Spotlight on sexually transmitted infections in the South East

2017 data
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Public Health England
133-155 Waterloo Road
Wellington House
London SE1 8UG
Tel: 020 7654 8000
www.gov.uk/phe
Twitter: @PHE_uk
Facebook: www.facebook.com/PublicHealthEngland

For queries relating to this document, please contact josh.forde@phe.gov.uk

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Spotlight on STIs in the South East

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1 Summary

Sexually transmitted infections (STIs) represent an important public health problem in particular areas and groups in the South East.

More than 52,000 new STIs were diagnosed in South East residents in 2017, representing a rate of 594 diagnoses per 100,000 population, which is the second lowest rate among Public Health England centres. Rates by upper tier/unitary local authority ranged from 405 new STI diagnoses per 100,000 population in West Berkshire to 1,549 new STI diagnoses per 100,000 population in Brighton and Hove.

The number of new STIs diagnosed in South East residents remained the same between 2016 and 2017. Rises were seen in the numbers of diagnoses of syphilis (by 22%), gonorrhoea (by 33%) and chlamydia (by 1%). Genital herpes decreased by <1% and genital warts by 3%. The number of syphilis diagnoses reported in 2017 was nearly three times the number reported in 2013.

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. In 2017 the chlamydia diagnosis rate among South East residents aged 15 to 24 years was well below this, at 1,494 per 100,000 residents, similar to the rate in 2016, but a 6% fall from the detection rate in 2013. The number of chlamydia tests among people aged 15 to 24 years in 2017 (177,717) fell 12% from 2016.

Men and women have similar rates of new STIs (611 and 559 per 100,000 residents respectively).

Where gender and sexual orientation are known, gay, bisexual and other men who have sex with men (MSM) account for 13% of South East residents diagnosed with a new STI in a specialist sexual health service (SHS) (77% of those diagnosed with syphilis and 51% of those diagnosed with gonorrhoea). Gonorrhoea diagnoses in MSM increased by 22% from 2016 to 2017.

South East residents aged between 15 and 24 years accounted for 52% of all new STI diagnoses in 2017.

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1 Sexual health services (SHSs) include both specialist (level 3) and non-specialist (level 1 & 2) SHSs. Specialist SHSs refer to genitourinary medicine (GUM) and integrated GUM/sexual and reproductive health (SRH) services. Non-specialist SHSs refer to SRH services, young people’s services, online sexual health services, termination of pregnancy services, pharmacies, outreach and general practice, and other community-based settings.
Spotlight on STIs in the South East

The white ethnic group has the highest number of new STI diagnoses: over 38,600 (87%). Although only 1% of new STIs are in black Caribbeans, they have the highest rate: 1,962 per 100,000, which is four times the rate seen in the white ethnic group (506.1 per 100,000). Where country of birth was known, 86% of South East residents diagnosed with a new STI in a specialist SHS in 2017 were UK-born.

The STI testing rate (excluding chlamydia aged <25 years) among South East residents (15,084 per 100,000) increased by 15% from 2013 to 2017, with a 3% increase from 2016 to 2017.

This summary does not report on all infections which can be acquired sexually eg it does not include data on HIV, hepatitis B, hepatitis A and Shigella. HIV data will be released in September 2018 and previous reports are available.²

Implications for prevention

The impact of STIs remains greatest in young heterosexuals aged 15 to 24 years, black ethnic minorities and MSM.³ Public Health England (PHE) is conducting and managing a number of initiatives to address this inequality.

Access to high quality information is essential for good sexual health and PHE has funded an on-line resource⁴ and a telephone helpline⁵ to provide advice on contraception, pregnancy and STIs.

The high rates of STIs among young people are likely to be due to greater rates of partner change.⁶ 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.⁷,⁸,⁹ PHE recently launched a health promotion campaign to promote condom use and positive sexual relationships among 16 to 24 year olds.¹⁰ The vast majority of areas in England have condom schemes which distribute condoms to young people (mostly

⁴ https://sexwise.fpa.org.uk/
⁵ https://sexwise.fpa.org.uk/where-to-get-help/helplines
⁶ Mercer CH et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). The Lancet 2013; 382(9907):1781-94.
¹⁰ https://www.nhs.uk/protect-against-stis-use-a-condom/home
under 20 years of age) through a variety of outlets with an estimated coverage of 6% in under 20 year olds.\textsuperscript{11}

There has been a long term decline in the chlamydia detection rate among 15 to 24 year olds and notable variations by geographic area, often reflecting rates of testing. Given the large drops in testing nationally and the high positivity of women within sexual and reproductive health services it is likely that some infected women are going undiagnosed.

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 SHSs 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 three 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 (CCP) to outline comprehensive case management for an episode of chlamydia testing, diagnosis and treatment.\textsuperscript{12} CCP support is delivered through facilitated workshops, the aim of which is to create action plans for how services might be improved or resources redistributed to most effectively identify infected individuals.

The increase in gonorrhoea diagnoses between 2016 and 2017 is concerning due to the ongoing circulation of high-level azithromycin resistant gonorrhoea.\textsuperscript{13} Additionally, the first detected case of extensively drug resistant \textit{Neisseria gonorrhoeae} with resistance to ceftriaxone and high-level resistance to azithromycin, the two antibiotics used as front-line dual therapy, was detected in the UK in March 2018.\textsuperscript{14} To detect any further importations or local circulation of similar multi-drug resistant strains, clinical laboratories should continue to refer \textit{N. gonorrhoeae} isolates with resistance to ceftriaxone or azithromycin to the PHE Reference Bacteriology at PHE Colindale for confirmation. General Practitioners are reminded to refer all suspected cases of gonorrhoea to specialist SHSs for appropriate management.\textsuperscript{15}

\textsuperscript{15} Royal College of General Practitioners (Sex; Drugs; HIV and Viral Hepatitis Group), British Association for Sexual Health and HIV. Sexually Transmitted Infections in Primary Care 2013 (RCGP/BASHH). Lazaro N: http://www.rcgp.org.uk/clinical-and-research/resources/a-to-zclinical-resources/sexually-transmitted-infections-in-primary-care.aspx
The long term trend for a rise of syphilis among MSM also remains a concern. There is evidence that condomless sex associated with HIV sero-adaptive behaviours (which include selecting partners perceived to be of the same HIV sero-status), is leading to increased STI transmission.\textsuperscript{16,17} PHE will publish an Action Plan, with recommendations for PHE and partner organisations, to address the continued increase in syphilis diagnoses in England.

Nationally, the rate of acute bacterial STIs in HIV-positive MSM is up to four times that of MSM who were HIV-negative or of unknown HIV status.\textsuperscript{18} 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 \textit{Shigella} spp. For those who are HIV negative, sero-adaptive behaviour increases the risk of HIV seroconversion as national figures indicate that 13\% of MSM who are infected with HIV are unaware of their infection.\textsuperscript{19}

As MSM continue to experience high rates of STIs they remain a priority for targeted STI prevention and health promotion work. HIV Prevention England\textsuperscript{20} 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 ran from June 2016 to the end of March 2018 in 42 specialist SHSS and HIV clinics across England.\textsuperscript{21} The experience of this pilot supported the decision to proceed to a phased national rollout of targeted HPV vaccination for MSM attending specialist SHSS and HIV clinics, in 2018. While a national impact on genital warts in this population is not expected to be seen for some time, 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. Data

\textsuperscript{17} Daskalopoulou M et al. Condomless sex in HIV-diagnosed men who have sex with men in the UK: prevalence, correlates, and implications for HIV transmission. Sexually Transmitted Infections 2017. DOI: 10.1136/sextrans-2016-053029.
\textsuperscript{20} http://www.hivpreventionengland.org.uk/
from a national probability sample indicate that men of black Caribbean or any other black backgrounds are most likely to report higher numbers of recent sexual partners and concurrent partnerships; this, coupled with assortative sexual mixing patterns, may be maintaining high levels of bacterial STIs in these communities. HIV Prevention England also delivers, on behalf of PHE, prevention activity targeted at black ethnic communities.

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 ethnic minorities 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.

PHE’s key messages

1. Strengthened local and national services for the prevention, diagnosis, treatment, and care of STIs need to be delivered to the general population as well as focus on groups with greater sexual health needs, including young adults, black ethnic minorities and MSM.

2. Local authorities need to enable young women to be tested for chlamydia when they access contraceptive services.

3. An informed and positive attitude to sexual health will be enhanced by statutory, high-quality relationship and sex education (RSE) in secondary schools; RSE will also equip young people with the skills to maintain their sexual health and overall wellbeing.

4. Immunisation for human papillomavirus in young girls and MSM as well as immunisation against hepatitis A and hepatitis B in MSM will reduce the risk of infection with these viruses.

5. Consistent and correct use of condoms can significantly reduce risk of STIs. The availability of condoms should be promoted through media campaigns as well as through local services including condom distribution schemes.

6. 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 three months if having condomless sex with new or casual partners
   - black ethnic minority men and women should have an STI screen, including an HIV test, annually if having condomless sex with new or casual partners

7. Open-access to services that provide rapid treatment and partner notification can reduce the risk of STI complications and infection spread.
2 Charts, tables and maps

Figure 1: New STI diagnoses by Public Health England centre (PHEC) of residence: England 2017. Data sources: GUMCAD, CTAD

![Chart showing STI diagnoses by Public Health England centre of residence in England 2017.](chart)

Figure 2: Number of diagnoses of the five main STIs: South East residents, 2013-2017. Data sources: GUMCAD, CTAD

![Chart showing number of diagnoses of five main STIs for South East residents from 2013 to 2017.](chart)

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.

Increases or decreases may also reflect changes in testing practices.
Figure 3: Diagnosis rates of the five main STIs: South East residents, 2013-2017. Data sources: GUMCAD, CTAD

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. Increases or decreases may also reflect changes in testing practices.

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

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>2017</th>
<th>% change 2013-2017</th>
<th>% change 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>New STIs</td>
<td>52,082</td>
<td>-5%</td>
<td>1%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>842</td>
<td>190%</td>
<td>22%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>4,001</td>
<td>58%</td>
<td>33%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>24,175</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>4,517</td>
<td>-3%</td>
<td>0%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>8,821</td>
<td>-21%</td>
<td>-3%</td>
</tr>
</tbody>
</table>

Please see notes for Figure 3.
Spotlight on STIs in the South East

Figure 4: Rate of new STIs per 100,000 residents by age group in the South East, 2017. Data sources: GUMCAD, CTAD

![Chart showing rate of new STIs per 100,000 residents by age group in the South East, 2017.](image)

Figure 5: Rates by ethnicity per 100,000 population of South East residents diagnosed with a new STI: 2017. Data sources: GUMCAD, CTAD

![Chart showing rates by ethnicity per 100,000 population of South East residents diagnosed with a new STI: 2017.](image)

Table 2: Proportion of South East residents diagnosed with a new STI by ethnicity: 2017

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number</th>
<th>Percentage excluding unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>38,611</td>
<td>87%</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>1,962.1</td>
<td>1%</td>
</tr>
<tr>
<td>Black African</td>
<td>1,622.1</td>
<td>3%</td>
</tr>
<tr>
<td>Other BME</td>
<td>599.6</td>
<td>9%</td>
</tr>
<tr>
<td>Unknown</td>
<td>7,739</td>
<td></td>
</tr>
</tbody>
</table>
Figure 6: Proportions of South East residents diagnosed with a new STI in specialist SHSs by world region of birth: 2017. Data sources: GUMCAD data only

Figure 7: Diagnoses of the five main STIs among MSM in specialist SHSs: South East residents, 2013-2017. Data source: GUMCAD data only

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.

The proportion of diagnoses reported in males of unknown sexual orientation has varied over time. For the South East, it was 1.2% of new STIs in 2013, 0.7% in 2016 and 4.0% in 2017.
Table 3: Percentage change in new STI diagnoses in MSM* diagnosed in specialist SHS: South East residents. Data sources: GUMCAD data only

<table>
<thead>
<tr>
<th>Diagnoses</th>
<th>2017</th>
<th>% change 2013-2017</th>
<th>% change 2016-2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>New STIs</td>
<td>5,572</td>
<td>38%</td>
<td>12%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>534</td>
<td>147%</td>
<td>-1%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1,885</td>
<td>56%</td>
<td>22%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>1,464</td>
<td>67%</td>
<td>24%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>193</td>
<td>18%</td>
<td>8%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>438</td>
<td>2%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Please see notes for Figure 7.

* The proportion of diagnoses reported in males of unknown sexual orientation has varied over time. For the South East, it was 1.2% of new STIs in 2013, 0.7% in 2016 and 4.0% in 2017.

Figure 8a: Rate of new STI diagnoses per 100,000 population among South East residents by upper tier local authority of residence: 2017. 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 South East residents by upper tier local authority of residence: 2017. Data sources: GUMCAD, CTAD

Figure 9: Chlamydia detection rate per 100,000 population aged 15-24 years in South East residents by upper tier local authority of residence: 2017. Data sources: GUMCAD, CTAD
Figure 10: Rate of gonorrhoea diagnoses per 100,000 population in South East residents by upper tier local authority of residence: 2017. Data source: GUMCAD

Figure 11: Map of new STI rates per 100,000 residents by upper tier local authority in the South East: 2017. Data sources: GUMCAD, CTAD
Figure 12: STI testing rate (excluding chlamydia in under 25 year olds) per 100,000 population in South East residents aged 15 to 64: 2017 Data sources: GUMCAD, CTAD

Figure 13: STI testing positivity rate (excluding chlamydia in under 25 year olds) in South East residents: 2017 Data sources: GUMCAD, CTAD
**Table 4:** Number of diagnoses of new STIs by PHEC of residence, data source and data subset: 2017 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 SHSs</td>
<td>Non-specialist SHSs</td>
<td>Enhanced GPs*</td>
</tr>
<tr>
<td>East Midlands</td>
<td>21,276</td>
<td>859</td>
<td></td>
</tr>
<tr>
<td>East of England</td>
<td>27,179</td>
<td>320</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>98,585</td>
<td>3,232</td>
<td></td>
</tr>
<tr>
<td>North East</td>
<td>14,026</td>
<td>19</td>
<td>1</td>
</tr>
<tr>
<td>North West</td>
<td>37,166</td>
<td>978</td>
<td>33</td>
</tr>
<tr>
<td>South East</td>
<td>43,135</td>
<td>833</td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>24,568</td>
<td>262</td>
<td></td>
</tr>
<tr>
<td>West Midlands</td>
<td>29,655</td>
<td>92</td>
<td></td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>27,405</td>
<td>232</td>
<td></td>
</tr>
</tbody>
</table>

**Table 5:** Number of diagnoses of the five main STIs in the South East by STI, data source and data subset: 2017 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 SHSs</td>
<td>Non-specialist SHSs</td>
<td>Enhanced GPs*</td>
</tr>
<tr>
<td>Syphilis</td>
<td>825</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>3,848</td>
<td>153</td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>16,061</td>
<td></td>
<td>8,114</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>4,379</td>
<td>138</td>
<td></td>
</tr>
<tr>
<td>Genital Warts</td>
<td>8,586</td>
<td>235</td>
<td></td>
</tr>
</tbody>
</table>

** This does not represent the total number of new STI diagnoses from enhanced GPs reporting to GUMCAD. The small number of diagnoses included here reflects poor data quality on the residence of cases

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


3.1 GUMCAD

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 2018.

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

CTAD 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 April 2018.

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 & 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
https://fingertips.phe.org.uk/profile/guidance
Tool for calculating common public health statistics and their confidence interval

ONS mid-year population estimates for 2016 were used as a denominator for rates for 2017. 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

As of this year, all analyses for this report include data from non-specialist (Level 2) SHSs and enhanced GP services as well as specialist (Level 3) SHSs.

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


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

5 About the Field Service

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

FS does this in two main ways, firstly by providing a flexible expert resource, available, as and when needed, to undertake epidemiological investigations for key health protection work and 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 FS epidemiology 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 FS team at fes.seal@phe.gov.uk

If you have any comments or feedback regarding this report or the FS, please contact josh.forde@phe.gov.uk

6 Acknowledgements

We would like to thank the following:

- local SHSs for supplying the SHS data
- local laboratories for supplying the CTAD data
- PHE Centre for Infectious Disease Surveillance and Control (CIDSC) HIV and STI surveillance teams for collection, analysis and distribution of data