NHS England

NHS Pharmacy Contraception Service Webinar

12th November 2024

Hosted by NHS England Midlands Region

Housekeeping Arrangements

The webinar will be recorded and made available online

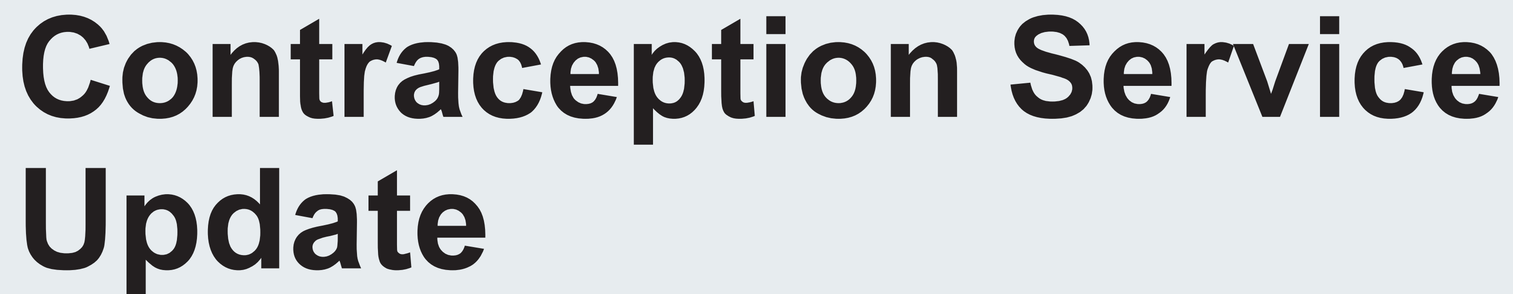
The slides will be emailed out after the webinar

You can type your questions throughout the webinar in the chat

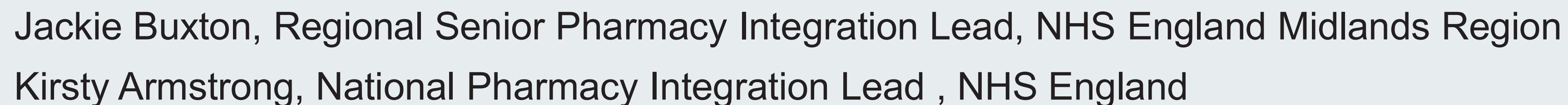
Please provide feedback at the end of the webinar via our feedback form

Agenda

Agenda Item	Topic
19:00	**Contraception Service Update** Presented by Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England Midland Region and Kirsty Armstrong, National Pharmacy Integration Lead , NHS England
19:10	**Delivering the Contraception Service – Community Pharmacists Insights** Aggie Stead, Pharmacy Manager, Asda Pharmacy, North Hykeham, Lincoln Shalina Anwar, ICS Community Pharmacy Clinical Lead, Birmingham and Solihull ICS
19:30	**Sharing Experience - GP Insights** Dr Joanne Watt, Associate Medical Director for Primary Care and PCNs, NHS England Midland Region
19:50	**Question and Answers**
20:00	**Closing Remarks** Presented by Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England – Midlands



Contraception Service Update

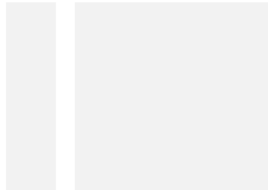
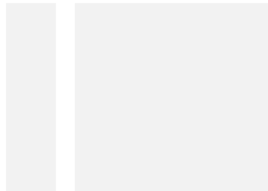
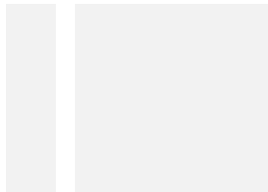


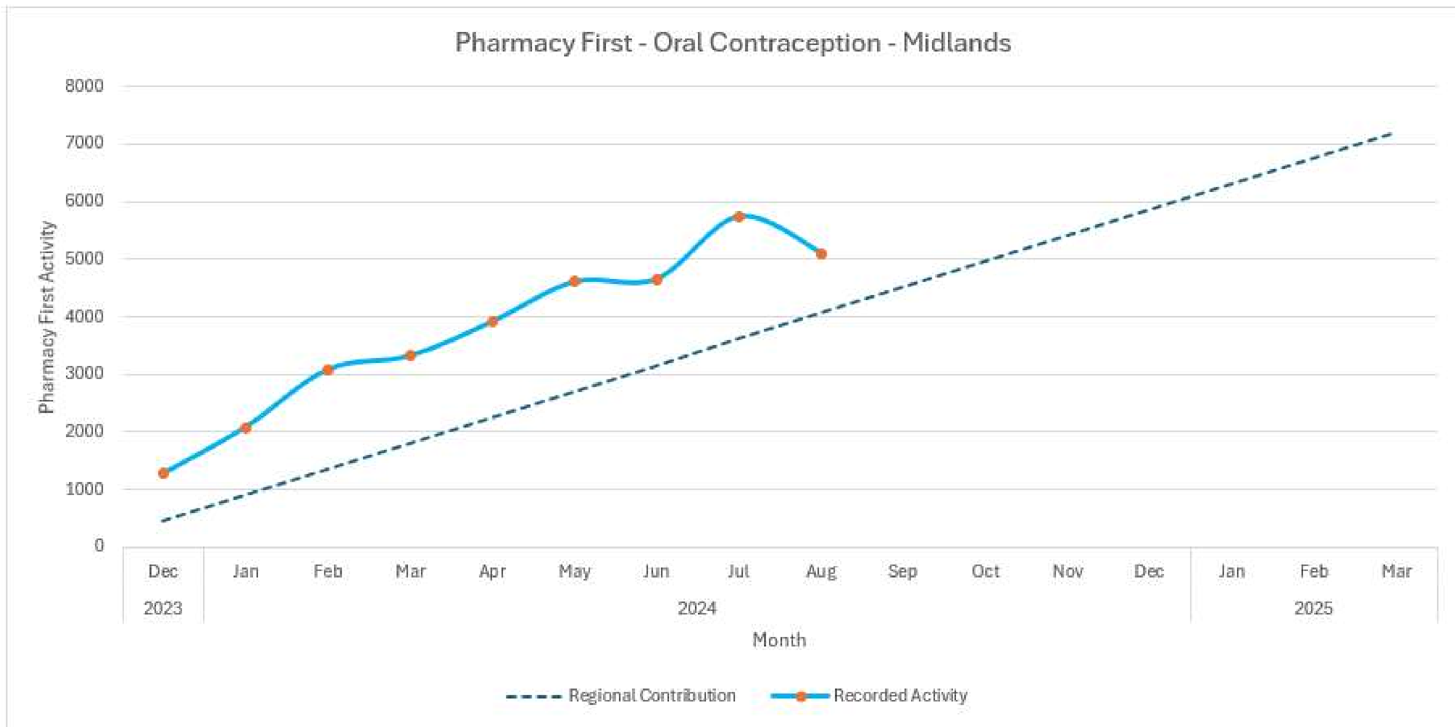
Jackie Buxton, Regional Senior Pharmacy Integration Lead, NHS England Midlands Region
Kirsty Armstrong, National Pharmacy Integration Lead , NHS England

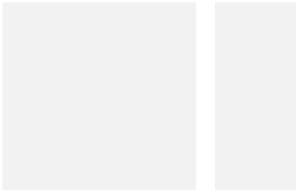
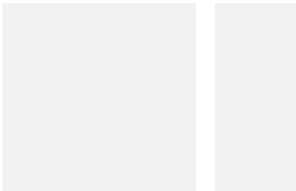
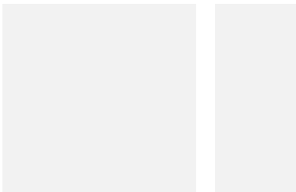
Aims and Objectives

1. Share good practice and top tips from community pharmacists delivering the service
2. Expand our knowledge from a GP with a special interest in sexual health
3. Build confidence to deliver the service, especially initiation
4. Consider how to promote the service
   - Recognising 12 months of the Contraception Service
5. Opportunity to ask questions

Pharmacy First - Recorded Activity vs Trajectory



Current Volumes

Month	Number of consultations	Number of ongoing consultations	Number of initiation consultations
Dec-23	5,143	4,604	539
Jan-24	9,012	7,895	1,117
Feb-24	11,154	9,317	1,837
Mar-24	13,667	11,432	2,235
Apr-24	17,789	14,986	2,803
May-24	20,785	17,345	3,440
Jun-24	21,810	18,377	3,433
Jul-24	27,256	22,919	4,337
Total	126,616	106,875	19,741

Service to date (Apr-23)	Number of consultations	Number of ongoing consultations	Number of initiation consultations
Total	142,312	122,571	19,741

Confidential – not for onward sharing

Pharmacy sign ups vs participation

No of contractors signed up

- Nov 2024 = 7939

Of these

- 5181 ‘opted in’ to extended service in Dec 2023

Getting ready to deliver service

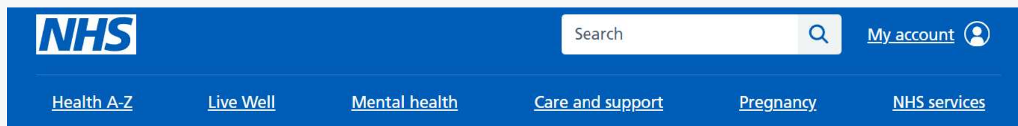
- Registration and payment via the NHSBSA's MYS platform - MYS – Pharmacy | NHSBSA
- Must be **READY TO DELIVER** at point of registration
- Must deliver **both** initiation and ongoing supply consultations

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

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

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

Find a Pharmacy



Home > NHS services > Pharmacies

Find a pharmacy that offers the contraceptive pill without a prescription

Use this service to find a pharmacy that offers the contraceptive pill for free. You do not need to see a doctor or nurse for a prescription.

A pharmacist may be able to supply the contraceptive pill if you need to:

- start using the contraceptive pill for the first time
- start the contraceptive pill again after a break from taking it
- get a supply of the contraceptive pill if it's already been prescribed to you

If the pharmacist gives you the contraceptive pill they will share this information with your GP if you give permission for them to do so.

Start

Pharmacy Profile Update

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

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

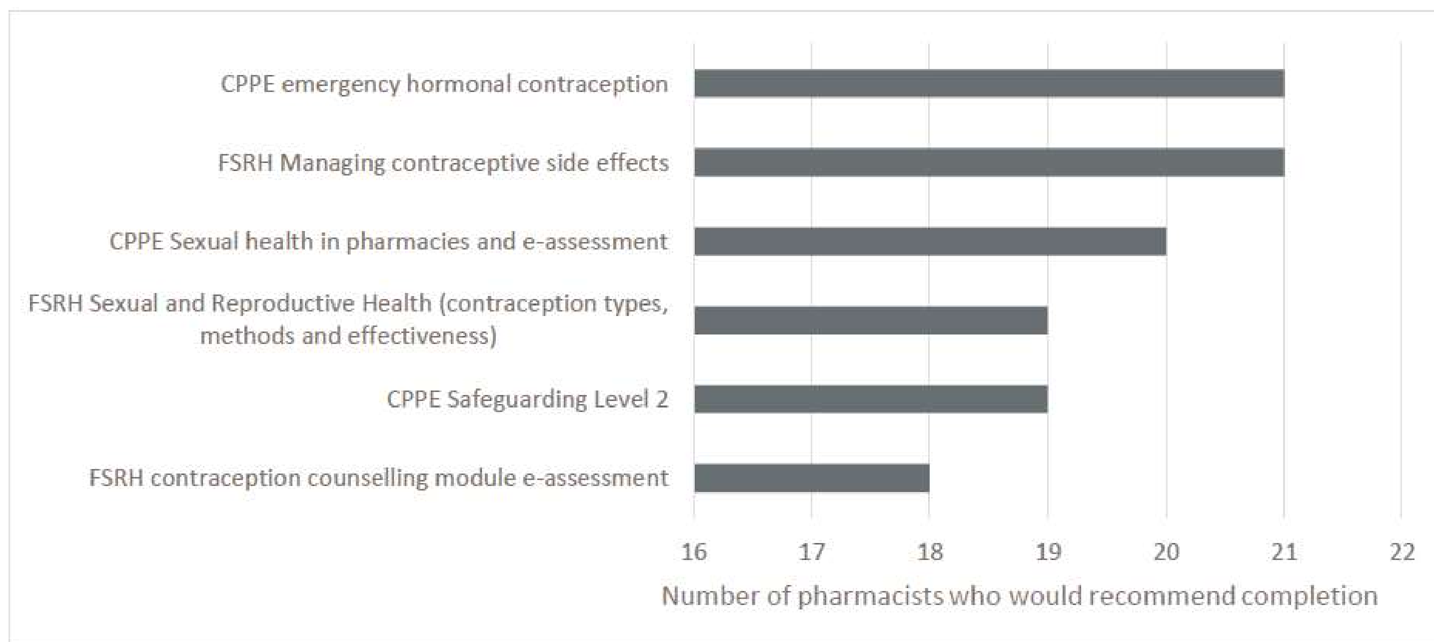
Contraception services

- NHS Pharmacy Contraception Service

Training

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

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



Safeguarding

Pharmacists delivering the service must have completed one of the recommended Safeguarding level 3 training materials **or** have direct access to professional advice from someone who can advise on Safeguarding at Level 3.

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

Or

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

Consultation Process

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

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

  (*service requirement to have a room)

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

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

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

    (*excludes Drospirenone)

Consultation Process

- Supply of Combined Pill requires Blood Pressure and BMI checks to be completed – can be done by a suitably trained pharmacy technician
- Where people meet inclusion criteria outlined in PGD, and subject to clinical appropriateness, a supply of contraception can be made
- Duration of supply can vary
    - Initiation – max 3 months - any oral contraception product
    - Ongoing supply – max 12 months – equivalent to previous product supplied
- Patients GP will receive a post event message via NHS mail or GP Connect: Update Record if the patient consents
- If the patient does not consent this does not prevent a supply from being made

Community Pharmacy Contraception Service

Aggie Stead,
Pharmacy Manager
Asda Pharmacy,
North Hykeham,
Lincoln

Consultation volume

Since April 2023 we delivered 355 service consultations (46 initiation consultations)

On average we deliver about 4-8 consultations weekly

Participation in the Tier 2 service pilot (Initiation of oral contraception) which helped with providing initiation consultations when the service was updated in Dec 2023.

Great feedback from customers about easy access, saving time and being able to be seen either straightaway or at the date/time that is convenient to them

Getting started

- Promoting the service at the pharmacy counter – pharmacy colleagues talking to patient about the service, offering to book an appointment when their next pill supply is due.
- Online booking system – appointment availability during the week and on the weekends.
- Using leaflets/flyers
- Ensure to advise that it is a free NHS service.

Engagement with local GP surgeries

- Emailed local surgeries about the service and agreed the referral process.
- Agreed the days when patients can simply walk-in and be seen straightaway.
- When communicating with the surgeries I included possible scenarios when referring a patient to us would free the appointment:
    - Pill-check due
    - Patient wishing to switch (due to side-effects)
    - Patient had a longer break, needs an appointment to restart
    - Patient on a waiting list for LARC, needs something in between

Continuation (repeat supply)

- Patient already taking the pill
- Nearly run out and requires repeat supply
- Consultations are usually straightforward as long as no contraindications, and patient happy to continue (no side-effects, taken correctly).
- Can supply between 3-12 months

Initiation (starting, re-starting or switching)

- Initial supply – 3 months
- https://cpe.org.uk/wp-content/uploads/2023/11/Contraception-pre-consultation-questionnaire.pdf – pre-consultation questionnaire
- https://www.contraceptionchoices.org/ - decision-making tools

Initiation – which pill to supply

- Follow the local formulary – preferred lower cost products
- COC: Ethinylestradiol/levonorgestrel 30mcg/150mcg
  - Levest®
  - Rigevidon®
- POP: desogestrel 75mcg
  - Desogestrel 75 microgram tablets (generic)
  - Cerelle®
  - Zelleta®

Switching (contraceptive ladder)

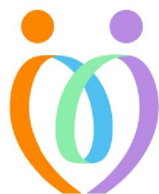
- Some patients will experience side-effects due to oestrogenic or progestogenic activity.
- Acne, oily skin, excess hair– switch to less androgenic progesterone such as desogestrel (Gedarel)® or gestodene (Millinette)®
- Trial and error for some patients until they find one that works for them

Top tips

- Keep some extra stock exclusively for the service, especially if the number of consultations increases
- Engage with your regular locums, ensure they are aware of the service, and where to find PGDs and service specification in your pharmacy
- Have guidelines available to access/saved on the desktop:
  - Local formulary
  - FSRH, NICE guidelines on switching, managing side-effects etc.
  - Contraceptive ladder

The value of the service:

- For the pharmacy team: increased confidence and building relationships with patients
- For me as a healthcare professional: improved clinical knowledge, improved relationships with local surgeries and other community pharmacies
- For local GP surgeries: being able to free appointments and focus on more complex patients
- For patients: convenience and time saving, increased access to oral contraception



Birmingham and Solihull
Integrated Care System
Caring about healthier lives

NHS Pharmacy Contraception Service

Shalina Anwar

ICS Community Pharmacy Clinical Lead

Strategies to Increase NHS Pharmacy Contraception Service Utilisation

Promotional Efforts

- *Prescription Bag Inserts*: including promotional Umbrella materials and stickers in prescription bags
- *Banners:* Umbrella service initially provided banners to increase the awareness- these may still be available.
- *Counter/Dispensing Staff Engagement*: Pharmacy staff are actively raising awareness about the contraceptive services when dispensing contraception prescriptions.
- Social Media Promotion: launched a social media campaign to promote the contraception services across various platforms.

Collaboration with Local Healthcare Providers

- *Surgery Partnerships*: discussions with surgery staff and Practice Managers to alleviate their nurse appointments by offering pill checks at our pharmacy.
- *Referral System*: established a referral pathway with local GPs and sexual health clinics to direct suitable patients to our service after initiation.

Targeted Outreach

- *New and Young Mothers*: raising awareness amongst new and young mums about the availability of contraception from the pharmacy as an alternative to GP visits.
- *School-friendly Appointments*: now offering appointments during school drop-off and pick-up times, which are peak hours preferred by many patients.
- *Raising Awareness*: at local schools, colleges and universities.

Mal Singh- Walker's Pharmacy Birmingham

Strategies to Increase NHS Pharmacy Contraception Service Utilisation

Value-Added Services

- *Free Condoms*: offering free condoms with all contraception prescriptions for missed doses.
- *Emergency Contraception Awareness*: when emergency hormonal contraception (EHC) is required, using this opportunity to inform patients about the ongoing contraception services.

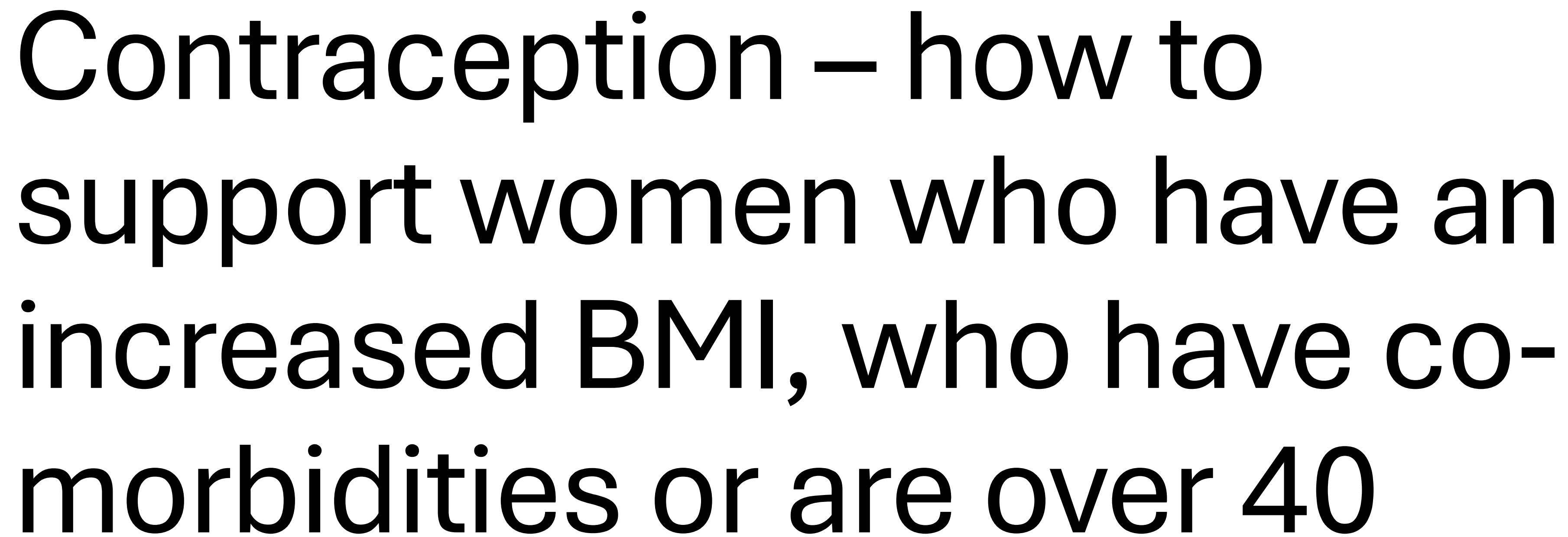
Community Engagement

- Word-of-mouth Promotion: encouraging our patients to tell their friends and colleagues about our services.
- *Local Events*: participating in community health events to showcase the contraception services.
- *Young Persons Clubs* - utilise notice boards of social clubs for raising awareness.

"These initiatives aim to make our NHS contraception services more accessible and appealing to a wider range of patients. We're already seeing positive results, with an increase in service uptake and positive feedback from our community"

Mal Singh- Walker's Pharmacy Birmingham

Contraception – how to support women who have an increased BMI, who have co-morbidities or are over 40



Dr Joanne Watt

GP with an interest in sexual health

FSRH Trainer

Associate Medical Director for Primary Care and PCNs NHSE Midlands

UK Medical Eligibility Criteria for Contraceptive Use (UKMEC)

- The UK MEC helps clinicians decide what contraceptives they can safely recommend based on the medical conditions of patients in their care. Funded by the FSRH and developed by our Clinical Effectiveness Unit, this key guidance is informed by robust and up-to-date evidence on when contraceptives can and cannot be safely used.
- https://www.fsrh.org/Public/Public/Standards-and-Guidance/uk-medical-eligibility-criteria-for-contraceptive-use-ukmec.aspx
- UKMEC is only for contraception, the Clinical Pharmacy service is only commissioned for contraception. Some clinicians working in other services will use some of these medications off-licence or for other services.
- Do we have to adhere to the UKMEC when providing contraception?- It is difficult to defend our actions from a complaint and gain medicolegal support if we do not

Definition of UKMEC categories

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

Initiation vs Continuation

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

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

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

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

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

UKMEC tips

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

What areas are covered by the UKMEC?

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

https://fsrh.org/Common/Uploaded%20files/Standards-and-Guidance/fsrh-ukmec-full-book-2019.pdf
Useful Resources | Minor illness? Think... | Smoking Cessation... | Pharmacy Medicine... | Transformation Tea... | Community Pharma... | Expenses Logon | BBC Sounds - My S... | NHS Digital ODS P... | Other favourites
Draw | 70 | of 175

Combined Hormonal Contraception (CHC) which includes Combined oral contraception (COC) Combined contraceptive transdermal patch and vaginal ring	CHC do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or postpartum), the correct and consistent use of condoms is recommended, either alone or with another contraception method. Male condoms reduce the risk of STI/HIV.	
CONDITION *See additional comments at end of section	**CATEGORY** I = Initiation C = Continuation	**CLARIFICATION/EVIDENCE** Most evidence available relates to COC use. However, this evidence is also applied to use of the contraceptive patch and ring.

Smoking		
a) Age <35 years	2	**Clarification:** UKMEC currently does not include use of e-cigarettes, as risks associated with their use are not yet established. **Evidence**: COC users who smoke are at an increased risk of CVD, especially MI, compared with those who do not smoke. Studies also show an increased risk of MI with an increasing number of cigarettes smoked per day.[23–34] The 35 year age cut off is identified because any excess mortality associated with smoking becomes apparent from this age.[35] The mortality rate from all causes (including cancers) decreases to that of a non-smoker within 20 years of smoking cessation. The CVD risk associated with smoking decreases within 1 to 5 years of smoking cessation.[35–37]
b) Age ≥35 years		
(i) <15 cigarettes/day	3	
(ii) ≥15 cigarettes/day	4	
(iii) Stopped smoking <1 year	3	
(iv) Stopped smoking ≥1 year	2	
Obesity		**Clarification:** The absolute risk of VTE in women of reproductive age is low. The relative risk of VTE increases with CHC use. Nevertheless, the absolute risk of VTE in CHC users is still low. **Evidence:** The risk of VTE rises as BMI increases over 30 and rises further with BMI over 35. Use of CHC raises this inherent increased risk further.[28,34,38–41] Limited evidence suggests that obese women who use COC do not have a higher risk of acute MI or stroke than obese non-users.[34,42–44]
a) BMI ≥30–34 kg/m^2	2	
b) BMI ≥35 kg/m^2	3	

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CARDIOVASCULAR DISEASE (CVD)		
Multiple risk factors for CVD (such as smoking, diabetes, hypertension, obesity and dyslipidaemias)	3	**Clarification**: When a woman has multiple major risk factors, any of which alone would substantially increase the risk of CVD, use of CHC may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended; for example, a combination of two risk factors assigned a Category 2 may not necessarily warrant a higher category.
Hypertension*		**Clarification:** For all categories of hypertension, classifications are based on the assumption that no other risk factors for CVD exist. When multiple risk factors do exist, the risk of CVD may increase substantially. **Clarification:** Women adequately treated for hypertension are at reduced risk of acute MI and stroke compared to untreated women. Although there are no data, CHC users with adequately controlled and monitored hypertension should be at reduced risk of acute MI and stroke compared with untreated hypertensive CHC users. Antihypertensive therapy may be initiated when the BP is consistently 160/100 mmHg or higher.[53] **Evidence**: Among women with hypertension, COC users are at an increased risk of stroke, acute MI and peripheral arterial disease compared with non-users.[23,25,28,32-34,54-69] Discontinuation of COC in women with hypertension may improve BP control.[70]
a) Adequately controlled hypertension	3	
b) Consistently elevated BP levels (properly taken measurements)		
(i) Systolic >140–159 mmHg or diastolic >90–99 mmHg	3	
(ii) Systolic ≥160 mmHg or diastolic ≥100 mmHg	4	

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a) BMI ≥30–34 kg/m²	2	
b) BMI ≥35 kg/m²	3	

Common UKMEC 3 and 4 conditions

- Age over 35 and has been a smoker within the last year
- Migraine with aura at any age
- Women with hypertension/IHD/CVD/CVA, even if controlled on medication
- Women with multiple risk factors for CVD e.g. hypertension, diabetes, hyperlipidaemia, increased BMI, smoking etc
- History of VTE or inherited thrombophilia
- Major surgery or prolonged immobility
- There are lots more-if she has other long-term conditions look at UKMEC
- Oral contraception may not be suitable for women on enzyme inducing medications
- Oral contraception may reduce efficacy of lamotrigine

Increased BMI (ideal BMI is 18.5-24.9)

62% of women in the Midlands have a BMI over 25

(NHS digital data 2021)

- BMI over 30 (or over 35) is UKMEC 1 (no restrictions) for POP (no need to double dose if increased BMI)
- BMI 30-34 is UKMEC 2 (benefits outweigh risks) for CHC
- BMI over 35 is UKMEC 3 (risks outweigh benefits) for CHC
- Risk of VTE increases with age as well as BMI
- LARC method efficacy i.e. IUCD, Implant and depo is not affected by increased BMI (Depo can cause further weight gain)
- If BMI>26 may reduce efficacy of EHC esp. levonorgestrel, Ulipristal in standard dose may be more effective (or double dose levonorgestrel to 3mg)
- Risk of reduced absorption of oral contraceptives following bariatric surgery-?LARC/non-oral route is a better option
- GLP1 receptor agonist medications (e.g. mounjaro) do not seem to affect absorption of oral contraception-more studies needed…
- Women increased BMI have a higher risk of pregnancy related complications esp. if comorbidities- need to optimise pregnancy planning

Women aged over 40 years

How can we support women to make safe and effective contraceptive choices?

When does risk of pregnancy/fertility stop?

- When she gets to age 55yrs
- If she has a hysterectomy/oophorectomy/sterilisation
- 2 years after the last period if menopause is under age 50
- 1 year after the last period if menopause is after the age of 50
- Do not assume that HRT, PCOS, endometriosis, increased BMI or pelvic inflammatory disease will provide contraception

Contraceptive considerations over 40

- Some risks increase with age especially the VTE risk
- Increased BMI is very common, as is the worry about weight gain
- Increasing prevalence of long-term conditions and cancers
- Some women will have tried lots of other methods before which may affect their preferences this time
- Increased risk of adverse maternal and neonatal outcomes in pregnant women aged >40 compared to <40.
- Family may be complete so reliability may be more important, ?LARC more reliable long term (may need oral contraception in the interim)
- Many women will also be experiencing peri-menopause symptoms (HRT is not contraception so they need contraception too), this may include heavy or prolonged periods or recurrent UTIs
- Assume fertility until age 55 (see previous slide)
- Abnormal bleeding may need investigation and referral to gynaecology via GP
- Don't forget to talk about condoms and risk of sexually shared infections

How to choose a product....

- Does oral contraception suit her lifestyle, risks and preferences?
- If preference is for CHC and she is UKMEC 1 or 2 for this- If no particular concerns about androgenic effects most GPs use Rigevidon/Levest (or equivalent) as per FSRH guidance. If keen to have less androgenic effect use Yasmin, Marvelon, Mercilon but VTE risk will be higher (see detailed slide on this)
- If she is UKMEC 3 or 4 for CHC, is she UKMEC 1 or 2 for POP? Has she tried POP before and how does she feel about irregular bleeding/no periods? If ok with irregular bleeding or no periods use Desogestrel 75mg , if keen to have a more regular cycle use Slynd (drospirenone) 4mg if authorised in your ICB
- What is the safest and most cost-effective option for the local health system (i.e. local formulary)?
- Which products have good availability?

POP summary and top tips

- Very few contraindications to POP, must still check UKMEC if co-morbidities
- Use Desogestrel 75mg first line, it is cheap and has 12 hour window to take it
- If using an older POP (e.g. Norethisterone) check that she understands the 3 hour window
- Must continue to take POP every day even if she has irregular bleeding/periods
- Approx 1 in 3 women have no periods on POP, 1 in 3 have regular light periods, 1 in 3 have irregular bleeding-all of these are normal patterns and she needs to expect these
- POP can be used as contraception in women using HRT (who do not have implant/IUCD)

Choosing the progestogen in the COC?

- If no worries about androgenic effects e.g. hair, acne, weight, mood/PMS choose COC containing:
- Levonorgestrel
- Norethisterone
- Norgestimate
- These have a lower risk of VTE than the other group on this slide (still higher risk than not using COC but lower risk than pregnancy)

- If concerns about androgenic effects e.g. hair, acne, weight, mood/PMS choose COC containing:
- Drospirenone
- Gestodene
- Desogestrel
- But slightly increased risk of VTE compared to the other group

How much oestrogen to give if COC chosen?

- Higher oestrogen dose in COC (if UKMEC 1 or 2) e.g. 30 or 35mg ethinylestradiol (EE) will give better bleeding control but increase oestrogen related risks i.e. VTE and MI/CVA risk, breast tenderness and possibly weight gain
- First line choice of COC should be <or =30mcg of EE for women over 40 yrs
- Lower oestrogen dose in COC (if UKMEC 1 or 2) e.g. 20mg EE will reduce oestrogen related risks (VTE and MI/CVA) but she may have more irregular bleeding
- You may need to make a pragmatic choice of COC according to local formulary and availability and review the choice of product at 3 months and then change product again, FSRH advise <30mcg or less of EE plus levonorgestrel/norethisterone first-line choice.
- Tricycling or extended regime COC can be used for women who need control of menstrual or menopausal symptoms
- Women under the age of 50 who are UKMEC 1 or 2 for COC may choose to use it to control menopausal symptoms
- At age 50 women should stop using COC and choose an alternative method of contraception

A few other considerations…

- Find out which oral contraception products are on your local ICB formulary (Ask your CPCL)
- Find out about your local sexual health and LARC fitting options
- Provide general signposting/information to patients who have menopause symptoms, consider finding out who manages menopause in your local GP practices (it might not be a GP)
- Find out about local weight loss services and pathways

Any Questions?

Question & Answers

Contraception Service Webinar Feedback