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Advanced Services Update Event: Focus on Emergency Contraception (EC) & the Pharmacy Contraception Service (PCS)

Tuesday 11th November 2025

Nicola Goodberry Kenneally – CEO, CPWY
Lisa Meeks – Services Implementation Lead, CPWY
Amanda Smith – Advanced Services Facilitator, CPWY
Dr Helen Padfield – Associate Specialist in Sexual Health,
Local Sexual Health
Dr Phil Xiu – Local GP and Lead DPP at DPP Support

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Housekeeping!

- There is no planned fire alarm for this evening but in the unlikely event of a fire alarm, please exit calmly via the nearest marked exit.
- Toilets can be found outside of the meeting room in the foyer.
- Photos and recordings may be taken at the event, if you do not want to be in any photos, please let one of the CPWY team know on departure.

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Tonight's Agenda

1. Prescribing support, education & CPD for community pharmacists – Dr Phil Xiu
2. Overview of recent key changes affecting Advanced Services – CPWY
3. Emergency Contraception & the Pharmacy Contraception Service – CPWY
4. Oral Emergency Contraception – Dr Helen Padfield



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DPP SUPPORT

FIND YOUR IDEAL HEALTHCARE ALLIANCE

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Find Your Ideal Healthcare Alliance

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Education and CPD for Community Pharmacists



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Advanced Services Overview

A Rundown of Key Changes

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Changes to Pharmacy First

- Updated clinical pathways, protocol and PGDs came into effect from 1st October 2025. Check you are using and have signed up to the most up-to-date documentation.
- Addition of an intermediary monthly payment band from 1st June 2025:
 - £500 for 20-29 clinical pathway consultations
 - £1000 for 30+ clinical pathway consultations
- Consultations need to be claimed within one month from the end of the month in which they were provided e.g. consultations provided in June need to be claimed on MYS by the last day of July.
- Consultation fee ↑ to £17 from 1st April 2025 (minor illness and clinical pathway consultations). Urgent supply consultations remain at £15.
- Bundling requirements to qualify for the monthly payment:**
 - From June 2025 - need to be registered to provide the PCS and HCFST
 - From October 2025 – plan to introduce a requirement to deliver at least one ABPM provision per month **has been delayed**
 - From March 2026, a specified number (yet to be agreed) of contraception consultations, including emergency contraception consultations, will need to be provided each month.
- Caps on the provision of Pharmacy First clinical pathways consultations**
 - New caps introduced from April 2025 with a monthly allocation which is updated each month. Any activity above the monthly cap will not receive the £17 per consultation fee. The Pharmacy First Clinical Pathways band assignments and monthly caps for each pharmacy are published on the [NHSSSA website](#) every month.



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Changes to NMS

- Now includes depression as an eligible therapeutic area (updated service specification and NMS Eligible Drug List – October 2025).
- No mandatory training related to the addition of depression to NMS, but a related training programme on consulting with people with mental health problems is included in the Pharmacy Quality Scheme for 2025/26.
- Wording in the specification regarding the timing of Intervention and Follow up consultations amended so the Intervention consultation is provided between 7-14 days after recruitment and the Follow up consultation is between 14-21 days after the Intervention (previously said consultations would “typically” take place between those time periods).
- Specification amended to include clarification on subcontracting of the service not being allowed.
- NMS payment structure and fees simplified in April to £14 for each consultation (e.g. £28 if the pharmacy has undertaken both the intervention and follow up consultations).



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Changes for Distance Selling Pharmacies!

- DSP pharmacies can no longer provide Directed Services, (Advanced, National Enhanced and Enhanced Services), face-to-face with the patient at the pharmacy premises.
- DSP pharmacies can now only provide Directed Services remotely from the DSP pharmacy premises, similar to the delivery of Essential Services or if the service specification permits, face-to-face with the patient off-site.

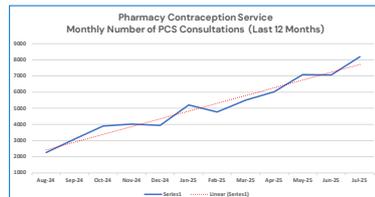


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Emergency Contraception (EC) & the Pharmacy Contraception Service (PCS)

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Let's start with "well done"



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Introduction

- Expansion of PCS to include oral EC aligns with ambitions in the:
 - Delivery plan for recovering access to primary care (May 2023)
 - Women's Health Strategy for England (August 2022)
- It represents another show of faith from Ministers and the NHS that pharmacies can improve access to services and reduce healthcare inequalities.
- PCS is part of the Gateway Criteria for the Pharmacy Quality Scheme 2025/26.
- PCS is part of the bundling requirements for the Pharmacy First Clinical Pathways fixed payment.

We would love all West Yorkshire pharmacy teams to choose to provide the service.



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Key Changes to the Service

Includes oral EC and updates to Combined Oral Contraceptive (COC) & Progestogen Only Pill (POP) PGDs	Provision by suitably trained and competent pharmacy technicians	Updated requirements for Standard operating procedures (SOP)	Clarification - Verbal consultations with the individual
Distance selling premises pharmacies (DSPs) only by remote provision from the pharmacy premises	Clarify need for expedient care & safeguarding the NHS purse	Clarification on use and need for timely provision	Addition of Drospirenone to POP patient group direction (PGD)
Requirement to review individual's GP record	Greater emphasis on information recording, particularly associated with safeguarding	Additional support & advice regarding pregnancy avoidance & sexually transmitted infections (STIs)	Change in minimum quantity of OC for ongoing supplies



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Key Changes

- Includes oral EC (2 new PGDs for Ulipristal acetate (UPA) & Levonorgestrel (LNG))
- Updates to COC and POP PGDs:
 - Additional exclusion criteria
 - Advice on use in combination with GLP-1 agonists
 - Clarification on minimum quantities to be supplied for ongoing supplies
 - Additional statement on depressed mood and depression
 - Additional advice on desogestrel and risk of meningioma
- Provision by suitably trained and competent pharmacy technicians
- Requirement to review individual's GP record (with consent).

Tip: refer to change histories within the PGD documents.



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Key Changes

- Clarification on use and need for timely provision:
 - Timely provision of oral EC or OC – referral to another provider where cannot meet the individual's needs
 - Clarification – PCS for contraceptive purposes only
 - No advance supplies of oral EC
- Addition of Drospirenone to POP PGD (licensed from menarche up to and including 49 years – all other POPs can continue to be provided up to and including 54 years)
- Change in minimum quantity of OC for ongoing supplies:
 - Minimum of 6 month's supply (if less is supplied- document clinical reasons)
 - Supplies can be made of up to 12 months duration in line with CoSRH guidance



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Key Changes

- Updated requirements for SOPs
 - To include process for escalation of clinical and non-clinical issues.
 - Review SOPs related to dispensing/supplying POM medicines where a pharmacy technician is to provide the service
- Greater emphasis on information recording particularly associated with safeguarding
 - Potential safeguarding issues and any actions
 - Details of any chaperones
- Additional support & advice regarding pregnancy avoidance & STIs
 - Need to be aware of local options - signpost or refer where facilities are in place
- Expedient care and safeguarding the NHS purse
 - PCS must not be offered as an alternative to dispensing an NHS prescription



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Competency & Training

- No additional mandatory training (EC training already a recommendation).
- EC learning & e-Assessment are also part of Domain 1 of the **Pharmacy Quality Scheme**.
- Specific skills and knowledge outlined in the service specification and the relevant PGDs.
- Pharmacy owners must keep documentary evidence that all pharmacy staff involved in any aspect of provision of the service are competent.
- Pharmacists and pharmacy technicians providing the service are responsible for remaining up to date with the skills and competencies identified.
- Clinical skills and knowledge covered listed training modules on [CPPE](#) and/or the [NHS England e-learning for healthcare \(elfh\)](#).



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Competency & Training

Mandatory Training

- Completed one of the recommended Safeguarding level 3 training materials

OR

Recommended Training

- Core / general
- Emergency contraception
- Initiation of contraception
- Other training to support clinical practice
- Pharmacy team training
 - Blood pressure & BMI measurement
 - Team briefing & SOPs




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Key Service Documents

- Service specification (including pathways)
- 4 PGDs (COC, POP, UPA & LNG), updated October 2025. Make sure you have read and are authorised to work under these new and updated PGDs!

Recommended reads:

- CPE Briefing O16/25: Pharmacy Contraception Advanced Service – What's changing
- CPE Briefing O17/25: Guidance on the NHS Pharmacy Contraception Advanced Service

Recommended watch:

- CPE on-demand webinar at <https://cpe.org.uk/our-work/updates-events/our-webinars/emergency-contraception-and-the-pccs-on-demand-webinar/>



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Resources and Guidance for the Pharmacy Team



Service provision

- Pre-consultation questionnaire for emergency contraception
- Pre-consultation questionnaire for oral contraception
- Conversation aid – initiating oral contraception (CPWY)



Service implementation

- Checklists
 - Pharmacy owner – implementing the PCS
 - Updated pharmacist & pharmacy technician implementing the PCS
 - Updated promoting the service to your GP practice / Sexual Health Clinics
 - Promoting the service to patients
- Updated PCS infographic aimed at GP practice teams / Sexual Health Clinic staff



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Resources (promotional)

- Updated patient leaflet template
- EC posters and OC posters
- Small flyers for prescription bags
- Updated posters & social media templates
- Editable posters, social media cards and suggested social media posts

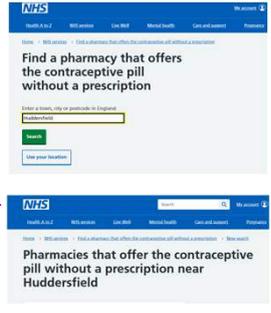
Available on the CPE website page for PCS (see under resources)




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Service Availability

- Endeavor to provide oral EC across all opening hours.
- For OC consultations, pharmacy owners can identify the hours and/or days of provision
- Don't forget to Update NHS Profile Manager so patients can find a pharmacy offering the service




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Emergency Contraception (EC)



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EC PGDs – Inclusion

Levonorgestrel (LNG)

- Presentation between 0 and 96 hours of UPSI or compromised OC
- Vomiting within 3 hours of taking oral EC

Ulipristal acetate (UPA)

- Presentation between 0 and 120 hours of UPSI or compromised OC
- Vomiting within 3 hours of taking oral EC



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EC PGD – Exclusions

Levonorgestrel (LNG)

- Presentation more than 96 hours since UPSI or compromised contraception
- Use of UPA-EC in the previous 5 days

Ulipristal acetate (UPA)

- Presentation > 120 hours since UPSI or compromised contraception
- Use of LNG-EC or **any** other progestogen in the previous 7 days
- Concurrent use of antacids, proton-pump inhibitors or H2-receptor antagonists including any OTC products being taken
- Severe asthma controlled by oral glucocorticoids
- Individuals using enzyme-inducing drugs/herbal products or within 4 weeks of stopping



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EC PGDs – Dosage

Levonorgestrel (LNG)

- Levonorgestrel 1.5mg (1 tablet) to be taken as soon as possible up to 96 hours after UPSI
- For individuals with a BMI of more than 26kg/m² or who weigh more than 70kg:
 - 3mg (two 1.5mg tablets) as a single dose as possible up to 96 hours after UPSI**
- For individuals taking enzyme inducing medicines or herbal products (whilst using enzyme-inducing drugs, or within 4 weeks of stopping them):
 - 3mg (two 1.5mg tablets) as a single dose as possible up to 96 hours after UPSI**

** Note: off-label use. The effectiveness of these regimens is unknown.

Ulipristal acetate (UPA)

One tablet (30mg) as a single dose taken as soon as possible up to 120 hours after UPSI



Repeat doses:

- If within 7 days of previous LNG-EC offer LNG-EC again (not UPA-EC)
- If within 5 days of UPA-EC then offer UPA-EC again (not LNG-EC)

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EC – FAQs

- Supply of pregnancy tests are not part of the service.
- If less than 13 years of age speak to the local safeguarding lead and follow local safeguarding policy.
- If not yet reached menarche, consider onward referral for further assessment or investigation.
- All individuals should be informed that insertion of a copper intrauterine device (Cu-IUD) within five days of UPSI or within five days from earliest estimated ovulation is the most effective method of EC.
- Both LNG and UPA are ineffective if taken after ovulation.
- UPA is more effective at delaying ovulation.
- If a Cu-IUD is appropriate and acceptable, supply oral EC and refer to the appropriate health service provider.
- Repeat dose can be given for vomiting within 3 hours of oral EC – **separate presentation**.



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EC PGDs – Advice to Provide

- Discuss all methods of EC.
- Ensure patient information leaflet is provided.
- Action to take if vomiting within 3 hours.
- Explain that menstrual disturbances can occur after the use of oral EC.
- Explain oral EC methods do not provide ongoing contraception, include how to access (PCS).
- Within one menstrual cycle – the dose may be repeated more than once should the need occur.
- If breastfeeding, LNG is secreted into breast milk. Potential exposure can be reduced if the tablet is taken immediately after feeding and avoids nursing for at least eight hours after. UPA: no need to avoid breastfeeding after a single dose.



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EC PGDs – Advice to Provide

- Individuals using or about to start hormonal contraception:
 - If supplied LNG – should restart their regular hormonal contraception immediately.
 - If supplied UPA – delay restarting regular hormonal contraception for 5 days following UPA use.
 - In both cases, avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised until fully effective.
- Pregnancy risk if there is further UPSI and ovulation occurs later in the same cycle.
- Pregnancy test 3 weeks after treatment especially if the expected period is delayed by >7 days or abnormal, or if using hormonal contraception.
- Promote the use of condoms – STIs prevention and advise on possible need for screening for STIs (where appropriate).
- No evidence of harm if someone becomes pregnant in a cycle when they had used oral EC.



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Emergency
contraception

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- ▶ Who needs EC?
- ▶ What is available?
- ▶ How to assess for EC
- ▶ Other considerations (interactions etc)
- ▶ Incorrect use of contraception
- ▶ Cases

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Who needs EC?

- Women who are not using contraception who have had UPSI and do not wish to be pregnant!
- Women who are using a contraceptive method but are at risk of pregnancy because of incorrect use
- Women who have had UPSI 21 or more days after giving birth
- Women who have had UPSI 5 or more days after fertilisation, miscarriage or ectopic pregnancy

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3 methods

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Ullipristal acetate (UPA, ELLAONE)

- ▶ Progesterone receptor modulator
- ▶ Licenced up to 120 hours after UPSI
- ▶ Works by delaying ovulation by about 5 days until sperm are no longer viable in the uterus
- ▶ Ineffective if given after ovulation
- ▶ Effectiveness reduced by enzyme inducers, progesterone and possibly PPIs
- ▶ Do not use in severe asthma requiring oral steroids

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Levonorgestrel

- ▶ Progestogen
- ▶ Licenced up to 72 hours after UPSI (Can be used off licence up to 96 hours)
- ▶ Works by delaying ovulation
- ▶ Ineffective if given after ovulation
- ▶ Effectiveness reduced by enzyme inducers

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Cu IUD

- ▶ Creates an environment which is hostile to both ovum and sperm
- ▶ Also causes a local inflammatory response in the endometrium which prevents implantation
- ▶ Can be used within 120 hours of UPSI or 120 hours after the earliest expected date of ovulation.
- ▶ Effective both before and after ovulation
- ▶ Provides ongoing reliable contraception
- ▶ Lidocaine spray now used for insertion

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Assessment

- Time since UPSI in hours
- 1st day of LMP
- What is their shortest cycle length
- Which day/days in the cycle did UPSI occur?
- What is the current day in the cycle?

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Assessment

- Have they been using a method of contraception?
- Have they already had EC this cycle?
- Medication history + St John's Wort
- Allergies

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Calculating the earliest expected date of ovulation

- ▶ Shortest cycle length minus 14 days

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Cycle length

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Ovulation

- ▶ If the patient is likely to have already ovulated – explain that oral EC may not be effective.
- ▶ Still give it but advise that a CU IUD is the most effective option.

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Example

- ▶ LMP 03/05/2025
- ▶ UPSI 11/05/2025
- ▶ Currently 13/05/2025
- ▶ Shortest cycle length 28 days

MAY						
M	T	W	T	F	S	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

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Example

UPSI day 9

Presented on day 11 (48 hours after UPSI)

Earliest expected date of ovulation day 14 (16th May)

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Other considerations

UPA effectiveness reduced if patient has taken progesterone within the previous 7 days.

Quick starting – if using UPA wait 5 full days before starting a method containing progesterone.

Enzyme Inducers can affect the efficacy of both UPA and LNG

Effectiveness of LNG may be reduced if **BMI > 26** or **weight > 70kg**. Use double dose.

UPA is more effective than LNG.

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Other considerations

Cu IUD is always the most effective method.

If a patient decides on a Cu IUD give oral EC as well in case they change their mind or struggle to access coil insertion within the time frame

Advise a **home PT** 3 weeks after the UPSI

Let the patient know what they have had either by giving the box or asking them to take a photo (makes it easier if they present again with another episode of UPSI in the next 7 days)

Discuss **ongoing contraception**

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Other considerations

STI risk, sign posting to testing

Safeguarding and consent

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New Guidance

BOTH LNG AND UPA ARE SAFE TO USE IN BREAST FEEDING WOMEN AND THEY DO NOT NEED TO "PUMP AND DUMP"

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Incorrect use of POP

- UPSI in the first 2 day of commencing
- UPSI in the 1st 2 days following missed/late pill
- UPSI in the 2 days after any diarrhoea or vomiting
- UPSI following commencement of an enzyme inducer

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Incorrect use of CHC

- UPSI in the 1st 7 days of use
- UPSI prior to or in the 7 days following missed pill or patch applied > 48 hours late
- UPSI in the 7 days after any diarrhoea or vomiting
- UPSI following taking enzyme inducer

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Incorrect use of implant

- UPSI in the first 7 days of use
- UPSI after the implant has expired
- UPSI after taking an enzyme inducer

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Incorrect use of Depo Provera/Sayan Press

- UPSI in the 1st 7 days after the first injection
- UPSI > 14 weeks since the last injection

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Incorrect use of IUD

- UPSI in the 7 days following insertion of a LNG IUD (not Cu IUD)
- UPSI after a Cu IUD/LNG IUD has expired

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Recently stopped contraception

- Consider using LNG rather than UPA in the following scenarios:
 - POP/CHC take in the last 7 days
 - Implant removed within the last 7 days
 - Mirena removed within the last 7 days
 - Depo stopped, still amenorrhoeic

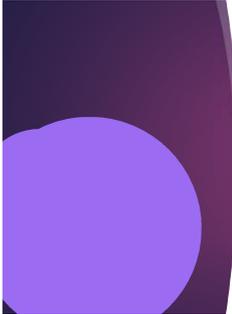
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Case 1

- ▶ 28 year old, nullip
- ▶ UPSI 7 days ago and 64 hours ago
- ▶ Not using any other contraception
- ▶ Currently day 10 of her regular 26 day cycle
- ▶ Not taking any medications
- ▶ 6th presentation for EC in the last 4 months
- ▶ Multiple sexual partners
- ▶ No PMH



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What is the best method of EC for her?

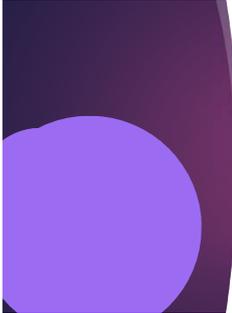
What other things would you want to discuss with her?

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- ▶ CU IUD is the most effective method and will also provide ongoing contraception.
- ▶ If she declines an IUD discuss ongoing contraception.
- ▶ She would like to have a think about different methods
- ▶ Which oral EC would you give?

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- ✓ UPA as it is the more effective out of the 2 oral methods
- 🏠 Remember to sign post for STI testing.
- 📦 She asks if she can take away a few boxes of UPA so that she doesn't need to come to the pharmacy each time. What do you tell her?

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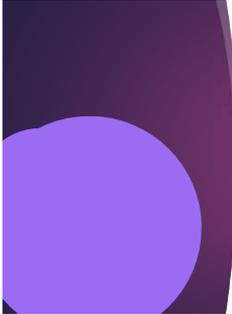


Case 2

- ▶ 40 year old lady
- ▶ Depo Provera – last injection 16 weeks ago
- ▶ UPSI 45 hours ago (only time in the last 2 weeks)
- ▶ Does she need EC?
- ▶ If so what can we offer?



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- ✓ Cu IUD or LNG
- 📄 There will still be circulating progesterone from the Depo so UPA should not be offered.

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Case 3



- ▶ 23 year old lady
- ▶ 2 weeks post partum
- ▶ UPSI 24 hours ago
- ▶ Which EC would you offer her?

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None! She is under 21 days post partum and therefore doesn't need it.

You could discuss contraception with her and either commence an oral method or sign post her to sexual health or her GP.

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Case 4

- ▶ 47 year old lady
- ▶ New relationship
- ▶ Regular cycle, shortest length 29 days
- ▶ UPSI on day 13 and day 18 (last night)
- ▶ Currently day 19
- ▶ What would be the best method of EC?



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- Cu IUD.
- Her earliest expected date of ovulation is day 15.
- She is current on day 19.
- She could have a CU IUD up until day 20
- Give oral EC anyway and sign post to sexual health

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Case 5

- ▶ 32 year old lady taking Cerelle
- ▶ Took her pill in the morning at her usual time and vomited 1 hour later
- ▶ Didn't take another
- ▶ Took her pill the following morning and had UPSI 2 hours later.
- ▶ Does she need EC?
- ▶ If so which can we offer?



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Yes. She has effectively missed a pill and so should have avoided UPSI for the following 2 days.

- Cu IUD/LNG
- UPA cannot be used as she has been taking POP

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Case 6

- ▶ 15 year old
- ▶ TOP 1 week ago
- ▶ UPSI 12 hours ago
- ▶ Does she need EC?
- ▶ If so which type?



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Yes, she needs EC

UPA/LNG (depending on whether you are quick-starting a method)

Sign post to Sexual health to consider IUD

What else do you need to consider?

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Safeguarding tips

- Follow your organisations policies and procedures
- See patients alone
- Private space
- Reassure that the consultation is confidential unless you are concerned about their safety or the safety of others

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Safeguarding

- Home circumstances. Witnessed/experienced any abuse or violence. Ever gone missing?
- Under the care of any services e.g. mental health or social services
- Who are they having sex with and where? Is there a large age gap?
- Is sex consensual?
- Any sex under the age of 13 must be reported to the police as legally cannot consent

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Q&A

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Thank you for attending our Advanced Services Update Event!

We would be really grateful if you would take some time to complete our feedback form.

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