General Pharmaceutical Council

clevertogether

Peer Discussion Online Workshop Report

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Purpose of this document

The purpose of this document is to report on the results of GPhC's first Clever Together crowdsourcing project. In doing so, this document will:

- demonstrate that participation in your online workshop is broadly representative of the GPhC's registrants population;
- present how we analysed the participants' contributions; and
- demonstrate how your participants have helped to identify nine types of peer discussion practices that are used to differing degrees in different settings.

This report also begins to outline some of the implications of these findings. Although we acknowledge to complete this element of the project we very much need the expertise of the GPhC.

Contents

Executive summary

The objective of this campaign was to engage a cohort of the GPhC's registrants to share, explore and co-create a peer validated list of peer discussion approaches that they can use when reflecting on their practice.

Our analysis of 3,700+ contributions made by over 1,300 registrants revealed 9 types of peer discussion clustered around drivers of peer discussion and the level of formality of the approach. Table 1 shows the weight of conversation for each type of peer discussion.

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	**TYPE 1:** 9%	**TYPE 2:** 8%	**TYPE 4:** 14%	**TYPE 7:** 8%	**40%**
	Defined - semi informal	0%	**TYPE 3:** 1%	**TYPE 5:** 14%	**TYPE 8:** 31%	**46%**
	Managed - formal	0%	0%	**TYPE 6:** 10%	**TYPE 9:** 4%	**14%**
	Grand Total	**9%**	**9%**	**38%**	**43%**	**100%**

Some key observation from our analysis are:

- The online workshop's participant population is broadly representative of the GPhC's registrant population.
- Pharmacy professionals contributed to the platform not only from the United Kingdom, but from wherever they were located at the time of the workshop. As a result, we have received contributions from six continents of the world: Africa, Europe, Asia, North America, South America and Australia.
- Overall, participants seem to view peer discussion as a strong mechanism for improving their practice and building relationships with pharmacy and other healthcare professionals.
- Within each combination of driver of peer discussion, level of formality and setting of practice our analysis revealed different methods, topics, and benefits of peer discussion.
- Participants made more contributions on proactive approaches to peer discussion.
- Interestingly, participants did not make any contributions related to semi-informal or formal approaches to 'reactive, unexpected incident' peer discussions.
- Stratification of contributions by job role revealed that pharmacy technicians did not make any contributions related to reactive peer discussion approaches.

This report presents our analysis of participants' qualitative contributions.

Our campaign objective

The objective of this campaign was to engage a cohort of the GPhC's registrants to share, explore and co-create a peer validated list of peer discussion that they can use when reflecting on their practice.

Our challenge question

To achieve the above objective we posed a challenge question:

"From the formal to the informal, what approaches to peer discussion do you use, what do you talk about and what's the benefit?"

Participants in our online workshop answered the question based upon three overarching settings of practice:

i. hospitals;
ii. community; and
iii. other (which included: Industry, Intermediate Care, Locum, Primary Care Pharmacy, Regulatory/Policy/Advisory Roles, Secure Environment/Prisons/Mental Health, Military, Academic, and Senior Leadership Roles).

Inviting our crowd

We used a personalised email to open the invite to participate in this online workshop to all of the GPhC registrants (70,000+ people). We indicated in our communications that participation would be on a first come, first served basis - capped to manage analytical burden to no more than 3,000 participants. We then allocated a quota for each setting of practice to ensure participation was representative of GPhC's registrant population:

- 63% community
- 31% hospital
- 12% other (registration requests from pharmacy professionals working in 'other' settings exceeded this quota. A decision was made to increase this quota and accept all registration requests. As a result, our analysis reveals this setting of practice to be over represented)

Empowering our crowd

We empowered our crowd to share and build insights / solutions to our challenge question in a number of ways:

- by ensuring they had access to the campaign platform through any web-enabled device so they could access the tools to share and then build and prioritise ideas (through commenting and voting);
- by ensuring we had nominated staff to facilitate the process;
- by using the following communication tools to get our crowd interested and inspired to take part in the conversation:
    - one press release;
    - two articles in the Regulate newsletter;
    - multiple tweets;

- a dedicated project webpage, including a video of peer discussion methods currently used by pharmacy professionals;
- an invitation email to all registrants;
- a reminder email to all registrants; and
- a close and thank you email to all workshop participants.

Understanding our crowd's contributions

Participation

Key observations

A total of 1,525 pharmacy professionals registered to take part in the online workshop, and 1,392 (91%) of them took part.

Of those who participated:

- 522 (38%) were active participants – submitting ideas, votes and/or comments; and
- 870 (62%) logged in to the platform as observers – taking time to view the content but electing not to share contributions.

For a first crowdsourcing campaign, with such large cohort of participants (1,525), this active/observer ratio ranks favourably compared to other organisations.

The profile of participation in terms of job role, location and setting of practice reveals the conversation was lighter than expected from those in the community setting and larger than expected from those categorised as 'other'. This is due to the fact that this cohort's application to take part in the online workshop exceeded the initial set quota of 12% and applicants were placed on a waiting list. When informed about this matter, the GPhC chose to grant them access. Despite this skew, how we have analysed their contributions leads us to feel comfortable that the conclusions we reach are reliable and not skewed by any particular subset of GPhC's registrants.

User geography

Pharmacy professionals contributed to the platform not only from the United Kingdom, but from wherever they were located at the time of the workshop. As a result, we have received contributions from six continents of the world: Africa, Europe, Asia, North America, South America and Australia.

Analysis

We have analysed the participation data by job role, country of practice, and setting of practice. This helped us to judge whether or not the population that took part in this online workshop is broadly representative of the GPhC's registrant population.

We note:

- each job role is broadly represented, with pharmacists having a slightly larger than expected number of contributions compared to pharmacy technicians;
- each country of practice is broadly represented, with England being slightly under represented; yet
- among the settings of practice, community is significantly under represented and 'other' settings of practice are significantly over represented.

Whilst skew of professional setting may be said to impact the aggregate-level analyses of all professionals, we believe the conclusions we reach remain representative as our analyses mostly focus on the settings of practice.

The following subsections share the stats that underpin these observations:

Job role

We are pleased with the balance of participation for each job role, but note that:

- pharmacists are over represented. While representing 69.47% of the GPhC's registrant population, 73.8% of participants come from this group;
- pharmacy technicians are underrepresented. While representing 30.53% of the GPhC's registrant population, 26.20% of participants come from this group.

Job Role	% Total Registrants	% Total Participants
Pharmacist	69.47%	73.80%
Pharmacy Technician	30.53%	26.20%

Country of practice

We are pleased with the diversity of registrants engaged per each country of practice, but note:

- England is under represented. While representing 82.95% of the GPhC's registrant population, 80.80% of participants come from this country;
- a small number of participants (0.60%) indicated their country of practice as 'United Kingdom'.

Country of Practice	% Total Registrants	% Total Participants
England	82.95%	80.80%
Overseas	2.63%	3.10%

Scotland	8.98%	10.80%
Wales	5.32%	4.60%
United Kingdom	N/A	0.60%
N/A	0.12%	0.10%

Setting of Practice

We are pleased with the diversity of registrants engaged per each setting of practice, but note:

- participants from 'other' settings of practice are significantly over represented. This is due to the fact that this cohort's application to take part in the online workshop exceeded the initial set quota of 12% and applicants were placed on a waiting list. When informed about this matter, the GPhC chose to grant them access.

Setting of Practice	% of Registrants	% Total Participants
Community	63%	40%
Hospitals	31%	29%
Other	12%	31%

Content analysis

Key observations

- Online workshop participants offered a total of 3,700+ contributions.
- We developed three frameworks to help us codify contributions from registrants, in order for us to be able to examine themes and understand the deeper semantics of the conversation:
    1. driver of peer discussion;
    2. level of formality; and
    3. already existing peer discussion approaches vs. aspirational approaches.
- The first framework revealed four overarching narratives regarding the driver of peer discussion:
    - Reactive: unexpected incident (9% of contributions)
    - Reactive: developmental training (9% of contributions)
    - Proactive: individual performance improvement (38% of contributions)
    - Proactive: group performance improvement (43% of contributions)
- Analysing the data using the first two frameworks revealed 9 types of peer discussion.
- The balance of contributions for these 9 types of peer discussion shifts when we explore the conversation related to each setting of practice.
- Pharmacy technicians did not make any contributions related to reactive peer discussion approaches.
- Overall, participants seem to view peer discussion as a strong mechanism for improving their practice and building relationships with pharmacy and other healthcare professionals.

Key stats

In total our crowd contributed:

- 150 ideas;
- 646 comments; and
- 2,987 votes.

Given that ideas and comments were on the platform for different lengths of time, we based our prioritisation of ideas on an adjusted score relating the number of likes and dislikes the contribution had attracted to the amount of time the contribution had been on the platform. For example, this process enables an idea that has been on the platform for one day, which received 20 votes to be ranked higher than an idea that has been on the platform for 15 days and had received 25 votes.

Crowd's favourite ideas per setting of practice

For the **community** setting of practice, we learned that the crowd's favourite ideas were:

- **Title:** Pharmacist Protected Learning.
  Quote: "Having Pharmacist Protected Learning Time (PPLT) is an opportunity for Pharmacists (and other regulated positions e.g. Techs) to address their own learning and professional development needs." *(79 likes, 5 dislikes, 34 comments – weighted score: 89).*

- **Title:** Peer discussion at work: overlap, informal discussion to share experience and review critical incidents.
  Quote: "I believe you need to have overlap to aid discussion whether this is for a couple of hours a day or doubling up as Pharmacists. Speaking to Pharmacists from a different sector of practice helps […] open your mind to the bigger picture away from your dispensing bench." *(54 likes, 8 dislikes, 22 comments – weighted score: 42).*

- **Title:** Faculty submissions.
  Quote: "We (community pharmacists) regularly see far more patients than any other part of the profession and are without doubt the most accessible healthcare provider in the community. Building the folio makes you really look at where you are as a person…" *(37 likes, 13 dislikes, 20 comments – weighted score: 40).*

For the **hospitals** setting of practice, we learned that the crowd's favourite ideas were:

- **Title:** "On the job" informal discussions/learning.
  Quote: "A lot of informal discussions take place in the workplace between less experienced and more experienced staff…" *(54 likes, 8 dislikes, 9 comments – weighted score: 42).*

- **Title:** Open plan office.
  Quote: "Just sitting in an open plan office and talking to peers and bouncing ideas off each other on a daily / hourly basis is useful. It helps to hear what other teams and specialities are doing and it promotes the sharing of best practice." *(45 likes, 11 dislikes, 6 comments – weighted score: 22).*

- **Title:** RPS Faculty Peer Review.
  Quote: "The practice assessment involved a case based discussion with your peers. This doesn't have to be clinical, it is a discussion of your work which reflects your professional area of practice. The faculty team were very supportive and I found the whole process very positive." *(21 likes, 3 dislikes, 8 comments – weighted score: 20).*

For **'other'** settings of practice, we learned that the crowd's favourite ideas were:

- **Title:** RPS Faculty peer review-enhancing my practice.
  Quote: "As an RPS Faculty member I have received high quality peer review from multiple sources. I had to submit peer testimonials from colleagues and people I have worked with across a range of academic activities who were able to freely comment on a range of my competences which were covered by the Faculty portfolio." *(27 likes, 9 dislikes, 18 comments – weighted score: 24).*

- **Title:** Pharmacists need discussions with HCPs other than pharmacists.
  Quote: "I think some of the best peer discussions I have had are with my peers from other healthcare professions. It never ceases to amaze me how differently we are perceived by others than how we perceive ourselves." *(29 likes, 0 dislikes, 9 comments – weighted score: 14).*

- **Title:** PBSGL.
  Quote: "We use a model called Practice Based Small Group Learning […] It comprises of a series of modules which have case reviews with questions for the purpose of provoking

discussion between peers as to what they might do in the situation in actual practice. The modules provide suggested answers and excellent reading materials but the most useful part for me is sharing experiences with peers and other HCP's." *(13 likes, 1 dislikes, 11 comments – weighted score: 9).*

What underpins the conversation – our semantic analyses

Two independent teams have completed semantic analysis of the data, one in a fully immersive mode and the other as a sense check to challenge and validate the first group's conclusions.

By reflecting upon literature regarding peer discussion and the data in hand, we developed three frameworks to help us codify contributions from registrants, in order for us to be able to examine themes and understand the deeper semantics of the conversation.

1. We first coded each idea based upon **the driver** to engage in peer discussions:
   - **Reactive – unexpected incident**: reacting to an unexpected incident (positive or negative) that triggers a peer discussion.
   - **Reactive – developmental training**: reacting to an unexpected need that develops a skill or area of knowledge/expertise.
   - **Proactive – individual performance improvement**: proactively seeking discussions that improve individual performance.
   - **Proactive – group performance improvement**: proactively seeking discussions that develop practices and profession of multiple people at once.

2. For the second level of analysis we examined **the level of formality** of peer discussions:
   - **Ad-hoc**: **informal** – likely to an undocumented process, driven in an ad hoc manner by registrants.
   - **Defined: semi-informal** - a standard process that is maintained. There is a rhythm to the process but the process itself is not rigorous, as it does not have specific and well-defined objectives and measures of success.
   - **Managed**: **highly formalised** - a standardised managed process that works towards specific objectives, and uses specific metrics of success.

3. The third level of analysis explored whether the contribution is:
   1. an **already existing peer discussion approach** that the pharmacy professionals are using, or
   2. a **proposed new approach** to peer discussion.

It is worth noting that we explored whether there could be a fourth level of analysis focused upon exactly 'who' was involved in the peer discussion. In hindsight, we should have added a layer to the challenge question because the data, as it stands, it does not provide any clear insight.

Our next task was to explore the data within the first framework - driver of peer discussion – at aggregate level. By coding and analysing the contributions using this framework, we were able to discern:

- the weight of the conversation dedicated to each theme;
- the favourite ideas within each theme; and
- the narrative that is typical within each theme.

We then used the first framework (driver of peer discussion) in combination with the second framework (level of formality) to further examine the data. Our analysis revealed 9 types of peer discussion. Within each type of peer discussion we uncovered four categories of information from the participant's contributions:

1. the peer discussion approach;
2. the topic(s) of discussion;
3. the benefits of having peer discussion; and
4. whether the peer discussion approach was in use or aspirational.

In the sections that follow, we present:

1. a quantitative analysis of the qualitative contributions by setting of practice and job role; and
2. the collective narrative shared by participants regarding the nine types of peer discussion - we present this within the four categories of information shared above.

1. A quantitative view of the contributions

Our analysis of participants' contributions revealed **9 types of peer discussion**. Table 1 presents the types of peer discussion uncovered when analysing the data across three settings and shows the weight of the conversation for each type of peer discussion.

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	**TYPE 1:** 9%	**TYPE 2:** 8%	**TYPE 4:** 14%	**TYPE 7:** 8%	**40%**
	Defined - semi informal	0%	**TYPE 3:** 1%	**TYPE 5:** 14%	**TYPE 8:** 31%	**46%**
	Managed - formal	0%	0%	**TYPE 6:** 10%	**TYPE 9:** 4%	**14%**
	Grand Total	**9%**	**9%**	**38%**	**43%**	**100%**

Table 1: The balance of contributions regarding what drives peer discussion and how formal the discussion across all settings.

This table reveals that the workshop participants shared:

- more contributions on proactive approaches to peer discussion (81%) rather than reactive, with more than half of these contributions (43%) focused around group performance development and the remaining (38%) individual performance improvement. This may suggest that workshop participants already see peer discussion as a valuable tool for improving the quality of their practice.
- limited contributions on peer discussion approaches that use manged-formal processes (14%). This may suggest that participants either have a preference for peer discussion processes that are not fully managed- formal, or they do not perceive formalised processes as peer discussion tools.
- contributions that mostly relate to type-8 of peer discussion approaches (31%).
- zero peer discussion approaches that use defined-semi informal (0%) or managed- formal (0%) processes when an unexpected incident occurs.

Interestingly, the balance of contributions for these 9 types of peer discussion shifts when we explore the conversation related to each setting of practice. These shifts uncover the nuances and the balance of conversation that are specific to each setting of practice (Tables 2, 3 and 4).

Setting of practice – **community**

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	**TYPE 1:** 15%	**TYPE 2:** 6%	**TYPE 4:** 17%	**TYPE 7:** 15%	**53%**
	Defined - semi informal	0%	**TYPE 3:** 2%	**TYPE 5:** 0%	**TYPE 8:** 34%	**36%**
	Managed - formal	0%	0%	**TYPE 6:** 9%	**TYPE 9:** 2%	**11%**
	Grand Total	**15%**	**8%**	**26%**	**51%**	**100%**

Table 2: The balance of contributions regarding what drives peer discussion and how formal the discussion in community settings.

Setting of practice – **hospital**

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	**TYPE 1:** 5%	**TYPE 2:** 11%	**TYPE 4:** 8%	**TYPE 7:** 4%	**28%**
	Defined - semi informal	0%	**TYPE 3:** 1%	**TYPE 5:** 29%	**TYPE 8:** 31%	**60%**
	Managed - formal	0%	0%	**TYPE 6:** 7%	**TYPE 9:** 5%	**12%**
	Grand Total	**5%**	**12%**	**44%**	**40%**	**100%**

Table 3: The balance of contributions regarding what drives peer discussion and how formal the discussion in hospital settings.

Setting of practice – **'other'**

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	**TYPE 1:** 6%	**TYPE 2:** 4%	**TYPE 14:** 28%	**TYPE 7:** 2%	**40%**
	Defined - semi informal	0%	**TYPE 3:** 0%	**TYPE 5:** 7%	**TYPE 8:** 24%	**31%**
	Managed - formal	0%	0%	**TYPE 6:** 23%	**TYPE 9:** 6%	**29%**
	Grand Total	**6%**	**4%**	**58%**	**32%**	**100%**

Table 4: The balance of contributions regarding what drives peer discussion and how formal the discussion.

Comparing and contrasting Tables 2, 3 and 4 revealed the following insights:

- Across all three settings there are:
    - more contributions on proactive peer discussion approaches than reactive peer discussions.
    - more contributions on informal or semi-informal peer discussion approaches than managed-formal ones.
    - more contributions on reactive peer discussion approaches using adhoc-informal processes than defined-semi informal ones.
    - zero contributions on reactive peer discussion approaches related to managed-formal processes.
- Between the three settings:
    - there are more contributions on managed-formal peer discussion processes in 'other' (29%) settings than community (11%) or hospital (12%) settings.
    - there are similarities between hospital and 'other' settings in terms of types of peer discussion approaches that they don't use.
    - community has the highest focus of contributions on Type 1 peer discussions (15%).
    - professionals in community settings tend to engage more in peer discussions that are driven by group performance improvement. This may be due to their lack of access to individual performance improvement methods such as ad-hoc face to face discussions, or it could be a reaction to the fact that they are isolated and thus seek groups of professionals to interact with.
    - while in 'other' settings, type 6 peer discussions attracted the largest concentration of contributions (23%), in community and hospital settings contributions on this type of peer discussion were limited (community 9%, hospitals 7%).

Job role- pharmacists and pharmacy technicians

We also explored the balance of contributions for each type of peer discussion by stratifying the data based on participants' job role. Table 5 and 6 present the contributions made by each pharmacists and pharmacy technicians as a percentage of total contributions made to each type of peer discussion. Interestingly, we observed that all contributions related to reactive peer discussion approaches (type 1, type 2 and type 3) were made by Pharmacists. Pharmacy technicians only made contributions on proactive peer discussion approaches.

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	9%	8%	15%	8%	**41%**
	Defined - semi informal	0%	1%	11%	32%	**44%**
	Managed - formal	0%	0%	11%	4%	**15%**
	Grand Total	**9%**	**10%**	**37%**	**44%**	**100%**

Table 5: The balance of contributions regarding what drives peer discussion and how formal the discussion for pharmacists

		Driver of Peer Discussion				
		Reactive: unexpected incident	Reactive: developmental training	Proactive: individual performance improvement	Proactive: group performance improvement	**Grand Total**
Level of Formality	Adhoc - informal	0%	0%	16%	16%	**33%**
	Defined - semi informal	0%	0%	20%	35%	**55%**
	Managed - formal	0%	0%	5%	7%	**12%**
	Grand Total	**0%**	**0%**	**42%**	**58%**	**100%**

Table 6: The balance of contributions regarding what drives peer discussion and how formal the discussion for pharmacy technicians

Please note that some of the contributions (i.e. seed ideas) were made by facilitators or GPhC staff, and thus were not coded by job role and were excluded from the tables above. As a result, when adding up the percentages of the two tables in each type of peer discussion, the result will not always be 100%.

In the subsections that follows, we present the deeper semantic analysis as a "collective narrative of the contributions share", providing quotes from participants to bring the narrative to life.

1. Each driver of peer discussion is presented as a "collective voice", a narrative that can be discerned from the ideas and comments shared by 1,300+ pharmacy professionals who participated in the three week GPhC online workshop. These narratives are then brought to life with quotes from the crowd.
2. Each type of peer discussion (clustered around the driver of peer discussion and its level of formality) is explored using four categories:
    a. What approaches to peer discussion are used?
    b. What is discussed?
    c. What are the benefits of having this type of peer discussion?
    d. What new approaches to peer discussion can we introduce?

2. Narratives around 9 types of peer discussions

Within each combination of driver of peer discussion, level of formality and setting of practice our analysis reveals the unique methods, topics, and benefits of peer discussion. We also highlight any commonalities across the three settings.

Reactive – unexpected incident (9% of total contributions)

Reviewing and reflecting on critical incidents with colleagues in a relaxed, open and honest way is a very useful aspect of our "on the job training". Some of the methods that we use include face to face conversations, email, or phone calls. These discussions enable us to:

- *uncover some of the assumptions, beliefs, and/or values that had led to occurrence of the critical incident;*
- *reflect on our course of action and identify our learning needs;*
- *learn from our peers' knowledge and experience; and*
- *build rapport with our colleagues and strengthening our professional relationships.*

TYPE 1: Adhoc – informal approaches to reactive, unexpected incident

For this cluster there were no contributions for the hospital setting and all findings were common between community and 'other' settings.

*Common across **community and 'other'** settings:*

- Peer discussion methods that we use are:
    - face to face meetings;
    - emails; and
    - phone calls.
- Topics of our discussion include:
    - a course of action taken when an incident occurs;
    - difficult decisions or cases;
    - loopholes in a process; and
    - new standards, regulations, or requirements.
- These discussions enable us to:
    - Reflect on our practice and learn from our mistakes;
    - Obtain a second opinion when in doubt;
    - feel less isolated and build rapport and relationships with my peers; and
    - gain and receive feedback in a safe and neutral environment.

Example evidence:

Some of the crowd's favourite ideas from the 'Reactive- unexpected incident' theme were:

- **Title:** Peer discussion at work: overlap, informal discussion to share experience and review critical incidents.
  Quote: "Experience is often passed on by word of mouth and on the job practical training,

but this can be significantly speeded up by informal discussion and helps build confidence... Talking builds rapport, relationships, support and concordance and can prevent miscommunication leading to errors." *(54 likes, 8 dislikes, 32 comments – adjusted score:20).*

- **Title:** Just Talking!
  Quote: "I job share with another pharmacist…When one of us comes across an interesting/difficult/funny situation then we tend to share it either via e-mail, text or a phone call…a positive benefit: gaining exposure from a colleague's experiences and reflections plus being able to comment from a position of neutrality." *(38 likes, 3 dislikes, 16 comments – adjusted score: 13).*

Reactive – developmental training (9% of total contributions)

We use peer discussions when we identify a gap in our knowledge or skill set. Methods that we use include evidence-based discussions with mentors and/or other peers. We can also leverage resources that are available to us such as internet sites and/or case studies that our peers have shared with us. These discussions enable us to:

- *draw on and use the knowledge of our peers; and*
- *identify career progression opportunities.*

TYPE 2: Adhoc- informal approaches to reactive, development training

For this cluster there were no common approaches across three settings. Furthermore, there were only relevant contributions for hospital and 'other' settings, but not for community settings.

*Specific to **hospital** settings:*

- Peer discussion methods that we use are:
  - mentoring schemes; and
  - face to face discussions.
- Topics of our discussion include:
  - clinical topics;
  - difficult decisions around patient care;
  - challenging work situations;
  - practice safety criteria; and
  - celebration and learning from positive behaviours and practices.
- These discussions enable us to:
  - obtain the opinion and advise of more experience and qualified practitioners; and
  - learn from our peers' experience and knowledge.
- New peer discussion methods that we can introduce are:
  - A platform to debate, challenge and learn from more experienced staff.
    - **Title:** Explain your decisions to less experienced staff
      Quote: "…they (pre-registrants) would like tutors and more experienced staff to explain their decisions (some apparently show them what to do in particular situations but don't explain why) and all would like a platform to

debate, challenge and learn from more experienced staff." *(8 likes, 0 dislikes, 0 comments – adjusted score: 5).*

*Specific to **'other'** settings:*

- The peer discussion methods that we use is:
    - review of peers' articles for journals and other publications.
- The topic of our discussion is:
    - journal articles.
- This discussion enables us to:
    - examine and improve our understanding of different topics and use this knowledge to improve our teaching; and
    - identify sections of the article that require further clarification.
- New peer discussion methods that we can introduce are:
    - developing a regional toolkit which shares good practice examples and offers effective solutions.
        - **Title**: "Toolkit to allow shared learning across organisational boundaries **quote**: "By developing a regional toolkit we aim to have shared learning from how to tackle these challenges. This will focus on good practice and provide support on introducing effective solutions. The toolkit will be based around peer support, using many of the approaches described by others in this process. The emphasis will be on sharing good practice examples, providing support to introduce in other organisations and hence reflecting on each other's experiences. This toolkit is in the development and piloting phase." *(3 likes, 0 dislikes, 0 comments – weighted score: 1).*

TYPE 3: Defined- semi informal approaches to reactive, development training

There were no common contributions across the three settings. There weren't any contributions specific to 'other' settings either.

*Common across **community and hospital** settings:*

- The peer discussion methods that we use is:
    - periodic peer group meetings.
- The topic of our discussion is:
    - scenarios we have faced and things we have learned that others might benefit from.
- These discussions enable us to:
    - No findings common across settings.

*Specific to **hospital** settings:*

- The peer discussion methods that we use is:
    - Regular MI (Medical Information) peer review meetings.
- The topics of our discussion include:
    - Sample of enquiries.
- These discussions enable us to:
    - share and expand our knowledge; and
    - improve the quality of our enquiry answering.
- New peer discussion methods that we can introduce are:
    - No findings specific to this setting.

Example evidence:

- **Title:** Learn from mistakes together.
  Quote: "lot of tasks we all pharmacists do, on the daily basis is evidence that contributes to safety. However, many times there is inconsistencies in practice compromising safety. Therefore, an approach where pharmacists can freely point out each other's, area of opportunities, promotes learning and consistency in required standards." (*21 likes, 2 dislikes, 12 comments – adjusted score: 7).*
- **Title:** Sharing Good Behaviours.
  Quote: "We probably need to do more to celebrate good practice when we see it and approach peers proactively so that we can learn from their skills but also acknowledge and recognise them, rather than waiting for someone to request feedback. We were talking yesterday at work about opening discussions with something like "that was great, how did you do that"." (17 *likes, 0 dislikes, 0 comments – adjusted score: 6).*

Proactive – individual performance improvement (38% of total contributions)

We think of peer discussions as a powerful way to proactively expand our knowledge and develop our skills. Some of the approaches that we use to improve our performance on an individual level include face-to-face discussions with our peers, regular 1:1 meetings with managers, 360 feedback mechanisms and annual PDRs, and discussions with a mentor. These peer discussion approaches enable us to:

- *reflect on our practice and using other peers as a guide and sounding board for identifying areas where we can improve our knowledge;*
- *share our experience and examples of good practice;*
- *learn about new ideas and initiatives; and*
- *build our confidence by learning about our colleagues challenges.*

TYPE 4: Adhoc – informal approaches to proactive, individual performance improvement

*Common across **hospital and 'other' settings**:*

- The peer discussion methods that we use are:
    - face to face discussions; and
    - connecting with colleagues via social media (i.e. Twitter).
- The topics of our discussion include:
    - No findings common across settings.
- These discussions enable us to:
    - overcome our feeling of isolation (especially in community and other settings);
    - build a network of peers in which we feel safe to ask for advice and help; and
    - improve the quality of our practice.

*Specific to **hospital** settings:*

- The peer discussion methods that we use are:
    - regular one on one meetings with managers;
    - LinkedIn; and
    - portfolio review.
- The topics of our discussion include:
    - No findings specific to this setting.
- These discussions enable us to:
    - identify our weaknesses; and
    - share our experience and learn from our peers.

- New peer discussion methods that we can introduce are:
    - Introducing a mechanism for offering anonymous feedback.
        - **Title:** Anonymous feedback.
          Quote: "… some people […] feel more confident to say what they really feel when typing their feelings/idea and submitting into an anonymous box of some kind. These people often have great feedback but are a little shy when in a group are afraid of being judged." *(5 likes, 7 dislikes, 10 comments – adjusted score: 8).*

*Specific to **'other'** settings:*

- The peer discussion methods that we use are:
    - face to face discussions with other healthcare professionals;
    - conferences for niche/specialist professional groups;
    - emails and phone calls;
    - verbal and written constructive feedback; and

- peer review forums held by local NHS organisations.

- The topics of our discussion include:
  - No findings specific to this setting.
- These discussions enable us to:
  - to better understand our peers' and other healthcare professionals points of view;
  - engage pharmacy students and improve their learning experience; and
  - learn about different approaches to patient care.
- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

TYPE 5: Defined – semi informal approaches to proactive, individual performance improvement

*Specific to **hospital** settings:*

- The peer discussion methods that we use are:
  - discussion with peers in an open plan offices;
  - periodic ward visits for junior pharmacists;
  - regular meetings with mentor;
  - "Peer buddies": periodic phone meetings;
  - peer review of pharmaceutical services using self-assessment framework based on Royal Pharmaceutical Society's Hospital Pharmacy Standards; and
  - case study presentations.
- The topics of our discussion include:
  - challenges that we face;
  - new topics we are learning about;
  - case studies; and
  - skills or areas of knowledge that we want to further develop.
- These discussions enable us to:
  - keep our knowledge up-to-date;
  - solve challenges that we are facing;
  - reflect upon and develop our skills;
  - push the boundaries of our knowledge;
  - develop and improve pharmaceutical services;
  - identify potential new areas of research.
- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

*Specific to **'other'** settings:*

- The peer discussion methods that we use is:
  - teaching observations.

- The topics of our discussion include:
    - verbal and written feedback about teaching performance.
- These discussions enable us to:
    - Identify areas for development.
- New peer discussion methods that we can introduce are:
    - No findings specific to this setting.

TYPE 6: Managed – formal approaches to proactive, individual performance improvement

*Common across **all three settings**:*

- The peer discussion method that we use is:
    - RPS (Royal Pharmaceutical Society) Faculty Peer Review and submissions.
- The topics of our discussion include:
    - our competencies and quality of performance.
- These discussions enable us to:
    - understand how our peers perceive our performance;
    - shape our future development plans; and
    - build confidence by receiving feedback.

*Specific to **community** settings:*

- New peer discussion methods that we can introduce are:
    - Include peer discussion as a mandatory part of the CPD process:
        - **Title:** Incorporation into CPD (Continuous Professional Development) **Quote:** "…I feel strongly that peer led discussion is the most useful tool for development. I think it should be a mandatory part of CPD and ideally participants should not have any commercial constraints." *(15 likes, 4 dislikes, 0 comments – adjusted score: 11).*

*Specific to **hospital** settings:*

- The peer discussion method that we use is:
    - Faculty mentor; and
    - 360 feedbacks and annual PDR (Personal Development Reviews).
- The topics of our discussion include:
    - Reflection on our performance: our knowledge and competencies.
- These discussions enable us to:
    - address the gaps in our knowledge and competencies;
    - develop performance improvement plans.
- New peer discussion methods that we can introduce are:
    - No findings specific to this setting.

Example evidence:

- **Title:** Have Two Pharmacists
  Quote: "Having recently worked in a pharmacy with two pharmacists due to volume of work. It is much easier to have peer to peer discussions and discuss changes and developments in pharmacy. Any concerns can be shared and courses of action agreed on." *(42 likes, 6 dislikes, 32 comments – adjusted score: 12).*
- **Title**: open plan office
  Quote: "Just sitting in an open plan office and talking to peers and bouncing ideas off each other on a daily / hourly basis is useful. It helps to hear what other teams and specialities are doing and it promotes the sharing of best practice*." (45 likes, 11 dislikes, 31 comments – adjusted score: 12).*

Proactive – group performance improvement (43% of total contributions)

We are seeking more collaborative ways of improving our practice by having peer discussions in group settings. Ideally, these groups include other healthcare professionals and pharmacists working in various organisations and settings of practice. Methods that we use to proactively improve our performance in a group setting include: team meetings, training days, social media forums, guest lectures, seminars, and shared team diaries. These group peer discussions enable us to:

- build a network of peers to overcome the feeling of isolation;
- work and learn across boundaries;
- pass on our knowledge to more junior staff in an efficient way; and
- keep up-to-date with latest findings, regulations, and policy changes.

TYPE 7: Adhoc-informal approaches to proactive, group performance improvement

*Common across **all three settings**:*

- The peer discussion methods that we use are:
  - No findings common across all three settings.
- The topics of our discussion include:
  - best practice examples;
  - latest research findings;
  - evidence based resources; and
  - our learnings from our experiences.
- These discussions enable us to:
  - overcome the feeling of isolation; and
  - build a network of peers from whom we seek advice;
  - reflect on our practice in a confidential, safe, honest and respectful environment.

*Specific to **community** settings:*

- The peer discussion methods that we use are:
    - attending training events and having informal discussion with attendees during the event;
    - "specialist" forums (e.g. Superintendents forum); and
    - 'focal point' events – organised using CPPE resources – for colleagues who work in together or in the same area.

- The topics of our discussion include:
    - No findings specific to this setting.
- These discussions enable us to:
    - feel reassured and build confidence by knowing that other people are facing the same challenges; and
    - understand how other pharmacy professionals deal with similar challenges.
- New peer discussion methods that we can introduce are:
    - introduce a closed Facebook group for pharmacy professionals
        - **Title:** Utilising Social Media.
          Quote: "…the best method of interaction and learning remains as study days or that sort of event but this isn't possible across the sector/health board/companies etc.
          […] A closed Facebook group for example to share articles, questions, learnings etc. could be a great way to gets lots of different views and solutions to problems." *(20 likes, 6 dislikes, 18 comments – adjusted score: 15).*

*Specific to **hospital** settings:*

- The peer discussion methods that we use are:
    - specialist group networking;
    - peer support to CCG medicines management team provided by PrescQIPP website; and
    - joining journal clubs.
- The topics of our discussion include:
    - No findings specific to this setting.
- These discussions enable us to:
    - exchange ideas and discuss challenges with colleagues who understand my area of work;
    - keep our knowledge up-to-date;
    - share our knowledge with our peers;
    - self-reflect on our practice; and
    - work and learn across boundaries.
- New peer discussion methods that we can introduce are:

- No findings specific to this setting.

Specific to **'other'** settings:

- The peer discussion methods that we use are:
  - pharmacy networks within an organisation; and
  - periodic unstructured meetings with peers.
- The topics of our discussion include:
  - specific topics that appeal most of the group's participants;
  - our areas of concern.
- These discussions enable us to:
  - No findings specific to this setting.
- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

TYPE 8: Defined- semi informal approaches to proactive, group performance improvement

*Common across **all three settings**:*

- The peer discussion methods that we use are:
  - Regular meetings involving different stakeholders and at different levels (organisational or inter-organisational).
- The topics of our discussion include:
  - good practice examples; and
  - exploration of various issues and potential challenges by sharing our thoughts and experiences.
- These discussions enable us to:
  - learn from others and know what we should do if we face similar challenging circumstances

*Specific to **community** settings:*

- The peer discussion methods that we use are:
  - local groups run by CPPE/LPC
  - using a common diary for handover notes and lessons learned; and
  - weekly dispensers forum in the pharmacy.
- The topics of our discussion include:
  - critical incidents and how we can learn from them; and
  - exploring more efficient ways of doing routine tasks.
- These discussions enable us to:

- No findings specific to this setting.

- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

*Specific to **hospital** settings:*

- The peer discussion methods that we use are:
  - conferences/seminars;
  - UKCPA speciality groups;
  - regular lunchtime presentations;
  - APTUK FPF self-development tool;
  - informal pharmacy ward rounds;
  - periodic “Professionalism meetings”;
  - study day/masterclasses;
  - Mini Peer Assessment Tool;
  - chief pharmacist peer support programme; and
  - weekly “Pharmacy Forum” session.
- The topics of our discussion include:
  - information we have read in journals or learned in conferences.
- These discussions enable us to:
  - connect with latest developments and policy changes;
  - socialise and learn more effectively;
  - improve our morale; and
  - identify potential challenges and solutions.
- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

*Specific to **‘other’** settings:*

- The peer discussion methods that we use are:
  - a clear set of criteria or standards to assess our peers; and
  - verbal and written feedback after doing a session.
- The topics of our discussion include:
  - share ideas or classify issues;
  - business and pharmacy topics; and
  - monthly WebEx.
- These discussions enable us to:
  - identify areas of development; and
  - give constructive and positive feedback to each other.
- New peer discussion methods that we can introduce are:

- No findings specific to this setting.

TYPE 9: Managed – formal approaches to proactive, group performance improvement

*Specific to **community** settings:*

For this setting, there was only one contribution referring to a new approach of peer discussion that could be introduced:

- **Title:** Future forum content
  Quote: "… in the future we could have a forum section where NHS boards and the GPhC could post developments or hot topics to create discussions and obtain the opinions of a larger audience." *(21 likes, 2 dislikes, 2 comments – adjusted score: 9).*

*Specific to **hospitals** settings:*

- The peer discussion methods that we use are:
  - periodic clinical supervision for all staff;
  - daily meetings where we discuss our commitments on our shared diary;
  - we meet with professionals from other disciplines; and
  - we use a self-assessment framework based on Royal Pharmaceutical Society's Hospital Pharmacy Standards to assess ourselves.
- The topics of our discussion include:
  - problems that we have faced;
  - we review recent death cases; and
  - we share what we learn after multidisciplinary meetings.
- These discussions enable us to:
  - develop and improve the quality of our work;
  - provide support for all professionals, especially the new ones; and
- New peer discussion methods that we can introduce are:
  - No finding specific to this setting.

*Specific to **'other'** settings:*

- The peer discussion methods that we use are:
  - external evaluation of our learning programmes and processes;
  - regular meetings with our manager; and
  - regular meetings with our practice team.
- The topics of our discussion include:
  - what our future career and professional development looks like.
- These discussions enable us to:
  - receive valuable advice that we can apply to our everyday practice; and
  - ensure the quality of learning programmes and processes.
- New peer discussion methods that we can introduce are:
  - No findings specific to this setting.

Example evidence:

- **Title**: A common diary.
  Quote: "We keep a diary in the dispensary with any handover notes for another pharmacist or any locum. This helps enable them to takeover and carry out the jobs efficiently. This diary is also used as a reminder for the jobs that needs to be done or followed up in day to day activities in a pharmacy…2nd half of the diary is intervention or new learning section." *(41 likes, 3 dislikes, 22 comments – weighted score: 14).*

- **Title:** Group Practice.
  Quote: "Group practice of pharmacists - we work together as a professional group, supporting each other, learning together and identifying and sharing best practise, in exactly the same way as a high performing GP group practice would do." *(40 likes, 4 dislikes, 7 comments – weighted score: 19).*

3. General observations

Based on our analysis of the data related to peer discussion approaches, we observed that the online workshop participants:

- have a preference for engaging in peer discussions approaches that use informal processes;
- are looking for a safe, relaxed and friendly environment to reflect on their practice and improve their performance;
- experience a strong sense of isolation when working in 'other' and community settings, and see peer discussion as a powerful tool to overcome this situation;
- strongly call for protected learning time to provide pharmacists with resources (time) to engage in peer discussions ;
- already perceive peer discussion as an effective tool to expand their knowledge and facilitate collaboration across boundaries of practice, especially by including other healthcare professionals rather than just pharmacists; and
- who work in community settings, strongly call for overlap in their shifts in order to have the opportunity to engage in peer discussion with their colleagues. However, this is out of GPhC's remit.

Participants also used this online workshop to discuss topics other than approaches to peer discussion. The most discussed topics were:

- Protected learning time for pharmacists can enable them to engage in peer review discussions.
  - **Title:** Pharmacist Protected Learning Time.
    Quote: "Having Pharmacist Protected Learning Time (PPLT) is an opportunity for Pharmacists (and other regulated positions e.g. Techs) to address their own learning and professional development needs." *(79 likes, 5 dislikes, 97 comments).*

- The separation between settings of practice should be dismantled. We should encourage working in different settings of practice to come together and share their knowledge.
  - **Title:** "Shared interest is paramount. Let's get rid of the Community/Hospital designations in forums"

- **Quote:** “The distinction made between community and hospital pharmacists is artificial and unhelpful. Peer groups are most useful when they consist of people who have a shared practice interest. They should be inclusive. All pharmacists, pharmacy technicians, other professions, and even service-users should be encouraged to participate depending on the topic of the forum or group.” (28 likes, 1 dislike)

- Pharmacy professionals are not clear on the legality of certain scenarios and would like GPhC to provide them with clear guidance. Furthermore, criminalisation of dispensing errors prevents pharmacists from discussing their errors and mistakes.
  - **Title:** “Decriminalisation of dispensing errors”
    Quote: “Maybe pharmacists would be more likely to share learnings from their errors and mistakes if there wasn't the fear of incriminating oneself?” (17 likes, 0 dislikes)
  - **Title:** “Clear advice needed”
    Quote: “It's impossible to get clear cut decisions about the legality of certain scenarios and their implications. Currently the GPhC does not provide advice, yet this is the body that will eventually rule on any breaches of law or ethics. This was always a problem with the RPS before it divested the regulatory role. We are still left to our own devices to interpret certain aspects of the law and in some cases this means we fail patients.”
- Community pharmacists should be given access to NHS pensions.
  - **Title:** “Community pharmacist access to NHS pensions?”
    Quote: “Why when we provide NHS services as independent contractors just like our GP colleagues who are also independent contractors, have no right to access NHS pensions schemes?” (21 likes, 8 dislikes)

Plan and act

Next steps

The next step of this process is to create a toolkit to which GPhC’s registrants can refer to when they seek to improve their practice through peer discussion.