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

PATIENT GROUP DIRECTION (PGD)

For the Supply of Combined Hormonal Contraceptive (CHC) Transdermal Patches in BPAS clinics

Version Number 3.1

Change History	
Version and Date	**Change Details**
Version 1 *April 2020*	New template. *Approved for use in BPAS November 2020.*
Version 1.1 *November 2020*	Minor rewording and highlighting of contents cautions section relating to individuals for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan. Acute porphyria added to exclusion criteria. *Version not adopted by BPAS.*
Version 1.2 *March 2022*	Addition of vaping/use of e-cigarettes where reference to smoking within PGD. Following exclusion criteria updated from 3-6 weeks to less than 6 weeks: 'Not breastfeeding and less than 6 weeks post-partum with other risk factors for venous thromboembolism (VTE). *Version not adopted by BPAS.*
Version 2.0 *April 2023*	Updated template – amended references and minor editing and wording changes/clarifications *Approved for use in BPAS 31/03/23.*
Version 2.1 *April 2023*	Addition of omitted exclusion criteria – individual weighing 90kg or above. *Approved for use in BPAS 09/05/23.*
Version 2.2 *June 2024*	Reinstated following review. Additions regarding information following EHC and abortion. Removed option for off-label dosing regimes. Added "current contract of employment with BPAS" to staff authorised.
Version 3.0 *November 2025*	Planned end of life review. Updated reference to FSRH to CoSRH. Minor rewording to align the RH PGDs content, and update terminology. Contraindication with interacting Hep C medicines added. Update SLWG and references. Added tailored dosing schedules. Links to local BPAS policies updated
Version 3.1 *January 2026*	Updated in line with UKMEC (2025), updated reference.

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

BPAS PGD Organisational Authorisations:

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

Name	Job title and organisation	Signature	Date
Mary Sexton	BPAS Clinical Director		26/02/2026
Dr Nigel Acheson	BPAS Medical Director		26/02/2026
Kalpesh Thakrar	BPAS Deputy Chief Pharmacist		04/03/2026

Authorising Body:

Dr Fiona Lemmens	Executive Clinical Director, Cheshire and Merseyside ICB		06/04/2026

Responsible person who has approved this PGD on behalf of BPAS	Name:	Heidi Stewart
	Position:	BPAS Chief Executive
	Signature:	
	Date:	26/02/2026

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

PGD DEVELOPMENT GROUP

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

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

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

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

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

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

	• Practitioners must complete 3-yearly BPAS PGD Theory Refresher training and competency assessment as per BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines • Practitioners must ensure they remain up to date with relevant clinical skills, management of anaphylaxis, BLS (as a minimum), with evidence of continued professional development • Practitioners are responsible for maintaining their competency to work under this PGD
The decision to supply any medication rests with the individual registered health professional who must abide by the PGD and any associated organisational policy	

Clinical condition or situation to which this PGD applies:	
Clinical condition or situation to which this PGD applies	• Contraception
Criteria for inclusion	• Individual (age from menarche to up to 50 years) presenting for contraception • Informed consent given • A recent, accurate blood pressure recording and BMI should be documented for all individuals prior to first CHC supply and repeated for each subsequent supply.
Criteria for exclusion	• Consent not given • Individuals under 16 years of age and assessed as not competent using Fraser Guidelines. • Individuals 16 years of age and over and assessed as lacking capacity to consent. • Known hypersensitivity to the active ingredient or to any component of the product as detailed in the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website • Less than 21 days after childbirth (for deliveries over 24 weeks gestation) • Breastfeeding and less than six weeks postpartum. • Not breastfeeding and less than 6 weeks post-partum with other risk factors for venous thromboembolism (VTE). • Individuals aged 50 years and over • Individual weighing 90kg or above • Significant or prolonged immobility • Major surgery. NB: Within 4 weeks before or until 2 weeks after full mobilisation following major elective surgery (>30 minutes duration) or any surgery on the legs or surgery which involves prolonged immobilisation of a lower limb. **Cardiovascular disease** • Individuals aged 35 years or more who currently smoke or stopped smoking less than one year ago (this includes vaping and the use of e-cigarettes) • Body Mass Index (BMI) equal to or greater than 35kg/m^2 • Blood pressure measurement (in clinic) greater than 140/90mmHg or

	controlled hypertension • Multiple risk factors for cardiovascular disease (CVD) (such as smoking which includes vaping/use of e-cigarettes, diabetes, hypertension, obesity and dyslipidaemias) Where more than one risk factor is present, clinical judgement must be applied. • Current or past history of ischaemic heart disease, vascular disease, stroke or transient ischaemic attack • Current or past history of venous thromboembolism • Individuals with multiple risk factors (defined as more than one risk factor) for VTE are excluded. Clinical judgement should be applied and advice from a prescriber sought. Examples of VTE risk factors include (but not exclusively) o family history of VTE, o immobility, o BMI> 35kg/m2 o superficial VTE, o ovarian and endometrial cancer, o inflammatory bowel disease, o sickle cell disease • Complicated valvular or congenital heart disease e.g. pulmonary hypertension, history of subacute bacterial endocarditis • First degree relative with venous thromboembolism which occurred at any age • Known thrombogenic mutations e.g. factor V Leiden, prothrombin mutation, protein S, protein C and antithrombin deficiencies • Cardiomyopathy with impaired cardiac function • Atrial fibrillation **Neurological Conditions** • Current or past history of migraine with aura at any age • Migraine without aura; when first attack occurred on a method of contraception containing an oestrogen • Multiple Sclerosis with prolonged immobility **Cancers** • Past or current history of breast cancer, or currently being treated for breast cancer • Undiagnosed breast mass (for initiation of method only) • Carrier of known gene mutations associated with breast cancer e.g. BRCA1or 2 • Malignant liver tumour (hepatocellular carcinoma) **Gastro-intestinal Conditions** • Viral hepatitis, acute or flare (for initiation only) • Benign liver tumour (hepatocellular adenoma) • Severe decompensated cirrhosis • Gallbladder disease; currently symptomatic or medically managed. • Cholestasis (related to past combined hormonal contraceptive use) **Other conditions** • Imminent planned major surgery (CHC should be stopped at least 4 weeks prior to planned major surgery or expected period of limited mobility). • Diabetes with end organ disease (retinopathy, nephropathy,

	neuropathy) • Positive anti-phospholipid antibodies (with or without systemic lupus erythematosus) • Organ transplant, with complications • Known chronic kidney disease (all stages) or acute renal failure • Acute porphyria **Medicines** • Individuals using enzyme-inducing drugs/herbal products or within 4 weeks of stopping them • Interacting medicines (other than enzyme inducers), including any medicines purchased as detailed in the current British National Formulary (BNF) or the Summary of Product Characteristics (SmPC) which can be accessed on the EMC website • Contraindicated in concomitant use with the medicinal products containing glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir.
Cautions/Circumstances in which further advice should be sought (including any relevant action to be taken)	• If the individual is less than 16 years of age an assessment based on Fraser guidelines must be made and documented. • If the individual is less than 13 years of age, the healthcare professional should speak to local safeguarding lead and refer to the policy Safeguarding Children and Young People • Discuss with appropriate doctor/independent non-medical prescriber any medical condition or medication of which the healthcare professional is uncertain • Individuals taking lamotrigine should be advised that CHC may interact with lamotrigine; this could result in reduced seizure control or lamotrigine toxicity • Sickle cell trait - there is a small increase in the risk of VTE with sickle cell trait, therefore alternatives to CHC should be prioritised. • **Offer LARC to all individuals, in particular those with medical conditions for whom pregnancy presents an unacceptable risk and those on a pregnancy prevention plan** • **If an individual is known to be taking a medication which is known to be harmful to pregnancy, a highly effective form of contraception is recommended. Highly effective methods include the LARC methods: copper IUD, LNG-IUD and implant. If a LARC method is unacceptable/unsuitable and a CHC is chosen then an additional barrier method of contraception is advised. as detailed in the FSRH CEU Statement- Contraception for women using known teratogenic drugs or drugs with potential teratogenic effects**
Action to be taken if the individual is excluded or declines treatment	• Explain the reasons for exclusion to the individual and document in the consultation record • Record reason for declining treatment in the consultation record • Where appropriate refer the individual to a suitable health service provider and/or provide them with information about further options

Description of treatment:	
Name, strength and formulation medicine	Each 20cm^2 transdermal patch contains 6 mg norelgestromin and 600 micrograms ethinylestradiol
Legal category	POM

<table>
<tr><td>Route of administration</td><td>Transdermal</td></tr>
<tr><td>Indicate any off-label use (if relevant)</td><td>Best practice advice given by College of Sexual and Reproductive Healthcare (CoSRH) is used for guidance in this PGD and may vary from the individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website

This PGD includes inclusion criteria, exclusion criteria and dosage regimes which are outside the market authorisation for many of the available products, but which are included within FSRH guidance - Combined Hormonal Contraception.

Specifically, the use of tailored CHC regimens is outside the manufacturer's licence, as is use in those under 18 years or over 45 years of age but is supported by the College of Sexual & Reproductive Healthcare (CoSRH). The regimes detailed within this PGD are permitted under this PGD.

Medicines should be stored according to the conditions detailed in the Storage section below. However, in the event of an inadvertent or unavoidable deviation of these conditions the local pharmacy or Medicines Management team must be consulted. Where medicines have been assessed by pharmacy/Medicines Management in accordance with national or specific product recommendations as appropriate for continued use this would constitute off-label administration under this PGD. The responsibility for the decision to release the affected medicines for use lies with pharmacy/Medicines Management.

Where a medicine is recommended off-label consider, as part of the consent process, informing the individual/parent/carer that the medicine is being offered in accordance with national guidance but that this is outside the product licence.</td></tr>
<tr><td>Dose and frequency of administration</td><td>

Each patch releases 33.9 mcg ethinylestradiol and 203mcg norelgestromin per 24 hours over a seven day period.
CoSRH guidance states that CHC can either be used following a standard or tailored regime.
Individuals should be given information about both standard and tailored CHC regimens to broaden contraceptive choice.

<u>Regimes</u>

The regime which can be advised is detailed below:

<table>
<tr><th>Type of regimen</th><th>Period of CHC use</th><th>Hormone (patch) free interval</th></tr>
<tr><td colspan="3">Standard use</td></tr>
<tr><td>Standard use</td><td>21 days (3 patches)</td><td>7 days</td></tr>
<tr><td colspan="3">Tailored use</td></tr>
<tr><td>Shortened hormone-free interval</td><td>21 days (3 patches)</td><td>4 days</td></tr>
<tr><td>Extended use (tri-cycling)</td><td>9 weeks (9 patches)</td><td>4 or 7 days</td></tr>
<tr><td>Flexible extended use</td><td>Continuous use (≥21 days) of active patches until breakthrough bleeding occurs for 3–4 days</td><td>4 days</td></tr>
</table>
</td></tr>
</table>

	<table><tr><td>Continuous use</td><td>Continuous use of active patches</td><td>None</td></tr></table> • A single patch applied at the same time each week for seven days starting on day 1-5 of the menstrual cycle with no need for additional protection. • The patch can be started at any time after day five if it is reasonably certain that the individual is not pregnant. Additional contraception is then required for seven days after the patch is applied • Thereafter the dosage regime detailed above should be followed. Individuals should have access to clear information (either written or digital) to support tailored CHC use. • When starting or restarting the CHC as quick start after levonorgestrel emergency contraception, additional contraception is required for 7 days and a pregnancy test should be performed 21 days after the last unprotected sexual intercourse. • In line with FSRH guidance - Combined Hormonal Contraception individuals using hormonal contraception should delay restarting their regular hormonal contraception for 5 days following ulipristal acetate use. Avoidance of pregnancy risk (i.e. use of condoms or abstain from intercourse) should be advised until fully effective. For CHC patches this is for 7 days after re-starting this method. • For guidance on changing from one contraceptive method to another, and when to start after an abortion and postpartum, refer to FSRH - Switching or Starting Methods of Contraception and FSRH Clinical Guideline: Contraception after Pregnancy • CHC can be safely started immediately at any time after abortion. If started within 5 days after abortion, no additional contraceptive precautions are required. If started 5 or more days after abortion, 7 days of additional contraceptive precautions are required.
Duration of treatment	• For as long as the individual requires CHC and has no contraindications to its use
Quantity to be supplied	Maximum of nine patches (Up to three months' supply) in appropriately labelled original packs. For all supplies ensure the individual is aware that the regimen to be taken may not be reflected in the dosage information printed on the product packaging or within the supplied PIL – ensure full details of regimen to be followed are supplied.
Storage	Medicines must be stored securely according to national guidelines, in line with the BPAS Medicines Management policy Medicines Management Policy and as detailed in the SmPC which can be accessed on the EMC website
Drug interactions	All concurrent medications, including those purchased should be considered for interactions. A detailed list of drug interactions is included in the individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website and the BNF Refer also to FSRH guidance on drug interactions with hormonal contraception Concomitant use with the medicinal products containing containing glecaprevir/pibrentasvir or sofosbuvir/velpatasvir/voxilaprevir is contraindicated. See Liverpool HEP Interactions

	Seek advice from an appropriate clinician/Medicines Advisory Service if required.
Identification and management of adverse reactions	A detailed list of adverse reactions is included in the individual Summary of Product Characteristics (SmPC) which can be accessed on the EMC website and the BNF The following possible adverse effects are commonly reported with CHC (but may not reflect all reported adverse effects): • Nausea • Breast tenderness • Headache and migraine • Temporary disturbances of bleeding patterns • Change in mood including depression • Fluid retention • Change in libido • Skin changes including acne Specific adverse events associated with transdermal patch CHC include: • Localised skin irritation Serious adverse effects - these are less common but the risks should be discussed with the individual: • Venous thromboembolic events (VTE) • Arterial thromboembolic disorders (including ischaemic heart disease) • Strokes (e.g. transient ischaemic attack, ischaemic stroke, haemorrhagic stroke) • Hypertension
Management and reporting procedure for adverse reactions	• Healthcare professionals and individuals/carers are encouraged to report suspected adverse reactions to the Medicines and Healthcare products Regulatory Agency (MHRA) using the Yellow Card reporting scheme on: http://yellowcard.mhra.gov.uk • Record all adverse drug reactions (ADRs) in the individual's clinical record. • Report via organisation incident policy: InPhase
Written information and further advice to be provided	• Provide manufacturer's information leaflet (PIL) provided with the original pack. • Individuals should be informed about the superior effectiveness of LARC. • Individuals should be provided with written information or a link to a trusted online resource to support safe, effective CHC use. • Explain mode of action, side effects, and benefits of the medicine. • Where CHC patches are supplied ahead of abortion treatment, advise the patient that if they choose to continue with their pregnancy, the contraception should not be started. If abortion treatment failure occurs after starting the CHC and a decision to continue the pregnancy is made, it should be stopped. The BPAS unit should be informed and any unused CHC should be returned to a BPAS unit or pharmacy for disposal. • Advise individual on how to apply the patch, remove the patch and how patch changes should be managed. • The patch should be applied immediately upon removal from the protective sachet.

	• To prevent interference with the adhesive properties of the transdermal patch, no creams, lotions or powders should be applied to the skin area where the transdermal patch is to be applied. • Advise the individual that the patch should not be applied to irritated or broken skin. The patch should not be put on the breasts. • Advise individual that only one patch should be worn at any one time. • Advise individual on action to take if the patch becomes partially or fully detached and any incorrect use. • Advise on patch disposal - the disposal label from the outside of the sachet should be peeled open. The used transdermal patch should be placed within the open disposal label so that the sticky surface covers the shaded area on the sachet. The disposal label should then be closed sealing the used transdermal patch within. The patch should be disposed of in normal household waste. Used transdermal patches should not be flushed down the toilet nor placed in liquid waste disposal systems. • Advise about the risks of the medication including failure rates and serious side effects and the actions to be taken noting that the risks of using CHC could outweigh the benefits. • **Serious symptoms:** the individual should stop using the CHC and seek urgently medical help if they experience calf swelling, heat or pain in the calf, shortness of breath, chest pain or haemoptysis. The individual should seek advice if they experience their first ever migraine or develops aura with existing migraine. • Individuals should be advised that current use of CHC is associated with a small increased risk of breast cancer which reduces with time after stopping CHC. • Individuals should be advised that current use of CHC for more than 5 years is associated with a small increased risk of cervical cancer the risk of which reduces over time after stopping CHC and is no longer increased by about 10 years after stopping. • Individuals should be advised that current use of CHC is associated with an increased risk of VTE/ATE. • Individuals using CHC should be advised about reducing periods of immobility during travel. • Individuals trekking to high altitudes (above 4500 m or 14 500 feet) for periods of more than 1 week may be advised to consider switching to a safer alternative contraceptive method. • Individuals should be advised to stop CHC and to switch to an alternative contraceptive method at least 4 weeks prior to planned major surgery or expected period of limited mobility. • Offer condoms and advice on safer sex practices and possible need for screening for sexually transmitted infections (STIs). • Ensure the individual has contact details of local service/sexual health services. • Advise individual to seek advice from a pharmacist, doctor or other prescriber before starting any new medications including those purchased. • Relevant BPAS patient information booklet relevant to their treatment, including Aftercare information.
Advice/ follow up treatment	• The individual should be advised to seek medical advice in the event of an adverse reaction.

	• The individual should be encouraged to tell all clinicians that they are taking the supplied medication in the event of other medication/s being prescribed. • The individual should seek further advice if they have any concerns. • Review prior to BPAS supply running out and then at least annually by GP or sexual and reproductive health services

Records to be kept	The following must be recorded in the patient records in line with the BPAS' Record Keeping policy Record Keeping, using black ink if written:
	• The consent of the individual and
	  ○ If individual is under 13 years of age record action taken
	  ○ If individual is under 16 years of age document capacity using Fraser guidelines.
	  ○ If individual is under 16 years of age and not competent, record action taken
	  ○ If individual over 16 years of age and not competent, record action taken
	• If individual not treated under PGD record action taken
	• Name of individual, address, patient BPAS identification number, date of birth
	• Relevant past and present medical and sexual history, including smoking status and family history.
	• Relevant medication history (to include over the counter, herbal medications, supplements and recreational drug use)
	• Examination findings including BMI and blood pressure.
	• Any known allergies and nature of reaction
	• Name of registered health professional operating under the PGD
	• Name of medication supplied
	• Date of supply
	• Dose supplied
	• Quantity supplied including batch number and expiry date in line with BPAS PGD policy Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines
	• Advice given, including advice given if excluded or declines treatment
	• Details of any adverse drug reactions and actions taken
	• Advice given about the medication including side effects, benefits, and when and what to do if any concerns
	• Any follow up and/or referral arrangements made
	• Any supply outside the terms of the product marketing authorisation
	• Recorded that supply is via Patient Group Direction (PGD)
	
	Records should be signed and dated (or a password controlled e-records) and securely kept for a defined period in line with local policy. Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines
	
	All records should be clear, legible and contemporaneous
	
	A record of all individuals receiving treatment under this PGD should also be kept for audit purposes in accordance with local policy. Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines

Key References

Key references (accessed December 2025)	• Electronic Medicines Compendium http://www.medicines.org.uk/ • Electronic BNF https://bnf.nice.org.uk/ • NICE Medicines practice guideline "Patient Group Directions" https://www.nice.org.uk/guidance/mpg2 • College of Sexual and Reproductive Healthcare (2019, amended 2020) Combined Hormonal Contraception FSRH Clinical Guideline: Combined Hormonal Contraception (January 2019, amended October 2023) | FSRH • College of Sexual and Reproductive Health Drug Interactions with Hormonal Contraception – May 2022 FSRH CEU Guidance: Drug Interactions with Hormonal Contraception (May 2022) | FSRH • College of Sexual and Reproductive Healthcare (2025) UK Medical Eligibility Criteria for Contraceptive Use. UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) | CoSRH • College of Sexual and Reproductive Healthcare Clinical Guideline: Quick Starting Contraception (April 2017) FSRH Clinical Guideline: Quick Starting Contraception (April 2017) | FSRH • BPAS Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines. Updated November 2024 Patient Group Directions (PGDs) and Other Legal Mechanisms for Supply of Medicines • BPAS Safeguarding Adults at Risk policy. Updated July 2025 Safeguarding Adults at Risk • BPAS Safeguarding Children and Young People policy. Updated August 2025 Safeguarding Children and Young People • BPAS Medicines Management Policy. Updated May 2025. Medicines Management Policy • BPAS Record Keeping Policy. Updated December 2023. Record Keeping

Audit and ongoing monitoring of this PGD

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

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

Appendix A: Approved Practitioner List

Patient Group Direction (PGD) name:	Supply of combined hormonal contraceptive (CHC) transdermal patches in BPAS clinics v3.1.	
	Valid from: 01/04/2026	**Expiry: 31/03/2029**

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

Registered health professional

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

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

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

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

Name (print)	Designation	Registration number	Signature	Date

Authorising manager

I confirm that the registered health professionals named above have declared themselves suitably trained and competent to work under this PGD. I give authorisation on behalf of BPAS for the above named health care professionals who have signed the PGD to work under it.

Name	Position	BPAS Treatment Unit	Signature	Date:

Note to authorising manager

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