

HELEN REMINGTON

A woman with a mission

■ By BOB LEACH, MPharm, FRPharms

Helen Remington is passionate about hospital pharmacy and has made a strong impact on its practice. Bob Leach went to interview her



Helen Remington: My enthusiasm spurs me on

Helen Remington was born in Stockton where she attended the local grammar school. She was interested in chemistry and biology and chose to read pharmacy at Aston University.

Bob Leach: *What happened after leaving Aston?*

Helen Remington: After qualifying in 1976, I undertook my preregistration training at St James's University Hospital, Leeds.

St James's turned out to be an excellent choice because I was encouraged to develop my potential to the full. Ian Marshall, district pharmaceutical officer, Vic Standing, principal pharmacist, and then later, Mike Spencer, were forward thinkers with an enabling management style. There was a real team spirit within the department, and this, together with continuing opportunities, encouraged me, like many colleagues, to stay.

After obtaining my masters qualification, I moved to Airedale Hospital, near Bradford, where I was responsible for clinical services. During my time at Airedale I benefited from the leadership of Peter Taylor, the chief pharmacist. His enthusiastic team developed

leading-edge services, such as an anticoagulant clinic, to meet patient needs.

After a few years, I moved back to Leeds to run drug information services. The section also had responsibility for clinical trials, formulary management and drug usage review. I was a staff pharmacist in the same post for some years, but because of the enabling environment I was able to vary the emphasis of the work. I had my three children while at "Jimmy's", taking maternity leave between the various phases of my work. I worked in paediatric oncology, respiratory medicine and neurology for two to three years each during my eight years as principal pharmacist, drug information.

BL: *I understand that you eventually became a chief pharmacist at St James's. Can you tell us about this?*

HR: This was in 1991. The post was responsible for the management of all patient services as part of a senior team reporting to the director of pharmacy, Ian Marshall.

It was an interesting and challenging post and, of course, provided new experiences. The responsibilities covered clinical services, medicines information (MI), inpatient, outpatient and aseptic dispensary services. All of the staff were wonderfully supportive and delivered the changing needs of the hospital during a time of significant growth and change. Clinical services had a sound foundation going back to the days of the late 70s

and this was developed to give input into direct patient care, consultant ward rounds, clinics, and teaching. The focus was to increase the amount of time devoted to the critical care clinical services to enable a more comprehensive service. New posts were established to create teams of post-graduate pharmacists in oncology and transplant directorates. These senior pharmacists were appointed to work closely with small medical teams, moving pharmacy nearer to a consultant role such as can be seen today.

Although I had undertaken various management training courses I felt the need to underpin my knowledge and completed the Diploma in Management Studies through Henley Management College, Brunel University in 1996. This training enabled me to look at new ways of working, for example, in the area of skill-mix. We therefore established accredited checking technicians and dispensing assistants (assistant technical officers) 10 years ago.

The MI unit was upgraded and its office accommodation was integrated with that for many of the clinical staff. The intention was to improve the MI skills of the clinical staff, making them a readily available resource for the MI staff and provide access to the best resources to all who required them. The principal pharmacist developed one of the early pharmacy websites. The move to a paperless system of working was well developed in this unit.

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In aseptics we were able to develop a paediatric centralised intravenous additive (CIVA) service, and then, with the assistance of manufacturing colleagues, to bring an outsourced cystic fibrosis antibiotic service back into the hospital from a commercial supplier which saved £250,000. This was a significant saving 10 years ago.

EL: *In 1996 you went to Addenbrooke's Hospital — what have been your major contributions to pharmacy practice at Cambridge?*

HR: I was appointed chief pharmacist at Addenbrooke's Hospital in 1996 and inherited a pharmacy which had experienced chronic under-investment. One of my first objectives was to increase staffing levels for clinical services and I now have a directorate structure with lead pharmacists managing teams in service centres.

EL: *Tell us about your departmental management arrangements.*

HR: The department is structured in a fairly traditional way with all the normal sections. Our senior managers are all currently pharmacists, with the exception of our chief technician who is responsible for dispensaries management. I formalised the senior team management structure in 1996 and it has remained fairly constant. We have reviewed all our working procedures, implemented necessary changes and obtained King's Fund (Health Quality Systems) accreditation for the department. All procedures are fully documented and we are working towards them being added to our website. [The website, nww.addenbrookes-pharmacy.nhs.uk is only available to readers who are linked up to the NHS net.] This will assist with the maintenance of up-to-date information and its ready access.

EL: *You were keen on skill mix at St James's, does this continue at Addenbrooke's?*

HR: Yes, I am keen on skill mix issues so have worked to ensure that all staff operate at the highest level of work they can undertake with confidence and competence. I have been particularly keen to ensure we maximise the contribution made by technical and assistant staff. For example the operational management of each section is the responsibility of a senior technician (medical technical officer, MTO4) and, as explained, the department has a chief technician who is a member of the senior management team. We introduced accredited checking technicians and defined the role in dispensing which assistants could undertake, four years ago. We have technicians on the wards examining patients' own medicines (PODs) on admission and to check that discharge medication from patient lockers matches pharmacist approved- or

pharmacist written- prescriptions; in the MI unit answering queries; supporting the principal in information and supply; managing our procurement section; and another is the pharmacy systems manager.

We were able to obtain funding from the North West Anglia Education Consortium to investigate the CPD requirements of all staff in the region and this should support the development of continuous training to meet these extended roles. We have already begun to address many of the needs brought about by these changes in practice.

EL: *What about technician registration?*

HR: As the role of technicians develops so their accountability must develop. They cannot underperform in one pharmacy and expect to secure posts in another hospital elsewhere; managers need to know they are employing safe practitioners. Therefore, I think registration is necessary. Currently, I believe the Royal Pharmaceutical Society of Great Britain could register technicians at the NVQ3 stage. The other professional work of the Association of Pharmacy Technicians would continue to meet the rest of the agenda, as it does now. I have been working within the Society's Council to address this issue.

EL: *What other initiatives have you been involved in?*

HR: We have developed trust policies and procedures for the entire range of medicine management activities across the trust and reviewed them again this year. We have also developed a medicines management strategy approved by the hospital board last year. In 1997, we put in place a strategy for the management of medication errors. All these policies are detailed on our website.

Another initiative resulted after I was asked by the trust chief executive to review the working of the drug and therapeutics committee (DTC). This led to the establishment of an affordability management arm — our drugs and finance committee, of which I am a member. The committee is in the early stages of development and meets whenever necessary if there is a financial inability to meet an approved DTC decision. The committee is also involved in horizon scanning and the preparation of the business cases for new drugs.

Another area of involvement concerns electronic prescribing and medicines administration. We have recently secured £300,000 of funding from the health authority to evaluate the role of electronic prescribing and medicines administration in the hospital. Our proposed system will use hand-held terminals and initially will not provide decision support to prescribers (ie level 3 on the government ladder), but will offer same-screen look-up of electronic

results. I am the project director for this work with a consultant as lead clinician. My deputy is the project manager. Again, details can be found on the website.

We have also negotiated funds (£620,000) for the redevelopment of aseptic facilities which are nearing completion, the extension and regrading of directorate pharmacist posts, and increases in numbers of preregistration student posts. More recently, we have extended the reuse of PODs during the inpatient period and have secured the appointment of four clinical technicians to cover all 14 medical wards. We have also negotiated with the health authority recently for the supply of 28-days discharge medication.

EL: *What are your current projects and work interests?*

HR: I am concerned about research and leadership issues within the profession. Practice developments should be based on research but some believe that much of this research, undertaken and reported from practice, lacks rigour. We need a more robust approach, more like the medical model, with tenure, so that practitioners could spend a year or more out of routine work to learn and apply research techniques to evaluate their work. For example, if nationally we were to fund 50 posts in an initial year, and expand to 200 posts over five years, we would have an established route to grow expertise and produce future leaders. We need funding and university co-operation, and such developments are required across pharmacy practice, in community pharmacy as well as in our hospitals. There are such potential opportunities for the profession to play a fuller role in patient care by practising at higher levels, assuming greater responsibility and increased accountability. For example, all the current issues about prescribing, medicines management and clinical governance provide a focus for higher level professional contributions.

Medication error management is another key issue. The Department of Health has highlighted it in such publications as *An organisation with a memory*, *Building a safer NHS for patients* and *Pharmacy in the future*. There are two key targets: the reduction to zero of patients dying or being paralysed by maladministered spinal injections, and the reduction by 40 per cent of serious errors in the use of prescribed medicines. Both are required by 2005. Addenbrooke's is one of 20 pilot sites established by the new National Patient Safety Agency to progress work in the field of a national reporting scheme. We are seeking a pharmacist to undertake aspects of identifying, reporting, analysing, learning from and implementing changes arising from medication errors. The appointee will work with the hospital risk management team.

I am also interested in supporting pharmacists and other professionals involved in errors. A punitive culture still operates within the NHS and needs to be replaced by supportive and corrective measures — this could be procedural changes to minimise further incidents. The Guild of Healthcare Pharmacists has raised, informally, with the British Medical Association, the degree of support available to pharmacists and doctors during the investigation of errors, and I would like to see a joint proposal to sponsor research in this field by the two bodies. There clearly is tension between the focus on increased professional regulation and the “no blame” culture espoused by government.

Re-engineering hospital services and automation is another topic in *Pharmacy in the future* and like every topic in that document it is crucial that we show we can respond to the challenge. I believe time is not on our side — all pharmacists, wherever they practice, will need to move fast. Certainly, hospital pharmacists need to be implementing discharge medicines procedures, inpatient self-administration schemes where appropriate, enhancing the role of technicians and so on. To release professional time I would consider direct ward delivery of supplies from wholesalers and automating some of our dispensing services — for example, a one-armed robot can select and label 800 items a day, at 10 seconds per item. Thus, it could label all our discharge drugs and ward stocks of discharge pre-packs which we currently buy in.

EL: *You have already mentioned that you have been working within the Society's Council to address the issue of technician registration. How else do you see the work of the Society's Council?*

HR: I enjoy it and was pleased to be elected on the two subsequent occasions after originally being co-opted, after serving on the Department of Health review of the arrangements for prescribing, supply, and administration of medicines (the Crown Review). I wondered if my Council and Guild duties would detract from my work at the hospital and have been keen to discuss this issue with my own pharmacy management team. They are happy with the way we work together and have confirmed there have not been problems. The hospital management team is used to many of our medical staff carrying out similar duties to a range of professional bodies and has been similarly supportive. Such work also allows me to bring a broader experience and add value to our hospital work.

I have always been interested in political matters so I am particularly pleased to serve on the Council, since this is where changes in professional policy and practice are agreed. Many of my electors are hospital pharmacists and it is important that the perspectives of hospital pharmacists who work

in a multiprofessional environment are represented. Such perspectives are often quite different from those of people working in community pharmacy.

Currently, I am a member of the Practice and Remuneration Committees and Deputy Chairman of the Education committee. I am also on the Ethics Working Party and the Pharmacy Prescribing Task Group; this latter is a particular interest for me. We are fortunate to have June Crown on the Task Force and we expect the department to consult on the issue of supplementary prescribing early in 2002.

Supervision and accountability
Again, Council is considering supervision and we need to make progress. The key principle is that of accountability. There is a quite widely held view that nothing less than a final check by the pharmacist will suffice. However, by developing a range of standard operating procedures and by wider employment of adequately trained technicians of proven competence, there is adequate room for manoeuvre. The pharmacist will always be accountable, but with robust frameworks it should be possible to change the way we work. The issue is common to both hospital and community pharmacy, although the current remuneration model in community pharmacy tends to discourage the employment of fully-trained support staff and obstructs progress. Clearly, it is Council's responsibility to determine the professional issues and the public interest while other bodies need to re-negotiate the NHS contract. The profession will have to grasp the issue of more pharmacists working from fewer premises providing an extended range of services — some in surgeries, clinics, nursing and care homes and in patients' own homes. Providing extended services including those off-site is clearly envisaged in *Pharmacy in the future* and accountability is the key issue to address.

EL: *You have also been a member of the Council of the Guild of Healthcare Pharmacists for some 10 years and are currently the President. Are there particular issues you would like to talk about in that capacity?*

HR: As mentioned earlier, I have had a long-established political interest in hospital matters and I hope this has helped my contribution to the Guild over the years. I have served on the Pharmaceutical Whitley Council for the past nine years, and in several other capacities. It has been a great benefit to have been a member of Guild Council while also sitting on RPSGB Council, as there is so much cross-fertilisation.

As President, I have been very keen to see the development of the Guild website (www.ghp.org.uk) and the inclusion of the Guild policy statements which we are anx-

ious to keep updated. Although recently our membership numbers have been fairly constant, we are keen to increase them by 1,000 over the next five years. A membership form is now available via the website. Membership provides the necessary cover for professional indemnity, along with NHS employment. Several issues of our journal *ghp* have carried details of the advantages of membership, and these have been sent to every hospital pharmacist and primary care pharmacist.

Currently, the Guild is working through a number of initiatives to provide services to members, such as, developing UK-wide professional standards for practice and medicines management. The former “regional” standards need updating and extending. For example, we need to define the responsibilities of clinical pharmacists with regard to NICE advice and the standards in the National Service Frameworks.

EL: *I wonder how you have managed to be so active and involved at work and within the profession as well as having a family of three?*

HR: I am enthusiastic to see pharmacists achieve a fuller role and that spurs me on. My husband leaves the house early since he commutes to London each day, and I get up early also and use that time for a variety of professional work. My children are independent, and as sensible as teenagers can be expected to be!

EL: *Do you have further personal ambitions that you would like to achieve and targets for the profession that you would hope to contribute towards?*

HR: I was most gratified and delighted to be awarded a Fellowship of the Society recently. At the moment, I think my sights are set on three main issues: prescribing, community pharmacists delivering medicines management, and establishing consultant pharmacist grades in hospital. The recent Audit Commission report *A spoonful of sugar* should assist with driving these forward. On the day it was published, I did a radio interview about the report and it was a worrying experience because I had never done one before!

EL: *Finally, do you have any advice to offer to younger pharmacists working in the NHS?*

HR: Before working clinically in the hospital sector, newly-qualified pharmacists have to complete a few years of serious academic and practice training and then the lifelong learning begins! They come to us now with high expectations and we will strive to meet them. I am sad to talk to new young pharmacists brimming with knowledge and aspirations who are ground down by repetitive dispensing work in the community. I will always try to influence change in this. Meanwhile — come and