

Our Ref: NG/RM/26002
Date: 21st January 2026

Nicola Griffiths
Deputy Director of Governance
North Staffordshire Combined Healthcare NHS Trust
Lawton House
Bellringer Road
Trentham
ST4 8HH

Reception: 0300 123 1535

Dear

Freedom of Information Act Request

I am writing in response to your e-mail of the 2nd January 2026. Your request has been processed using the Trust's procedures for the disclosure of information under the Freedom of Information Act (2000).

Requested information:

Under the Freedom of Information Act 2000, I would like to request the following information relating to chemsex or sexualised drug use within your Trust. This is part of a research project being conducted at King's College London. I have pasted the questions below and also attached them for convenience. Please let me know if you have any questions about the information being requested or need any clarification.

Please see Appendices 1 and 2 attached.

If you are dissatisfied with the handling of your request, you have the right to ask for an internal review of the management of your request. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to: Dr Buki Adeyemo, Chief Executive, North Staffordshire Combined Healthcare Trust, Trust Headquarters, Lawton House, Bellringer Road, Trentham, ST4 8HH. If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF.

Yours sincerely



Nicola Griffiths
Deputy Director of Governance

FOI questions:

1. Service Provision

- a. Does your Trust currently provide any clinical or non-clinical services that explicitly address any of the following (e.g., within sexual health, mental health, addiction, or emergency care settings) (please put an X for Yes or No for each):

Reference	Yes	No	b. If Yes, please describe the nature of each of these services (e.g. dedicated chemsex clinic, integrated support within substance use or sexual health services or other). If you have more than one service for one item, please specify the nature of each service.	c. If Yes, please provide any documents, guidelines or websites/ URLs for each of these services
Chemsex		X		
Sexualised drug use		X		
Gamma-hydroxybutyrate (GHB) / gamma-butyrolactone (GBL) use	X		Pharmacological and psychosocial interventions within an inpatient setting.	<u>Edward Myers Unit (Substance Misuse Inpatient Service) - North Staffordshire Combined Healthcare NHS Trust</u> Please see Appendix 2 attached
Crystal methamphetamine use	X			
Mephedrone use	X			
LGBTQ+ health issues	X		Support with LGBTQ+ mental health issues and support is an inherent part of our service offer within Community Mental Health Teams, Talking Therapies, CAMHS and other services.	This is not a specific dedicated service.

2. Referrals and Care Pathways

- a. Does your Trust have an established referral pathway or protocol for patients identified as engaging in any of the following (please put an X for Yes or No for each):

Reference	Yes	No	b. If Yes, please say which departments are involved in these pathways (e.g. sexual health, mental health,	c. If Yes, please provide any documents, guidelines or protocols that refer to, or
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			A&E, drug and alcohol teams etc). If you have more than one pathway for one item, please specify the departments for each.	describe, such pathways.
Chemsex		X		
Sexualised drug use		X		
Gamma-hydroxybutyrate (GHB) / gamma-butyrolactone (GBL) use	X		Local Community, drug and alcohol teams	<u>Edward Myers Unit (Substance Misuse Inpatient Service) - North Staffordshire Combined Healthcare NHS Trust</u> Please see Appendix 2 attached.
Crystal methamphetamine use	X			
Mephedrone use	X			

- d. Are there any formal partnerships with external or community-based organisations that provides care or services specifically for LGBTQ+ or individuals that participate in chemsex, sexualised drug use or use of GHB/GBL, meth or mephedrone (e.g. Controlling Chemsex, Terrence Higgins Trust, London Friend)? **No**
- e. If yes to question 2d, please 1) state all external or community-based organisations that your trust has a formal partnership with and please 2) provide any documents, guidelines or protocols that refer to, or describe, these partnerships. **N/A**

3. Workforce and Training

- a. Have any staff received training specifically relating to chemsex, sexualised drug use or LGBTQ+ needs in the last 3 years? **Yes**
- b. If yes to question 3a, please state:
- The type of staff trained (e.g. clinicians, counsellors, health advisers). **Open offer to all staff groups**
 - For what services the training was provided for. **Open offer to all staff groups**
 - The name(s) of the training provider(s) and any relevant documents or website/URL. **In House, Staffordshire and Stoke on Trent ICS, Unison**
 - The approximate number of staff trained. **Information Not Held**

4. Monitoring and Evaluation

- a. Does your Trust collect data on the number of service users presenting with issues related to chemsex or sexualised drug use? **No**
- b. If yes to question 4a, please provide available data (by year, from 2020 to present) on:
- Number of individuals assessed or treated
 - Type of service accessed (e.g., sexual health, A&E, mental health)
 - Any outcome measures collected (if available)

REFERRAL FORM - EDWARD MYERS

Norths Staffordshire Combined Healthcare
Harplands Hospital
Hilton Road
Stoke – on –Trent
ST4 6TH

Tel: 01782 441715

Email: referrals.edwardmyers@combined.nhs.uk

DATE REFERRAL RECEIVED
(EMC USE ONLY)

DATE PLACED ON WAITING LIST
(EMC USE ONLY)

REFERRING SERVICES INFORMATION

Name and Job Title of Referrer	Service:
	Address and Postcode
Telephone number:	Email:
Date referral form completed:	SPOC Contact No:
Reason for referral:	

PATIENT DEMOGRAPHICS

NHS NO:			
FORENAME:		SURNAME:	
DOB:		TITLE	Miss Mrs Mr Ms (delete / circle as appropriate)
Address:			
Postcode:			
Contact Number:		Email Address:	
Gender	MALE FEMALE (delete / circle as appropriate)	Registered Disabled	Yes No (delete / circle as appropriate) If yes please provide details:
Preferred Language		Religion	
Ethnicity		Country of Birth	
Relationship status	Single Divorced Married Widowed Co-Habiting (delete / circle as appropriate)		
Sexuality	Heterosexual Bi-Sexual Homosexual Other Prefer not to say (delete / circle as appropriate)		
Dietary Requirements		Spiritual Needs	

NEXT OF KIN DETAILS

NOK Name:	Relationship:
Contact Number:	Address:
2 ND Contact Number (if available)	
Do you consent for EMC to share information with your NOK and contact them in an emergency? YES NO (delete / circle as appropriate)	

SOCIAL CIRCUMSTANCES

Housing Situation (rented/private/hostel/NFA etc)			
Who does the patient live with?			
Is this Accommodation Stable?	Yes No (delete / circle as appropriate)		
Where will the patient go once detox is completed? (discharge planning)			
Employment Status			
Parental responsibility of dependents under the age of 18?	Yes No (delete / circle as appropriate)		
If yes please fill in the following: Add additional lines as necessary:			
Name	Gender	DOB	Live at home? Y/N
Who will be looking after the children during your stay at EMC?			
Any Social Services Involvement?		Yes No N/A (delete / circle as appropriate)	
If yes contact, please provide the name and contact number of the professional			
Any Pets? If yes what arrangements are in place for their care?			

Other Professionals Involved: (probation, social workers, CPNs etc)

Name	Organisation / Relationship to Service User	Contact No.

Why is the Service User not Suitable for a Community Detox?

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BBVs

Has the service user been tested for Blood Borne Viruses?	Yes No N/A (delete / circle as appropriate)
If yes what was the date/result?	Date: Result:
Has the service had Hep B vaccinations?	Yes No N/A (delete / circle as appropriate) Date:

Current Alcohol Use

Current Alcohol Use	Yes No (delete / circle as appropriate)
Continuous/ Binge drinking?	
Type of Alcohol Consumed? (include % abv and volume)	
SADQ Score	Date:
Alcohol Audit Score	Date:
Previous alcohol detox?	Yes No (delete / circle as appropriate) Dates & Places:

History of alcohol withdrawal symptoms and any previous problems?		
Longest Period of Abstinence?		

Substance Misuse

Does the service user currently inject?		Yes No (delete / circle as appropriate)					
Where?	Arms Legs Hands Feet Groin Neck Other	(delete / circle as appropriate)					
Has the service user injected in the past?		Yes No (delete / circle as appropriate)					
Does the service user currently share injecting equipment?		Yes No (delete / circle as appropriate)					
Has the service user ever shared injecting equipment?		Yes No (delete / circle as appropriate)					
Any injecting relating complications?							

Drug Using History & Previous Treatment (including cost, periods of abstinence, triggers to relapse etc)

Physical Health

General Practitioner		Community Pharmacy	
Name:		Name:	
Address:		Address:	
Postcode:		Postcode:	
Contact No:		Contact No:	
Email Address:		Email Address:	

Past Medical History

Has the service user got any health issues?

Current Prescribed Medication (Add more rows if necessary)

Medication	Dose	Frequency	Route	Prescribed by:
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				

10.				
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Weight	Height	BMI

Is the service user pregnant	Yes No N/A
	(delete / circle as appropriate)
If yes how many weeks?	
Ante Natal Care?	

Psychiatric History

Any current / mental health needs / problems? Including self-harm / suicidal ideation?	
Mental Health Involvement?	Yes No N/A
	(delete / circle as appropriate)

Life / Significant Events?

Forensic History – Including spent / current / pending / prison sentenced /tags etc

Preparations for Detox

Commitment to pre detox engagement?

Evidence of stability on prescribed medication/ reduced stopped illicit use / reduction in alcohol consumption etc.

Discharge Plan

Is the service user returning to their home address?	Yes No (delete / circle as appropriate)		
If no, where is their discharge destination and for how long? (if rehab please provide address / contact no.)			
Is aftercare in place?	Dayhab	Rehab	Other (please specify)

Risk ASSESSMENT

Please give details of any identified risks (self, others, neglect, vulnerability)

Any additional information:

Name of the person completing the form:		
Date:		Signed:

Name of Service User:		
Date:		Signed:

PLEASE NOTIFY THE EMC TEAM OF ANY CHANGES FOLLOWING ANY CHANGE IN CIRCUMSTANCES

THIS REFERRAL MAY BE DELAYED IF THERE IS MISSING OR INCOMPLETE INFORMATION

EMC CHECK LIST:

Please tick:

Full bloods within the last 4 weeks U&Es, LFTs, FBC, INR, GGT, Mg, PO4	
ECG (for drug detoxification / known Cardiac history)	
Any recent hospital letters/ discharge letters/ clinic letters	
External Risk Assessments	
Summary Care Record	
Any Safeguarding concerns?	
Recent Urine Drug Screen	