staffing levels and a reduction in the number of vacancies within Adult Social Care. However, the loss of experienced Social Workers and Wellbeing Workers who have been replaced by relatively new and recently trained staff meaning there continues to be pressures around workforce capacity. Alongside this, the financial pressures on councils and care providers remain a significant factor. A new national workforce strategy for Adult Social Care will be launched in July 2024, outlining a new vision and long term workforce priorities linked to wider national government led reforms for the sector. Across the independent care sector, the following workforce challenges remain:

- Pay and conditions linked to national long term funding plans for Social Care.
- Projections show a need for 25% more posts by 2035 if the number of adult social care posts grows proportionally to the projected number of people aged 65 and over in the population (Skills for Care 2023).
- Recruitment and retention still remain challenging, with 8.9% vacancy and 36% turnover rates.
- Lack of career development is one of the main reasons staff leave adult social care. The launch of the Care Workforce Pathway, new qualifications, subsidised training and new apprenticeship opportunities are positive steps to help make adult social care a real career choice.

Within Leeds City Council, we face similar challenges and our response is focussed on the following:

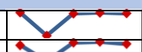
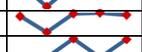
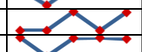
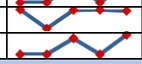
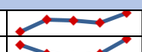
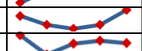
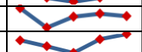
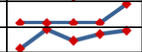
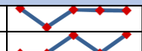
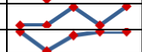
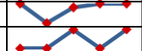
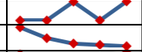
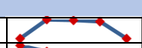
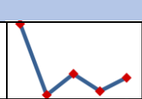
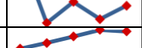
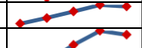
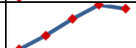
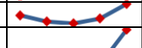
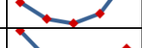
- Productivity, workloads and wellbeing
- Skills availability (e.g. experienced social work).
- New ways of working linked to service transformation and prioritisation (e.g. HomeFirst) including further Health and Care integration.
- New roles to meet community needs.
- Optimising the opportunities offered by digital technology to address workforce challenges.

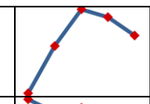
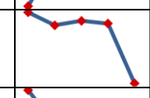
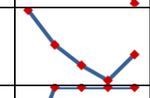
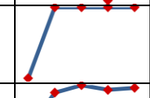
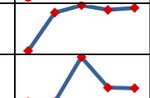
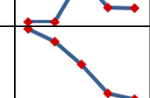
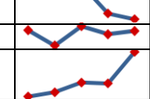
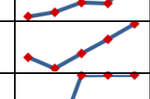
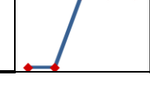
We also continue to:

- Recruit and develop a social care workforce that is representative of the diverse communities within the city and building inclusive workplaces.
- Embed our Adult Social Care Practice framework and Supervision Policy in line with the continued professional development (CPD) requirements for all social care staff.

Appendix 2b presents the 2023/24 Leeds results alongside historical data and comparisons to 2022/23 averages for the region, peer authorities and England as 2023/24 data is not yet published nationally.

Appendix 2b: Adult Social Care Performance Measures

	ASCOF Measure	Source	CQC Assessment Framework	Leeds Result	Leeds Trend							Comparisons 22/23					
												Yorkshire & Humber		Peer LAs*		England	
				2023-24 Provisional	2019-20	2020-21	2021-22	2022-23	2023-24 Provisional	1yr trend	5yr trend	Avg.	Rank (of 15)	Avg.	Rank (of 16)	Avg.	Rank (of 152)
Objective 1: Quality of Life																	
1A	quality of life of people who use services	SU Survey	Yes	19	19.7	NA	18.8	19.5	19.0	⇩		19.2	4	18.8	1.0	19.0	16.0
1B	quality of life of people who use services - adjusted	SU Survey	Yes	0.377	0.351	NA	0.406	0.426	0.377	⇩		0.416	5	0.409	4	0.411	42
1C	quality of life of carers	Carers Survey	Yes	7.1	NA	NA	7.4	NA	7.1	⇩		NA	NA	NA	NA	NA	NA
1D	overall satisfaction of people who use services with their ca	SU Survey	Yes	62.0%	66.7%	NA	64.4%	65.8%	62.0%	⇩		66.4	8	62.5	3	64.4	55
1E	overall satisfaction of carers with social services	Carers Survey	Yes	39.7%	NA	NA	32.5%	NA	39.7%	⇧		NA	NA	NA	NA	NA	NA
Objective 2: Independence																	
2A	proportion of people who received short-term services durin	SALT/CLD	Yes	75.3%	65.7%	71.9%	71.4%	70.3%	75.3%	⇧		51.6	4	51.5	3	57.8	31
2B	number of adults aged 18 to 64 whose long-term support ne	SALT/CLD	No	18.2	16.2	13.3	12.0	13.3	18.2	⇧		16.9	7	11.9	9	14.6	92
2C	number of adults aged 65 and over whose long-term suppo	SALT/CLD	No	519.0	561.1	458.1	516.2	531.5	519.0	⇩		646.3	4	575.7	6	562.8	74
2D	proportion of older people (65 and over) who were still at ho	SALT/CLD	Yes	84.9%	83.1%	81.4%	79.5%	83.4%	84.9%	⇧		83	6	83.8	7	82.3	74
2E	proportion of people who receive long-term support who live	SALT/CLD	Yes	49.5%	NA	NA	NA	NA	49.5%	NA		NA	NA	NA	NA	NA	NA
2E	proportion of people who receive long-term support who live	SALT/CLD	Yes	80.5%	74.8%	80.9%	77.3%	79.4%	80.5%	⇧		80.3	9	78.6	10	80.4	94
Objective 3: Empowerment																	
3A	proportion of people who use services who report having co	SU Survey	Yes	70.9%	80.2%	NA	74.8%	71.4%	70.9%	⇩		78.8	16	74.9	15	77.2	133
3B	proportion of carers who report that they have been involve	Carers Survey	Yes	60.7%	NA	NA	58.4%	NA	60.7%	⇧		NA	NA	NA	NA	NA	NA
3Ci	proportion of people who use services who have found it ea	SU Survey	Yes	71.4%	71.5%	NA	57.8%	71.8%	71.4%	⇩		70.1	6	65.7	1	67.2	25
3Cii	proportion of carers who use services who have found it eas	Carers Survey	Yes	58.1%	NA	NA	57.1%	NA	58.1%	⇧		NA	NA	NA	NA	NA	NA
3Di	proportion of people who use services who receive direct pa	SALT/CLD	Yes	14.8%	16.2%	15.4%	15.0%	14.9%	14.8%	⇩		26.7	12	26.3	13	26.2	111
3Dii	proportion of carers who use services who receive direct pa	SALT/CLD	Yes	85.6%	83.7%	65.6%	79.4%	80.5%	85.6%	⇧		81.7	10	78.3	11	76.6	102
Objective 4: Safety																	
4A	proportion of people who use services who feel safe	SU Survey	Yes	71.5%	69.4%	NA	71.9%	70.4%	71.5%	⇧		72.5	13	68.5	4	69.7	69
4B	proportion of section 42 safeguarding enquiries where a risk	SAC	No	88.7%	89.0%	86.7%	89.2%	87.2%	88.7%	⇧		93.3	13	91.5	14	90.5	119.0
Objective 5: Social Connections																	
5Ai	proportion of people who use services, who reported that th	SU Survey	Yes	49.2%	49.4%	NA	40.5%	49.0%	49.2%	⇧		46.5	4	44.0	2	44.4	23
5Aii	proportion of carers who use services, who reported that the	Carers Survey	Yes	29.2%	NA	NA	30.8%	NA	29.2%	⇩		NA	NA	NA	NA	NA	NA
Objective 6: Continuity and Quality of Care																	
6A	proportion of staff in the formal care workforce leaving their	Skills for Care	No	NA	NA	NA	31.6%	30.4%	28.3%	NA	NA	NA	NA	NA	NA	NA	NA
6B	percentage of residential adult social care providers rated g	CQC Directory	Yes	79.5%	87.8%	83.5%	78.7%	74.3%	79.5%	⇧		80.4	13	80.8	14	83.1	133
Additional Local Measures																	
BL10	Percentage of people with a concluded safeguarding enquiry for whom their desired outcomes were fully or partially met	SAC	No	94.4%	97.2%	93.5%	94.6%	93.7%	94.4%	⇧		98.0%	13	95.2%	10	94.8%	82
	Number of safeguarding concerns	SAC	Yes	13209	9785	10915	12205	13526	13209	⇩							
	Number of safeguarding concerns (per 100,000 pop.)	SAC	No	2069	1568	1738	1943	2119	2069	⇩		1413	3	1465	4	1313	23
	Number of safeguarding enquiries	SAC	No	4056	3435	3095	2990	3261	4056	⇧							
	Number of safeguarding enquiries (per 100,000 pop.)	SAC	No	635	551	492	476	511	635	⇧		518	8	517	6	387	36
	Percentage of safeguarding concerns that meet S42 threshold	SAC	Yes	30.7%	35.1%	28.4%	24.5%	24.1%	30.7%	⇧		36.7%	12	35.3%	11	29.5%	96
	Percentage of individuals lacking capacity who were supported by advocate, family or friend during the safeguarding process	SAC	Yes	92.5%	NA	NA	92.5%	92.6%	92.5%	⇩		87.1%	8	84.2%	9	83.1%	68
	Number of people awaiting a Care Act Assessment	other	Yes	NA	NA	NA	1441	1457	1254	⇩							

	Mean waiting time for a Care Act Assessment	other	Yes	NA	NA	18	32	29	22	⇩								
	The number of support requests received from new clients by local authority that resulted in a service, per 100,000 population ^	SALT	No	NA	1972	1611	1735	1657	NA	NA								
BL1	Percentage of referrals for social care resolved at initial point of contact or through accessing universal services	other	No	29.4%	33.5%	30.3%	28.4%	27.0%	29.4%	⇧								
BL3	Ratio of people who receive community-based support vs people who are supported in care homes	other	No	2.4	2.2	2.4	2.4	2.4	2.4	⇔								
BL4	Average number of people completing a re-ablement service each month	other	No	NA	NA	113	135	121	127	⇧								
	The time it takes for phone calls to be answered in the contact centre (in secs).	other	No	225	NA	NA	736	236	225	⇩								
	Proportion of long term service users who have had a service for more than 12 months and have received a review in the last 12 months	other	Yes	41.9%	61.3%	57.8%	51.5%	43.5%	41.9%	⇩		52	13	55	11	57	118	
	Number of Telecare installations	other	No	4,063	4,093	3,455	4,268	3,931	4,063	⇧								
	Number of carer's assessments carried out (average per month)	other	No	322	44	71	131	126	322	⇧								
	Total Leeds Directory Users (average unique users per quarter)	other	No	13,982	7375	5191	8141	10,938	13,982	⇧								
	Accessible information standard - Percentage of current service users that have accessible information needs record updated	other	No	95.6%	NA	NA	95.2%	95.6%	95.6%	⇔								

Appendix 3: Active Lifestyles

Percentage of Physically Active Adults

Ref.	Key Performance Indicators (KPI) (*=cumulative)	2023/24 Target	Q4 2022/23 Result & RAG	Q1 2023/24 Result & RAG	Q2 2023/24 Result & RAG	Q3 2023/24 Result & RAG	Q4 2023/24 Result & RAG
10	**Annual KPI** Percentage of physically active adults	**<20.9% of people are inactive** (132,900) (Nov 2018-Nov 2019)	**24.3%** (Nov 2021 – Nov 2022)	**No update**	**No update**	**No update**	**23.9%** (Nov 2022 – Nov 2023)

This KPI is now measured on an annual basis rather than biannual. The Inactive rate for Leeds has fallen from November 2021 to November 2022 (24.3%) to 23.9% for the period Nov 2022 to Nov 2023. Which now means less than 160,000 adults are inactive and over 443,000 are now classed as very active which is up by 0.8% to 66.4%. It is also lower than the National (25.7%), regional (27.7%) and core cities (25%) averages.

The levels of inactivity in the city remain highest in the most deprived areas of the city and whilst there is an improvement in people moving from inactive to active or fairly active, this shift has been greater in the least deprived areas (1.8% change) compared with most deprived (0.7% change). This indicates there is a continued need to focus work with these communities to better understand the barriers to physical activity including environmental factors and identify the preferred type of activity.

Ageing Well

The action plan is being reviewed and refreshed with Public Health (PH) now taking the leading role in this. A new strength programme video has been developed to highlight the importance of strength training which will help to promote the campaign further.

LEAP

Funding is now confirmed from PH, ICB and Active Leeds until March 2025 (mix of underspend and new funding). Active Leeds are working on ways to better integrate the LEAP pathway into Active Leeds Leisure Centres through training up leisure centre staff. This will better support the community as well as have an impact on the waiting lists for this programme and should increase memberships. Six month outcomes have just been released which highlight a great corelation to improvements in activity levels by participants and improved overall well being scores as well as physical attributes such as lowering blood pressure and medication levels.

Active Workplaces:

The Active Workplaces approach has three elements that work together:

- The Active Workplaces Network: This is a platform for sharing research, insight, and current best practice.

- Wellbeing Leads Thinking Group: A smaller focused thinking group of Wellbeing Leads that are invested in collaboration and joining up to support and learn from each other's challenges and solutions.
- Developing partnerships with organisations: Co–creating approaches with the workplaces to engage workers and managers in physical activity. This includes approaches for prevention and resilience as well as physical and mental health. The offer to workplaces within the model includes but not limited to consultancy, delivery staff, events, training and capacity building, health and wellbeing coaching, confidence and capability building.

The innovative Active Workplaces approach has been recognised by key agencies like Public Health Wales and Greater Manchester (GM) Moving, and as such we have been invited to join a UK wide forum to share best practice and contribute to learning / evidence base.

Get Set Leeds Local:

GSLL supports Leeds City Council's locality-based approach focusing work in areas within the top 1% most disadvantages neighbourhoods with a focus on building on existing strengths and capacity in communities. Work is currently focussed in four of our priority localities in Leeds; Seacroft, New Wortley, Beeston and Holbeck. In addition to this over the next two years GSLL Project Team will begin to embed its approach within the Easterly Grove, St Wilfreds priority locality within the Gipton and Harehills ward.

Over the last 4 years the GSLL team have supported multiple community projects covering a wide range of physical activities to local residents. These projects celebrate moving more in a variety of ways including Football, roller skating, cycling, dance, swimming, running and play as well as litter picking and gardening. Many of these projects have received our community chest pot funding, training and larger co-production funds along with further support and guidance from the Active Leeds team. Key to this has been the teams support in building connections with other assets in their communities. The variety of projects are celebrated in our GSLL newsletter released twice a year, sharing the journeys of these projects.

We have been working closely with the RFU on a pilot project that will be rooted in the Inner East of the City and will be co-productive by its nature. Working with residents to understand the barriers to movement and the perception of engaging in Rugby activities. Jason Robinson has been part of our conversations with residents and we are in advanced talks about significant funding for a full project. We are leading a 'Consortia' of partners to position Leeds as connected place to investment for the RFU.

DfT Active Travel Social Prescribing Project:

Active Leeds, Public Health, Leeds Integrated Care Board and partners have been working on the project for the last with the project based on community and partner engagement, centred around several interventions including:

- communication,
- a focus on the physical and social environment,
- the development of three urban trails (one in each of the ward areas),

- a range of walking activities such as led walks and buddying schemes,
- learn to ride sessions,
- development of bike hubs
- a bike voucher scheme.

Two Walk It Ride It Officers have now been in post for five months with one Officer focusing on building the pathways from Social Prescribing into walking and cycling activities and the other leading on community conversations, engagement and activation.

There are now several different referral pathways in place, some examples include:

- Social Prescribing (Linking Leeds and from the Primary Care Network),
- Clinical pathways (including Shape Up 4 Surgery),
- Self-referral,
- and from the Third Sector.

Achievements to highlight are:

- Walking commissions have been set-up with Health for All and Touchstone.
- Cycling group has recently started with Shantona Women's Group.
- 15 walk leaders have been trained from the local area.
- Cycle North and British Cycling are adapting offers to better meet need.
- Love Exploring App in all three wards.
- Active Travel Master Plan and Complementary Measures guidance developed.
- Urban Trails developed.

The 21st Sport Leeds Sports Awards was held at Elland Road, to celebrate the sporting community in Leeds. Recognising everyone involved in sport right across the pathways, from community organisations, grassroot teams, school teams, university teams to the elite level. However, it is also a time to thank all those that make it possible for so much talent in Leeds to be developed from all the coaches, volunteers, officials, club committee members, parents, funders, and supporters. A very successful night highlighting all that is good in Leeds.

Online sign ups were introduced for Active Leeds Swimming Lessons for the first time which has seen the number of children enrolled in to the programme up to nearly 14k. The last quarter of the year produced strong growth in health and fitness memberships, As well as things such as the number of referrals being received and dealt with in the health programmes team,

Children's Healthy Holiday activities continue to deliver more with community venues and leisure centres activities growing to support this such important initiative.

Strategic Lead for the Kit, Clothing and Equipment Partnership – which re-distributes kit, clothing and equipment around the City supporting our communities to get active and stay active – over 10,000 items have been re-purposed. Together for Sport continues to grow with sport kit donations and other providers supporting the kit exchanges to ensure Active Leeds continues to expand the reach.

Active Leeds supported International Women's day with a week-long of activities aimed at women and girls as well as their families. Things included Zumba sessions, wellbeing talks and advice, menopause cafes and the promotion of the latest collaboration with our partner Sweaty Betty, launching a brand-new Sports Hijab, re-designed to better suit those that want to preserve their modesty while moving, which the Leeds Girls Can Team helped to design. There was a Family Colour Fun Run or Walk event at John Charles on the 10th March which was a huge success with it being fully sold out thank you for sharing the event and well done Victoria for pulling this event together.