

This Patient Group Direction (PGD) must only be used by registered healthcare professionals who have been named and authorised by their organisation to practise under it. The most recent and in date final signed version of the PGD should be used.

PATIENT GROUP DIRECTION (PGD)

For the supply of a combined oral hormonal contraceptive (COC) by in
BPAS clinics.

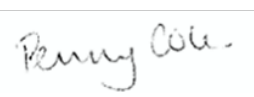
Version Number 3.2

Change History	
Version and Date	Change Details
Version 1 April 2020 To version 1.2	See previous version for historical updates
Version 2.0	Updated template – amended references and minor editing and wording changes/clarifications. Strengthened detail on use in individuals requiring control of problematic bleeding caused by the subdermal implant, IUS or medroxyprogesterone injection for up to three months. Addition by BPAS of information to provide to client in the event COC supplied ahead of abortion treatment and client chooses to continue with pregnancy. Inclusion criteria and associated points with reference to individuals requiring control of problematic bleeding caused by subdermal implant, IUS or medroxyprogesterone removed as not applicable to BPAS. <i>Version adopted by BPAS 01/04/23.</i>
Version 2.1 April 2023	SPS update: exclusion added relating to Zoely® (not applicable to BPAS) <i>For version control, approved for use in BPAS 09/05/23.</i>
Version 2.2 October 2023	Updated PGD development group members Statement added in exclusion criteria regarding consideration of lactose/sucrose content in individual products.
Version 2.3 May 2024	Added information re: starting after EHC or abortion Removed option for off-label dosing regimes. Added “current contract of employment with BPAS” to staff authorised
Version 3.0 November 2025	Planned end of life review. Added tailored dosing schedules. Added statement on management of people using 30mcgEE/LNG combination who have missed two pills in week one of cycle in dose and frequency section. Added statement on advice when used in combination with GLP-1 agonists. Clarified statement on Qlaira. Added statement on advice on desogestrel and risk of meningioma. Clarified statement regarding omitted pills. Updated reference to FSRH to CoSRH. Minor rewording to align the RH PGDs content, and update terminology. Contraindication with interacting Hep C medicines added. Update SLWG and references.
Version 3.1 January 2026	Updated in line with UKMEC (2025), updated reference.
Version 3.2 May 2026	Added Multiple Sclerosis to exclusion criteria

N.B. Review and update may occur prior to this period if national guidance changes or legal or clinical issues arise

BPAS PGD Organisational Authorisations:

This PGD is not legally valid until it has had the relevant organisational authorisations below.

Name	Job title and organisation	Signature	Date
Penny Cole	BPAS Deputy Chief of Nursing and Midwifery		19/05/2026
Dr Ingrid Granne	BPAS Chief Medical Officer		19/05/2026
Kalpesh Thakrar	BPAS Deputy Chief Pharmacist		14/05/2026

Authorising Body:

Dr Fiona Lemmens	Executive Clinical Director, Cheshire and Merseyside ICB		15/07/2026
------------------	--	---	------------

Responsible person who has approved this PGD on behalf of BPAS	Name: Heidi Stewart
	Position: BPAS Chief Executive
	Signature: 
	Date: 19.05.2026

Glossary	
ATE	Arterial thromboembolism
BPAS	British Pregnancy Advisory Service
BMI	Body Mass Index
BLS	Basic life support
BNF	British National Formulary
COC	Combined oral contraceptive
CoSRH	College of Sexual and Reproductive Health
CVD	Cardiovascular disease
EHC	Emergency hormonal contraception
IUD	Intrauterine device
LARC	Long-acting reversible contraception
LNG-IUD	Levonorgestrel intrauterine device
MHRA	Medicines Health Regulatory Agency
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
SmPC	Summary of medicinal product characteristics
STI	Sexually transmitted infection
VTE	Venous thromboembolism

PGD DEVELOPMENT GROUP

Date PGD template comes into effect:	1 st April 2026
Review date:	1 st September 2028
Expiry date:	31 st March 2029

This PGD template has been peer reviewed by the Reproductive Health PGDs Short Life Working Group in accordance with their Terms of Reference.

Note the working group and approving organisation(s) agreement to the content only applies to the national template and does not extend to any local adaptations made to any of the content which are solely the responsibility of the organisation authorising the PGD. The most up to date version of the template is available from the [SPS national PGD template webpage](#).

This section MUST REMAIN when a PGD is adopted by an organisation.

Name	Designation
Alison Crompton	Community pharmacist
Bola Sotubo	NHS North East London ICB pharmacist
Carmel Lloyd	Royal College of Midwives (RCM)
Dr Cindy Farmer	Senior Vice President, Professional Learning and Development, College of Sexual and Reproductive Healthcare (CoSRH)
Clare Livingstone	Royal College of Midwives (RCM)
Dipti Patel	Local authority pharmacist
Emma Anderson	Centre for Postgraduate Pharmacy Education (CPPE)
Heather Randle	Royal College of Nursing
Julia Hogan	Clinical Nurse Specialist
Kate Devonport	National Unplanned Pregnancy Association (NUPAS)
Kirsty Armstrong	National Pharmacy Integration Lead, NHS England
Lisa Knight	Community Health Services pharmacist
Michelle Jenkins	Clinical Nurse Specialist Sexual Health Blackpool Teaching Hospitals, and member of Courses and CPD Committee, College of Sexual and Reproductive Healthcare (CoSRH)
Portia Jackson	Lead Pharmacist iCaSH, Cambridgeshire Community Services
Rachel Logan	Senior Pharmacist, BPAS
Tanya Lane	CoSRH Registered Trainer MSI reproductive Choices
Jo Jenkins	Associate Director Medicines Governance, Medicines Use and Safety, Specialist Pharmacy Service
Kieran Reynolds	Advanced Specialist Pharmacist - Medicines Governance Specialist Pharmacy Service
Rosie Furner (Working Group Co-ordinator)	Advanced Specialist Pharmacist PGDs and Medicine Mechanisms, Specialist Pharmacy Service
Sandra Wolper	Out of Hospital Care Lead, Medicines Use and Safety, Specialist Pharmacy Service

Characteristics of staff authorised to use this PGD:	
Qualifications and professional registration	Current contract of employment with BPAS Registered healthcare professional (HCP) listed in The Human Medicines Regulation 2012, Schedule 16 Part 4 legislation as able to practice under Patient Group Directions.
Initial training	The registered healthcare professional authorised to operate under this PGD must have undertaken appropriate education and training and successfully completed the competencies to undertake clinical assessment of patients ensuring safe provision of the medicines listed in accordance with local policy: • Must be familiar with the medicine and observant to changes in the BNF and Summary of Product Characteristics (SmPC) • Pharmacological knowledge relating to the administration and supply of the medicine, its uses, contraindications, dosage and adverse effects including tailored dosing schedules. • Must have completed CoSRH 'Essential Contraception for Abortion Care Providers' training or equivalent. Essential Contraception for Abortion Care Providers CoSRH • Must have completed BPAS in-house contraception training https://bpas.kallidus-suite.com/learn/ • Individual must have completed BPAS Essentials of Contraception interactive session • Must be competent in the administration of adrenaline for anaphylaxis and have up to date Basic Life Support (BLS) skills as a minimum Individual has undertaken appropriate training for working under PGDs for the supply and administration of medicines: • Recommended training - eLfH PGD elearning programme • Must have completed BPAS in-house PGD training package https://bpas.kallidus-suite.com/learn/ Must have completed required BPAS training (including updates) in safeguarding children and vulnerable adults in line with BPAS policy: BPAS Safeguarding Adults at Risk policy. BPAS Safeguarding Children and Young People policy.
Competency Assessment	• Individuals operating under this PGD must be assessed as competent (see appendix A) or complete a self-declaration of competence for contraception supply. • Staff operating under this PGD are encouraged to review their own competency using the NICE Competency Framework for Health Professionals using Patient Group Directions
Ongoing training and competency	• Individuals operating under this PGD are personally responsible for ensuring they remain up to date with the use of all medicines and guidance included in the PGD - if any training needs are identified these should be addressed and further training provided as required. • Practitioners must complete 3-yearly BPAS PGD Theory Refresher training and competency assessment as per BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines

	- Practitioners must ensure they remain up to date with relevant clinical skills, management of anaphylaxis, BLS (as a minimum), with evidence of continued professional development - Practitioners are responsible for maintaining their competency to work under this PGD
The decision to supply any medication rests with the individual registered health professional who must abide by the PGD and any associated organisational policy.	

Clinical condition or situation to which this PGD applies:	
Clinical condition or situation to which this PGD applies	Contraception
Criteria for inclusion	- Individual (age from menarche to up to 50 years) presenting for contraception. - Informed consent given. - A recent, accurate blood pressure recording, and Body Mass Index (BMI) should be documented for all individuals prior to first COC supply and repeated for each subsequent supply.
Exclusion criteria	- Consent not given - Individuals under 16 years of age and assessed as not competent using Fraser Guidelines - Individuals 16 years of age and over and assessed as lacking capacity to consent - Known hypersensitivity to an active ingredient or to any constituent of the product - see the Summary of Product Characteristics which can be accessed on the EMC website - Some COC products contain lactose/sucrose – individuals with rare hereditary problems of galactose intolerance, total lactase deficiency, fructose intolerance or glucose-galactose malabsorption or sucrase-isomaltase should not take these medicines. Where applicable, check product excipients before supplying. - Less than 21 days after childbirth (for deliveries over 24 weeks gestation) - Breastfeeding and less than six weeks postpartum. - Not breastfeeding and less than 6 weeks post-partum with other risk factors for venous thromboembolism (VTE). - Individuals aged 50 years and over. - Significant or prolonged immobility. - Major surgery. NB: Within 4 weeks before or until 2 weeks after full mobilisation following major elective surgery (>30 minutes duration) or any surgery on the legs or surgery which involves prolonged immobilisation of a lower limb Cardiovascular disease - Individuals aged 35 years or more who currently smoke or stopped smoking less than one year ago (this includes vaping and the use of e-cigarettes) - BMI equal to or greater than 35 kg/m² - Blood pressure measurement (in clinic) greater than 140/90 mmHg or controlled hypertension - Multiple risk factors for cardiovascular disease (CVD) (such as smoking which includes vaping/use of e-cigarettes, diabetes, hypertension,

	obesity and dyslipidaemias) Where more than one risk factor is present, clinical judgement must be applied. • Current or past history of ischaemic heart disease, vascular disease, stroke or transient ischaemic attack • Current or past history of venous thromboembolism • Individuals with multiple risk factors (defined as more than one risk factor) for VTE are excluded. Clinical judgement should be applied and advice from a prescriber sought. Examples of VTE risk factors include (but not exclusively) ○ family history of VTE, ○ immobility, ○ BMI > 35kg/m², ○ superficial VTE, ○ ovarian and endometrial cancer, ○ inflammatory bowel disease, ○ sickle cell disease • Complicated valvular or congenital heart disease e.g. pulmonary hypertension, history of subacute bacterial endocarditis • First degree relative with venous thromboembolism at any age • Known thrombogenic mutations e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies • Cardiomyopathy with impaired cardiac function • Atrial fibrillation Neurological Conditions • Current or past history of migraine with aura at any age • Migraine without aura; when first attack occurred on a method of contraception containing an oestrogen • Multiple sclerosis with prolonged immobility • Zoely® and desogestrel containing products – individuals with a meningioma or a history of meningioma Cancers • Past or current history of breast cancer, or currently being treated for breast cancer • Undiagnosed breast mass (for initiation of method only) • Carrier of known gene mutations associated with breast cancer e.g. BRCA1 or 2 • Malignant liver tumour (hepatocellular carcinoma) Gastro-intestinal Conditions • Viral hepatitis, acute or flare (for initiation only) • Benign liver tumour (hepatocellular adenoma) • Severe decompensated cirrhosis • Gallbladder disease; currently symptomatic or medically managed. • Any bariatric or other surgery resulting in malabsorption. • Cholestasis (related to past combined hormonal contraceptive use) Other conditions • Imminent planned major surgery (COC should be stopped at least 4 weeks prior to planned major surgery or expected period of limited mobility). • Diabetes with end organ disease (retinopathy, nephropathy, neuropathy) • Positive anti-phospholipid antibodies (with or without systemic lupus
--	--

	erythematosus) • Organ transplant, with complications • Known chronic kidney disease (all stages) or acute renal failure • Acute porphyria • Individuals requiring control of problematic bleeding caused by the subdermal implant, IUD or medroxyprogesterone injection Medicines • Individuals using enzyme-inducing drugs/herbal products or within 4 weeks of stopping them • Individuals taking any interacting medicines (other than enzyme inducers), including any medicines purchased as detailed in the current British National Formulary (BNF) or the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website • Contraindicated in concomitant use with the medicinal products containing glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir.
Cautions/Circumstances in which further advice should be sought (including any relevant action to be taken)	• If the individual is less than 16 years of age an assessment based on Fraser guidelines must be made and documented. • If the individual is less than 13 years of age, the healthcare professional should speak to local safeguarding lead and refer to the policy Safeguarding Children and Young People • Discuss with an appropriate prescriber any medical condition or medication of which the healthcare professional is uncertain. • Individuals taking lamotrigine should be advised that COC may interact with lamotrigine; this could result in reduced seizure control or lamotrigine toxicity. • Consideration should be given to the current disease status of those with severe malabsorption syndromes, such as acute/active inflammatory bowel disease or Crohn's disease. Although the use of oral contraception is not contra-indicated it may be less effective and so these individuals should be advised to consider long-acting reversible contraception (LARC). • Individuals should be advised that it is possible that medications that induce diarrhoea and/or vomiting (e.g. orlistat, laxatives, GLP-1 agonists) could reduce the effectiveness of COC. • Individuals receiving GLP-1 agonists must use effective contraception. Note some GLP-1 agonists may reduce the effectiveness of oral contraception and additional barrier methods are recommended - refer to the specific product SmPC which can be accessed on the EMC and CoSRH advice regarding GLP 1 agonists and contraception. Provide CoSRH patient information leaflet (PIL). • Sick cell trait - there is a small increase in the risk of VTE with sickle cell trait, therefore alternatives to CHC should be prioritised. • Offer LARC to all individuals, in particular those with medical conditions for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan. • If an individual is known to be taking a medication which is known to be harmful to pregnancy, a highly effective form of contraception is recommended. Highly effective methods include the LARC methods: copper IUD, LNG-IUD and implant. If a LARC method is unacceptable/unsuitable and a COC is chosen, then an additional barrier method of contraception is advised. See CoSRH statement: Contraception for women using known teratogenic drugs (Feb 2018) FSRH.

Action to be taken if the individual is excluded or declines treatment	• Explain the reasons for exclusion to the individual and document in the consultation record • Record reason for declining treatment in the consultation record • Where required refer the individual to a suitable health service provider and/or provide them with information about further options.
---	--

Description of treatment:	
Name, strength and formulation medicine	• This is a list of generic combined oral contraceptive pills. • This PGD does not restrict which brands can be supplied – refer to the BPAS formulary for the list of available products • See http://www.mhra.gov.uk/spc-pil/ or http://www.medicines.org.uk for further information and further brand information including full details of adverse effects and interactions. • COC containing ≤30micrograms ethinylestradiol in combination with levonorgestrel or norethisterone is a reasonable first-line choice of CHC to minimise cardiovascular risk. <u>Monophasic</u> • Ethinylestradiol 20micrograms and desogestrel 150micrograms • Ethinylestradiol 20micrograms and drospirenone 3mg • Ethinylestradiol 20micrograms and gestodene 75micrograms • Ethinylestradiol 30micrograms and desogestrel 150micrograms • Ethinylestradiol 30micrograms and drospirenone 3mg • Ethinylestradiol 30micrograms and gestodene 75micrograms • Ethinylestradiol 30micrograms and levonorgestrel 150micrograms • Ethinylestradiol 35micrograms and norgestimate 250micrograms • Ethinylestradiol 35micrograms and norethisterone 500micrograms • Ethinylestradiol 35micrograms and norethisterone 1mg • Mestranol 50microgram and norethisterone 1mg tablets <u>Monophasic every day</u> • Ethinylestradiol 20micrograms and drospirenone 3mg + 7 inactive • Ethinylestradiol 30micrograms and gestodene 75micrograms + 7 inactive • Ethinylestradiol 30micrograms and levonorgestrel 150micrograms + 7 inactive • Estradiol (as hemihydrate) 1.5mg and nomegestrol acetate 2.5mg + 4 inactive <u>Phasic</u> • Ethinylestradiol 30/40/30micrograms and levonorgestrel 50/75/125micrograms • Ethinylestradiol 35micrograms and norethisterone 0.5/1mg <u>Phasic every day</u> • Estradiol valerate 3/2/2/1mg + dienogest 0/2/3/0mg + 2 inactive • Ethinylestradiol 30/40/30 micrograms and levonorgestrel 50/75/125micrograms + 7 inactive

Legal category	POM																								
Route / method of administration	Oral																								
Indicate any off-label use (if relevant)	Best practice advice given by College of Sexual and Reproductive Healthcare (CoSRH) is used for guidance in this PGD and may vary from the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website This PGD includes inclusion criteria, exclusion criteria and dosage regimen which are outside the market authorisation for many of the available products, but which are included within CoSRH guidance. Specifically: the use of tailored COC regimen is outside the manufacturer's licence but is supported by the College of Sexual & Reproductive Healthcare (CoSRH). The regimes detailed within this PGD are permitted under this PGD. Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected medicines for use lies with pharmacy/Medicines Management. Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/parent/carer that the medicine is being offered in accordance with national guidance but that this is outside the product licence.																								
Dose and frequency of administration	CoSRH guidance states that COC can either be taken following a standard or tailored regimen. Individuals should be given information about both standard and tailored COC regimen to broaden contraceptive choice. <u>Monophasic COC products/regimen</u> - Monophasic COC can either be taken as a standard regimen or in a tailored regimen depending on the choice of the individual. - The regimens which can be advised are detailed below: <table><tr><th>Type of regimen</th><th>Period of COC use</th><th>Hormone (pill) free interval</th></tr><tr><td colspan="3">Standard use</td></tr><tr><td>Standard use</td><td>21 days (21 active pills)</td><td>7 days</td></tr><tr><td colspan="3">Tailored use</td></tr><tr><td>Shortened hormone-free interval</td><td>21 days (21 active pills)</td><td>4 days</td></tr><tr><td>Extended use (tri-cycling)</td><td>9 weeks (3x21 active pills)</td><td>4 or 7 days</td></tr><tr><td>Flexible extended use</td><td>Continuous use (≥21 days) of active pills until breakthrough bleeding occurs for 3–4 days</td><td>4 days</td></tr><tr><td>Continuous use</td><td>Continuous use of active pills</td><td>None</td></tr></table>	Type of regimen	Period of COC use	Hormone (pill) free interval	Standard use			Standard use	21 days (21 active pills)	7 days	Tailored use			Shortened hormone-free interval	21 days (21 active pills)	4 days	Extended use (tri-cycling)	9 weeks (3x21 active pills)	4 or 7 days	Flexible extended use	Continuous use (≥21 days) of active pills until breakthrough bleeding occurs for 3–4 days	4 days	Continuous use	Continuous use of active pills	None
Type of regimen	Period of COC use	Hormone (pill) free interval																							
Standard use																									
Standard use	21 days (21 active pills)	7 days																							
Tailored use																									
Shortened hormone-free interval	21 days (21 active pills)	4 days																							
Extended use (tri-cycling)	9 weeks (3x21 active pills)	4 or 7 days																							
Flexible extended use	Continuous use (≥21 days) of active pills until breakthrough bleeding occurs for 3–4 days	4 days																							
Continuous use	Continuous use of active pills	None																							

	- For the monophasic regimen detailed above a single tablet is to be taken at the same time each day starting on day 1-5 of the menstrual cycle with no need for additional precautions. - Individuals should have access to clear information (either written or digital) to support tailored COC use. <u>Monophasic everyday, phasic and phasic everyday COC products/regimens</u> - For monophasic everyday, phasic and phasic everyday regimens a single tablet is to be taken at the same time each day starting on day 1-5 of the menstrual cycle with no need for additional precautions. The exceptions to this are: - Qlaira®, which should be started on day 1, or if not, additional precautions should be used for 9 days after starting. - Zoely®, which should be started on day 1, or if not, additional precautions should be used for 7 days after starting. - Thereafter follow manufacturer's instructions for individual product use. <u>For all COC products/regimens</u> - COC can be started at any time after day 5 of the menstrual cycle if it is reasonably certain that the individual is not pregnant. Additional precautions are then required for 7 days after starting (9 days for Qlaira®) - When starting or restarting the COC as quick start after levonorgestrel emergency contraception, additional contraception is required for 7 days and a pregnancy test should be performed 21 days after the last unprotected sexual intercourse. - In line with CoSRH guidance individuals using hormonal contraception should delay restarting their regular hormonal contraception for 5 days following ulipristal acetate use. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised until fully effective. For COC this is 7 days after re-starting this method, (9 days for Qlaira®). - If, in a current user of 30mcg EE/LNG COC, two to seven pills are missed in the first week of pill taking, it may be appropriate to offer UPA-EC and restart COC on a quick starting basis. The individual should be referred to a prescriber in this specific circumstance and is excluded from supply of UPA-EC using PGD.as detailed in the FSRH Response to study: Banh, et al (November 2020) FSRH - For guidance on changing from one contraceptive method to another, and when to start after an abortion and postpartum, refer to CoSRH - Switching or Starting Methods of Contraception and CoSRH Clinical Guideline: Contraception after Pregnancy - COC can be safely started immediately at any time after abortion. If started within 5 days after abortion (or within 1 day for Qlaira® or Zoely®), no additional contraceptive precautions are required. If started after this, 7 days of additional contraceptive precautions are required (9 days for Qlaira®).
Duration of treatment	For as long as the individual requires COC and has no contraindications to its use.
Quantity to be supplied	Maximum of three months' supply in appropriately labelled original packs. For all supplies be aware that the regimen to be taken may not be reflected in the dosage information printed on the product packaging or within the supplied PIL – ensure full details of regimen to be followed are supplied.

Storage	Medicines must be stored securely according to national guidelines, in line with the BPAS Medicines Management policy Medicines Management Policy and in accordance with the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website
Drug interactions	Individuals concurrently prescribed enzyme inducing medicines/herbal products or within 4 weeks of stopping them are excluded from treatment under this PGD and must be referred to an appropriate prescriber: All concurrent medications, including those purchased should be considered for interactions. A detailed list of drug interactions is included in the individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website and the BNF Refer also to FSRH guidance on drug interactions with hormonal contraception Concomitant use with the medicinal products containing containing glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir is contraindicated. See Liverpool HEP Interactions Seek advice from an appropriate clinician/Medicines Advisory Service if required.
Identification and management of adverse reactions	A detailed list of adverse reactions is included in individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website or the BNF The following possible adverse effects are commonly reported with COC (but may not reflect all reported adverse effects): • Nausea • Breast tenderness • Headache and migraine • Temporary disturbances of bleeding patterns • Change in mood including depression • Fluid retention • Change in libido • Skin changes including acne Serious adverse effects - these are less common, but the risks should be discussed with the individual: • Venous thromboembolic events • Arterial thromboembolic disorders (including ischaemic heart disease) • Strokes (e.g. transient ischaemic attack, ischaemic stroke, haemorrhagic stroke) • Hypertension
Management and reporting procedure for adverse reactions	• Healthcare professionals and individuals/carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme on: http://yellowcard.mhra.gov.uk • Record all adverse drug reactions (ADRs) in the individual's clinical record. • Report via organisation incident policy. Insight

Written information and further advice to be given to the individual	• Provide patient information leaflet (PIL) provided with the original pack. • Individuals should be informed about the superior effectiveness of LARC. • Individuals should be provided with written information or a link to a trusted online resource to support safe, effective COC use. • Explain mode of action, side effects, and benefits of the medicine. • Advise on action if vomiting or severe diarrhoea occurs and missed pill advice- see FSRH Clinical Guideline: Combined Hormonal Contraception (January 2019, amended October 2023) CoSRH. • Advise about the risks of the medication, including failure rates and serious side effects and the actions to be taken noting that the risks of using COC could outweigh the benefits. • In line with CoSRH Guideline Quick Starting Contraception individuals using hormonal contraception should delay restarting their regular hormonal contraception for 5 days following ulipristal acetate use. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised until fully effective. For COC this is 7 days after re-starting this method, (9 days for Qlaira®). • If, in a current user of 30mcg EE/LNG COC, two to seven pills are missed in the first week of pill taking, it may be appropriate to offer UPA-EC and restart COC on a quick starting basis. The individual should be referred to a prescriber in this specific circumstance and is excluded from supply using PGD for UPA-EC as detailed in FSRH Response to study: Banh, et al (November 2020) FSRH • Where COC is supplied ahead of abortion treatment, advise patient that if they choose to continue with their pregnancy, the contraception should not be started. If abortion treatment failure occurs after starting the COC and a decision to continue the pregnancy is made, it should be stopped. The BPAS unit should be informed, and any unused COC should be returned to a BPAS unit or pharmacy for disposal. • Serious symptoms: the individual should stop taking the COC and seek medical help urgently if they experience calf swelling, heat or pain in the calf, shortness of breath, chest pain or haemoptysis. The individual should seek advice if they experience their first ever migraine or develops aura with existing migraine. • Individuals should be advised that current use of COC is associated with a small increased risk of breast cancer which reduces with time after stopping COC. • Individuals should be advised that current use of COC for more than 5 years is associated with a small increased risk of cervical cancer; the risk of which reduces over time after stopping COC and is no longer increased by about 10 years after stopping. • Individuals should be advised that current use of COC is associated with an increased risk of VTE/ATE. • Individuals using COC should be advised about reducing periods of immobility during travel. • Individuals trekking to high altitudes (above 4500 m or 14500 feet) for periods of more than 1 week may be advised to consider switching to a safer alternative contraceptive method. • Individuals should be advised to stop COC and to switch to an alternative contraceptive method at least 4 weeks prior to planned major surgery or expected periods of limited mobility. • Advise that non enzyme inducing antibiotics do not interact with COC and if these are prescribed COC should be continued as normal with no
--	--

	additional precautions required. • Provide CoSRH PIL on GLP-1 agonists and contraception as appropriate (see cautions). • Offer condoms and advice on safer sex practices and possible need for screening for sexually transmitted infections (STIs) • Ensure the individual has contact details of local services/sexual health services. • Advise individual to seek advice from a pharmacist, doctor or other prescriber before starting any new medications including those purchased. • Offer relevant BPAS patient information booklet relevant to their treatment, including Aftercare information.
Advice/ follow up treatment	• The individual should be advised to seek medical advice in the event of an adverse reaction. • The individual should be encouraged to tell all clinicians that they are taking the supplied medication in the event of other medication/s being prescribed. • The individual should seek further advice if they have any concerns. • Review prior to BPAS supply running out and then at least annually by GP or sexual and reproductive health services
Records	The following must be recorded in the patient records in line with the BPAS' Record Keeping policy Record Keeping, using black ink if written: • The consent of the individual and ○ If individual is under 13 years of age record action taken ○ If individual is under 16 years of age document capacity using Fraser guidelines. ○ If individual is under 16 years of age and not competent, record action taken ○ If individual over 16 years of age and not competent, record action taken • If individual not treated under PGD record action taken • Name of individual, address, patient BPAS identification number, date of birth • Relevant past and present medical and sexual history • Relevant medication history (to include over the counter, herbal medications, supplements and recreational drug use) • Examination findings where relevant • Any known allergies and nature of reaction • Name of registered health professional operating under the PGD • Name of medication supplied • Date of supply • Dose supplied • Quantity supplied, including batch number and expiry date in line with BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines • Advice given, including advice given if excluded or declines treatment • Details of any adverse drug reactions and actions taken • Advice given about the medication including side effects, benefits, and when and what to do if any concerns • Any referral arrangements made • Any supply outside the terms of the product marketing authorisation • Recorded that supply is via Patient Group Direction (PGD) Records should be signed and dated (or password-controlled e-records) and securely kept for the defined period as specified in the BPAS PGD policy.

	Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines All records should be clear, legible and contemporaneous. A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with the BPAS PGD policy. Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines
--	--

Key References	
Key references (accessed December 2025)	• Electronic Medicines Compendium http://www.medicines.org.uk/ • Electronic BNF https://bnf.nice.org.uk/ • NICE Medicines practice guideline “Patient Group Directions” https://www.nice.org.uk/guidance/mpg2 • College of Sexual and Reproductive Healthcare (2019, amended 2020) Combined Hormonal Contraception FSRH Clinical Guideline: Combined Hormonal Contraception (January 2019, amended October 2023) FSRH • College of Sexual and Reproductive Health Drug Interactions with Hormonal Contraception – May 2022 FSRH CEU Guidance: Drug Interactions with Hormonal Contraception (May 2022) FSRH • College of Sexual and Reproductive Healthcare (2025) UK Medical Eligibility Criteria for Contraceptive Use. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) CoSRH • College of Sexual and Reproductive Healthcare Clinical Guideline: Quick Starting Contraception (April 2017) FSRH Clinical Guideline: Quick Starting Contraception (April 2017) FSRH • CoSRH Clinical Guideline: Problematic Bleeding with Hormonal Contraception (July 2015) FSRH Clinical Guideline: Problematic Bleeding with Hormonal Contraception (July 2015) FSRH • CoSRH CEU Statement: Response to Recent Publication Regarding Banh, et al. (November 2020) The effects on ovarian activity of delaying versus immediately restarting combined oral contraception after missing three pills and taking ulipristal acetate 30 mg • CoSRH CEU statement: Use of desogestrel and risk of intracranial meningioma (July 2025) Use-of-desogestrel-and-risk-of-intracranial-meningioma.pdf • CoSRH statement: Glucagon-like peptide-1 (GLP-1) agonists and oral contraception (January 2025) CEU-statement-GLP-1-agonists-and-contraception.pdf • CoSRH: GLP-1 agonists and contraception Patient information leaflet (February 2025) Patient-information-GLP-1-agonists-and-contraception.pdf • BPAS Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines. Updated November 2024 Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines • BPAS Safeguarding Adults at Risk policy. Updated July 2025 Safeguarding Adults at Risk • BPAS Safeguarding Children and Young People policy. Updated August 2025 Safeguarding Children and Young People

	• BPAS Medicines Management Policy. Updated May 2025. Medicines Management Policy • BPAS Record Keeping Policy. Updated December 2023. Record Keeping
--	--

Audit and ongoing monitoring of this PGD

Please refer to the 'Audit' section of the BPAS Patient Group Direction policy for additional guidance in relation to PGD audit. [Patient Group Directions \(PGDs\) and Other Legal Mechanisms for Supply of Medicines](#)

The PGD audit tool is available here: [British Pregnancy Advisory Service - Audit Tools - All Documents \(sharepoint.com\)](#).

Appendix A: Approved Practitioner List

**Patient Group
Direction
(PGD) name:**

Supply of a combined oral hormonal contraceptive (COC) in BPAS clinics v3.2

Valid from: 01/06/2026

Expiry: 31/03/2029

Before signing this PGD, check that the document has had the necessary authorisations. Without these, this PGD is not lawfully valid.

Registered health professional

By signing this patient group direction, you are indicating that you agree to its contents and that you will work within it and agree with the following statement:

'I confirm that I have read and understood the content of this Patient Group Direction and that I am willing and competent to work to it within my professional code of conduct.'

Patient group directions do not remove inherent professional obligations or accountability.

It is the responsibility of each professional to practice only within the bounds of their own competence and professional code of conduct.

Name (print)	Designation	Registration number	Signature	Date

Authorising manager

<i>I confirm that the registered health professionals named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of BPAS for the above-named health care professionals who have signed the PGD to work under it.</i>				
Name	Position	BPAS Treatment Unit	Signature	Date:

Note to authorising manager.

- Score through unused rows in the list of registered health professionals to prevent additions post managerial authorisation.
- If registered health professional signatures need to be added at a later date, e.g. due to staffing changes, a separate Approved Practitioner List must be signed, ensuring the correct PGD name and version is detailed.
- This authorisation sheet should be retained to serve as a record of those registered health professionals authorised to work under this PGD for the period specified in the BPAS PGD policy.
- This list must be stored by the Treatment Unit in a designated folder and be available for immediate inspection, alongside any training / competency records. If a registered professional works across multiple sites, they must sign the Approved Practitioner List for each PGD at each BPAS site where they will use the PGD.