NHS Pharmacy Contraception Service Webinar

11th July 2024

Hosted by NHS England Midlands Region

Housekeeping Arrangements

The webinar will be recorded and made available online

The slides will be emailed out after the webinar

You can type your questions throughout the webinar in the chat

Please provide feedback at the end of the webinar via our feedback form

Agenda

Agenda Item	Topic
19:00	**Contraception Service Update and Context** Presented by Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England Midland Region Kirsty Armstrong, National Pharmacy Integration Lead , NHS England
19:10	**Delivering the Contraception Service – Community Pharmacists Insights** Harvinder Singh, Glasshouse Pharmacy, Nottingham Alex Ruiz Carrasco, Old Chapel Pharmacy, Oswestry, Shropshire
19:30	**Sharing Experience - GP Insights** Dr Joanne Watt, Associate Medical Director for Primary Care and PCNs, NHS England Midland Region
19:50	**Question and Answers**
20:00	**Closing Remarks** Presented by Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England – Midlands

Contraception Service Update and Context

Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England Midlands Region
Kirsty Armstrong, National Pharmacy Integration Lead , NHS England

Aims and Objectives

1. Share good practice and top tips from community pharmacists delivering the service
2. Expand our knowledge from a GP with a special interest in sexual health
3. Build confidence to deliver the service, especially initiation
4. Consider how to promote the service
5. Opportunity to ask questions

Questions from you so far…….

SLA/Service Spec questions:

- How do I start delivering the service? I would like a step by step guide of questions to be asked in consultation. Will we be able to initiate contraception services? At any point do we need to take patient blood pressures or weight? General reinforcement of initiation process if possible please.
- Is the service linked to PharmOutcome as some GPs are not getting the information from PharmOutcome and so will not have up to date information about the patient.
- After 12 months supplying from community pharmacy does the patient have to have a review with the GP or can community pharmacy continue supply if everything is ok with the patient

Training questions:

- Any training needed? What is the learning requirement to provide this service? How to undertake training on initiation of contraception service? How do I get accredited to offer free pill service? Will there be ongoing CPD available?

Specific questions:

- Patients who want pills to control bleeding rather than contraception Do not feel fully competent in initiating a Contraceptive. Which one do we choose? What are the side-effects and benefits of each?
- How to initiate contraception in women who have high BMI? Do we have to record weight, BMI, blood pressure anywhere specifically? What blood pressure is too high to initiate contraception, e.g. as long as systolic is under 140 mmHG will initiating be ok? Referrals for continuation of treatment with combined pill where patient BMI exceeds the guidelines. We have been criticised by the GP for referring back to them in these scenarios. The PGD is clear on this. What would be the commissioners view on this? Best resources to use for helping patients decide which contraceptive to use.
- First line choices for contraception? Which contraceptive to choose? I would like presenters to cover clinical reasoning behind decision making process as to whether COC or POP should be initiated for a patient (when initiating the contraceptive for the first time). How to choose which pill to give e.g. if COC such a wide choice - what guides our choice? Feel unsure about initiating it with regard to discussing the risks.

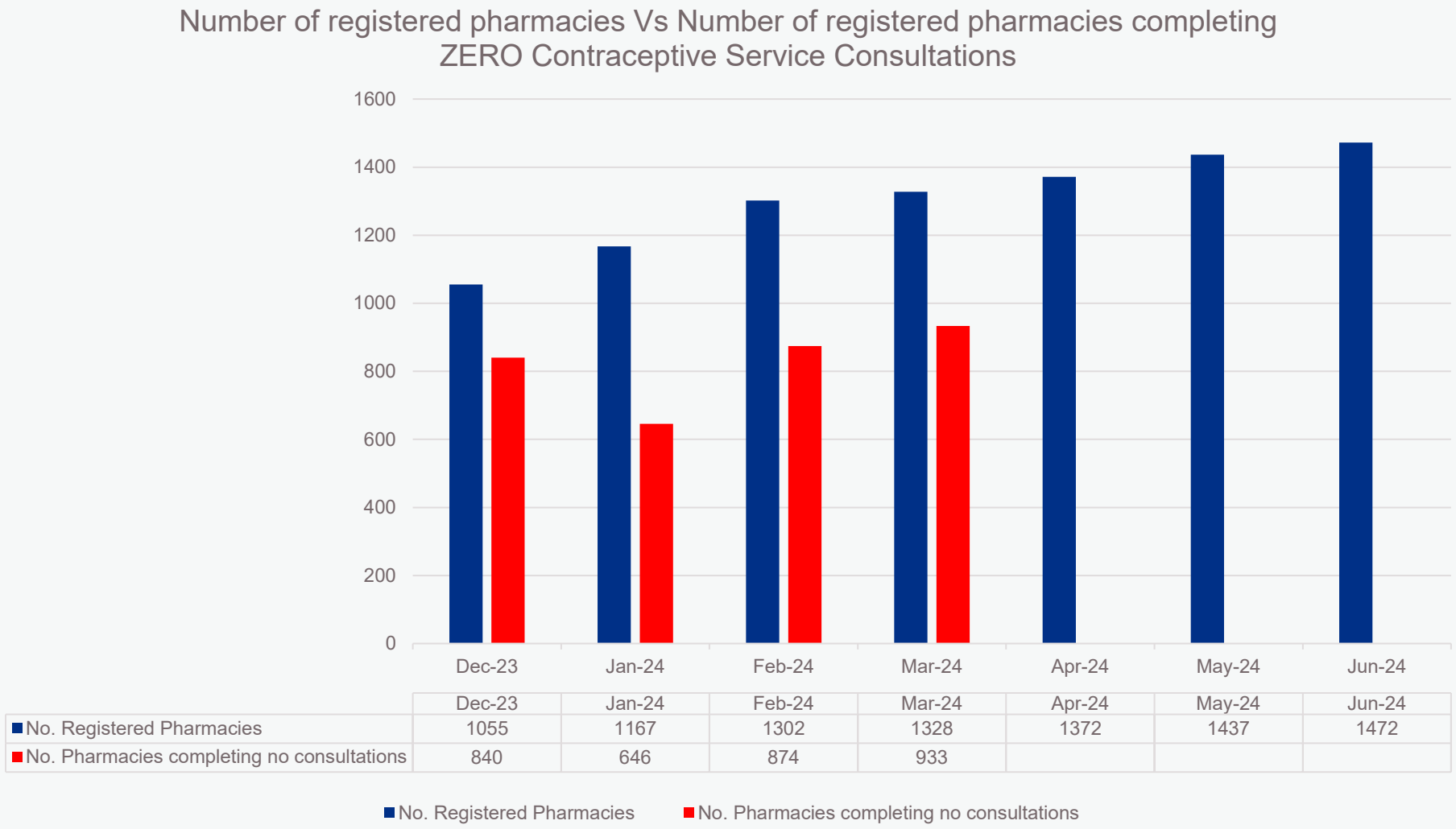
Young people:

- I feel uneasy starting off young people on contraception though I've many years of experience providing EHC

Promoting the service:

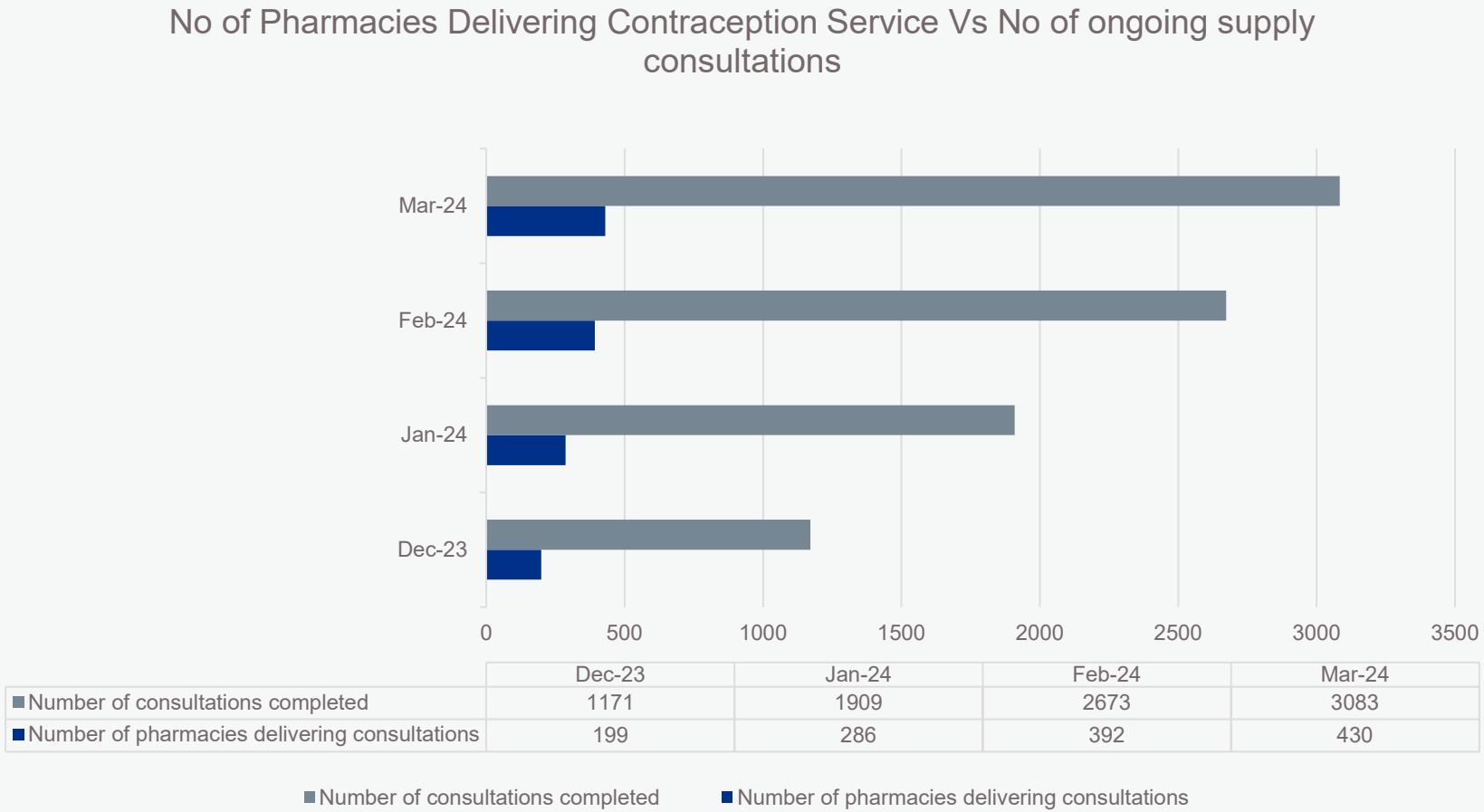
- Any hints or tips about PCN engagement to promote the service ?
- How are the NHS advertising this service? Not very well known.

Number of registered pharmacies Vs Number of registered pharmacies completing ZERO Contraceptive Service Consultations



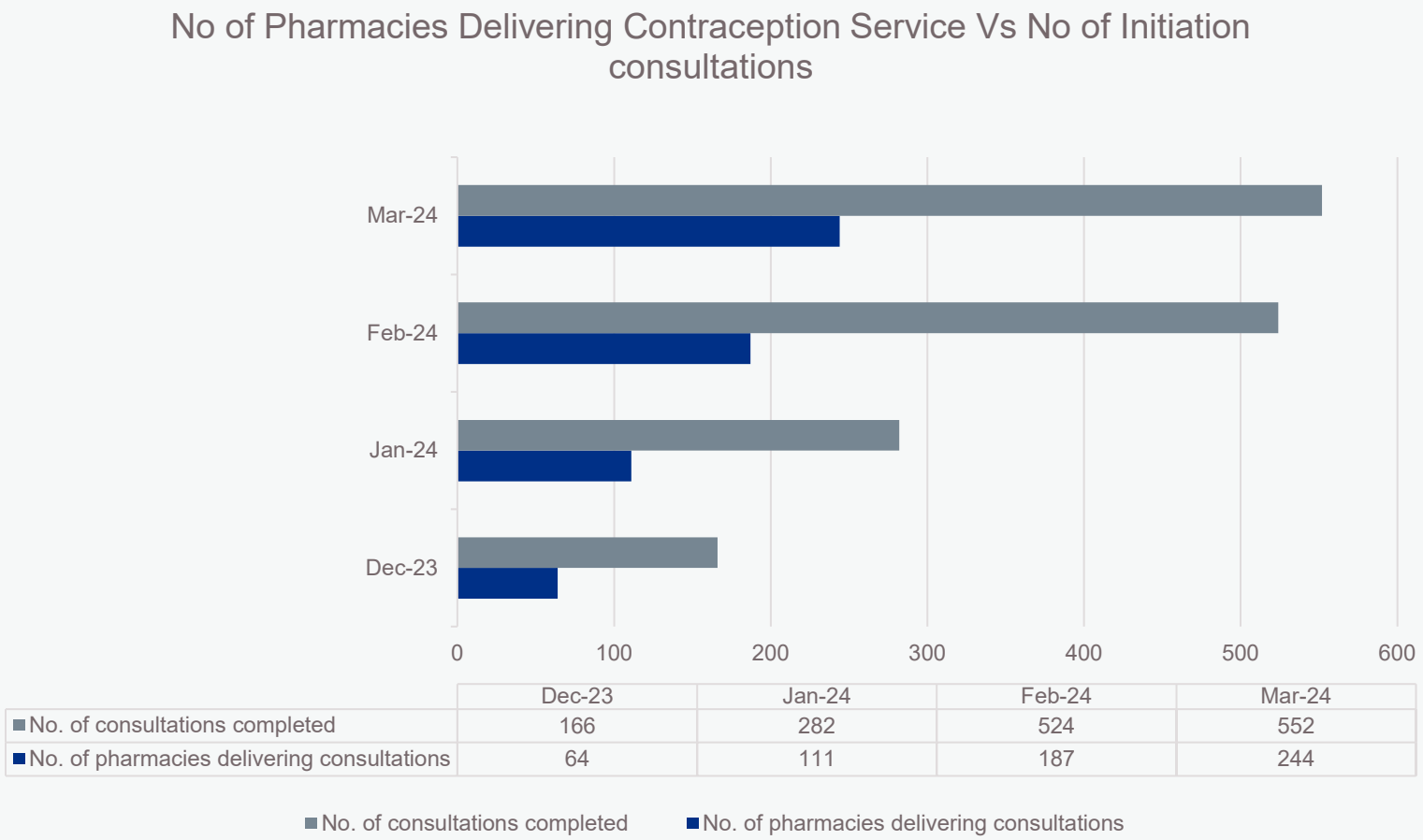
	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24
No. Registered Pharmacies	1055	1167	1302	1328	1372	1437	1472
No. Pharmacies completing no consultations	840	646	874	933			

Ongoing Supply Consultations



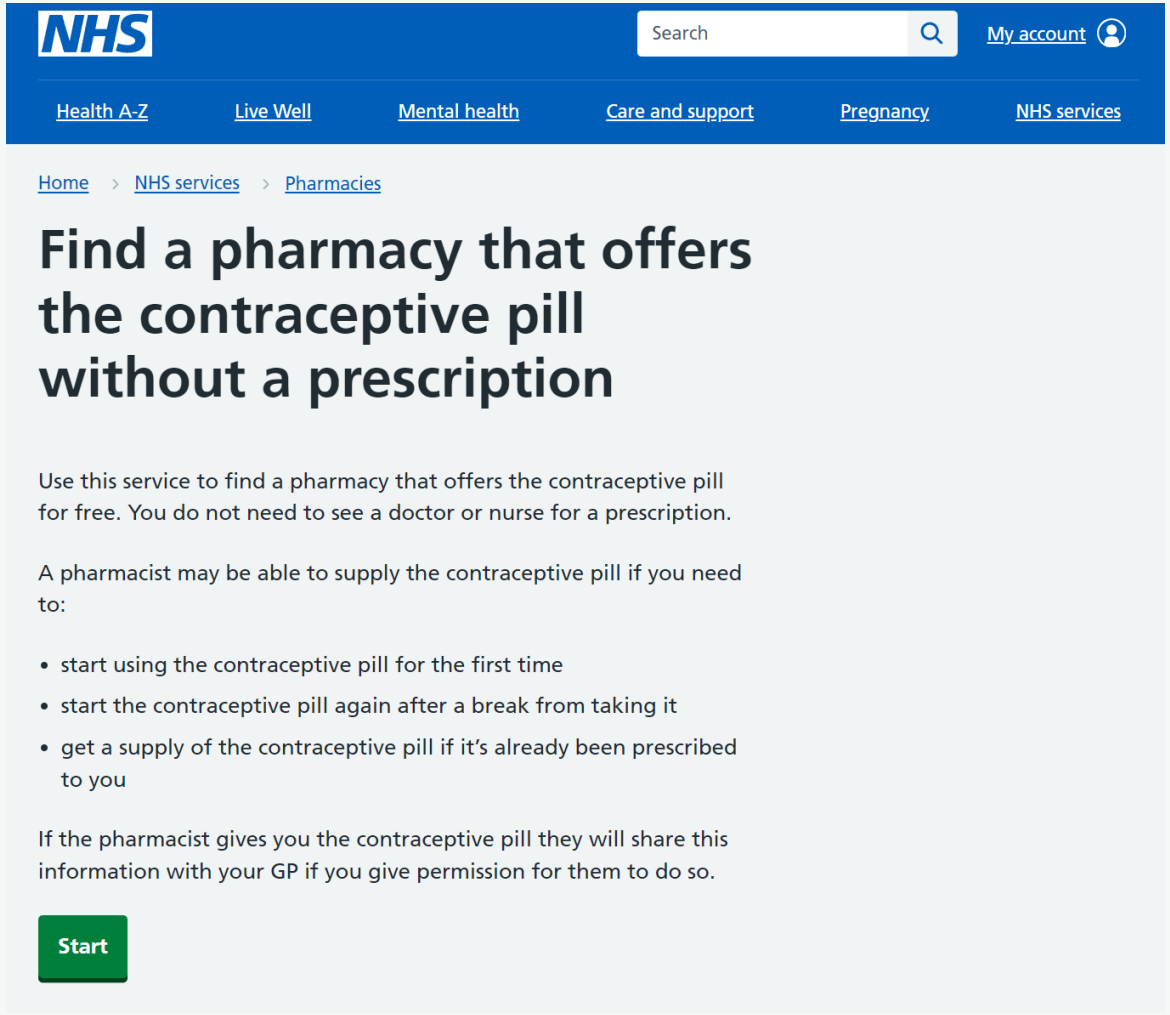
Month	Total No of registered pharmacies	% of Pharmacies delivering consultations
Dec 23	1055	19%
Jan 24	1167	24%
Feb 24	1302	30%
March 24	1328	32%

Initiation of Oral Contraception Consultations



Month	Total No of registered pharmacies	% of Pharmacies delivering consultations
Dec 23	1055	6%
Jan 24	1167	10%
Feb 24	1302	14%
March 24	1328	18%

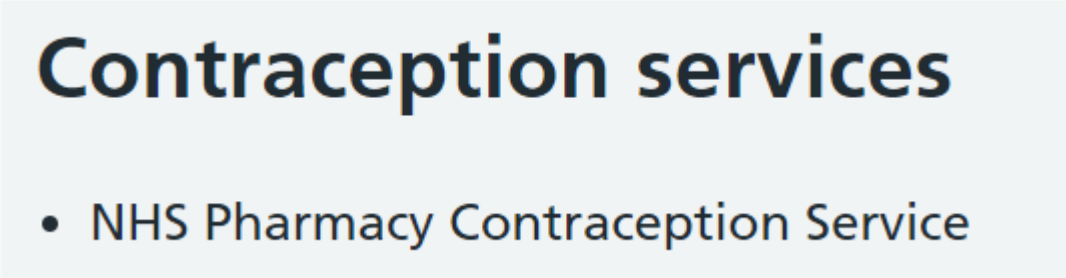
Find a Pharmacy



Pharmacy Profile Update

To return as part of the 'find a pharmacy that offers the contraceptive pill without prescription,' search function

Pharmacy Profile Manager needs to be updated and ***NHS Pharmacy Contraception Service selected***.



Getting ready to deliver service

- Registration and payment via the NHSBSA's MYS platform - MYS – Pharmacy | NHSBSA
- Must be **READY TO DELIVER** at point of registration
- Must deliver **both** initiation and ongoing supply consultations

Item	Payment
Consultation fee	Payment of £18 per consultation
Pharmacy set up costs	£900 per pharmacy premises paid in instalments as follows: • £400 paid on signing up to deliver the service via the NHSBSA MYS portal. • £250 paid after claiming the first 5 consultations; and • £250 paid after claiming a further 5 consultations (i.e. 10 consultations completed).

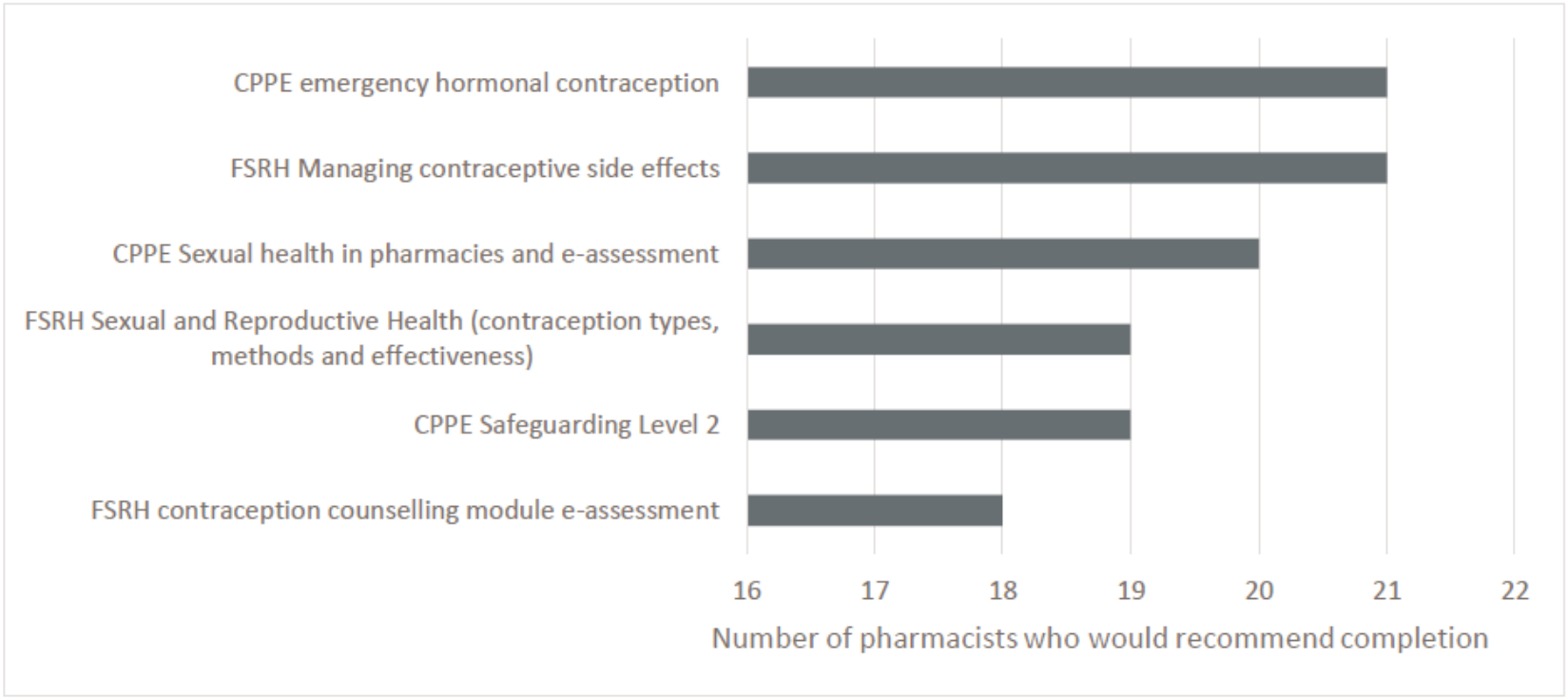
Must use an IT solution which meets the minimum digital requirements of the service (as specified within the NHS technical toolkits) i.e. Pharmoutcomes, Cegedim, Sonar or Positive

Before commencement of the service, the pharmacy contractor must ensure that pharmacists and pharmacy staff providing the service are competent to do so in line with the specific skills and knowledge, and the relevant PGDs.
This may involve completion of training'

Training

Pharmacists responding to an evaluation survey reported which of the training modules they would recommend pharmacy colleagues complete prior to delivering OC consultations.

Figure 10: Training modules recommended by more than 75% of the 22 survey respondents



Safeguarding

Pharmacists delivering the service must have 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.

•Safeguarding Level 3 – – Safeguarding Children and Adults Level 3 for Community Pharmacists – video on elfh

Or

•Safeguarding Level 3 Learning for Healthcare Safeguarding Children and Young People (SGC) – Safeguarding Children Level 3

Consultation Process

- Person can be:

  •Identified as clinically suitable by the community pharmacist and accept the offer of the service;
  •Self-refer to a community pharmacy;
  •Referred by their general practice;
  •Referred from a sexual health clinic (or equivalent); or
  •Referred from other NHS service providers, e.g., urgent treatment centres or NHS 111.

- Consultation done face to face (in consultation room*) or remotely via video/telephone conference
  (*service requirement to have a room)

- To be eligible to access this service a person must:

  Be an individual seeking to be initiated on an OC, or seeking to obtain a further supply of their ongoing OC:

  - Combined Oral Contraceptive (COC) – from menarche up to and including 49 years of age; **OR**
  - Progestogen Only Pill (POP) – from menarche up to and including 54 years of age*
    (*excludes Drospirenone)

Consultation Process

- Supply of Combined Pill requires Blood Pressure and BMI checks to be completed – can be done by a suitably trained pharmacy technician

- Where people meet inclusion criteria outlined in PGD, and subject to clinical appropriateness, a supply of contraception can be made

- Duration of supply can vary

    - Initiation – max 3 months - any oral contraception product
    - Ongoing supply – max 12 months – equivalent to previous product supplied

- Patients GP will receive a post event message via NHS mail or GP Connect Update Record if the patient consents

- If the patient does not consent this does not prevent a supply from being made

Delivering the Contraception Service – Community Pharmacists Insights

Harvinder Singh, Glasshouse Pharmacy, Nottingham

Alex Ruiz Carrasco, Old Chapel Pharmacy, Oswestry, Shropshire

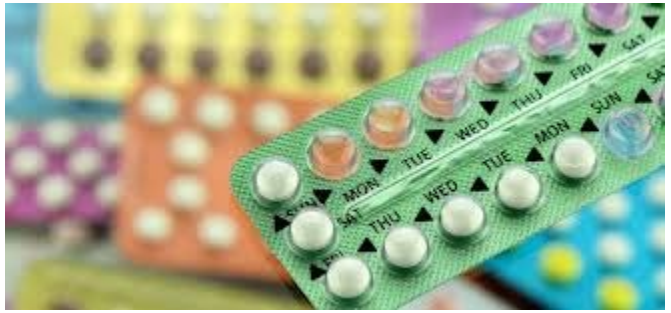
Contraception Service

My way into a new service

Contraception Service

Contraception Training

- **CPPE Emergency contraception** www.cppe.ac.uk/gateway/ehc
- **CPPE contraception** Contraception : CPPE including contraception e-assessment Contraception (2024) : CPPE or the following four subsections of module 3 – **Contraceptive choices of the FSRH sexual and reproductive health e-learning** (e-SRH) www.e-lfh.org.uk/programmes/sexual-and-reproductive-healthcare/ on elfh:
- o 03_01: Mechanism of action, effectiveness and UKMEC
- o 03_02: Choosing contraceptive methods
- o 03_03: Combined hormonal contraception
- o 03_04: Progestogen only methods (oral and injectable).



- **CPPE consultation skills for pharmacy practice**
- www.cppe.ac.uk/gateway/consultfound and e-assessment www.cppe.ac.uk/programmes/l/consult-a-06

- **CPPE Sexual health in pharmacies** www.cppe.ac.uk/programmes/l/sexual-e-01 and e-assessment www.cppe.ac.uk/programmes/l?t=Sexual-A-14&evid or the following four subsections **of module 9 – STIs of the FSRH e-SRH** www.e-lfh.org.uk/programmes/sexual-and-reproductive-healthcare on elfh:
- o 09_01: Epidemiology and transmission of STIs
- o 09_02: Sexually transmitted infection (STI) testing
- o 09_03: STI management
- o 09_04: Partner notification.

Contraception Training

- and one subsection in the **External resources module of the Sexual Health** (PWP) www.portal.elfh.org.uk/Component/Details/546276 e-learning on elfh

- FSRH – Contraception counselling eLearning.

Contraception training (Pill Initiation)

- **Module 2 of FSRH e-SRH on eLfH**:

02-01 Health history and risk assessment

02-02 Confidentiality, chaperones, and consent

- **Module 3 of the FSRH e-SRH on eLfH**:

03-07 Barrier contraceptives

- **Module 5 of the FSRH e-SRH on eLfH**:

05-01 Managing bleeding problems in women using contraceptives

05-02 Managing contraceptive side-effects

05-03 Managing side-effects and complications of IUD and IUS

- **Shadowing for a day an Independent Prescriber nurse in Cambrian Surgery Oswestry**

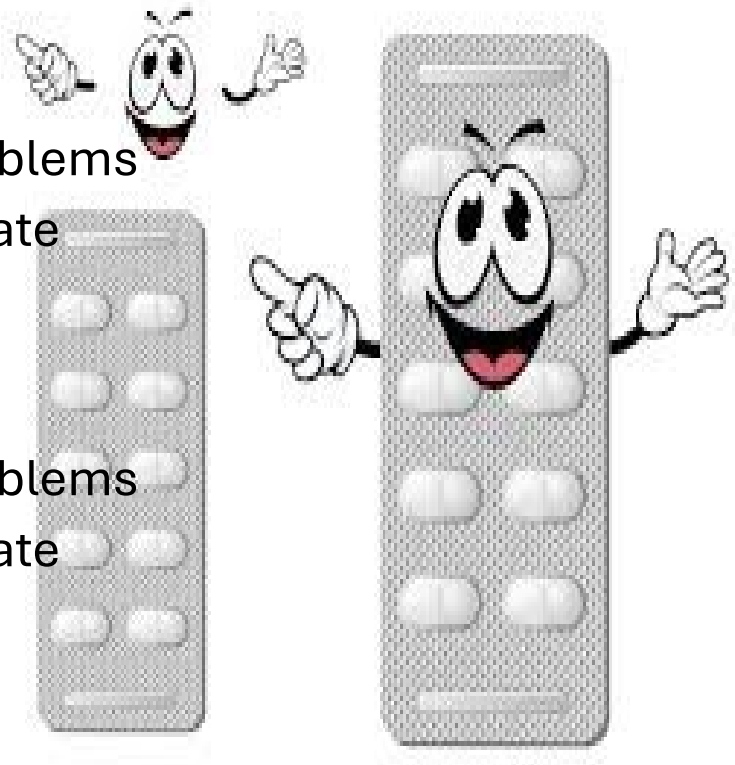
Useful Websites for consultation discussions

- https://www.sexwise.org.uk/contraception/which-method-contraception-right-me
- https://www.brook.org.uk/best-contraception-for-me/
- https://www.contraceptionchoices.org/whats-right-for-me

Contraception Service

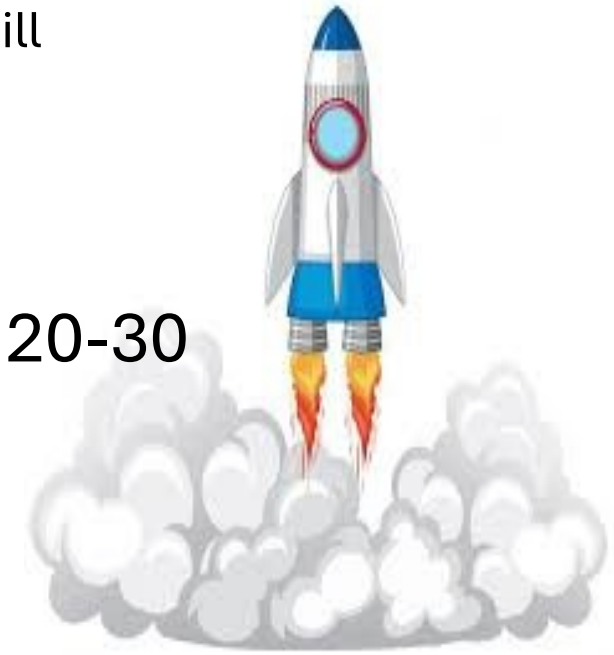
- Progesterone Only Pill
    - General discussion about the treatment and potential problems
    - Discuss long term contraception methods when appropriate

- Combined Only Pill
    - General discussion about the treatment and potential problems
    - Discuss long term contraception methods when appropriate
    - Blood Pressure Check
    - BMI (height and weight)

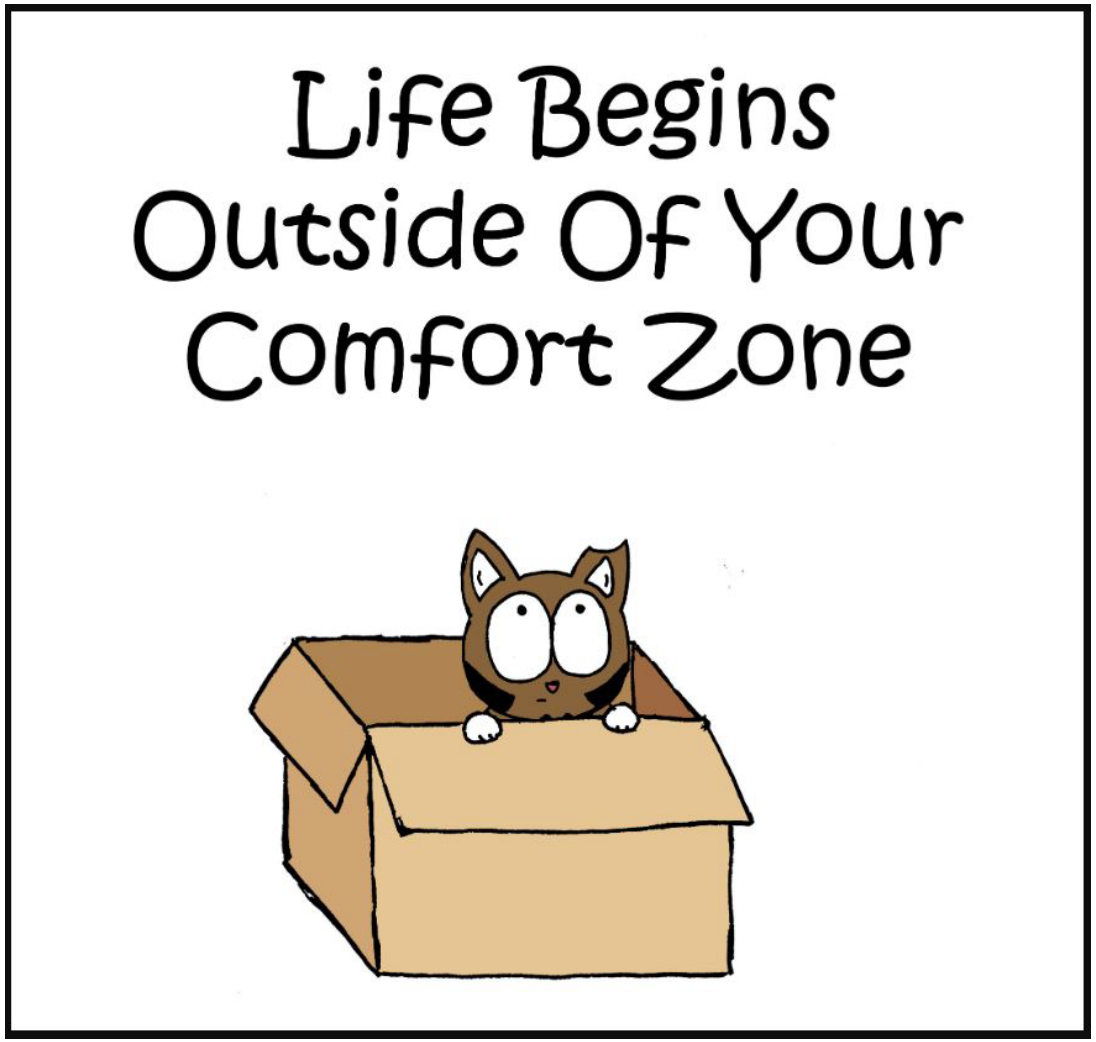


Contraception: Service Launch

- Discussion with Surgeries about the service:
    - Started with a soft launch with mainly Progesterone Only Pill
    - Open the service to combine Pills
    - Initiation of contraception Pill for patients
- We has gone from 2-5 consultations a month to 20-30 consultations actually
- Still Learning



Contraception Service



UKMEC & Young People's Contraception

Dr Joanne Watt
GP with an interest in sexual health
FSRH Trainer
Associate Medical Director for Primary Care and PCNs NHSE Midlands

UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)

- The UK MEC helps clinicians decide what contraceptives they can safely recommend based on the medical conditions of patients in their care. Funded by the FSRH and developed by our Clinical Effectiveness Unit, this key guidance is informed by robust and up-to-date evidence on when contraceptives can and cannot be safely used.
- https://www.fsrh.org/Public/Public/Standards-and-Guidance/uk-medical-eligibility-criteria-for-contraceptive-use-ukmec.aspx

Definition of UKMEC categories

UKMEC 1	A condition for which there is no restriction for the use of the method
UKMEC 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
UKMEC 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method. The provision of a method requires expert clinical judgement and/or referral to a specialist contraceptive provider, since use of the method is not usually recommended unless other more appropriate methods are not available or not acceptable
UKMEC 4	A condition which represents an unacceptable health risk if the method is used

Initiation vs Continuation

The initiation (I) and continuation (C) of a method of contraception can sometimes be distinguished and classified differently.

The duration of use of a method of contraception prior to the new onset of a medical condition may influence decisions regarding continued use.

However, there is no set duration and clinical judgement will be required.

Percentage of women experiencing an unintended pregnancy within the first year of use with typical use and perfect use (modified from Trussell et al.)

Method	Typical use (%)	Perfect Use (%)
No Method	85	85
Fertility awareness based method	24	0,4-5
Female Diaphragm	12	6
Male condom	18	2
Combined oral contraception	9	0.3
Progestogen only pill	9	0.3
Progestogen only injectable	6	0.2
Copper intrauterine device (coil)	0.8	0.6
Levororgestrel intrauterine system (hormone coil)	0.2	0.2
Progestogen only implant	0.05	0.05
Female sterilisation	0.5	0.5
Vasectomy	0.15	0.1

UKMEC tips

- https://www.ukmec.co.uk/
- Remember the UKMEC describes safety not efficacy and does not indicate the best method
- Use the highest UKMEC to guide your choice for a method-do not add them together but do consider multiple UKMEC to guide choices
- Record UKMEC in your clinical notes and share with the GP
- Some of the conditions in UKMEC may also pose a risk in an unintended pregnancy
- UKMEC does not include drug interactions
- Full guidance for specific methods is available on the FSRH website :
- https://www.fsrh.org/Common/Uploaded%20files/documents/fsrh-ceu-clinical-guideline-progestogen-only-pills-aug22-amended-11july-2023-.pdf
- https://www.fsrh.org/Common/Uploaded%20files/documents/fsrh-guideline-combined-hormonal-contraception-october-2023.pdf
- https://www.fsrh.org/Common/Uploaded%20files/Standards-and-Guidance/fsrh-ukmec-full-book-2019.pdf

What areas are covered by the UKMEC?

- Reproductive history including postpartum and breastfeeding
- Smoking, BMI and Bariatric Surgery
- Organ transplant recipient
- CVD including hypertension, vascular disease, IHD, stroke, AF, dyslipidaemia, VTE, other cardiac conditions
- Neurological disorders incl migraine, IIH, Epilepsy, Depression
- Breast and reproductive tract conditions/cancers and STIs
- HIV
- Endocrine conditions including diabetes, thyroid, gallbladder, hepatitis, cirrhosis, IBD
- Anaemias
- Rheumatic disorders including RA, SLE, anti-phospholipid antibodies

Combined Hormonal Contraception (CHC) which includes Combined oral contraception (COC) Combined contraceptive transdermal patch and vaginal ring	CHC do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraception method. Male condoms reduce the risk of STI/HIV.	
CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation C = Continuation	**CLARIFICATION/EVIDENCE** Most evidence available relates to COC use. However, this evidence is also applied to use of the contraceptive patch and ring.
Smoking		
a) Age <35 years	2	**Clarification:** UKMEC currently does not include use of e-cigarettes, as risks associated with their use are not yet established. **Evidence**: COC users who smoke are at an increased risk of CVD, especially MI, compared with those who do not smoke. Studies also show an increased risk of MI with an increasing number of cigarettes smoked per day.[23–34] The 35 year age cut off is identified because any excess mortality associated with smoking becomes apparent from this age.[35] The mortality rate from all causes (including cancers) decreases to that of a non-smoker within 20 years of smoking cessation. The CVD risk associated with smoking decreases within 1 to 5 years of smoking cessation.[35–37]
b) Age ≥35 years		
(i) <15 cigarettes/day	3	
(ii) ≥15 cigarettes/day	4	
(iii) Stopped smoking <1 year	3	
(iv) Stopped smoking ≥1 year	2	
Obesity		
a) BMI ≥30–34 kg/m^2	2	**Clarification:** The absolute risk of VTE in women of reproductive age is low. The relative risk of VTE increases with CHC use. Nevertheless, the absolute risk of VTE in CHC users is still low. **Evidence:** The risk of VTE rises as BMI increases over 30 and rises further with BMI over 35. Use of CHC raises this inherent increased risk further.[28,34,38–41] Limited evidence suggests that obese women who use COC do not have a higher risk of acute MI or stroke than obese non-users.[34,42–44]
b) BMI ≥35 kg/m^2	3	

Combined Hormonal Contraception (CHC) which includes Combined oral contraception (COC) Combined contraceptive transdermal patch and vaginal ring	CHC do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraception method. Male condoms reduce the risk of STI/HIV.	
CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation C = Continuation	**CLARIFICATION/EVIDENCE** Most evidence available relates to COC use. However, this evidence is also applied to use of the contraceptive patch and ring.
CARDIOVASCULAR DISEASE (CVD)		
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	3	**Clarification**: When a woman has multiple major risk factors, any of which alone would substantially increase the risk of CVD, use of CHC may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two risk factors assigned a Category 2 may not necessarily warrant a higher category.
Hypertension*		**Clarification:** For all categories of hypertension, classifications are based on the assumption that no other risk factors for CVD exist. When multiple risk factors do exist, the risk of CVD may increase substantially. **Clarification:** Women adequately treated for hypertension are at reduced risk of acute MI and stroke compared to untreated women. Although there are no data, CHC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive CHC users. Antihypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or higher.[53] **Evidence**: Among women with hypertension, COC users are at an increased risk of stroke, acute MI and peripheral arterial disease compared with non-users.[23,25,28,32-34,54–69] Discontinuation of COC in women with hypertension may improve BP control.[70]
a) Adequately controlled hypertension	3	
b) Consistently elevated BP levels (properly taken measurements)		
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	3	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	4	

Progestogen-only Contraception (POC) **Progestogen-only pill (POP)** **Progestogen-only injectable: depot medroxyprogesterone acetate (DMPA)** **Progestogen-only implant (IMP)**	**POC do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraception method. Male condoms reduce the risk of STI/HIV.**			
CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation, C = Continuation			**CLARIFICATION/EVIDENCE**
	IMP	DMPA	POP	
Hypertension*				For all categories of hypertension, classifications are based on the assumption **that no other risk factor for CVD exist.** When multiple risk factors do exist, risk of CVD may increase substantially. **Clarification:** Women adequately treated for hypertension are at a reduced risk of acute myocardial infarction (MI) and stroke compared with untreated hypertensive women. Although there are no data, POC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive POC users. Antihypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or greater.[87] **Evidence:** Limited evidence suggests that among women with hypertension, those who used POP or DMPA have a small increased risk of cardiovascular events compared with women who do not use these methods.[58]
a) Adequately controlled hypertension	1	2	1	
b) Consistently elevated BP levels (properly taken measurements)				
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	1	1	1	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	1	2	1	
c) Vascular disease	2	3	2	**Clarification:** *Vascular disease* includes: coronary heart disease presenting with angina, peripheral vascular disease presenting with intermittent claudication, hypertensive retinopathy and TIA.

Young people and contraception

Up to 18 years, although may be relevant up to age 25

Contraceptive choices for young people
Legal and ethical issues

- Be aware of the law, under 13 year olds cannot consent to sex
- If 13 or over assess competence to consent, e.g. using fraser guidelines
- Age 13-16 is not legal but not automatically criminalised in law
- Be professionally curious
- Be aware of the potential for age differences or people in positions of authority
- Know who you can talk to locally about safeguarding concerns/sexual assault
- Confidentiality
- “Are you able to say no if you don’t want to have sex?”

Contraceptive options

- Make sure they are aware of all options including LARC
- Ensure they know the follow up plan
- How do they seek help if there are problems
- Emergency contraception if needed

Concerns and risks

- Weight gain- no evidence with CHC, only depo has evidence that it causes weight gain
- Acne-all CHC can improve acne, if no improvement with first line consider less androgenic CHC or higher oestrogen. Implant may make acne worse. Slynd may be the best POP for people with acne
- Mood changes/ Depression-no evidence that hormonal contraceptives cause this
- Fertility-no delay in return with CHC or POP, delay if using depo

Concerns and risks cont’d

- Bleeding patterns- CHC and POP may change this, pain often improves with both CHC and POP
- Bones health- Depo is associated with a small loss in bone mineral density
- Thrombosis-slight increase with CHC but absolute risk is small
- Cancer-CHC does not increase overall risk of cancer, reduced ovarian cancer risk, slightly increases breast and cervical
- STIs-need to use condoms in addition to oral contraception

STIs

- Chlamydia may be asymptomatic in 70% of women and 50% of men
- Infections can cause a change in discharge, bleeding between period or after sex
- Pelvic pain needs investigating, especially if it is causing pain during sex
- Checks can be done via your local sexual health clinic or via GP practice

More links and information

- https://www.fsrh.org/Common/Uploaded%20files/documents/fsrh-guideline-contraception-young-people-may-2019.pdf
- Always check how the contraception is being used
- Have they changed partner since you last spoke to them-STI risk
- Don’t forget about ectopic pregnancies, make sure they do a pregnancy test
- Talk to other professionals if you have safeguarding concerns

Any Questions?

Question & Answers

Contraception Service Webinar Feedback

https://forms.office.com/e/Q6W05msfam