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Pharmacy Contraception Service

Pharmacy Technician Training Event

Wednesday 7th October 2026

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Learning Outcomes

- Understand the responsibilities and regulations of working under a Patient Group Direction.
- Strengthen knowledge and confidence in delivering the Pharmacy Contraception Service (PCS).
- Recognise when consultations need to be escalated to another healthcare provider.
- Learn practical tips to help conduct consultations.
- Develop skills to manage challenging consultations.
- Practise consultations and clinical decision-making using real-life scenarios.
- Create a personalised Action Plan with SMART objectives.

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Agenda

- Patient Group Directions (PGDs)
- Overview of the Pharmacy Contraception Service
- Oral Contraception – key points
- Emergency Contraception – key points
- Comfort break
- Consultations – practical tips
- Putting it into practice
- Action plan
- Close



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Using Patient Group Directions

A Whistle-Stop Tour & Key Points

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What is a PGD?

Patient Group Direction — the legal mechanism

- The legal mechanism and written instruction that allows **named** registered healthcare professionals to supply and / or administer medicines to groups of patients that fit the criteria laid out in the PGD without the need for a prescription or an instruction from a prescriber.
- Only registered health professionals listed in the Human Medicines Regulations may work under PGDs. However, being listed in the Regulations does not automatically mean a professional can use a PGD.
- You must be **named and authorised** to work under a PGD, and work within the scope of the service it covers.

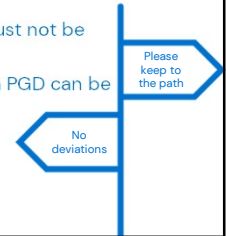


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PGDs Are Not Prescriptions

The key legal and clinical distinction

- A PGD is not a form of prescribing.
- The named healthcare professional is responsible for assessing that the individual meets the criteria set out in the PGD.
- No deviations from the PGD are permitted: supply/administration must exactly follow the PGD
- Only the medicine, formulation and exact quantity specified in the PGD may be supplied/administered.
- If inclusion criteria are not met or an exclusion applies, the patient must not be treated under the PGD and should be referred as directed.
- No element of the supply and/or administration of medicines under a PGD can be delegated.



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Professional Responsibility

The PGD does not remove accountability

- PGDs do not remove inherent professional obligations or accountability. It is your responsibility to practice only within the bounds of your own competence and in accordance with the GPhC Codes of Professional Conduct.
- Ensure that you have undertaken relevant training and can demonstrate competency to practice under the PGD – keep evidence of this!
- Ensure that you have signed the PGD and have been individually authorised to work under it.
- Ensure that you are using the most current approved PGD and that it is in date.
- You must only work within the parameters of the PGD – you are responsible for assessing that the patient fits the criteria set out in the PGD (failure to comply with the PGD could result in a criminal prosecution under the Medicines Act).
- Keep up to date with current best practice.



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Before Working Under a PGD

A practical readiness checklist

- ✓ Complete initial training and continuing professional development.
- ✓ Be assessed as competent and authorised by the provider organisation.
- ✓ Sign the appropriate documentation.
- ✓ Use the most recent, in-date, final signed copy of the PGD.
- ✓ Read and understand the PGD and its context.
- ✓ Have evidence of training and competency to support authorisation.



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Working Under a PGD

When practising under a PGD you must:

- not delegate responsibility
- ensure that you can determine that the patient meets the inclusion criteria as set out in the PGD and that no exclusion criteria apply
- assess each individual patient's circumstances and preferences
- recognise when signposting or referral to another health professional or service is needed, as specified in the PGD
- understand relevant information about the medicine included in the PGD, such as:
 - how to administer the medicine
 - how the medicine acts within the body
 - dosage calculations
 - potential adverse effects and how to manage them
 - drug interactions, precautions and contraindications
 - storage requirements, including maintenance of the 'cold chain'
 - follow-up arrangements.
- be able to advise the patient or their carer about the medicine as appropriate.



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The PGD Decision Point

Think: Include → Exclude → Act → Refer



4. The PGD decision point

Think: Include → Exclude → Act → Refer



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Clinical Knowledge Matters

Safe PGD use depends on more than knowing the legal framework

Before using any PGD, take time to refresh your knowledge of the relevant conditions, therapeutic areas and specific medicines involved. For each PGD you use, you should be confident in:

- How the medicine works and how to administer it.
- Any dosage calculations required.
- Potential adverse effects and how to manage them
- Drug interactions, contraindications and precautions
- Storage requirements
- Follow-up arrangements, including any monitoring.



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Practical Requirements

Safe supply, administration and documentation

- Provide an appropriately labelled pack when supplying a medicine.
- Provide the manufacturer's patient information leaflet.
- Check whether the patient is exempt from NHS prescription charges; collect the appropriate charge where required.
- Document the date/time, patient details, allergies/adverse events, how criteria were met, and medicine details.
- For relevant medicines, record batch number and expiry date as recommended by national guidance.
- Record that the medicine was supplied/administered under a PGD, the practitioner's name/signature, information provided and consent.



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Key Takeaways

If you remember only six things.....



A PGD is a legal framework for named, authorised healthcare professionals to supply/administer specified medicines to defined patient groups.



The patient must meet the PGD criteria **exactly** — no improvisation outside the PGD.



The practitioner remains accountable; PGD activity cannot be delegated.



Competence, current documentation, clinical knowledge, records and governance are essential.



Although pharmacy technicians are legally permitted to work under PGDs, they must first have the appropriate training, competency and authorisation to deliver the service safely.



You must be **named and authorised** to work under a PGD, and work within the scope of the service it covers

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The Pharmacy Contraception Service

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Before we begin...

We want to recognise that although today's topic is a clinical one, contraception and pregnancy are also deeply personal subjects. Some of us may have personal experiences that could make aspects of today's discussion difficult.

Please be mindful of your own wellbeing throughout the session. If you need to step out or take a moment, please do so – there is no need to explain why.



Pregnancy & Infant Loss Awareness



Community
Pharmacy
West Yorkshire

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Overview

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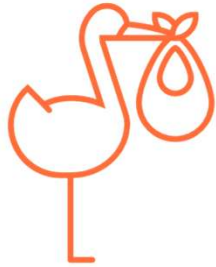
Quiz Question!



What was the estimated number of births in the UK in 2025?

1. 6,500
2. 65,000
3. 650,000

Answer: 650,000!



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Quiz Question!



How many sperm are present in 3–5ml of semen?

1. 3,500
2. 350,000
3. 350 million

Answer: 350 million!!!



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Quiz Question!



What is the probability of a women of good reproductive age, who is having regular intercourse during their fertile period, getting pregnant in any given menstrual cycle?

1. 5 – 10%
2. 14 – 18%
3. 20 – 25%

Answer: 20 – 25%!



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Why is Contraception Important?

- Helps control the population
- Prevents unwanted pregnancy
- Allows women to complete education or get to a particular point in their career before becoming pregnant
- Prevents risk and harm to women who have medical or physical conditions that would be affected by pregnancy
- Allows people to limit the number of children they have
- Allows people to plan when they have children
- Environmental impact: "I've never seen an [environmental] problem that wouldn't be easier to solve with fewer people – or harder, and ultimately impossible, with more"

Sir David Attenborough,
Patron of Population Matters
April 2009



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Pharmacy Contraception Service

- Increased access to contraception for women.
- Wider range of providers, giving women more choice.
- Extended opening hours.
- Reduce health inequalities.
- Create additional capacity in GP practices and Sexual Health Clinics for more complex cases.



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Pharmacy Contraception Service

- NHS commissioned service from community pharmacies, introduced on 24th April 2023.
- Update in October 2025 allowed provision by suitably trained pharmacy technicians and addition of Emergency Contraception (EC).
- 3 parts to the service:
 - *Initiation of oral contraception (OC).*
 - *Ongoing supplies of oral contraception (OC).*
 - *Supply of Emergency Contraception (EC).*
- Pharmacists must provide all parts of the service.
- Pharmacy technicians can choose to provide parts of the service.



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PCS Requirements

- Where a pharmacy technician is providing the service using a PGD, the pharmacy contractor must have an SOP in place to include the process of how the responsible pharmacist will supervise associated activities connected to the supply of medicines, such as labelling.
- All consultations should be verbal (face-to-face or remote) and must be provided from the pharmacy premises. Distance-selling pharmacies must provide remote consultations only.
- All consultations must be directly with the person accessing the service, and for whom the medication is for.



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Oral Contraception (OC) Key Points

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Quiz Question!



If someone decides they would like to start a COC, what would be useful information to know about their menstrual cycle and lifestyle?

- Do they have regular periods, or are they erratic?
- How long is their usual cycle?
- Do they have any symptoms associated with their periods? E.g pain, headaches, mood disorders, etc.
- When is their next period due?
- What is their lifestyle like? Is it chaotic or orderly?



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Initiation Considerations

POP

- No bleed (for some)
- Chance of breakthrough bleeds at random times
- May reduce symptoms associated with periods
- Daily dose so no need to remember to restart on a particular day
- Fewer side-effects

COC

- Regular bleed (frequency depends on selected regime) and can choose when they have it
- Much less chance of breakthrough bleeds
- Can help to control symptoms associated with periods
- Need to remember to restart after pill-free break
- Slightly increased side-effect profile



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Regime Options for COC

- Standard Use: Take a pill daily for 21 days, then a 7-day pill-free break.
- Shortened hormone-free interval: Take a pill daily for 21 days, then a 4-day pill-free break.
- Extended use (Tricycling): Take a tablet daily for 9 weeks, then a 4 or 7-day pill-free break.
- Flexible extended use: Take a pill daily and have a 4-day pill-free break when convenient.
- Continuous use: Take a pill daily with no pill-free break.



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OC – Ongoing Supplies

- Check patients GP record to see which contraceptive pill they are currently taking and when they last had a supply (supplies may be under 'Prescribed elsewhere' section if the patient got their last supply from pharmacy or sexual health clinic).
- Discuss Long-Acting Reversible Contraception (LARC).
- Review current pill with the patient – any issues? Any changes to their health?
- For COC, does their current regime suit them? Ensure they know the importance of restarting the pill on the correct day.
- May need to do BP and BMI measurements (if taking COC).
- Discuss length of supply to be given.



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OC – Length of Supply

- Initiation – can only supply 3 months.
- Ongoing supplies – Supply 6 – 12 months. Preference is for 12 months to be supplied as this minimises the chance of the patient accidentally running out and risking unwanted pregnancy. If giving 6 months, a good idea to note why in the notes.
- 3 months can still be given for an ongoing supply but there must be a clinical reason, and this should be documented in the record.



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Guidance for Patients Using Glucagon-like Peptide-1 (GLP-1) Agonists

- GLP-1 agonists include: tirazepatide (Mounjaro™), semaglutide (Ozempic™, Wegovy™), dulaglutide (Trulicity™), exenatide (Byetta™, Bydureon™), lixisenatide (Adlyxin™) or liraglutide (Victoza™, Saxenda™).
- Used for diabetes and some are licensed for weight loss
- People using them for weight loss may be accessing them privately and may not consider them to be 'medication' when you ask what medicines people are taking, so worth asking a specific question about 'weight loss medication'.
- All individuals taking these medicines should be advised to use contraception.
- Individuals using **tirazepatide (Mounjaro™)** and oral contraception should switch to a non-oral contraceptive method, or add a barrier method of contraception, for four weeks after initiation and for four weeks after each dose increase.



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Any Questions?



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Emergency Contraception (EC) Key Points

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Emergency Contraception (EC)

- Two types of EC can be supplied under this service:
 - Ulipristal acetate (UPA)
 - Levonorgestrel (LNG)
- Supplies are authorised via Patient Group Directions (PGDs).
- May require weight and/or BMI measurement.
- Patient may need to be signposted to GP or Sexual Health Clinic for Intrauterine Device (IUD) fitting.



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EC – Things to Take into Consideration

- No age limit – any woman of childbearing potential is eligible.
- Possible interactions with other medication – check PGDs.
- Expected ovulation date – where are they in their current cycle?
- What type of EC is likely to be the most effective for them?
- Any previous doses of EC already taken in the current cycle?
- Any other episodes of unprotected sexual intercourse (UPSI) in the current cycle with no EC taken?
- Will they need a double dose of LNG? (Weight >70kg/BMI >26kg/m², or taking enzyme inducing drugs).

Enzyme inducing drugs	
Antiepileptics	Carbamazepine, eslicarbazepine, oxcarbazepine, phenobarbital, phenytoin, primidone, rifinamide, topiramate
Antibiotics	Rifabutin, rifampicin
Antiretrovirals	Always use the HIV Drug Interaction Checker
Antidepressants	St John's wort
Others	Modafinil, bosentan, aprepitant



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Calculating Expected Ovulation Date

- Need to know the usual length of the women's cycle, e.g. Y days
- The next menstrual period always starts 14 days after ovulation, so subtract 14 days from the end of the cycle, e.g. $Y - 14 = X$ (expected ovulation day).
- First day of last menstrual period (LMP) is Day 1.
- Work out which date falls on day X of the current cycle.

e.g. Usual cycle length 26 days

$$26 - 14 = 12$$

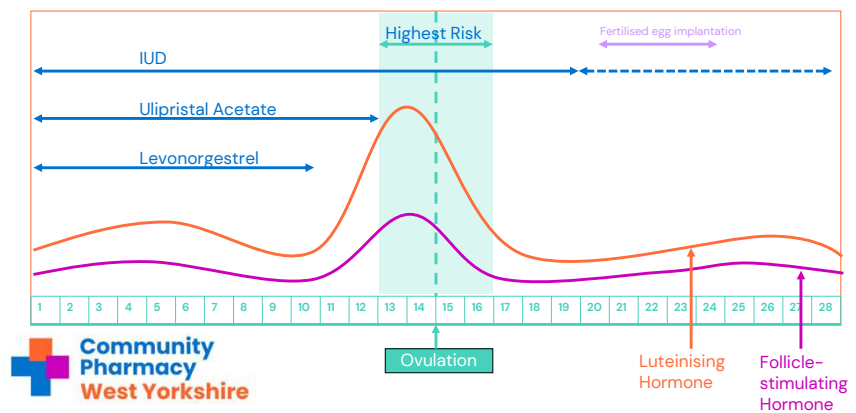
Expected ovulation date will be day 12 of current cycle



Usual cycle length	Expected ovulation day of cycle
26 days	12
28 days	14
30 days	16

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Effective window of Emergency Contraception



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Quiz Question!



If the expected ovulation date is imminent or has passed, or the woman has opted to get an IUD fitted, would you still supply oral EC?

Answer: Yes!!!

There is no way to know for definite when ovulation will occur, and the women may not be able to get an IUD fitted in time, so EC should always be supplied (provided no exclusions).



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Emergency Contraception (EC) Efficacy

Intrauterine Device (IUD/Copper coil) most effective

- Can be used up to 5 days after expected ovulation date, or within 5 days of a single episode of UPSI, whichever is later
- Can be used if there has been more than one episode of unprotected sexual intercourse (UPSI) in the same cycle (provided within 5 days of expected ovulation date)

Ulipristal acetate (UPA)

- Most effective oral EC
- Effective for 120 hours after UPSI – no reduction in efficacy over that time

Levonorgestrel (LNG)

- Slightly less effective than UPA
- Can be used up to 96 hours after UPSI, but efficacy reduces over that time

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EC Efficacy Comparison

If 1000 women had a single episode of UPSI and then all used a particular type of EC...

Form of Emergency Contraception	Number that would become pregnant
No EC	55
Levonorgestrel	22
Ulipristal acetate	14
IUD	1



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Repeat Doses of Oral EC

- Always check if a woman has already used oral EC recently.
- Repeat doses of the same oral EC are okay.
- Progestogens can reduce the effectiveness of UPA, meaning that LNG can interact with UPA and stop it working. If a different EC is given, you must ensure the appropriate gaps are taken into consideration.



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EC after Missed Contraception & UPSI

Refer to current CoSRH guidance:

- **Patch/ring** – if patch detachment/ring removal for >48 hours, EC may be needed.
- **COC** – if two or more active pills are missed (>12 hours late), EC may be needed.
- **POP** – if one missed pill (>3 hours – traditional POP, >12 hours – desogestrel, > 24 hours – drospirenone), EC would be needed.
- **Injection** – if >14 weeks since last contraceptive injection or within first 7 days after late injection, EC would be needed.
- **Implant** – if recently expired and used for < 4 years, EC would be needed.



Note: Ulipristal PGD exclusion
if any progestogen
used/taken in previous 7 days

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Quiz Question!



What should you always recommend a woman do, three weeks after taking oral EC?

Answer: Take a pregnancy test.

We've seen that oral EC is not 100% reliable, so women should always be advised to take a pregnancy test after 3 weeks of taking EC



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Any Questions?



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Comfort Break



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Consultations – Practical Tips

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Confidentiality

- Always remember that women accessing this service may feel embarrassed, even if they don't appear to be!
- Ensure requests for a contraception consultation are dealt with sensitively and discreetly.
- Discussions should always take place in the consultation room.
- When providing consultations, you will need to check if the patient consents to you sharing details of the consultation with their GP Practice – they can decline to do this if they wish.



Q. Can you promise the patient that you definitely won't share anything they tell you with anyone else?
 A. No, there may be occasions when you need to share information because the patient may be at risk. You should always discuss this with them first.

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Consent

- As the contraception service is available to patients from a young age, you may find yourself providing a consultation to someone under the age of 16.
- You may also be asked to provide a consultation to someone with reduced mental capacity.
- In these circumstances it is important to assess whether the patient has enough capacity to consent to receive the service.
- You can ascertain this by talking to them and finding out if they understand why they want contraception, how to take it and the possible risks, etc.
- For younger patients, it's always a good idea to encourage them to discuss their contraception with an adult in their life, but they may decline to do this.



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Safeguarding

- Pharmacists or pharmacy technicians providing this service must have completed Safeguarding Level 3 training, or have direct access to someone that has.
- Ensure you know what to do if a safeguarding issue arises.
- There are specific questions that should be asked when conducting consultations for young people, to ensure they are not at risk – these are listed onscreen on the consultation record.
- Have a plan in place for what to do if you need help with a possible safeguarding issue.



NHS Safeguarding Guide



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Chaperones

- Either party (pharmacy staff or patient) may request or offer a chaperone be present during the consultation.
- Details of the chaperone should be recorded in the clinical record.
- Particularly recommended if male pharmacist or pharmacy technician is offering the service.
- May help to make the person accessing the service more at ease.
- Could be a good opportunity for pharmacy technicians to observe consultations when training.



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Challenging Consultations and When to Refer

- Some consultations may be challenging due to:
 - Complexity
 - Unfamiliar situations
 - Fear of safeguarding issue
 - Regime or pill changes
 - Side-effects
- You are not expected to deal with everything yourself. You can ask for help from the pharmacist or even signpost the patient to their GP or Sexual Health Clinic.



Task: Spend 5 minutes discussing how you might explain to a patient that you would like to ask for further advice. When you've come up with a phrase that you're happy with, record it on your worksheet.

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Any Questions?



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Putting it into Practice

- Role play – What a good consultation looks like.
- Over to you!

Pair up in twos or threes and look at the list of suggested scenarios. Discuss each one between yourselves and make some notes of what you would consider in each scenario, and what the possible outcome could be.
- Feedback discussion.



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Example Scenario: patient comes in for EC because she is taking COC but has missed two days...

Consider:

- Which week were the tablets missed in?
- Were they the first two doses of the pack?
- Have the other doses in the current pack been taken correctly?
- Is EC needed? If so, which one could you supply?

Possible Outcomes:

- No EC needed.
- EC supplied (LNG as UPA excluded if progestogen taken in previous 7 days).
- EC supplied and patient signposted for LARC.



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Scenarios

1. Patient comes in for EC but doesn't know when their last period was.
2. Young girl comes in for EC. You supply that and ask if she would like to discuss OC. She tells you her boyfriend doesn't want her to use contraception.
3. Patient needs ongoing supply of COC but BP is 145/89mmHg.
4. Patient wants to start OC but doesn't want their GP to know because her mum works at the doctors.
5. Patient wants EC but already had one supply of UPA two days ago.



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Scenario 1. Patient comes in for EC but doesn't know when their last period was.

Consider:

- Risk already pregnant?
- Likely point in cycle – is she able to make a rough guess?
- Any other UPSI or use of EC in same cycle?
- Using any other forms of contraception? Would they like to discuss ongoing contraception?

Possible Outcome:

- Supply EC.
- Supply EC and refer for IUD/LARC.
- Supply EC and quick start OC.



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Scenario 2. Young girl comes in for EC. You supply that and ask if she would like to discuss OC. She tells you her boyfriend doesn't want her to use contraception.

Consider:

- Safeguarding issue?
- Capacity issue? Does she understand the risks of not using contraception? Pregnancy. STIs.

Possible outcome:

- Supply EC (and possibly start OC).
- Ask pharmacist to support.
- Assess capacity and explain risks.
- Safeguarding report.



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Scenario 3. Patient needs ongoing supply of COC but BP is 145/89mmHg.

Consider:

- PGD exclusions.
- Would patient be happy to switch to POP?
- What other options are available?
- Offering ABPM or further BP check when more relaxed, and then if low, could continue on COC.

Possible outcome:

- Initiation of POP instead.
- No supply and referral to GP/sexual health clinic.
- Provide ABPM and possibly continue on COC if average daytime reading okay.
- BP check when more relaxed and if result <140/90mmHg can still supply COC.



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Scenario 4. Patient wants to start OC but doesn't want their GP to know because her mum works at the doctors.

Consider:

- Patient consent to share information.
- How do you ensure information is not shared with the GP practice?
- May want to discuss implications of not sharing.

Possible outcome:

- Ensure record is marked as no consent to share with GP practice.
- Patient wishes followed and confidentiality maintained.
- Patient advised to take empty packet with her to future consultations.



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Scenario 5. Patient wants EC but already had one supply of UPA two days ago.

Consider:

- Which EC to supply?
- Likely ovulation date
- Any other UPSI in cycle?
- Contraception needs – would they like to discuss OC or LARC?
- Any safeguarding concerns?

Possible outcome:

- Supply further dose of UPA
- Supply UPA and refer to GP or Sexual Health Clinic for IUD
- Supply OC as well and/or refer for LARC



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Action Plan

- Time to set yourself some **SMART** goals!
- What are **you** going to do after this training session?
- Some suggestions:
 - ✓ Complete one or more of the training courses.
 - ✓ Create a PCS resources folder.
 - ✓ Find out where you can signpost patients to for LARC or IUD fitting in your area.
 - ✓ Discuss with your pharmacist what procedure to follow if you are worried there might be a safeguarding risk.
 - ✓ Prepare other team members to act as chaperones.



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Learning Outcomes

- Understand the responsibilities and regulations of working under a Patient Group Direction.
- Strengthen knowledge and confidence in delivering the Pharmacy Contraception Service (PCS).
- Recognise when consultations need to be escalated to another healthcare provider.
- Learn practical tips to help conduct consultations.
- Develop skills to manage challenging consultations.
- Practise consultations and clinical decision-making using real-life scenarios.
- Create a personalised Action Plan with SMART objectives.

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