# GGC CPIP Notebook
## Summer 2025

## All change in the Community Pharmacy Development Team - Pamela Macintyre

June 2025 was a bittersweet month as we wished Alan Harrison all the best in his retirement but also shed a few tears and considered the gaping hole he was leaving behind and the wealth of experience he was taking with him.

During his 10 years in post he has met many challenges head on, including navigating the choppy Covid 19 waters, rolling his sleeves to help at the Distribution centre whilst always advocating fiercely for community pharmacy. The only undefeated quest was the disposal of sharps bins……. that may take another century.

As we move into winter planning season, we are delighted that Rachel Bruce will be joining to lead up the Community Pharmacy Development Team in early autumn. With a wealth of experience across the sectors including a regular community pharmacy locum, Rachel is looking forward to working alongside the GGC community pharmacy network to develop and improve services.

*"GGC now has over 200 Independent Prescribers offering Pharmacy First Plus across 187 sites, this is a fantastic resource for the patients of GGC to access services and use the advanced practice skills of my pharmacy colleagues. I am aware of the competing priorities that are a daily challenge for the community pharmacy network, IPs in particular who often feel they are spinning plates! I hope that we can work collaboratively to support each other and strengthen the network. This year may be particularly challenging as we navigate the changes in the FTY year alongside supporting DPPs and the technical staff within pharmacy teams to develop. I am very much of the ethos that there is no 'I' in team and look forward to working with both the Clarkston team and the extended network team in Glasgow"*

Pamela Macintyre will be absorbing some of Alan's role until Rachel takes up post.

Please contact ggc.cpdevteam@nhs.scot if you have any queries or visit our website for useful contacts and resources https://www.communitypharmacy.scot.nhs.uk/nhs-boards/nhs-greater-glasgow-clyde/


**Have you recently moved job or moved to a new location within your pharmacy group?**

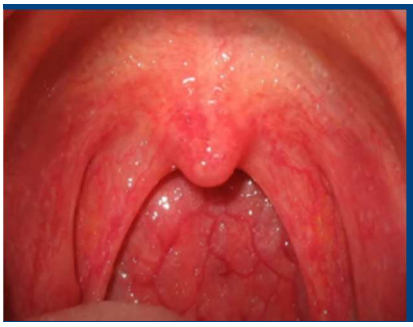
Your prescriber code is linked to your contractor code. If you move this will require to be updated on our records. You should also ensure that NSS is advised if the service is no longer being provided so they can adjust payments.

**Please remember to contact the CPDT and update them** ggc.cpdevteam@nhs.scot

MORE INFO

For more information on GGC CPIP resources click here or scan the QR code.

Sign up to the NES mailchimp here and follow @NHSGGCPharmacy on X



# Consultation Conundrum:

## Patient on Systemic Anti-Cancer Treatment with a sore throat

Female, 58 years old with Myeloma (6y), bone marrow transplant 2022, current systemic anti-cancer treatment is 2 weekly Elranatamab subcutaneously (a biospecific monoclonal antibody) and weekly immunoglobulin. Other usual medication: Aciclovir 200mg BD, bisacodyl 5mg BD, Duloxetine 40mg nocte (back pain), fexofenadine 180mg OM, co-trimoxazole 960mg (thrice weekly), omeprazole 20mg OM.

Returned from weekend away at concert and throat is red, some pain on swallowing but can swallow, feels well in herself. Had bloods at clinic last week but is not back again until next week and looking for something to ease her symptoms.

**What would you do?**

**CPIP 1:** Concerns that the patient is immunocompromised and although bloods had been okay a few days ago, things can change quickly and as the patient had been in a crowded area, potentially a higher risk of infection. Sore throat can be a red flag for some immunosuppressed patients so I do not think I would feel comfortable prescribing antibiotics, but on examination of the image, it does look more viral in origin. I would check some basic observations and if they were out with normal, I might complete a NEWS score to help with any onward referral. If the observations were normal, I would consider a throat spray and pain relief with a strong worsening statement and advice to advise treatment centre of this occurrence. I would give them a copy of my observations,

**IP Trainee:** Initially, I would cry that such a complicated patient had presented but although I think out with my remit…… I would advise the patient that it does not look bacterial at present and after doing some checks of her BP and temperature to check within normal range. I would offer something like a sore throat spray/gargle to ease the pain and recommend some regular paracetamol. I would also advise the patient to contact their cancer nurse ASAP for further guidance and give a strong worsening statement that if symptoms get worse or if she begins to feel unwell to contact GP or OOH as she is immunocompromised. She should not wait to be seen if needed.

**ANP:** Looking at the picture, I would want to exclude that there was no white/pus on the right-hand side of the image. I would take a history and consider history, frequency of symptoms to see if any pattern or if related specifically to treatment. There is no uvular deviation in the image and the patient reports they can swallow. I would check temperature and pulse and complete NEWS score if needed. It seems like the patient's priority is symptomatic relief, they are not demanding antibiotics but the concern here it that it is an immunocompromised patient. I would give a strong worsening statement and also take into account the severity of symptoms, the patients **Ideas, Concerns and Expectations (ICE)** and preferences. If I was unsure if there was a bacterial element, I may err on the side of caution and give an antibiotic. Time of presentation may also sway this, a delayed antibiotic could be an option if they presented late on a Friday evening or Saturday.

**What actually happened – CPIP**: Patient presented, they were well known to the pharmacy and sister was nurse with whom she had discussed her symptoms before attending. She had previously been treated for a viral sore throat and a separate bacterial sore throat during the course of her treatments over the years. It was a Monday afternoon when the patient attended so I did feel that there were options for me to refer onto if needed. I was able to view her blood results on clinical portal. I checked the patients' temperature, BP and pulse and they were all normal for the patient. The patient was keen to avoid an antibiotic unless needed as they were prone to oral thrush and stomach upset when they required to take an additional course over and above their prophylactic co-trimoxazole. We agreed to try a Difflam Spray with regular paracetamol (dispersible so they could gargle with it). Pt knew they should not take NSAIDs due to potential kidney issues in myeloma and would increase fluids including honey drinks. They would email their clinic nurse to update them and if needed attend the clinic later in the week if required. A strong worsening statement was given alongside a link to Leaflets to discuss with patients: RTI Leaflet | RCGP Learning. This is a resource I often use as it has versions in many languages which can help when English is not a patient's first language.

**What happened next?** The patient was back in the pharmacy later in the week to collect their serial prescription and advised that they were feeling much better and had not required additional antibiotics. They were thankful that they had not required to attend the clinic or OOH services earlier in the week and could be managed locally at the pharmacy.

**GP Comment:**
If feeling unwell/febrile/worrying NEWS score, then probably best for the patient to contact their cancer nurse as they will likely get them in for contemporaneous bloods. Bear in mind NEWS is a hospital-based scoring system but appreciate it can be used to gauge a patient 'wellness' at a point in time.

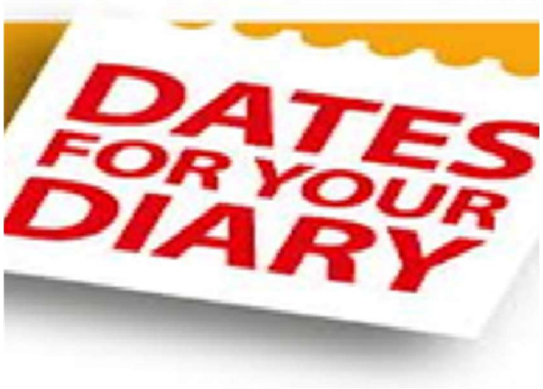
If it was me, I would go symptom relief if confident viral, Abx if confident bacterial/tonsillitis (prescribe as per GGC Abx guidelines) or advise to contact cancer team if systemic concerns. That's what we would do if the patient was a direct presentation to GP practice.

**Useful Information & Links for further training:**

Cancer treatments and drugs A to Z | Macmillan Cancer Support

BOPA 'Let's Communicate Cancer Series' : CPPE


**If you have any ideas for clinical conundrums, please send them to lorna.brown8@nhs.scot**




- **Peer Review session** – come along and share a case with peers or just listen #GetInvolved (Tuesday August 12th @ 7pm) Join here
- **Lifestyle Medicine –** How a community pharmacist incorporates a holistic approach into their consultations - date TBC September 25
- **Introductory Webinar for new CPIPs –** date TBC October 25

If you have any ideas for webinar topics, then please contact lorna.brown8@nhs.scot – we need your help to make the sessions relevant for you and your needs.

**Alternatively, get in touch if you would like to get involved with a GGC Journal/Case Presentation Club as part of advanced practice journey.**

# Are you taking the plunge and undertaking the Designated Prescribing Practitioner (DPP) role?

Whether undertaking the role for a legacy pharmacist or as part of the new Foundation Training Year syllabus, if you are taking the plunge and becoming a DPP in the next few months, get in touch - we can discuss how we can support each other in unchartered waters. NES are continuing to offer support and drop-in sessions for current or potential DPPs that can be booked on Turas. I used the DPP resources to help me complete my application, they available on TURAS.

Have you recently been a DPP? Send in your top tips and share the secrets to success. Many will be happy to hear them. If we can arrange some support, perhaps via the new Teams channel. Please let the Community Pharmacy Development team know what we can do to help.

## Struggling to access the Teams Chat?

1. Email ggc.cpdevteam@nhs.scot and a request for full Teams access will be made
2. Complete Teams chat consent form (previous WhatsApp consent will transfer over)
3. Ensure you have Teams on iPad/Phone/Laptop
4. If you have more than one Teams account, make sure the nhs.scot one is the one listed for GGC chat.
5. Once full access granted, CPDT member will add you to the CP Teams Chat

**GGC CPIP Audit – Have you completed your PCA (16) stipulated training for Pharmacy First Plus?**

Following a surge of queries, we clarified with NHS Education Scotland the multiple questions pertaining to completion of the 4 days of the clinical skills courses detailed in PCA (16). There is a document from Community Pharmacy Scotland Clinical skills training for community pharmacists | Turas | Learn which still stands and will continue to do so until any revised service is introduced.

Therefore, if you have outstanding courses and were originally **NES funded** please **contact pharmacy@nes.scot.nhs.uk** to determine capacity for them to complete.

If you were originally **self-funded or employer funded**, you should contact Community Pharmacy Scotland to express interest in attending the courses - **contact enquiries@cps.scot**.

If you feel that you have equivalent experience or have completed a certified course e.g. the original 30 hours common clinical conditions NES module, something delivered by CPPE/ HEIW in Wales or an ACE course, please get in touch with the CPDT so that we can complete the appropriate checks.