Spotlight on sexually transmitted infections in the East Midlands 2016 data
About Public Health England

Public Health England exists to protect and improve the nation’s health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health, and are a distinct delivery organisation with operational autonomy to advise and support government, local authorities and the NHS in a professionally independent manner.

Public Health England
Wellington House
133-155 Waterloo Road
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

Prepared by: Josh Forde and Paul Crook, Field Epidemiology Services, South East and London and Srilaxmi Degala, Field Epidemiology Services, East Midlands. For queries relating to this document, please contact: srilaxmi.degala@phe.gov.uk

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1. Executive summary

Sexually transmitted infections (STIs) represent an important public health issue in the East Midlands. Out of all 9 of the PHE centres it has the seventh highest rate of new STIs in England.

More than 28,100 new STIs were diagnosed in East Midlands residents in 2016, representing a rate of 602 diagnoses per 100,000 adults. Rates by upper tier local authority ranged from 491 new STI diagnoses per 100,000 population in Derbyshire to 1,102 new STI diagnoses per 100,000 population in Nottingham City.

The number of new STIs diagnosed in East Midlands residents fell by 5% between 2015 and 2016. Falls were seen in the numbers of 4 of the 5 major STIs: gonorrhoea decreased by 12%, chlamydia by <1%, genital herpes by 12% and genital warts by 8%. Syphilis increased by 20%.

PHE recommends that local areas should be working towards achieving a chlamydia detection rate of at least 2,300 per 100,000 among individuals aged 15 to 24 years. This is an indicator in the Public Health Outcome Framework. In 2016, the chlamydia diagnosis rate among East Midlands residents aged 15 to 24 years was 1,820 per 100,000 residents.

Men and women have similar rates of new STIs (570 and 630 per 100,000 residents respectively).

Where gender and sexual orientation are known, men who have sex with men (MSM) account for 8% of East Midlands residents diagnosed with a new STI in a specialist sexual health clinic (SHC) (76% of those diagnosed with syphilis and 27% of those diagnosed with gonorrhoea).

STIs disproportionately affect young people. East Midlands residents aged between 15 and 24 years accounted for 60% of all new STI diagnoses in 2016.

The white ethnic group has the highest number of new STI diagnoses: over 18,500 (85%). Although only 2% of new STIs are in black Caribbeans, they have the highest rate: 1,709 per 100,000, which is 4 times the rate seen in the white ethnic group. Where country of birth was known, 89% of East Midlands residents diagnosed in a specialist SHC in 2016 with a new STI were UK-born.
1.1. Implications for prevention

The impact of STIs remains greatest in young heterosexuals 15 to 24 years, black ethnic minorities and MSM, and PHE is conducting and managing a number of initiatives to address this inequality.

To improve the sexual health of young people, PHE is undertaking formative research for a health promotion campaign to promote condom use and positive sexual relationships among this population. Additionally, statutory, high-quality relationship and sex education at all secondary schools will equip young people with the information and skills to improve their sexual health. Locally, within the East Midlands, we have addressed the issue of child sexual exploitation (CSE) and are now working closer with local authorities to understand the role of Public Health on this agenda.

There is a notable variation in the chlamydia detection rate among 15 to 24 year olds by geographic area, often reflecting rates of testing. Local authorities with detection rates below the PHOF recommended indicator of 2,300 per 100,000 population should consider means to promote chlamydia screening to most effectively detect and control chlamydia infections.

Local areas should focus on embedding chlamydia screening for 15 to 24 year olds into a variety of non-specialist SHCs and community-based settings, focusing on those which serve the populations with the highest need based on positivity. They should also emphasise the need for repeat screening annually and on change of sexual partner, as well as the need for re-testing after a positive diagnosis within 3 months of initial diagnosis; and ensure treatment and partner notification standards are met.

To help local areas improve their chlamydia detection rate in 15 to 24 year olds, PHE developed the chlamydia care pathway to outline comprehensive case management for an episode of chlamydia testing, diagnosis and treatment.

Of particular concern is the continuing rise of syphilis nationally among MSM. There is evidence that condomless sex associated with HIV sero-adaptive behaviours (which includes selecting partners perceived to be of the same HIV sero-status), is leading to increased STI transmission.

Nationally, the rate of acute bacterial STIs in HIV-positive MSM is up to 4 times that of MSM who were HIV-negative or of unknown HIV status. This suggests that rapid STI transmission is occurring in dense sexual networks of HIV-positive MSM. Sero-adaptive behaviour increases the risk of infection with STIs, hepatitis B and C, and sexually transmissible enteric infections like *Shigella* spp. For those who are HIV negative, sero-adaptive behaviour increases the risk of HIV seroconversion as 13% of MSM nationally are unaware of their infection.
As MSM continue to experience high rates of STIs they remain a priority for targeted STI prevention and health promotion work. HIV Prevention England have been contracted to deliver, on behalf of PHE, a range of activities which include promoting condom use and awareness of STIs, which are particularly aimed at MSM.

The continued reduction in genital warts is associated with the high coverage of HPV vaccination in adolescent girls through the National HPV Vaccination Programme. While young heterosexual men stand to benefit from female only HPV vaccination through herd protection, this is not necessarily the case for MSM. As a result, a targeted HPV vaccination pilot programme for MSM was introduced in England in 2016 to inform the potential national rollout of vaccination of MSM attending specialist SHCs and HIV clinics: www.gov.uk/government/publications/hpv-vaccination-pilot-for-men-who-have-sex-with-men-msm. HPV vaccination of MSM will provide direct protection against HPV infection with the aim of reducing the incidence of genital warts and HPV-related cancers.

The high rate of STI diagnoses among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. HIV Prevention England also delivers, on behalf of PHE, prevention activity targeted at these groups. PHE is collaborating with academic institutions to improve understanding of the behaviours, attitudes, and other factors influencing their STI risk and support the delivery of timely interventions which maximise patient and public health benefit.

Health promotion and education remain vital for STI prevention, through improving risk awareness and encouraging safer sexual behaviour. Consistent and correct condom use substantially reduces the risk of being infected with an STI. Prevention efforts should include condom provision, ensuring open access to sexual health services with STI screening and robust contact tracing, and should focus on groups at highest risk such as young people, black and minority ethnic (BME) and MSM. Effective commissioning of high quality sexual health services, as highlighted in the Framework for Sexual Health Improvement in England, will promote delivery of these key messages.
1.2. PHE’s key messages

- statutory, high-quality relationship and sex education in secondary schools will equip young people with the skills to improve their sexual health and overall wellbeing

- strengthened local and national prevention activities need to focus on groups at highest risk, including young adults, BME and MSM

- consistent and correct use of condoms can significantly reduce risk of STIs

- rapid, open access to treatment and partner notification can reduce the risk of complications and infection spread

- regular testing for HIV and STIs is essential for good sexual health:
  - anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner
  - MSM should test annually for HIV and STIs and every 3 months if having condomless sex with new or casual partners
  - BME men and women should have a regular STI screen, including an HIV test, if having condomless sex with new or casual partners

- PHE East Midlands to respond to outcomes of the commissioning survey, to develop a repository of key information and lead locally on the national specification

- PHE East Midlands to continue to improve data quality and ensure timely reporting by working with and supporting local providers

- PHE East Midlands to continue to hold events and conferences to bring together stakeholders across different organisations both inside and outside of the sexual health network and promote joint working to tackle specific issues such as child sexual exploitation, Chemsex and teenage pregnancy
2. Charts, tables and maps

2.1. Overview

The rate of New STI diagnoses made within the East Midlands is the third lowest when compared to the rest of England. The STI rate for London is greater than the other regions as would be expected, as seen in Figure 1.

Diagnoses of Chlamydia remains to be the highest amongst all STIs. Since 2012, there has been a small overall decline in the number of chlamydia diagnoses in the East Midlands. Syphilis and gonorrhoea have also shown increases since 2012, 84% and 19% respectively. Between 2015 and 2016 all of the 5 main STIs except syphilis have shown decreases in diagnoses. Syphilis has shown a rise in diagnoses of 20% in the East Midlands.

This increase is not as steep as seen between 2014 and 2015 (47%). Between 2015 and 2016 there has been a decline in gonorrhoea diagnoses, both within the East Midlands and nationally. It is unclear exactly why this might be the case considering other STIs, eg syphilis and chlamydia, have not shown the same pattern. This is mostly seen amongst MSM and is thought to be attributable to increases in repeat testing and prompt treatment of cases.

Figure 1: New STI diagnoses by public health centre (PHEC) of residence: England 2016. Data sources: GUMCAD, CTAD
Figure 2: Diagnoses of the 5 main STIs: East Midlands residents, 2012-2016. Data sources: GUMCAD, CTAD

![Graph showing diagnoses of the 5 main STIs: Syphilis, Gonorrhoea, Genital Herpes, Genital Warts, and Chlamydia (CTAD) for East Midlands residents from 2012 to 2016.]

Figure 3: Diagnosis rates of the 5 main STIs: East Midlands residents, 2012-2016. Data sources: GUMCAD, CTAD

![Graph showing diagnosis rates per 100,000 population for the 5 main STIs: Syphilis, Gonorrhoea, Genital Herpes, Genital Warts, and Chlamydia (CTAD) for East Midlands residents from 2012 to 2016.]

Table 1: Percentage change in new STI diagnoses: East Midlands residents. Data sources: GUMCAD, CTAD

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>2015</th>
<th>2016</th>
<th>% change 2012-2016</th>
<th>% change 2015-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>New STIs</td>
<td>29,799</td>
<td>28,164</td>
<td>-12%</td>
<td>-5%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>230</td>
<td>276</td>
<td>84%</td>
<td>20%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>2,041</td>
<td>1,787</td>
<td>19%</td>
<td>-12%</td>
</tr>
<tr>
<td>Chlamydia (CTAD)</td>
<td>15,446</td>
<td>15,392</td>
<td>-8%</td>
<td>0%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>2,262</td>
<td>1,992</td>
<td>-14%</td>
<td>-12%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>5,024</td>
<td>4,633</td>
<td>-15%</td>
<td>-8%</td>
</tr>
</tbody>
</table>
2.2. Risk groups

**Recommendation 1:** Statutory, high-quality relationship and sex education in secondary schools will equip young people with the skills to improve their sexual health and overall wellbeing.

Young adults (ages 15 to 24) are still at highest risk compared to the other age groups. As 15 to 24 year olds are the focus of chlamydia screening, the rate of infections amongst younger people is likely to be higher as well as their rate of attendance to level 3 Sexual Health Services. Therefore, possibly complicating the picture. Looking closer at the data, young females have a significantly greater rate of infection than young males, particularly comparing males and females in the 15 to 19 age group. This may be an artefact of testing where, perhaps, young females might be more likely to present to testing sites and attend contraceptive services, or due to behavioural differences between young males and females.

**Recommendation 2:** Strengthened local and national prevention activities need to focus on groups at highest risk, including young adults, BME and MSM.

The pattern of infections in the over 25s has a different picture, when comparing males and females, as above 25, there are more new infections amongst males than females. The greater number of new infections amongst males could be due to the number of MSM cases contributing to the figures. The numbers of New STIs amongst MSMs has increased both over the longer and shorter terms (table 3). 49% between 2012 and 2016, and 4% between 2015 and 2016. Over the long term, between 2012 and 2016, the greatest increase has been in the number of syphilis infections, 160%, followed by a 76% increase in gonorrhoea.

Over the short term, gonorrhoea has shown a 22% decrease in diagnoses and genital herpes a 5% decrease. However, syphilis, chlamydia and genital wards have risen (55%, 23% and 13% respectively). Some of this increase can be attributable to the change in testing techniques but the percentage change is notably higher in this risk group compared to the overall change. This would imply recent changes in behaviour amongst MSM, who appear to be putting themselves at greater risk than previously.

Table 2 shows that the highest proportion of New STIs occur amongst the white ethnic group representing 85% of new infections, with the smallest proportions being amongst the black Caribbean and black African. However, Figure 5, which looks at the rate of infections within these ethnic groups, shows that black ethnic groups, particularly the black Caribbean ethnicity, actually are at greater risk than any other ethnic group.

**Recommendation 3:** Consistent and correct use of condoms can significantly reduce risk of STIs.
Recommendation 4: Rapid, open access to treatment and partner notification can reduce the risk of complications and infection spread.

Recommendation 5: Regular testing for HIV and STIs is essential for good sexual health:

- anyone under 25 who is sexually active should be screened for chlamydia annually, and on change of sexual partner
- MSM should test annually for HIV and STIs and every 3 months if having condomless sex with new or casual partners
- black ethnic minority men and women should have a regular STI screen, including an HIV test, if having condomless sex with new or casual partners

Figure 4: Rate of new STIs per 100,000 residents by age group in the East Midlands, 2016. Data sources: GUMCAD, CTAD
Figure 5: Rates by ethnicity per 100,000 population of East Midlands residents diagnosed with a new STI: 2016. Data sources: GUMCAD, CTAD

Table 2: Proportion of East Midlands residents diagnosed with a new STI by ethnicity: 2016 Data sources: GUMCAD, CTAD

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number</th>
<th>Percentage excluding unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>18,505</td>
<td>85%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>494</td>
<td>2%</td>
</tr>
<tr>
<td>Black African</td>
<td>672</td>
<td>3%</td>
</tr>
<tr>
<td>Other BME</td>
<td>2,153</td>
<td>10%</td>
</tr>
<tr>
<td>Unknown</td>
<td>6,340</td>
<td></td>
</tr>
</tbody>
</table>

Figure 6: Proportions of East Midlands residents diagnosed with a new STI by world region of birth: 2016. Data sources: GUMCAD, CTAD
Figure 7: Diagnoses of the 5 main STIs among MSM in specialist sexual health clinics: East Midlands residents, 2012-2016. Data source: GUMCAD data only

Table 3: Percentage change in new STI diagnoses in men who have sex with men (MSM) diagnosed in specialist sexual health clinics: East Midlands residents. Data sources: GUMCAD data only

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>2016</th>
<th>% change 2012-2016</th>
<th>% change 2015-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>New STIs</td>
<td>1,696</td>
<td>49%</td>
<td>4%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>208</td>
<td>160%</td>
<td>55%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>481</td>
<td>76%</td>
<td>-22%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>423</td>
<td>35%</td>
<td>23%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>56</td>
<td>30%</td>
<td>-5%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>184</td>
<td>60%</td>
<td>13%</td>
</tr>
</tbody>
</table>
2.3. Geography

The highest rate of infections occurred in Nottingham, both including and excluding Chlamydia figures for 15 to 24 year olds. Nottingham’s rate including chlamydia figures is both significantly higher than any of the other local authorities within the East Midlands as well as the England and East Midlands rates. Where the chlamydia figures are removed, in Figure 8b, the rates for upper tier local authorities are closer together, Derby and Northamptonshire are greater than Leicester, unlike in Figure 8a.

Again, Nottingham has the highest chlamydia detection rate and has increased since 2015, along with Lincolnshire, Leicestershire, Derby, Derbyshire and Rutland. The other upper tier authorities have shown decreases with Leicester showing the greatest decrease in detection rate. Changes in services and reporting of chlamydia data may have affected the figures across the East Midlands. However, PHE are working with local colleagues to ensure data quality improves and the Public Health indicators are more robust.

East Midlands figures for gonorrhoea are significantly higher in the main cities and Northamptonshire compared to the East Midlands rate.

Figure 8a: Rate of new STI diagnoses per 100,000 population among East Midlands residents by upper tier local authority of residence: 2016. Data sources: GUMCAD, CTAD
Figure 8b: Rate of new STI diagnoses (excluding chlamydia diagnoses in persons aged 15-24 years) per 100,000 population aged 15-64 years among East Midlands residents by upper tier local authority of residence: 2016. Data sources: GUMCAD, CTAD

Figure 9: Chlamydia detection rate per 100,000 population aged 15-24 years in East Midlands residents by upper tier local authority of residence: 2016. Data sources: GUMCAD, CTAD
Spotlight on STIs in the East Midlands

Figure 10: Rate of gonorrhoea diagnoses per 100,000 population in East Midlands residents by upper tier local authority of residence: 2016. Data source: GUMCAD

![Gonorrhoea diagnoses rate graph](image)

Figure 11: Map of new STI rates per 100,000 residents by upper tier local authority in the East Midlands: 2016. Data sources: GUMCAD, CTAD

![STI rates map](image)

New STIs
Rate per 100,000 pop.

<table>
<thead>
<tr>
<th>No diagnoses</th>
<th>&lt;500</th>
<th>&gt;=500 and &lt;750</th>
<th>&gt;=750 and &lt;1000</th>
<th>&gt;=1000 and &lt;2000</th>
<th>&gt;=2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Midlands rate (38.2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>England (64.9)</td>
<td>84</td>
<td>63</td>
<td>54</td>
<td>45</td>
<td>37</td>
</tr>
<tr>
<td>Nottingham</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derby</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leicester</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northamptonshire</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Rutland</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leicestershire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Northamptonshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Derbyshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lincolnshire</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 - Derby (714.6)
2 - Nottingham (1101.9)
3 - Leicester (750.1)
### Table 4: Number of diagnoses of new STIs by PHEC of residence, data source and data subset: 2016
Data sources: GUMCAD, CTAD

<table>
<thead>
<tr>
<th>PHEC of residence</th>
<th>GUMCAD</th>
<th>CTAD*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist SHCs</td>
<td>Non-specialist SHCs</td>
<td></td>
</tr>
<tr>
<td>East Midlands</td>
<td>19,559</td>
<td>685</td>
<td>7,920</td>
</tr>
<tr>
<td>East of England</td>
<td>25,814</td>
<td>350</td>
<td>7,009</td>
</tr>
<tr>
<td>London</td>
<td>97,545</td>
<td>2,150</td>
<td>17,857</td>
</tr>
<tr>
<td>North East</td>
<td>14,036</td>
<td>39</td>
<td>3,315</td>
</tr>
<tr>
<td>North West</td>
<td>36,794</td>
<td>717</td>
<td>16,828</td>
</tr>
<tr>
<td>South East</td>
<td>41,059</td>
<td>1,003</td>
<td>9,633</td>
</tr>
<tr>
<td>South West</td>
<td>24,257</td>
<td>132</td>
<td>8,985</td>
</tr>
<tr>
<td>West Midlands</td>
<td>31,124</td>
<td>866</td>
<td>9,755</td>
</tr>
</tbody>
</table>

### Table 5: Number of diagnoses of the 5 main STIs in the East Midlands by STI, data source and data subset: 2016
Data sources: GUMCAD, CTAD

<table>
<thead>
<tr>
<th>5 main STIs</th>
<th>GUMCAD</th>
<th>CTAD*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Specialist SHCs</td>
<td>Non-specialist SHCs</td>
<td></td>
</tr>
<tr>
<td>Syphilis</td>
<td>272</td>
<td>4</td>
<td>276</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1,714</td>
<td>73</td>
<td>1,787</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>7,472</td>
<td>7,920</td>
<td>15,392</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>1,890</td>
<td>102</td>
<td>1,992</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>4,295</td>
<td>338</td>
<td>4,633</td>
</tr>
</tbody>
</table>

*Including site type 12 chlamydia from GUMCAD.
3. Information on data sources

For more information on local sexual health data sources please access the PHE guide: www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data

Comments and caveats for figures and tables:

- GUMCAD started in 2009. Reporting of sexual orientation is less likely to be complete for earlier years, so rises seen may be partly artefactual

- any increase in gonorrhoea diagnoses may be due to the increased use of highly sensitive nucleic acid amplification tests (NAATs) and additional screening of extra-genital sites in MSM

- any decrease in genital wart diagnoses may be due to a moderately protective effect of HPV-16/18 vaccination

- any increase in genital herpes diagnoses may be due to the use of more sensitive NAATs

- any increase or decrease may reflect changes in testing practices

- due to changes in 2012 to the surveillance of chlamydia diagnosed outside level 3 Sexual Health Services, comparisons for chlamydia and for new STIs before and after 2012 are not robust and, therefore, have not been presented

3.1. GUMCAD surveillance system

This disaggregate reporting system collects information about attendances and diagnoses at specialist (level 3) and non-specialist (level 2) sexual health services. Information about the patient’s area of residence is collected along with demographic data and other variables. GUMCAD superseded the earlier KC60 system and can provide data from 2009 onwards. GUMCAD is the main source of data for this report. The data extract used was produced in April 2017.

Due to limits on how much personally identifiable information sexual health clinics are able to share, it is not possible to deduplicate between different clinics. There is a possibility that some patients may be counted more than once if they are diagnosed with the same infection (for infection specific analyses) or a new STI of any type (for new STI analyses) at different clinics during the same calendar year.
3.2. CTAD surveillance system

The CTAD surveillance system collects data on all NHS and LA/NHS-commissioned chlamydia testing carried out in England. CTAD is comprised of all chlamydia (NAATs) tests for all ages (with the exception of conjunctival samples), from all venues and for all reasons. CTAD enables unified, comprehensive reporting of all chlamydia data, to effectively monitor the impact of the NCSP through estimation of the coverage of population screening, proportion of all tests that are positive and detection rates. The data extract used was produced in February 2017.

3.3. New STIs

New STI diagnoses comprise diagnoses of the following: chancroid, LGV, donovanosis, chlamydia, gonorrhoea, genital herpes (first episode), HIV (acute and AIDS defining), *Molluscum contagiosum*, non-specific genital infection (NSGI), non-specific pelvic inflammatory disease (PID) and epididymitis, chlamydial PID and epididymitis (presented in chlamydia total), gonococcal PID and epididymitis (presented in gonorrhoea total), scabies, pediculosis pubis, syphilis (primary, secondary and early latent), trichomoniasis and genital warts (first episode), *Mycoplasma genitalium*, shigella.

3.4. Calculations

Confidence Intervals were calculated using Byar’s method:
http://www.erpho.org.uk/statistical_tools.aspx

ONS mid-year population estimates for 2015 were used as a denominator for rates for 2016. ONS ceased producing estimates of population by ethnicity in 2011. Estimates for that year were used as a denominator for rates for 2016.
4. Further information

Please access the online ‘Sexual and Reproductive Health Profiles’ for further information: http://fingertips.phe.org.uk/profile/sexualhealth

For more information on local sexual health data sources please access the PHE guide: www.gov.uk/government/publications/sexual-and-reproductive-health-in-england-local-and-national-data

Local authorities have access to LA sexual health epidemiology reports (LASERs) and the HIV and STI portal. They should contact srilaxmi.degala@phe.gov.uk if they do not have access to this information.

5. About Field Epidemiology Services

The Field Epidemiology Service (FES) supports Public Health England Centres and partner organisations through the application of epidemiological methods to inform public health action.

FES does this in 2 main ways. Firstly, by providing a flexible expert resource, available as and when needed, to undertake epidemiological investigations for key health protection work. Secondly, through the expert analysis, interpretation and dissemination of surveillance information to PHE Centres, local health partners, service providers and commissioners of services.

Within the FES network, excellence and innovation is encouraged. We foster academic collaborations and take active part and lead in research, development and training.

You can contact your local FES team at: fes.em@phe.gov.uk

If you have any comments or feedback regarding this report or the FES service, please contact: srilaxmi.degala@phe.gov.uk
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