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Advanced Services Update Event:

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

Tuesday 3rd February 2026

Nicola Goodberry Kenneally – CEO, CPWY
Lisa Meeks – Head of Services & Contractor Support, CPWY
Amanda Smith – Advanced Services Facilitator, CPWY
Dr Katie Fermor – Associate Specialist and Contraception Lead, Wakefield Integrated Sexual Health

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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.

Please ensure you have entered your car registration on arrival at reception.

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Tonight's Agenda

1. An overview of recent key changes affecting Advanced Services – CPWY
2. The addition of emergency contraception to the Pharmacy Contraception Service – CPWY
3. Oral emergency contraception – Dr Katie Fermor, Spectrum Community Health CIC

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Advanced Services Overview

A Rundown of Recent 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.
- Bundling requirements to qualify for the monthly payment:
  - Must be registered to provide the PCS and HCFS*
  - 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

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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 was included in this year's Pharmacy Quality Scheme.
- 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 to Adult Flu & COVID-19 Vaccination Services

- COVID-19 Vaccination Service becomes an Advanced Service from 1st April 2026.
- New service specification for seasonal vaccinations which covers both COVID-19 & Adult Flu. Runs from 1st April 2026 to 31st March 2027 and covers both Spring 2026 COVID-19 campaign **AND** A/W seasonal vaccination programmes.
- Can offer both COVID-19 and adult flu, OR just adult flu.
- Spring COVID-19 campaign runs from 13th April – 30th June 26.
- Service commencement date for the AW programmes TBC.
- Fees for both vaccinations uplifted but additional fee for housebound patients removed.
- Must use NBS for COVID-19 vaccinations, but this is still not a requirement for flu.

IMPORTANT

Several changes to service requirements – ensure you have read the service specification. Key changes to be aware of:

- **Registration is now a requirement for both services.**
- Must seek agreement from the commissioner to provide off-site vaccinations.
- Vaccines must be stored overnight at CQC/GPhC registered premises.
- Training requirements updated and include the completion of e-Learning for healthcare website modules.

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Changes to Adult Flu & COVID-19 Vaccination Services – Registration Deadlines

- Registration open now for Spring COVID-19 campaign. If interested need to register ASAP **(2nd February was the deadline** to ensure vaccine supplies in time for the start of the campaign). You will need to complete the **electronic registration declaration form** which is an interim arrangement in place until the MYS registration is available in April 2026.
- MYS will be available for registration and de-registration from 1st April 2026, for both the COVID-19 and Adult Flu.
- If you register for COVID-19 you will be automatically registered for the Adult Flu Vaccination Service. This will be automatic, regardless of whether you registered via the interim form or the MYS portal.
- **Pharmacies that want to provide only the Adult Flu Vaccination Service will be able to sign up from 1st April 2026 on the MYS portal.**
- The deadline to register to provide COVID-19 and/or Adult Flu vaccinations on MYS is **30th November 2026.**

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

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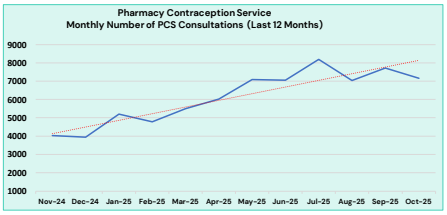
Let's Start with "Well Done"



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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

- Have direct access to professional advice from someone who can advise on Safeguarding at Level 3

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 016/25: Pharmacy Contraception Advanced Service – What's changing
- CPE Briefing 017/25: 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-pcs-on-demand-webinar/

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Resources and Guidance for the Pharmacy Team

Service implementation

- Checklists:
  - *Pharmacy owner – implementing the PCS*
  - *Pharmacist & pharmacy technician – implementing the PCS*
  - *Promoting the service to your GP practice / Sexual Health Clinics*
  - *Promoting the service to patients*
- PCS infographic for GP practice teams/ Sexual Health Clinic staff
- CPE briefing for pharmacy teams 019/25 – The PCS
- CPE briefing for pharmacy teams: 022/25 – Top tips for providing the PCS

Service provision

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

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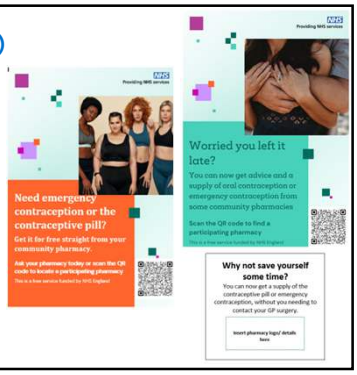
Resources (promotional)

- 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
- NEW – CPE patient facing website – https://communitypharmacy.org.uk/

Resources available on the CPE website page for PCS



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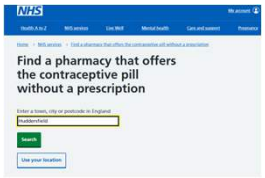
Service Availability

- 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

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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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Spectrum Community Health CIC

Emergency Contraception Update 3.2.26

Dr Katie Fermor, Contraception Lead, Wakefield Integrated Sexual Health Service

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Introduction

Spectrum Community Health CIC

- Making an assessment of pregnancy risk
- Choosing the best option for Emergency Contraception for the person in front of you
  - Ella One (Ulipristal)
  - Levonorgestrel
  - OR Copper IUD?
- Consideration of drug interactions/contraindications
- Cases

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Contraception Consultation

- Emergency Contraception choice discussion
- Safeguarding assessment and action as appropriate
- Advice/signposting for Copper coil/ongoing contraception and STI screening
- Free condoms for 13-25s via C-Card scheme: C-Card venues - Spectrum Sexual Health
- Wakefield clinic - Spectrum Sexual Health: Under 19s on Tuesdays and Thursdays 3-5pm, Test no Talk for any age 9am-12noon Mondays, Wednesdays, Thursdays and Fridays

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Emergency Contraception PGD: Inclusions

Levonorgestrel (LNG)	• Presentation within 96 hours of UPSI (including compromised oral contraception) • Vomiting within 3 hours of taking oral EC
Ulipristal Acetate (UPA)	• Presentation within 120 hours of UPSI • Vomiting within 3 hours of taking oral EC

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EC PGD: Exclusions

Levonorgestrel (LNG)
- Presentation more than 96 hours since UPSI
- Use of UPA-EC in the previous 5 days

Ulipristal acetate (UPA)
- Presentation > 120 hours since UPSI
- 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 steroids
- Individuals using enzyme-inducing drugs (EID) including some herbal products or within 4 weeks of stopping

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Drug Interactions and UPA

- **PROGESTOGENS**
- Quick starting hormonal contraception after ***UPA*** may reduce its EC effectiveness
- CoSRH advises avoid UPA if any progesterone containing medication has been taken in the **preceding 7 days**
  - Care needed with missed pills/late DMPA as may still be progesterone circulating
- Also a theoretical risk that ***UPA*** may reduce efficacy of hormonal contraception
  - **Progesterones should be withheld for 5 days after taking UPA**

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Other exclusions

- Known or suspected pregnancy
  - Consider pregnancy test if more than 3 weeks after UPSI and not had normal period since
  - No evidence of harm if very early pregnancy
- <21 days after childbirth
- <5 days post miscarriage, abortion, ectopic pregnancy or uterine evacuation for GTD
- Known hypersensitivity to product active ingredient or any components

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Levonorgestrel (LNG) Dosage

- Levonorgestrel 1.5mg (1 tablet): take as soon as possible up to 96 hours after UPSI
- **If BMI more than 26kg/m2 or weight more than 70kg:**
  - 3mg (two 1.5mg tablets) up to 96 hours after UPSI**
- **If 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 up to 96 hours after UPSI**

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

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Ulipristal acetate (UPA) dosage

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

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How does LNG work?

- Licensed for up to 72 hours after UPSI, some efficacy up to 96 hours
- Efficacy decreases with time post UPSI
- LNG-EC inhibits ovulation, delaying or preventing follicular rupture and causing luteal dysfunction
- If taken prior to the start of the LH surge, LNG inhibits ovulation for the next 5 days, until sperm from the UPSI for which it was taken are no longer viable.
- In the late follicular phase, however, LNG-EC becomes ineffective
- Studies have not shown a significant EC effect of LNG-EC administered after ovulation
- After taking LNG-EC, ongoing contraception risk with ovulation later in cycle

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How does Ulipristal/UPA work?

- UPA 30 mg – a selective progesterone receptor modulator
- Acts by delaying ovulation for at least 5 days, until sperm from the UPSI for which EC was taken are no longer viable; licensed for 120 hours after UPSI
- UPA-EC delays ovulation even after the start of the luteinising hormone (LH) surge whereas LNG-EC is no longer effective after the start of the LH surge.
- UPA-EC cannot inhibit ovulation at or after the LH peak.
- UPA-EC has not been demonstrated to be effective as EC when administered after ovulation.
- Importantly, after UPA-EC, the majority of women will go on to ovulate later in the cycle and are therefore at risk of pregnancy from subsequent UPSI. It is essential that women are made aware of this risk and advised regarding ongoing contraception.

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Who is suitable for UPA?

UPA-EC is more effective than LNG-EC so should be first line choice for most women

Important choice if an emergency IUD has been declined and patient midcycle due to effect closer to the LH surge

It is suitable also for breastfeeding women (change in guidance)

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EHC can be given more than once in the same cycle:

Evidence suggests that UPA-EC and LNG-EC do not disrupt an existing pregnancy and are not associated with fetal abnormality
If UPA-EC already taken once (or more) in a cycle, can offer UPA-EC again after further UPSI
If LNG-EC already taken once (or more) in a cycle, can offer LNG-EC again after further UPSI
If a woman has already taken UPA-EC, LNG-EC should not be taken in the following 5 days
If a woman has already taken LNG-EC, UPA-EC could theoretically be less effective if taken in the following 7 days

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History Taking: Pregnancy Risk Assessment

All episodes unprotected sex (UPSI) this cycle
LMP: first day of natural menstrual bleed
Using any contraception currently? NB reported “period”
Any medical conditions?
Any current medications? Including any EC use already this cycle

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Contraception Failure: POP

- Desogestrel POP and "traditional" POPs (eg Levonorgestrel, Norethisterone) are both effective after 2 days of correct pill taking
- If a single dose is missed there could be a pregnancy risk
- Desogestrel is counted as missed if >12 hours late
- Traditional POPs are missed if 3+ hours late
- Both can be affected by diarrhoea/vomiting/concurrent use of EID

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Contraception Failure: Combined Hormonal Contraceptive pill, patch or ring

- When quick starting take 7 days to become effective so UPSI in these 7d requires EC
- Missed pills or errors in use shortly prior to hormone free interval (HFI) or a delay restarting = risk, if it's more than 8 days there is a risk with UPSI
- With COC, vomiting and diarrhoea also may reduce effectiveness
- With all CHC, EID can reduce effectiveness
- fsrh-ceu-recommended-actions-after-incorrect-use-of-chc-march-2020-amended-jul-2021-.pdf

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Contraceptive Failure: DMPA/Sayana

- CoSRH guidance supports effectiveness up to 14 weeks after an injection
- No interaction with EID
- After 14 weeks EC would be needed for UPSI

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Contraceptive Failure: Implant

- Licensed for 3 years
- If fitted as a quick start method will take 7 days to become effective
- EID can reduce effectiveness

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Contraceptive failure: Coils

- Sex within first 7 days of fitting a hormone coil (if no other method previously in place)
- Partial or complete expulsion
- Sex when device out of licence

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How likely is pregnancy from an episode of unprotected sex?

Pregnancy is theoretically possible after UPSI on most days of the cycle

Emergency Contraception should always be offered if there has been UPSI

BUT risk of pregnancy is highest after UPSI that takes place during the 6 days leading up to and including the day of ovulation

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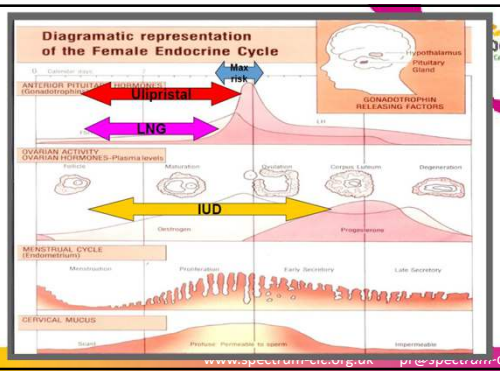

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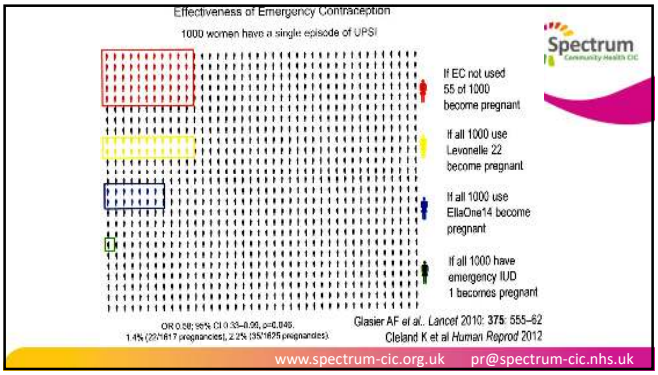

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Emergency (Copper) IUD

- Mode of action: copper component creates toxic environment for sperm, changes chemistry in fallopian tubes and uterus, prevents implantation
- Efficacy is 99%: most effective method, should be explained and offered to everyone, especially if after expected date of ovulation
- Can be fitted:
  - Up to 5 days after single episode UPSI
  - If patient is sure of their usual length of cycle and date of LMP, can be fitted up to day 19 of a 28 day cycle (or expected date of ovulation + 5 days)
- If opting for IUD: signpost and give EHC anyway- it's time sensitive and IUD may not be successfully fitted/patient may change her mind re coil

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Case 1

19 year old requests emergency contraception

What do you need to ask her?

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19 year old requesting Emergency Contraception

No current method of contraception	UPSI over a week ago and also last night	She is currently on day 11 of a regular 28 day cycle	Not taking any medications
BMI is 25.5	Priority is to avoid a pregnancy	What method(s) can you offer?	What else might you consider?

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19 year old requesting Emergency Contraception

Cu-IUD most effective method and will also provide ongoing contraception	• 2x episodes UPSI up to day 10 of 28d cycle. Currently day 11 • Earliest expected ovulation day 14; can fit up to day 19
If she declines IUD discuss provision of ongoing contraception	
She is interested in a pill rather than the coil	• Which would be suitable?

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EC choice: Case 1

UPA would be better as more effective and no contraindications

She is interested in a pill for ongoing contraception- what do you need to consider?

Also remember signposting to C-card, STI screening

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Case 2: Ebony

Ebony is desperate to avoid another pregnancy, her baby is 2.5 weeks old and she had sex for the first time last night

Does she need contraception? What could be offered?

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Case 2: Ebony

Ebony doesn't need EC as she is <3 weeks postnatal

She would benefit from a discussion of contraception choices, offer of provision of a pill or signposting to where to obtain LARCs eg Spectrum/GP.

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Case 3: Zainab

- Zainab is 35 and requests EC
- She usually takes Desogestrel
- She had a short-lived vomiting and diarrhoeal illness, onset an hour after taking her pill 2 days ago
- She didn't take another at the time
- She had sex yesterday morning, then remembered about her pill so she took it later in the day- this was 7 hours after the usual time
- Does she need EC and what can be offered if so?

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Case 3: Zainab

- **Yes- Zainab needs EC** as she missed a POP pill and then had UPSI
- She should have used condoms or abstained for 2 days while she re-established correct pill taking
- She could have Cu-IUD, assuming correct pill taking prior to the UPSI
- She could also have LNG
- UPA should be avoided due to recent POP and interaction

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Case 4: Sophie

- 23 year old student Sophie, has had multiple episodes of UPSI since LMP 16 days ago (has app). Last UPSI was 2 days ago.
- On closer questioning this "period" was actually a withdrawal bleed as she had taken off her contraceptive patch and didn't have any further supply.
- She should have reapplied a patch after her 7-day break- 9 days ago.
- Her BMI is 29.
- What could you offer her?

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Case 4: Sophie

- We can't be sure that her bleed was a true period, and this matters when considering whether we can calculate earliest expected ovulation for Em-IUD fitting
- She has had multiple episodes of sex since the bleed
- The hormone free interval has been extended to 16 days
- Can a coil be fitted in this circumstance?

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Case 4: Sophie

- Can a coil be fitted in this circumstance?
  - NO – the latest a coil could be fitted according to CoSRH guidance would be day 13 of an extended hormone free interval
  - The earliest recorded ovulation in studies of women using CHC was day 8 of HFI: 8+5=13
  - NB if in any doubt, please do signpost for a discussion re IUD as the coil fitter will make the judgement

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Case 4: Sophie

- Sophie could have either pill, UPA would likely be more effective for her
- She hasn't had any Progestogens in the last 7 days so there is no interaction
- She could be signposted to obtain further patches or potentially provided with a supply of COC assuming no other contraindication to this on assessment
- She would need to DELAY restarting CHC until 5 days after taking UPA, and then it would be a further 7d until the CHC is effective
- She might opt for LNG EC (BMI 29 so double dose needed), which would allow her to quick start the CHC

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Case 5: Belinda

Belinda is a 34 year old who last had DMPA injection 17 weeks ago

She has had multiple episodes of UPSI

What would you advise regarding EC?

Other issues?

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Case 5: Belinda

- What would you advise regarding EC?
  - Recommend caution with UPA as MAY be less effective with residual Progesterone still circulating from DMPA
  - LNG fine to give as long as no further contraindications
  - Multiple episodes of UPSI, some >5 days ago and no cycle to estimate ovulation, so not suitable for em IUD
  - For single episode UPSI <5 days ago, after the 14 weeks, IUD can be offered
- Other issues?
  - C Card, screening, follow up pregnancy testing, access and choice of ongoing method

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Case 6: Mila

- 17 year old, Mila, who had LNG 6 days ago, presents with further episode of UPSI last night, not sure of LMP
- What would you offer?

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Case 6: Mila

- 17 year old, Mila, who had LNG 6 days ago, presents with further episode of UPSI last night, not sure of LMP
- What would you offer?
  - More than 1xUPSI this cycle, at least one more than 5 days ago and not sure of dates- can't offer IUD
  - Consider pregnancy test today
  - Is 6 days since LNG, hence can't offer UPA (Progesterone within last 7 days)
  - Give further LNG; could also quick start eg POP
  - Follow up pregnancy test in 3 weeks, screening, condoms/C Card, safeguarding assessment

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Case 7: Terri

- Terri is 39 and has recently started a new relationship.
- She has a regular cycle, shortest cycle length is 30 days
- She had UPSI on days 17 and 19
- Today is day 20
- What would be best to offer her?

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Case 7: Terri

- Earliest expected ovulation is day 16 (30-14=16)
- Terri is on day 20 so likely to have ovulated, hence the CuIUD is the best option
- She could have this fitted until day 21 (16+5)
- If she opts for a coil,
  - Signpost to Spectrum
  - Give her oral EC anyway; there's a chance this may still be and she may change her mind about the coil

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Useful websites

- Drug interactions:
  - https://bnf.nice.org.uk/treatment-summary/contraceptives-interactions.html
  - www.fsrh.org/standards-and-guidance/current-clinical-guidance/drug-interactions
- Patient information:
  - https://spectrum-sexualhealth.org.uk/contraception/emergency-contraception/
  - https://www.contraceptionchoices.org/ContraceptionChoices/Contraception-Methods/emergency-contraception.aspx

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Spectrum Community Health CIC

Thank you for listening

Any questions?

www.spectrum-cic.org.uk
pr@spectrum-cic.nhs.uk

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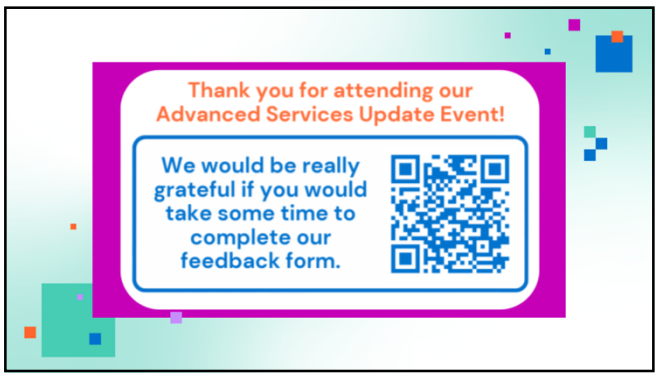
Thank you for attending our Advanced Services Update Event!
We would be really grateful if you would take some time to complete our feedback form.

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Email: info@cpwy.org
Website: www.cpwy.org
X: @cpwyinfo
LinkedIn: CPWY

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