An evaluation of the Pharmacy First Service for Emergency Hormonal Contraception

Dr S Martin

Dr J Brown

Dr G Fleming

Prof. M Scott

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Contents

List of Abbreviations

Acronym	Full term
COC	Combined oral contraceptive
CPNI	Community Pharmacy Northern Ireland
Cu-IUD	Copper Intrauterine device
DH	Department of Health
EHC	Emergency hormonal contraception
LCG	Local Commissioning Group
LMP	Last menstrual period
LNG-EC	Levonorgestrel
MOIC	Medicines Optimisation Innovation Centre
OOH	Out of Hours
OTC	Over the Counter
POM	Prescription only medicine
POP	Progesterone only pill
SPPG	Strategic Performance and Planning Group
STI	Sexually Transmitted Infection
UPA-EC	Ulipristal Acetate
UPSI	Unprotected sexual intercourse

1. Overview of Pharmacy First Service for Emergency Hormonal Contraception

A core theme of the 'Health and Wellbeing 2026: Delivering Together'[1] strategy and the Community Pharmacy Strategic Plan 2030[2] is an enhanced role for the primary and community care sector in delivering a new model of person-centred care. Primary and community care is considered to be the appropriate setting to meet the majority of the health and social care needs of the population.

A Pharmacy First Service is a service whereby patients are encouraged to consult with a participating community pharmacy rather than their GP for a defined list of common conditions. The pharmacist will give advice and if appropriate, supply medication from an agreed formulary or refer the patient to the GP if necessary. Medicines, when deemed necessary, are supplied free of charge.

Improving the sexual health and wellbeing of the population is one of the public health priorities for Northern Ireland. In response to this priority the Pharmacy First Service for emergency hormonal contraception (EHC)[3] was introduced to ensure that women and young people have timely access to EHC when clinically indicated.

1.1 Methods of EHC

The Copper Intrauterine device (Cu-IUD), sometimes referred to as "the coil", is the most effective method of emergency contraception. A Cu-IUD cannot be inserted in a community pharmacy setting. Where insertion of a Cu-IUD is not possible, the alternative is oral EHC.

There are two types of oral EHC, Ulipristal Acetate (UPA-EC) and Levonorgestrel (LNG-EC). UPA-EC has been demonstrated to be more effective than LNG-EC.[4]

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[1] https://www.health-ni.gov.uk/publications/health-and-wellbeing-2026-delivering-together
[2] Community Pharmacy Strategic Plan 2030 (health-ni.gov.uk)
[3] Pharmacy First Service for Emergency Hormonal Contraception (EHC) Service Specification - https://bso.hscni.net
[4] The faculty of sexual and reproductive healthcare (FSRH) guideline Emergency Contraception fsrh-guideline-emergency-contraception03dec2020-amendedjuly2023-11jul.pdf

Prior to the introduction of the Pharmacy First Service for EHC, patients could only obtain EHC from community pharmacy by making an 'Over the Counter' (OTC) purchase or via a prescription issued by a GP Practice. Before the Pharmacy First Service for EHC commenced, it was estimated that 21,600 EHC products were purchased and 6,000 EHC products were supplied via GP Prescription each year.

1.2 Pharmacy First Service for EHC

The Pharmacy First Service for EHC was commissioned by the Strategic Performance and Planning Group (SPPG) of the Department of Health (DH) and commenced in July 2022.

The service is open to women and young people aged 13 years or over who are registered with a GP in Northern Ireland and aims to provide, where clinically appropriate, EHC in circumstances where potential failure of regular contraceptive method is recognised, or unprotected sexual intercourse (UPSI) has taken place.

The objectives of the service, as outlined in the service specification are:

- To provide information on emergency contraception, including offering advice on the superior effectiveness of Cu-IUD and signposting for this as appropriate.
- To increase knowledge, especially amongst younger women, of the availability of EHC and hormonal contraception (i.e. Desogestrel 75 microgram tablets) from community pharmacies.
- To improve access to EHC and sexual health advice.
- To increase the appropriate use of EHC by women and young people who have had UPSI / contraception failure; and reduce the incidence of unplanned pregnancies.
- To ensure treatment is in line with best practice and NI formulary.[5]
- To refer women and young people, as appropriate, into mainstream contraceptive services.

[5] NI formulary – Emergency contraception: 7.3.5 Emergency contraception | NI Formulary

- To increase the knowledge of risks, such as Sexually Transmitted Infections (STIs), associated with UPSI.
- To encourage the use of condoms amongst women and young people presenting for EHC, to enable them to protect themselves against STIs and unplanned pregnancy. Condoms are available free of charge at local sexual health clinics.
- To refer women and young people who may be at risk of having contracted a STI to an appropriate service.

Spending objectives as outlined in the business case for funding are:

	Objective	**Baseline**	**Target**	**Specific actions to achieve objective**	**How will the customer be better off? (i.e. Outcomes)**
1.	To increase the appropriate use of EHC by women and young people who have had unprotected sex / contraception failure; and reduce the incidence of unplanned pregnancies.	0 - service not yet commissioned	Up to 27,600 patients including those individuals who currently access this service via their GP Practice	Provision of free effective EHC products	Numbers of patients receiving EHC Proportion of patients receiving the first line form of EHC compared to baseline (prescribing data for 6 months before introduction of the service) Feedback from service users (from service user feedback survey)
2.	To provide 3 month bridging contraception where appropriate	0 - service not yet commissioned	Up to 13,800 patients	Provision of free bridging contraception where deemed appropriate following consultation	Number of patients receiving 3 months bridging contraception
3.	To refer women and young people, as appropriate, into other services e.g. GP, GUM, SH Clinic, Gateway Team	0 - service not yet commissioned	Not possible to set target - each referral will be based on clinical need of the individual patient	Refer where appropriate	Number of patients referred

2. Evaluation

As part of an agreed business plan with the DH, the regional Medicines Optimisation Innovation Centre (MOIC) was asked to complete an evaluation of the Pharmacy First Service for EHC.

Initially, MOIC was to evaluate user satisfaction with this initiative via Service User questionnaires. However, MOIC's role in the evaluation of the service was subsequently expanded to conduct a full evaluation of the service including an analysis of a comprehensive sample of consultation forms.

2.1 Evaluation methodology

The following outcome measurement and analysis was undertaken:

- *Pharmacy First Consultation Form*

During consultations for the supply of EHC, community pharmacists complete a consultation form. SPPG obtained a database of consultation activity for all participating pharmacies across all Local Commissioning Group (LCG) areas in Northern Ireland as of the end of March 2024. A sampling framework was developed by MOIC whereby pharmacies were ranked and categorised in terms of volume of consultations completed. A random sample of 10% was selected for analysis from each category taking into consideration geographical spread.

The process for data sharing detailed below was then followed:

1. The random sample of consultation forms to be called in from selected community pharmacies was shared with SPPG.
2. SPPG retrieved the selected consultation forms from the community pharmacies.
3. Staff at SPPG redacted the consultation forms to remove patient identifiable data and each consultation form was assigned a unique identifier. Redacted information was stored on an electronic database held by SPPG.
4. Redacted consultation forms were shared with MOIC via Egress or as paper copies.

5. Data from the consultation forms were inputted into an electronic database for analysis by MOIC staff.

Analysis of consultation form data was completed using Microsoft Excel.

There were two versions of the consultation form for the Pharmacy First Service for EHC. Version 1 was used from commencement of the service until end of March 2024. SPPG then revised the consultation form to gather further information on the ages of those using the service. Other minor revisions were also made to facilitate record-keeping during the consultation. Community pharmacies were asked to use the new Version 2 consultation form from 1st April 2024. In order to achieve the sample size for the evaluation both Version 1 and Version 2 forms were accepted for analysis. However, pharmacies were asked to send in their most recent consultations. For some sections of the evaluation data was only available from Version 2 forms, this is indicated in the relevant sections of this report.

Versions 1 and 2 of the consultation form are included in Appendix 1 and a data flow map, and privacy notice for the service are included in Appendices 2 and 3.

- *Service user feedback*

Stakeholder feedback was obtained using a questionnaire that was co-designed by MOIC, SPPG and CPNI. The questionnaire was launched as an online survey via Citizens Space. Service users were asked to complete the survey after their consultation using a QR code link.

Data was exported from Citizens Space to Microsoft Excel and descriptive statistics were used to summarise responses.

The service user questionnaire is included in Appendix 4.

2.2 Interim analysis

An interim analysis of the consultation form data by MOIC identified a number of issues which will be discussed in detail later in this report. Following discussion with SPPG

and Community Pharmacy Northern Ireland (CPNI) it was agreed that an in-depth analysis of data by MOIC was not possible. Instead, MOIC agreed to produce a report summarising data from the consultation forms and points of learning.

3. Results – consultation forms

Within the results section figures have been rounded to one decimal place so may not sum precisely to 100.0% in some tables.

3.1 Sampling of consultation forms

SPPG obtained a database of consultation activity for all participating pharmacies as of the end of March 2024. At that time 33,419 consultations had been conducted across 378 pharmacies.

Pharmacies were ranked and categorised in terms of volume of consultations completed and a random sample of 10% was selected from each category taking into consideration geographical spread. The sample requested was 3046 consultation forms from 60 pharmacies. In addition, all participating pharmacies were asked to return all consultation forms for patients aged under 16.

LCG	Sample requested		Sample returned*
Belfast	882	29.0%	923
Northern	447	14.7%	486
Southern	565	18.5%	621
South Eastern	536	17.6%	529
Western	616	20.2%	669
Total	**3046**	**100%**	**3228**

*Sample returned includes records for service users aged under 16

As stated earlier, during the process of data entry, MOIC staff noted a number of issues relating to data quality and a short interim analysis was completed before all forms were added to the database. The interim analysis included consultation forms

from all LCGs except for those from the South Eastern LCG, which had not been received by MOIC at that stage. When MOIC received consultation forms returned by the South Eastern LCG (n= 529) they were reviewed by two senior members of MOIC staff and it was ascertained that the data quality issues identified were also present in this sample. Following consultation with SPPG and CPNI it was agreed that MOIC would not proceed with inputting data from the South Eastern LCG data and the evaluation would be based on data from the remaining four LCG areas.

The final sample included for analysis consisted of n=2,699 consultation forms. Of these, approximately a third were Version 1 forms (n=791/2699) and two thirds were Version 2 forms (n=1908/2699).

3.2 Referral pathways into the Pharmacy First Service for EHC

The majority of patients had self-referred into the Pharmacy First Service for EHC, with 5% of individuals referred into the service via alternative routes i.e. via Pharmacist, GP, Out of Hours (OOH) or other route.

Referral pathway	No. of Patients	% of Patients
Self-referral	2483	92.0%
Pharmacist	97	3.6%
GP practice	33	1.2%
OOH	2	0.1%
Police Service NI	1	0.1%
Unknown	83	3.1%
Total	**2699**	**100%**

3.3 Age range of patients accessing EHC service

Over 40% of the sample were aged between 16 and 25 years old. Due to potential issues arising from redaction 8% of the sample was classified as older than 16 years of age.

Age range	No. of Patients	% of Patients
13-15	142	5.3%
16-20	548	20.3%
21-25	573	21.2%
26-30	411	15.2%
31-35	267	9.9%
36-40	196	7.3%
41-50	165	6.1%
51-60	2	0.1%
>16	217	8.0%
Unknown	178	6.6%
Total	**2699**	**100%**

3.4 Age of partner where patient age was under 16 years old

All pharmacists providing the service had received training on the mandatory reporting requirements relating to sexual offences, including contacting the Police Service NI in cases where a patient was aged under 16 years old and reported their sexual partner was aged 18 years or over. The Police Service NI were already involved with the one patient for whom this was the case.

Age of partner for <16s	No. of Patients	% of Patients
13	2	1.4%
14	23	16.2%
15	71	50.0%
16	25	17.6%
17	5	3.5%
> 18	1	0.7%
Unknown	15	10.6%
Total	**142**	**100%**

3.5 Fraser competence

Fraser guidelines help people who work with children to balance the need to listen to children's wishes with the responsibility to keep them safe. The Fraser guidelines apply specifically to advice and treatment about contraception and sexual health.

Within the service specification for the Pharmacy First Service for EHC it states that if a young person is believed to be under 16 years of age, the pharmacist must assess their 'Fraser Competence'. The service specification also states that the discussion with the young person should be fully documented using the Fraser competency form and should include an assessment of the young person's maturity to understand the proposed treatment.

For the 142 patients who were aged under 16 years 133 had Fraser competency forms completed of which 72 forms were submitted to MOIC for analysis. Seven consultation forms stated there was no Fraser competency form completed and two were left blank.

Of those under 16 (n=142), 128 were classified as Fraser competent, two as not Fraser competent and 12 were unanswered. The two clients classified as not Fraser competent were supplied EHC. The consultation form did not provide the opportunity for pharmacists to explain the rationale for decisions of this kind.

3.6 Safeguarding issues by age range

Within the service specification, pharmacists are advised that the possibility of physical, sexual and emotional harm including coercion and/or exploitation should be considered when a woman or young person presents for EHC.

In total, it was indicated on 16 consultation forms that there were safeguarding issues (n=16/2699; 0.6%). Further details were provided on four of these forms.

For the four cases where details of the safeguarding concern had been recorded, the client was already involved with other professionals (e.g. Police Service NI, Rowan centre, hospital) before coming to community pharmacy to access EHC. The

safeguarding section had not been ticked in approximately 20% of consultation forms (n=532/2699; 19.7%).

3.7 Reason for EHC request

Pharmacists were asked to record the reason for the EHC request. The majority of patients, nearly 70%, requested EHC due to UPSI.

Reason for EHC request	No. of Patients	% of Patients
UPSI	1861	69.0%
Condom failure	585	21.7%
Missed pill	180	6.7%
Other*	25	0.9%
Unknown	48	1.8%
Total	**2699**	**100%**

*"Other", reasons included: Patient had only commenced contraceptive pill, implant out of date, late or missed contraceptive injection, Cu-IUD failed.

3.8 Oral EHC supplied

Nearly 90% of patients were supplied Ulipristal Acetate.

Oral EHC supplied	No. of Patients	% of Patients
Ulipristal Acetate 30mg x 1 tablet	2379	88.1%
Levonorgestrel 1.5mg (POM) x 1 tablet	204	7.6%
Levonorgestrel 1.5mg (POM) x 2 tablets (3mg) unlicensed indication	79	2.9%
Unknown	37	1.4%
Total	**2699**	**100%**

3.9 Suitability of supply – Ulipristal Acetate

In line with the service specification pharmacists are advised to take a full history from patients regarding their menstrual history, medication history and current contraception use in order to determine the most appropriate choice of EHC. Pharmacists are also advised to follow the College of Sexual and Reproductive Health (CoSRH) (previously known as the Faculty of Sexual and Reproductive Health (FSRH)) decision-making algorithm (Figure 1).

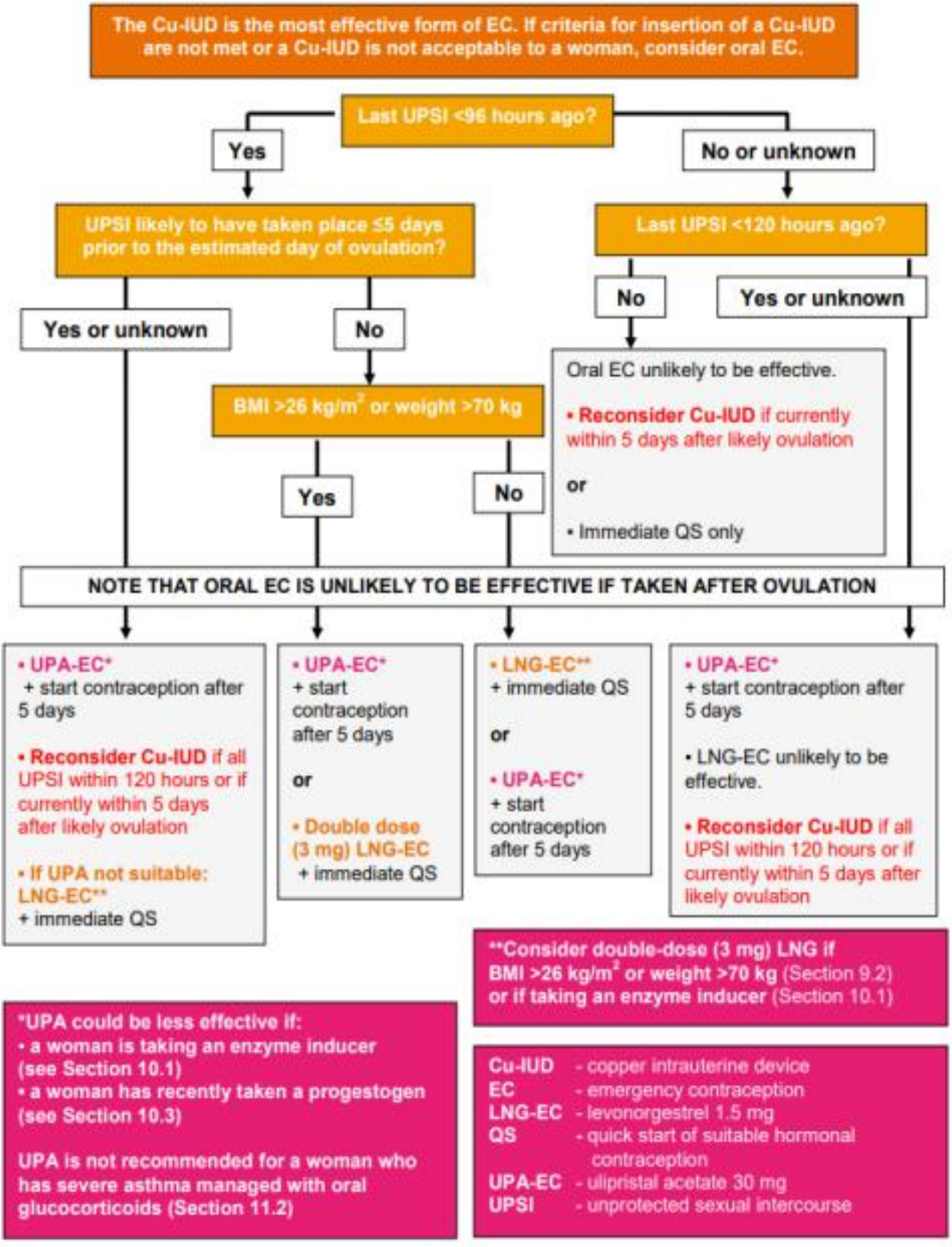


Figure 1: College of Sexual and Reproductive Health (CoSRH) decision-making algorithm.

An analysis of data recorded for menstrual history, medication history and current contraception use is presented below with a commentary on whether the data supports the choice of treatment supplied.

3.9.1 Menstrual history

The consultation form provides a section for pharmacists to record menstrual history and to use this information to provide appropriate advice regarding the likely efficacy of the EHC supplied. Information recorded within the section “menstrual history” on the consultation forms was variable and data cleansing was required to enable analysis. This is detailed below.

“Date of last menstrual period (LMP)” and “Day in cycle”

The steps in data cleansing for “date of LMP” and “day in cycle” are outlined below.

1- Cases were excluded where “date of last LMP” wasn’t recorded.
2- Cases were excluded if the “date of LMP” was recorded but was after the recorded consultation date i.e. recording error.
3- Outliers were excluded i.e. “day in cycle” was greater than day 40 if there was no corroborating information recorded on the form by the Pharmacist.
4- Cases were excluded where the variance between the recorded and excel calculated “day in cycle” was greater than 5 days.

As a result of the steps above nearly 32% of the sample was excluded from the analysis. The Microsoft Excel calculated “day in cycle” data was used for analysis to eliminate human error.

Day in cycle – range	No. of Patients	% of Patients
1-6	131	4.9%
7-11	447	16.6%
12-16	541	20.0%
17-21	364	13.5%
22-26	200	7.4%
27-31	107	4.0%
32-36	41	1.5%
37-41	4	0.1%
42-46	5	0.2%
47-51	2	0.1%
Unable to calculate	857	31.8%
Total	**2699**	**100%**

Cycle/bleeding pattern

Information recorded for the field “cycle/bleeding pattern” was variable. For data cleansing purposes, the data for this field was simplified to: irregular, regular or blank. Consultation forms were coded as “Irregular” where cycle duration was outside the range of 21-35 days or for cases where a statement had been made to indicate an irregular cycle, examples include statements such as: recent termination, perimenopausal, postpartum, recent commencement or termination of hormonal contraception, PCOS, patient unsure of cycle, or irregular. Any consultation forms where the cycle/bleeding pattern was recorded as: normal, usual, regular etc. or where the cycle duration was recorded as lasting between 21-35 days was coded as “Regular”. Approximately 10% of consultation forms had no information recorded for “cycle/bleeding pattern”.

Cycle pattern	No. of Patients	% of Patients
Regular	1855	68.7%
Irregular	580	21.5%
Unknown	264	9.8%
Total	**2699**	**100%**

Earliest likely date of ovulation

Within the service specification pharmacists are directed to calculate the earliest likely date of ovulation (estimated as the date of the start of LMP plus the number of days in the shortest cycle minus 14). It is noted that the consultation form does not provide pharmacists with a space to record this information.

Based on the data available an estimate of the percentage of the sample who were post ovulation, is approximately 26.7%. For the purpose of estimation "post ovulation" was defined as greater than or equal to day 17 in cycle.

The service specification for the Pharmacy First Service for EHC and the Patient Group Direction (PDG) for both Ulipristal Acetate and Levonorgestrel state that available evidence indicates "EHC administered after ovulation is ineffective".

Was patient informed that oral EHC is ineffective if taken after ovulation

On Version 2 consultation forms (n=1908/2699), pharmacists were asked to tick a box to confirm that the patient had been informed that oral EHC is ineffective if taken after ovulation. On over 25% of these consultation forms this box was not ticked; therefore, it is unknown if this advice was given.

Patient informed regarding effectiveness	No. of Patients	% of Patients
Yes	1381	72.4%
Unknown	527	27.6%
Total	**1908**	**100%**

3.9.2 Other UPSI or EHC this cycle

On 102 consultation forms it was indicated that the client had at least one other instance of UPSI since their LMP (n=102/2699). Of those, 35 had been supplied EHC previously this cycle.

3.9.3 Hours after UPSI

Guidance within the service specification states that oral EHC should be given and taken as soon as possible with further advice provided for patients greater than 96 and 120 hours past UPSI as shown in Figure 2.

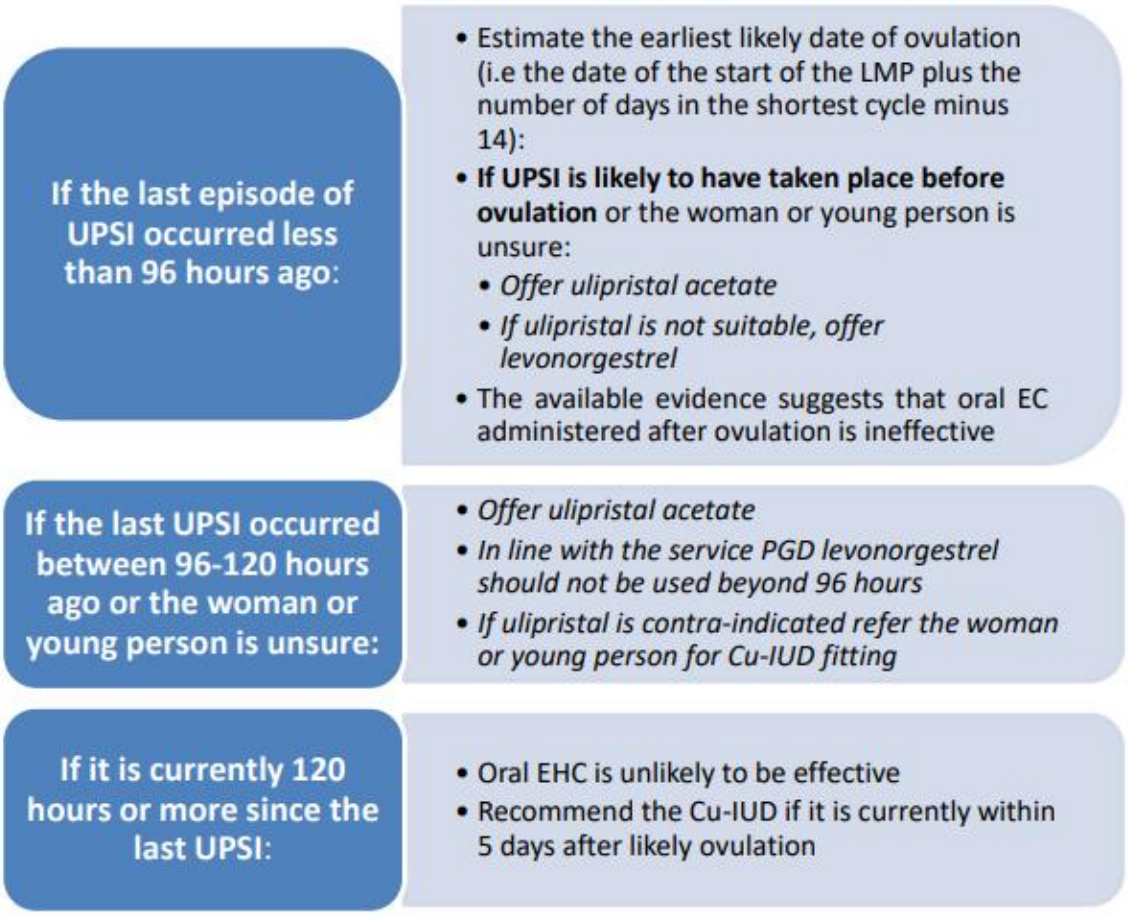


Figure 2: Guidance on supply of oral EHC in relation to hours after UPSI.

Over 60% of the sample presented for consultation within 24 hours of UPSI. Of the 25 patients who presented between 96-120 hours after UPSI, 23 (n=23/25) were supplied Ulipristal Acetate and no supply of oral EHC was recorded in the other two cases.

Ulipristal Acetate is recommended to be taken “no later than 120 hours after UPSI”. However, the five patients for whom UPSI occurred greater than 120 hours prior to the request for EHC, were supplied Ulipristal Acetate.

Hours after UPSI	No. of Patients	% of Patients
≤12	520	19.3%
13-≤24	1159	42.9%
25-≤48	578	21.4%
49-≤72	203	7.5%
73-≤96	52	1.9%
97-≤120	25	0.9%
≥121	5	0.2%
Unknown	157	5.8%
Total	**2699**	**100%**

3.9.4 Medical history

The Pharmacy First service for EHC specification describes a number of scenarios in which Ulipristal Acetate is not the preferred treatment. It states:

- Ulipristal Acetate is not suitable for use by women or young people who have severe asthma controlled by oral glucocorticoids. The antiglucocorticoid effect of UPA may affect asthma control
    - *Offer Levonorgestrel*
- Ulipristal Acetate is not suitable for use by women or young people taking antacids, proton-pump inhibitors or H2-receptor antagonists.
    - *Offer Levonorgestrel*
- If the woman or young person is taking liver enzyme-inducing drugs or is within 28 days of stopping a liver enzyme-inducing drug:

- The copper intrauterine device (Cu-IUD) is the preferred option.
- If the Cu-IUD is contraindicated or not acceptable, *offer double dose (3 mg) Levonorgestrel* to be taken as a single dose as soon as possible and within 96 hours of UPSI. Explain that this recommendation is outside the product licence and is based on expert clinical judgement.
- Ulipristal Acetate is not recommended.

The tables below show the number of patients for whom one of the following: having severe asthma controlled by oral glucocorticoids; taking antacids, proton-pump inhibitors or H2-receptor antagonists; or, taking liver enzyme-inducing drugs; was recorded on the consultation form. Cases where patients were supplied Ulipristal Acetate are highlighted under each table.

Asthma	**No. of Patients**	**% of Patients**
No	2609	96.7%
Yes	28	1.0%
Unknown	62	2.3%
Total	**2699**	**100%**

Of the 28 patients indicated as having severe asthma controlled by oral glucocorticoids 23 (n=23/28) were supplied Ulipristal Acetate.

Antacids, proton-pump inhibitors or H2-receptor antagonists	**No. of Patients**	**% of Patients**
No	2218	82.2%
Yes	86	3.2%
Unknown	395	14.6%
Total	**2699**	**100%**

Of the 86 patients indicated as taking antacids, proton-pump inhibitors or H2-receptor antagonists 34 (n=34/86) were supplied Ulipristal Acetate.

Liver enzyme	No. of Patients	% of Patients
No	1859	68.9%
Yes	18	0.7%
Unknown	822	30.5%
Total	**2699**	**100%**

Of the 18 patients indicated as taking liver enzyme-inducing drugs 13 (n=13/18) were supplied Ulipristal Acetate.

3.9.5 Current contraception

Within the service specification pharmacists are advised that if the woman or young person has recently taken or used a product containing progestogen or progesterone {e.g. for contraceptive purposes (including contraceptive pills, progestogen IUD and progestogen implant), EHC, gynaecological indications, or hormone replacement therapy}, they should be aware that the effectiveness of Ulipristal Acetate, could theoretically be reduced if the progestogen was taken in the 7 days prior to taking Ulipristal Acetate and could be reduced if the progestogen is taken in the 5 days after taking Ulipristal Acetate. In these situations, pharmacists are advised to offer Levonorgestrel (although it is unknown whether Ulipristal Acetate taken when there may still be circulating progestogen is more or less effective than Levonorgestrel).

The vast majority of patients reported that they were not using any form of regular contraception. Of the 174 cases where “Other” was selected, condom use was recorded for n=98/174 cases, no further detail was provided for n=66/174 cases and the remaining 10 cases included statements such as “barrier” or “unknown pill”.

Of those cases where the patient was using some form regular hormonal contraception (Progesterone only pill (POP), combined oral contraceptive (COC), injection, implant, IUD, patch) nearly half (n=168/340) were supplied Ulipristal Acetate. In these 168 cases the supply of Ulipristal Acetate appears to be contrary to the service specification guidance. However, it is recognised that the consultation form does not provide space for the pharmacist to document the rationale for supply of ulipristal in these cases.

Regular Contraception	No. of Patients	% of Patients
None	1953	72.4%
COC	153	5.7%
POP	128	4.7%
Implant	29	1.1%
IUD/S	14	0.5%
Injection	9	0.3%
Patch	7	0.3%
Other	174	6.4%
Unknown	232	8.6%
Total	**2699**	**100%**

3.10 Suitability of supply – Levonorgestrel

The service specification provides advice on the supply of Levonorgestrel in cases where Ulipristal Acetate is not indicated, that is, where patients have severe asthma controlled by oral glucocorticoids; take antacids, proton-pump inhibitors or H2-receptor antagonists; take liver enzyme-inducing drugs; or, where the patient has recently taken or used a progestogen containing products. In these cases, it is advised that patients are supplied:

- Levonorgestrel 1.5mg (Prescription only medicine (POM)) as a single dose as soon as possible and within 96 hours of UPSI
- Levonorgestrel 2 x 1.5mg (3mg unlicensed dose) as a single dose and within 96 hours of UPSI for clients:
    - o With a body mass index of more than 26kg/m2 or who weigh more than 70kg.
    - o Taking enzyme-inducing medicines or herbal products.

Of the 283 patients supplied Levonorgestrel (1.5mg and 3mg doses) it could be deduced from analysis of other data fields that:

- For n=54/283 patients their current medication use (i.e. use of: oral glucocorticoids; antacids, proton-pump inhibitors or H2-receptor antagonists; or, liver enzyme-inducing drugs) supported the supply of Levonorgestrel.

- Of the remaining 229 patients 159 were on some form of hormonal contraception supporting the supply of levonorgestrel.

For 26 of the remaining 70 cases the reason for supply of Levonorgestrel was recorded as: Ulipristal Acetate out of stock n=9; Weight n=7; Breastfeeding n=3; Patient wants to start other contraception quickly n=2; Patient preference n=2; Patient on Lamotrigine n=1; Patient missed contraceptive pill n=1; and, reason not clear n=1. No reason could be identified from the data recorded on the consultation form for the remaining 44 patients.

For the 37 patients (n=37/2699) where no form of EHC was recorded on their consultation form, additional information was provided in n=6 cases. The reasons stated were: not needed (n=3/37); post ovulation (n=2/37); and, chance of pregnancy (n=1/37).

3.11 Bridging contraception

The service specification states that all consultations regarding EHC should include advice regarding the importance of ongoing contraception and information about the available contraceptive methods. The pharmacist is directed to ensure that after taking EHC the woman or young person has access to her contraceptive method of choice. The guidance highlights that quick starting of suitable contraception (immediately after LNG-EC or >5 days after UPA-EC) should always be offered and follow-up pregnancy testing advised.

Bridging contraception was supplied in 7% of cases (n=192/2699; 7.1%).

3.11.1 Reasons for low uptake of bridging contraception

Patient eligibility for bridging contraception is detailed within the service specification and outlines that any woman or young person not already taking an oral contraceptive (or using other regular hormonal contraceptive) should be offered a three-month supply of POP Desogestrel via this Pharmacy First Service. Few medical conditions restrict the use of the POP, details of which are included in the service specification.

Reasons for not supplying bridging contraception (n=2507/2699; 92.9%) are outlined in the table below. On version one consultation forms there was no field for recording the reason for non-supply, which accounts for nearly 600 of the responses highlighted as "unknown" in the table below (n=597/2507; 23.8%). The other 23.1% of blank responses were from version two forms where pharmacists are asked to capture why bridging contraception was not supplied.

Reasons for non-supply of bridging contraception	**No. of Patients**	**% of Patients**
Declined	692	27.6%
Already using alternative contraception	320	12.8%
Client wishes to discuss with GP	103	4.1%
Client reports side effects from use of Desogestrel or states that they have been advised not to take	87	3.5%
Client will consider	24	1.0%
Not required	23	0.9%
Other health considerations	19	0.8%
Client "unsuitable"	18	0.7%
Client doesn't want hormonal contraception	15	0.6%
Client has recently stopped contraception	11	0.4%
Insufficient supply in dispensary	2	0.1%
Other	17	0.6%
Unknown **n=597/1176 unknown results are from version 1 consultation forms where there was no field for recording the reason for non-supply**	1176	46.9%
Total	**2507**	**100%**

Two cases (n=2/192) of apparent unsuitable supply of bridging contraception were identified: one patient was identified as having severe malabsorption syndrome and the other was confirmed as having unexplained vaginal bleeding. Within the service

specification severe malabsorption syndrome and unexplained vaginal bleeding are included in the list of medical conditions where the use of POP is restricted.

3.12 Signposting for CU-IUD

The Cu-IUD is the most effective method of emergency contraception and one of the objectives of the Pharmacy First service for EHC includes offering advice on the superior effectiveness of Cu-IUD and signposting for this as appropriate. The service specification states “all individuals should be informed that insertion of a Cu-IUD within five days of UPSI or within five days from earliest estimated ovulation is the most effective method of emergency contraception”.

From version two forms it can be shown that Cu-IUD was discussed as the most effective form of emergency contraception in 75.5% of cases.

Was Cu-IUD discussed as the most effective form of emergency contraception	No. of patients	% of patients
Yes	1441	75.5%
No	113	5.9%
Unknown	354	18.6%
Total	**1908**	**100%**

A third of patients were signposted for Cu-IUD. There is no space on the consultation forms for pharmacists to record the reasons for why patients were not signposted

Was client signposted for Cu-IUD	No. of Patients	% of Patients
No	1100	40.8%
Yes	846	31.3%
Unknown	753	27.9%
Total	**2699**	**100%**

3.13 Advice and counselling

As part of the consultation pharmacists were asked to confirm that they had: given verbal advice and counselling in line with the guidance provided in the service specification; given patients a printed copy of the “know your options” leaflet; and, asked patients to scan the QR code and complete the confidential online survey. Results shown in this section are only based on data from Version 2 forms (n=1908/2699 consultation forms).

Approximately 84% of consultation forms indicated that patients had been given verbal advice and counselling in line with guidance provided in the service specification.

Advice and counselling	No. of Patients	% of Patients
Yes	1598	83.8%
No	19	1.0%
Unknown	291	15.3%
Total	**1908**	**100%**

A similarly high percentage of patients (81.7%) were given a copy of the “know your options” leaflet.

Know your options leaflet	No. of Patients	% of Patients
Yes	1559	81.7%
No	46	2.4%
Unknown	303	15.9%
Total	**1908**	**100%**

Over 70% of patients were asked to scan the QR code and complete the confidential online survey.

Patient survey	No. of Patients	% of Patients
Yes	1380	72.3%
No	66	3.5%
Unknown	462	24.2%
Total	**1908**	**100%**

Reasons had only been recorded for three cases where the patient had not been: provided advice or counselling; given the leaflet; or, asked to complete the online survey. Reasons included: no phone; no copy of leaflet; and, no Wi-Fi available.

3.14 Onward referral

Two objectives of the service were in relation to onward referral of patients, these were:

- To refer women and young people, as appropriate, into mainstream contraceptive services.
- To refer women and young people who may be at risk of having contracted a STI to an appropriate service.

In total, 4% of patients (n=113/2699; 4.2%) were referred to another professional as an outcome of their consultation. Onward referral to sexual health clinics (n=71/113) was the most frequent referral, followed by referrals to GP (n=37/113), OOH (n=6/113) and the Police Service NI (n=2/113). Six referrals were categorised as “Other” and included referrals to: family planning; reproductive health services; and, Brae clinic in Londonderry.

Of the 113 onward referrals, “Reason for referral” was detailed in 105 cases and is summarised in the table below.

Reason for onward referral	No. of Patients	% of Patients
Cu-IUD or other contraceptive options	91	86.7%
STI screening in addition to contraceptive advice	6	5.7%
Apparent serious incident with involvement of Police Service NI or other professionals	4	3.8%
Irregular bleeding	3	2.9%
Possible termination	1	1.0%
Total	**105**	**100%**

4. Results – service user feedback

Feedback has been collected from service users of the Pharmacy First service for EHC via the online survey on an ongoing basis from commencement of the service. As of the end of March 2025 there were 500 responses in total. This figure represents less than 1% of the total number of consultations completed during this period which was 57,340. This reflects only a small proportion of patients using the service and does not provide robust evidence.

It should be noted that in the service user questionnaire the term “morning after pill” was used as a patient friendly term for EHC. This is reflected in the discussion of the results below.

4.1 Age breakdown of respondents

Over a third of responses via the online survey were from individuals aged 21-25. As may be expected there was a very low response rate, 0.2%, from individuals aged under 16 years old.

Age range	No. of responses	% of responses
13-15	1	0.2%
16-20	109	21.8%
21-25	169	33.8%
26-30	105	21.0%
31-35	53	10.6%
36-40	40	8.0%
41-50	23	4.6%
Total	**500**	**100%**

4.2 Awareness of the Pharmacy First service for EHC

When asked how they found out about the service, over half of respondents said they were made aware of the service via word of mouth from friends or family. Approximately 4% of respondents stated they were signposted to the service from another healthcare professional e.g. GP, clinic or OOHs. This finding is consistent with the data from the consultation forms which showed low referral rates into the service from GP and OOHs (1.3%).

Route into Pharmacy First service for EHC	No. of responses	% of responses
Word of mouth from friends or family	260	52.0%
Referral/Recommendation from your community pharmacy	77	15.4%
Poster / Advert / Social media such as Facebook or Instagram	30	6.0%
Referral from your GP practice	15	3.0%
Referral from other clinic (sexual health / GUM / common youth)	2	0.4%
Referral from the OOH medical centre	2	0.4%
Other - no further detail provided	114	22.8%
Total	**500**	**100%**

4.3 Prior use of EHC

When asked if they had ever needed to use EHC before, over two thirds of respondents (n=357/500; 71.4%) confirmed they had taken EHC previously.

Prior use of EHC	No. of responses	% of responses
Yes	357	71.4%
No	141	28.2%
Unknown	2	0.4%
Total	**500**	**100%**

Of those who had previously taken EHC over 60% had obtained it by purchasing EHC from the community pharmacy and over 25% had previously used the Pharmacy First service for EHC. Approximately 10% had requested 'the morning after pill' from their GP / OOHs / Common Youth or Sexual Health Clinic.

How did you get the morning after pill before?	No. of responses	% of responses
Bought it from your community pharmacy	225	63.0%
Used this service previously i.e. the Pharmacy First service for EHC	93	26.1%
Requested a prescription from your GP	22	6.2%
Contacted OOH medical centre	7	2.0%
Attended a sexual health / GUM clinic / common youth	5	1.4%
Other	5	1.4%
Total	**357**	**100%**

*Other – online service, family planning

4.4 Why did patients choose community pharmacy for this service?

When asked why they chose the Pharmacy First service for EHC over half of respondents stated that it was "easier to go to the pharmacy" and also chose

community pharmacy as they “didn’t have to book an appointment”. The fact that there was no payment for the service was ranked as the third most frequent reason for choosing community pharmacy.

Why choose community pharmacy	No. of responses	% of responses
Easier to go to pharmacy	273	54.60%
Don’t have to book an appointment	252	50.40%
No payment required for this service	214	42.80%
Private and Confidential	178	35.60%
Pharmacy opening hours suited me	149	29.80%
Recommended to me	83	16.60%
Regular customer of this pharmacy	74	14.80%
Could not get an appointment with GP	49	9.80%
Other	5	1.0%

*Other = Didn’t want to use up a GP appointment; Pharmacy was close by; and, only option opened on a Sunday.

4.5 Consultation

The vast majority of respondents stated that their consultation was conducted in a private consultation area in the pharmacy (96.4%).

Consultation area	No. of responses	% of responses
At the pharmacy in a private consultation area	482	96.4%
At the pharmacy counter	16	3.2%
Other - no further detail provided	2	0.4%
Total	**500**	**100%**

Nearly all respondents (n=492/500) confirmed that they were happy with where the consultation took place.

Happy with consultation environment	No. of responses	% of responses
Yes	492	98.4%
Unsure	6	1.2%
No	2	0.4%
Total	**500**	**100%**

Over 80% of respondents recalled that their consultation was completed in under 15 minutes.

Consultation duration	No. of responses	% of responses
Less 10 mins	172	34.4%
10-15 mins	235	47.0%
15-20 mins	80	16.0%
20-30 mins	8	1.6%
Unsure – not long	2	0.4%
Unknown	3	0.6%
Total	**500**	**100%**

When asked if they felt at ease during their consultation, over 95% of participants confirmed that they had felt at ease.

Did you feel at ease?	No. of responses	% of responses
Yes	478	95.6%
Unsure	9	1.8%
No	6	1.2%
Unknown	7	1.4%
Total	**500**	**100%**

4.6 Advice and information provided

Participants were asked whether they had been provided with advice and information as outlined in the service specification. Overall, the majority of respondents confirmed they had been provided with the necessary advice and information. Approximately 18% of respondents said that the pharmacist had not provided information on the risks

of UPSI such as STIs; and, nearly 20% of respondents stated they had not been provided with a copy of the information leaflet “Knowing your options”. However, of these 97 individuals 45 had accessed the service after November 2024 when the Know your options leaflet had been removed from circulation.

	No. of responses	% of responses
As part of the consultation did the pharmacist provide advice on the different types of Emergency Contraception, how they work and potential side effects?		
Yes	491	98.2%
No	8	1.6%
Unknown	1	0.2%
As part of the consultation did the pharmacist discuss with you the how well emergency contraception should work and what you should do if it doesn’t work?		
Yes	491	98.2%
No	6	1.2%
Not sure	1	0.2%
Unknown	2	0.4%
As part of the consultation did the pharmacist provide information on the risks of UPSI such as STIs?		
Yes	397	79.4%
No	89	17.8%
Not sure	12	2.4%
Unknown	2	0.4%
Discuss the importance of regular on-going contraception and where to access this?		
Yes	476	95.2%
No	22	4.4%
Unknown	2	0.4%
Provide you with a printed information leaflet (Knowing Your Options)?		
Yes	385	77.0%
No	97	19.4%
Not sure	17	3.4%
Unknown	1	0.2%

4.7 Bridging contraception

Approximately a third of respondents stated that they had not been offered a three-month supply of bridging contraception.

Offered/supplied bridging contraception	No. of responses	% of responses
Yes	312	62.4%
No	161	32.2%
Not sure	26	5.2%
Unknown	1	0.2%
Total	**500**	**100%**

4.8 Onward referral

Approximately 30% of respondents reported that they had been referred to other services such as: GP / OOH / GUM or Sexual health clinic / Gateway.

Onward referral	No. of responses	% of responses
Yes	151	30.2%
No	311	62.2%
Not sure	35	7.0%
Unknown	3	0.6%
Total	**500**	**100%**

Of these respondents 25 individuals provided further details on their referral with most common reasons including onward referral for: contraceptive services e.g. Cu-IUD; STI screening; or, to discuss unexplained vaginal bleeding.

4.9 If this service had not been available in the pharmacy, what would you have done?

Nearly half the participants stated that they would have bought EHC either in a community pharmacy or online if the Pharmacy First service for EHC had not been

available. Nearly 45% said they would have contacted their GP, family planning/sexual health clinic/common youth clinic, or OOH medical centre; with 6.4% of respondents saying they would have done “nothing”.

What would you have done?	No. of responses	% of responses
Bought the morning after pill in a community pharmacy or online	236	47.2%
Contacted your GP practice	144	28.8%
Attended a family planning / sexual health clinic / common youth clinic	51	10.2%
Nothing	32	6.4%
Contacted the OOH medical centre	29	5.8%
Other	2	0.4%
Unknown	6	1.2%
Total	**500**	**100%**

4.10 Satisfaction with the Pharmacy First service for EHC

Overall, satisfaction with the Pharmacy First service for EHC was high amongst those who completed the survey, with detailed results discussed below. However, as highlighted previously we cannot assume that these findings are representative of the wider group.

When asked if they found the process of getting EHC straightforward nearly all participants confirmed they had (n=494/500; 98.8%). Of the two people who didn’t find the process straightforward one felt it took too long and the other hadn’t been supplied EHC and was unhappy as they didn’t understand why.

Similarly, nearly 99% of participants (n=494/500; 98.8%) agreed that it was helpful being able to access the EHC free of charge from the community pharmacy. The benefits of the service identified by participants included: that the service was easily accessible (local, convenient opening hours that covered weekends, no requirement

to book an appointment); that it was free to use; that patients found staff non-judgemental; and, that the service was fast.

Comments from participants are included below:

“This is the first time I have ever felt comfortable and at ease when experiencing this type of consultation. I felt heard, respected, reassured and most importantly not judged or undermined. When I asked at the counter when first arriving I was greeted with nothing but kindness, reassurance and patience. Overall, I feel more confident leaving knowing all my options - this is the first time I have experienced this level of care when discussing anything to do with this topic. Thank you so much.”

“It helped me because I have a strict budget and my Lidl shop is £31- £38 - but I’ve paid £30 for the MAP [morning after pill] and I did not have that spare, when I realised I could get the morning after pill for free, I cried happy tears. It helped me so much. And accessing the pill for 3 months is a great help. It caused a lot of my stress to calm. It helped me”

“Quick and easy, convenient. With pressures on GP services it would have been much slower and more disruptive to have to phone in, wait for call back at an unpredictable time and then pick up a prescription. Having found details of the pharmacy online I could just walk in at a time/place that fitted my day.”

When asked how likely they would be to access the Pharmacy First service for EHC again if they needed EHC, nearly all participants stated they were very likely (n=471/500; 94.2%) or likely (n=20/500; 4.0%) to use it again.

Overall, approximately 99% of participants stated that they were satisfied with the service provided by the community pharmacist.

The most frequent suggestions for service improvement included: greater promotion/awareness raising of the service; streamlining/shortening the consultation process; and, ensuring privacy of consultations including the initial discussion.

Comments from participants included:

“I think it should be more advertised, I only knew due to having a friend in the industry. There are a lot of woman/ girls out there who are unable to buy the morning after pill due to the price or are unable to [contact] their Drs. This is a brilliant way of helping deprived areas grow for the better.”

“It would be good for it to be better advertised on social media for young women and girls. I had to search for my options in a panic, it would have been nice to know my options before feeling so stressed. I never knew it was a readily available form of emergency contraception.”

“It is very unclear where the participating pharmacies can be found on the website, and the provided map lags so it is difficult to view the available locations. It is also difficult to find the webpage itself for the service. However, these are software technical issues and have nothing to do with the in person experience at the pharmacy at all!”

5. Discussion

5.1 Data quality

As highlighted within the results section, it was identified from a preliminary analysis that there were issues relating to the quality of the consultation form data. When these issues were confirmed, the decision was taken not to input an outstanding batch of consultation forms (n=529 records) from the South Eastern LCG area

A weakness was the level of missing data in multiple sections of the consultation form, with the proportion of missing data in many fields ranging from 10% to nearly 50%.

In some fields while data was recorded there were issues with the accuracy of the information documented, primarily within the menstrual history section of the consultation form and a considerable amount of data cleansing was conducted on the data arising from this section of the consultation form.

5.2 Level of achievement in meeting service objectives

5.2.1 To provide information on emergency contraception, including offering advice on the superior effectiveness of Cu-IUD and signposting for this as appropriate.

In the service user questionnaire participants were asked if the pharmacist had discussed with them: the different types of Emergency Contraception, how they work and potential side effects; how well emergency contraception should work and what you should do if it doesn't work; and, the importance of regular on-going contraception and where to access this. Over 95% of respondents confirmed they had received this information from the pharmacist. A slightly lower proportion of respondents confirmed they had been provided the printed "Knowing Your Options" information leaflet. However, as highlighted previously, service user feedback came from less than 1% of all consultations and there is a risk of positive bias in these results.

Consultation form data shows 31.3% of the sample were signposted for Cu-IUD.

5.2.2 To increase knowledge, especially amongst younger women, of the availability of EHC and hormonal contraception (i.e. Desogestrel 75 microgram tablets) from community pharmacies.

The level of uptake of the service would suggest an awareness of the availability of EHC from community pharmacies. However, some comments from service users appear to suggest a lack of awareness regarding the specific Pharmacy First service for EHC. In addition, a greater promotion and awareness raising of the service was one of the most common suggestions for improvement.

The consultation form data shows 59.1% (n=1128/1908; data only available from version two forms of patients) of patients were offered a supply of bridging contraception. Similarly, 62.4% of respondents confirmed they had been offered bridging contraception. However, the supply of bridging contraception was low at 7%. It is not possible to determine why uptake of bridging contraception was low.

Due to the relatively small proportion of the sample aged under 16 years (approx. 5%) it was not meaningful to look at this group in isolation.

5.2.3 To improve access to EHC and sexual health advice.

As per the two points above, the results do suggest that the Pharmacy First service for EHC has facilitated access to EHC and sexual health advice.

5.2.4 To increase the appropriate use of EHC by women and young people who have had UPSI / contraception failure; and reduce the incidence of unplanned pregnancies.

As highlighted within the results section, nearly 90% of patients received Ulipristal Acetate. However, there are examples suggestive of inappropriate supply due to: current medication use (individual was using either: oral glucocorticoids; antacids, proton-pump inhibitors or H2-receptor antagonists; or, liver enzyme-inducing drugs) or use of progestogen containing products.

Of the 283 patients supplied Levonorgestrel (1.5mg and 3mg doses) the reason for this supply was unclear in approximately 15% of cases (n=44/283).

There is no data available within this evaluation to confirm whether the Pharmacy First service for EHC has reduced the incidence of unplanned pregnancies.

5.2.5 To ensure treatment is in line with best practice and NI formulary.

See point 5.2.4

5.2.6 To refer women and young people, as appropriate, into mainstream contraceptive services.

Analysis of the consultation form data showed that 4% of patients were being referred onto another professional, with the most common onward referral to sexual health clinics. In contrast, a much higher percentage of respondents to the service user

survey, reported that they had been referred to other services such as: GP / OOH / GUM or Sexual health clinic / Gateway.

This discrepancy may be explained by the fact that pharmacists may have viewed these onward referrals as signposting rather than referrals as a formal process for referrals is not available. In addition, we have to take in to consideration that the, results from service user feedback are not representative of the overall population accessing the service.

5.2.7 To increase the knowledge of risks, such as STIs, associated with UPSI.

Within the service user survey participants were asked if the pharmacist had provided them with information on the risks of UPSI such as STIs. A high proportion of respondents confirmed they had been provided with this information. However, providing information does not equate to increased knowledge, therefore we are unable to assess the level of achievement in meeting this objective.

5.2.8 To encourage the use of condoms amongst women and young people presenting for EHC, to enable them to protect themselves against STIs and unplanned pregnancy.

The objective is unable to be assessed as no relevant data is captured on the consultation form.

5.2.9 To refer women and young people who may be at risk of having contracted a STI to an appropriate service.

UPSI was the most common reason cited for requesting EHC (69.0%). These individuals may have been at risk of having contracting a STI but just six individuals were referred for STI screening as per the consultation form data.

6. Learning points

1. Whilst the response rate to the patient feedback survey was low at just 1%, the high level of satisfaction with the service was encouraging. A review of service objectives should be conducted to determine their appropriateness as some may be overly ambitious given the constraints of community pharmacy practice e.g. lack of formal processes for onward referral.

2. There is a need to improve the quality of data being collected as part of the service to enable more accurate evaluation. One method to minimise missing data would be to move to electronic recording of the data, where fields could be assigned as mandatory and further clarification on data to be recorded could be provided to pharmacists as necessary. Of particular note was the menstrual history section of the consultation form. If EHC is to be supplied regardless of ovulation status it would seem advisable to condense the data to be recorded within this section for the benefit of both the pharmacist and patient.

3. Additional/refresher training for pharmacists delivering the service may be needed which addresses any issues highlighted within this report, such as: accurate recording of information; unsuitable supply of EHC i.e. supply to individuals deemed as not Fraser competent or unsuitable due to drug interactions; low uptake of bridging contraception; and, low rates of signposting for Cu-IUD.

4. Consideration should be given to making this a more holistic service with formal mechanisms for onward referral to other services.

Appendices

Appendix 1: Pharmacy First service for Emergency Hormonal Contraceptive - Patient Consultation Form

Consultation form – Version 1

Patient name, Address & Postcode		**Pharmacy name, Address & phone number**	
Patient age / DOB		**Contractor Number**	
GP Practice		**Date of consultation**	
1. Initial assessment (ensure privacy notice is discussed with the patient and verbal consent for service obtained)			
Consultation type:	In person in the pharmacy □		Video consultation □
Referral method:	Self-referral □ By pharmacist □ By GP practice □		By OOHs □ Other, specify_____
Patient age:	Age 13□ 14□ 15□ years 16 years or over □ If < 16 years; age of sexual partner: _____ **If partner is over 18 years of age and patient requesting treatment is under 16 years, there is a statutory duty to contact Police Service NI** (complete section 6 below)		
Fraser assessment:	If age 13, 14 or 15 has a Fraser assessment been carried out **Yes / No**		Is the patient Fraser competent **Yes / No** If no, complete section 6 below
Safeguarding issues:	Have any issues been identified **Yes / No** **For example:** *Concerns regarding coercion, assault, abuse or exploitation*		If yes, complete section 6 below
Reason for EHC request:	Unprotected Sexual Intercourse (UPSI) □ Condom failure □		Missed pill □ Other, specify_____
2. Menstrual history			

Last menstrual period (LMP):	Date of LMP: Day in cycle: Cycle / bleeding pattern: _____	Any other UPSI since LMP: _____ Hours after intercourse: _____ Other EHC this cycle / date: _____
3. Medical history		
Current medication / allergy status:	Severe asthma controlled by oral steroids **Yes / No** (*if yes consider Levonorgestrel)* Antacids/proton-pump inhibitors/H2-receptor antagonists **Yes / No** (*if yes consider Levonorgestrel*) Liver enzyme inducers may reduce the effectiveness of oral EHC (if yes *consider 3mg dose of Levonorgestrel)*	
Porphyria:	**Yes / No** if yes refer to Sexual Health Clinic for Cu-IUD insertion (complete section 6 below)	
Severe hepatic dysfunction:	**Yes / No,** if yes refer to cautions in PGD and advise the woman that FRSH guidance advises that pregnancy poses a significant risk in hepatic dysfunction and thus ulipristal is acceptable	
Severe malabsorption syndrome (IBD/Crohn's):	**Yes / No** if yes refer to cautions in PGD: the use of oral EHC is not contra-indicated but it may be less effective (insertion of Cu-IUD is the most effective method of EC)	
Unexplained vaginal bleeding:	**Yes / No** if yes supply oral EHC and recommend the woman sees her GP for investigation of unexplained vaginal bleeding (complete section 6)	
Weight / BMI:	Weight in kg_____ or BMI_____	
Regular contraception:	Patch□ COC□ POP□ Injection□ Implant□ IUD/S□ Other□ None □	
4. Treatment		
Oral EHC supplied:	**First line (including when BMI>26 or weight >70kg)** • Ulipristal Acetate 30mg x 1 tablet □ **Second line (when ulipristal not indicated):** • Levonorgestrel 1.5mg (POM) x 1 tablet □ • Levonorgestrel 1.5mg (POM) x 2 tablets (3mg) unlicensed indication □ *please state reason for unlicensed supply*_____	

	Please tick if a second dose of EHC has been supplied *(patient vomits within 3 hours)* □
Bridging contraception:	Patient is suitable for supply of bridging POP Desogestrel **Yes / No** If yes, Desogestrel 75 micrograms (POM) 3 x 28 tablets supplied □ Verbal advice given regarding pill taking / timing / potential adverse effects □ Advised to arrange further supply before 3 months' supply runs out □
Oral EHC not supplied:	EHC was not supplied for the following reason _____
Signposted for Cu-IUD:	**Yes / No** If yes oral EHC also supplied: Ulipristal 30mg □ or Levonorgestrel 1.5mg □ or Levonorgestrel 3mg □
Medication supplied via:	PGD using PV1 □ or IP pharmacist prescription □

5. Advice & counselling

Discussion with patient provides information on the following points:

- Oral versus Cu-IUD emergency contraception □
- Mode of action of oral emergency contraception □
- Potential side effects □
- Action to take if vomiting within 3 hours □
- Timing of next bleed, could be earlier or later □
- Pregnancy test may be required if next period is more than 7 days late or lighter than usual □
- Interaction with other hormones □
- Failure rate and next steps □
- Risk of STIs □
- Patient may need to return if further UPSI and need for future contraception □
- Unlicensed use and obtain consent □
- Provide information on family planning and sexual health services available locally □
- Encouraged to take EHC at time of supply □
- Patient Information Leaflet supplied □
- Encouraged to complete feedback survey (when available) □

6. Referral to another professional (GP, OOH, Sexual Health Clinic, Gateway team, Police Service NI)

Patient referred to: GP / Out-of-hours medical centre / Sexual Health Clinic / Gateway team or Police Service NI;

Please specify: _____

Date of referral: _____

Reason for referral: _____

_____

Details of response (if any) from the organisation: _____

_____

7. Patient declaration

I have been advised on the use of emergency contraception, STIs & ongoing contraception and I understand the advice given to me by the pharmacist.

Patient signature_____

Date_____

Consultation form Version 2

Patient name, Address & Postcode		**Pharmacy name, Address & phone number**	
Patient DOB		**Contractor Number**	
GP Practice		**Date of consultation**	

6. Initial assessment (ensure privacy notice is discussed with the patient and consent for the service is obtained)

Referral method:	Self-referral □ By pharmacist □ By GP practice □ By OOHs □ By SH:24 □ Other, please specify:	
Age of woman or young person:	Age of woman or young person: _____ If patient is < 16 years; check the age of her sexual partner and record here: _____ **If the partner is aged 18 years or over, the pharmacist has a statutory duty to contact Police Service NI** *(complete section 6 below)*	
Fraser assessment:	If age 13, 14 or 15 has a Fraser assessment been carried out? **Yes / No**	Is the patient Fraser competent? **Yes / No** If no, complete section 6 below
Safeguarding issues (consider for all women):	Have any issues been identified? **Yes / No** **For example:** *Concerns regarding coercion, assault, abuse or exploitation*	If yes, complete section 6 below
Reason for EHC request:	Unprotected Sexual Intercourse (UPSI) □ Condom failure □ Missed pill □ complete section 3 below Other □, please specify:	**Please tick to confirm that the patient has been informed that oral EHC is ineffective if taken after ovulation** □

7. Menstrual history

Last menstrual period (LMP):	Date of LMP: _____ Day in cycle: _____ Usual cycle / bleeding pattern: _____	Any other UPSI since LMP: _____ Hours since this episode of UPSI: _____ Other EHC this cycle / date: _____

8. Medical history	
Current medication / allergy status:	Severe asthma controlled by **oral** steroids **Yes / No** (*if yes consider Levonorgestrel)* Antacids/proton-pump inhibitors/H2-receptor antagonists **Yes / No** (*if yes consider Levonorgestrel*) Liver enzyme inducers **Yes / No** (*if yes consider 3mg dose of Levonorgestrel)*
Porphyria:	**Yes / No** if yes refer to Sexual Health Clinic for Cu-IUD insertion (complete section 6 below)
Severe hepatic dysfunction:	**Yes / No,** if yes refer to cautions in PGD and explain that that FRSH guidance advises that pregnancy poses a significant risk in hepatic dysfunction and thus ulipristal is acceptable
Severe malabsorption syndrome:	**Yes / No** if yes refer to cautions in PGD: the use of oral EHC is not contra-indicated but it may be less effective (insertion of Cu-IUD is the most effective method of EC)
Unexplained vaginal bleeding:	**Yes / No** if yes supply oral EHC and recommend the woman or young person sees her GP for investigation of unexplained vaginal bleeding (complete section 6)
Regular contraception:	COC □ POP □ If missed pill please record number of days since last pill taken _____ Injection □ Implant □ IUD/S □ Patch □ None □ Other □ _____
9. Treatment	
Oral EHC supplied:	**First line (including when BMI>26 or weight >70kg)** • Ulipristal Acetate 30mg x 1 tablet □ **Second line (when ulipristal not indicated):** **Weight / BMI:** _____ • Levonorgestrel 1.5mg (POM) x 1 tablet □ • Levonorgestrel 1.5mg (POM) x 2 tablets (3mg) unlicensed indication □ *please state reason for unlicensed supply*_____ **Please tick if a second dose of EHC has been supplied *(patient vomits within 3 hours)*** □
Oral EHC NOT supplied:	EHC was not supplied for the following reason _____
Bridging contraception:	**Was the patient offered a supply of bridging contraception? Yes □ No □** • If no, please specify the reason why a supply of bridging contraception was not offered: _____

	Was Desogestrel 75 micrograms (POM) 3 x 28 tablets supplied? Yes □ No □ • If no, please provide reason why a supply of bridging contraception was not accepted: _____ • If yes, bridging contraception was supplied, confirm that verbal advice was provided regarding timing of pill taking and potential adverse effects □ • Confirm that the patient was advised to arrange further supply before the 3 months' supply runs out □
Signposted for Cu-IUD:	Was Cu-IUD discussed as the <u>most effective</u> form of emergency contraception **Yes** □ **No** □ Was the patient signposted for Cu-IUD? **Yes** □ **No** □

10. Advice & counselling

Tick to confirm that the patient was: • Given verbal advice and counselling in line with guidance provided in the service specification □ • Given a printed copy of the Know Your Options leaflet □ • Asked to scan the QR code and complete the confidential online survey □	If not please give reason:	

6. Referral to another professional (GP, OOH, Sexual Health Clinic, Gateway team, Police Service NI)

Patient referred to: GP / Out-of-hours medical centre / Sexual Health Clinic / Gateway team or Police Service NI;

please specify: _____

Date of referral: _____

Reason for referral: _____

Details of response (if any) from the organisation: _____

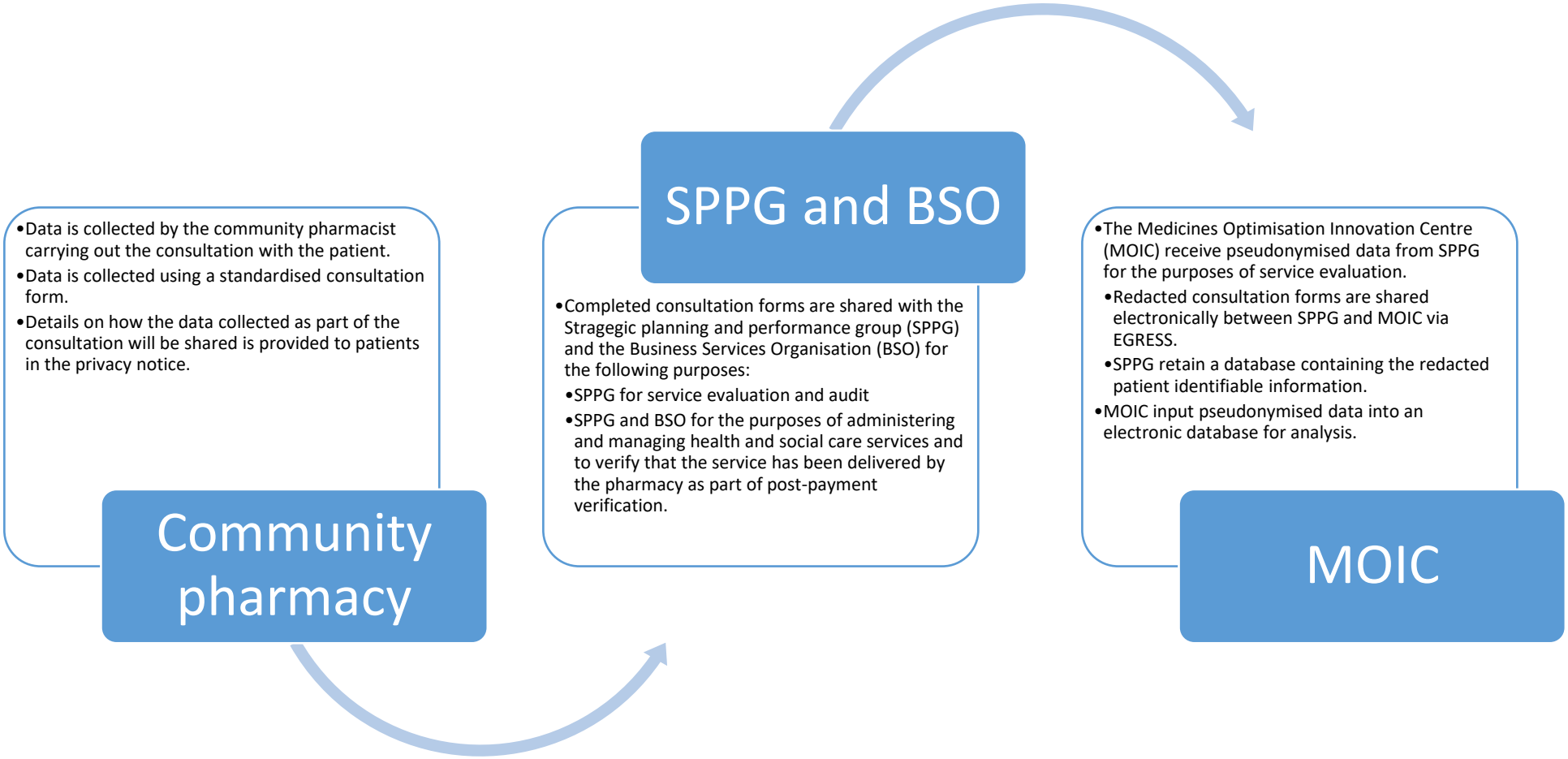
8. Patient declaration (patient signature required for consent)

I have been advised on the use of Emergency Hormonal Contraception, Sexually Transmitted Infections and ongoing contraception and I understand the advice given to me by the pharmacist.

Patient signature_____

Date_____

Appendix 2: MOIC evaluation of Pharmacy First Service for Emergency Hormonal Contraception - Data flow map



Appendix 3: Privacy notice for Pharmacy First Service for Emergency Hormonal Contraception

Health and Social Care Board

Pharmacy First Service
Privacy Notice for person accessing this service
"Protecting & Using Your Information"

At _____ *(insert pharmacy details)* we are committed to the highest privacy standards. During your Pharmacy First consultation with our pharmacist, we will only collect data that is necessary for us to deliver the best possible service. This policy provides detailed information on why we collect your personal information as part of this service, how we use it and the very limited conditions under which we may disclose it to others. Personal information that is processed about you is governed by the Data Protection Act 2018 and the General Data Protection Regulation (GDPR).

What is a Pharmacy First Service?

Pharmacy First Service is a service whereby patients are encouraged to consult with their community pharmacist first rather than their GP, for a list of common conditions. The aim of a Pharmacy First Service is to move activity, including consultations and advice for common conditions, from GP practices to community pharmacies. As part of this service, **personal information will be processed about you.**

Why are you processing my personal information / Lawful basis for processing?

- Your personal information will be processed to enable the provision of the Pharmacy First Service.
- We rely on the following lawful basis when processing your personal information for the Pharmacy First Service:
    - Legitimate Interests: processing is necessary for the purposes of the legitimate interests pursued by this Pharmacy except where such

interests are overridden by the interests or fundamental rights and freedoms of the data subject; and

- Public Task: processing is necessary for a task carried out in the public interest.

As the information we process about you constitutes health data it is classed as 'Special Category' data therefore a further lawful basis is required which we have identified as:

- Processing is necessary for the purposes of preventive or occupational medicine.

What categories of personal data are you processing?

Patient identifiable information including your name, address, health & care number, date of birth, contact details (address & telephone number) and details about the symptoms you are suffering. If appropriate, information about medicines you have been supplied, or reasons why you require onward referral to your GP.

Where do you get my personal data from?

Your personal data originates from information that you provide during the Pharmacy First consultation. Personal details such as your health & care number, address and date of birth may already be recorded on the pharmacy's Patient Medication Record system and used during the consultation. Personal data held by your GP practice may also be accessed via your Electronic Care Record.

Do you share my personal data with anyone else?

Your personal data may be shared with the following:

- Your GP practice to help them provide care for you
- The Health and Social Care Board (HSCB) for service evaluation and audit
- The HSCB and the Business Services Organisation (BSO), for the purposes of administering and managing health and social care services and to verify that the service has been delivered by the pharmacy as part of post-payment verification.
- With Medicines Optimisation Innovation Centre (MOIC) for the purposes of service evaluation

How long do you keep my personal data?

This record will be retained in the pharmacy for a period of eight years after the conclusion of treatment for adults; for children and young people, the record will be kept until the patient's 25th birthday or 26th if the young person was 17 at the conclusion of treatment or eight years after death. HSCB & BSO as health-care organisations hold information in line with the DH Retention Policy identified in the document 'Good management, Good Records' which can be viewed at DHs Good Management, Good Records Section M, outlines the requirements for retention and disposal of community pharmacy held records: https://www.health-ni.gov.uk/sites/default/files/publications/health/gmgr-disposal-schedule.pdf

What rights do I have?

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- You have the right to object to the processing, in specific circumstances
- You have rights in relation to automated decision making and profiling

Further information on your rights is available at: https://ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr

How do I complain if I am not happy?

If you have any questions or concerns regarding how we use your personal information you can contact: ___*(insert name/contact details of relevant pharmacy staff member)*

_____

If we cannot resolve your concerns you have the right to lodge a complaint with the Information Commissioners office:

I**nformation Commissioner's Office**

Wycliffe House

Water Lane

Wilmslow

Cheshire

SK9 5AF

Tel: 0303 123 1113

Email: casework@ico.org.uk Website: https://ico.org.uk/global/contact-us/

Review - This document will be kept under review and updated as required; we reserve the right to make any changes and updates to this privacy policy without giving you notice as and when we need to. Our most up to date privacy policy is always available upon request.

Appendix 4: Service User Evaluation Questionnaire

Emergency hormonal contraception feedback

Overview
You recently received emergency hormonal contraception (the morning after pill) from community pharmacy. This is a new service and we would appreciate if you would provide feedback regarding your experience by completing this short survey.

About you

1 What age are you? *(Required)*

Accessing the Pharmacy First Emergency Hormonal Contraception (morning after pill) service

2 How did you find out about the service?
Please select only one item
Referral/Recommendation from your community pharmacy
Referral from your GP practice
Referral from the Out of Hours medical centre
Referral from other clinic (sexual health / GUM / common youth)
Poster / Advert / Social media such as Facebook or Instagram
Word of mouth from friends or family
Other

3 Have you ever needed to use the morning after pill before?
Please select only one item
Yes
No

Accessing emergency hormonal contraception previously

4 If yes, how did you get the morning after pill before?

Please select only one item

Bought it from your community pharmacy

Used this service previously i.e. the Pharmacy First EHC service

Requested a prescription from your GP

Contacted Out Of Hours medical centre

Attended a sexual health / GUM clinic / common youth

Other

If other, please specify:

Choosing community pharmacy

5Why did you choose to use your community pharmacy for this service? (tick all that apply)

Please select all that apply

Don’t have to book an appointment

No payment required for this service

Regular customer of this pharmacy

Recommended to me

Could not get an appointment with GP

Easier to go to pharmacy

Pharmacy opening hours suited me

Private and Confidential

Other

If other, please specify:

Regarding your consultation

6Where did your consultation with the pharmacist take place?

Please select only one item

At the pharmacy in a private consultation area

At the pharmacy counter

By video call (via zoom)

Other

If other, please specify:

7Were you happy with where your consultation took place?

Please select only one item

Yes

No

Unsure

8Approximately how long did your consultation take?

9Did you feel at ease during your consultation?

Please select only one item

Yes

No

Unsure

Satisfaction with your consultation

10As part of the consultation did the pharmacist:

Provide advice on the different types of Emergency Contraception, how they work and potential side effects?

Please select only one item

Supply you with the morning after pill?

Please select only one item

Discuss with you the how well emergency contraception should work and what you should do if it doesn't work?

Please select only one item

Provide information on the risks of unprotected sexual intercourse such as Sexually Transmitted Infections(STIs)?

Please select only one item

Discuss the importance of regular on-going contraception and where to access this?

Please select only one item

Offer or supply you with 3 months of the contraceptive pill?

Please select only one item

Provide you with a printed information leaflet (Knowing Your Options)?

Please select only one item

Refer you to any other service such as: GP / OOH / GUM or Sexual health clinic / Gateway

Please select only one item