Sexual Health Needs Assessment

Leeds 2018/19

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Abbreviations used in this report

AIDS – acquired immune deficiency syndrome
AMU – acute medical unit
ART – anti-retroviral therapy
BBV – blood borne virus
BME – Black & Minority Ethnic
CASH – contraception and sexual health
CCG – Clinical Commissioning Group
EHC – emergency hormonal contraception
ESHPS – enhanced sexual health pharmacy scheme
GUM – genitourinary medicine
HBV – Hepatitis B virus
HCV – Hepatitis C virus
HE – higher education
HIV – human immunodeficiency virus
HNA – health needs assessment
IUD – intra uterine device
IUS – intra uterine system
LA – Local Authority
LARC – long acting reversible contraception
LSH – Leeds Sexual Health clinics
LSOA – lower layer super output area
MSM – men who have sex with men
MSOA – middle layer super output area
NEET – not in education, employment or training
NICE – National Institute for Health & Care Excellence
ONS – Office for National Statistics
PHE – Public Health England
PHI – Public Health Intelligence team
PHOF – Public Health Outcome Framework
PrEP – Pre – exposure Prophylaxis
RSE – Relationships & Sex Education
SEND – special educational needs and disabilities
SRH – Sexual & Reproductive Health services
STI – sexually transmitted infection

Contents

This report includes information from a range of sources, including some that are unavailable to the public. In order to protect sensitive information, this document summarises key findings when necessary. The full analysis is available to inform and support commissioning and service development

Executive summary

Good sexual health is essential to general wellbeing and is a global health priority for all. Good sexual health positively impacts upon all of society, from babies and children to adults of all ages – not just those who are sexually active. Good sexual health reduces the burden of disease, affords people more choice and freedom to have the sex they want, when they want it, as safely as possible and allows people more choice on if and when to have children. The repercussions of good sexual health have a positive impact on physical and reproductive health and wellbeing, but also interpersonal, educational and financial wellbeing.

Conversely, the consequences of poor sexual health also impact upon all of society, affecting both health and social outcomes. The treatment and management of these outcomes and their wider negative repercussions incur costs to society and the public purse.

This report highlights that certain groups are at greater risk of poor sexual health outcomes. These groups experience inequality in various forms. Deprivation and poverty is closely linked with poor sexual health, but other inequalities also impact upon outcomes, often intertwining with and exacerbating financial hardship. Groups that are more vulnerable and have less capability and capacity (through mental or physical illness, disability, lack of support or education, cultural and societal barriers or those who are victims of abuse, exploitation or stigma) are less able to make positive, informed choices and tend to experience poorer outcomes.

Key Findings of this Report

• Sexual health will always be a priority for the city: Leeds has a much larger than average population of young people and students and a higher than average proportion of females of childbearing age. As Leeds is demographically different to other authorities in the region, caution must be exercised when comparing the city's data with other authorities.

• Under 18 conception rates have continued to decline at a local, regional and national level. However, rates in some areas of the city remain stubbornly high and there continues to be a strong correlation between teenage conceptions and deprivation in the city.

• Women are still more likely to choose a short acting or user-dependent (and less effective) method of contraception such as the pill, rather than a more effective LARC (long acting reversible contraception) method, such as an implant.

• Under 18 abortion rates are declining, in line with the under 18 conception rate. However, abortion rates for all women are showing an increasing trend, particularly amongst over 25s. Women aged 25-29 show the highest rates. Abortions for all women are taking place earlier, indicating prompt access to services and the increased use of medical abortion.

• The HIV prevalence rate in the city is showing an increasing trend and is higher than the target rate for local authorities, with some areas of Leeds further exceeding the city rate. The rate of people diagnosed with HIV at a late stage has remained similar since 2011 well exceeds the target of below 25%. However, increased accessibility to HIV testing and the development of opportunistic screening in the city is uncovering unknown cases and improving the outcomes for these people. Work to reduce stigma around testing, promoting better understanding of treatment and the U=U message, alongside the use of PrEP should lead to a reduction in late diagnoses and onward transmission.

• MSM (men who have sex with men) and Black Africans remain most at risk of becoming infected with HIV.

• Chlamydia detection rates are very high. Although incidences of the infection are high in young people across the city, ensuring unknown infections are treated will reduce further transmission and infection sequelae. The use of online ordering of self-tests has greatly increased amongst young people.

• Leeds has high rates of other STIs. High rates of syphilis and gonorrhoea in particular reflect high levels of risky sexual behaviour. The burden of STIs continues to be greatest in young people and MSM. The importance of correct and consistent condom use remains an important prevention message.

Recommendations

Reducing inequalities in sexual health is a key public health priority, but also feeds into the wider priority for the city to reduce inequality as a whole. A key action for Leeds must be to tackle the root causes of poverty that lead to differences in outcomes for those living in the most deprived and least deprived circumstances. Strategic partners in Leeds must prioritise programmes of work that increase protective factors and reduce risk factors for poor sexual health, particularly with young people and those who are vulnerable. For example, work to build resilience, self-esteem and confidence and to promote informed consent in sexual relationships.

Improving sexual health outcomes for those who are most deprived will in turn reduce sexual health-related risk factors for deprivation (e.g. poor physical and mental health and its effects on employment; the ability to control fertility and family size impacting on the number of unwanted or unplanned children and the physical, mental and financial burden this can create).

Continued investment in sexual health will lead to cost savings in other arenas. For example, preventing an unplanned teenage pregnancy will not only save on health care costs (abortion services, antenatal and maternity care), but also the social welfare costs to support the children and the teenage parents themselves. In 2013, the FPA estimated that by 2020, providing services to support children from

unintended pregnancy could account for between 10% & 15% of the UK's anticipated social welfare spending (Unprotected Nation: The Financial and Economic Impacts of Restricted Contraceptive and Sexual Health Services, FPA, 2013). Similarly, increasing the uptake of STI and HIV testing in the most at risk groups will reduce transmission, saving huge amounts in treatment costs of the infections and diseases themselves, but also the repercussions in terms of physical and mental health and impacts on fertility.

Strategic partners and commissioners must ensure that service provision reflects the levels of need in the city's population, including additional tailored prevention and support for identified groups. This includes ensuring the population is confident in the services they can access in primary care and community settings, not just specialist sexual health services. To achieve this, the workforce must be skilled, confident and equipped to deliver sexual health services appropriately.

Strategies must continue to update knowledge and awareness of advances in HIV treatments to tackle misinformation and myths amongst most at risk groups, as well as the general public, to reduce stigma, fear and discrimination. Ensuring health professionals and the wider workforce are well informed and updated should also be a priority. This will contribute to an increase in testing rates, improved understanding of risk, a reduction in late diagnosis and improve the identification of clinical indicators.

Commissioned services and programmes of work must have an explicit focus on relationships and sexual health and utilise all contacts where opportunities to promote self-esteem, resilience and the negotiation of safe sex can take place. This will ensure there are no missed opportunities to share prevention messages (particularly around the potential consequences of risky sexual behaviour) or to provide contraception, treatment or access to abortion swiftly.

In conclusion, improving sexual health is everyone's business and cannot be looked at in isolation from other strategies to improve the health and welfare of the city's population. A skilled and confident workforce, well-resourced services and embedding sexual health messages into all health promotion programmes, alongside wider work to reduce inequality, are key.

Introduction

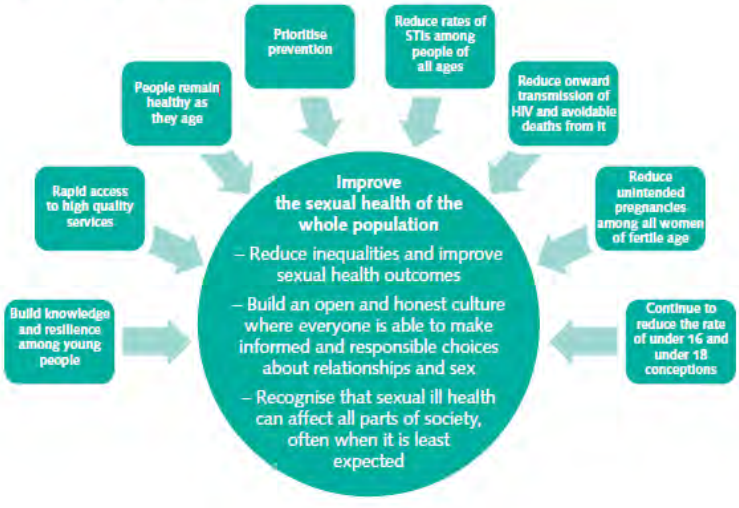
The World Health Organisation defines sexual health as a state of physical, emotional, mental and social wellbeing in relation to sexuality; it is not just the absence of disease, dysfunction or infirmity. Good sexual health is essential to general wellbeing and the consequences of poor sexual health can be serious. They include:

- unintended pregnancies and abortions
- psychological consequences of sexual coercion and abuse
- limited educational, social and economic opportunities for teenage mothers, young fathers and their children
- chronic or recurrent illnesses and infections, such as HIV and herpes
- cervical and other genital cancers
- hepatitis, chronic liver disease and liver cancer
- pelvic inflammatory disease, which can cause ectopic pregnancies and infertility.

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity and certain populations are at greater risk of poor sexual health outcomes. These include men who have sex with men (MSM), young people (especially those who are looked after), minority ethnic groups (especially those of Black African origin) and sex workers. Reducing inequalities in sexual health is a key public health priority.

At a national level, the strategic direction for improving sexual health and reducing sexual health inequalities is set out in the Department of Health's "Framework for sexual health improvement in England" (2013). The Government's ambitions for improving sexual health outcomes are outlined in the diagram below:

Figure 1: Key objectives



Progress in these ambitions are measured using the Public Health Outcomes Framework (PHOF) indicators: reducing under 18 conception rates, maintaining a

high chlamydia detection rate and reducing the late diagnosis of HIV.

This report will look at the key current sexual health data available for Leeds, on a citywide and (where possible) ward or postcode level, to examine how well the city is progressing towards meeting these ambitions. Where available, Leeds will be benchmarked against national and regional comparators. The report will provide a more detailed understanding of the sexual health needs of the population and help identify future actions and priorities to improve the sexual health of the city. It will ultimately support decision making on future commissioning, service planning and service design.

Developments since Sexual Health Needs Assessment 2007

The last Sexual Health Needs Assessment for Leeds was completed in 2007. Since this time, the city has seen many changes, both directly and indirectly affecting sexual health work. These changes and developments are summarised below:

- Following national austerity measures introduced in 2009/10 by the government, local government funding was reduced, impacting upon services across the city.
- As part of the government's reforms, in April 2013, responsibility for **commissioning many public health services became fragmented**, as it moved from the NHS to shared responsibility between local authorities, clinical commissioning groups (CCGs) and NHS England. A new executive agency of the Department of Health, Public Health England, was set up to 'protect and improve the nation's health and wellbeing, and reduce health inequalities' at a national and local level. These changes included the Director of Public Health and all Public Health staff moving from the NHS into the Local Authority.
- The **"managed approach" to street-based sex work** in the city was launched in late 2014, through partnership working between Safer Leeds, Leeds City Council, West Yorkshire Police and third sector partners. The approach aims to provide a long-term sustainable solution to the wide ranging concerns and issues raised by residents, businesses and the general public, as well as concerns about the vulnerability and safety of the women selling sex. The Managed Approach is not a legal "red light zone", but is about managing and lessening the impact of existing activity. A key element of the Approach is to work with sex workers in the area to encourage more reporting of offences, increase their safety and provide targeted support and services to improve their health and wellbeing, with a view to assisting them to exit street based sex work (see Chapter 4 for more information).
- In 2015, the city's contraception and sexual health (CASH) services and genitourinary medicine (GUM) services were integrated to become **Leeds Sexual Health**. A new hub clinic in the city centre was opened, with four spoke clinics across the city. The young people-only (13-19s) Citywise clinic

was closed in late 2015, but young people are able to use the universal clinics as well as specific clinic times for under 18s only. Alongside the opening of the new service, a new version of the www.leedssexualhealth.com website was launched. This includes information and signposting to all sexual health services available in the city and educational content on relevant topics. Users are now able to book clinic appointments online and live chat with a health advisor.

- Leeds is part of the currently ongoing national **PrEP Impact Trial**. PrEP (HIV Pre-exposure Prophylaxis) is a medicine for HIV negative people who are considered at-risk of acquiring the infection. Alongside treatment as prevention and safer sex practises, PrEP is another means to reduce the transmission of HIV. The trial is designed to measure how many people at high risk of acquiring HIV will take up the offer of PrEP, and so is focused on: Men who have sex with men (MSM); trans men and trans women; HIV-negative people who have HIV positive partners that are not on effective treatment and heterosexual people who are considered to be at high risk of HIV acquisition.
- For the first time, **new legislation will make Relationships and Sex Education (RSE) statutory, applying to ALL schools** (academies, free, maintained, special, independent). The Department for Education (DfE) have published what will be included in the revised Relationship Education (primary) and Relationship and Sex Education (secondary) statutory curriculum, introducing RSE as part of the basic school curriculum, with no parental right to withdraw from Relationships Education at primary or secondary school. Parents will have 'right of excusal' from sex education at secondary school – however, a young person can opt themselves in from age 15. The curriculum will become mandatory for all from September 2020 (see Chapter 4 for more information).
- Other notable changes include the introduction of **EllaOne (Ulipristal acetate)** – a new emergency hormonal contraception method effective up to 5 days after unprotected sex, increasing the window of opportunity for women to easily access prevention from unwanted pregnancy. The emergence of **Chemsex** practises amongst men who have sex with men have led to concerns that sexual risk taking behaviours associated with this type of drug use could, in part, be responsible for the rise in STIs and HIV in this group (see chapter 3).

As Leeds is a large, diverse city, the sexual health behaviours and needs of the population are always evolving. His HNA is a snapshot in time – trends must be continually monitored to keep abreast of any significant changes.

Chapter 1: Local demographics

Population

Leeds has a resident population of 784,846 (ONS, 2017), with 50.9% females and 49.1% males. The population is concentrated in the inner city wards, with the outer wards having lower populations. Leeds has the highest population of 15-59 year olds in the region.

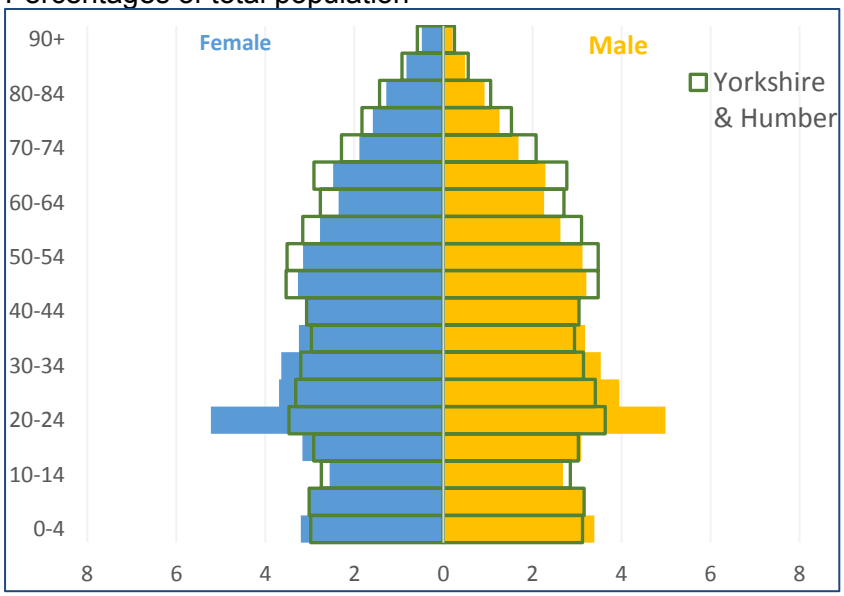
The population is predominantly young, with 16% aged 15-24. This proportion has decreased since 2007, when 18.2% of the population were in this age group, however, Leeds still has by far the highest numbers in the region in this age group.

2011 Census data	No of 15-24s
Leeds	124,709
Sheffield	98,443
Bradford	71,047
Kirklees	56,373
Kingston upon Hull, City of UA	41,456
Wakefield	39,585
Doncaster	38,354
East Riding of Yorkshire UA	36,175
York UA	33,843
Rotherham	31,444
Barnsley	27,923
Calderdale	24,050
North East Lincolnshire UA	20,792
North Lincolnshire UA	19,677
Harrogate	16,773
Scarborough	12,808
Hambleton	9,608
Selby	9,460
Richmondshire	7,781
Craven	5,633
Ryedale	5,390

20-24 year olds are the largest age group in the city, making up 10% of the population. This is a higher proportion than the rest of Yorkshire & Humber as a whole (see graph below), likely to be due to the large student population in the city. Leeds has four higher education institutions and many of these students reside in Leeds whilst enrolled in courses. Around 9% of the city's population are students.

Findings from the national survey of sexual attitudes and lifestyles (Natsal) show most young people become sexually active and start forming relationships between the ages of 16 and 24. Therefore, the high proportion of young people in the city will skew the sexual health data for Leeds and caution must be exercised when benchmarking against other authorities.

ONS 2016 Mid-Year Estimates
Percentages of total population



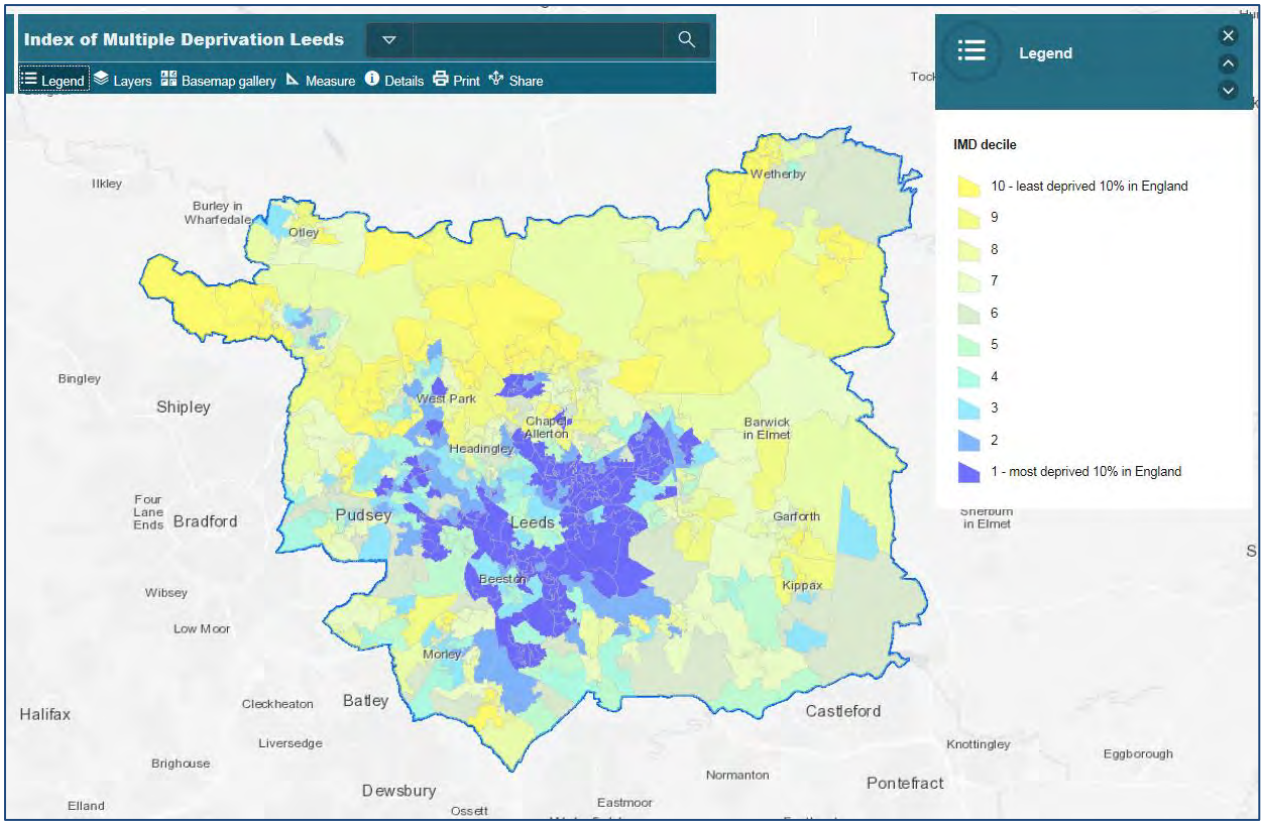
Deprivation & Poverty

The Leeds Director of Public Health in his 2017 report describes Leeds as ‘a city with a greater concentration of most deprived and least deprived neighbourhoods’.

Almost a third (30.4%) of the Leeds population live within an area that is in the 20% most deprived in England (2014, IMD2015). This proportion is significantly higher than the England average (20.2%).

There 105 LSOAs in the city (21.78%) that are within the 10% most deprived in England, whereas 40 LSOAs in the city are amongst the least deprived 10% of all areas. The number of deprived LSOAs has been increasing – in 2010 there were 88 in the 10% most deprived. 19.6% of under 16s in Leeds live in poverty (2015, HM Revenue and Customs).

As with many cities the higher levels of deprivation tend to be clustered around the city centre while less deprived LSOAs are larger in area (due to lower population density) and more suburban (see IMD 2015 map below, Leeds Observatory):



Ethnicity

Although predominantly white in ethnicity (85%), the population of Leeds contains significant ethnic minority populations, the largest in 2011 being Asian or Asian British (7.75% - ONS Census 2011). This group is also the largest in more recent figures from the PHI Audit of GPs 2016/17: 7.55% of residents are from an Asian background. The areas (MSOAs) in the city with the highest Black & Minority Ethnic (BME) proportions are Harehills Triangle/Harehills and Chapeltown, which are significantly higher than the Leeds average. Other areas also show a much greater diversity than the city as a whole, where high proportions of the population are non-white British or were born elsewhere – see tables below. The most ethnically diverse areas are predominantly in the inner areas of the city and are amongst the most deprived in the city. Leeds is a receiving city for migrants and those seeking asylum.

MSOA	% of population that are non-White British, Census 2011
Leeds average	*19%*
Harehills Triangle	89%
Harehills	72%
Chapeltown	71%
Beeston Hill	66%
Lincoln Green & Ebor Gardens	65%
Little London & Sheepscar	54%
Gipton North	52%
Oakwood & Gipton Wood	51%

MSOA	% of population with non-British country of birth, Census 2011
Leeds average	11%
Lincoln Green & Ebor Gardens	45%
Harehills Triangle	44%
Little London & Sheepscar	40%
Harehills	39%
Beeston Hill	37%
Chapeltown	33%
City Centre	32%
Little Woodhouse	28%
Holbeck	26%
Gipton North	25%
Oakwood & Gipton Wood	25%
Harehills – Comptons, Sutherlands, Nowells	24%

Educational attainment and employment

The city as a whole shows very similar educational attainment levels for GCSEs to the rest of the country and the region – see table below.

Percentage of pupils at the end of key stage 4 achieving at GCSE and equivalents: 5+ A*-C grades including English and mathematics GCSEs

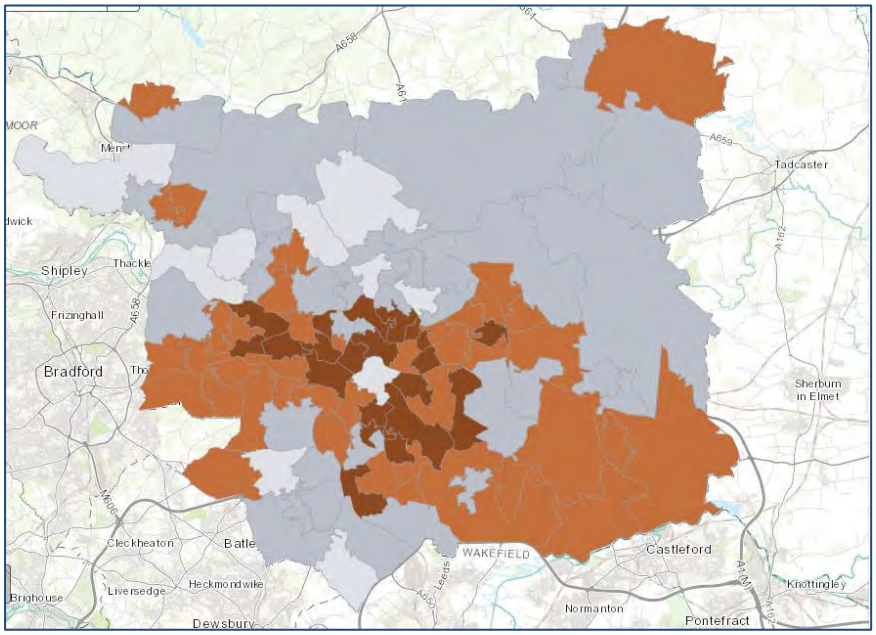
	2015/16
Leeds	54.2%
Yorkshire & Humber	55.7%
England	53.5%

SOURCE: DfE - SFR03/2017: GCSE and equivalent results in England 2015/16 (revised)

However, attainment varies across the city. Generally the north of the city has the highest attainment, with the west, inner east and south of the city doing less well –

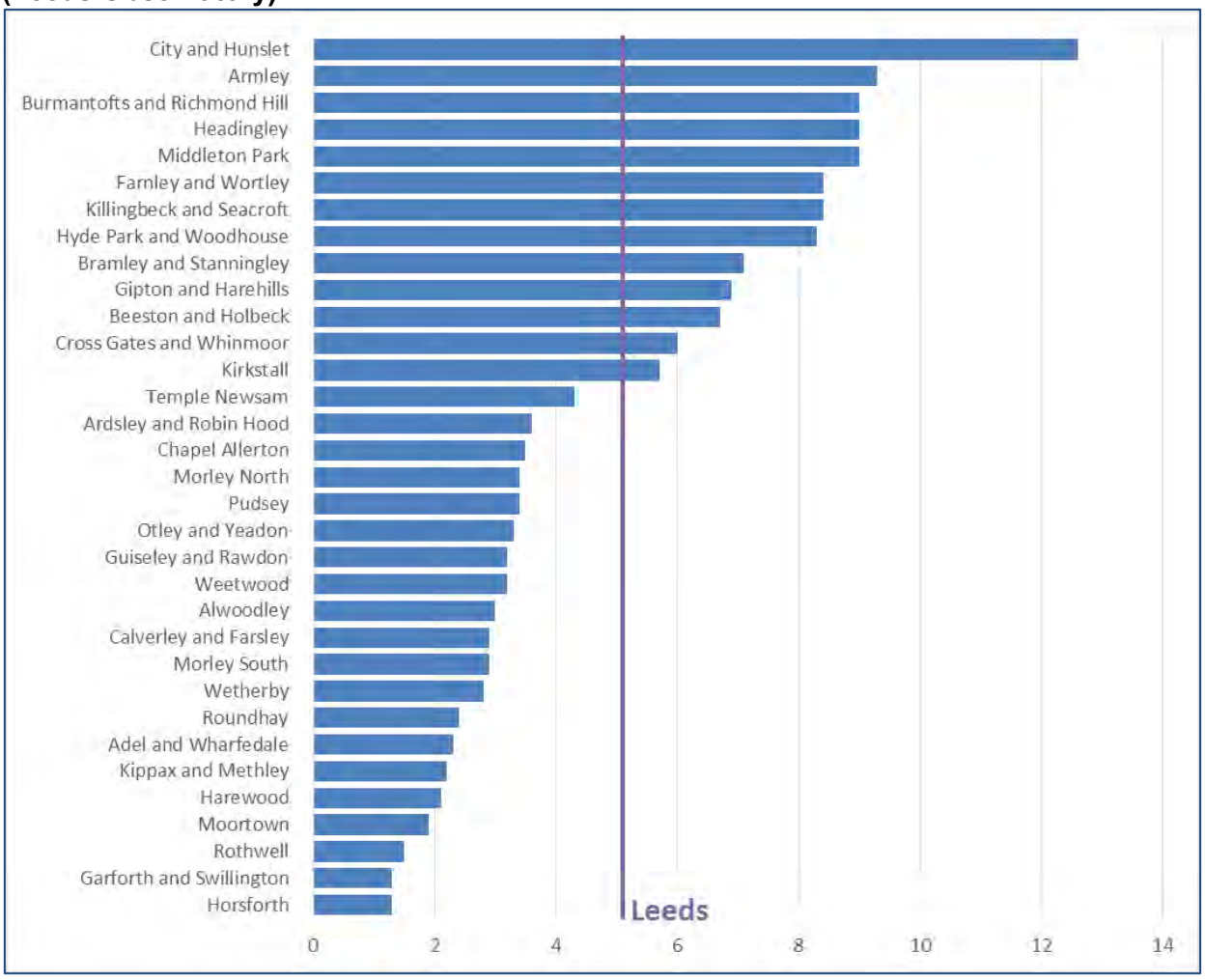
again largely corresponding with deprivation. The inner city areas tend to have the lowest levels of attainment – see map below:

Map showing areas where Key Stage 4 students achieved a "good" grade 2015-16. Lighter shaded areas show where the highest percentage of pupils achieved a good grade, darker areas the lowest percentage.



This trend in variation across the city is also seen in the NEET (young people Not in Education, Employment or Training) figures by Ward – see below:

Percentage of Young People who are NEET by Ward - May 2017 (Leeds Observatory)



SOURCE: Leeds Children's Services NEET data - Leeds Observatory

The percentage of the population classed as unemployed is below that of both the rest of the region and England, for all age groups – see table below.

Unemployed % (Jan 2016-Dec 2016)

	Aged 16+	Aged 16-19	Aged 20-24	Ethnic Minority 16+
Leeds	4.1	16.7	7.8	8.1
Yorkshire & Humber	5.2	19.8	10	8.3
England	4.8	20.9	10.2	8.4

16-19s are the group with the highest unemployment percentage. Females in this age group have the highest proportion of unemployment, which is higher than the rest of the region and England. People from ethnic minorities are also more likely to be unemployed in Leeds – particularly males (see table below).

Unemployed % (Jan 2016-Dec 2016)

		Leeds	Yorkshire & Humber	England
Aged 16+	All	4.1	5.2	4.8
	Males	4.1	5.5	4.9
	Females	4.2	4.9	4.8
Aged 16-19	All	16.7	19.8	20.9
	Males	14.3	25.0	24.3
	Females	19.1	14.8	17.4
Aged 20-24	All	7.8	10.0	10.2
	Males	7.9	9.8	11.6
	Females	7.6	10.2	8.6
Ethnic Minority aged 16+	All	8.1	8.3	8.4
	Males	10.7	8.4	8.1
	Females	4.7	8.2	8.9

Source: Annual Population Survey - ONS - NOMIS 2017

Chapter 2: Reproductive Health

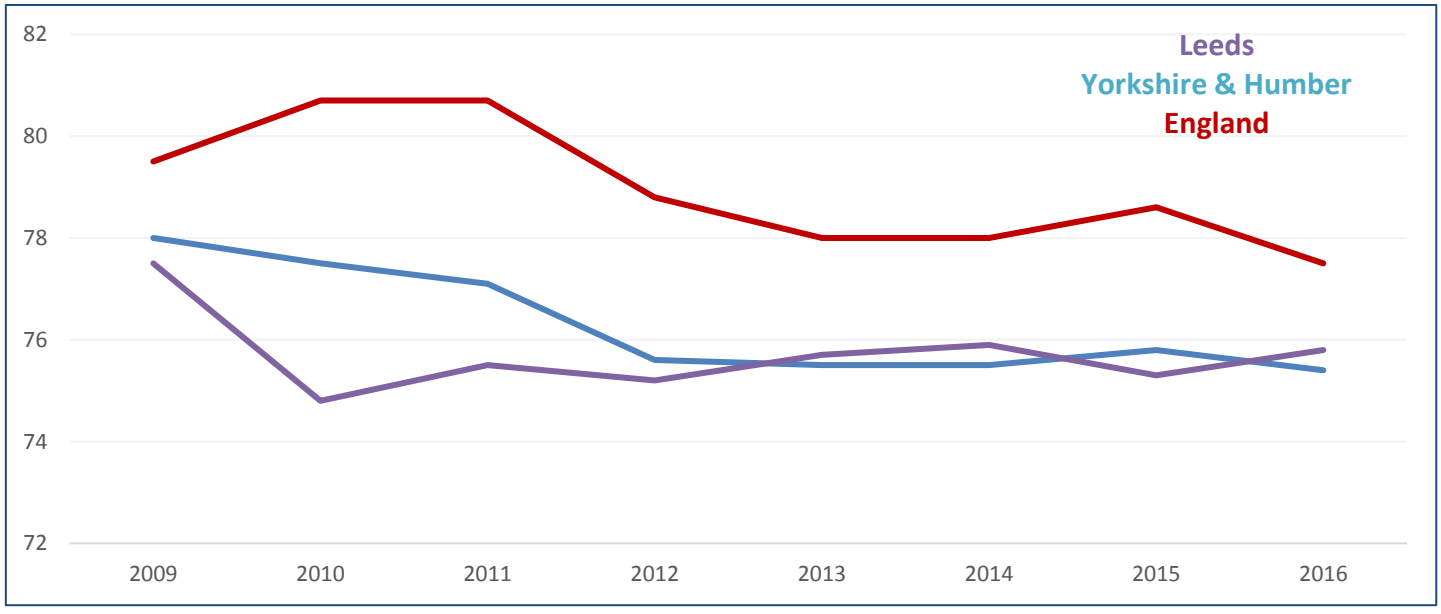
Conception

Around half the female population in Leeds are of childbearing age – (aged 15-44: 49.69% according to ONS 2016 mid-year estimates and 51.22% according to the PHI GP audit figures). This proportion is higher than the country and region.

The conception rate has remained steady since 2011 and is very similar to that of the wider region, however, it remains lower than the England rate. See graph and table below:

	All Conceptions: Rate per 1,000 women in age group*							
	2009	2010	2011	2012	2013	2014	2015	2016
England	79.5	80.7	80.7	78.8	78	78	78.6	77.5
Yorkshire & Humber	78	77.5	77.1	75.6	75.5	75.5	75.8	75.4
Leeds	77.5	74.8	75.5	75.2	75.7	75.9	75.3	75.8

*Rates per 1,000 women aged 15 to 44.



SOURCE: ONS - Conception Statistics

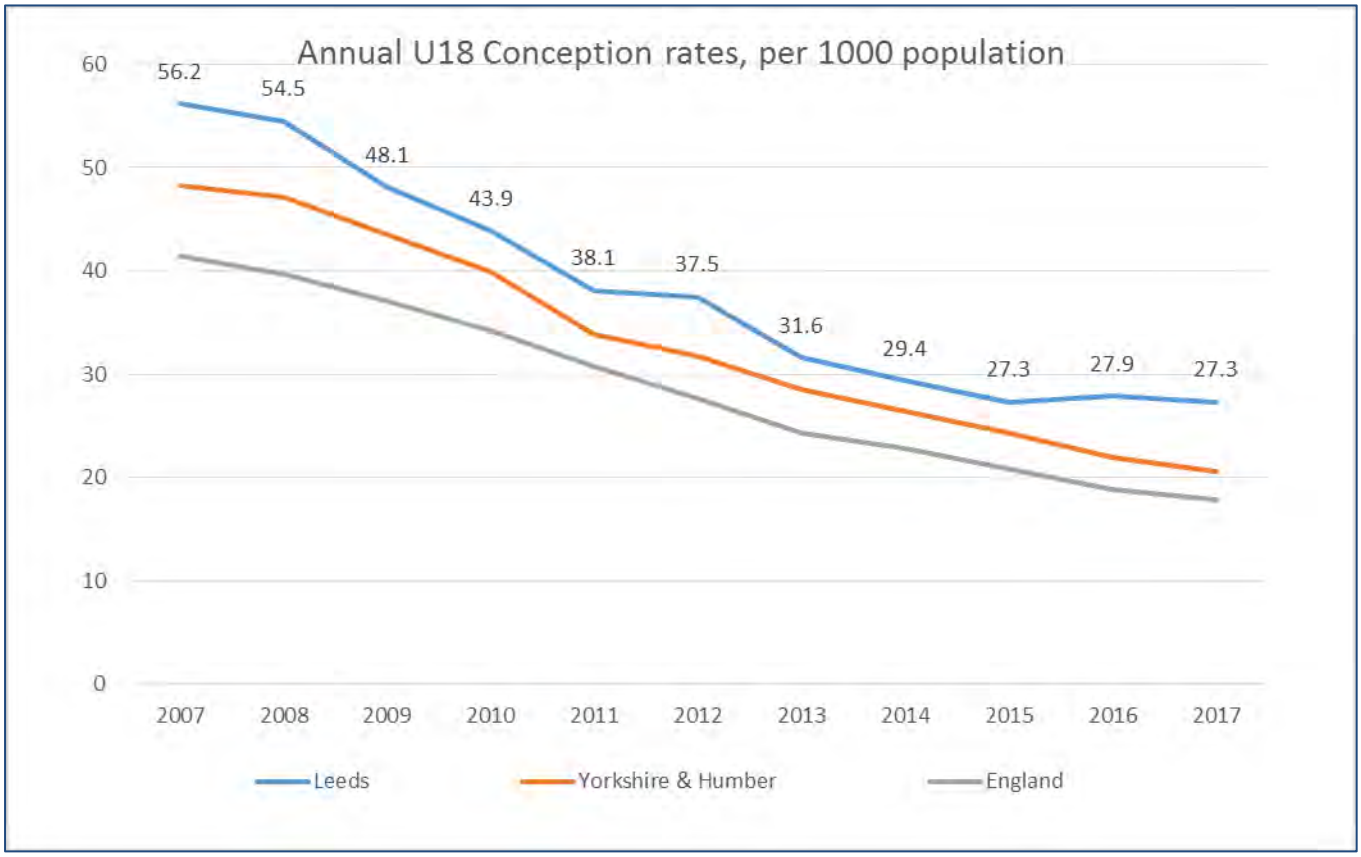
Under 18 conceptions account for 2.53% (2016, ONS Conception Statistics) of all conceptions in Leeds. This is comparable to both the region and England.

Under 18 conceptions/Teenage Pregnancy

Teenage pregnancy is a cause and consequence of education and health inequalities for young parents and their children, therefore reducing rates of under 18 conceptions is an ambition in Department of Health's A Framework for Sexual Health Improvement in England and an indicator in the Public Health Outcomes Framework (PHOF 2.04).

Teenage pregnancy rates have continued to decline at a local, regional and national level. This is positive, but should not lead to complacency. 1998 was the baseline year of the Teenage Pregnancy Strategy, which aimed to reduce teenage conceptions by 50%. ONS figures in 2017 show a national reduction of 61.8% and a regional reduction of 61.2%. However, Leeds has yet to meet the 50% target – reducing under 18 conceptions by 45.8% in the same period.

The graph and table below show the decline in under 18 conceptions per 1000 15-18 year old women since 2007:

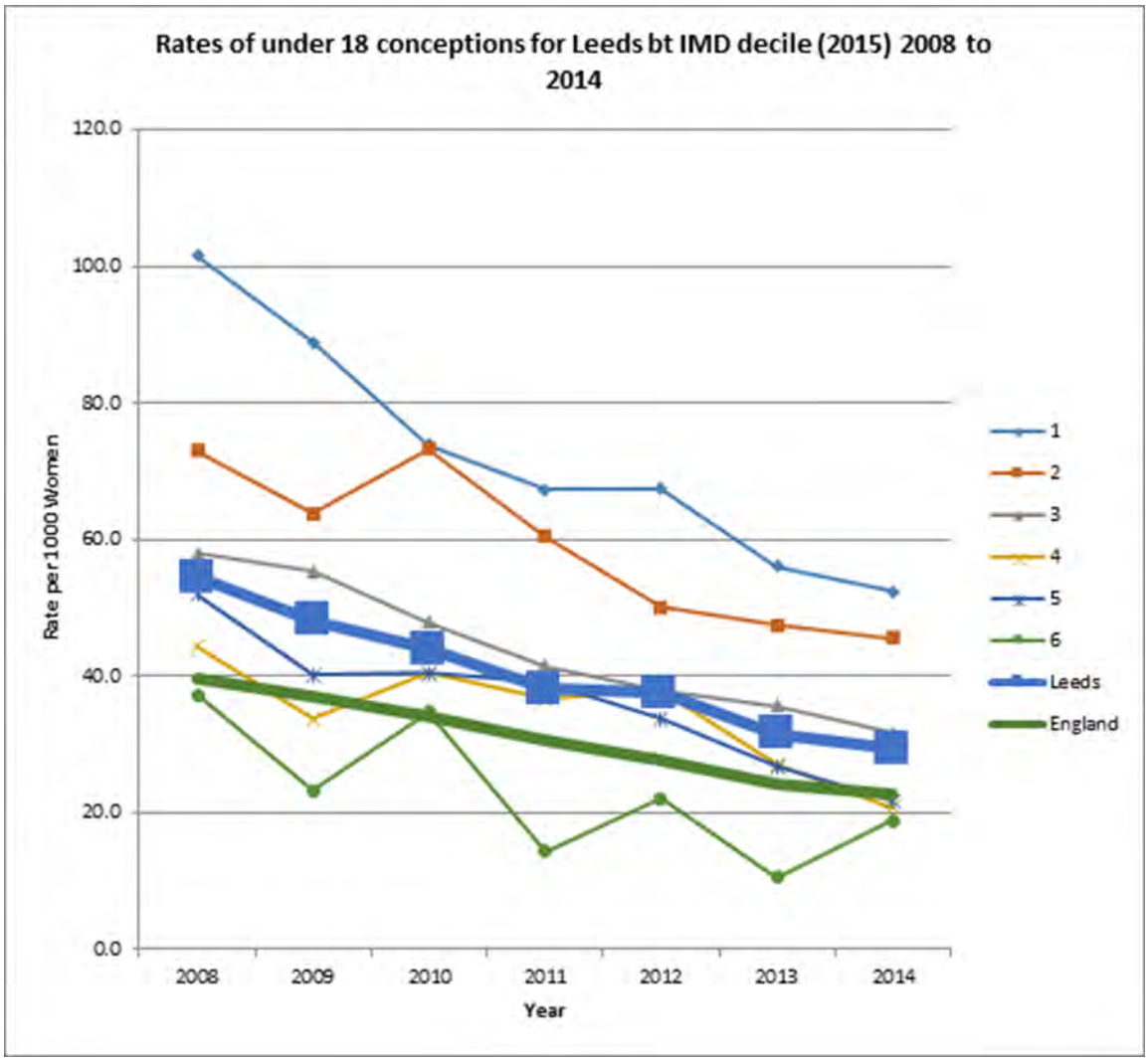


	Under 18 Conception Rate per 1,000 women in age group										
	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Leeds	56.2	54.5	48.1	43.9	38.1	37.5	31.6	29.4	27.3	27.9	27.3
Yorkshire & Humber	48.3	47.1	43.5	39.9	33.8	31.7	28.5	26.4	24.3	22	22
England	41.4	39.7	37.1	34.2	30.7	27.7	24.3	22.8	20.8	18.8	18.8

The annual rates have plateaued since 2015.

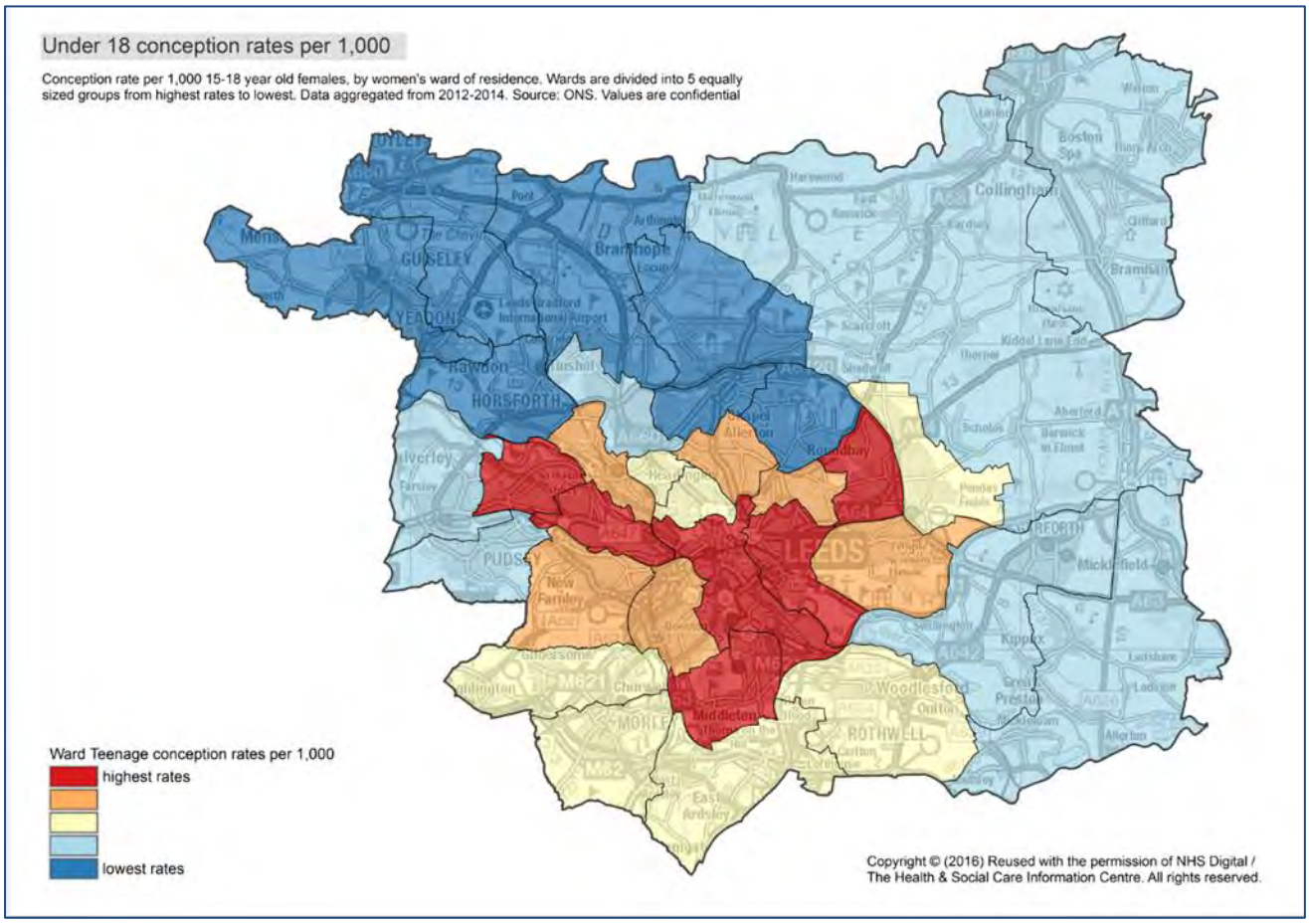
A note on sub-Leeds level under 18 conception data: *There is a lack of robust, up-to-date conception data at a ward level. The latest data with full ward coverage was for the period 2012-14 (in 2013-15, the ward level data was provided, but with incomplete coverage). The 2012-14 data is presented here. However, the ward boundaries used for the 2012-14 data have since been changed. Therefore, caution should be exercised when drawing conclusions on a ward level as the picture may have changed somewhat since the publication of the most recent, reliable data. Conception data at the IMD decile level for Leeds is available up to 2014, which again is out of date, but gives an indication of recent trends.*

There is a strong relationship between teenage conceptions and deprivation. The graph below shows the most up-to-date IMD decile data. Deciles 1 and 2 (the most deprived) have the highest conception rates – well above the rates for the city as a whole and national rates. However, although all deciles have shown improvements in rates, these deciles show the greatest reduction over time.



IMD Deciles do not easily translate into wards, but the most recent ward level data show that the distribution of conceptions across the city is highest in the inner city, more deprived wards, with the lowest rates occurring in the outer, more affluent

wards. See map below, where wards are colour coded from highest to lowest, by conception rate (aggregated data from 2012-2014):



(source: Conception rate per 1000 15-18 year old females, by woman's ward of residence. Data aggregated from 2012-2014, ONS).

Unplanned pregnancy: contraception & abortion

Unplanned pregnancies can end in abortion or maternity. Although many of these pregnancies that continue will become wanted, unplanned pregnancy can cause financial, housing and relationship pressures, impact on existing children and in some cases lead to further burden on the social care system. The Department of Health's 'Framework for Sexual Health Improvement in England' (2013) includes the ambition to reduce unwanted pregnancies among all women of fertile age through: increased knowledge and awareness of all methods of contraception among all groups; and increased access to all methods (including LARC and emergency hormonal contraception), for women of all ages and their partners. Alongside this, swift and easy access to abortion services to ensure women who seek to end an unwanted pregnancy (in accordance with the Abortion Act, 1967) can do so without delay is also an important factor. Local abortion rates are indicators of the level of

access to good quality contraception services and advice, as well as highlighting problems with individual use of contraceptive methods (PHE Fingertips, 2018).

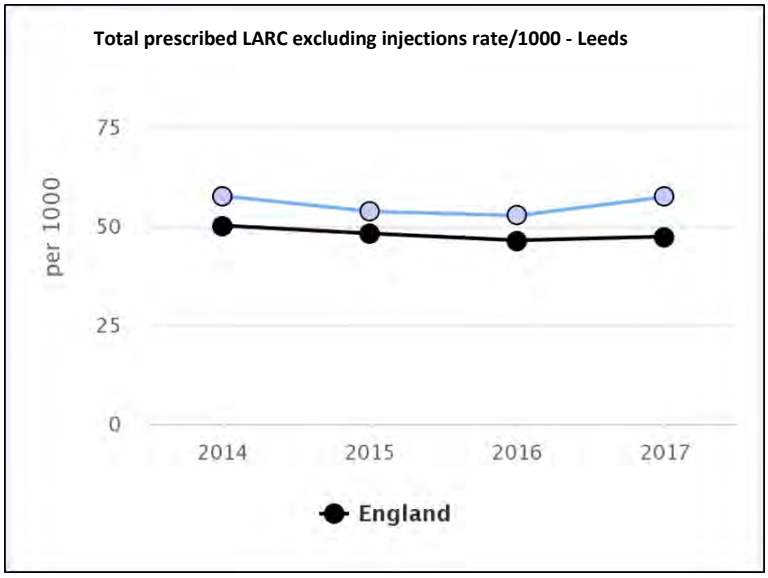
Contraception

To effectively reduce unwanted pregnancies, including teenage conceptions, both women and men should have knowledge, easy access to and choice of all available methods of contraception.

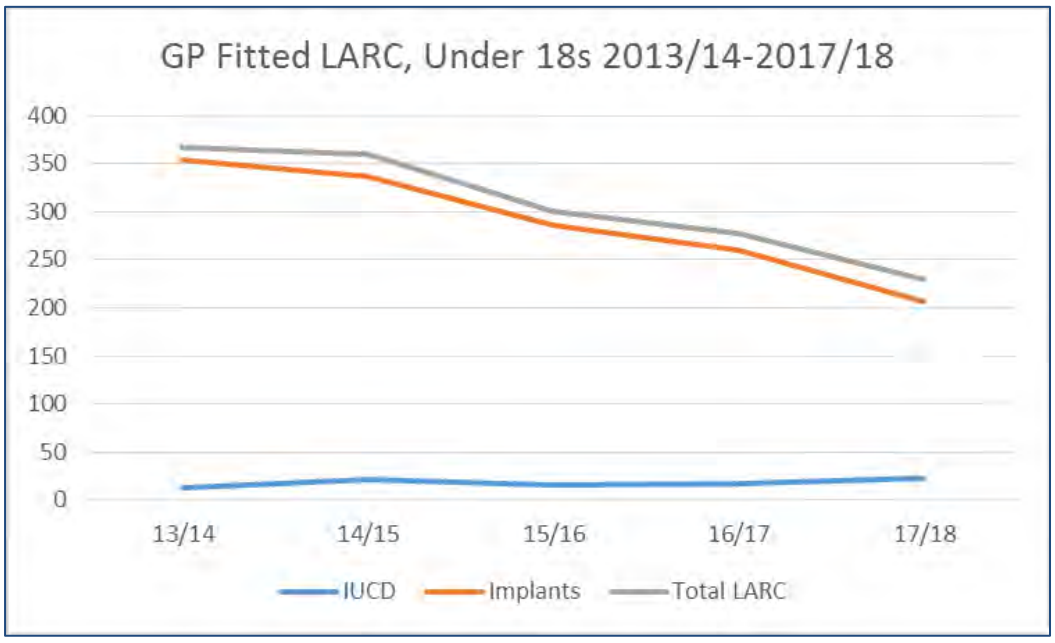
The National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 advises that LARC (long acting reversible contraception) methods, such as implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. Implants, IUS and IUD can remain in place for up to 3, 5 or 10 years depending on the type of product. Contraceptive injections are not categorised as LARC because they rely on timely repeat visits every 12 weeks. Consequently, the failure rate of typical use of contraceptive injections is more comparable to that of the combined oral contraceptive.

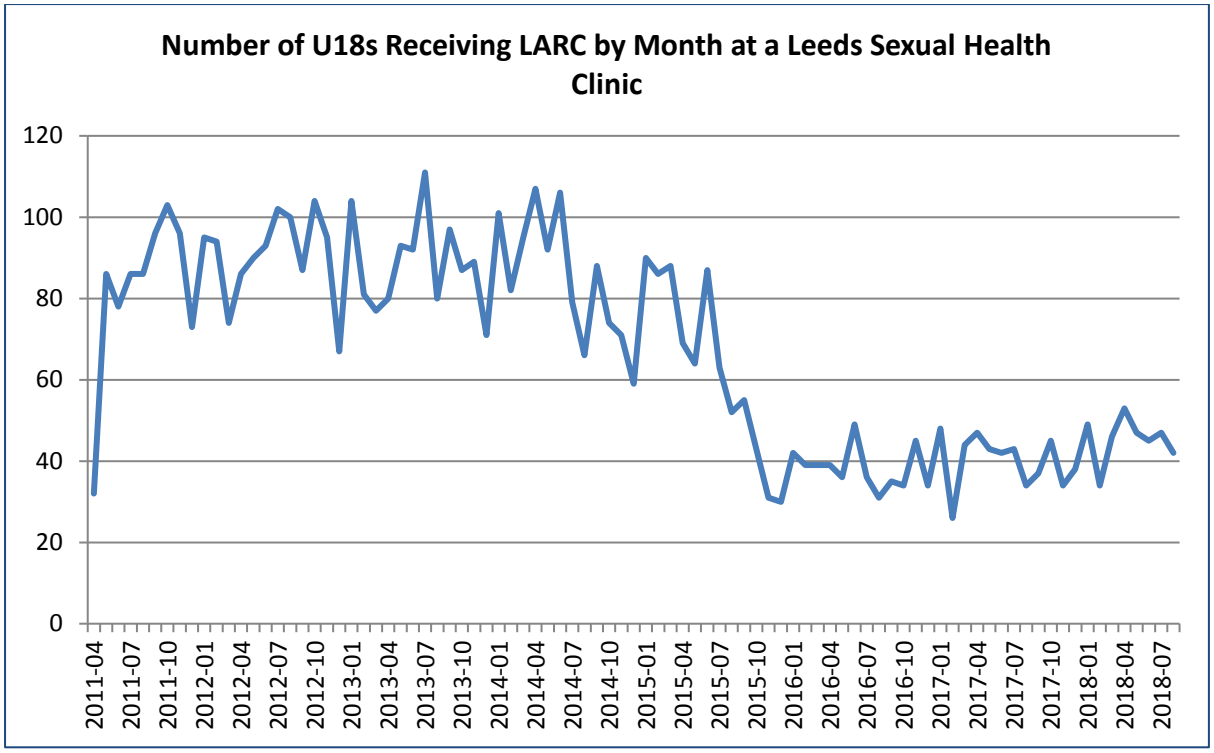
A strategic priority is to ensure access to the full range of contraception is available to all. The intention is to encourage informed choice rather than to promote LARC methods at the expense of other contraceptive methods. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy. There are difficulties in accurately measuring LARC use however, as data reflects initiation of LARC, but does not measure method continuation.

Total prescribed LARC in Leeds (excluding injections, as prescribed by GPs and sexual & reproductive health services (SRH)), per 1000 15-44 year old women, was declining, but has begun to increase, remaining higher than the national rate. In 2017, the rate was 57.4 per 1000 (see graph below):

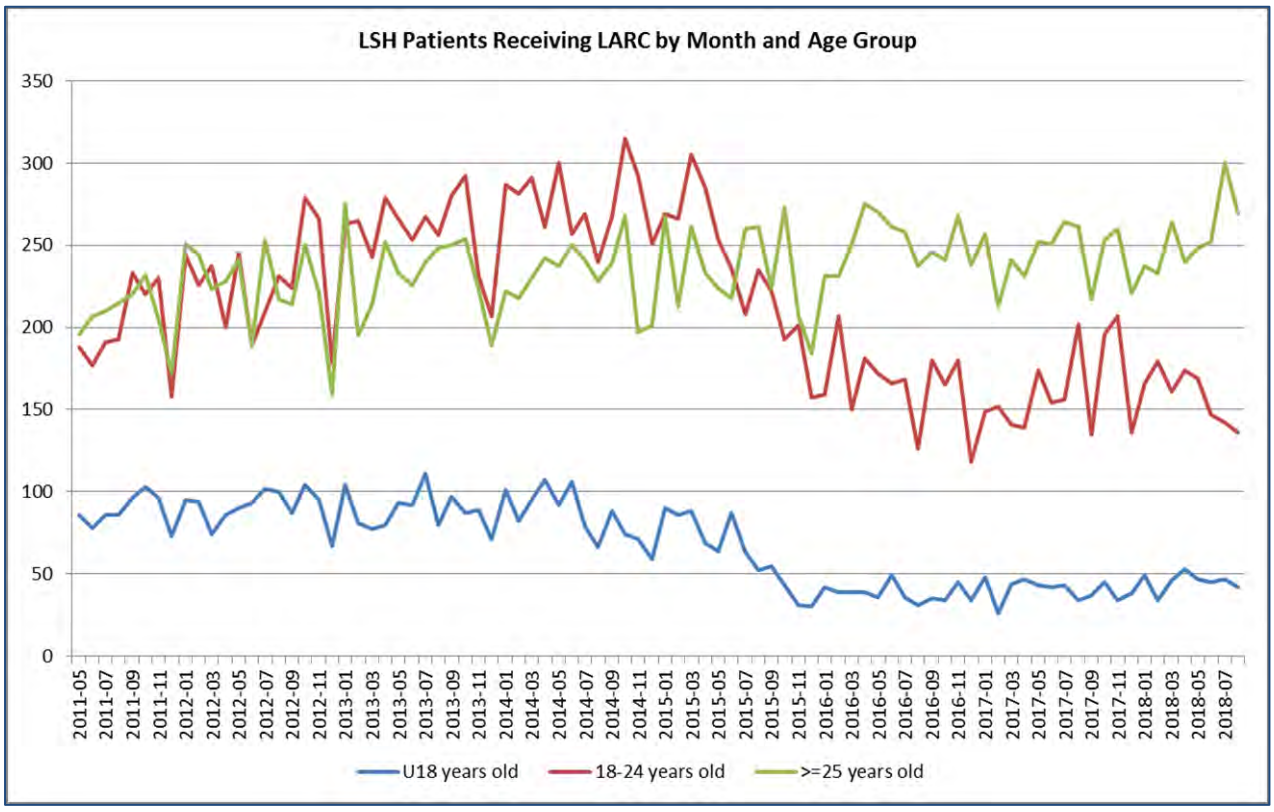


Numbers of LARC fittings to under 18s in Leeds is declining however – both fittings performed by GPs and by Leeds Sexual Health (LSH) clinics – see graphs below:





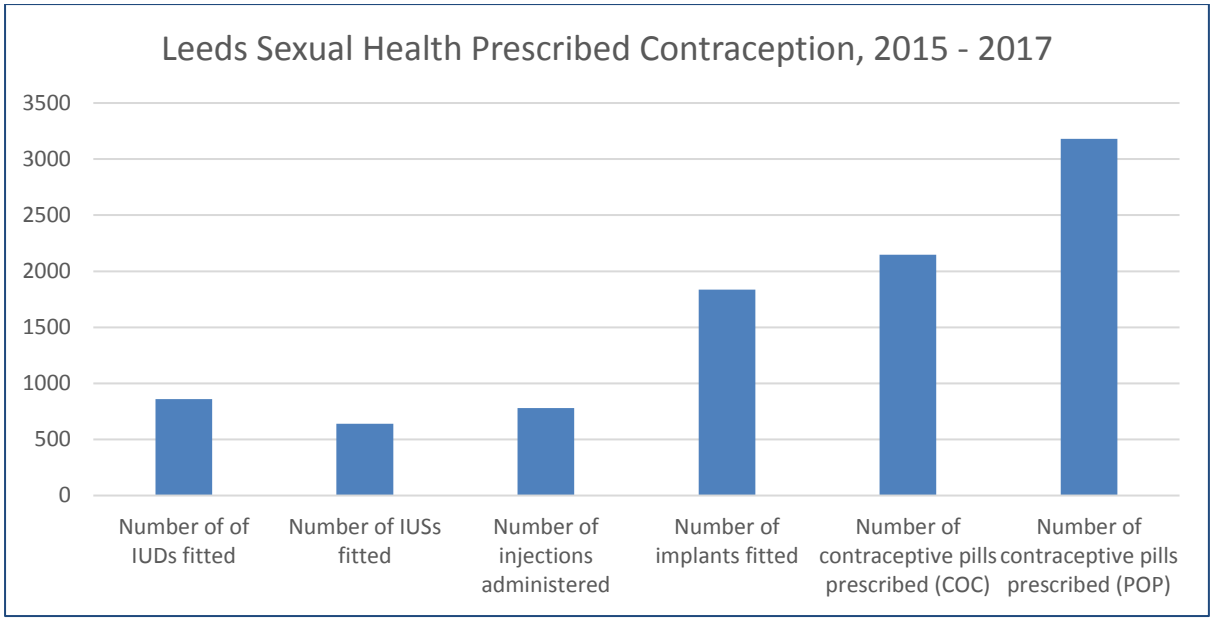
The decline in fittings at LSH clinics could be attributed to the closure of Citywise dedicated young people's clinic at the end of 2015, when fitting numbers begin to fall. However, this does not explain the continuing decline seen in GP fittings, nor the accompanying decline in fittings in the 18-24s age group at LSH (see graph below, showing fittings by month, sorted by age range).



This data suggests that further investigation into younger women's understanding and perceptions of LARC access and acceptability is necessary, alongside further understanding of whether a decline in LARC use in this age range reflects any changes in sexual behaviour (when considered alongside declining under 18 conception rates).

Women of all ages are more likely to access LARC via their GP in Leeds: the rate per 1000 (15-44 year old women) of GP prescribed LARC in 2016 was 40.1, whereas the rate of LARC prescribed in a SRH was 12.6 per 1000. The GP LARC rate is significantly above the national rate, but the SRH LARC rate is significantly lower than the national rate and is amongst the lowest rates in the region. Leeds has good coverage of GP services that are commissioned to provide LARC fitting, with trained staff able to administer these methods. Every ward of the city has at least one surgery with a fitter, with several having 3 or more. Accessing contraception via GP services eases the burden on busy SRH services and means that women can access a service closer to where they live. Additionally, women attending a SRH service for LARC fitting only will very likely not be the highest priority after triage, so may have to wait or be asked to return at a later date during busy clinics. This will further drive women to GP services and explain the lower rate of prescribing in SRH services. This may also explain why the rate of women aged under 25 attending specialist contraceptive services in Leeds is declining, and at 81.3/1000 (2017), is one of the lowest in the region and significantly lower than the England rate. This comparatively low rate may also be due to coding issues – if women attend primarily for a GUM issue, but are subsequently prescribed contraception, they may not be represented in the data. However, as covered above, further investigation into younger women's perceptions of contraception is required to fully understand these figures.

However, when women do access contraception from a SRH service in Leeds, they are more likely to choose non-LARC methods: 65.5% of women chose user-dependent methods that require compliance daily in 2016. This is higher than the national average and one of the highest percentages in the region. When looking specifically at short acting hormonal methods (the pill, contraceptive patch and ring), almost half of women accessing contraception in SRHs choose these methods (47.8% in 2016). This is reflected in numbers of contraceptives prescribed by the Leeds Sexual Health clinics from their opening in 2015 to the end of 2017, showing the pill is the most prescribed:



Looking at LARC choice in SRHs by age, in Leeds only 19.7% of under 25s chose LARC at a SRH in 2016; 34% of over 25s chose LARC (source: NHS Digital). These proportions are amongst the lowest in the region. See tables below:

Under 25s choose LARC excluding injections at SRH Services (%) 2016 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	87,377	20.6	20.4	20.7
Yorkshire and the Humber region	–	8,789	22.8	22.4	23.3
Kingston upon Hull	–	1,295	34.1	32.6	35.6
Rotherham	–	920	29.9	28.3	31.5
Bradford	–	611	28.9	27.0	30.8
Sheffield	–	616	27.2	25.4	29.0
East Riding of Yorkshire	–	624	26.5	24.8	28.4
Kirklees	–	632	24.3	22.7	26.0
North Yorkshire	–	545	23.8	22.1	25.6
North East Lincolnshire	–	266	22.7	20.4	25.2
North Lincolnshire	–	266	21.6	19.4	24.0
Calderdale	–	348	21.2	19.3	23.2
Barnsley	–	247	21.2	18.9	23.6
Leeds	–	1,027	19.7	18.7	20.8
York	–	597	18.3	17.0	19.7
Wakefield	–	311	16.8	15.2	18.6
Doncaster	–	484	10.9	10.0	11.9

Source: NHS Digital

Over 25s choose LARC excluding injections at SRH Services (%) 2016 — Proportion - %

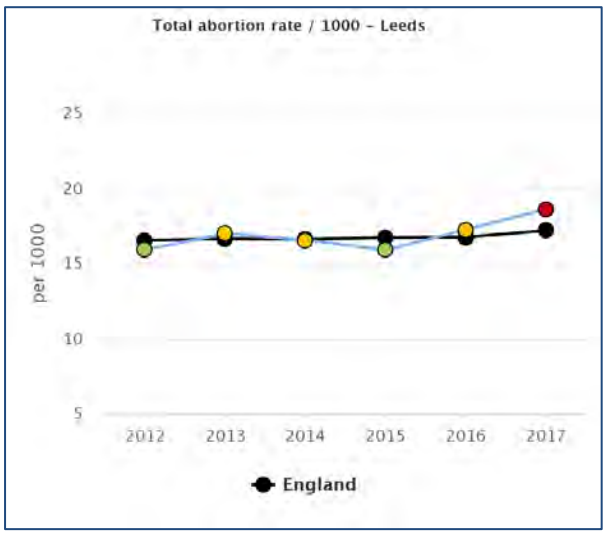
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	151,794	35.7	35.5	35.8
Yorkshire and the Humber region	–	11,648	36.7	36.2	37.3
Sheffield	–	556	46.8	43.9	49.6
Kingston upon Hull	–	1,578	46.4	44.7	48.1
East Riding of Yorkshire	–	694	46.4	43.9	48.9
Bradford	–	1,583	42.2	40.6	43.8
North East Lincolnshire	–	328	42.1	38.6	45.5
Kirklees	–	1,307	39.8	38.2	41.5
North Yorkshire	–	625	37.6	35.3	39.9
Rotherham	–	904	35.9	34.0	37.8
Calderdale	–	479	34.3	31.9	36.8
Leeds	–	1,454	34.0	32.6	35.5
Barnsley	–	328	32.4	29.6	35.3
York	–	480	27.8	25.7	29.9
Wakefield	–	425	27.5	25.3	29.7
North Lincolnshire	–	123	27.2	23.3	31.5
Doncaster	–	784	24.4	22.9	25.9

Source: NHS Digital

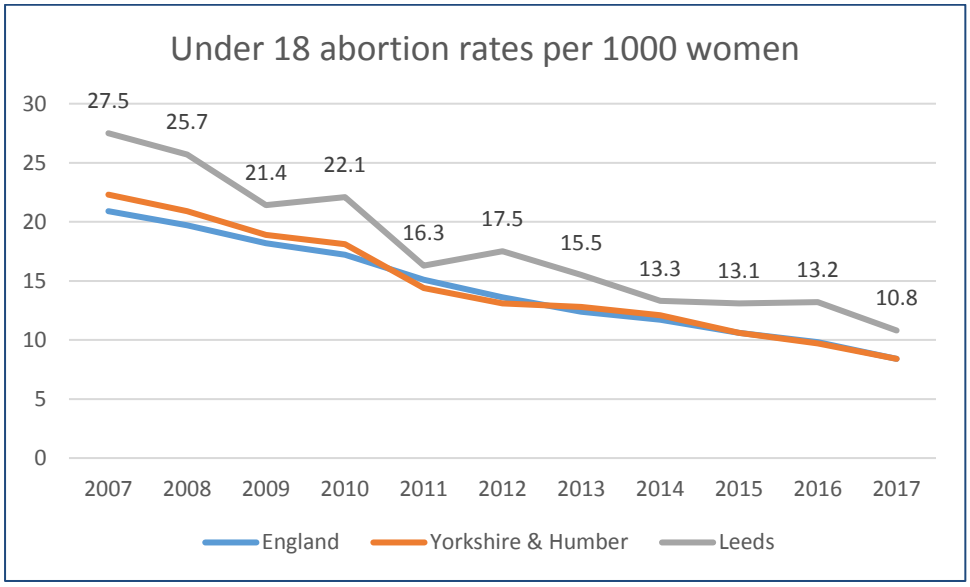
This may be due to women preferring a method they can access immediately, rather than having to return. Alternatively, they may choose a hormonal, short acting bridging method until they can be fitted with LARC at a later date. The data may also reflect that women (of all ages) have a lack of information or mistrust of LARC methods and need access to effective contraceptive counselling and advice.

Abortion

In 2017, around 24% of all conceptions in Leeds ended in abortion and around 43% of under 18 conceptions ended in abortion (ONS, 2017). The total abortion rate per 1,000 female population aged 15-44 years was 18.6 (2017) and is showing an increasing trend, which is higher than the national rate and third highest in the region.



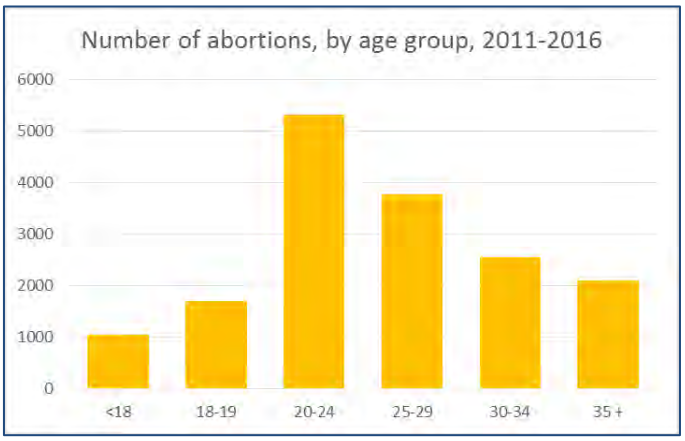
Under 18 abortion rates however, have declined by 52% since 2007, following the annual decline in the under 18 conception rate (see graph below). Rates still suggest that at least half of under 18 conceptions are unplanned.



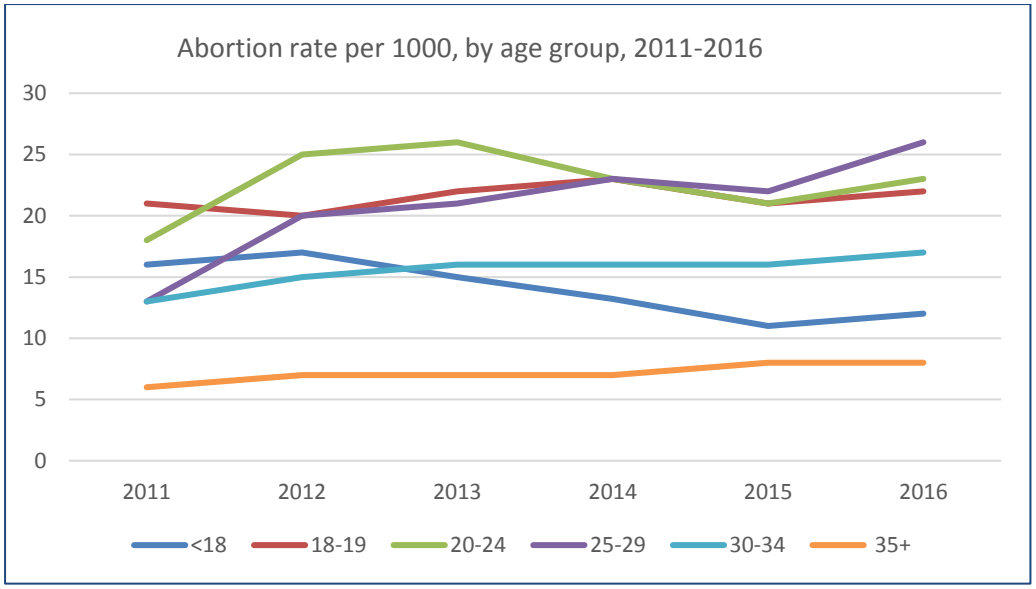
Source: ONS Conception Statistics

When looking at the number of abortions performed in Leeds from 2011-2016, the highest number of abortions were amongst 20-24 year olds (see graph below) – this follows the pattern regionally and nationally. 20-24s are the largest age group in the city, so it is expected that numbers in this sexually active group are highest, when many young people are not ready to begin a family.

Leeds number of abortions by age group, 2011-2016:

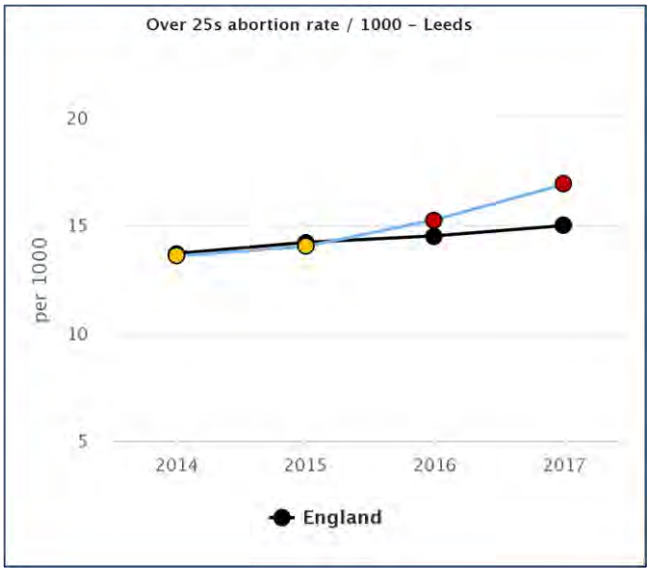


However, in 2016, the abortion rate per 1000 women (aged 15-44) was highest in the 25-29 year old age bracket and is the group showing the largest annual increase since 2015 – see graph below.



Department of Health Abortion Statistics, England & Wales

Leeds has the second highest over-25 abortion rate in the region (16.9 per 1000 in 2017 – this is significantly higher than the national rate of 15/1000). The rate is showing an increasing trend. See graph below:



Repeat abortions and abortion after a previous birth

Among women under 25 years who had an abortion in 2017: The percentage of those who had had a previous abortion was 26.6%, which is not significantly different to the regional or national rate and has remained at a similar rate since 2012. The percentage of those who had had a previous birth was 24.1%, which is significantly better than the England rate and the second best in the region.

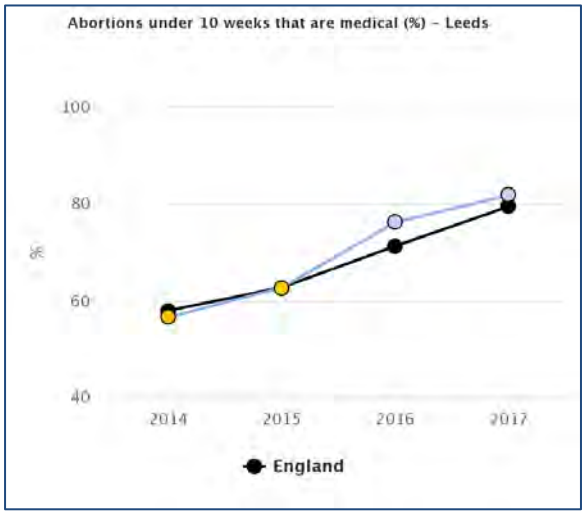
Ethnicity

The vast majority of abortions in Leeds in 2016 (68%) were to white British women. Of the abortions to women in other ethnic groups, 24% were to white women from other backgrounds (not including Irish women). (CCG abortion data, 2016). Further, more detailed data is available on ethnicity breakdown, but numbers are very small.

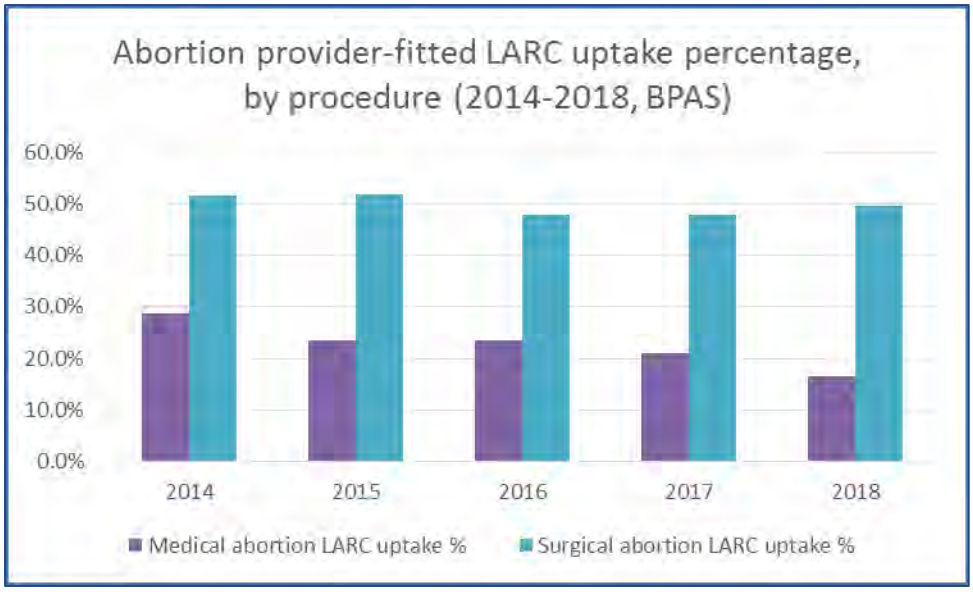
Gestation

The earlier that abortions are performed, the lower the risk of complications and the more cost effective the procedure. High proportions of earlier procedures also indicate prompt access to services. 80.1% of all abortions in Leeds (2017) took place under 10 weeks. This was significantly higher than the England percentage.

The choice of early medical abortion is likely to have contributed to the increase in the overall percentage of abortions performed at under ten weeks' gestation. The percentage of abortions using this method is on the increase in Leeds and is higher than the percentage nationally (81.8% in Leeds, while in England the percentage was 79.4%) – see graph below:



However, it is important that women are still given a choice of medical or surgical procedure. Some women may opt for surgical methods to avoid experiencing the symptoms of induced pregnancy loss or for practical purposes: surgical procedures generally require only one trip to the provider site, avoiding undue disruption to work/home life. Women may also wish to have intrauterine LARC fitted during the procedure, preventing future unplanned pregnancy. Figures from BPAS show that around half of women choose to have a LARC fitting by the abortion provider during a surgical procedure, whereas less women choose to do so after medical (and numbers are declining), which is likely to reflect the fact that fitting cannot be performed at the same time (see graph below):



When LARC cannot be fitted directly after the procedure, women are invited in to have a fitting at the provider site soon after. Many women do not take up this offer with BPAS, however, Marie Stopes International report more success.

Geographical

In 2016, the areas of the city that are most highly populated with females had the highest numbers of terminations in women over 18, corresponding with the areas that are most deprived (see individual ward maps, chapter 5).

Numbers of under 18 abortions are very small for all areas. The highest number of terminations in 2016 in this age group largely correspond with the areas where teenage conceptions are highest. The exceptions are the Pudsey, Calverley & Farsley, Morley and Headingley areas, which had some of the highest numbers of under 18 terminations, but not highest conceptions. This may indicate that young women in these areas are less likely to continue with a pregnancy, perhaps due to higher aspirations or educational attainment.

Chapter 3: HIV & STIs

HIV

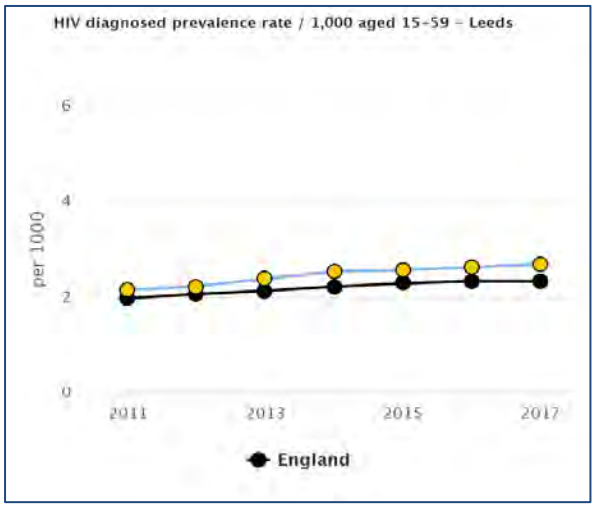
Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to live into old age if diagnosed promptly.

With progressive strengthening of combination prevention (including condom use, expanded HIV testing, prompt ART and availability of PrEP), HIV transmission, AIDS and HIV-related deaths could be eliminated in the UK. The recent encouraging changes are dependent upon sustained prevention efforts. The inconsistencies between groups and geographies demonstrate that combination prevention needs to be replicated for all those at risk of acquiring of HIV, whoever they are and wherever they live. (PHE LASER, 2016).

HIV remains an important public health concern in Leeds. Those most at risk of becoming infected are still MSM and those from Black African communities. In England in 2016, 48% of new HIV diagnoses were in gay and bisexual men; 53% of new HIV diagnoses were in white and 20% were in black African populations. Although the proportion of new diagnoses in the white population is higher, given the relative sizes of the white and black African populations, the prevalence rate per 1,000 15-59 year olds was much higher in black Africans than in the white population.

People living with diagnosed HIV in Leeds:

In 2017, the diagnosed HIV prevalence rate in Leeds was 2.68 per 1,000 population aged 15-59 years, similar to the England rate of 2.32 per 1,000. The goal is for LAs to have a prevalence rate of <2.
Leeds has the highest prevalence rate in the region and the trend has been increasing since 2011 (see graph below).



In some areas of the city, the prevalence rate is higher than the city average, as expected in an urban area where population and deprivation vary widely across the

LA. Further detail is available, however numbers on a sub-Leeds level are very small, so cannot be shared publically, but are used to inform targeted work.

Opportunistic HIV testing: Blood Borne Virus (BBV) Screening in Primary Care & HIV Screening in Acute Medical Unit (AMU) and Accident & Emergency

The UK National Guidelines for HIV Testing 2008 indicate that LAs/NHS should implement HIV testing for all general medical admissions and new registrants into primary care where HIV Prevalence exceeds 2 in 1000. Prevalence rates of 2-5/1000 are classed as “high”. Prevalence is also linked to late diagnosis: two thirds of late diagnoses are in LAs with high/extremely high prevalence areas. As Leeds has a “high” prevalence rate (2.68/1000), with some areas showing rates higher than the city average, the Public Health Sexual Health team sought to secure funding to run a primary care screening pilot at the end of 2015, in order to reduce the numbers of late diagnoses. This pilot, implemented across selected city-wide general practices, sought to introduce HIV, Hepatitis B and C (HBV/HCV) screening into new patient registration. Practices with estimated high HIV prevalence were chosen. In the first 8 months of the pilot, testing across all conditions increased by almost 250% compared to before the pilot began, with high positivity rates. The individuals diagnosed with a condition through this pilot can now access the appropriate care, with probable improvements to their prognoses and a reduction in their risk of transmitting these conditions to others. The next phase of the pilot now continues in a more targeted area of the city, with a collaboration of practices working together to increase screening.

In the same year (January 2015), CCG funding was secured to begin a project which aimed to offer a routine HIV test to all patients up to and including 65 years of age admitted to the acute medical unit (AMU) at St James University Hospital Leeds. The AMU consists of four acute wards and an acute medical assessment area. HIV testing has been offered since the beginning of the project on an opt-out basis by the doctor or nurse practitioner admitting the patient. HIV testing has been shown to be highly acceptable to patients, resulting in high testing and positivity rates (in the first 6 months of the project, 59.9% of admissions were tested for HIV). To support the testing of large numbers of patients in a busy acute setting, a HIV testing nurse was employed. The nurse has been an important factor in the project’s success and greatly improved the testing rate. The project continues to run, identifying unknown infections (often at a late stage, after previous missed opportunities for testing), those who were aware of their status but not accessing treatment and the status of the partners of those identified as positive. The unit ensures positive patients are seen promptly by a HIV doctor and can commence treatment without delay.

In response to the NICE recommendation for routine testing for HIV in emergency departments, in regions of high prevalence, Leeds Teaching Hospitals NHS Trust (LTHT), has this year (2018) begun a pilot BBV screening programme within Accident & Emergency in the city. Patients aged between 16 and 65 attending A&E in Leeds, who undergo routine blood tests, will be provided with testing for Hepatitis

B, Hepatitis C and HIV as part of the 'Get Tested Leeds' six-month pilot. The programme is a collaboration between the trust and US-based research company Gilead Sciences.

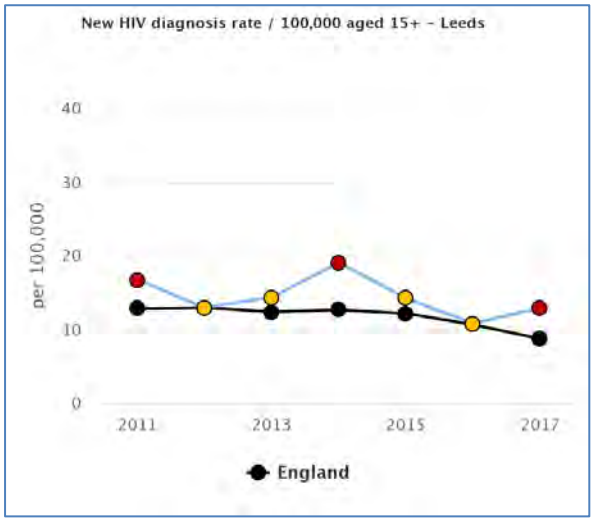
HIV new diagnoses

The 2017 new diagnosis rate (for those aged 15+, in all settings in the city) was 12.9 per 100,000, which is significantly higher than the national rate and the highest rate in the region. See table and graph below:

New HIV diagnosis rate / 100,000 aged 15+ 2017 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	3,948	8.7	8.4	8.9
Yorkshire and the Humber region	↓	251	5.6	4.9	6.4
Leeds	→	83	12.9	10.3	16.0
Sheffield	→	33	6.9	4.7	9.7
Kingston upon Hull	→	13	6.1	3.3	10.5
Bradford	→	25	6.0	3.9	8.9
Doncaster	→	13	5.1	2.7	8.8
Barnsley	→	10	5.0	2.4	9.2
Calderdale	→	8	4.7	2.0	9.2
North East Lincolnshire	→	5	3.8	1.2	8.9
North Lincolnshire	→	5	3.5	1.1	8.3
North Yorkshire	→	18	3.5	2.1	5.5
Kirklees	→	11	3.1	1.6	5.6
Wakefield	→	8	2.9	1.2	5.6
York	→	5	2.8	0.9	6.6
East Riding of Yorkshire	→	8	2.8	1.2	5.5
Rotherham	→	6	2.8	1.0	6.1

Source: Public Health England



When looking at new HIV diagnoses, from 2008/09 – 2016/17 (GUMCADv2 Report: Numbers of All Diagnoses and Services, Patients from Leeds attending all (GUM & Non-GUM) services), the majority of new diagnoses were to males (69.47%), 66% of these males were homosexual or bisexual. Nationally and regionally, there has been a continued decline in new HIV diagnoses among black African heterosexual men and women. This decline is due to changing patterns of migration, with fewer people from high HIV prevalence countries coming to the UK.

HIV late diagnosis

Knowledge of HIV status, particularly early diagnosis, increases survival rates, improves quality of life and reduces onward transmission. Late diagnosis of HIV is the most important predictor of morbidity and mortality. Those diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Late diagnosis is a critical component of the Public Health Outcomes Framework (PHOF indicator 3.04) and monitoring is essential to evaluate the success of local HIV testing efforts.
In Leeds, between 2015 and 2017, 53.4% of HIV diagnoses were made at a late stage of infection (CD4 count =<350 cells/mm³ within 3 months of diagnosis – when ART should begin) compared to 41.1% in England. Ideally, the percentage of late diagnoses should be below 25%. Leeds' percentage has remained steady since 2011-2013.
In Leeds and the rest of the region, in 2016, heterosexuals were more likely to be diagnosed late than MSM. By ethnic group, black Africans were more likely to be diagnosed late than the white population.

Offer and uptake of HIV testing at eligible attendances in specialist sexual health services (SHSs)

Increased HIV testing reduces undiagnosed infection and late diagnosis. Knowledge of HIV status increases survival rates, improves quality of life and reduces transmission.

In 2017, in Leeds, there was a 79.6% uptake of HIV tests, in SHSs (number of eligible new episodes where a HIV test was accepted, out of the times it was offered – includes multiple tests/offers to the same person).
This percentage is significantly better than the England average.
In women, the uptake was 73.5% (significantly higher than England), men: 86% (similar to England) and in MSM the uptake was very good: 97.9%. The uptake in MSM in Leeds is on the increase, is significantly higher than England and is the second highest in the region (after Calderdale).
At Leeds Sexual Health Clinics in 2017/18, there was a 48% uptake of HIV tests to Black Africans attending. This falls well below the 90% target for the service. Uptake in females was much lower than in males (35% compared to 75%). The low uptake of tests is likely to be due to fear of stigma around HIV and the consequences of a positive diagnosis, as well as low perceptions of risk and perhaps concerns around confidentiality.

HIV testing coverage

HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. In 2017, among eligible new attendees to a specialist SHS in Leeds, 63.4% were tested for HIV. This is significantly worse than the England

average of 65.7%. Sheffield, Rotherham, Calderdale and Bradford all have higher coverage (see table below):

HIV testing coverage, total (%) 2017 — Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	1,006,652	65.7	65.6	65.8
Yorkshire and the Humber region	↓	71,166	59.2	58.9	59.5
Sheffield	↑	8,897	82.2	81.4	82.9
Rotherham	↑	3,908	79.5	78.4	80.6
Calderdale	↑	3,968	74.0	72.8	75.2
Bradford	↑	5,984	68.8	67.8	69.7
Leeds	↓	11,510	63.4	62.7	64.1
North Yorkshire	↓	5,907	63.2	62.2	64.2
Kirklees	↓	6,290	61.8	60.9	62.8
East Riding of Yorkshire	↓	2,441	57.6	56.1	59.1
York	↓	3,935	54.2	53.1	55.4
Doncaster	↓	4,229	53.1	52.0	54.2
Kingston upon Hull	↓	3,358	52.3	51.1	53.6
Barnsley	↓	3,674	46.9	45.8	48.0
North Lincolnshire	↓	1,957	40.1	38.7	41.5
North East Lincolnshire	↓	1,762	38.7	37.3	40.1
Wakefield	↓	3,346	34.8	33.8	35.7

Source: Public Health England

The coverage for men (70.3%) and MSM (86.7%) is significantly worse than England, whereas coverage of women (57.7%) increased in 2017, after previously declining and is similar to the national average.

Chemsex

Public Health England have raised concerns that ChemSex could be behind rising rates of HIV and sexually transmitted infections in gay men/MSM, which have been increasing nationally for several years. ChemSex is defined by the use of three specific drugs ("chems") in a sexual context. These three drugs are methamphetamine, mephedrone and GHB/GBL. The term is commonly used by gay men in sexual networking sites. ChemSex involves using one or more of these three drugs, in any combination, to facilitate or enhance sex, with or without other drugs. ChemSex commonly refers to sex that can sometimes last several days. There is little need for sleep or food, when under the influence of these drugs. The heightened sexual focus and loss of inhibition enables more extreme, risky sex, for longer, often with more partners and with less fear of STIs including HIV and HCV. Sharing injections is common – further increasing the risk of transmission of blood borne viruses. ChemSex is therefore much more risky than drug-free sex. As well as the sexual risk, using these drugs can have other serious side effects, such as risk of overdose, mental health issues and risk of assault whilst intoxicated.

Chemsex practices have been well documented in London over the past decade, and similar trends are emerging across the UK and Europe. However, data in Leeds for 2017/18 show that very few gay men/MSM presented at drug services in the city and, of those that did, even fewer cited use of one of the ChemSex drugs, or that they were injecting.

Staff from Leeds MESMAC were asked to comment on this data. Staff reported that there is definitely a need for support in the city, despite the lack of men accessing services regarding ChemSex: "This particular group of MSM will rarely

present to a general city-wide catch all drug/alcohol support service unless they are at crisis point. They may not see their drug use as an issue at all as it is considered “normal” for them and many of the LGBT community.

There is a marketing and training issue here. Many LGBT users would not perceive themselves as having the same issues or needs as the rest of the service users accessing drug/alcohol dependency services. This may put them off accessing the service completely.

To address these issues, services need to look at how they present themselves to chems users: the sorts of outreach they do, the branding, their understanding of gay sexual culture, their cultural competency, their confidence in discussing sex with their service users and their understanding of mental health and isolation issues facing MSM.

Additionally, there is frequently an underlying need to seek psychosexual counselling of some sort - the Chemsex is a way of dealing with an underlying problem, usually to do with isolation, depression, compulsive app use, lack of intimacy, a variety of things. It could even be argued that drug services may not really be the best places to deal with these complex issues.
In terms of training we need to be sure that the workers and services are culturally competent.”

MESMAC can offer comprehensive training to drug and alcohol services on gay and wider LGBT+ awareness and sexual health, ensuring that their services are accessible, acceptable and appropriate to these populations. MESMAC recently began a joint monthly drop-in with Forward Leeds, to begin to offer a drug service to the LGBT community that will seek to address their needs appropriately.

Sexually Transmitted Infections (STIs)

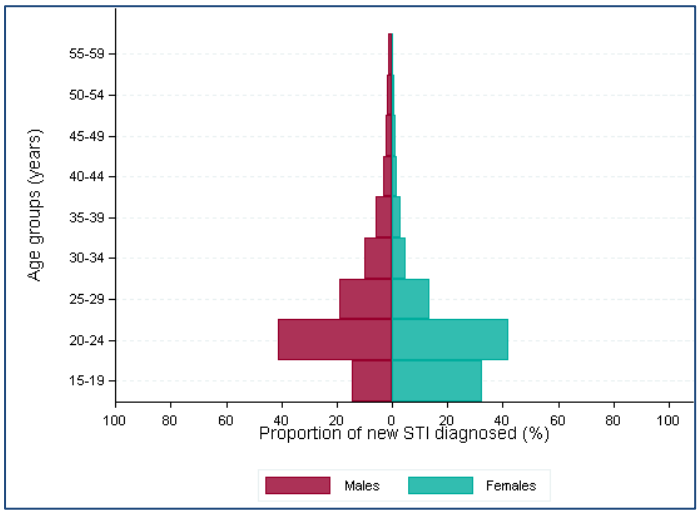
Leeds has the highest rate of new sexually transmitted infections (STIs) diagnoses in the region: a rate of 1117 per 100,000 residents (compared to 743 per 100,000 in England, 2017). High infection rates cannot be just be explained by high chlamydia diagnosis rates in young people however (see chlamydia section below). When excluding chlamydia diagnoses in 15-24s, Leeds’ new STI diagnosis rate is 811 per 100,000 residents, which is the second highest rate in the region. However, as Leeds has an unusually high population of young people of sexually active age, then higher rates of other STIs are not surprising.

However, the STI testing rate (all tests done for syphilis, HIV, gonorrhoea and chlamydia - excluding chlamydia in 15-24s) is significantly worse than the England average (13,605/100,000 15-64 year olds, compared to 16,739/100,000) . This rate is closely linked to the new STI diagnosis rate: although testing rates are low, diagnosis rates are still high, suggesting that those most at risk in Leeds are being successfully targeted and are accessing testing. This is further supported by the high STI testing positivity in 2017. Excluding positivity for chlamydia in 15-24s, the STI

testing positivity was 6%, which is significantly higher than the national percentage and the second highest in the region.

The burden of STIs continues to be greatest in young people, MSM and black ethnic minorities. The graph below shows new STI diagnoses by age and gender in 2016:

Proportion of new STIs by age group and gender in Leeds: 2016



Source: GUMCAD, numbers & rates of new diagnoses

Almost a quarter of new STI diagnoses were in MSM in 2016 and black Africans continue to be disproportionately affected by HIV.

Young people are more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Leeds, an estimated 10.8% of 15-19 year old women and 12.5% of 15-19 year old men presenting with a new STI at a SHS during the 5 year period from 2012 to 2016 became re-infected with an STI within 12 months.

Chlamydia

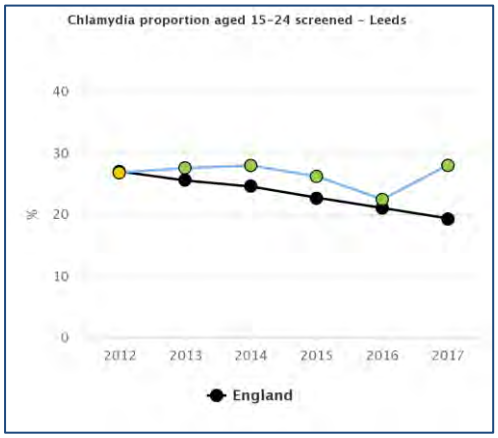
Public Health England (PHE) recommends that local authorities should be working towards achieving a chlamydia detection rate of at least 2,300 per 100,000 population aged 15-24 (PHOF indicator 3.02). Leeds chlamydia detection rate in 2017 was 3475/100,000 15-24 year olds – the highest rate in the region and significantly higher than the England average (see table below). The detection rate is not seen as a measure of morbidity, but of control activity, which will reduce the incidence of reproductive sequelae and interrupt transmission to others. High detection levels should eventually lead to a lower prevalence rate.

Chlamydia detection rate / 100,000 aged 15-24 (PHOF indicator 3.02) 2017 — Crude rate - per 100,000

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↓	126,828	1,882	1,872	1,892
Yorkshire and the Humber region	↑	15,890	2,244	2,210	2,280
Leeds	↑	4,482	3,475	3,374	3,578
North East Lincolnshire	→	573	3,219	2,961	3,494
North Lincolnshire	↓	443	2,433	2,212	2,671
Doncaster	→	824	2,416	2,254	2,587
Calderdale	↓	509	2,210	2,022	2,410
Wakefield	↓	794	2,161	2,014	2,317
Kirklees	→	1,175	2,142	2,021	2,268
Kingston upon Hull	↓	770	2,083	1,939	2,236
Barnsley	→	552	2,025	1,859	2,201
Rotherham	↓	596	2,010	1,852	2,178
York	↑	722	1,985	1,843	2,136
North Yorkshire	↑	1,158	1,907	1,799	2,020
Sheffield	↓	1,712	1,695	1,616	1,777
Bradford	→	1,112	1,635	1,540	1,734
East Riding of Yorkshire	↑	468	1,366	1,245	1,495

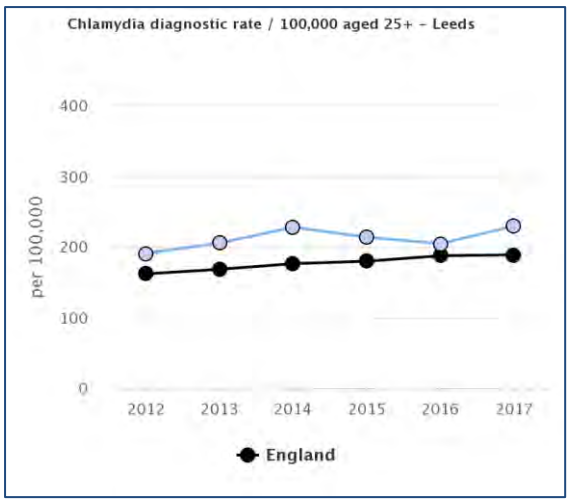
Source: Public Health England

28% of 15-24 year olds in Leeds were screened in 2017, which is the highest percentage in the region and significantly higher than the England average. Despite a national testing/diagnosis decline (likely due to a national reduction in service provision) Leeds has seen a large increase in testing from 2016 to 2017 in this age group (by more than 7000 tests) – see graph below:



In 2017, the detection rate per 100,000 15-24s was highest in females than males (females: 4536/100,000, males: 2373/100,000).

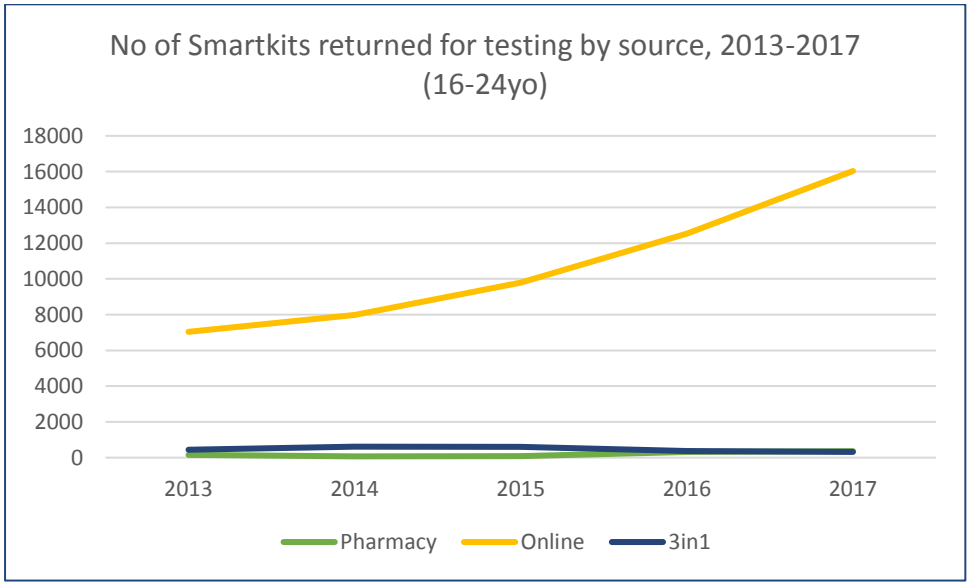
Chlamydia testing in Leeds has increased in all ages from 2016 to 2017. The diagnosis rate per 100,000 over 25s in 2017 was 230/100,000 – again the highest in the region and significantly higher rate than the England average. This rate has increased since 2016 – see graph below:



Preventx Chlamydia/Gonorrhoea Screening Smartkits

Preventx postal kits for chlamydia & gonorrhoea self-screening are available through a variety of settings in Leeds. These kits provide all equipment needed to complete a self test at home (urine sample or vaginal swab), which is then returned by post for screening. Negative results are generally relayed via text, positive results are passed to Leeds Sexual Health Service, who will contact the individual by phone or letter to arrange treatment.

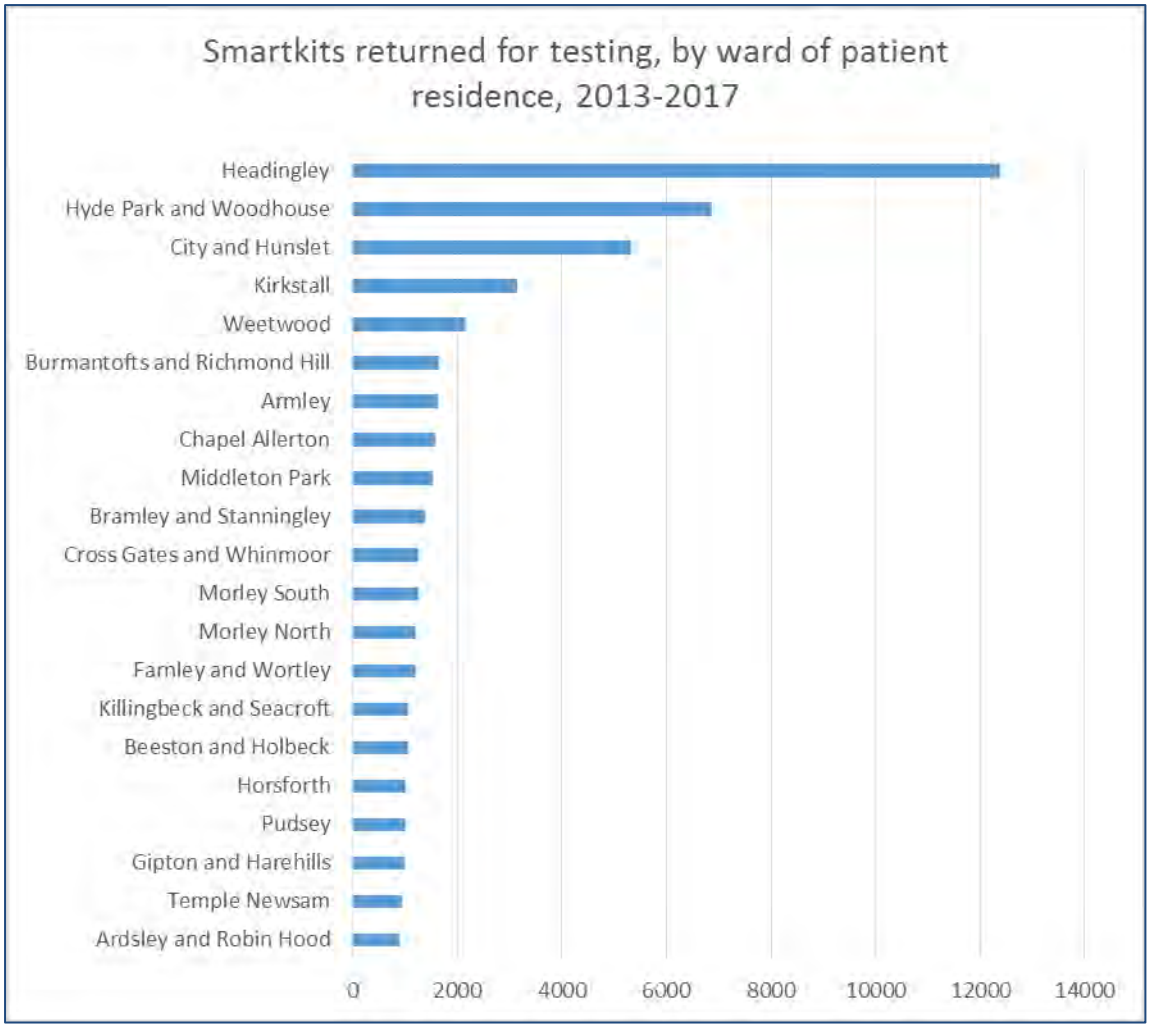
The kits are available to be posted home via the Freetest.me website, by texting for a test or by picking up a test from community based settings, i.e. 3 in 1 sites or enhanced sexual health pharmacies (see Chapter 4). Online or text ordering of tests is only available to 16-24 year olds. Under 16s are able to get a self-test from a 3 in 1 site only, but are expected to complete the test onsite, after a consultation to discuss relationships and sexual health. Online ordering is by far the most popular method of accessing the kits and continues to increase rapidly - see graph below:



In 2017, 96% of returned kits were ordered online, 2% were picked up from enhanced sexual health pharmacies and 2% from 3 in 1 sites. 70% of kits were returned by females, 30% by males (this ratio has been very similar since 2009). The average user age in 2017 was 21.

The ordering of kits online was limited to 16-24s at the end of 2016 to ensure activity did not continue to exceed budget and to target testing at those most at risk. (Positivity for over 24s was only at 4% over 2016, with around 6000 kits returned. The number of tests returned by over 24s had been increasing year on year, increasing by over 40% from 2015). Despite this age restriction, kits returned still increased from 2016 to 2017. This could be explained by over 24s still accessing tests by entering a false date of birth when ordering online. There is anecdotal evidence from Leeds Sexual Health that a small number of patients accessing treatment have provided false information to get a test. However, if this is widespread practice, over 24s have not diluted positivity.

In 2017, 16,524 Smartkits were screened for young people aged under 25, with a 9.7% positivity rate. 34% of all screens were to those living in predominantly student populated areas (Headingley and Hyde Park & Woodhouse). When looking at activity from 2013-2017, young people from these wards have been the most active in using the postal screening service (see graph below):



However, these wards did not have the highest positivity. The National Chlamydia Screening Programme (NCSP) (Towards achieving the chlamydia detection rate, PHE, 2014) recommends that local authorities commission services that achieve a positivity rate of 5–12%. Many wards in the city exceed this.

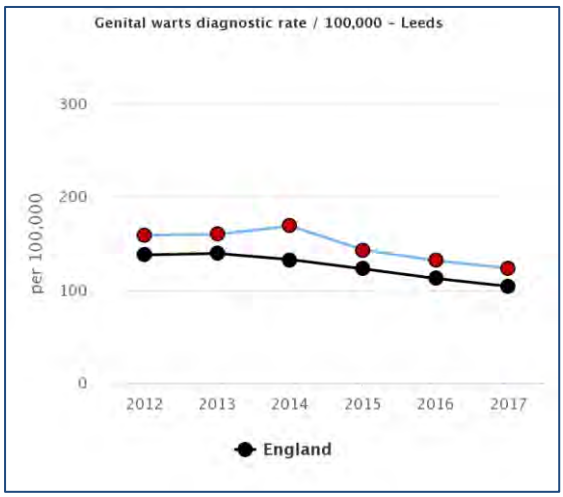
Wards with over 12% positivity, 2017, shown below:

Ward	No of tests returned	No of positives	Positivity
Burmantofts	490	70	14.3%
Bramley & Stanningley	396	56	14.2%
Ardsley & Robin Hood	259	35	13.5%
Morley South	350	45	12.9%
Killingbeck & Seacroft	331	41	12.5%
Weetwood	553	68	12.3%
Otley and Yeadon	203	25	12.3%
Garforth & Swillington	189	23	12.2%

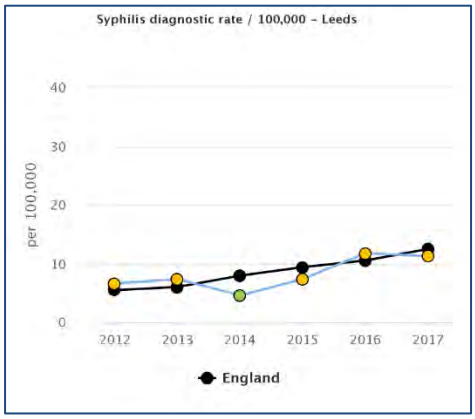
(Headingley positivity 2017: 9%, Hyde Park & Woodhouse positivity 2017: 7.5%)

Several of the wards with the highest positivity are outer wards, where there is less access to services and a further distance to travel to city centre services. The ability to be able to order a postal kit online ensures that people in these areas can still get tested easily, detecting STIs that may otherwise go untreated. High positivity rates in these areas (and other areas of the city) may indicate that infection rates are high. However, they also imply that those at risk are seeking tests and treatment. Diagnosing and treating these infections should reduce the incidence of reproductive sequelae of chlamydia infection and interrupt transmission onto others.

Genital warts are the second most commonly diagnosed sexually transmitted infection (STI) in the UK. Recurrent infections are common with patients returning for treatment. Leeds has the highest genital warts diagnostic rate in the region and is significantly higher than the England rate (123.3/100,000). However, the rate is declining, largely due to the effects of the HPV vaccine. The target for HPV population vaccination coverage is 90% or above (12-13 year old females) – Leeds coverage in 2016/17 was 93%.



Leeds **syphilis** diagnostic rate has been increasing since 2014, as it has in the majority of the country (see graph below). In 2017, the rate was 11.3 per 100,000 - similar to the rate for England as a whole and the third highest in the region. Syphilis is an important public health issue in men who have sex with men (MSM) among whom incidence has increased over the past decade.

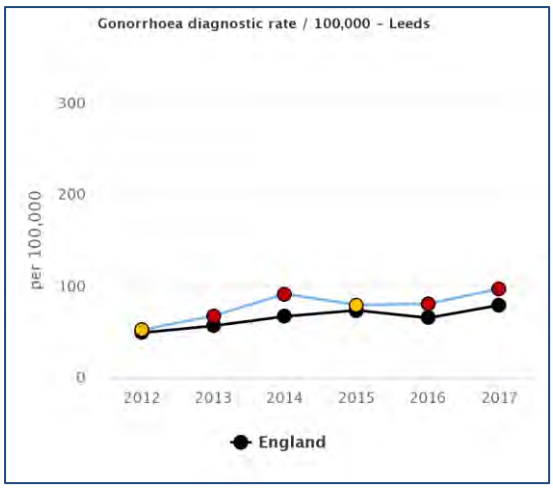


Leeds' **gonorrhoea** diagnostic rate is 96.8/100,000 (2017), which is highest in the region (see below):

Gonorrhoea diagnostic rate / 100,000 2017 — Crude rate - per 100,000

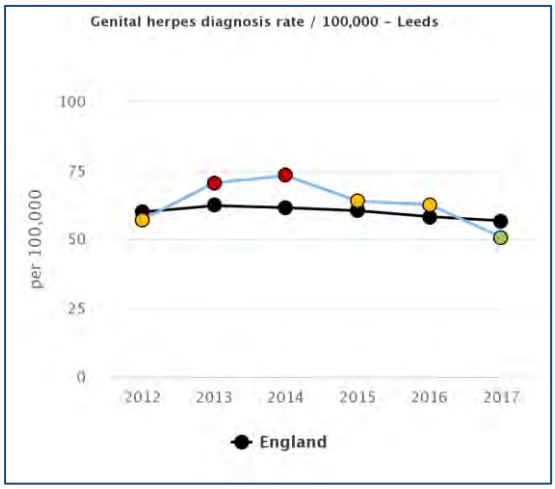
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	↑	43,547	78.8	78.1	79.5
Yorkshire and the Humber region	↑	2,869	52.9	51.0	54.9
Leeds	↑	756	96.8	90.0	103.9
Kingston upon Hull	↑	200	76.9	66.6	88.3
North East Lincolnshire	↑	106	66.3	54.3	80.2
York	↑	137	66.2	55.6	78.3
Sheffield	↑	334	58.2	52.1	64.8
Doncaster	↑	175	56.9	48.8	66.0
North Lincolnshire	↑	85	49.8	39.7	61.5
Kirklees	→	209	48.0	41.7	55.0
Bradford	↑	225	42.3	36.9	48.1
Wakefield	↑	138	40.9	34.4	48.4
Calderdale	↓	81	38.7	30.8	48.2
Barnsley	→	87	36.0	28.8	44.4
Rotherham	↓	88	33.6	26.9	41.4
East Riding of Yorkshire	↑	90	26.6	21.4	32.7
North Yorkshire	↑	158	25.9	22.0	30.3

Source: Public Health England



It should be noted that if high rates of gonorrhoea and syphilis are observed in a population, this reflects high levels of risky sexual behaviour. However, high gonorrhoea rates can also be used as a
measure of STI testing and treatment: as the majority of cases are diagnosed in sexual health clinics, a high rate also implies good access to services.

Genital herpes is the most common ulcerative sexually transmitted infection seen in England. Recurrent infections are common with patients returning for treatment. Leeds' genital herpes diagnostic rate is decreasing and is significantly lower than the England average, at 51.7/100,000.



Chapter 4: Prevention

Relationships & Sex Education

Currently, all Leeds schools (primary, secondary and special educational needs & disability (SEND) schools) are able to access support in the planning and delivery of Relationships & Sex Education (RSE) via the Health & Wellbeing Service – a team of consultants and specialist practitioners. The Service can deliver sessions directly to pupils or work with identified secondary schools to deliver targeted group work and one-to-one support for young people identified as requiring additional support. The Service can also support schools with RSE through advisory meetings, CPD (continuing professional development), model policies, schemes of work and resources.

Within the Healthy Schools Programme, schools work through an online self-evaluation tool, “School Health Check”, including Sex and Relationship Education as one of its four core themes. Each ‘criteria’ has been matched, where possible, to descriptors in the current Ofsted inspection framework. Through this online tool, the Health & Wellbeing Service are able to view how schools and settings are auditing their policies, practice, provision and curriculum in relation to RSE.

The service also manages the My Health My School Survey, a perception survey capturing the self-reported health behaviours of children and young people across the city. It is aimed at pupils in years 5, 6, 7, 9 and 11 and has recently launched a SEND and a Post 16 version of the survey. Included in the survey and where age appropriate, there are questions about RSE, sexual health, PSHE lessons and if the young person would know who to go to for support if they needed it. The results of the survey are shared with services to support in identifying impact measures and to steer where support and resources are needed to best support children and young people across the city.

For the first time, new legislation (Children & Social Work Act - 2017) will make Relationships and Sex Education (RSE) statutory, applying to ALL schools (academies, free, maintained, special, independent). The Department for Education (DfE) have published what will be included in the revised Relationship Education (primary) and Relationship and Sex Education (secondary) statutory curriculum, introducing RSE as part of the basic school curriculum, with no parental right to withdraw from Relationships Education at primary or secondary school. Parents will have ‘right of excusal’ from sex education at secondary school – however, a young person can opt themselves in from age 15. Health Education will be mandatory too and will include content on puberty, mental health, first aid and more. Schools that are currently ready to deliver the revisions are encouraged to implement curriculum changes from September 2019. The curriculum will become mandatory for all from September 2020. The new curriculum includes content on safe, healthy relationships, including those conducted online and will support pupils to develop

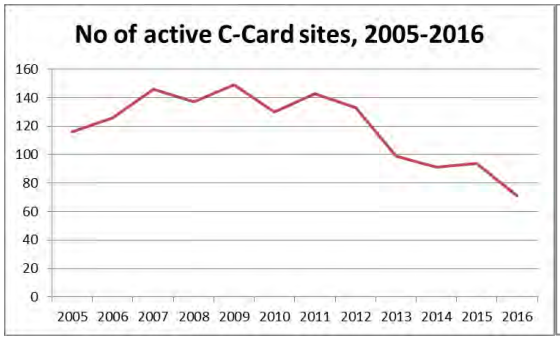
safe, fulfilling and healthy sexual relationships, at the appropriate time. All content should be medically and legally accurate and taught in a factual, impartial way so that pupils are clear on their rights and responsibilities as citizens, whilst recognising there are a range of opinions and perspectives regarding RSE.

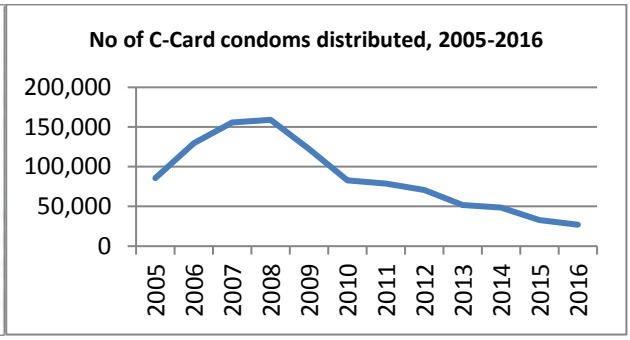
3 in 1/C-Card Scheme

The 3 in 1 scheme is delivered by a range of organisations and services across the city, in community venues. Staff who work with 13-24 year old young people access standardised training to allow them to set up a confidential drop in service to enhance their offer of support to service users. Young people accessing a 3 in 1 site can join the C-Card scheme, where they are given a condom demonstration and consultation around their relationships and sexual health, then provided with a membership card which allows them to collect condoms, lubricants and oral sex dams from any of the 3 in 1 venues in the city. 3 in 1 sites can also provide onsite pregnancy tests as well as self-screening, postal return kits for both chlamydia and gonorrhoea (Preventx SmartKits – see Chapter 3 for further detail). These are the only non-clinical venues where under 16s can access a STI kit of this kind in the city. The ambitions of the scheme are to:

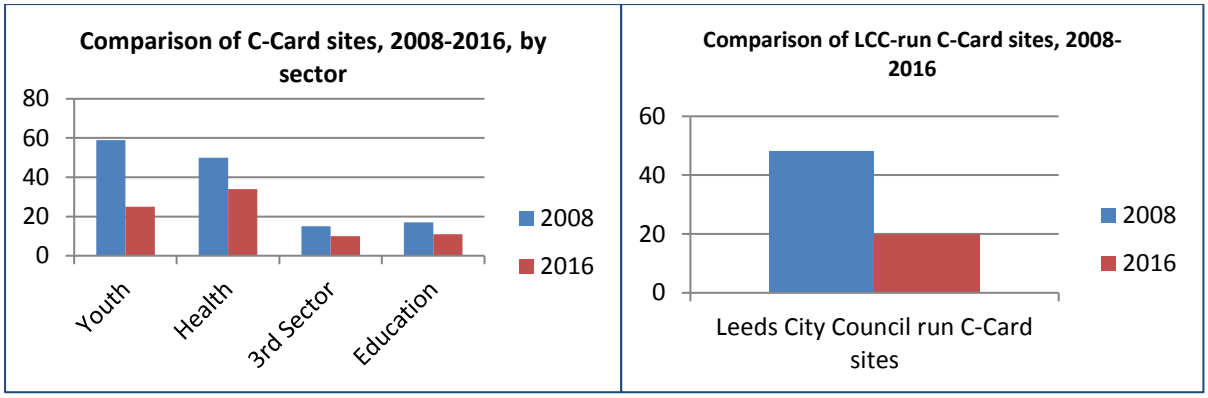
- Reduce barriers to accessing and using condoms;
- Provide young people with easy to access services, in their locality;
- Reduce unintended teenage pregnancy and STI transmission;
- Give professionals already working with young people the tools and confidence to support them around sex and relationships and signpost effectively.

The 3 in 1 scheme (in particular the C-Card aspect) has over the past decade been a very well-known and well utilised provision. It is used by 15-19s most regularly and males are slightly more active users than females. However, the number of sites offering C-Card have declined and numbers are at their lowest, as is the number of condoms distributed in the city (see graphs below):





The graphs below show the decline in C-Card sites by sector they are delivered by, from 2008 to 2016. All sectors have seen reductions in sites, but the youth sector has seen the biggest decrease. Those run by Leeds City Council organisations have more than halved.

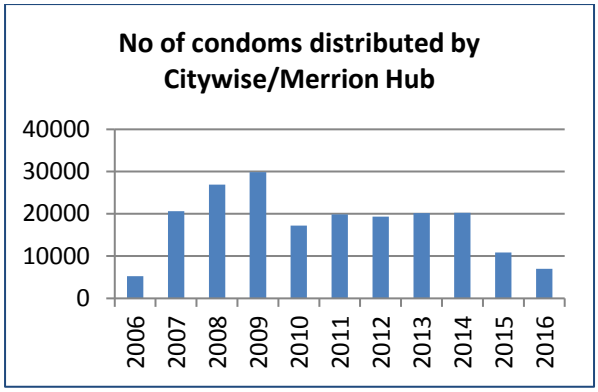


There are several potential explanations for this decline, including complacency around reducing teenage conceptions since rates have been reducing, a change in young people's sexual behaviour or a need to promote services more effectively.

There is some evidence that young people are waiting longer to have sex. The most recent results (2016/17) from the My Health, My School survey of Leeds school pupils saw a decline for the fourth year running of those reporting 'ever having sexual intercourse'. 26% of year 11 pupils surveyed reported that they have had sex, which is the lowest percentage since the survey began. However, as the survey is only completed by a proportion of school age pupils in the city, it does not include all those eligible to access the scheme.

It is likely however, that cuts to local authority funding, restructuring of teams and changing remits, particularly within Children's Services, have been largely responsible for the closure of some sites. The youth service, for example, reduced the number of sites they ran due to reduction in staff capacity, which particularly impacted upon some of the outlying areas of the city. Leeds City College also saw staff changes and loss of counselling/welfare staff who had previously run the 3 in 1 scheme at the various college sites. This led to there being no provision of sexual health support/free condoms at any of the Leeds City College sites, which was a great loss in terms of access for both pre and post 16 young people, including those with additional vulnerabilities. Leeds College of Building (independent from Leeds City College) were the second highest distributor of condoms after Leeds Sexual Health in 2016, suggesting the FE sector is ideally placed to host such services for young people.

The service that saw by far the highest C-Card activity in 2016 was the Leeds Sexual Health Merrion Clinic. The Medivend condom vending machine is also located at this venue, giving users the choice of accessing products quickly and discreetly. The service has also seen a decline in C-Card use, in line with the citywide decline:



Citywise, the dedicated young people's sexual health service, closed in 2015 and was absorbed into the new integrated sexual health service. Clinic changes did not lead to a reduction in the numbers of young people accessing sexual health services, however, staff have reported that they do not always have the time to fill in C-Card paperwork during consultations in busy clinics, so figures returned from the service may not fully represent the condoms that are distributed. Unfortunately, however, if young people are not issued with a C-Card, they may not be aware of community based services they can access. They are also then unable to use the Medivend machine.

There have been some positives to the reduction in 3 in 1 sites. Some sites were seldom used and continuing to refresh training for staff was difficult. Removal of such sites means that there is less risk of young people attending a poor quality service where staff were not up to date on training/practice.

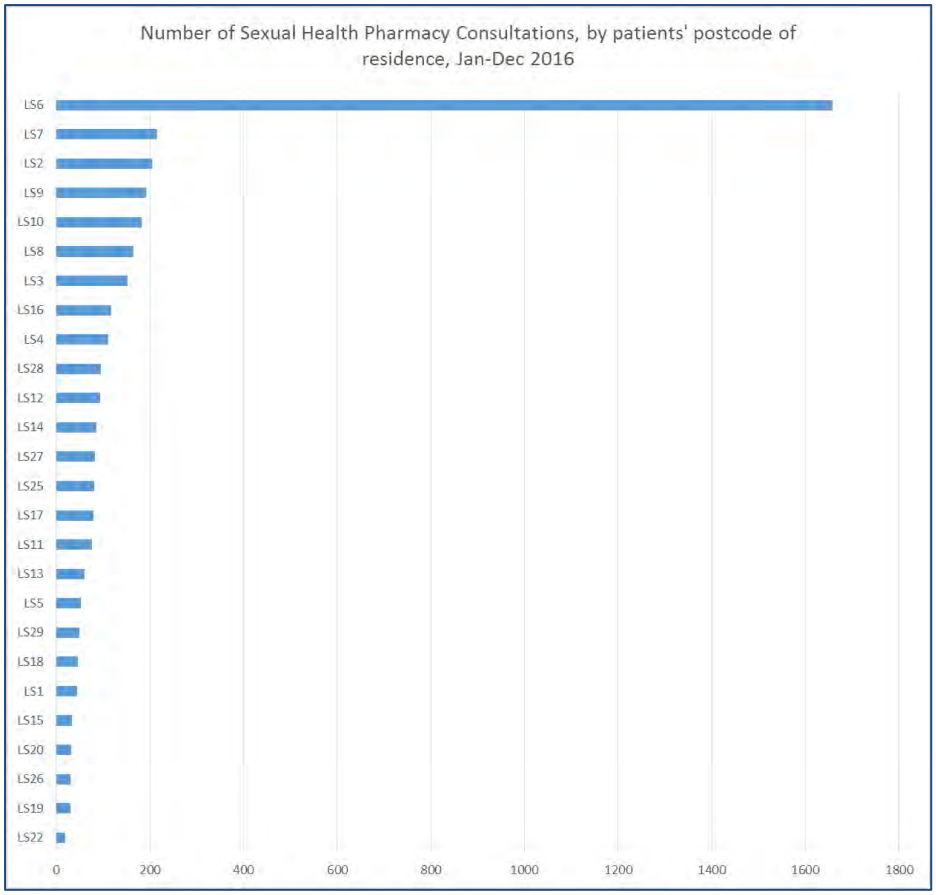
The change in behaviour around C-Card usage could suggest that the young people that need condoms are accessing them and that there have been changes to sexual activity in the city, in response to improvements in SRE provision. Another encouraging finding of the most recent My Health, My School survey was that of those that reported that they had ever had sex, all year groups saw a rise in reporting 'either using a condom or a condom and another form of contraception' the last time they had sex (across secondary age: 57%, Year 11 respondents only: 52%). However, the amount of Year 11 pupils reporting 'never using any form of protection' the last time they had sex reached its highest (31%), although responses from Year 9 pupils did see an improvement, with the lowest figure for 7 years (25%).

These findings, alongside the under 18 conception and abortion rates in particular areas of the city, as well as STI rates, suggest that there is still a need to continue to promote condom use and provide sex and relationships guidance in the community. The continued high levels of interest in staff training suggests that workers still feel that the service is essential to the young people they work with. Leeds City College, for example, have identified staff to attend the 3 in 1 training to ensure the service can be re-established in all their sites and the youth service have reinstated previously suspended sites where possible, again nominating new staff for training.

Enhanced Sexual Health Pharmacy Scheme

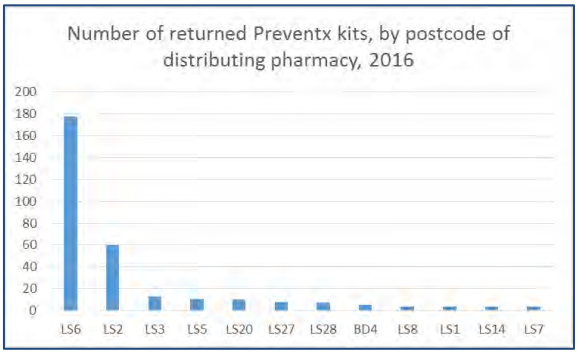
The Public Health Sexual Health Team commission pharmacy-based services in Leeds which support the delivery of two main sexual health-related Public Health Outcomes Framework measures: the under 18 conception rate and chlamydia diagnosis rate (15–24 year olds). Until March 2018, 38 sites were commissioned across the city to deliver the enhanced sexual health pharmacy scheme (ESHPS). Pharmacies across the city could provide free emergency hormonal contraception (EHC) without a prescription, chlamydia/gonorrhoea postal testing kits (for 16-24s only) and onsite pregnancy testing. The sites were selected based on their location within Sexual Health priority areas: areas where there are high levels of teenage conceptions, higher rates of terminations and areas that are geographically more isolated from city centre services. Many of the sites had extended opening hours (i.e. evenings and weekends) to increase accessibility, removing the need to wait for a GP appointment or access a sexual health clinic.

Uptake of the ESHPS has been high, with the majority of consultation requests being for EHC after unprotected sex or contraception failure. However, when looking at the distribution of users across the city, activity is skewed towards a particular area of the city. The majority (40%) of consultations were to people living in the LS6 area of the city (which covers the whole of the Headingley ward and a small proportion of Hyde Park & Woodhouse, Weetwood and Chapel Allerton wards). See graph below:

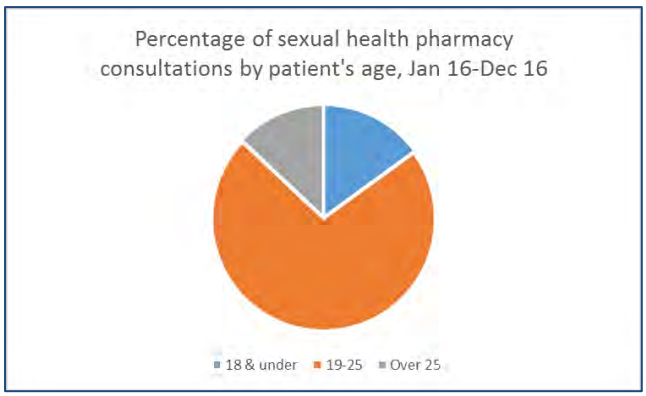


4135 consultations in total. 40% were to LS6 residents.

In 2016 there were 3 pharmacies located in the LS6 area, which may go some way to explain the increased activity in this area. However, LS10 and LS8 (as well as the city centre, LS1) also had 3 pharmacies each at this time, but did not see the same levels of activity. Similarly, where ESHPS pharmacies distributed chlamydia/gonorrhoea testing kits, the majority of returned tests were given out by pharmacies in LS6 (see graph below):

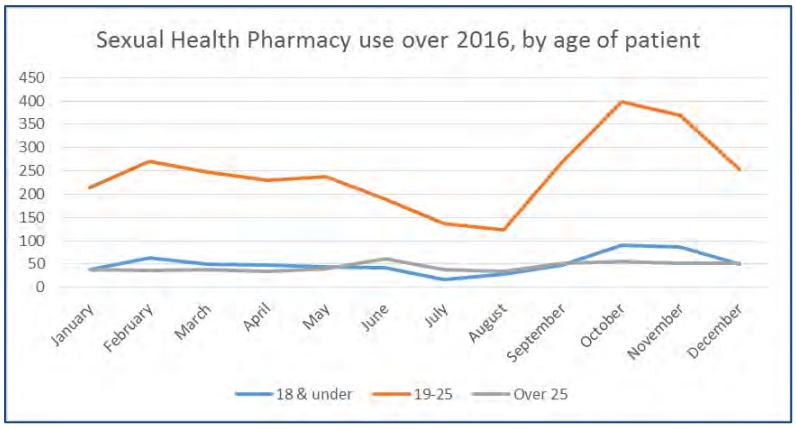


The ESHPS service was predominantly used by 19-25s (72%), with only 1% of consultations being to under 16s (see chart below):



When considering the demographics of the city, 10% of the population are in the 20-24 age group (which forms the largest single age group), who are likely to be sexually active, so the higher activity in this group is not surprising.

The number of consultations remained fairly steady throughout the year for both 18s and unders and over 25s, however, the number of consultations with 19-25 year olds dipped over the summer months, with October and November being most active. See graph below:



These trends seem to suggest that the service is predominantly used by the student population of the city, who tend to live in the Headingley/Hyde Park & Woodhouse/Meanwood areas and fall within this age range. The fluctuations in use over the year seem to correspond with the summer period (when students are more likely to leave the city to return home), with the largest spike being in October, when Fresher's week occurs and the academic year begins. This suggests more work needs to be done by student's unions, welfare services and student GP practices to promote regular contraception use, particularly LARC methods, as well as consistent condom use.

Although numbers of under 18s using the service are comparatively low, the average use of 50 consultations per month should have had a positive impact on conception rates in the city, if it is assumed that the majority of consultations lead to the prevention of a potential unplanned pregnancy.

The use of the service across all age groups should also have impacted on termination rates, again in preventing unplanned and unwanted pregnancy.

New ESHPS contracts from April 2018

The ESHPS contract was renewed in April 2018. Some minor changes to the contract were introduced: pregnancy testing is no longer offered as a service, except to check for pregnancy before providing EHC – removing the requirement to have an onsite toilet. This opened up the scheme to more pharmacies. The criteria for joining the scheme were also refreshed – pharmacies were eligible to apply to join the scheme if they were located within or geographically close to an area with one or more of the criteria below. Areas that met several criteria were allocated more pharmacies, to further increase accessibility in these areas.

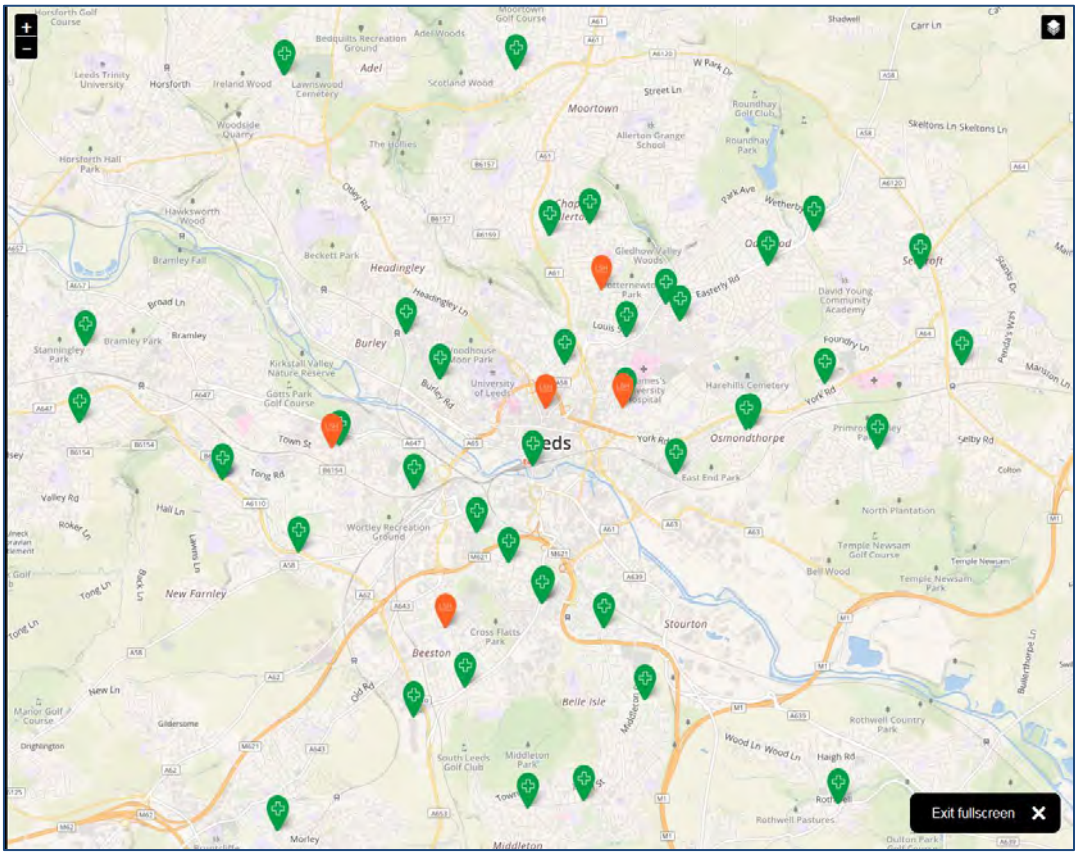
Criteria used to identify target areas for ESHPS Pharmacies:

- Wards with higher under 18 conception rates than the Leeds rate
- Wards with higher under 18 conception rates than the England rate
- Wards that contain postcode areas where termination numbers are highest
- Wards that contain a top 1% most deprived LSOA
- Wards that contain a top 10% most deprived LSOA

Pharmacies that expressed interest in joining the scheme were then ranked according to their proximity to deprived LSOAs, as well as their opening times (those with extended evening and weekend times were prioritised). There are now 39 pharmacies on the scheme, but the distribution of sites has now changed to better meet the needs of the population in terms of impacting on the most deprived and those areas where under 18 conceptions and terminations are highest. The wards/postcode areas below all have pharmacies:

Wards with pharmacies – 2018	Postcode areas with pharmacies – 2018
Alwoodley Armley Beeston Hill & Holbeck Bramley & Stanningley Burmantofts & Richmond Hill Chapel Allerton City & Hunslet Crossgates & Whinmoor Farnley & Wortley Gipton & Harehills Headingley Hyde Park & Woodhouse Killingbeck & Seacroft Middleton Park Morley North Morley South Pudsey Rothwell Weetwood	LS1 LS3 LS6 LS7 LS8 LS9 LS10 LS11 LS12 LS13 LS14 LS15 LS16 LS17 LS26 LS27 LS28

There are no longer ESHPS pharmacies in the outer areas of Wetherby, Guiseley & Rawdon, Otley & Yeadon. Bramley & Stanningley now have a service. Services are much more concentrated on the inner areas of the city, in the most populated areas. See site map from www.leedssexualhealth.com below (green markers denote ESPHS pharmacies, orange markers show Leeds Sexual Health clinics):



The Managed Approach to Street-Based Sex Work

The “Managed Approach” to street-based sex work in the city was launched in late 2014, through partnership working between Safer Leeds, Leeds City Council, West Yorkshire Police and third sector partners. The approach aims to provide a long-term sustainable solution to the wide ranging concerns and issues raised by residents, businesses and the general public, as well as concerns about the vulnerability and safety of the women selling sex.

Before the Managed Approach was introduced, a range of enforcement activities had been undertaken over many years to tackle and remove street sex work from the Holbeck area. As with many other similar arrangements nationally, this enforcement-only approach was largely ineffective in reducing street sex work prevalence and didn’t provide meaningful safeguarding for the women involved or address the complex factors that influence sex work. A recent systematic review of research showed that approaches to street sex work that prioritise enforcement can be detrimental to sex workers’ health, supporting the Leeds approach:

‘*sex workers who had been exposed to repressive policing (such as recent arrest, prison, displacement from a work place, extortion or violence by officers) had a three times higher chance of experiencing sexual or physical violence by anyone, for example, a client, a partner, or someone posing as a client. They were also twice as likely to have HIV and/or other sexually transmitted infections (STIs), compared with sex workers who had avoided repressive policing practices.*’

(Platt et al; Associations between sex work laws and sex workers’ health: a systematic review and meta-analysis of quantitative and qualitative studies. PLOS Medicine, 2018).

However, the Managed Approach is not a legal red light zone, but is about managing and lessening the impact of existing activity. The rules of the approach are kept under review, but in summary are:

No offences will be tolerated at any time within residential areas;

No offences will be tolerated between 6 a.m. and 8 p.m.;

No offences will be tolerated outside businesses which are operating;

Business premises will be respected and litter disposed of responsibly;

Drug use, trafficking, organised crime and coercion will at no time be tolerated;

Crime, public order and anti-social behaviour will not be tolerated

Indecency will not be tolerated at any time.

A key element of the Managed Approach is to work with sex workers in the area to encourage more reporting of offences, increase their safety and also provide targeted support and services to improve their health and wellbeing, with a view to assisting them to exit street based sex work. Leeds City Council works with a number of third sector partners to provide services to sex workers, including 1-to-1 intensive support, support in crisis and for those experiencing abuse, exploitation or violence; sexual health, harm reduction, welfare and housing support, as well as intensive support for women who have drug and/or alcohol addiction:

- Basis provide evening outreach and 1-to-1 intensive support for women with complex needs. The Joanna Project also support women with complex needs, based in a house within the Holbeck area. Both work closely with other partners.
- West Yorkshire Police have a Designated Sex Worker Liaison Police Officer whose role is to work closely with sex workers and both Basis and Joanna to ensure the women have the support they need and feel confident in reporting crime.
- Leeds Sexual Health Service has targeted resources and support to empower women to make informed choices about their sexual health and wellbeing. Their outreach team work in partnership with other organisations supporting women in the area, to offer outreach contraception, screening and treatment to both on street and indoor workers who find it difficult to access services.
- Forward Leeds, the alcohol and drug service for the city, provides intensive support to sex workers with a drug and/or alcohol addiction, via a number of workers and key partners, ensuring women are kept safe and engaged in treatment.
- Housing Leeds work closely with partners, including Basis' Housing First project, to provide outreach housing advice and support to sex working women, making links to supported accommodation.

This partnership outreach approach that is responsive to the complex lifestyles and barriers faced by these women has led to a vast increase in the number of sex workers accessing sexual health services for testing, treatment and contraception. This includes a high diagnosis rate of STIs (leading to treatment) and a higher than average uptake of LARC, compared to the national average. It has also enabled innovative work including increased access to cervical smear testing for women who have either never accessed screening, or were well overdue (leading to a high percentage of abnormal results) and offering MMR vaccines to Romanian women, to help tackle a measles outbreak within this group. A flexible, personal, outreach approach has meant that women needing support can be identified and sought out to ensure treatment and follow up is accessed in a timely way.

Constant liaison and communication between partner organisations have also enabled safeguarding and trafficking concerns to be actioned whilst minimising the risk of losing information or unnecessary duplication. This is particularly important when working with migrant sex workers, who tend to have a lack of trust in and understanding of services, move addresses or even countries regularly and are generally guarded and reticent to share information due to the stigma surrounding their work.

Chapter 5: Ward Maps

Sexual Health Indicator Ward Maps

Each ward of the city has been ranked on a number of sexual health indicators, where data is available at this level. Where data is not collected on this basis, postcode districts have been mapped alongside wards to give an indication of activity within that ward area.

Each indicator has been rated and colour coded for each area – from highest level of activity to lowest level of activity.

Here is a summary of the indicators shown, with key observations for the city, below:

Number of GP-fitted LARC

Data shown: Number of implants and IUCDs (Long Acting Reversible Contraception – does not include injections), fitted by Leeds GPs, by women's ward of residence, from April 2016-April 2017. *Source: Leeds GP data extraction programme*.

The wards with the highest female populations in the city show the highest numbers of GP LARC fittings, as expected. However:

Wards that have higher activity than expected for the female population:

Rothwell

Wards that have lower activity than expected for the population:

Beeston & Holbeck

Chapel Allerton

Under 18 conception rate per 1000

Data shown: Conception rate per 1000 15-18 year old females, by woman's ward of residence. Data aggregated from 2012-2014. *Source: ONS.*

A note on sub-Leeds level under 18 conception data: *There is a lack of robust, up-to-date conception data at a ward level. The latest data with full ward coverage was for the period 2012-14 (in 2013-15, the ward level data was provided, but with incomplete coverage). The 2012-14 data is presented here. However, the ward boundaries used for the 2012-14 data have since been changed. Therefore, caution should be exercised when drawing conclusions on a ward level as the picture may have changed somewhat since the publication of the most recent, reliable data. Conception data at the IMD decile level for Leeds is available up to 2014, which again is out of date, but gives an indication of recent trends (see Chapter 2).*

Rates largely correspond with deprivation, with the inner city wards having the highest rates and the lowest rates occurring in the outer, more affluent wards.

Number of GP-prescribed EHC

Data shown: Number of emergency hormonal contraception (EHC) prescribed by Leeds GPs, by woman's ward of residence. From October 2016-October 2017. *Source: Leeds GP data extraction programme.*

The wards with the highest female populations in the city show the highest activity in terms of EHC prescriptions. The wards with the very highest rates are:

Chapel Allerton
Headingley
Hyde Park & Woodhouse
City & Holbeck
Gipton & Harehills
Killingbeck & Seacroft

Women also have access to EHC through the enhanced sexual health pharmacy scheme – see chapter 4. People living in LS6 were by far the biggest users of the service, predominantly for EHC, in 2016. 40% of all enhanced sexual health pharmacy contacts that year were to people living in this postcode area (which covers the whole of the Headingley ward and a small proportion of Hyde Park & Woodhouse, Weetwood and Chapel Allerton wards).

Number of Terminations, 18+

Data shown: Number of terminations provided by BPAS or Marie Stopes to women aged 18 or over, April 2016-March 2017, by woman's postcode of residence. *Source: Leeds CCG termination data.*

In Leeds, the areas of the city that are most highly populated with females have the highest numbers of terminations in women over 18. The numbers look higher than expected in the lesser populated Harewood ward, but the LS14 postcode area covers the more populated Seacroft and Thorner, which is partly within this ward area.

Although LS6 covers a fairly small geographic area, it covers a highly populated area, including all of the Headingley ward. Numbers of terminations are particularly high in this area, where many students and young professionals live.

The majority of the Kirkstall ward shows fairly low levels of terminations. However, this ward does have a high LARC and EHC activity, suggesting good accessibility and uptake of these GP services in this area.

Number of Terminations, under 18s

Data shown: Number of terminations provided by BPAS or Marie Stopes to women aged 17 or under, April 2016-March 2017, by woman's postcode of residence. *Source: Leeds CCG termination data.*

Numbers are very small for all areas. The highest number of terminations in this age group largely correspond with the areas where teenage conceptions are highest. The exceptions are the Pudsey, Calverley & Farsley; Morley and Headingley areas, which had some of the highest numbers of under 18 terminations, but not highest conceptions. This may indicate that young women in these areas are less likely to continue with a pregnancy, perhaps due to higher to aspirations or educational attainment.

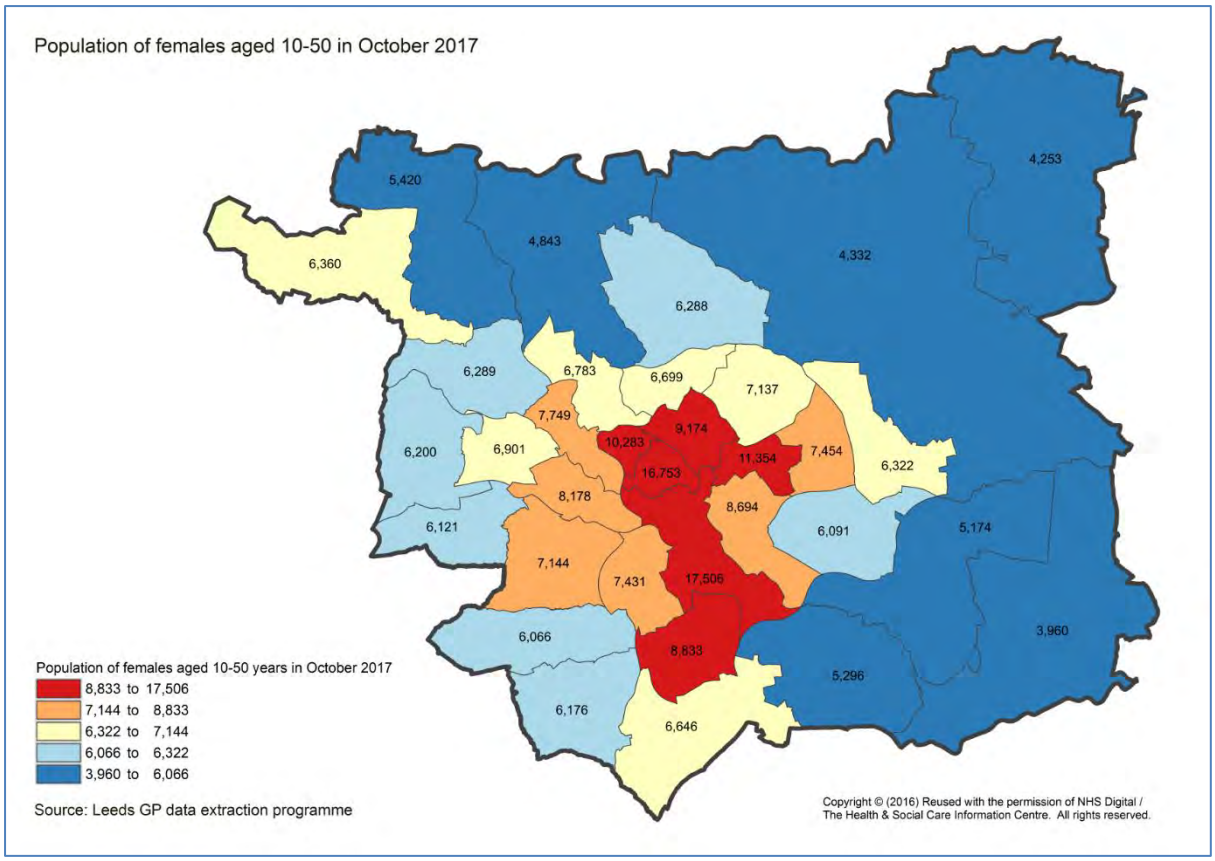
Number of Leeds Sexual Health Service clinic users

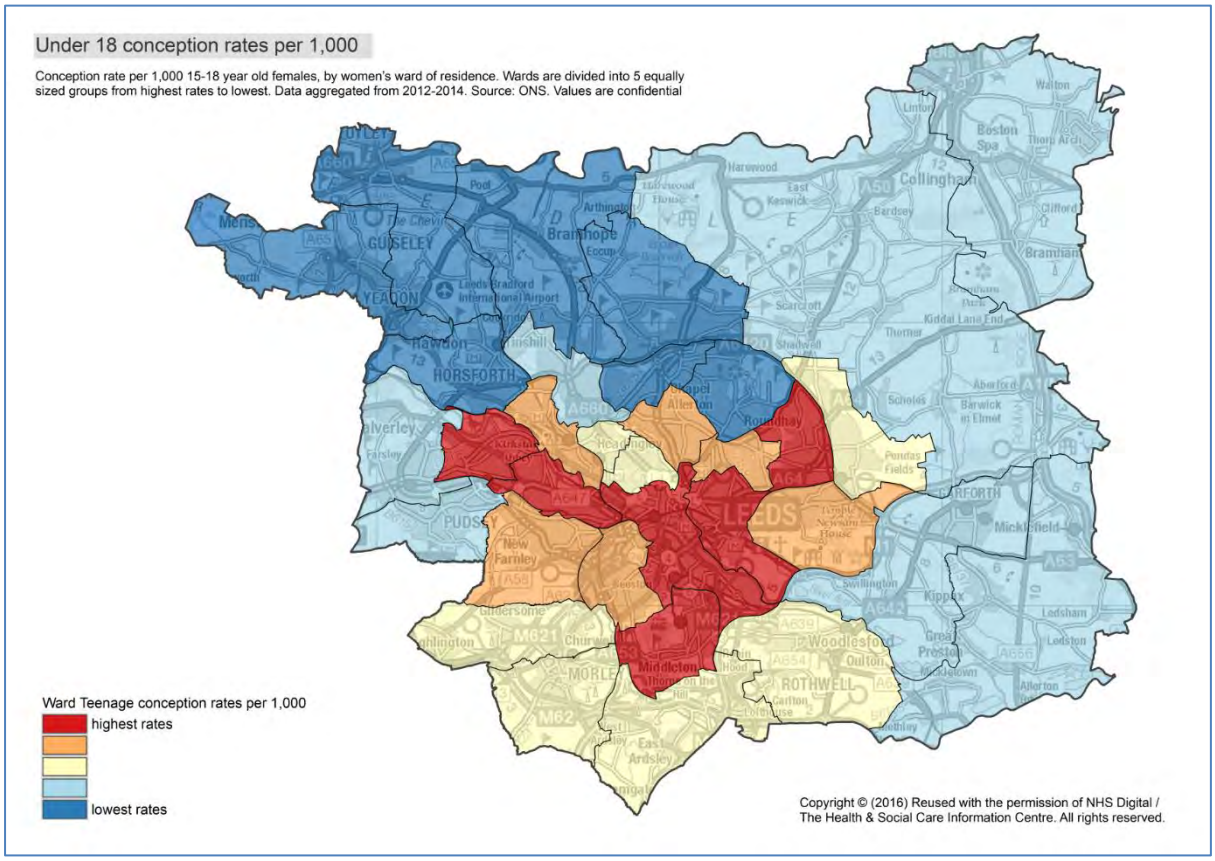
Data shown: Number of unique service users accessing a Leeds Sexual Health clinic (both the city centre hub clinic and the spoke clinics) from July 2015-October 2017, by service user's postcode of residence. *Source: Leeds Sexual Health service user data.*

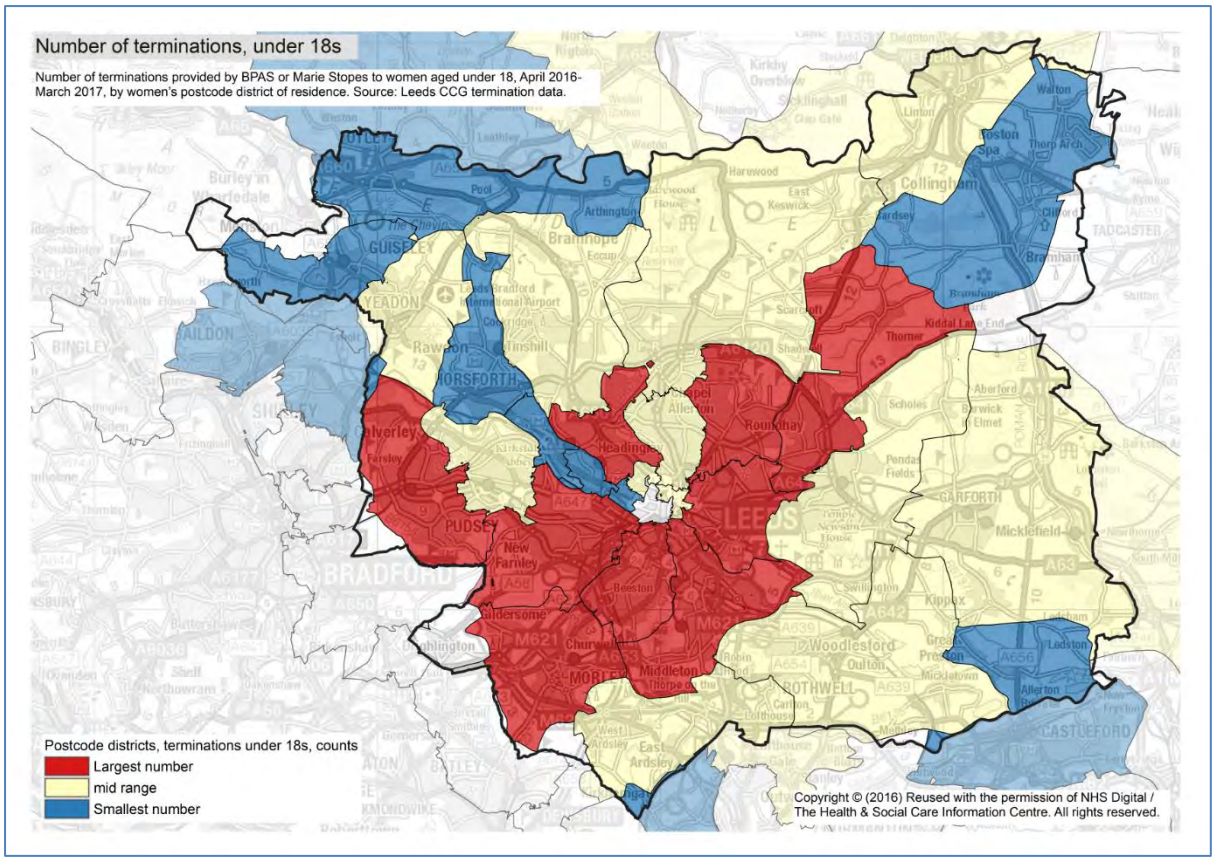
The service is available to all in the city, and highest use is likely to correspond with areas of the city that are most populated. However, high usage could indicate issues with using GP services, e.g. capacity, ease of access, and availability of trained staff.

The use of the clinic is pretty evenly spread across the city, with highest numbers attending, as expected, from the inner, more populated areas of the city. Interestingly, the postcode district where Reginald Centre is located is not amongst the very highest areas for number of attendances. The Kirkstall area shows lower than expected attendances, for the size of its population.

Citywide maps, showing indicators by ward






Number of terminations, under 18s
Number of terminations provided by BPAS or Marie Stopes to women aged under 18, April 2016-March 2017, by women's postcode district of residence. Source: Leeds CCG termination data.
Postcode districts, terminations under 18s, counts
Largest number
mid range
Smallest number
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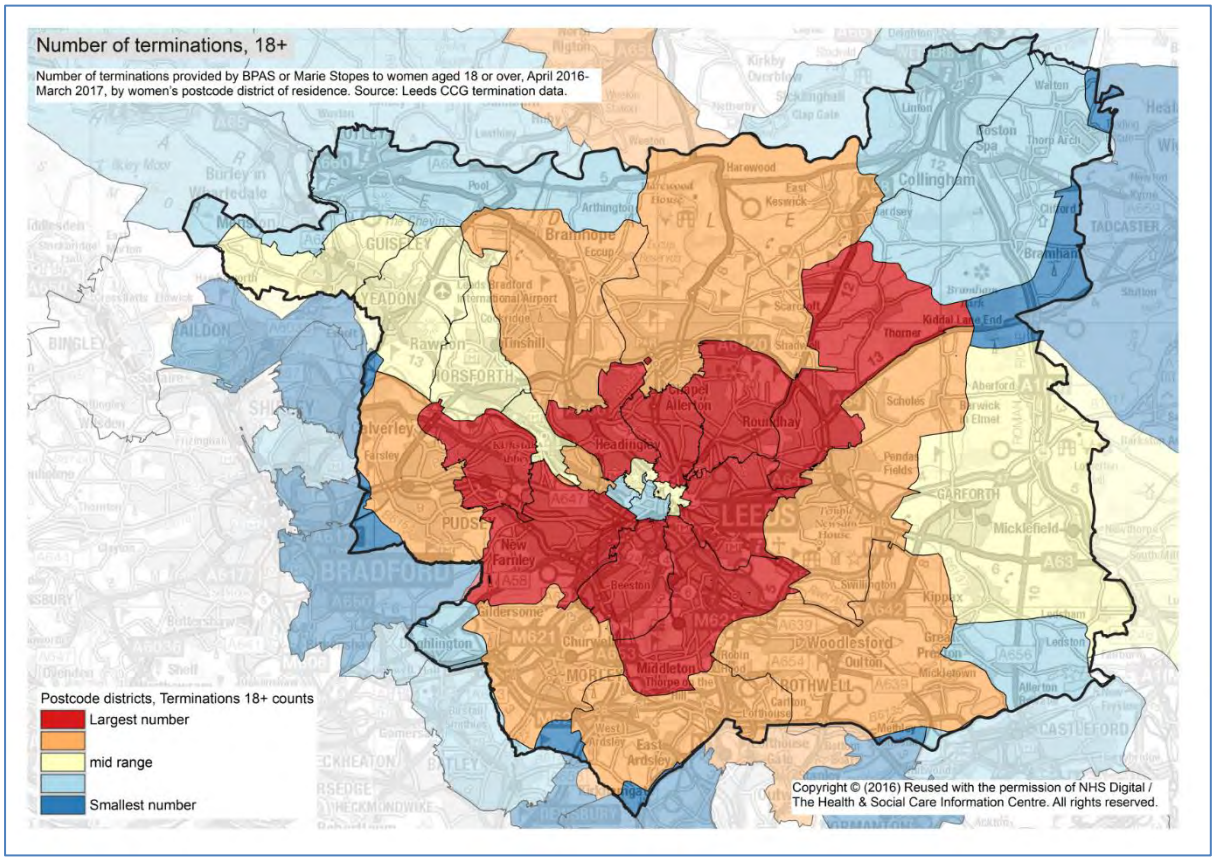
Number of terminations, 18+
Number of terminations provided by BPAS or Marie Stopes to women aged 18 or over, April 2016-March 2017, by women's postcode district of residence. Source: Leeds CCG termination data.
Postcode districts, Terminations 18+ counts
Largest number
mid range
Smallest number
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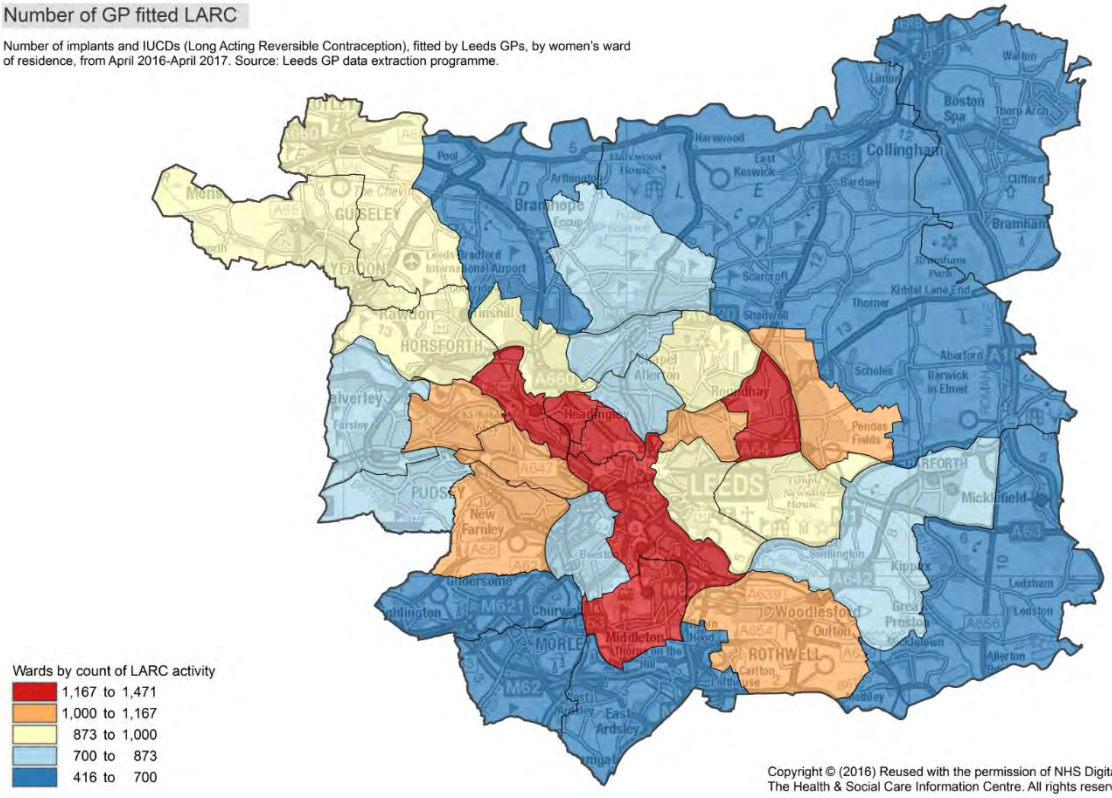
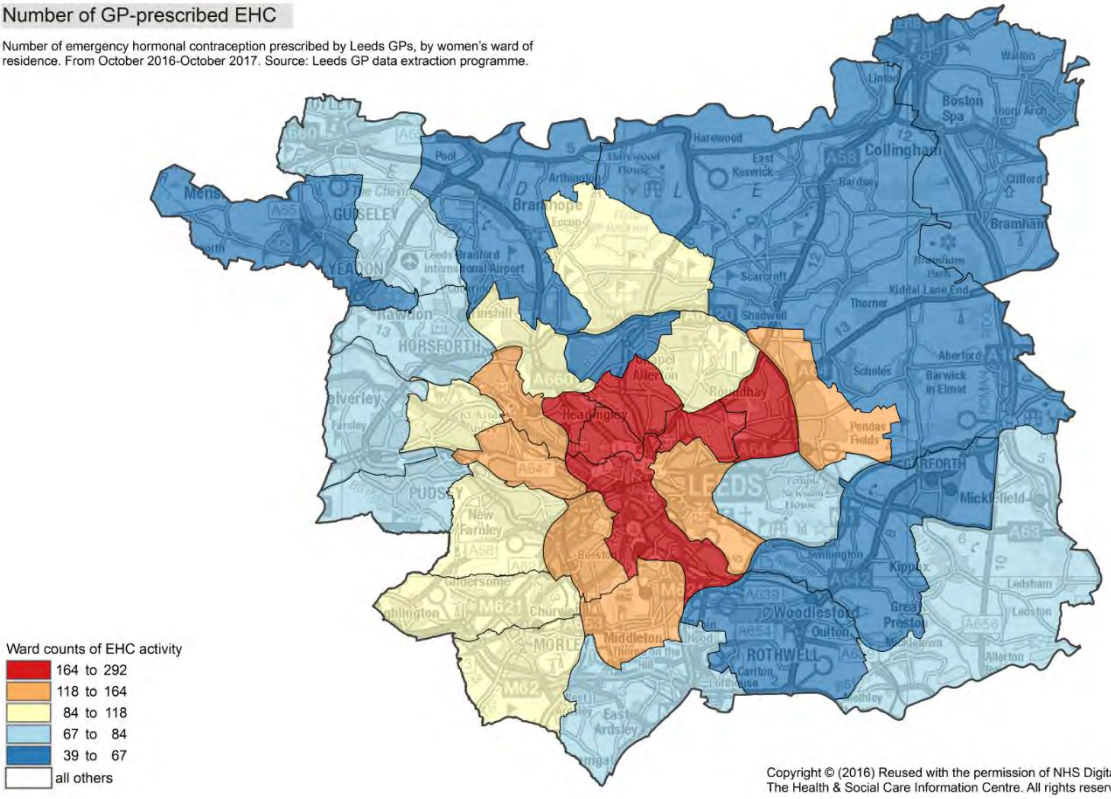
Number of GP fitted LARC

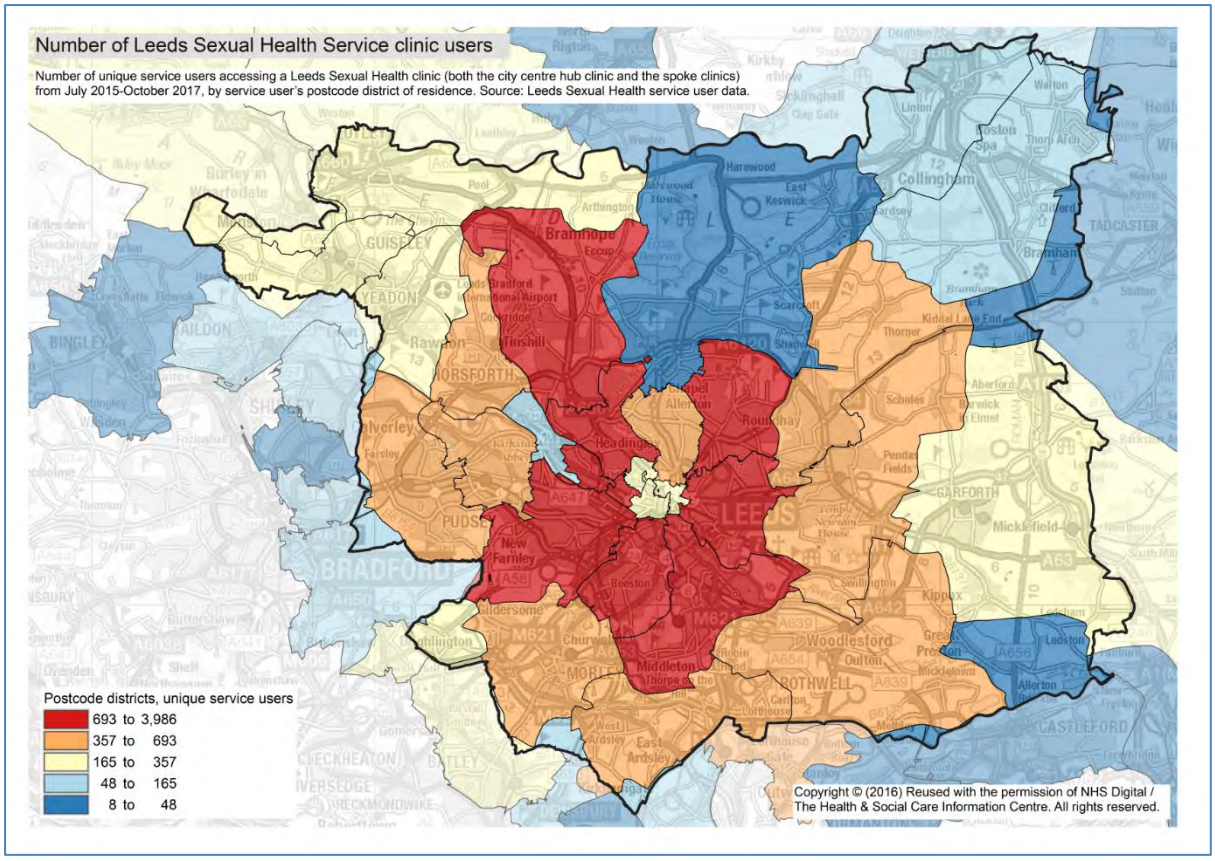
Number of implants and IUCDs (Long Acting Reversible Contraception), fitted by Leeds GPs, by women's ward of residence, from April 2016-April 2017. Source: Leeds GP data extraction programme.



Number of GP-prescribed EHC

Number of emergency hormonal contraception prescribed by Leeds GPs, by women's ward of residence. From October 2016-October 2017. Source: Leeds GP data extraction programme.




Number of Leeds Sexual Health Service clinic users
Number of unique service users accessing a Leeds Sexual Health clinic (both the city centre hub clinic and the spoke clinics) from July 2015-October 2017, by service user's postcode district of residence. Source: Leeds Sexual Health service user data.
Postcode districts, unique service users
693 to 3,986
357 to 693
165 to 357
48 to 165
8 to 48
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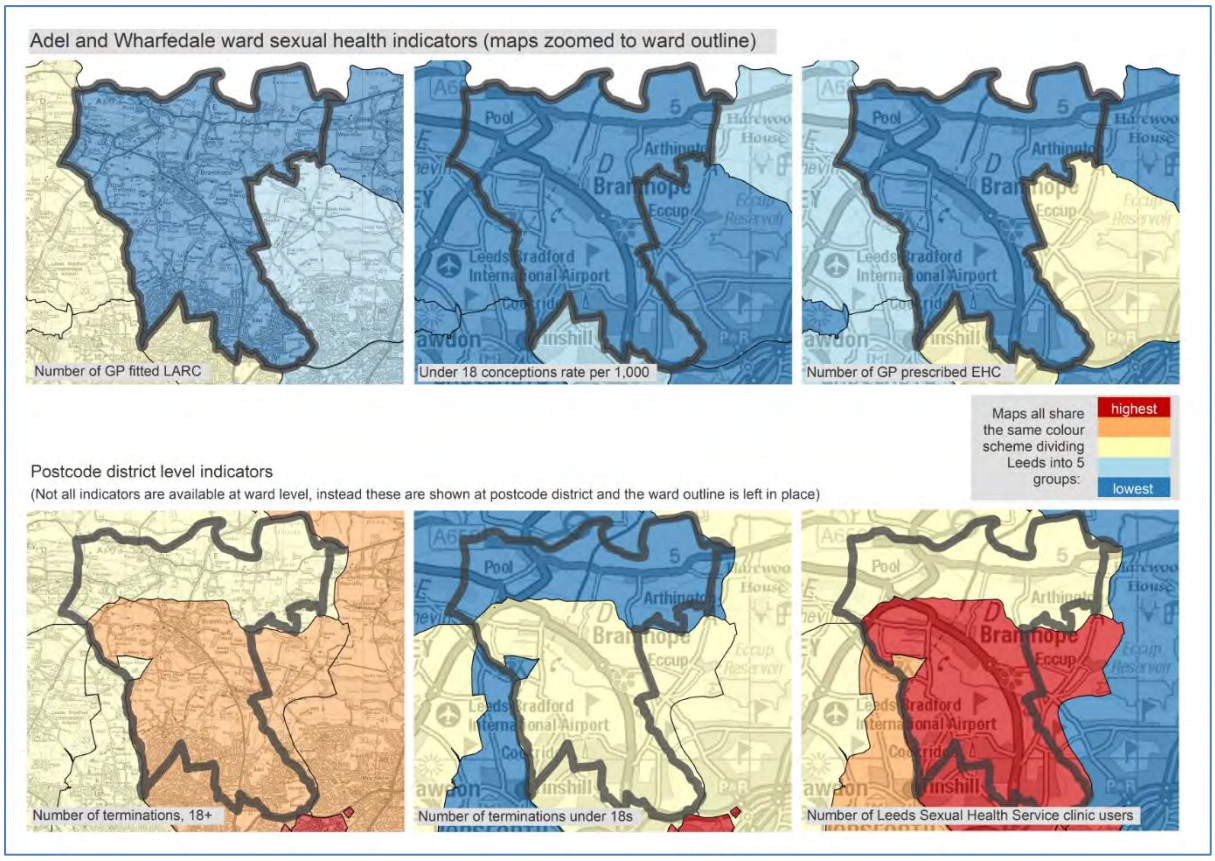
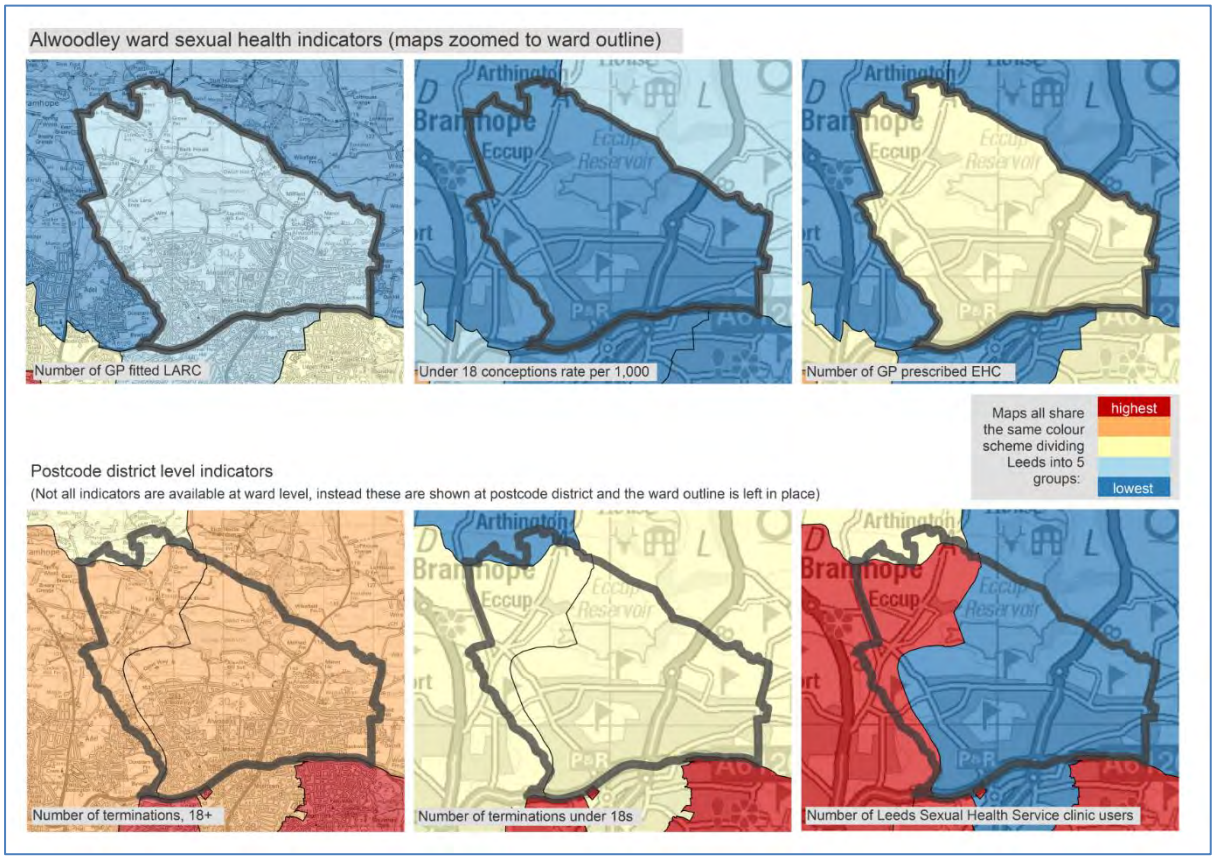
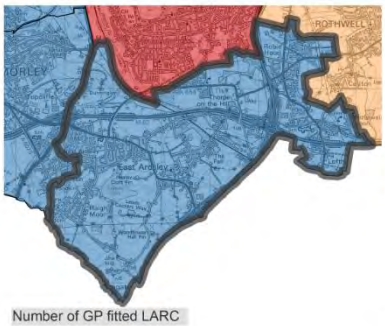
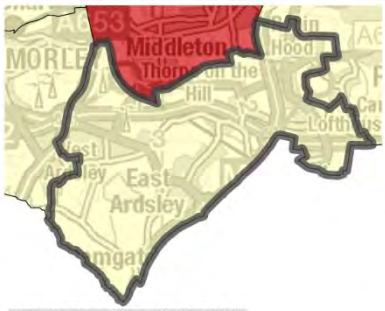
Individual ward maps (in alphabetical order)

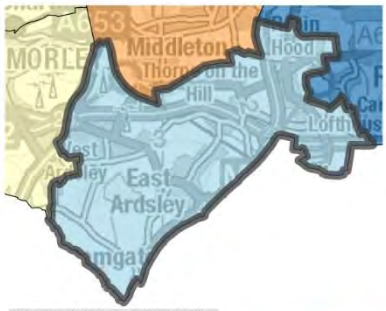




Ardsley and Robin Hood ward sexual health indicators (maps zoomed to ward outline)



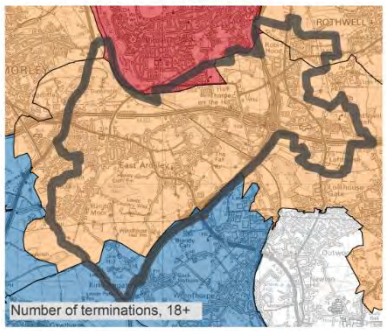


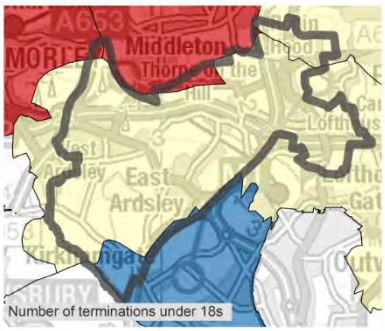


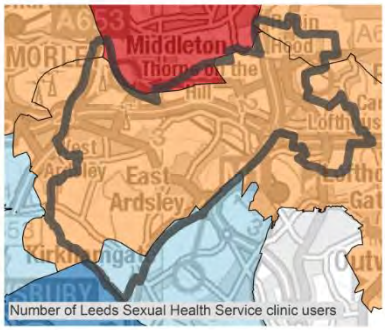
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

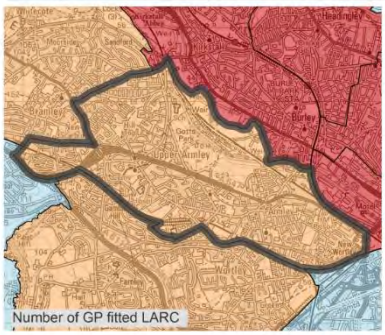
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

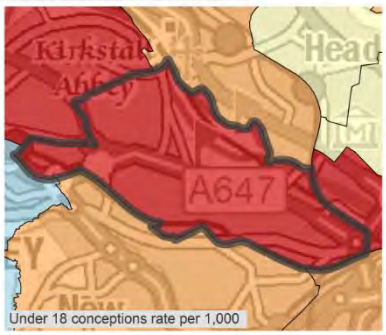


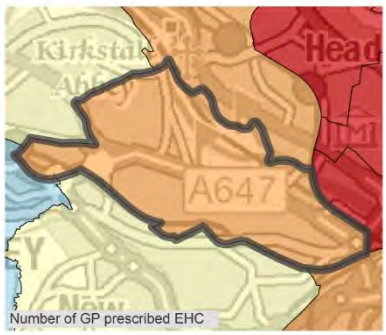




Armley ward sexual health indicators (maps zoomed to ward outline)



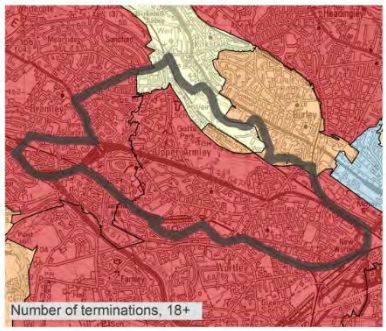


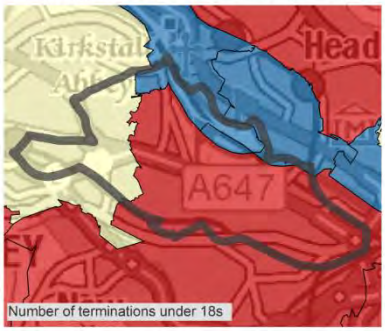


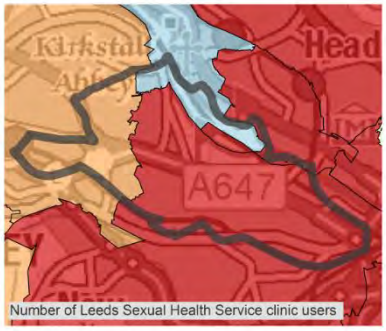
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

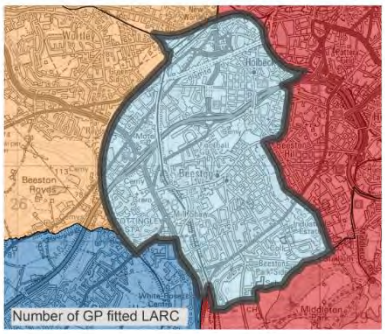
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

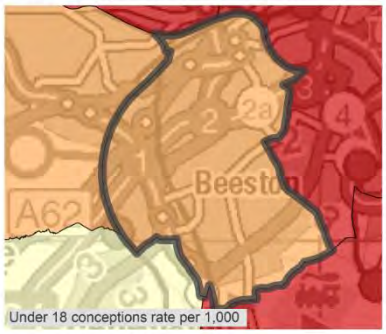


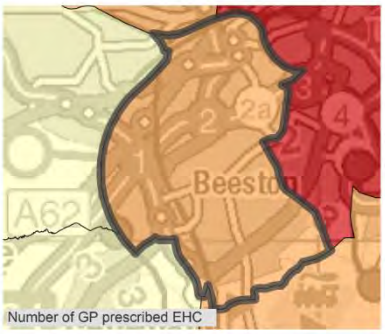




Beeston and Holbeck ward sexual health indicators (maps zoomed to ward outline)



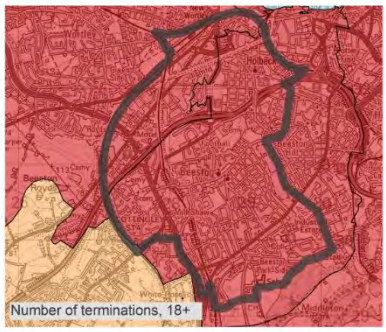


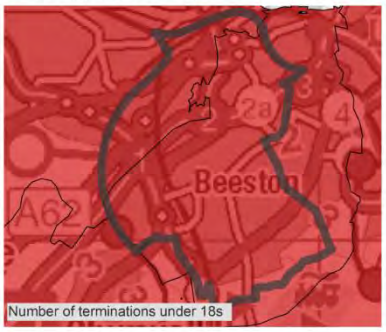


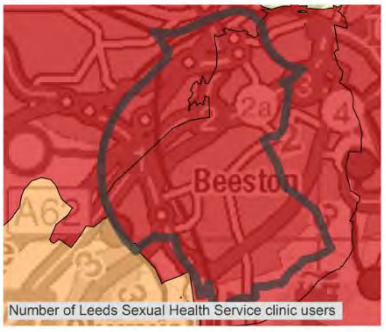
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

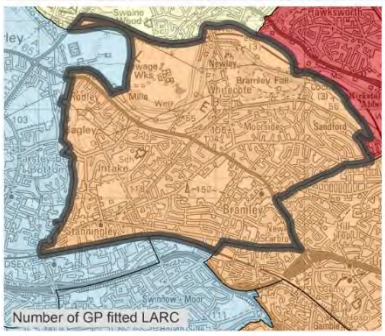
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

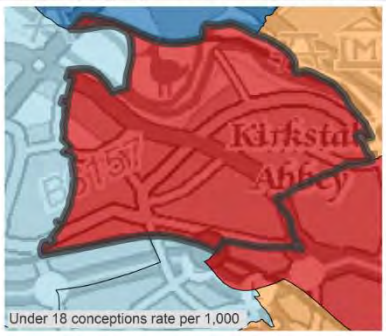


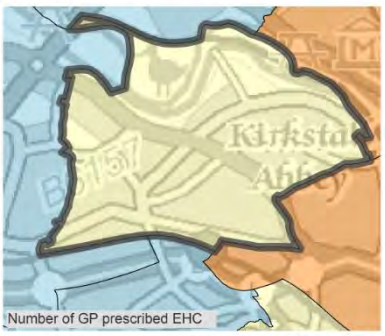




Bramley and Stanningley ward sexual health indicators (maps zoomed to ward outline)



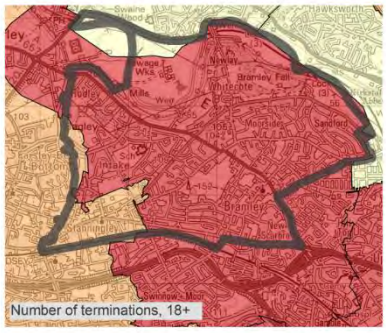


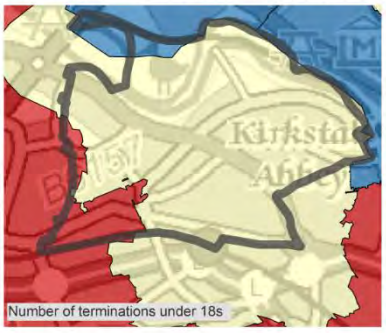


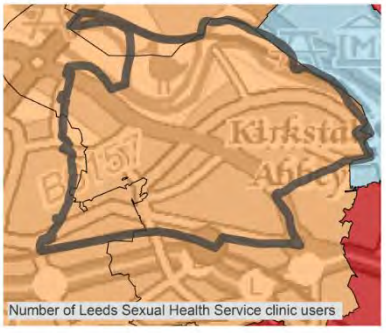
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

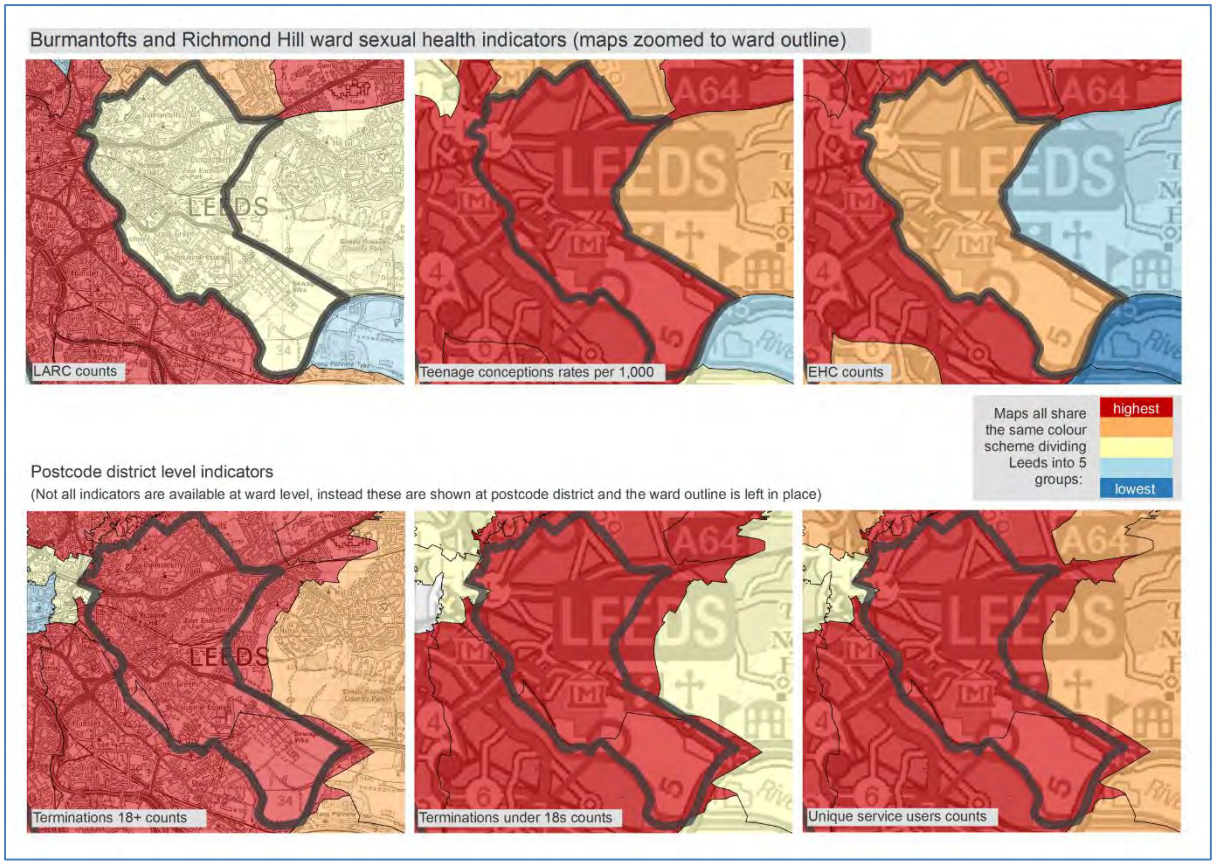
Postcode district level indicators

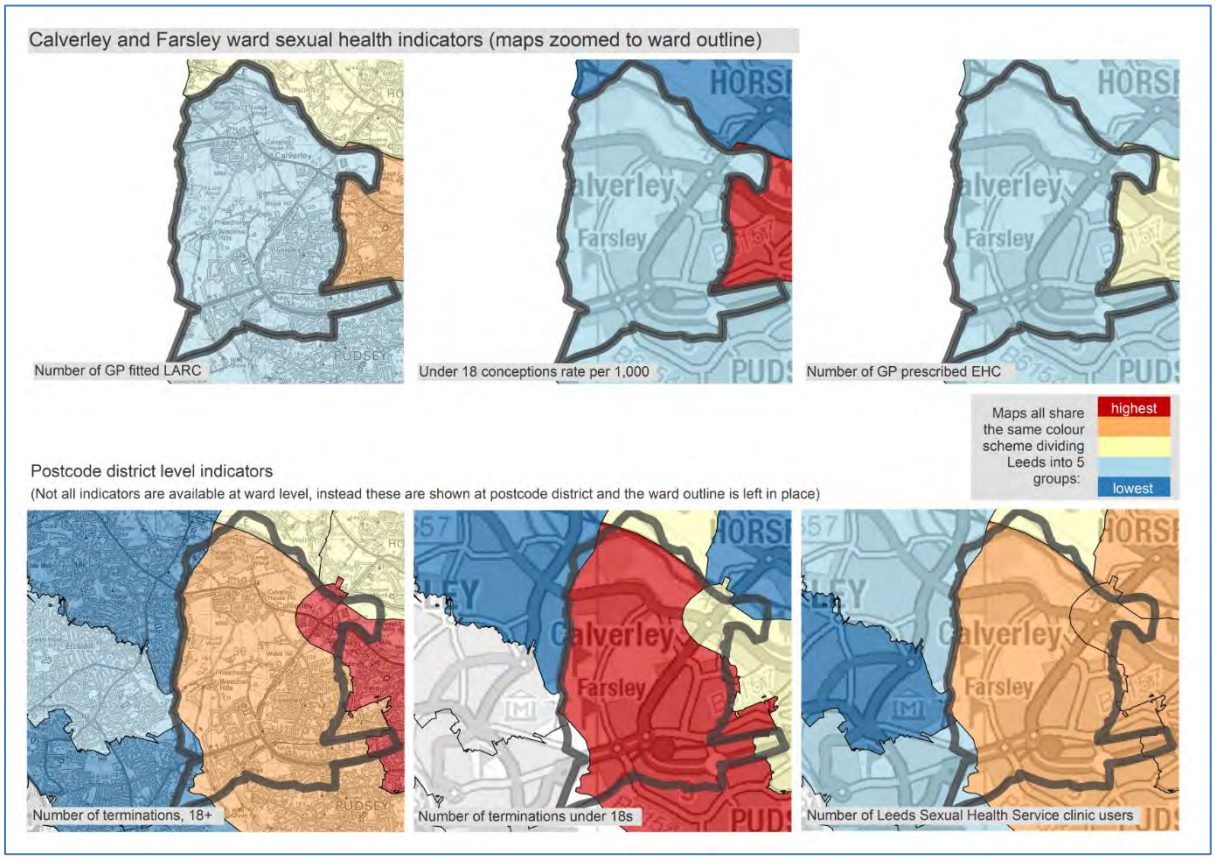
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



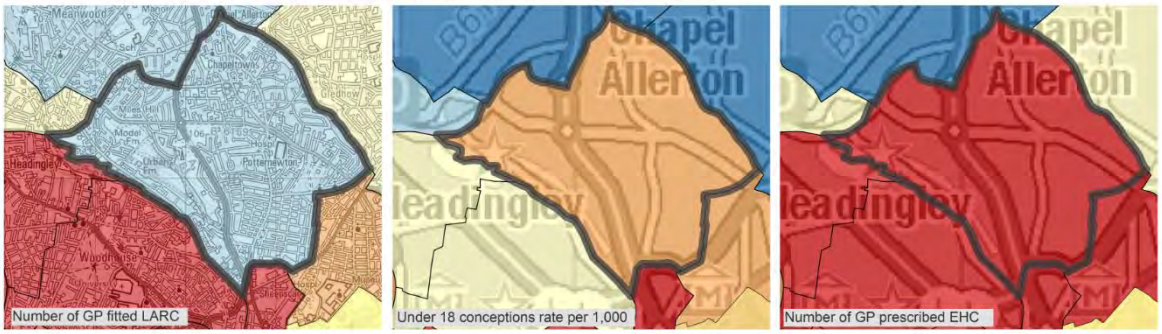





Burmantofts and Richmond Hill ward sexual health indicators (maps zoomed to ward outline)
LARC counts
Teenage conceptions rates per 1,000
EHC counts
Maps all share the same colour scheme dividing Leeds into 5 groups:
highest
lowest
Postcode district level indicators
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)
Terminations 18+ counts
Terminations under 18s counts
Unique service users counts


Calverley and Farsley ward sexual health indicators (maps zoomed to ward outline)
Number of GP fitted LARC
Under 18 conceptions rate per 1,000
Number of GP prescribed EHC
Maps all share the same colour scheme dividing Leeds into 5 groups:
highest
lowest
Postcode district level indicators
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)
Number of terminations, 18+
Number of terminations under 18s
Number of Leeds Sexual Health Service clinic users

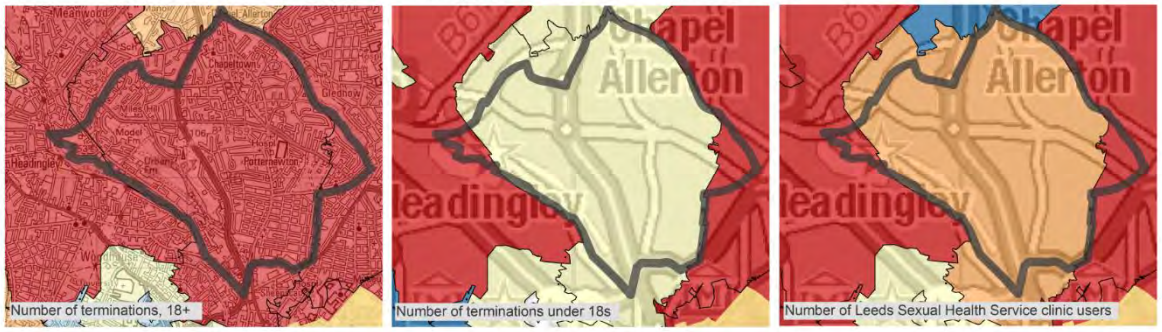
Chapel Allerton ward sexual health indicators (maps zoomed to ward outline)



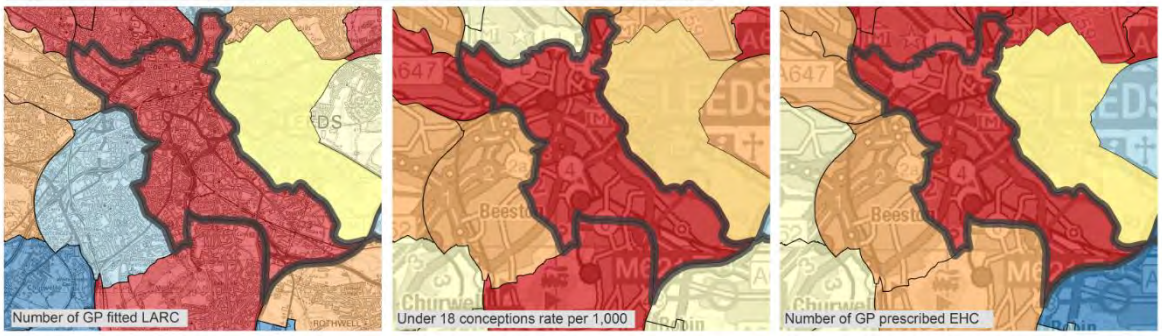
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



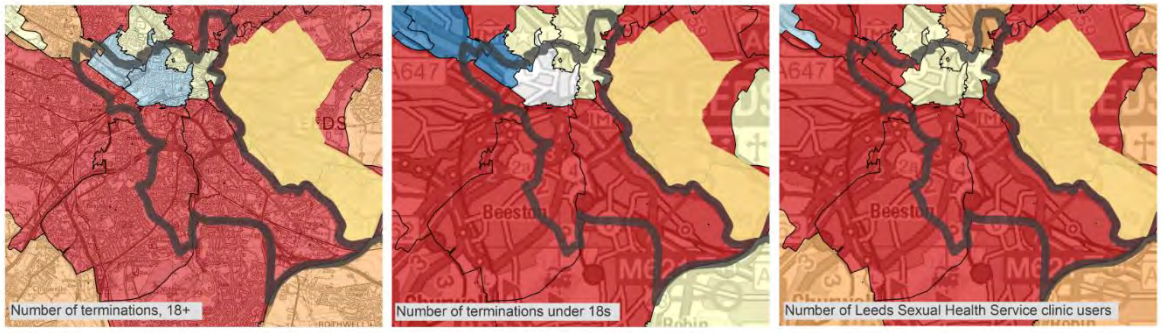
City and Hunslet ward sexual health indicators (maps zoomed to ward outline)



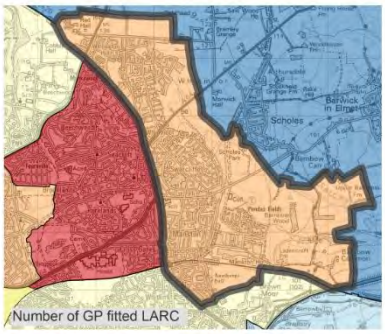
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

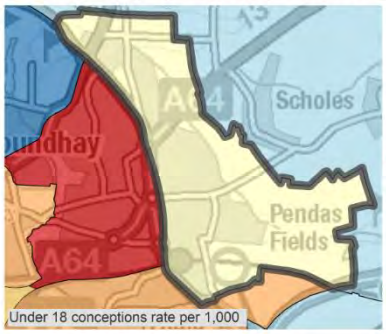
Postcode district level indicators

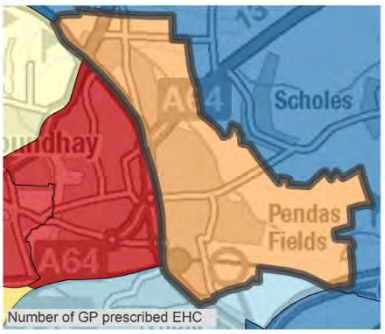
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



Cross Gates and Whinmoor ward sexual health indicators (maps zoomed to ward outline)



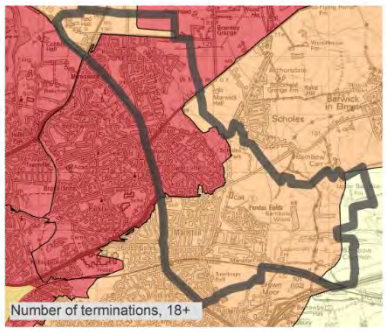


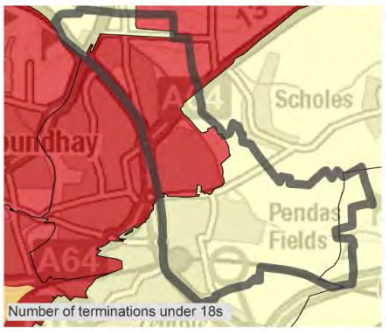


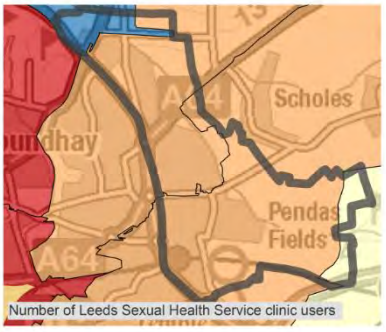
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

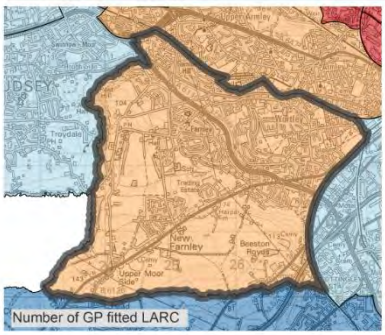
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

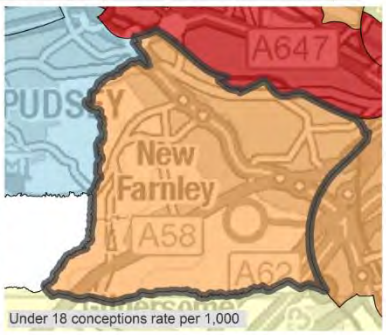


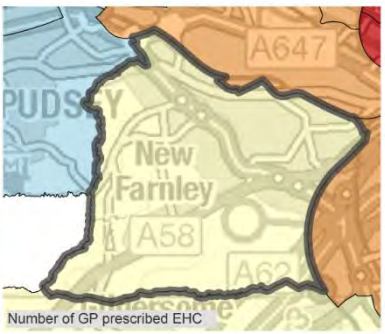




Farnley and Wortley ward sexual health indicators (maps zoomed to ward outline)



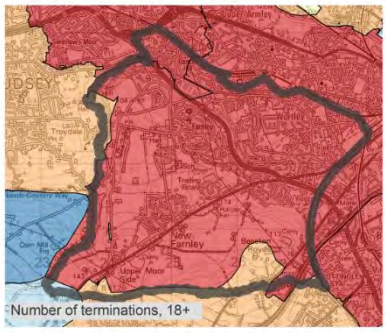


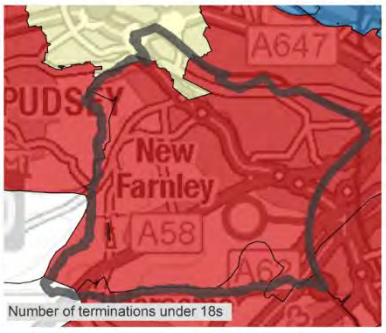


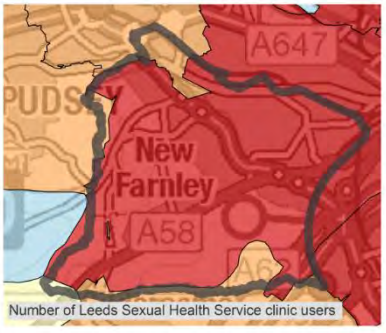
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

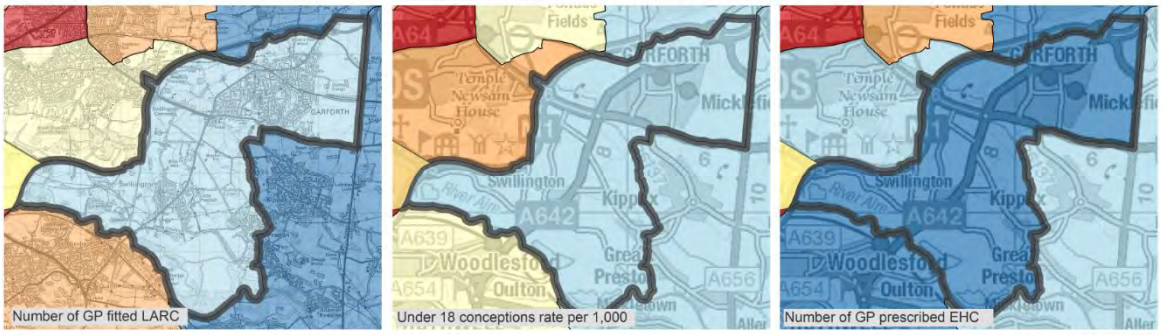
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)







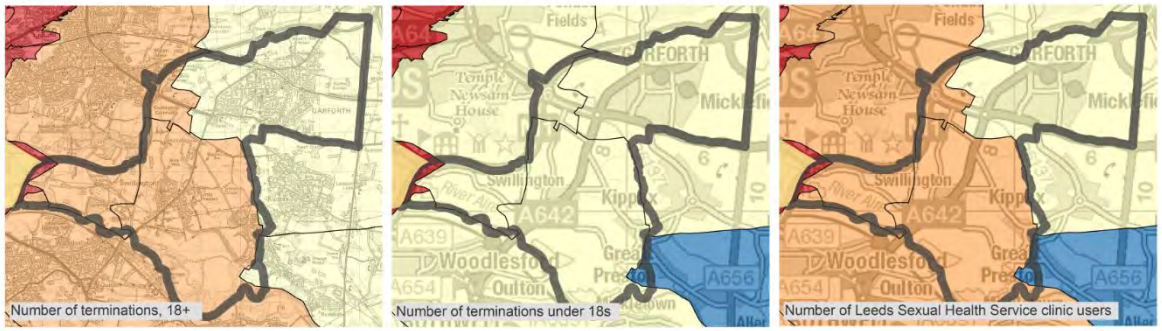
Garforth and Swillington ward sexual health indicators (maps zoomed to ward outline)



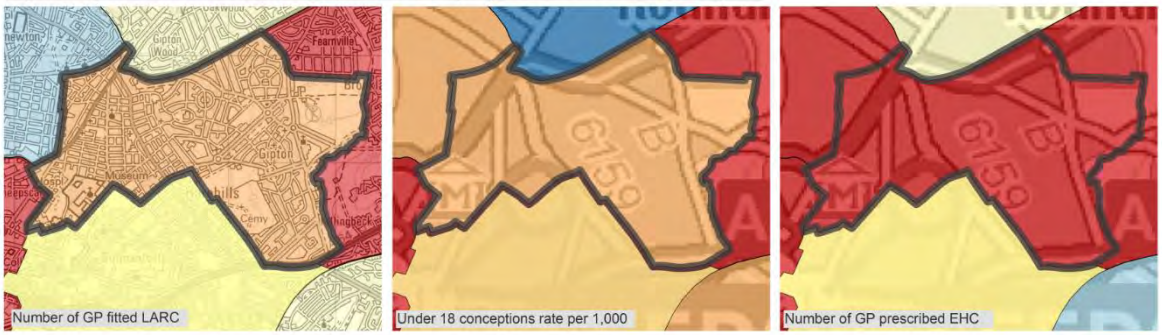
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



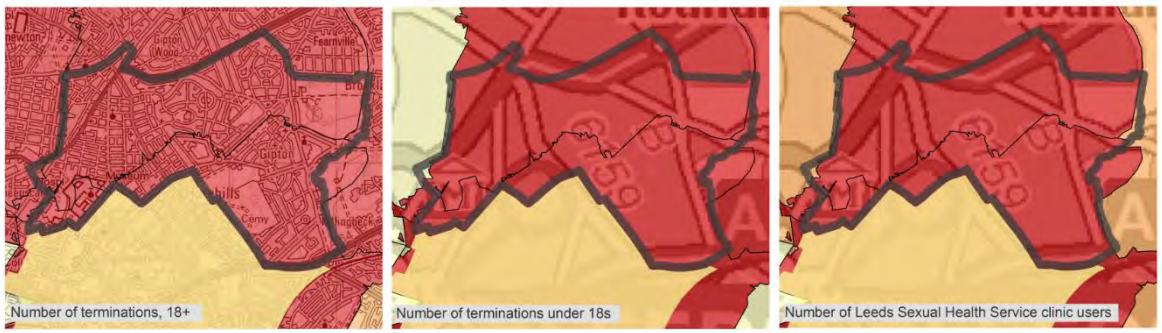
Gipton and Harehills ward sexual health indicators (maps zoomed to ward outline)

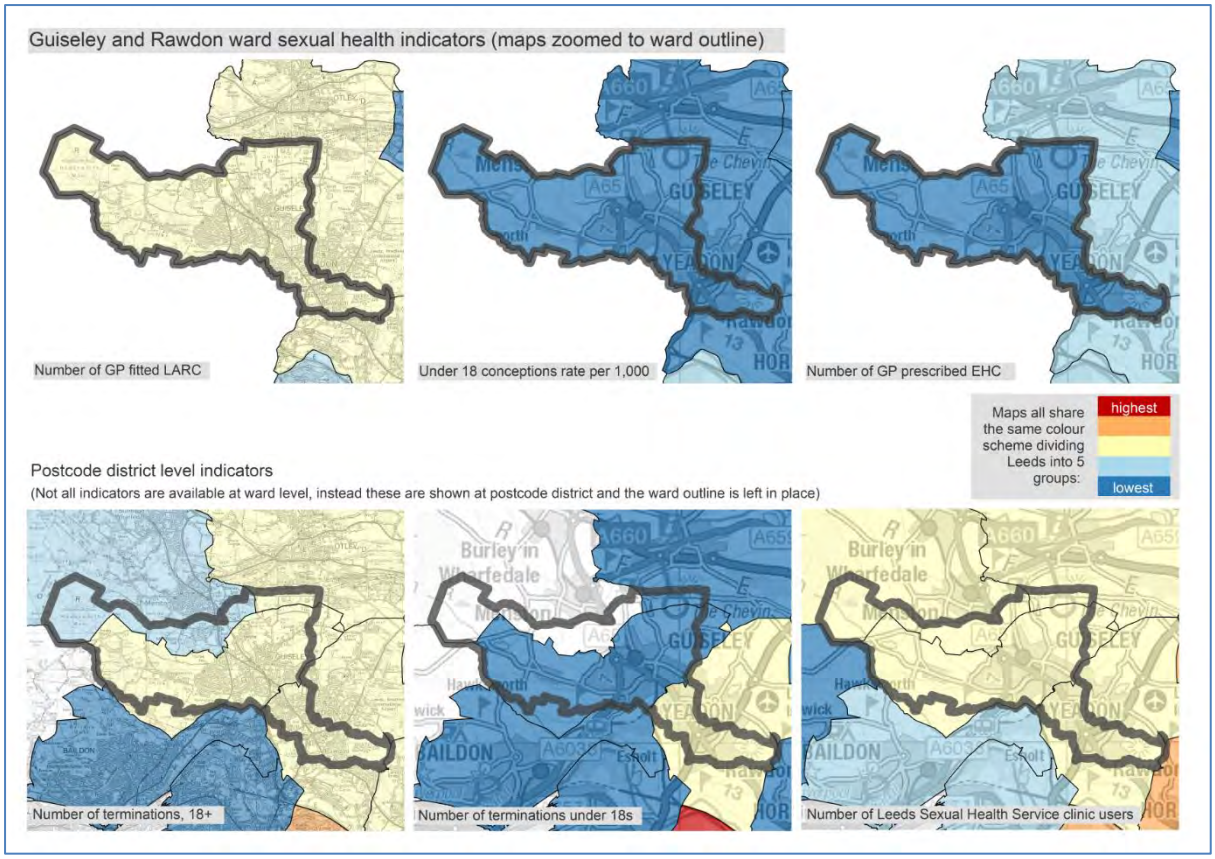


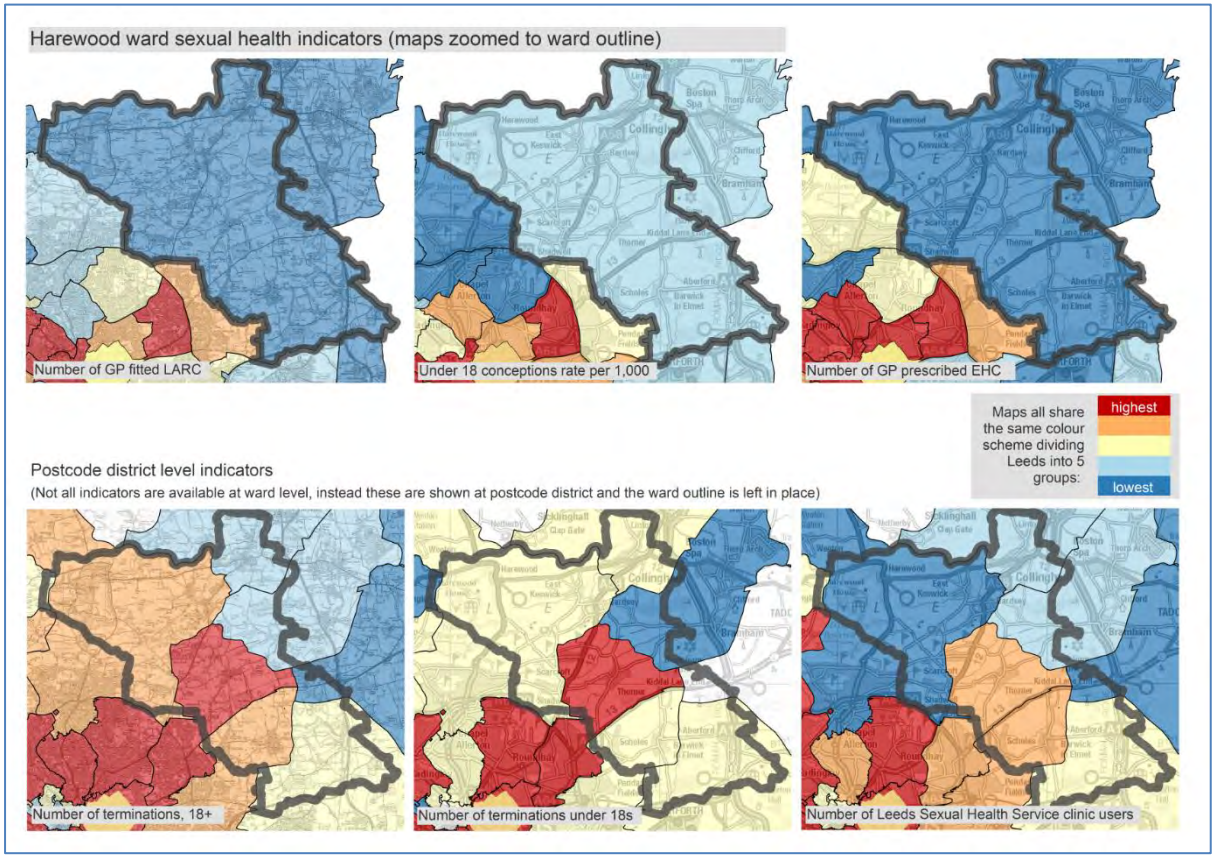
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

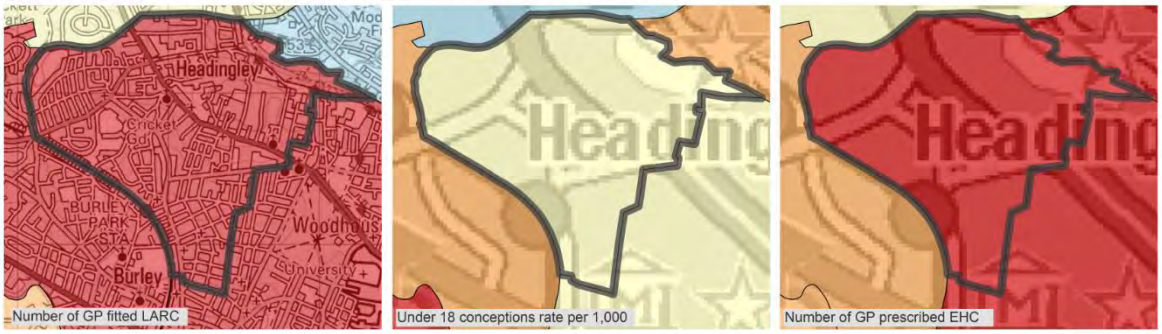
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)




Guiseley and Rawdon ward sexual health indicators (maps zoomed to ward outline)
Number of GP fitted LARC
Under 18 conceptions rate per 1,000
Number of GP prescribed EHC
Maps all share the same colour scheme dividing Leeds into 5 groups:
highest
lowest
Postcode district level indicators
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)
Number of terminations, 18+
Number of terminations under 18s
Number of Leeds Sexual Health Service clinic users


Harewood ward sexual health indicators (maps zoomed to ward outline)
Number of GP fitted LARC
Under 18 conceptions rate per 1,000
Number of GP prescribed EHC
Maps all share the same colour scheme dividing Leeds into 5 groups:
highest
lowest
Postcode district level indicators
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)
Number of terminations, 18+
Number of terminations under 18s
Number of Leeds Sexual Health Service clinic users

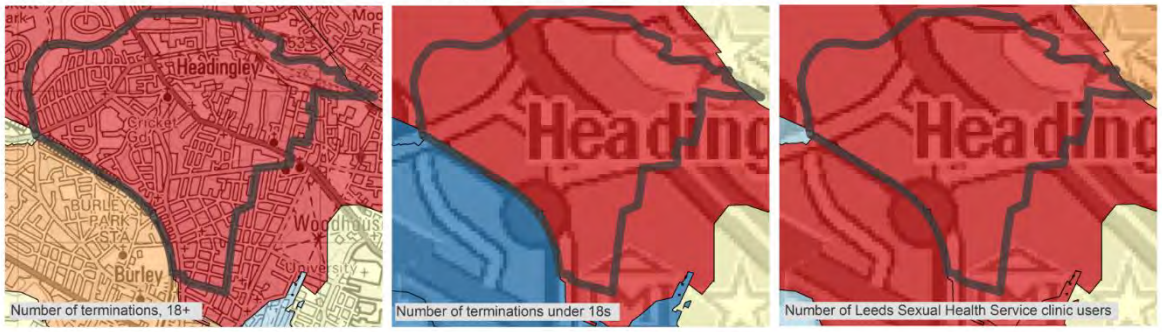
Headingley ward sexual health indicators (maps zoomed to ward outline)



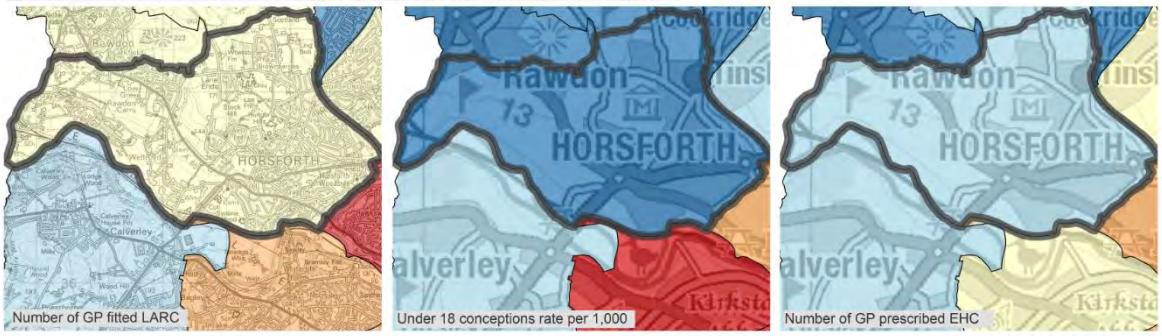
Maps all share the same colour scheme dividing Leeds into 5 groups: highest / lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



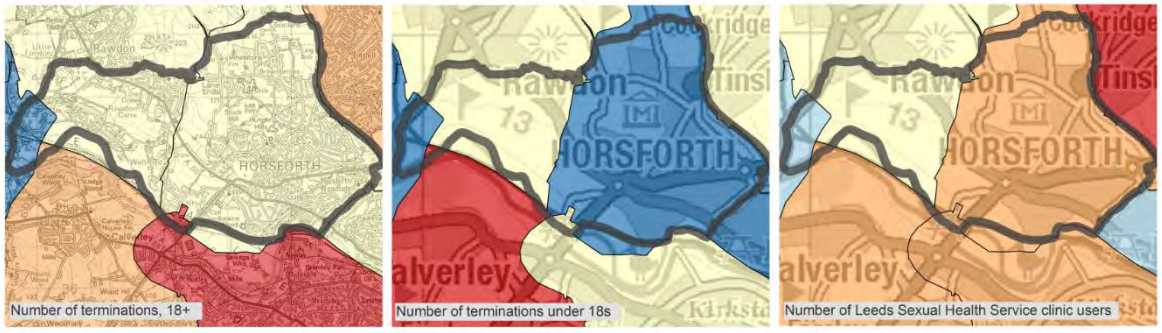
Horsforth ward sexual health indicators (maps zoomed to ward outline)



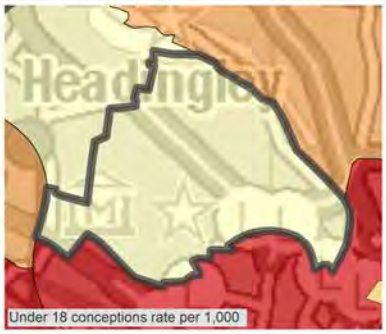
Maps all share the same colour scheme dividing Leeds into 5 groups: highest / lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



Hyde Park and Woodhouse ward sexual health indicators (maps zoomed to ward outline)

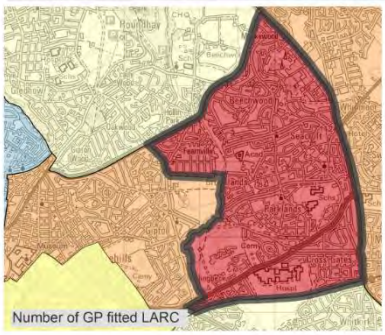


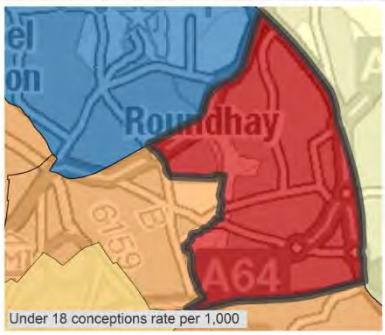
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

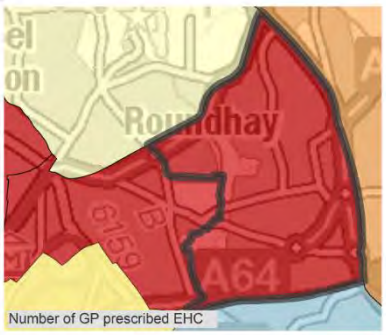
Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

Killingbeck and Seacroft ward sexual health indicators (maps zoomed to ward outline)



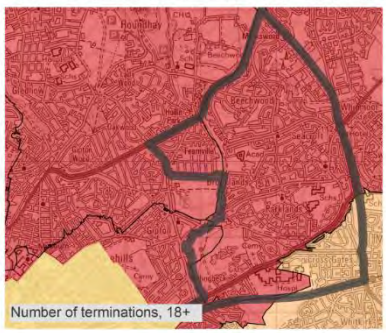


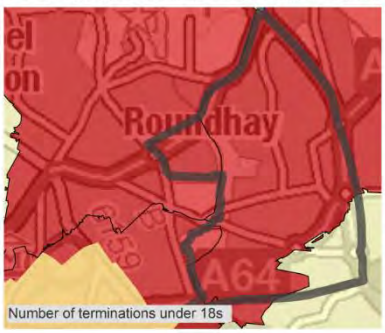


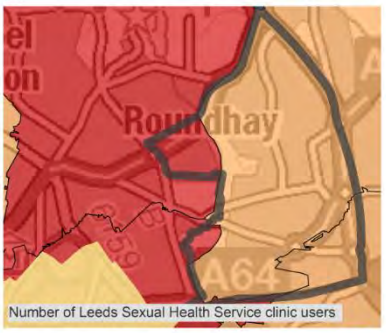
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

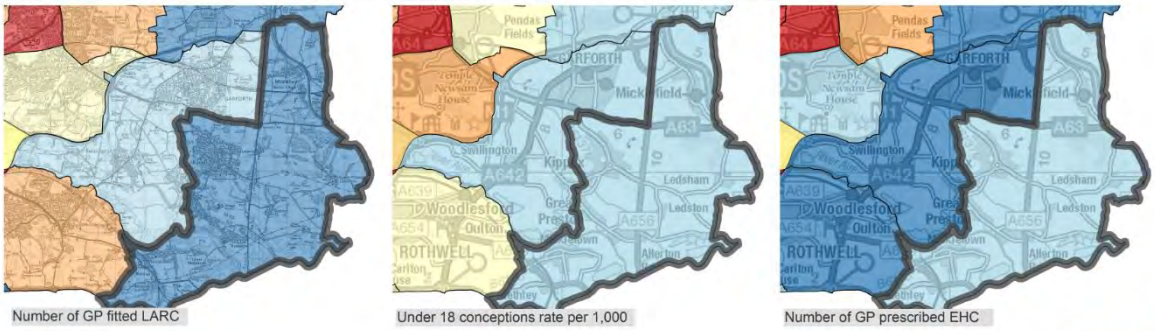
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)







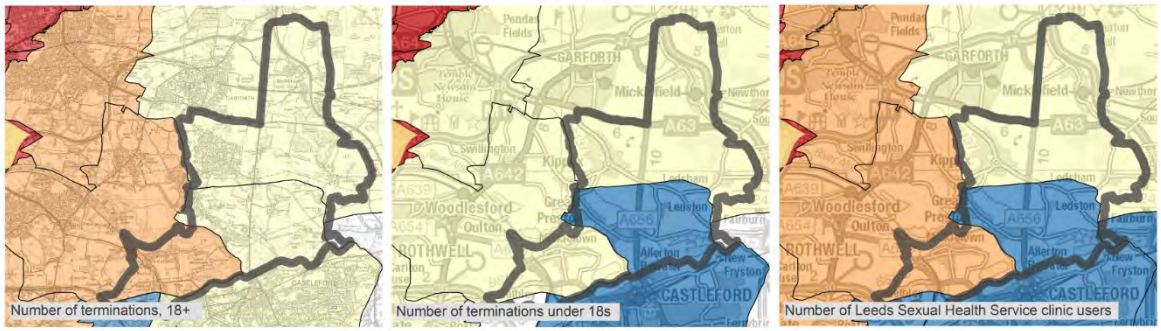
Kippax and Methley ward sexual health indicators (maps zoomed to ward outline)



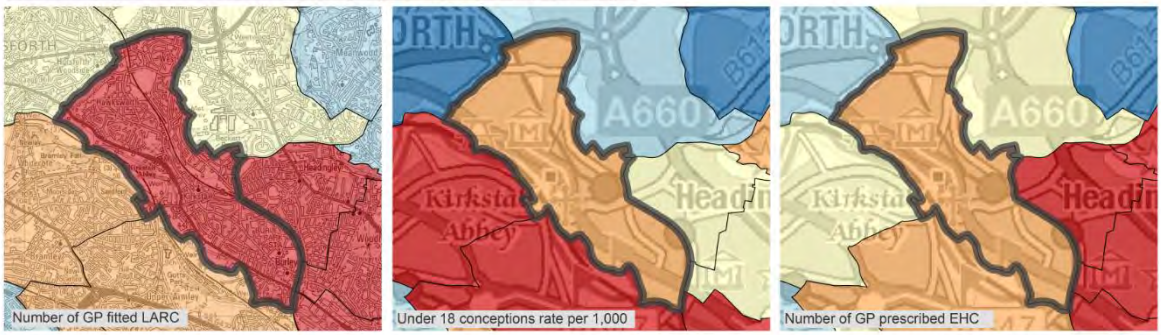
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



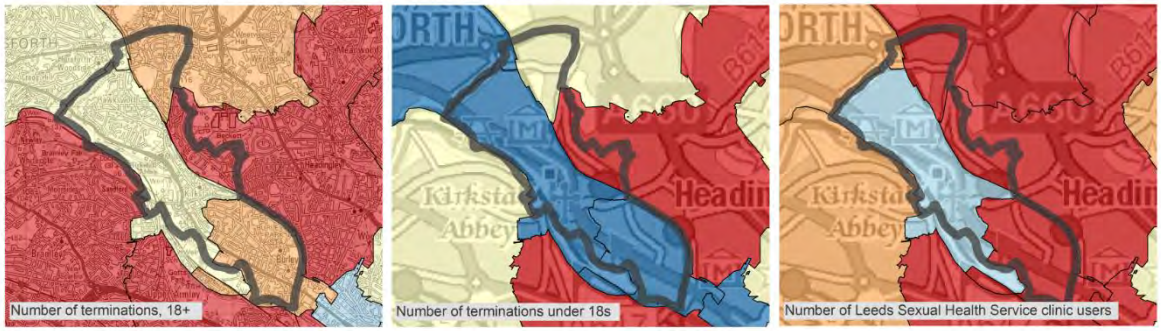
Kirkstall ward sexual health indicators (maps zoomed to ward outline)



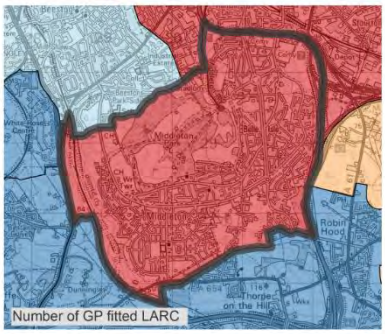
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

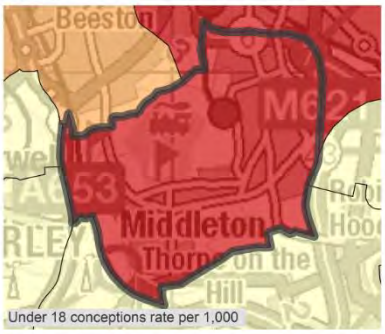
Postcode district level indicators

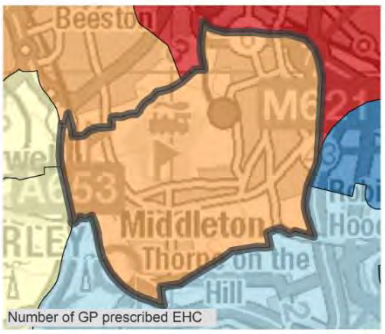
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



Middleton Park ward sexual health indicators (maps zoomed to ward outline)



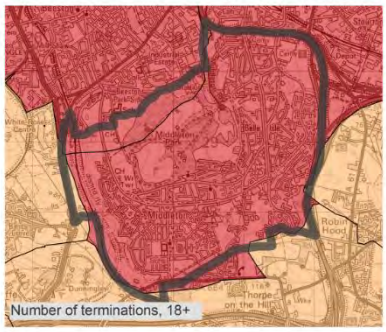


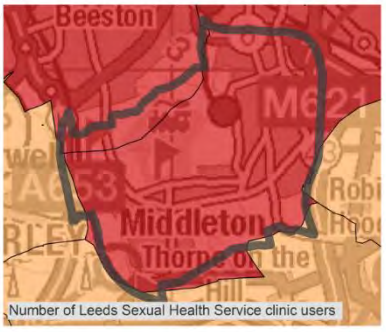


Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

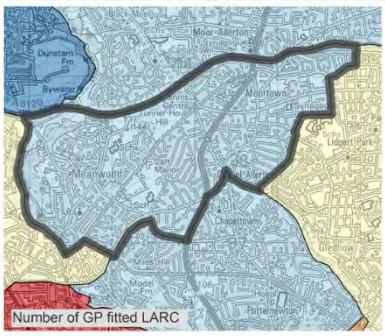
Postcode district level indicators

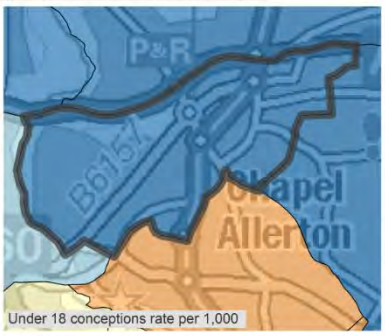
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

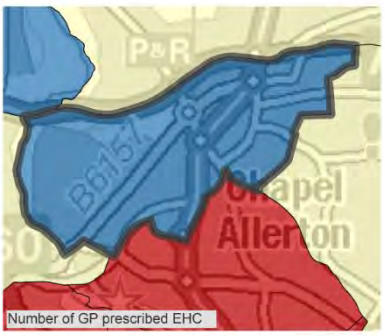




Moortown ward sexual health indicators (maps zoomed to ward outline)



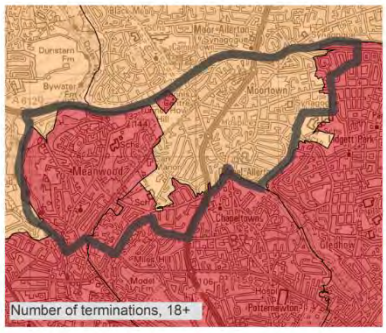


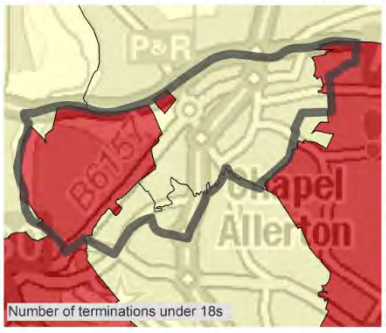


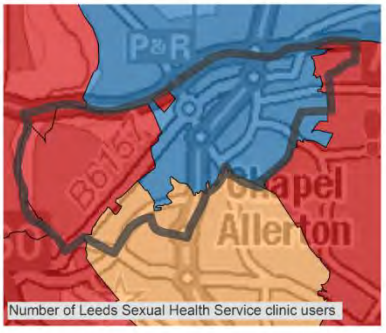
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

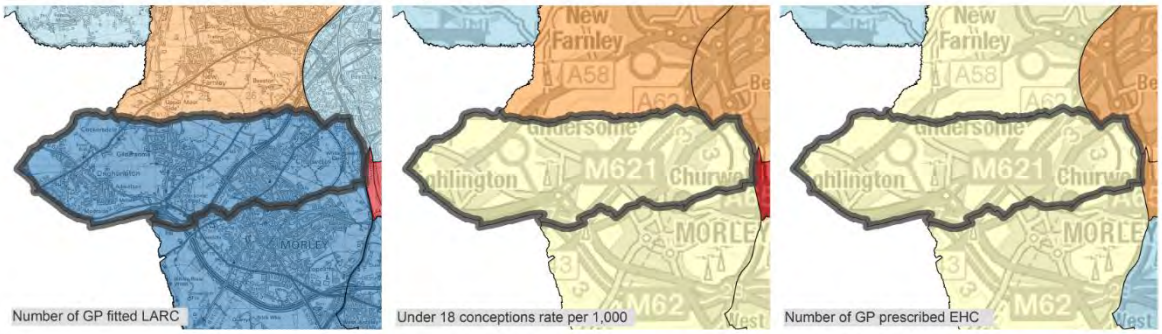
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)







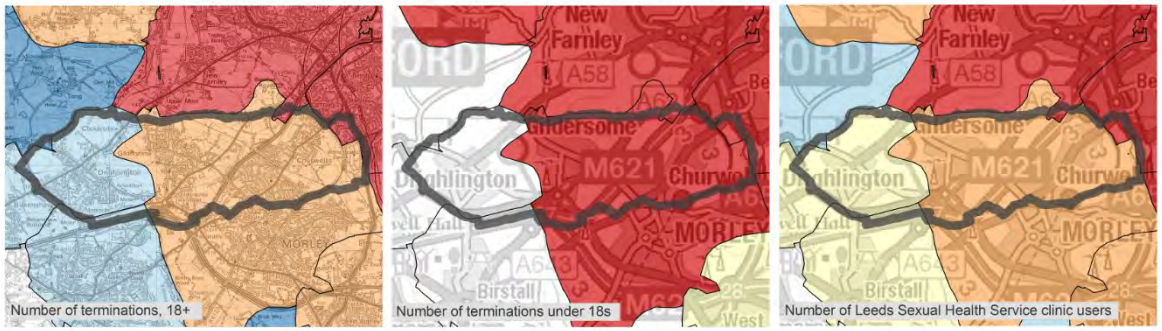
Morley North ward sexual health indicators (maps zoomed to ward outline)



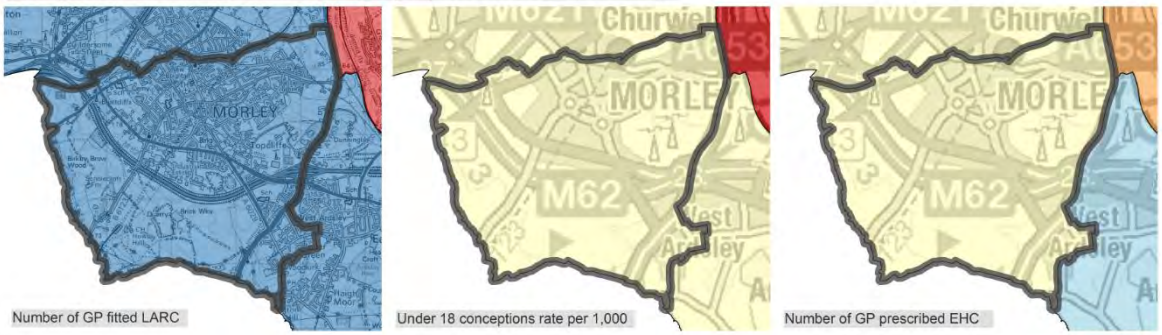
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



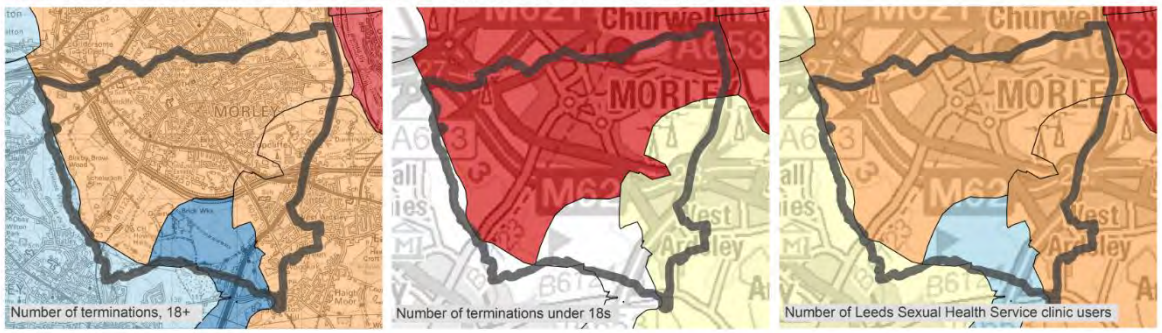
Morley South ward sexual health indicators (maps zoomed to ward outline)



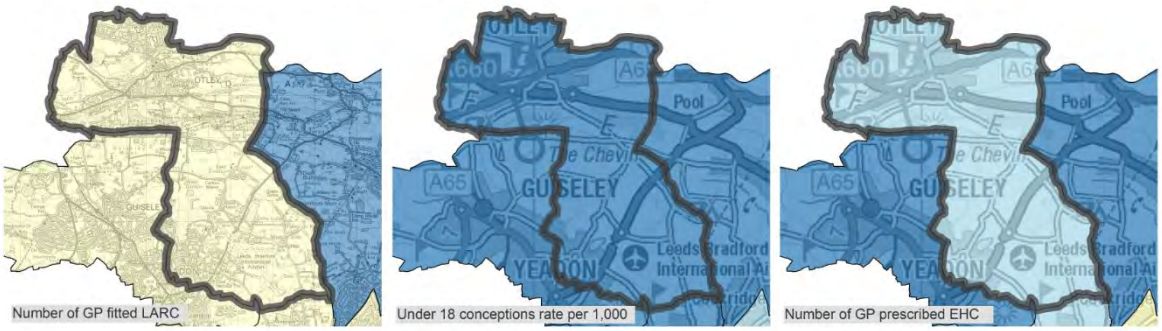
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



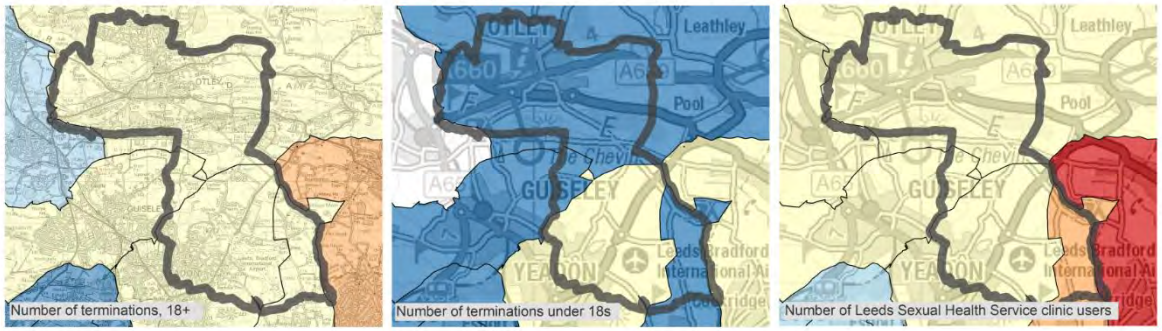
Otley and Yeadon ward sexual health indicators (maps zoomed to ward outline)



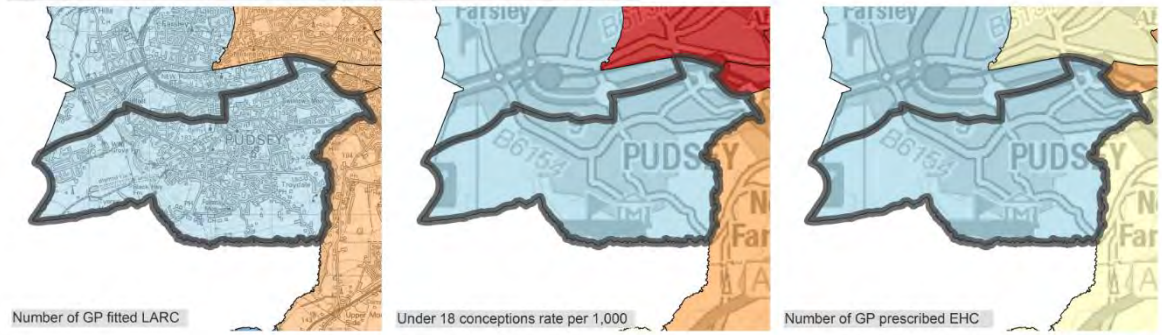
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



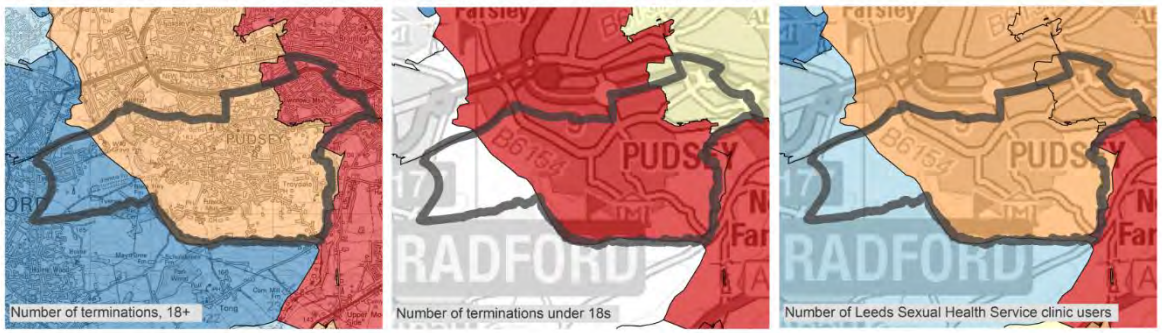
Pudsey ward sexual health indicators (maps zoomed to ward outline)



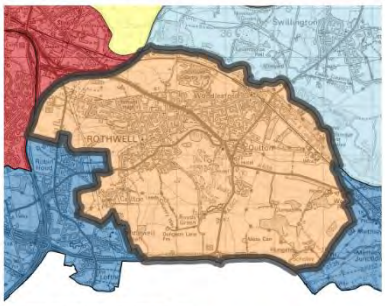
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

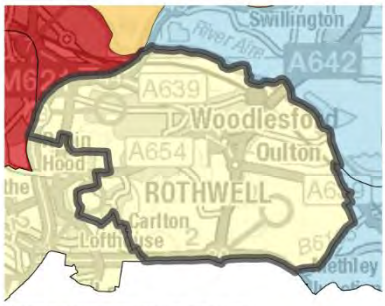
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



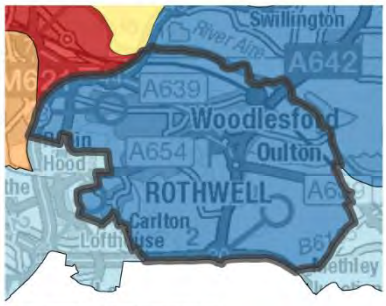
Rothwell ward sexual health indicators (maps zoomed to ward outline)



Number of GP fitted LARC



Under 18 conceptions rate per 1,000

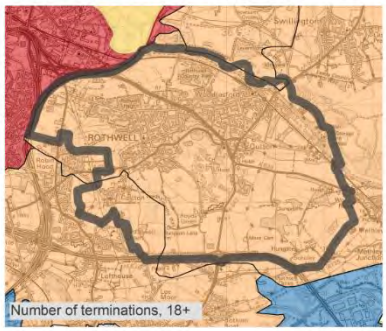


Number of GP prescribed EHC

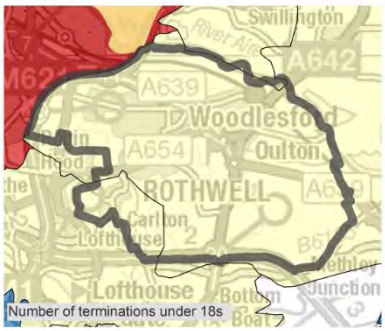
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

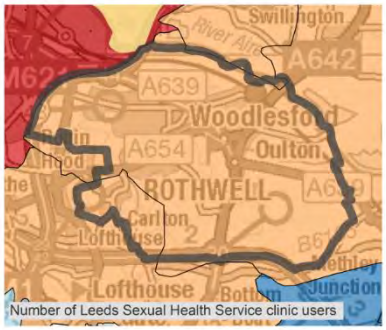
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



Number of terminations, 18+

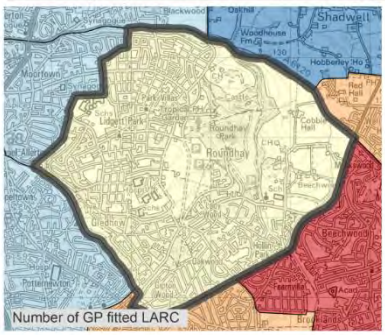


Number of terminations under 18s

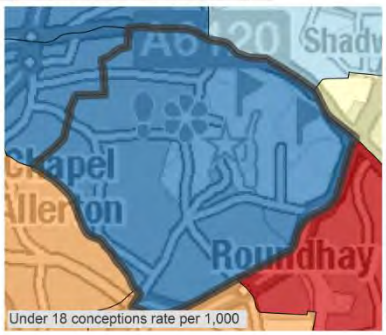


Number of Leeds Sexual Health Service clinic users

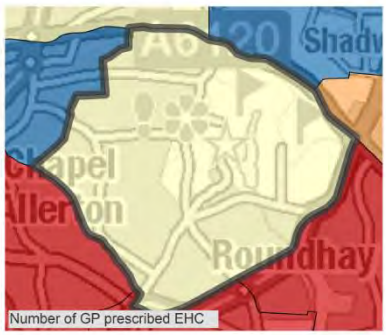
Roundhay ward sexual health indicators (maps zoomed to ward outline)



Number of GP fitted LARC



Under 18 conceptions rate per 1,000

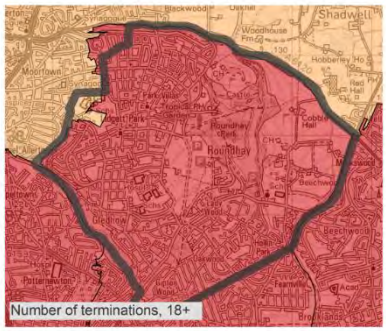


Number of GP prescribed EHC

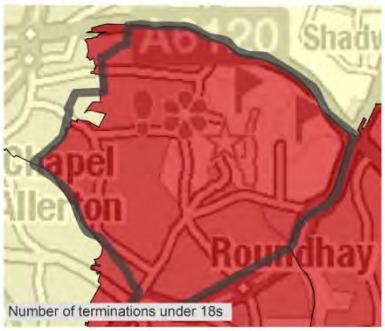
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

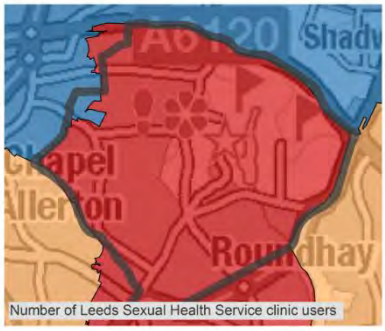
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)



Number of terminations, 18+

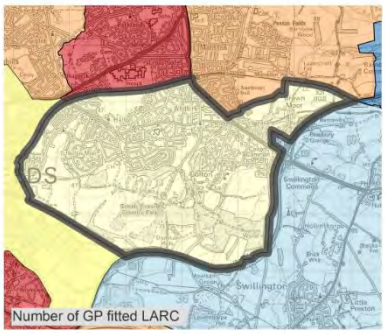


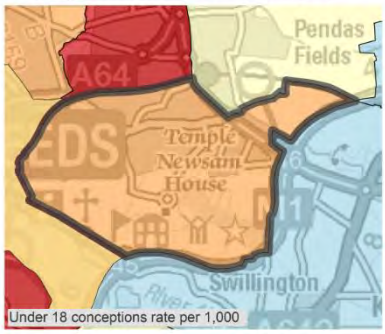
Number of terminations under 18s

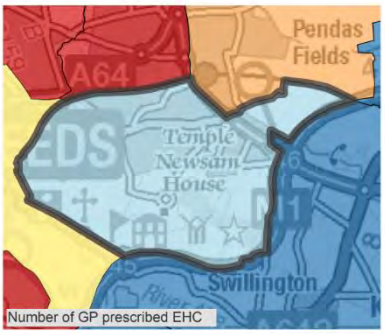


Number of Leeds Sexual Health Service clinic users

Temple Newsam ward sexual health indicators (maps zoomed to ward outline)



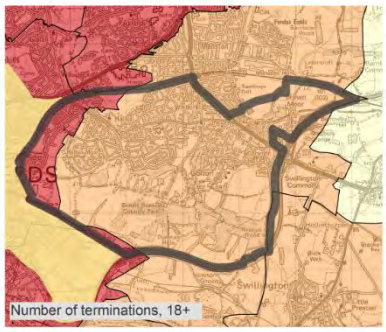


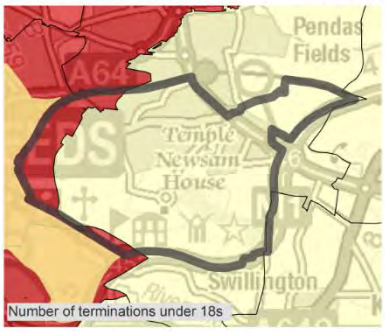


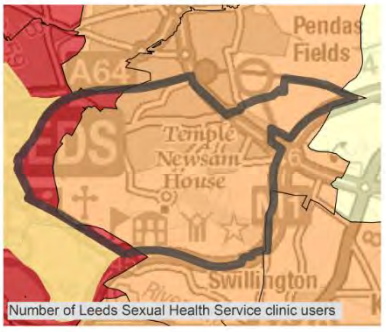
Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

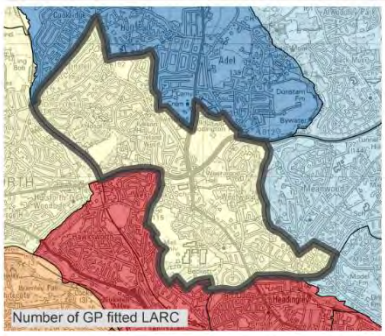
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)

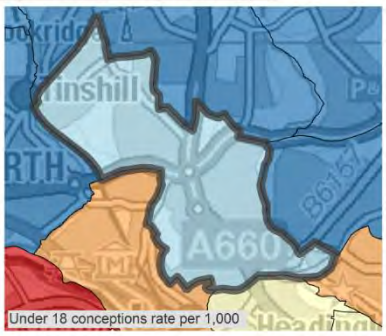


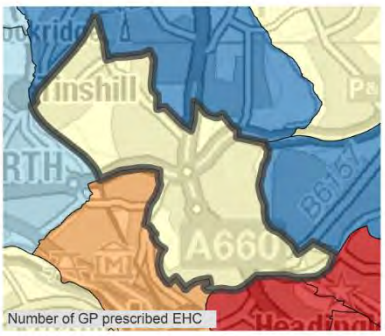




Weetwood ward sexual health indicators (maps zoomed to ward outline)







Maps all share the same colour scheme dividing Leeds into 5 groups: highest, lowest

Postcode district level indicators

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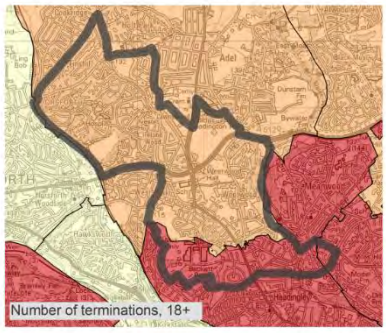

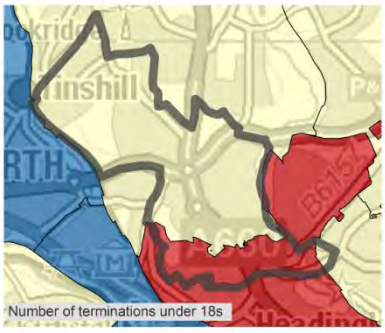

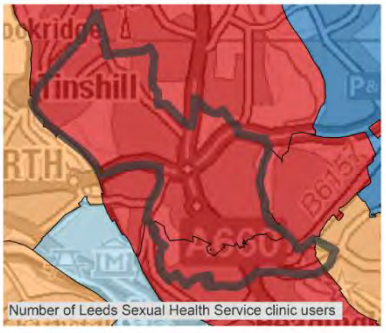

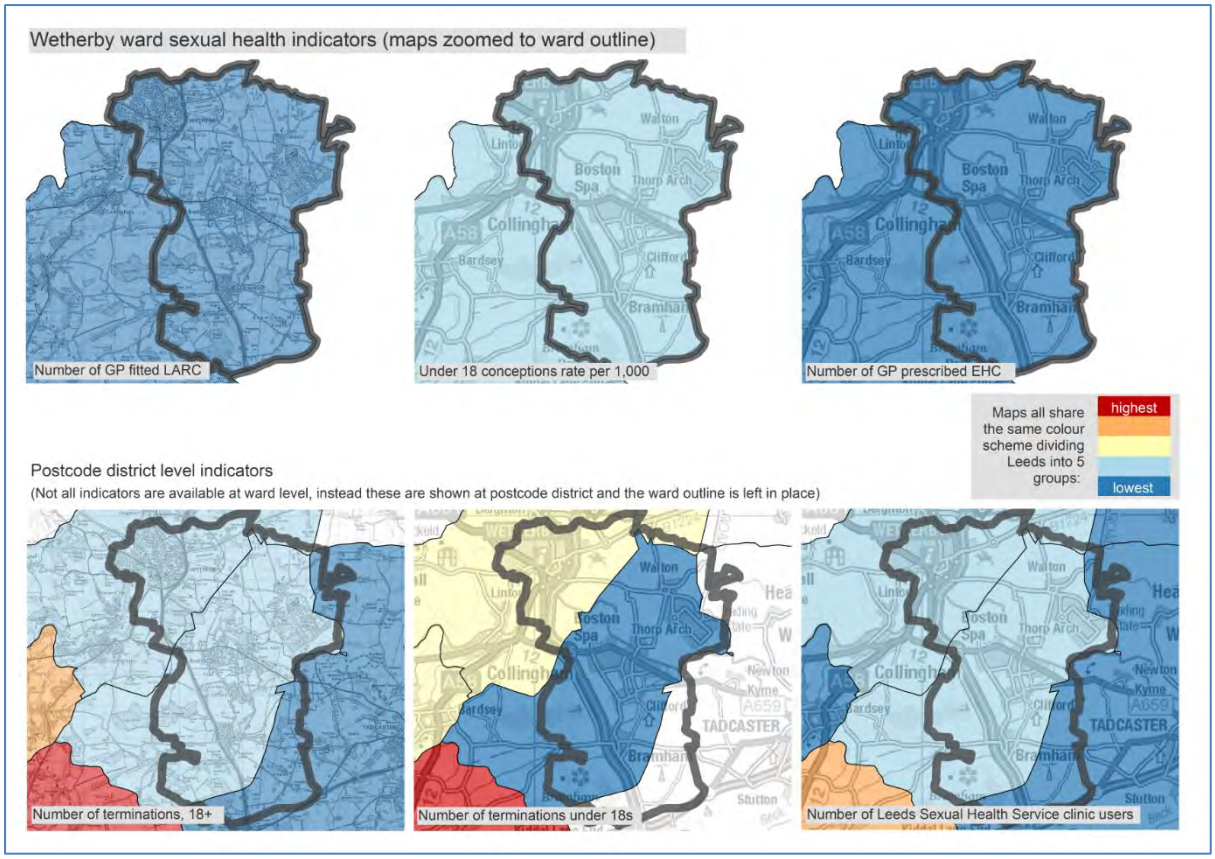
Wetherby ward sexual health indicators (maps zoomed to ward outline)
Number of GP fitted LARC
Under 18 conceptions rate per 1,000
Number of GP prescribed EHC
Maps all share the same colour scheme dividing Leeds into 5 groups:
highest
lowest
Postcode district level indicators
(Not all indicators are available at ward level, instead these are shown at postcode district and the ward outline is left in place)
Number of terminations, 18+
Number of terminations under 18s
Number of Leeds Sexual Health Service clinic users