Peer Discussion in Practice: Experiences of Pharmacy Technicians in the Participation of Revalidation for Registration

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Intellectual Property and Publication Statements

I confirm that the work submitted is my own and that appropriate credit has been given where reference has been made to the work of others.

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"Those we love don't go away; they walk beside us every day. Unseen, unheard, but always near; still loved, still missed and very dear" - Anonymous

Abstract

As the pharmacy technician role continues to evolve across pharmacy sectors in Great Britain, professional revalidation is a key mechanism for ensuring ongoing competence and reflective practice. One component of the General Pharmaceutical Council (GPhC) revalidation process, peer discussion, offers an opportunity for pharmacy technicians to engage in meaningful conversations about their practice. However, little is known about how this group experience peer discussion, what value they derive from it and what support they need to participate effectively. Understanding these experiences is essential to shaping future guidance and adopting a culture of reflective learning within the pharmacy workforce.

This study explores the experiences of pharmacy technicians participating in peer discussion as part of the GPhC revalidation process. It examines how they perceive its value, the strategies they use to identify suitable peers and the types of support considered beneficial for meaningful engagement. Guided by an interpretivist paradigm, the research employs a qualitative methodology comprising of an online survey, which gathered 325 responses, and one-to-one online interviews with nine participants from across Great Britain and the three key pharmacy sectors.

Following thematic analysis, three overarching themes were identified. The first, *Fostering Meaningful Discussions*, explored how natural interactions were translated into structured reflections, how outcomes were synergised and how engagement was navigated. The second, *Strategic Peer Selection for Meaningful Discussion*, encompassed intrinsic motivations and extrinsic influences shaping peer choice. The third, *Navigating the Landscape of Peer Discussions*, addressed procedural ambiguities, the evolving nature of peer discussions and the role-specific challenges.

Findings suggest that while peer discussions are widely valued, pharmacy technicians often encounter uncertainty around peer selection and procedural clarity. In response, the study recommends clearly defining the purpose of peer discussion as a tool for reflective practice and professional development alongside flexible implementation and tailored guidance to support confident, context-sensitive engagement.

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Glossary

AHP	Allied Health Professions consisting of 14 roles
APTUK	Association of Pharmacy Technicians UK - professional leadership body
ARRS	Additional Roles Reimbursement Scheme
CASP	Critical Appraisal Skills Programme health research checklist
CoP	Community of Practice
COREQ	Consolidated Criteria for Reporting Qualitative Research checklist
CPD	Continuing Professional Development
CPPE	Centre for Pharmacy Postgraduate Education
DMP	Data Management Plan
ELT	Experiential Learning Theory
EndNote	Reference management tool
FE	Further Education
FtP	Fitness to Practise
GMC	General Medical Council – regulator for medics
GP	General Practice (primary care)
GPhC	General Pharmaceutical Council - regulator for pharmacy professionals
Grandparenting	Transitional registration for experience pharmacy technicians' pre-regulation
HRA	Health Research Authority
HEE	Health Education England - NHS body for education and workforce development across England
HEIW	Health Education and Improvement Wales - special Health Authority within NHS Wales for education and workforce development
ICS	Integrated Care System - partnership of organisations that come together to plan and deliver joined up health and care services
IET	Initial Education and Training standards
IP	Independent Prescriber
IPE	Interprofessional Education
IT	Information Technology
LPP	Legitimate Peripheral Participation
MDT	Multidisciplinary Team
MS	Microsoft
NES	NHS Education for Scotland - education and training body within NHS Scotland for education and workforce development
NHSE	National Health Service in England
NHS REC	NHS Research Ethics Committee
NIHR	National Institute for Health and Care Research
NMC	Nursing and Midwifery Council - regulator for nurses and midwives
NPTGS	National Pharmacy Technician Group Scotland
P2P	Peer to Peer support
PAL	Peer Assisted Learning
PCN	Primary Care Network - alliance of GP surgeries working collaboratively
PCPA	Primary Care Pharmacy Association
PGD	Patient Group Direction
Pharmacy Technician (PT)	An individual who has met the pharmacy technician education, training, experience and fitness to practice requirements to register with the GPhC

Pharmacist	An individual who has met the pharmacist education, training, experience and fitness to practice requirements to register with the GPhC
Pharmacy Support Staff	Collective term for the regulated, but not registered, pharmacy workforce
PGR	Post Graduate Researchers
PLB	Professional Leadership Body
PREP	Post-Registration Education and Practice (nursing and midwifery)
PRG	Peer Review Groups
PSNI	Pharmaceutical Society of Northern Ireland
PSW	Peer Support Worker
PTTO	Pharmacist and Pharmacy Technician Order
Revalidation	The process of making a healthcare professional officially approved to practise
RP	Responsible Pharmacist - oversees operations of a registered pharmacy
RPS	Royal Pharmaceutical Society - professional leadership body for Pharmacists.
RTA	Reflexive Thematic Analysis
Secondary Care	Healthcare services typically provided in hospitals
SPIDER	Search tool – Sample Phenomenon of Interest Design Evaluation Research type
TURAS	Gaelic for ‘journey’ – NHS Scotland CPD and appraisal platform
UKCPA	United Kingdom Clinical Pharmacy Association

Chapter 1: Introduction

This study explores the experiences of pharmacy technicians participating in peer discussion as part of their professional revalidation with the General Pharmaceutical Council (GPhC).

This introductory chapter provides the background to the study, beginning with an overview of the roles within pharmacy teams and the various sectors of pharmacy practice. It also examines the history of pharmacy technicians as a profession and the process of revalidation.

The chapter concludes by outlining my personal position and experience as a pharmacy technician involved in revalidation, as well as the rationale behind conducting this study.

1.1 Pharmacy Professions

In Great Britain there are two pharmacy professions: pharmacist and pharmacy technician. Pharmacists complete a four-year Master of Pharmacy (MPharm) degree followed by a foundation training year in practice, building a portfolio of competence through workplace observations. Following successful completion of these components, trainee pharmacists must pass a registration assessment and confirm their Fitness to Practice (FtP) to meet the requirements to register as a pharmacist with the GPhC (2021b).

Pharmacists, with appropriate training, can take on roles such as Responsible Pharmacist (RP) or Independent Prescriber (IP). Pharmacy business owners are required to appoint an RP to oversee the operations of a registered pharmacy (*The Medicines (Pharmacies) (Responsible Pharmacist) Regulations*, 2008). Pharmacists who have completed a GPhC-accredited course and qualified as an IP have the authority to prescribe independently for any condition within their clinical competence. Commencing in 2026, all newly registered pharmacists will be qualified as IPs (GPhC, 2021a).

Table 1 shows the number of pharmacists on the GPhC register by location of registered address as of 31st October 2024.

Date	All	England	Scotland	Wales	Other
31st October 2024	65,919	55,710	5,669	2,819	1,721

Table 1: GPhC Pharmacists Registrant Data
Adapted from GPhC (2024a)

By comparison, pharmacy technicians complete a two-year training programme accredited by the GPhC. During this period, they compile evidence of their competence

against a set of Initial Education and Training (IET) Standards, which were updated in 2017 to replace the previous 2010 standards (GPhC, 2017b). These revised standards aimed to better reflect the evolving scope of the pharmacy technician role and to ensure consistency in training quality across sectors.

Upon successful completion of the training programme, which is designed to enable the trainee to demonstrate competence against the IET Standards, and following submission of FtP declarations, trainees register as pharmacy technicians with the GPhC (GPhC, 2017b).

A recent evaluation of these IET Standards by ICF Consulting Services Limted and the Centre for Pharmacy Workforce Studies (2023) found that the 2017 standards have generally enhanced the preparedness of newly registered pharmacy technicians for safe, effective and autonomous practice within diverse pharmacy settings. However, the report also identified inconsistencies in training delivery across sectors and highlighted the need for improved support in workplace-based learning. These findings suggest that while the IET framework has strengthened the professional foundation of pharmacy technicians, further refinement is needed to ensure consistency and equity in training experiences.

This aligns with earlier work by Schafheutle et al. (2017), whose mixed-methods study highlighted variation in how training was delivered and assessed, with some pharmacy technicians reporting limited opportunities to apply their learning in practice. Their research contributed to ongoing conversations about the evolving purpose and delivery of pharmacy technician education, particularly in relation to workplace integration and experiential learning.

Similar concerns were raised in Boughen and Fenn’s (2016) study, which explored the roles and perceptions of pharmacy technicians across the UK. Their report highlighted significant variation in how the role was understood and implemented across sectors, with some pharmacy technicians taking on advanced responsibilities while others remaining confined to more traditional tasks. While the study provided valuable qualitative insights into the profession’s potential, it also revealed a lack of standardisation in role expectations and career development pathways.

More recently, the Post-Registration Frameworks and Career Pathways report commissioned by HEIW and published by APTUK (2025a) has advanced these conversations by offering an evidence-based foundation for career progression and workforce planning. It emphasises the strategic positioning of pharmacy technicians and the importance of structured, meaningful development beyond initial registration. Alongside this, APTUK’s Professional Leadership: Fit for the Future report further

reinforces the need for inclusive leadership models and sector-wide investment in pharmacy technician development (APTUK, 2025b). Together, these contributions reflect a growing recognition of the complexity and diversity within pharmacy technician practice, and the importance of aligning educational frameworks with real-world demands.

This evolving professional landscape is reflected in the expanding scope of responsibilities that pharmacy technicians may undertake in practice. With appropriate training, they may perform the final accuracy check of dispensed medicines and products, pre- and in-process checks within pharmacy aseptic services, provide services under a Patient Group Direction (PGD) and hold enhanced roles in medicines management, leadership, education and training. In line with proposed changes to pharmacy supervision legislation, pharmacy technicians will soon be authorised to carry out or supervise the preparation, assembly, dispensing, sale and supply of medicines, with pharmacists delegating these tasks where appropriate. These changes aim to maximise the contribution of pharmacy professionals (Department of Health and Social Care, 2025).

Table 2 shows the number of pharmacy technicians on the GPhC register by location of registered address as of 31st October 2024.

Date	All	England	Scotland	Wales	Other
31st October 2024	26,689	22,175	2,586	1,751	177

Table 2: GPhC Pharmacy Technician Registrant Data
Adapted from GPhC (2024a)

While pharmacists have been a regulated profession since 1852 (RPS, 2021), the pharmacy technician role has undergone a more recent process of professionalisation. Although recognised as part of the accredited pharmacy workforce by the Department of Health and Social Services committee in 1952, pharmacy technicians did not become a fully regulated profession until 2011 (APTUK, 2021).

To support this transition, a ‘grandparenting’ clause was introduced when registration was first implemented in Great Britain. This allowed experienced pharmacy technicians who had been practising prior to the new requirements to become registered without completing the updated educational standards. Instead, they could demonstrate their competence through a combination of relevant work experience and previously acquired qualifications. This approach helped maintain workforce continuity while upholding the integrity of the profession (NHS Pharmacy Education & Development Committee, 2011).

In addition to registered professionals, pharmacy teams also include a regulated workforce known collectively as pharmacy support staff. These roles involve tasks such as dispensing and supplying medicines and products, providing advice on their use and assisting pharmacy professionals in delivering pharmacy services. Pharmacy support staff work under the supervision of a pharmacist or pharmacy technician to carry out these responsibilities. While they are not directly registered with the GPhC, the GPhC regulates the education and training of 'pharmacy support staff'. They also approve training providers and courses that offer relevant education for this workforce (GPhC, 2025).

The pharmacy roles described can be found across teams in various sectors of pharmacy. The next section will provide descriptions of the key pharmacy sectors.

1.2 Pharmacy Sectors

The pharmacy profession encompasses three key sectors: community pharmacy, which includes online pharmacies; primary care, which involves Primary Care Networks (PCN) and General Practice (GP); and secondary care, which includes hospitals (GPhC, 2019; NHS Providers, 2020). Additionally, pharmacy professionals may also work in various fields, including the pharmaceutical industry, health commissioning organisation such as NHS England, professional regulatory bodies, research, education or training, the armed forces, the healthcare in justice sector and the emergency services.

Data from the GPhC (2019) survey of pharmacy professionals showed that most pharmacists (61%) and pharmacy technicians (46%) work within community pharmacy settings. The creation of PCNs in 2019, as part of the NHS Long Term Plan, along with the subsequent Additional Roles Reimbursement Scheme (ARRS) funding for the roles of clinical pharmacist and pharmacy technician, is expected to increase the number of pharmacy professionals working within primary care (Department of Health and Social Care, 2019).

Within community pharmacy, the pharmacist will often be the sole pharmacist on the premises and therefore, will comply with the legislation by undertaking the role of RP (*The Medicines (Pharmacies) (Responsible Pharmacist) Regulations*, 2008). Pharmacy technicians may also be part of the workforce; however, unlike the role of the RP, there is no legal requirement to have a pharmacy technician in a community pharmacy. This structural difference contributes to variability in team composition across settings.

In both community and primary care sectors, the pharmacist and pharmacy technician may be the only professionals of their kind within the team. According to the 2024

Community Pharmacy Workforce Survey, the average number of employed pharmacy technicians per community pharmacy is 1.2 full-time equivalents, with many sites reporting no pharmacy technician presence at all (NHS England, 2025b). This contrasts with an average of 1.79 pharmacists per site, reflecting a more consistent staffing due to the RP designation.

NHS England (2025d) data from June 2025 shows an average of just over two pharmacy technicians per PCN (2,618 full-time equivalent pharmacy technicians across1,294 PCNs), which equates to fewer than one pharmacy technician for every two GP practices (6,210 practices in England). This suggests that pharmacy technicians in primary care are often shared across multiple sites, which may limit their visibility, continuity and integration within individual practice teams.

In contrast, while secondary care includes the same pharmacy roles, the specialised nature of hospital care and the clinical expertise of individual pharmacy professionals mean that pharmacists and pharmacy technicians are rarely the sole representatives of their profession in the team.

To practise in any sector in Great Britain, pharmacists and pharmacy technicians must be registered with the GPhC and meet their requirements. The next section will describe the GPhC and their regulatory role.

1.3 The General Pharmaceutical Council (GPhC)

The GPhC plays a crucial role in regulating pharmacy professionals and ensuring the safety and quality of pharmacy services. It is built on a legacy of regulatory frameworks dating back to the first foundations of a Pharmaceutical Society of Great Britain, founded in 1841. Since 1933, this organisation registered pharmaceutical chemists and druggists. In 1988, it was granted the title Royal Pharmaceutical Society (RPS) (2021).

Following recommendations from the Health Act in 1999 to “modernise and strengthen regulation of healthcare professionals” (*The Health Act*, 1999, p.60), the Pharmacist and Pharmacy Technician Order (PTTO) was enacted. The PTTO overhauled the regulation of pharmacists and, for the first time, extended regulation to pharmacy technicians (Department of Health and Social Care, 2007b). Under the PTTO, the completion of continued professional development became a statutory requirement, and a voluntary register for pharmacy technicians was created with the RPS.

The PTTO was repealed in 2010 by the Pharmacy Order (*The Pharmacy Order*, 2010), which enshrined the recommendations from Trust, Assurance and Safety: The Regulation of Health Professionals in the 21st Century, stating that “professional regulation needs to sustain confidence of both the public and professionals through

demonstratable impartiality" (Department of Health and Social Care, 2007b, p.2). As a result, the regulatory functions of the RPS were transferred to the GPhC.

In Northern Ireland, pharmacists are registered with the Pharmaceutical Society of Northern Ireland (PSNI), with pharmacy technician not currently a registered profession (PSNI, 2021).

Both the GPhC and PSNI have developed professional standards, FtP and revalidation models for pharmacy professionals, which I will now describe.

The Professional Standards

The Pharmacy Order required the GPhC to set standards across four areas (*The Pharmacy Order*, 2010):

- pharmacy professionals
- registered pharmacies
- initial education and training for pharmacists
- initial education and training for pharmacy technicians

The standards for pharmacy professionals outline nine key expectations that every pharmacist and pharmacy technician must be accountable for. Figure 1 gives an overview of the GPhC professional standards.

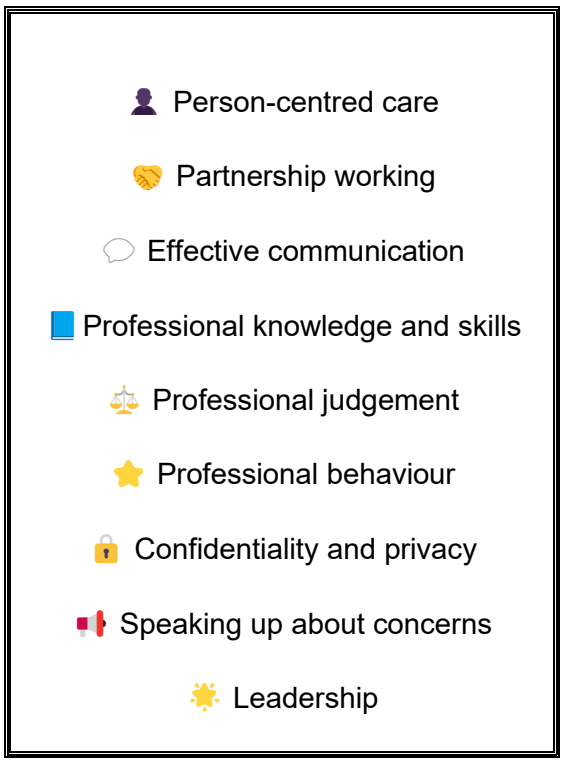

Figure 1: Summary of the GPhC Pharmacy Professional Standards
Adapted from GPhC (2017a)

These standards describe how safe and effective care should be delivered, serving as both a statement of patient expectations for pharmacy professionals and a reflection of the professional standards that pharmacy professionals hold for themselves and their colleagues (GPhC, 2017a). The pharmacy professional standards support FtP by establishing clear expectations for the behaviour, skills and knowledge required of pharmacy professionals.

Fitness to Practise (FtP)

Being fit to practise means a pharmacy professional not only has the skills and knowledge to do their job safely and effectively but also possesses the health and character for their role. At initial registration, pharmacy professionals must demonstrate their FtP by meeting the required education and training standards. This includes providing evidence of qualifications, completing the registration exam (for pharmacists) and confirming their adherence to the GPhC's professional and ethical standards.

Once registered, pharmacy professionals are required to make an annual declaration of their FtP. As part of this process, they confirm that they are continuing to meet the pharmacy professional standards, have the necessary skills, knowledge and competence to perform their role safely and effectively, and have not been subject to any health conditions, criminal convictions or disciplinary action that could impair their ability to practise safely. In addition to the annual declaration of FtP, pharmacy professionals must provide evidence of their continuous competence and professional development. The following section will outline both the previous and current models for demonstrating this.

1.4 Continuing Professional Development (CPD)

Continuing Professional Development (CPD) is the process by which professionals actively engage in learning activities to maintain, enhance and expand their knowledge and skills. It is an essential component of most healthcare professions, ensuring practitioners stay up to date with developments in their field (Shlom, 2014). The pharmacy profession was an early adopter of CPD in the UK, following RPS member feedback expressing that CPD should be compulsory. It became a mandatory requirement of the RPS (2001) Code of Ethics and was extended to include pharmacy technicians in the RPS (2009) updated Code of Ethics for Pharmacists and Pharmacy Technicians. From March 2009, practising pharmacy professionals were required to make a minimum of nine CPD records per year.

The recording system for these records was based on a four-stage CPD cycle, with registrants able to begin a record at either the reflection on practice or the action stage. The cycle is shown in Figure 2.

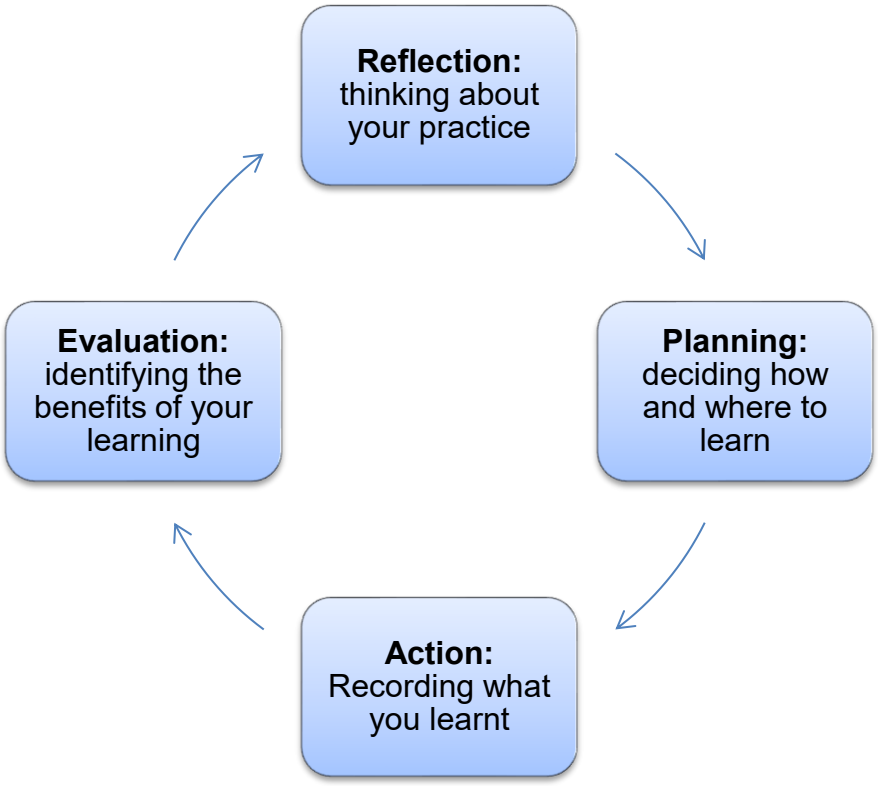

Figure 2: The Continuing Professional Development Cycle
Reproduced from Tyers (2016, p.38)

The pharmacy CPD cycle model was grounded in key learning theories, including David Kolb's Experiential Learning Theory (ELT). Kolb's ELT is a widely recognised model that describes learning as a continuous cycle as shown in Figure 3 on the next page. Individuals begin with a concrete experience by actively participating in an activity. They then move into reflective observation, considering what happened and how they felt. This leads to abstract conceptualisation, where they form theories or ideas from their reflections. Finally, they engage in active experimentation by applying those ideas to new situations in order to test and refine their understanding (Kolb, 1984).

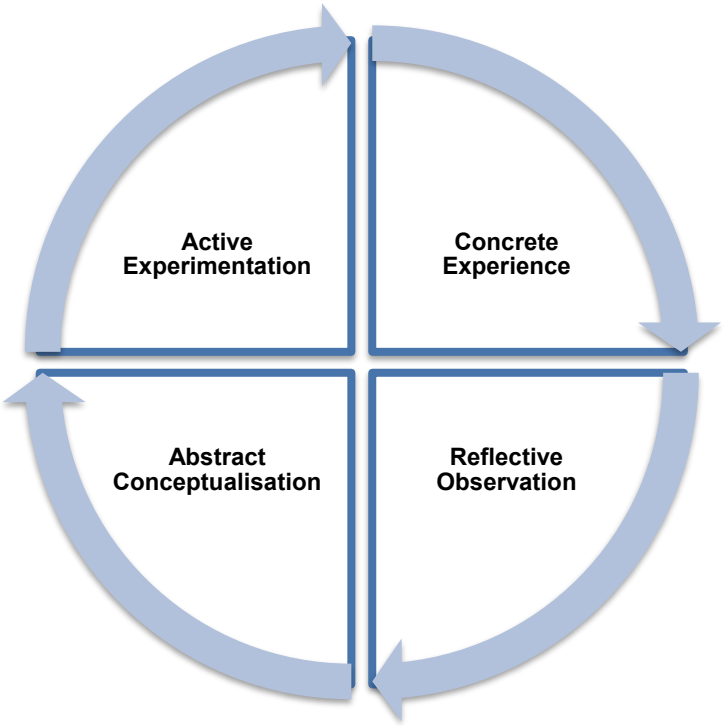

Figure 3: Kolb's ELT Cycle
Adapted from Kolb (1984, p.70)

These stages represent a continuous loop where individuals gain new knowledge, reflect on it, create theories or ideas based on the experience and then apply the learning in practice. This model is particularly relevant in healthcare CPD, where learning is often based on real-life experiences, ongoing reflection and the practical application of knowledge in patient care. It is important to distinguish CPD from traditional continuing education, which tends to focus on formal instruction and time-based metrics. CPD by contrast, encourages reflective and experiential learning that supports professional growth and adaptability (Bullock et al., 2020). Reflection is a central theme in many CPD frameworks in healthcare and aligns with Kolb's observation stage. Healthcare professionals are often required to document their reflections on practice and seek feedback from peers or mentors, which feeds back into the cycle of learning (Bradbury et al., 2010; Oelofsen, 2012). The continuous and iterative nature of Kolb's model appears to resonate with the principles underpinning revalidation frameworks, which emphasise the importance of lifelong learning. This conceptual alignment suggests that revalidation may play a meaningful role in supporting pharmacy professionals to remain reflective, competent and current in their practice.

In the next section, I will describe the journey to revalidation as a mechanism for maintaining professional standards and adopting lifelong learning. A more detailed

exploration of Kolb's model and its relevance to professional development will be presented in Chapter 2.

1.5 Revalidation

Revalidation aims to strengthen the regulatory framework to better align with the evolving needs of the profession and simultaneously enhance public trust and confidence in healthcare professionals. The notion of revalidation for healthcare professionals' dates back over two decades. Over that time, the impetus for revalidation has fluctuated between two distinct interpretations: one as a perceived mechanism for identifying dangerous professionals, most notably in the aftermath of Shipman (Department of Health and Social Care, 2007a), and the other as a process to support continued FtP, as originally described in the Bristol Royal Infirmary Inquiry (2001).

Following these failings in the health sector, key reports recommended that all health professionals undertake revalidation (Keogh, 2013). The Department of Health and Social Care (2007b, p.31) define revalidation as: "a mechanism that allows health professionals to demonstrate that they remain up-to-date and fit to practice".

Medical Revalidation

The journey to medical revalidation began in 2000 (GMC, 2000), with proposals outlined in 2007 (Department of Health and Social Care, 2007b) and statutory obligation commencing in a phased approach from 2012-2016 (GMC, 2013).

Revalidation requirements for doctors run on a five-year cycle, with the process linked to the doctor's licence to practise and continued registration with the General Medical Council (GMC). Each doctor is assigned a responsible officer who oversees the revalidation process. Typically, a responsible officer is a senior doctor or healthcare manager who supports the doctor in gathering the necessary evidence for revalidation and reviews their revalidation portfolio. Supporting information is gathered across a number of domains, including the requirement for an annual appraisal with "good medical practice" as the focus (GMC, 2013, p.1).

An appropriately appointed and trained appraiser must complete appraisals. Basic eligibility criteria for appraisers are that they have a minimum of five years' experience in their clinical speciality or field of practice, familiarity with revalidation requirements and completion of formal appraiser training to understand the GMC revalidation requirements and Good Medical Practice guidelines (GMC, 2013). In addition, they are trained to give constructive feedback, assess evidence, manage difficult conversations, assess FtP and respect ethical considerations. Appraisers undergo continuing education to stay up to date with revalidation practices and are supported through peer

review and a moderation system. Gatrell and White (2023, p.20), writing about medical revalidation, propose Kolb as a “useful model of learning for well-conducted appraisal meetings”, aligning medical revalidation with the principles of CPD previously discussed.

Following the Command Paper, Enabling Excellence: Autonomy and Accountability for Health and Social Care Staff (Department of Health and Social Care, 2011) the government outlined strategic reform for the regulation of healthcare workers in the UK. The strategy included proposals for revalidation of professionals other than medical doctors, with a requirement to demonstrate significantly increased safety and quality of care for users of healthcare services. This resulted in the implementation of revalidation frameworks for other healthcare professionals.

Nursing and Midwifery Revalidation

The journey to revalidation for nurses and midwives began in 2001 with the publication of the Post-Registration Education and Practice (PREP) standards handbook. The PREP standards set out the legal requirements for registration renewal and included evidence of 450 hours of practice and 35 hours of CPD (Fairley-Murdoch and Ingram, 2017). The system relied on the registrant complying with the standards, with only a small percentage of registrants audited by the Nursing and Midwifery Council (NMC). Building on the PREP standards, the NMC introduced their revalidation framework in 2016, ensuring a more robust system by introducing third-party verification (NMC, 2020).

Their revalidation framework runs on a three-year cycle, during which time registrants must provide evidence of the following:

- completing at least 450 practice hours
- undertaking 35 hours of CPD, with at least 20 of those involving participatory learning
- collecting five pieces of practice-related feedback
- writing five reflective accounts of how they have applied learning in practice
- completing a discussion with their reflective discussion partner on those reflective accounts

This reflective discussion must take place with another NMC registrant. In addition, registrants must declare that they are capable of safe and effective practice and confirm appropriate professional indemnity arrangements.

The NMC revalidation model combines professional development, reflection, feedback and practice hours to encourage lifelong learning, self-assessment and continuous

improvement in nursing and midwifery practice (NMC, 2020). Fairley-Murdoch and Ingram (2017, p.33) describe the revalidation journey for nurses and midwives. Like medics, they refer to Kolb's ELT. They describe it as "a model which encompasses reflection and can be useful when attempting to demystify new knowledge or information". This shows how ELT supports professionals in making sense of learning during revalidation.

After the introduction of revalidation for medics, nurses and midwives, the pharmacy profession became the next healthcare sector to adopt this model. The following section will outline the pharmacy revalidation process.

1.6 Pharmacy Revalidation

The journey to revalidation for the GPhC began with a commissioned review of its existing CPD model, as outlined in the previous section, to inform the development of the pharmacy revalidation framework (IFF Research Ltd, 2015). After piloting the framework (Solutions for Public Health, 2017), further updates were required following the publication of the Williams review into gross negligence manslaughter in healthcare (Williams, 2018).

The Williams review was prompted by the conviction of a paediatrician, Dr. Hadiza Bawa-Garba, for gross negligence manslaughter following the death of a child. Her reflective notes on the incident were controversially used as evidence against her in court. The review raised concerns among healthcare professionals about the implications of reporting and learning from errors as part of professional development. It aimed to provide recommendations to ensure that the legal framework supports a culture of transparency and continuous learning in healthcare. In response, the GPhC emphasised that reflection and discussion related to errors and learning are vital for patient safety (GPhC, 2018c). Consequently, guidance was updated to confirm that no specific details of errors should be recorded in revalidation records, but rather how the process of discussions has improved practice.

In 2018, the revised pharmacy revalidation framework was launched. Throughout 2019, pharmacy professionals completed the GPhC (2018b) full revalidation framework which comprises three equally important components:

- four CPD entries of which at least two must demonstrate planned learning
- a reflective account aligned to the professional standards required by the GPhC in the revalidation window
- a peer discussion

In 2020, due to the Covid-19 pandemic, full revalidation requirements for pharmacy professionals were suspended. During this period, the annual revalidation requirement was reduced to a single reflective account related to maintaining the professional standards during the global health crisis. The following sections provide a more detailed overview of the full revalidation requirements, which were reintroduced from October 2022 (GPhC, 2020).

Continuing Professional Development (CPD) Records

Pharmacy professionals are encouraged to complete sufficient CPD to ensure they can practise safely and effectively. As part of the annual revalidation process, they are required to submit four CPD entries, all of which must be relevant to the services they provide to patients or service users. Additionally, two of these CPD activities must be planned. While unscheduled learning activities are recognised as valuable, greater emphasis is placed on the planning of CPD to “assure the public that pharmacy professionals remain up to date with current practices” (GPhC, 2018b, p.10).

An example of a planned CPD activity is attending a two-day conference on new drug therapies, designed to deepen knowledge of recent developments in pharmacy practice. This event is scheduled in advance and aligns with the pharmacy professional's goals and the specific needs of their practice. In contrast, an example of an unplanned CPD activity is reflecting on a dispensing error, identifying its cause and pursuing further learning to develop preventative strategies, such as recognising look-alike sound-alike (LASA) medicines. The pharmacy professional then applies this new knowledge to practice, aiming to prevent future errors.

Reflective Account

Annually, the GPhC identify the pharmacy standards on which pharmacy professionals must reflect. As part of the reflective account, professionals must produce a summary of where they work, a brief overview of their area of practice and a description of the users of their services. In addition, they must submit a reflective statement explaining how they have met one or more of the identified standards, supported by examples from their practice (GPhC, 2018b, p.13).

In 2025, registrants are required to reflect on one or more of the following standards in their reflective account (GPhC, 2024b):

- Standard one: pharmacy professionals must provide person-centred care.
- Standard two: pharmacy professionals must work in partnership with others.
- Standard five: pharmacy professionals must use their professional judgement.

The CPD and reflective account submissions require registrants to provide real-life examples that demonstrate the application of their learning in practice.

Peer Discussion

In addition to the CPD and reflective account, the GPhC requires an annual peer discussion. Peer discussion is defined by the GPhC (2018b, p.10) as, “a learning and development activity that encourages you to engage with others in your reflection on learning and practice”.

Pharmacy professionals are encouraged to select an appropriate peer, with an emphasis on autonomy in choosing their own peer and a requirement to sign a declaration confirming this. Unlike the GMC (2013) and NMC (2020), there is no requirement for the peer to be trained or a registered professional. The GPhC (2018a, p.2) even states that “almost anyone can be a peer”, with the main exceptions being concerns around objectivity or if the peer is a health professional under a regulatory sanction.

Peer discussions are often conducted in person, however, they may also take place using any real-time communication method, such as web chat platforms or telephone. Prior to the discussion, the pharmacy professional should consider the topic and information to be shared. The GPhC (2018b) encourages discussions related to CPD activities, the reflective account and other aspects of practice, such as significant event or complaint reviews. The emphasis is on the discussion aiding reflection and aiming to “influence your development positively, rather than for your peer to make an assessment of you” (GPhC, 2018b, p.12).

During the peer discussion, the peer is encouraged to ask questions about the pharmacy professional’s practice, offer suggestions and challenge assumptions. Peers can access a guide from the GPhC (2018a) to support them in their role. This guide explains the purpose of peer discussions, who can serve as a peer and outlines the steps to take before, during and after the discussion. Notes of the discussion may be

made by the pharmacy professional; however, as highlighted in the Williams review, these may not always be submitted as part of revalidation (Williams, 2018). The contact details of the peer are included in the submission, and peers may be contacted by the GPhC to confirm the discussion took place.

Pharmacy professionals record and submit their revalidation entries using the MyGPhC online platform, a secure system provided by the GPhC. This platform allows registrants to log CPD entries, a reflective account and the peer discussion, as well as manage their registration renewal. It also includes guidance and troubleshooting support to help users navigate the revalidation process efficiently.

Engaging in peer discussion enables pharmacy professional to critically reflect on their practice, synthesise insights into new approaches and identify areas for further development. Through this process, they are encouraged to seek feedback, describe any resulting changes to their practice and provide real-life examples of improved outcomes. Ultimately this process enhances clinical skills and knowledge, contributes to better patient care and supports continuing professional development (Oelofsen, 2012).

The final part of this section on revalidation provides a visual representation of the GPhC process at Figure 4, followed by an overview of the support available to pharmacy professionals. This sets the stage for a discussion of my personal experience and positionality as both a pharmacy technician and researcher.

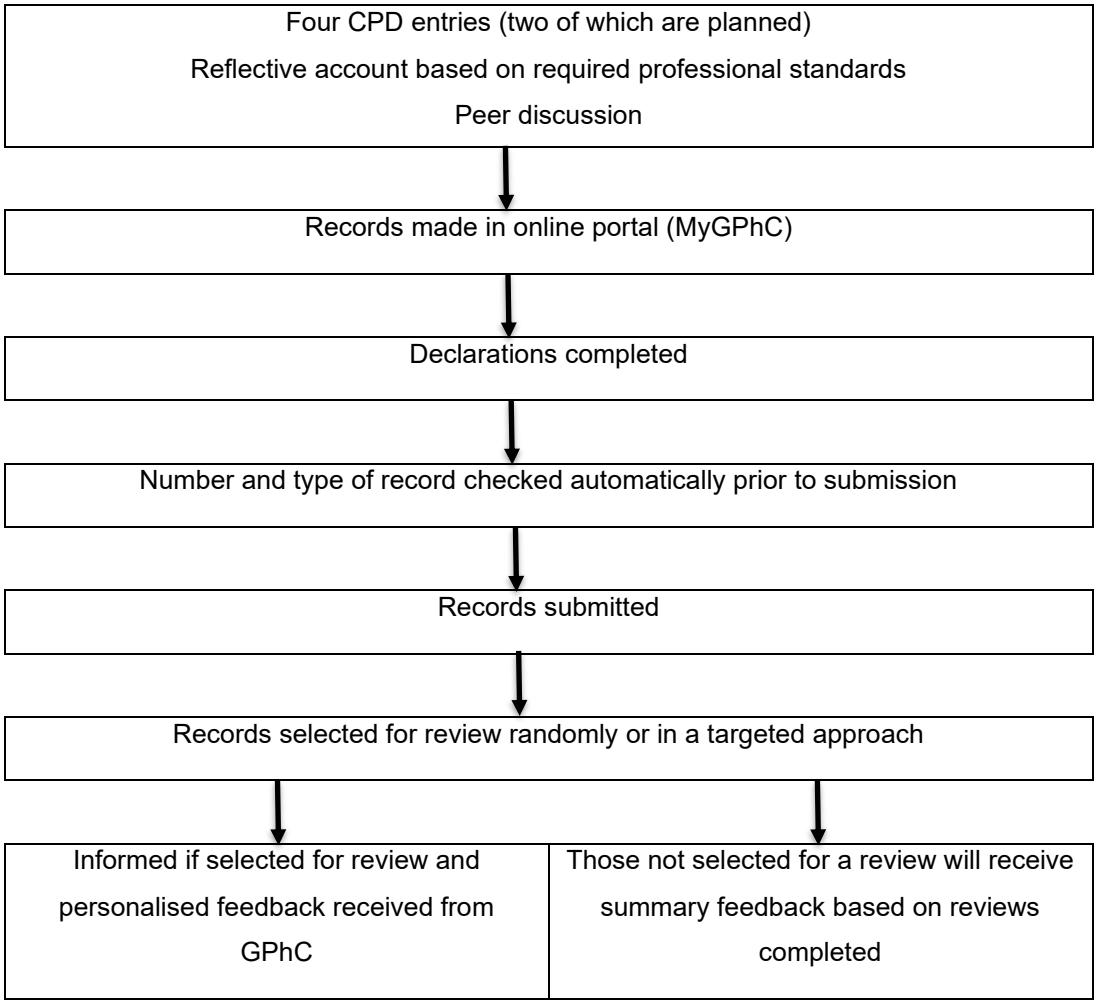

Figure 4: Pharmacy Revalidation Process
Adapted from GPhC (2018b, p.6)

Support for Revalidation

In addition to the resources provided by the GPhC, pharmacy professionals can access support and training from various organisations. Pharmacists can turn to the RPS which, although its regulatory functions were transferred to the GPhC, continues to serve as the Professional Leadership Body (PLB) for pharmacists. RPS members can access a wide range of resources, training courses and guidance to support revalidation, as well as tools to help track learning and reflect on professional development (RPS, 2019). However, pharmacy technicians are not eligible to join the RPS and instead have their own PLB, the Association of Pharmacy Technicians UK (APTUK), which offers its members access to local and national branches for support in fulfilling CPD and revalidation requirements (APTUK, 2021).

Pharmacy professionals can also access education, training, mentoring and networking opportunities tailored to their specific country of practice. In England, the Centre for Pharmacy Postgraduate Education (CPPE) offers evidence-based learning and CPD

opportunities, including both online and in-person programmes (CPPE, n.d.). In Scotland, NHS Education for Scotland (NES) provides resources to support pharmacy professionals' CPD, with specific guidance for developing evidence for revalidation submissions (NHS Education for Scotland, 2024). In Wales, Health Education and Improvement Wales (HEIW) offer a range of training courses and learning opportunities that align with NHS Wales workforce priorities and can contribute to revalidation (HEIW, n.d.).

Additionally, the GPhC signposts support from various organisations, such as Pharmacist Support, which is an independent charity for pharmacists in the UK. However, pharmacy technicians currently cannot access their services (Pharmacist Support, 2025). The United Kingdom Clinical Pharmacy Association (UKCPA) and the Primary Care Pharmacy Association (PCPA) are also signposted by the GPhC. The UKCPA is a membership organisation for the clinical pharmacy community, offering various educational opportunities to both pharmacy professions (UKCPA, n.d.). In contrast, the PCPA supports members, who may be pharmacists or pharmacy technicians, working in primary care (PCPA, n.d.). Although the use of these resources is not mandatory, pharmacy professionals are encouraged to access them freely to support their CPD and revalidation efforts.

1.7 International Perspectives on Revalidation and Registration of Pharmacy Technicians

While the regulatory framework for pharmacy technicians in Great Britain is well established, as previously outlined, international approaches vary significantly in terms of statutory recognition, continuing education and professional oversight.

In Canada, pharmacy technicians are required to register with provincial regulatory bodies such as the Ontario College of Pharmacists. Entry to the profession involves completion of an accredited college programme, national examinations and provincial law assessments. Continuing education is mandatory for maintaining registration and professional inspections may include individual performance reviews as well as site audits (Hemsworth, 2018).

New Zealand does not currently offer statutory regulation for pharmacy technicians, although the Pharmaceutical Society of New Zealand has developed standards for accuracy checking and proposed a scope of practice and code of ethics. Pharmacy technician education is delivered across Levels 4 to 6, with Level 5 broadly comparable to the UK's Level 3. CPD is encouraged but there is no formal revalidation process akin to the Great Britain model (Hemsworth, 2021).

Across Europe, the 2017 EAPT survey highlighted considerable variation in pharmacy technician education and regulation. Some countries maintain formal registers and require CPD, while others rely on employer-led training or informal standards (European Association of Pharmacy Technicians, 2017). This lack of harmonisation presents challenges for cross-border recognition and professional mobility, particularly in the context of evolving pharmacy roles and workforce pressures.

After outlining the profession and the requirements for revalidation, I will now describe my position and experience as both a pharmacy technician and researcher.

1.8 My Position and Experience

It is good practice within the qualitative research tradition for the researcher to disclose their personal history, motivations for choosing the research topic and research orientation (Flick, 2022). In this section, I provide information on my background, relevant experience and interests that led to this study.

I began my training as a pharmacy technician in 1989, at the age of sixteen, and have worked continuously in pharmacy technician roles ever since. Over the years, I have held various positions within both secondary care in the NHS and Further Education (FE) for pharmacy, working for both public and independent training providers. For most of the period during which the thesis was developed, I held a portfolio career with two employers: a leadership position within the Integrated Care System (ICS) for Derby and Derbyshire, and a programme development role at an independent training provider.

In August 2025, I transitioned from my role at the independent training provider to a new academic appointment at a university in the Midlands. I continued to maintain a portfolio career, combining this new university role with my ongoing NHS leadership position. While this appointment represents a significant development in my professional journey, the insights and experiences informing this thesis are grounded in my previous roles, particularly those involving pharmacy technician education, workforce development and professional support.

In addition to my paid roles, I volunteer with APTUK, where I am a Fellow member and co-chair of the East Midlands branch. I also served on the board of directors for four years, from 2017 to 2021, initially as secretary and later as director of digital strategy. This experience has provided me with valuable insight into the diverse roles of pharmacy technicians, the various sectors of pharmacy and the differences across the UK in pharmacy technician education and support. It was during my time volunteering in this capacity that I first encountered pharmacy technicians requesting access to

peers for peer discussion, which led me to question why they were unable to identify a suitable peer from their own practice.

In my roles, I am often the sole pharmacy technician in a world of pharmacists. I have encountered marginalisation and professional barriers at both local and national levels, relating not only to my own role but also to the broader contribution of pharmacy technicians. Whilst my current NHS employer has shown vision and support in appointing a pharmacy technician to a leadership role, the focus at managerial levels remains primarily on pharmacists. Although this imbalance is not acknowledged within the revalidation framework, where both professions complete the same requirements, it may influence how pharmacy technicians identify and select peers for discussion. The aim of my study is to provide insight to the regulator and professional leadership bodies on the experiences of pharmacy technicians participating in peer discussion. This study is not simply an academic exercise but an opportunity to offer practical recommendations for improving the peer discussion element of revalidation. As both pharmacists and pharmacy technicians engage with the same revalidation framework, it is anticipated that the findings will be valuable to the wider pharmacy profession.

Regarding my research skills, I completed a Master of Education (MEd) in Information and Communication Technology in 2017, which provided me with foundational research skills. Modules from my MEd were mapped to the Doctorate in Clinical Education (DClinEd) and contributed to my progress towards formal transfer into the research stage of the doctorate. Additionally, I completed two taught units of the DClinEd, focusing on database searching for a narrative literature review (O'Leary, 2017) and preparing a research proposal for transfer. These modules reintroduced me to the interpretivist paradigm of qualitative research, which emphasises understanding individuals' beliefs, motivations and reasoning to explore social interactions (Clark et al., 2021). I also gained experience in Reflexive Thematic Analysis (RTA) (Braun and Clarke, 2006). This academic background has provided me with the theoretical framework necessary for my study on the experiences of pharmacy technicians participating in peer discussion as part of GPhC revalidation.

1.9 Chapter Summary

In this introductory chapter, I have outlined the roles within the pharmacy team and the key sectors where they are employed. I have also discussed the route to registration, healthcare revalidation models and the pharmacy revalidation framework, highlighting how regulatory developments have shaped the evolving role of the pharmacy technician.

Additionally, I have explained my position and experience in both pharmacy practice and research and shared the motivations behind my interest in peer discussion within pharmacy technician revalidation.

I conclude this chapter with an overview of the thesis structure, before transitioning to the literature review in Chapter 2.

1.10 Thesis Structure

This thesis is structured to explore the experiences of pharmacy technicians participating in peer discussion within the context of revalidation, using an interpretivist paradigm. The study is presented across nine chapters, guiding the reader through a reflexive and iterative research process.

Chapter 1: Introduction introduces the research topic, offering background on the pharmacy technician role, the revalidation process and the significance of peer discussion in professional development.

Chapter 2: Literature Review presents a critical review of the literature, examining existing research on peer support and professional learning, particularly within healthcare context. This chapter positions the current study within the broader academic discourse.

Chapter 3: Methodology and Methods outlines the research methodology, detailing the interpretivist approach, research design, data collection methods and ethical considerations. It also discusses the researcher's positionality and the reflexive stance adopted throughout the study.

Chapter 4: Survey presents the initial findings from the survey dataset, incorporating both quantitative and qualitative responses. These findings inform purposive sampling and the development of the semi-structured interview guide.

Chapter 5: Interviews introduces the themes generated from the interview data and describes the process of theme development using reflexive thematic analysis. This chapter emphasises the active role of the researcher in interpreting meaning and constructing themes.

Chapter 6: Analysis and Interpretation of Findings offers a deeper interpretive analysis of the data within the identified themes. It explores the nuanced and situated experiences of pharmacy technicians, highlighting the complexity and diversity of their perspectives.

Chapter 7: Discussion situates the key findings within the relevant theoretical frameworks and existing literature. It presents a detailed and context-sensitive interpretation of the findings. This chapter also provides a critical appraisal of the study's scope and boundaries, considering how these factors may shape the interpretation and application across diverse settings.

Chapter 8: Recommendations offers practical recommendations for pharmacy technicians, the regulator, educators and stakeholders. It also outlines the ethical considerations taken throughout the research process and describes the dissemination strategy for sharing findings with relevant professional audiences.

Chapter 9: Reflections on the Research Journey concludes with a final reflection on my personal and academic development throughout the research process. It also outlines the proposed next steps and details the planned dissemination of findings to relevant audiences.

Chapter 2: Literature Review

2.1 Introduction

This literature review will examine the range of published data on the use of peers within healthcare, health professional education and the broader educational context.

While traditional literature reviews primarily aim to identify explicit research gaps (Hart, 2018), this review takes a different approach by exploring existing studies on peer-related challenges and motivators in the wider healthcare workforce. This is particularly important given the lack of literature specifically addressing peer dynamics and the pharmacy workforce. By comparing findings across peers within healthcare settings, the review aims to construct an understanding of whether the experiences of pharmacy technicians align with or differ from those of other healthcare roles.

Using what Braun and Clarke (2022, p.120) describe as the “making the argument model”, this review will aim to provide a rationale for the research questions and position the study within the existing body of knowledge. A previous narrative review, conducted as part of a module in the DClinEd programme, had already highlighted the lack of research on pharmacy professionals’ revalidation, particularly regarding peer discussion, and the noted absence of research on the revalidation of pharmacy technicians (Hall, 2021).

In selecting a model for my literature review, I initially considered both scoping and narrative review approaches. Given that pharmacy literature on this topic was limited, a broader search into the use of peers within healthcare settings was necessary. A scoping review approach was deemed most suitable as it facilitated an exploration of the wider concept of peer interactions across healthcare. Scoping reviews allow for the inclusion of both empirical and grey literature such as online media, meeting minutes and policies, all of which were valuable for this research (Peters et al., 2021).

This approach would also enable the mapping of existing literature to define peers and explore the characteristics of peer interactions within healthcare. Additionally, conducting a scoping review could provide insight into how research on peer interactions in healthcare settings has been approached, helping to identify methodological trends and gaps in the evidence base.

Mak and Thomas (2022) highlighted the growing use of scoping reviews in health professions education, citing their alignment with the interpretivist and constructivist paradigms commonly adopted by healthcare researchers. These factors initially supported the consideration of a scoping literature review for this study.

However, one of the key elements of a scoping review, identifying a gap in the literature, as outlined by Peters et al. (2021), was not central to my review. My aim was not to fill gaps in knowledge about peer discussions in revalidation but rather to contribute to what Braun and Clarke (2022, p.120) describe as the “rich tapestry of understanding” on revalidation and peer topics.

Additionally, scoping reviews typically require a research team to facilitate the synthesis of literature, making them unsuitable for an individual researcher (Mak and Thomas, 2022). Although I had support from a small team of supervisors, forming a broader research team for a scoping review was not feasible. The limited existing literature on the topic further challenged the suitability of this approach.

Given these considerations, I decided against using a scoping review and opted to explore the narrative review approach instead.

Having previously completed a narrative review as part of the taught units on the DClinEd programme, I recognised that narrative reviews are well suited to both under-researched topics and more established fields. This experience highlighted the adaptability of narrative reviews across various contexts. The search strategy I will describe later adheres to a core principle of narrative reviews: clearly providing the justification for inclusion and exclusion criteria (Sukhera, 2022b).

Upon further investigation into narrative reviews, I came to understand that the term “narrative review” encompasses a range of review types (Sukhera, 2022a), each with its own methodology and approach. These include at least five distinct subtypes: state-of-the-art, meta-ethnographic, meta-narrative, critical and integrative.

To determine the most appropriate approach for my study, I reviewed each subtype in relation to the nature of the literature and the aims of my research. Table 3 (on the following page) summarises the key characteristics of each subtype, along with the rationale for inclusion or exclusion.

Subtype	Definition/Purpose	Reason for Exclusion or Consideration	Source
Meta-ethnographic	Synthesises qualitative studies to develop new conceptual understandings	Too narrow for the broader scope of my review	Sukhera (2022a)
Meta-narrative	Explores multiple research traditions with conflicting assumptions or findings	Literature lacks diversity or tension; approach unnecessarily complex and misaligned	Sukhera (2022b)
Integrative	Synthesises studies using diverse methodologies (quantitative, qualitative, mixed methods)	Literature is predominantly qualitative and descriptive; lacks methodological diversity	Grant and Booth (2009)
State-of-the-art	Summarises research over time, highlighting developments and changes	Considered viable; initially intriguing due to its chronological structure and guided questions	Sukhera (2022a)
Critical	Synthesises and interrogates literature through an interpretive lens	Considered viable; aligns with methodology and allows for evaluative judgement and positionality	Grant and Booth (2009); Sukhera (2022b)

Table 3: Comparison of Narrative Review Subtypes

As shown in Table 3, three subtypes were excluded due to misalignment with the aims and methodological requirements of the study. This left state-of-the-art and critical narrative reviews as the most viable options. Initially, I was intrigued by the concept of a state-of-the-art review, which summarises research along a timeline, highlighting changes and developments over time. As described in Chapter 1, the implementation of revalidation models was shaped by significant policy changes and constructed in response to evolving regulatory priorities. However, while these changes marked pivotal moments in healthcare provision and the professional development of healthcare workers, they did not necessarily reflect an evolution in our understanding of healthcare itself. Instead, these shifts were often driven by the need to address and

move beyond catastrophic errors (Department of Health and Social Care, 2007b; Keogh, 2013).

Sukhera (2022b, p.416) outlines three critical questions for state-of-the-art reviews: “where are we now in our understanding, how did we get here and where should we go next”?

Initially, the structure provided by these three questions seemed appealing, offering a sense of security that answering them would ensure the review was robust. However, as I began to apply this approach, it became clear that it did not align with my research questions or the nature of the literature.

The limited body of existing literature on this topic makes it difficult to construct a comprehensive overview of current understanding. The implementation of peer discussion for pharmacy technicians is recent and has been shaped primarily by policy, rather than emerging organically from practice. This constrains the ability to trace a clear development pathway. Furthermore, given the nascent state of research in this area, it is premature to outline future directions without first establishing a more robust understanding of the present. While the structure provided by the state-of-the-art review initially seemed reassuring, it quickly proved inadequate and did not support the direction of my study.

Therefore, after a process of elimination, I determined that a critical narrative review would be the most suitable approach. This method offers a “narrative synthesis that brings an interpretative lens” (Sukhera, 2022b, p.416), which aligns well with the methodology of my study. It not only synthesises the literature but also interrogates assumptions, power dynamics and gaps in knowledge (Grant and Booth, 2009). A critical narrative review encourages a more analytical approach to reading, informed by the researcher’s positionality, and avoids merely summarising existing literature (Gregory and Denniss, 2018).

In selecting this approach, I reflected on the characteristics of a critical review as outlined by Saunders and Rojon (2011). I recognised that criticality in reviewing literature involves not only understanding previous studies but also applying my own evaluative judgement, drawing on my experience as both a researcher and a pharmacy professional.

In the next section, I will outline the process of my literature review. It is important to note that while my initial literature search was conducted before data collection, the synthesis of the literature occurred only after both data collection and initial analysis. This approach allowed me to understand the existing literature at the time of my data

analysis, while also enabling continuous engagement with the literature throughout and after the analysis process (Braun and Clarke, 2006).

2.2 Literature Search Process

From my professional role as a pharmacy technician, I was aware of information produced by the regulator (GPhC, 2018b) and pharmacy education and training providers (APTUK, 2021; CPPE, n.d.; RPS, 2019) regarding the completion of peer discussions for revalidation. However, I was uncertain about the extent of published research on this topic.

I began with an initial search on Google Scholar to identify key concepts and terminology related to the use of peer discussion in health professional education. I noted keywords and synonyms from highly cited articles. While Google Scholar is a valuable resource, I was aware of concerns about its adherence to the rigorous search protocols and inclusion criteria typically found in systematic reviews (Gehanno et al., 2013). However, these concerns are not relevant here, given the narrative nature of the review.

My aim was to locate a broad range of literature, including grey literature such as reports, conference papers and other non-peer-reviewed sources, which are often essential for providing a more comprehensive understanding of the topic (Sukhera, 2022b). Google Scholar's wide accessibility and inclusion of grey literature made it an ideal starting point for my review. This exploratory search informed the strategy I used for subsequent database searches.

Following this, I created a concept map to visually represent the relationships and connections between key ideas and themes. This map helped me clarify the structure of the literature and guide the synthesis process. By illustrating how various concepts interrelate, the concept map in Figure 5 (on the following page) supported a more organised and focused approach to the review, informing my next steps.

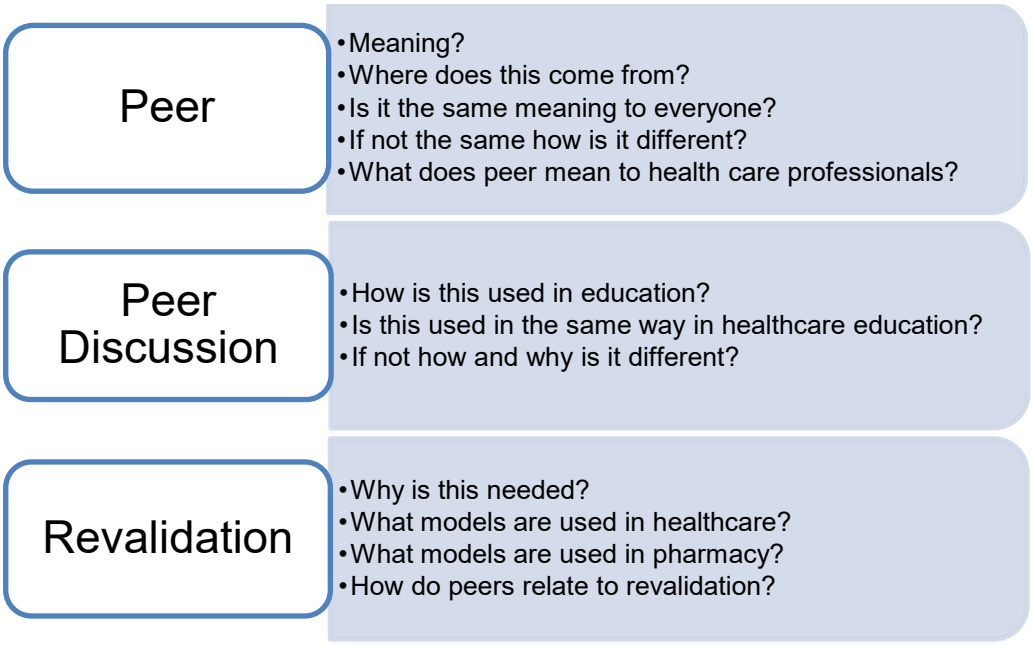

Figure 5: Concept Map
Adapted from de Ries et al. (2022)

The concept map helped me define the research areas and refine my search strategy. By combining the identified keywords, synonyms and the visual framework from the concept map, I conducted an initial database search. This ensured a more targeted and structured approach to gathering relevant literature.

Database Search Strategy

Building on this foundation, the search strategy was structured using the SPIDER tool (Sample, Phenomenon of Interest, Design, Evaluation, Research type), which is particularly effective for qualitative studies. This approach proved valuable in generating more focused and manageable search results, allowing for a more targeted selection of relevant literature (Cooke et al., 2012).

Keyword searches included the use of wildcards and truncation to capture variations of relevant terms. For example, ‘pharm*’ was used to include pharmacy, pharmacy technician, pharmacist and pharmaceutical.

Table 4 shows the SPIDER search tool used in the literature review.

S	Sample	pharmacy technicians, pharmacists, pharmacy, healthcare professionals, healthcare staff, healthcare education	“pharm*” OR “healthcare”
P or I	Phenomenon or Interest	peer discussion, peer conversations, peer interactions, peer feedback, peer assessment, revalidation	“peer” OR “revalidation”
D	Design	interviews, observations, focus groups, case studies	“interview” OR “focus group” OR “case stud*” OR “observ*”
E	Evaluation	understanding, experiences perceptions, opinion, knowledge	“understand*” OR “experienc*” OR perce*” OR “opinion*” OR “know*”
R	Research type	qualitative, mixed methods, interpretative, constructivist	“qualitative” OR “mixed method*” OR “interpret*” OR “constructiv*”

Table 4: SPIDER Search
Adapted from Cooke et al. (2012)

The SPIDER terms were applied to search a variety of databases, including EBSCO databases such as CINAHL (nursing and health), ERIC (education) and British Education Index (British education and training). Searches were also conducted across Ovid databases including Embase, Medline, Global Health (health and medicine) and HMIC (health/NHS). Additional searches were conducted on Web of Science (social and physical sciences) and Scopus (health).

To ensure relevance, inclusion criteria were set to include only articles published after 2000, focusing on contemporary research and preparatory work for revalidation of healthcare professionals in the United Kingdom. Only English-language articles from countries with comparable healthcare systems were considered. These included Great Britain and Northern Ireland, the Republic of Ireland, the United States of America, Canada, New Zealand and Australia, selected for their similar approaches to pharmacy professional roles.

The table in Appendix 1 presents the results of the initial literature search conducted on 5th September 2022, with additional relevant resources added on a rolling basis. To maintain currency and ensure comprehensive coverage, weekly notifications were set up to alert me to any recent developments or newly published articles.

Table 5 provides a summary of the screening and selection process, showing how the initial 5,448 publications were refined to the final 95 included in the literature review.

Stage	Number (+/-)	Remaining total
Total publications from initial search	+5448	5448
Duplicates removed	-2445	3003
Irrelevant by title/abstract removed	-2824	179
Further duplicates removed at first evaluation	-5	174
Irrelevant after first evaluation	-22	152
Removed following CASP/COREQ review	-84	68
Added through hand searching	+8	76
Added from search notification articles	+19	**95**

Table 5: Summary Table of Screening Stages
See Appendix 1 for Full Table

Additional Identified Literature

In addition to searching electronic databases, I explored specific professional websites likely to offer relevant resources. Organisations such as APTUK, RPS, GPhC and the Department of Health and Social Care provided access to grey literature, including meeting minutes, White Papers and discussion documents. This type of documentation was particularly valuable, as revalidation had been developed and implemented across various healthcare professions. As a member of APTUK, I had full access to their publications. However, as I am neither a member nor eligible for membership with the RPS, I was limited to open-access materials available on their website.

To supplement this, I searched for research conducted by doctoral students using the EThOS database. I also employed the snowballing technique (Hart, 2018) to identify additional references cited by other authors, which helped uncover relevant studies that may have been missed in the initial search.

Finally, as both a practicing pharmacy technician and a DClinEd student, I gathered additional insights through my professional networks. These included my supervisors, fellow postgraduate researchers at the University of Leeds, colleagues from both of my professional roles and members of APTUK.

To ensure the quality and accuracy of the search strategy, it was reviewed by a healthcare librarian at University Hospitals of Derby and Burton. This provided an additional layer of validation to the process.

2.3 Study Selection

Results from the database searches were uploaded into EndNote, where duplicates were identified and removed. I then reviewed the titles and abstracts of all articles, archiving irrelevant ones without deletion. Articles that did not relate to the use of peers within healthcare or health education settings were excluded. Relevant articles were

stored within the thesis literature search group in EndNote. Full-text articles were located and uploaded to the appropriate folder, and a backup copy of the library was regularly saved to the university cloud space. In this context, university cloud space refers to the secure Microsoft (MS) OneDrive storage provided to all students as part of their institutional MS 365 account. This platform is hosted and managed by the university and offers encrypted, access-controlled storage for research materials, ensuring that all data related to the study were backed up in a secure environment.

The literature identified spanned across various research paradigms. To enable a thorough critical appraisal, I used two frameworks: the CASP (Critical Appraisal Skills Programme) checklist for evaluating systematic reviews (CASP, n.d.) and the COREQ (Consolidated Criteria for Reporting Qualitative Research) checklist for assessing interview and focus group studies (Tong et al., 2007). While some argue that appraisal frameworks are not essential for narrative reviews (Grant and Booth, 2009; Saunders and Rojon, 2011), the volume of literature necessitated a structured system for efficient processing. As a part-time postgraduate researcher, it was important to manage my time effectively, and these frameworks supported a systematic approach to the review.

Reading the abstracts of selected studies also prompted reflection on how my personal and professional experiences might shape my interpretations. I was a carer for both my late sister, who had autism, and my late father, who had dementia. These experiences gave me a deep appreciation of the value of peer support groups for individuals and their families. As a pharmacy professional, I have also benefited from peer support in various roles. Rather than attempting to eliminate these influences, I approached the literature reflexively acknowledging how my background informs the lens through which I engage with the research. The use of appraisal frameworks supported a critical and transparent engagement with the literature, helping me to remain aware of how my positionality might influence interpretation.

The articles included in the review are detailed in a summary table adapted from McLoughlin et al. (2018), which records the analysis of each study and its relevance to the research topic. The summary also includes CASP or COREQ scores, study setting, design, population sampled and sample size. CASP and COREQ scores ranged from three to twenty-eight; however, no studies were excluded solely based on their framework scores. The summary table, with examples of included literature, is provided in Appendix 2.

The three-pass approach described by Keshav (2007) was employed to review the articles. In the first pass, I conducted a general overview of the articles listed in the summary table, as shown in Appendix 2. The primary goal of this stage was to

determine whether further review was necessary or if the article should be archived in EndNote. Articles that progressed to the second pass were read in greater detail, and CASP or COREQ appraisals were completed during this stage. Throughout the first and second passes, articles were annotated directly in EndNote and sorted into thematic group sets or archived accordingly.

For the third pass, articles were printed from EndNote files to facilitate easier navigation between papers, compared to switching between open documents on-screen. During this stage, I correlated and contrasted information, themes, key concepts, terminology and definitions across the articles, recording these on the summary sheet. Further annotations were made using coloured page tabs and highlighted text to trace areas of resonance, tension and conceptual significance.

The literature search table in Appendix 1 was continuously updated throughout the review process, with articles added or removed as necessary. The initial database search yielded 5,448 publications. After removing duplicates and screening titles and abstracts for relevance, 68 studies remained. An additional 27 publications were identified through hand searching and ongoing search alerts, resulting in a final total of 95 publications included in the literature review. This iterative process supported a flexible and responsive approach to literature searching, allowing for the inclusion of additional sources relevant to the evolving focus of the study.

Table 6 provides an overview of the methodologies used in the articles that were included in the literature review.

Methodology	**Systematic review**	**Interview**	**Focus group**	**Semi-structured interviews**	**Focus group**	**Survey**	**Questionnaire**	**Observation**	**Case study**	**Good practice article**	**Dissertation**	**Poster abstract**
Mixed		6	4		6	5	4				3	2
Qualitative	5	9	8	20	8	3		3	3	2		3
Quantitative							1					

Table 6: Methodology of Articles Included in Literature Review

While engaging with the literature, I noted a lack of research specifically focused on pharmacy professionals. However, as I continued analysing my data and refining themes, subthemes and codes, I began to recognise resonances between my

developing interpretations and findings from studies involving other healthcare professions. These parallels did not emerge as objective similarities, but rather as interpretive connections shaped by my engagement with both the data and the literature. In this way, the literature became part of the analytic process, not to validate themes, but to enrich and contextualise the meanings I was constructing within the pharmacy-related data.

For example, hierarchy and perceptions of superiority influenced how peers were identified and perceived in several studies, particularly in relation to nurses and medics. Nursing staff, for instance, were often viewed as subordinate to medical professionals, a dynamic explored in the literature (Alfaro et al., 2019; Cunningham et al., 2019). The integration of the literature review and initial data analysis reflects the “open and evolving process of reflexive thematic analysis” (Braun and Clarke, 2022, p.121), further strengthening the insights derived from both sources.

Through my engagement with the literature, I noted a noticeable underrepresentation of pharmacy technicians, particularly in relation to peer discussion and revalidation practices. This underrepresentation may be attributed to their relatively recent establishment as a registered profession. However, it may also reflect variability in registration practices and professional development requirements across different countries, as outlined in section 1.7.

Additionally, factors such as lower engagement in research or fewer research-focused roles compared to other healthcare professions may have contributed to their limited presence in published studies (NHS England, 2024).

This literature review examines the concept of peer discussion within healthcare and health professional education, with a focus on defining peers in healthcare settings to establish a foundation for understanding the multifaceted roles. To appreciate the dynamics of these peer relationships, I will explore the educational theories that underpin them, highlighting both structured and informal peer-facilitated approaches. This will illuminate how individuals learn through social interactions and the importance of community and collaboration. The review further explores key benefits and challenges identified through my engagement with the literature, including the role of mutuality and the influence of power dynamics.

2.4 Defining Peers in a Healthcare Context

For this thesis, a peer is understood as an individual who occupies a broadly comparable professional position, level of responsibility or experiential perspective to another, such that meaningful dialogue, mutual understanding and shared professional

insight can occur. This working definition is not drawn from any single source; rather, it is the product of critical engagement with a diverse set of definitions across healthcare, education and peer-support literature. Existing conceptualisations variously emphasis shared lived experience (Barker et al., 2018; Debyser et al., 2019), equivalent stages of training or practice (Cunningham and Zlotos, 2016; Nash et al., 2022), or collaborative learning relationships grounded in reciprocity (Alfaro et al., 2019). Each of these definitions offers useful but partial insights. To show clearly how these strands informed the definition adopted in this thesis, Table 7, on the following page, summarises the key elements of selected definitions, highlighting their conceptual emphases and indicating which aspects were incorporated or deliberately excluded in shaping my working definition.

Author	Key elements of their definition	Strengths/limitations	Elements adopted	Elements excluded
Alfaro et al. (2019)	Near-peer = individuals at different stages of training who share professional commonalities	Strong on reciprocity, collaborative learning and relational parity; limited because definition is tied to educational setting and hierarchical tutor-tutee structures	Reciprocity; mutual learning; low hierarchy; shared professional context; reflective dialogue	Stage-of training requirements; tutor-tutee structure; student-specific dynamics; anatomy/IPE context
Barker et al. (2018)	Peer = shared lived experience; mutual understanding; experiential knowledge; equality	Strong on mutuality and relational equality; but definition tied to lived experience of a specific phenomenon	Mutuality; relational parity; experiential insight	Lived experience requirements
Cunningham and Zlotos (2016)	Peer = colleague of similar professional status engaging in mutual support; shared learning and validation of practice	Strong on professional parity, mutual support, reflective dialogue and shared content; limited because definition is tied to role-specific CPD structures and small-group formats	Comparable professional standing; mutual support; reciprocal learning; reflective dialogue; safe environment	Small group learning mechanics
Debyser et al. (2019)	Peer = shared lived experience; equality, openness, trust, hope-giving, dual patient-professional identity	Strong on relational equality, mutual understanding and experiential insight; limited as definition is tied to mental health recovery and PSW role identity	Equality; relational parity; trust; openness; mutual understanding; reflective, supportive dialogue	Lived experience requirement; recovery orientation
Nash et al. (2022)	Peer = colleague of similar professional status, constructive critique and support wellbeing	Strong on professional parity, mutual support, reflective dialogue and shared content; limited by definition tied to role-specific CPD structures	Comparable professional standing; reflective dialogue; mutual learning; trust	Speciality-specific emotional burdens; psychiatrist-specific CPD; crisis debriefing

Table 7: Summary of Existing Definitions of 'Peer' and Their Contributions to the Working Definition Used in This Thesis

Drawing across the definitions summarised in Table 7, I adopt a working definition of ‘peer’ that incorporates elements of relational parity, mutual understanding, shared professional context and reflective dialogue, while deliberately excluding requirements tied to lived experience, stage-of-training hierarchies or role-specific CPD structures. While lived experience is not part of the working definition adopted for this thesis, it remains conceptually relevant when considering the broader landscape of peer roles within healthcare.

The literature presents a range of definitions of peers within healthcare settings, encompassing roles and interactions that contribute to the professional development and support of healthcare practitioners as well as to patient care. Within this broader landscape, three distinct mechanisms for peer support are commonly discussed: Peer Support Worker (PSW), Peer-to-Peer support (P2P) and Peer Assisted Learning (PAL).

Peer Support Worker (PSW)

Before discussing PSW, it is important to note that this strand of the literature sits within a different domain from the focus of the thesis. PSW roles are primarily designed to support patients or service users through shared lived experience rather than to develop the professional competencies of healthcare practitioners. However, this literature remains relevant because the GPhC permits a wide range of individuals to act as peers for pharmacy revalidation, including expert patients (GPhC, 2018b). Insights from PSW literature will therefore help illuminate concepts such as mutuality, experiential knowledge and the dynamics of supportive relationships; ideas that can enhance the understanding of how peer interactions function more broadly within healthcare even when the purpose and context differ from those of professional peer discussions.

The literature frequently discusses the role of expert patients as PSWs within healthcare settings or other environments related to health improvement. These roles are among the most clearly defined, consistently described as involving individuals with lived or mutual experiences (Barker et al., 2018; Debyser et al., 2019). Despite this clarity, the terminology used to describe PSWs is wide-ranging, with twelve different terms identified across the literature.

Some of the less standardised terms include peer specialists (Bochicchio et al., 2021; Cabral et al., 2014), peer facilitators (Cunningham et al., 2022; McKeon et al., 2021) and peer navigators (Flora et al., 2020). These variations reflect the adaptability and multifaceted nature of peer support roles, which are shaped by the specific needs, settings and philosophies of different healthcare environments.

For example, peer specialists use their lived experiences and formal training to support the physical health of patients with serious mental illness (Bochicchio et al., 2021). Peer facilitators work to enhance the motivation of emergency services workers to engage in mental health treatments and help challenge traditional hierarchies between participants and practitioners (McKeon et al., 2021). Trained peer navigators provide mentorship and support to cancer patients and caregivers (Flora et al., 2020).

These distinctions illustrate the importance of context when interpreting and applying findings from the literature, as different terms may imply subtle differences in roles, responsibilities and intended outcomes.

Peer-to-Peer Support (P2P)

Within the context of this literature review, P2P is defined as support between individuals in comparable professions or between students learning among equals or matched peers (Cunningham and Zlotos, 2016; Nash et al., 2022). This includes terminology such as buddy systems and collaborative learning within peer groups (Alfaro et al., 2019). P2P emphasises the collaborative nature of learning among equals, facilitating the sharing of knowledge, skills and experiences to enhance collective expertise.

For example, Blake et al. (2021) described the use of wellbeing buddies for healthcare workers in an acute NHS hospital during the Covid-19 pandemic. This illustrates how P2P can be applied in practice to support wellbeing and professional resilience during challenging times. Similarly, peer support has been identified as a promising intervention for community pharmacists, particularly those in the early stages of their careers, who often work in isolation and report feeling undervalued and stressed (Magola et al., 2022). Research suggests that peer support can reduce burnout and improve workplace engagement, as seen in other healthcare professions such as nursing and medicine.

Furthermore, the Pharmacy Professional Recovery Group (PPRG) offers a real-life example of P2P in action, providing a confidential space for pharmacists and pharmacy technicians recovering from addiction to share experiences and rebuild confidence (Cawdron, 2025). This initiative highlights the potential of peer support not only for professional development but also for personal recovery and resilience.

Peer Assisted Learning (PAL)

Over a third of the articles reviewed were categorised under PAL, which refers to informal or structured learning among participants from similar social or professional groups (Callese et al., 2019; Markowski et al., 2021; Olaussen et al., 2016). This includes models such as mentoring and preceptorship. While often structured as

senior-to-junior relationships, these still fall within the PAL framework due to their emphasis on shared professional identity, experiential learning and mutual engagement in practice.

In this context, the term ‘peer’ refers to individuals who, despite differences in experience or seniority, share a common professional background. Mentoring and preceptorship are therefore considered peer-based approaches because they involve relational learning between members of the same profession, typically aimed at supporting transitions from student to registrant or ongoing professional development. These relationships are distinct from supervisory or managerial oversight, as they are developmental, supportive and grounded in mutual respect.

Studies have highlighted the role of mentoring and preceptorship in supporting transitions into professional practice, offering structured guidance and support (Bartlett et al., 2023; Jassim et al., 2022; McIntyre et al., 2018). Collaborative learning among peers has also been described as central to maintaining professional development and continuous learning (Alfaro et al., 2019; Sharif-Chan et al., 2016).

Across the PAL literature, 11 different terms were used to describe related concepts, including near-peer (Alfaro et al., 2019; Sharif-Chan et al., 2016), mentorship (Chesluk et al., 2015; McIntosh et al., 2014) and preceptorship (Bartlett et al., 2023; Jassim et al., 2022; McIntyre et al., 2018). These terms are particularly relevant in studies focused on pharmacist education and training (Bartlett et al., 2023; Schindel et al., 2019). The term ‘preceptor’ is also increasingly used within the NHS, particularly in nursing and midwifery, and has recently been extended to Allied Health Professions (AHP). NHS England (2023) has promoted a national preceptorship framework as a key strategy for workforce development and retention, aligning with the NHS Long Term Workforce Plan.

More recently, the concept of preceptorship has also gained traction within pharmacy. A pilot study in Scotland explored the development for advanced pharmacists, designed to support transitions into autonomous and patient-centred roles. Built on expert consensus, the programme aimed to enhance confidence and capability among practitioners, further aligning pharmacy with broad NHS workforce development strategies (McLean et al., 2025).

Distinguishing P2P from PAL

While both P2P and PAL involve interactions between individuals with shared professional identities, they differ in purpose and structure. P2P typically refers to reciprocal, informal support between individuals of similar status or experience, often focused on emotional wellbeing, shared challenges or mutual encouragement. In

contrast, PAL encompasses more structured or semi-structured learning relationships, such as mentoring or preceptorship, where there may be a difference in experience or seniority, but the relationship remains grounded in mutual respect and shared learning. The distinction lies in the intent, namely that P2P centres on mutual support, while PAL is primarily oriented toward guided learning and professional development.

2.5 Theoretical Underpinnings

To appreciate the dynamics of peer relationships, I will analyse several key theories identified in the literature that provide a foundation for understanding these interactions.

Communities of Practice (CoP)

Social learning theory offers a valuable lens through with to understand how people develop professionally through interaction with others. Lave and Wenger (1991) introduced the concept of CoP through their study of apprenticeship learning in various settings, including tailors, butchers and midwives in West Africa. They observed that learning occurs not only through formal instruction but also through active participation in everyday work alongside more experienced members of a community. This process, termed legitimate peripheral participation (LPP), allows newcomers to gradually assume greater responsibility and become full participants in their professional group.

In their study of midwives, for example, Lave and Wenger (1991) illustrated how new practitioners learned not through structured teaching, but by observing, assisting and gradually becoming more involved in the practice of experienced midwives. This form of learning was deeply embedded in the social and cultural content of the work, highlighting how knowledge is constructed and shared through doing, rather than simply through telling.

This concept is particularly relevant in healthcare settings, where much learning occurs informally through shared experiences, conversations and collaborative problem-solving. In the context of peer support and professional development, CoPs offer a useful framework for understanding how pharmacy technicians learn from one another, build confidence and develop their professional identities. While there is limited literature specifically focused on pharmacy, studies across healthcare professions suggest that CoPs can support reflective practice, continuous learning and a sense of belonging within a professional community.

More recent work by Hindi et al. (2022) begins to address this gap, using CoP theory to explore experiential learning among pharmacist students placed in general practice settings. Their findings highlight how learners gradually integrate into the workplace through observation, participation and relationship-building, echoing Lave and Wenger’s original formulation. Importantly, this study illustrates how identity formation

and professional confidence are shaped not just be formal teaching, but by the social and cultural dynamics of the practice environment.

For example, Seneviratne et al. (2017) provide a rich, qualitative exploration of how critical care pharmacists develop into advanced-level practitioners, emphasising the role of mentoring, work-based learning and reflective practice. While the study highlights the value of informal CoPs, such as local networks and peer support, it also notes that these are not always accessible or consistent in the support they offer. Although CoPs can be powerful, they are not universally available or reliable. The study acknowledges that pharmacists working in regions without active networks, or those practising in isolation, may be disadvantaged; yet it does not fully explore the institutional responsibility for addressing these disparities. Furthermore, while integration into multidisciplinary teams (MDTs) is framed as beneficial, the authors suggest that learning within medical CoPs may not always align with pharmacists' specific developmental needs, pointing to a potential misalignment between interprofessional learning and role-specific competencies.

This tension is echoed in Bunniss and Kelly's (2013, p.1199) ethnographic account of collective learning in secondary care, where hospitals are described as an "animated web of shared learning". However, their study also highlights how power dynamics, particularly the dominance of medical professionals, shape participation in these learning networks. While doctors were often observed engaging in open, shared learning with one another, other staff (including nurses, porters and domestic workers) frequently self-censored or deferred their questions, perceiving themselves as unworthy of a doctor's attention.

Similar dynamics are explored in Cunningham et al.'s (2016) study of interprofessional learning between GPs and pharmacists. While many participants valued the opportunity to learn together, some GPs expressed discomfort when pharmacists disrupted the established peer-support dynamic of their groups. In some cases, pharmacists were welcomed as equals; in others, they were perceived as outsiders, tolerated but not fully integrated. Likewise, Cunningham et al. (2022) found that first contact physiotherapists, despite being enthusiastic about learning, felt the need to 'prove' themselves when joining interprofessional groups. Some feared being overshadowed by GPs, while others preferred to remain in uni-professional groups to maintain psychological safety.

Nash et al. (2022) and Schindel et al. (2019) both explore the value of peer-based learning within single-profession communities, psychiatrists and pharmacists, respectively. Their findings suggest that small group learning supports professional

development, enhances confidence in evolving roles and contributes to providing emotional wellbeing through shared experiences and reduced isolation. However, while both studies offer compelling accounts of the benefits of peer learning, they leave several critical issues underexamined.

First, both studies largely assume that peer learning environments are inherently inclusive and effective. Nash et al. (2022) emphasise the safety and cohesion of peer review groups but offer limited analysis of how power dynamics, group hierarchies or interpersonal conflict might affect participation. Although some challenges are acknowledged, such as dominant members or administrative overload, these are treated as minor exceptions rather than structural concerns. Similarly, Schindel et al. (2019) present peer and workplace learning as preferred models of professional development but do not critically assess how access to such learning may vary across settings, particularly for pharmacists in isolated or under-resourced roles.

MacEachen et al. (2007, p.159) provide an account of how peer groups offer more than just practical support to injured workers, describing a “community of understanding” where individuals feel heard, validated and more than ‘just a number’”. The study illustrates how these groups address emotional, social and procedural needs often overlooked by formal return-to-work systems. Although not explicitly framed as CoPs, these groups exhibit key CoP characteristics: mutual engagement through shared experience, navigation of complex systems and the construction of self-worth. These informal learning communities were constructed in response to systemic gaps, demonstrating how CoPs can form outside formal professional settings to meet complex social and identity needs.

However, while the authors celebrate the value of peer support, they also raise a critical concern: these groups may inadvertently mask deeper systemic failures. By stepping in to fill gaps left by under-resourced or poorly designed systems, peer support can reduce the visibility of structural issues and potentially delay necessary policy reforms. This critique, however, could be extended further. The paper does not fully explore the implications of relying on unpaid or under-supported peer advocates to perform roles that arguably belong to trained professionals. Nor does it consider the emotional toll or risk of burnout experienced by peer helpers, many of whom are simultaneously navigating their own recovery or professional challenges.

Across the studies, the concept of CoP is complicated by the reality that not all members experience these communities equally. Rather than being inherently inclusive, CoPs are shaped by professional identities, histories and hierarchies that can both enable and constrain learning. These findings challenge the assumption that

simply bringing professionals together will lead to collaboration. Instead, they call for a more critical examination of how power dynamics, trust and belonging are enacted in practice. They also understate the emotional and logistical demands involved in sustaining peer learning.

For instance, Nash et al. (2022) highlight the emotional support offered by peer groups as a benefit; however, they do not examine the potential burden of providing such support, especially during periods of professional crisis. Similarly, Schindel et al. (2019) highlight the value of peer interaction but do not question whether these roles are formally recognised, supported or compensated. This echoes concerns raised in other contexts, such as MacEachen et al. (2007), about the reliance on unpaid peers to fill systemic gaps. Investigating who gets to participate, what voices are missing and how these communities interact with the broader structures of power and policy is essential to fully understanding the value and limitations of social learning. These themes that will be explored further in a later section.

Interprofessional Education (IPE)

Building on the foundational work of Lave and Wenger (1991), who introduced CoPs as a model of situated learning, Wenger (1998) later expanded this concept to explore how individuals construct professional identities and meaning through participation in social learning systems. This evolution is particularly relevant in healthcare, where professionals must continuously adapt and collaborate within complex, high-pressure environments. Wenger's emphasis on engagement, mutual accountability and shared repertoires resonates with the realities of interprofessional healthcare teams, where learning is embedded in practice rather than confined to formal instruction.

Interprofessional education, is widely recognised as an evidence-based approach that supports collaboration between two or more professional groups (Jeeva et al., 2021). Freeth (2007) applies these ideas directly to IPE, arguing that effective collaboration in healthcare is not simply a matter of co-locating professionals, but of cultivating shared understanding and mutual respect through intentional, theory-informed learning experiences. Freeth et al. (2008) further note that in healthcare settings, IPE occurs both formally and informally: through ward rounds, case discussions and audits. These learning moments, whether planned or spontaneous, are essential for developing the collaborative competencies required to deliver safe, person-centred care.

The literature shows a spectrum of IPE applications, each shaped by context, professional culture and power dynamics. For example, Asad and Chreim (2016) explored the integration of PSWs into interprofessional mental health teams. Their findings illustrate the challenges of role ambiguity and professional legitimacy,

particularly when expert patients lacked access to the clinical language and norms of healthcare professionals. While the study offers valuable insights into the lived experiences of PSWs, it stops short of proposing how structured IPE interventions might address these barriers. This limits its practical applicability and leaves a gap in understanding how peer roles might support or guide newcomers within a CoP. In Lave and Wenger's (1991) theory, this support is a key mechanism through which novices move from LPP to becoming fully engaged members. Without exploring how peer roles contribute to this process, an important dimension of learning and identity development in real-life professional settings is overlooked.

Cunningham et al. (2016) similarly identified entrenched role perceptions and professional boundaries as barriers to collaboration between GPs and pharmacists, as previously described. Notably, newly qualified GPs were more open to IPE, suggesting that professional identity formation may be more malleable in the early stages of a career. This is supported by Wenger's (1998, p.152) emphasis on identity as a "trajectory shaped through participation". However, the study does not explore how these insights could inform the design of IPE interventions to support more experienced professionals. In a follow-up study, Cunningham et al. (2022, p.170) adopted a "stepping stone" approach, initially excluding GPs from IPE sessions with first contact physiotherapists due to concerns about intimidation and power imbalance. While pragmatic, this strategy may inadvertently reinforce the very hierarchies it seeks to navigate. It also raises ethical questions about whose learning is prioritised and how inclusivity is negotiated in the design of IPE. These issues remain unexplored in the study.

Alfaro et al. (2019) offer a contrasting perspective by examining IPE in a pre-clinical anatomy setting involving nursing and medical students. Their study found that when professional roles were clarified in advance, students were better able to engage collaboratively, despite initial concerns about hierarchy. This finding supports Freeth's (2007) argument that structured preparation and role awareness are key to successful IPE. Alfaro et al's.,(2019) use of near-peer teaching reflects Lave and Wenger's (1991) concept of mutual engagement, further developed in Wenger's (1998) later work, where learning is co-constructed through shared activity. However, the study's focus on anatomy, a relatively neutral and non-clinical context, may limit its applicability to more complex, real-life interprofessional tasks. Furthermore, the voluntary nature of participation and the absence of longitudinal follow-up raise questions about the sustainability of the observed benefits.

Jeeva et al. (2021) provide a broad review of simulation-based IPE over a seven-year period (2013-2020). They highlight IPE's potential to improve team coordination, role clarity and confidence in high-risk scenarios. While the review synthesises a range of positive outcomes, it tends to underplay the challenges of implementation, such as resource constraints, learner anxiety and the transferability of simulation learning to clinical practice. Additionally, the review does not sufficiently explore how simulation contributes to shaping individual identities or building a sense of community, both of which are central to Wenger's (1998) theory of learning. Although framed as an investigation, the review's limited scope, drawing on only ten papers and relying solely on Google Scholar and the Conestoga database, is further constrained by its use of just four terms in the search process. This narrow strategy raises concerns about the breadth of its literature base, potentially overlooking relevant studies and leaving important questions unanswered regarding the long-term impact of simulation-based IPE.

Reid et al. (2018b) offer a valuable counterpoint by evaluating a large-scale IPE initiative involving over 600 first-year students from ten health and social care programmes in a higher educational institution in the UK. While the intervention aimed to build collaboration and patient safety awareness, the study described unintended consequences, most notably the reinforcement of professional stereotypes and hierarchies. Although the IPE initiative described by Reid et al. (2018b) was generally well-received, the study highlighted inconsistencies in facilitation, which limited its ability to support mutual engagement and equitable participation. These findings are particularly relevant when viewed through Wenger's (1998) concept of identity formation in CoPs. At early stages of training, students are still negotiating their professional identities, and poorly facilitated IPE can inadvertently embed hierarchical assumptions rather than challenge them. However, the study did not include pharmacy students, which limits the direct applicability to pharmacy education. Given the unique position of pharmacy within healthcare teams, often bridging clinical and community settings, the absence of this profession leaves a gap in understanding how pharmacy students might experience or contribute to early IPE initiatives.

Depasquale et al. (2024) address this gap by examining the nature and extent of IPE in pharmacist MPharm programmes delivered across 10 UK schools of pharmacy. Their study found that while all institutions delivered compulsory IPE, primarily through campus-based activities involving a range of professional groups, there were considerable variation in pedagogical approaches, assessment methods and time allocation. Practice-based IPE was far less developed, with most initiatives still at the pilot stage. Respondents noted that placements offered unplanned opportunities for

IPE, but these were inconsistently experienced and rarely structured. These findings echo concerns raised by Reid et al. (2018b), particularly around the reinforcement of hierarchies and the need for intentional design. Both studies highlight the risks of poorly facilitated IPE, whether through exclusion of key professional groups or lack of structure, and point to the need for more inclusive, theory-informed approaches.

Together both studies illustrate that while IPE holds significant promise for enhancing collaboration and improving care, its success depends on more than simply bringing professionals together. The literature brings attention to the importance of addressing role clarity, power dynamics and the timing of IPE interventions. As Freeth (2007) argues, IPE must be intentionally designed to challenge stereotypes and promote equitable participation. Yet many studies do not fully put these principles into practice, leaving gaps in both the theoretical framing and practical implementation of IPE.

In conclusion, IPE is a vital component of modern healthcare education, offering opportunities to build connected collaborative teams. However, its implementation is fraught with challenges, particularly those related to hierarchy and professional identity. These issues will be explored in later sections, which examine mutuality and the dynamics of effective relationships.

Next, I will explore coaching, mentoring and preceptorship approaches, and how these methods enhance professional development through structured support and personalised guidance.

Coaching, Mentoring and Preceptorship

Coaching, mentoring and preceptorship are distinct, yet overlapping approaches to professional development, each grounded in different traditions and theoretical underpinnings. Coaching, with its origins in sport psychology, is typically short-term, goal-oriented and performance-focused, aiming to unlock a person’s potential through structured questioning and feedback (Parsloe and Leedham, 2017). Mentoring, by contrast, draws from classical traditions of apprenticeship and Greek philosophy, and is characterised by a longer-term developmental relationships in which a more experienced individual offers guidance, support and role modelling (Olaussen et al., 2016). Preceptorship, often used in clinical education, involves a more formal supervisory relationship where the preceptor provides direct instruction, models professional behaviours and assesses competence.

While these roles differ in structure and intent, they all share a relational foundation and a commitment to supporting growth. Notably, coaching and mentoring are increasingly adapted to peer-based models that emphasise mutual learning and reduce hierarchy (Bartlett et al., 2023; Clutterbuck, 2023). In these models, peers support one another

and both individuals learn from the experience, rather than one person always being the expert. Preceptorship, by contrast, remains more traditionally structured due to its formal assessment and regulatory functions, though elements such as shared reflections and collaborative learning can still be incorporated to enhance relational dynamics (Bartlett et al., 2023).

This peer-based approach is particularly relevant in healthcare context. Peers, including expert patients or early-career professionals, may act as informal mentors or coaches. By offering lived experience, emotional support and practical guidance, these peers contribute to professional development in ways that complement more formalised structures (Cawdron, 2025).

The emphasis on structure and clarity in peer-based approaches is reinforced by Parsloe and Leedham (2017), who observe that the evolving nature of coaching and mentoring has introduced new complexities, often blurring the distinction between the two. To navigate this, they advocate for a practical, simplified approach that avoids rigid role definitions and unrealistic expectations. Central to their guidance is the importance of agreeing on the purpose and focus of discussions, while recognising the value of informal dialogue. However, they emphasise that structured, purposeful conversations are more likely to produce meaningful outcomes.

This perspective closely aligns with the GPhC's (2018a) requirements for peer discussion in revalidation. The GPhC stipulates that peer discussions should be planned, focused and formally recorded, with a clear topic and reflection on its impact on practice. This mirrors Parsloe and Leedham's (2017) emphasis on clarity, discipline and shared purpose.

Despite these similarities, there are also significant differences. Parsloe and Leedham (2017) promote flexibility in how coaching and mentoring relationships are shaped, encouraging adaptability to individual needs and contexts. In contrast, the GPhC peer discussion is a formal regulatory requirement, with specific expectations for documentation and submission. This introduces a level of structure and accountability that extends beyond the more informal and developmental nature of coaching and mentoring. Furthermore, while Parsloe and Leedham (2017) allow for a broad interpretation of who may act as a coach or mentor, the GPhC specifies that the peer must be someone who understands the registrant's scope of practice. These distinctions highlight the balance between reflective dialogues and regulatory assurance in professional development.

Clutterbuck (2023) introduces the concept of horizontal mentoring, which positions mentoring as a reciprocal, non-hierarchical exchange of knowledge and support. While

this model offers a refreshing departure from traditional top-down approaches, it arguably presents an idealised view of mentoring relationships. The emphasis on mutuality and equality may overlook the subtle power dynamics, professional hierarchies and contextual constraints that often shape real-life interactions, particularly in regulated professions such as pharmacy, where roles and responsibilities are often clearly delineated. In the context of pharmacy technician revalidation, where peer discussion is intended to support reflective practice, horizontal mentoring offers a useful conceptual lens. However, its practical application may be uneven, as it assumes a level of confidence, communication skill and psychological safety that may not be universally present. These assumptions warrant closer scrutiny considering the diverse experiences, workplace cultures and structural realities of healthcare professional practice.

The literature on development and support roles in healthcare increasingly recognises a broader spectrum of contributors, including formally trained professionals and PSWs. The latter are often individuals with lived experience and are commonly referred to as expert patients (Barker et al., 2018; Debyser et al., 2019). While much of the literature focuses on professional development in the traditional sense, such as coaching, mentoring and preceptorship for clinicians, there is a growing body of work exploring how individuals without formal professional status also engage in meaningful learning, identity forming and role modelling (Flora et al., 2020; McKeon et al., 2021). This broader view challenges narrow definitions of professionalism and invites a more inclusive understanding of how people grow into supportive, guiding roles within healthcare systems. It also raises important questions about legitimacy, recognition and power dynamics that shape who is seen as a credible source of guidance or expertise (Cunningham et al., 2019; Gregory and Denniss, 2018).

Role models are a recurring theme across the literature, traditionally described as individuals who uphold the values of their profession and act in ways others aspire to emulate (Bäckryd, 2019; Jee et al., 2016). However, this framing often assumes a stable and universally accepted set of virtues, overlooking how role modelling is shaped by context, power and identity. For example, Bäckryd (2019) draws on virtue ethics to argue professionalism is sustained through socialisation into communities that uphold compassion, discernment and trustworthiness. While this presents an appealing version of professional conduct, it is largely theoretical and not strongly supported by empirical evidence in healthcare settings. In contrast, Jee et al. (2016) provide an account of professional socialisation in pharmacy, showing how trainee pharmacists learn through exposure to role models in practice. However, their study does not fully

interrogate how variations in training environments, and the availability or quality of role models, may reinforce inequalities in access to professional development.

Barker et al. (2018) and Afshar et al. (2022) offer more grounded perspectives, showing how PSWs act as role models through mutuality and shared identity rather than formal authority. Yet these studies also describe tensions: PSWs often face scepticism from professionals and must continually justify their legitimacy (Asad and Chreim, 2016; Debyser et al., 2019). This suggests that role modelling is not a neutral or universally empowering process. It can reinforce exclusion if institutional cultures fail to recognise alternative forms of expertise. What remains underexplored is how PSWs themselves navigate these tensions over time, and how systems might better support their integration without requiring them to conform to traditional professional norms.

Mentoring is widely promoted as a key mechanism for development in healthcare, with effective mentors described as those who listen, guide and support mentees in developing their own paths (Pololi and Evans, 2015). The group peer mentoring model described by Pololi and Evans (2015) offers an alternative to traditional one-to-one mentoring, emphasising peer relationships, reflective practice and values alignment. While the reported outcomes such as increased vitality, collaboration and personal growth are compelling, their overwhelmingly positive nature raises questions about selection bias and generalisability. The study was conducted within a single institution and does not critically examine how structural barriers such as time constraints, professional hierarchies or lack of diversity might limit the model's applicability in other settings. Moreover, although the authors highlight the importance of culture change, they do not fully explore how such change might be resisted or unevenly experienced across different groups.

Preceptorship, often framed as a structured form of supervision, is another widely used model in healthcare education. Bartlett et al. (2023) provide a more critical lens, highlighting tensions between educational and managerial roles, particularly in community pharmacy settings. Their findings show that preceptorship is often shaped by competing demands, unclear expectations and inconsistent support. Jassim et al. (2022) reinforce this by drawing attention to the emotional and logistical burden placed on preceptors, which is often overlooked in policy and practice. While both studies call for standardised assessment and improved support, they stop short of exploring how such reforms might be resisted in practice. McIntosh et al. (2014) add to this conversation by emphasising the importance of working relationships in shaping learning, though their work does not fully consider how these relationships are influenced by organisational culture or power dynamics.

Despite the emphasis on relational learning and identity formation across coaching, mentoring and preceptorship models, the literature tends to overlook how social and structural factors, such as gender, race, professional hierarchy or cultural background, shape these experiences. Most studies assume a level playing field, rarely addressing how access to mentoring or perceptions of legitimacy may be influenced by systemic inequalities or unconscious bias. For example, few studies critically examine whether certain groups are more likely to be excluded from mentoring networks, or how cultural norms may affect who is seen as a credible mentor or mentee. This lack of attention to equity and inclusion limits the applicability of these models and risks reinforcing existing hierarchies within healthcare.

To summarise, while the literature offers valuable insights into how development and support roles operate within healthcare, it often presents these models in idealised terms. A more critical approach would not only examine how these models succeed, but also explore when, why and for whom they fall short. This includes examining the hidden rules, power relationships and beliefs about who counts as an expert, which shape how coaching, mentoring and preceptorship function in practice. These insights into role modelling, legitimacy and power dynamics also raise important considerations for my own research practice. As explored further in Chapter 3, I remain attentive to how my positionality and perceived authority may influence participants' responses, particularly in interviews where relational dynamics mirror those found in peer relationship contexts.

In later sections, I will discuss the mutuality of these peer relationships and explore the dynamics that contribute to their effectiveness. Next, I will explore the closing section on theoretical underpinnings, focusing on experiential learning and reflection.

Experiential Learning and Reflection

Learning from experience is a core component of professional development and forms the basis of the revalidation model for pharmacy (GPhC, 2018b). This process is often framed as highly individualised, with the impact of learning shaped by each person's unique context and prior experience. Beard and Wilson (2006) argue that experience is not a single, isolated event but a complex and layered process shaped by past experiences, context and social interactions. This perspective highlights that experiential learning is not just about what happens in the moment, but how individuals interpret and connect experiences over time.

Pharmacy technicians, in particular, have a well-established tradition of vocational training, dating back to their formal recognition in the 1950s (APTUK, 2021). Their education has been grounded in practical, workplace-based experiences rather than

purely academic instruction. This tradition aligns closely with the principles of experiential learning, where knowledge is constructed through active engagement in real-life tasks. Despite this, there remains limited research on how pharmacy technicians themselves conceptualise and engage with experiential learning in practice. This gap in understanding is particularly striking given the increasing autonomy and expanded responsibilities pharmacy technicians now undertake across all sectors. Boughen and Fenn (2016) emphasise that pharmacy technicians in Great Britain are engaging in more complex, patient-facing activities, supported by evolving education and training standards. Their review highlights the importance of aligning qualifications with real-life practice and calls for further research to ensure that experiential learning is optimised to support safe, person-centred care. Recent updates to supervision frameworks announced in July 2025 further reinforce this trajectory, introducing enhanced oversight and competency-based progression models aimed at supporting advanced and autonomous practice (Department of Health and Social Care, 2025). These reforms underscore the need for tailored supervision strategies that reflect the evolving scope of pharmacy technician roles within multidisciplinary care teams.

Experiential learning relies heavily on reflective practice, which has been formalised by regulatory bodies such as the GPhC as a mechanism for developing professionalism. In its revalidation framework, the GPhC (2018b, p.5) defines reflective practice as: “the critical evaluation of practice and learning to find ways to benefit further the people using your services”.

While this definition emphasises outcomes for service users (patients), the formalisation has drawn criticism for reducing reflection to a procedural or bureaucratic exercise, rather than a meaningful learning process. Bradbury et al. (2010) offer a more critical perspective, arguing that reflective practice is often individualised and decontextualised, placing the burden of learning on the practitioner while ignoring the structural and institutional forces that shape professional behaviour. In this form, reflection loses its critical edge and becomes a technical exercise, something to be demonstrated rather than experienced.

To understand how experiential learning and reflection are interconnected, Kolb’s (1984) experiential learning cycle is frequently cited as a foundational framework. The model proposes that learning occurs through a four-stage cycle: concrete experience, reflective observation, abstract conceptualisation and active experimentation. This cyclical process has been influential in shaping professional development models in

healthcare (Oelofsen, 2012), where reflection is positioned as a key mechanism for learning from practice.

However, Kolb's model has been critiqued for its overly linear and prescriptive structure, which assumes that all learners progress through the stages in a fixed sequence (Bassot, 2016). In practice, learning is often non-linear and context-dependent, with individuals revisiting stages, skipping steps or engaging in reflection in more fluid and informal ways. Bassot (2016) also notes that learners may exhibit tendencies, such as activism, that influence how they engage with learning, preferring immediate action over prolonged reflection. However, it is important to distinguish between recognising tendencies and endorsing fixed learning styles.

Recent research has challenged the validity of categorising learners into discrete types, arguing that such classifications oversimplify the complexity of learning and lack empirical support (Artino et al., 2023; Patil and Newton, 2023). The assumption that matching teaching methods to a learner's 'style' improve outcomes has been widely debunked, with concerns it may even be harmful to pigeonholing learners and creating unrealistic expectations (Patil and Newton, 2023).

Therefore, while models like Kolb (1984) and Honey and Mumford (1986) may offer language to describe learning preferences, their use should be critically evaluated in light of contemporary evidence. Moreover, the Kolb model does not fully account for social, emotional or organisational influences on learning, factors that are particularly relevant in the dynamic and collaborative environments in which pharmacy technicians operate. These limitations suggest that while Kolb's (1984) model offers a useful starting point, it may not fully capture the complexity of experiential learning in practice.

To complement Kolb's experiential learning cycle, Schön's (2017) concept of reflection-on-action offers a more flexible and practice-oriented model. It focuses on how individuals make sense of their actions after an event, enabling them to obtain insights and apply learning retrospectively. This approach aligns well with the structure of revalidation, where pharmacy professionals are required to reflect on past experiences to demonstrate ongoing competence. However, while Schön's model is more adaptable than Kolb's, it still assumes that individuals have the time, support and reflective capacity to engage meaningfully with their experiences, conditions that may not always be present in busy or resource-constrained settings such as in healthcare.

Building on this, Thompson and Thompson (2023) introduce reflection-for-action, a forward-looking model that encourages practitioners to anticipate future challenges and prepare accordingly. This proactive approach is particularly relevant in peer

discussions, where professionals are expected to reflect not only on what has happened but also on how they can improve future practice for the benefit of service users (GPhC, 2018b). While this model promotes a more dynamic and anticipatory form of reflection, it also places a significant mental and emotional burden on practitioners, especially those who may lack confidence or structured support in reflective practice.

Together, these models underline the value of both retrospective and anticipatory reflection in supporting continuing professional development and improving patient care. However, they are often presented in abstract terms, with limited evidence on how they are enacted in everyday practice. This highlights a need for more context-sensitive research that explores how reflective models are understood, supported and experienced across different roles within the pharmacy workforce.

Summary

This section has critically examined a range of theoretical frameworks relevant to peer relationships in healthcare settings, including communities of practice, interprofessional education, coaching, mentoring and preceptorship and experiential learning with reflective practice. While each framework offers valuable insights into how peers support and enhance professional development and learning, they also present limitations. For example, models such as coaching and mentoring often assume hierarchical relationships or structured support, which may not reflect the more informal and reciprocal nature of peer discussions in pharmacy practice. Similarly, while CoP highlight the value of shared learning, they may overlook the power dynamics or institutional constraints that shape participation.

These theoretical perspectives are particularly relevant to the current study, which explores how pharmacy technicians experience peer discussion as part of the GPhC revalidation process. Despite the regulatory emphasis on peer engagement, there is limited literature that critically examines how pharmacy technicians interpret, navigate and derive value from these interactions. The frameworks discussed provide a conceptual lens through which to sensitise the analysis of peer discussion and to explore how these interactions are shaped by professional identity, workplace culture and access to reflective learning opportunities.

The next section will build on this foundation by critically exploring the benefits and challenges of peer involvement in healthcare learning. This will include an analysis of mutuality, trust and power, and how these dynamics influence the effectiveness and authenticity of peer relationships.

2.6 Mutuality in Peer Relationships

Understanding the mutual benefits of peer relationships is crucial for appreciating how these interactions contribute to professional growth and well-being. In healthcare, peer relationships are often framed as reciprocal and developmental, offering advantages to both the provider and recipient of support. This framing is echoed in the GPhC's revalidation framework, where peer discussion is positioned as a reflective activity designed to enhance practice and benefit service users, most of whom are patients (GPhC, 2018b). The GPhC encourages open, honest conversations with a trusted peer, emphasising mutual respect and developmental intent.

However, this framing warrants closer scrutiny. Although the literature consistently highlights positive outcomes for expert patients in PSWs roles, such as increased self-worth, identity reconstruction and social validation (Debyser et al., 2019; McKeon et al., 2021; Vandewalle et al., 2018), these benefits are often presented uncritically with limited attention to the structural and emotional cost of such roles. For instance, Debyser et al. (2019) and Vandewalle et al. (2018) emphasise the transformative potential of peer work, portraying it as a pathway from a devalued identity, for example, associated with addition or mental health illness, to one of social contribution. Yet, this narrative may risk romanticising recovery and underplaying the ongoing vulnerabilities that PSWs face.

The emotional labour associated with giving back is substantial, and expectations of mutual benefit may obscure the irregularities in power, recognition and support within healthcare teams. While McKeon et al. (2021) report that peer-facilitators gained a sense of purpose and connection, their study also describes tensions such as feelings of inadequacy and comparison with other peers, which complicate the notion of mutuality.

These findings may suggest that the benefits of peer work are not uniformly experienced and may depend heavily on contextual factors such as role clarity, self-confidence, team dynamics and institutional support. Critically, few studies investigate the conditions under which mutuality breaks down or becomes burdensome. The literature tends to focus on the positive outcomes of peer work, with less emphasis on the risks of burnout, role strain or re-traumatisation. This focus on positive outcomes may reflect a broader pattern in recovery-oriented research, where stories of empowerment are often highlighted, while the systemic barriers and institutional challenges are overlooked.

Healthcare professionals also report benefits from engaging in peer support roles, often paralleling those experienced by expert patients. These include enhanced self-

awareness, professional growth and a sense of connection (Bochicchio et al., 2021; Forchuk et al., 2020). However, while the literature frequently highlights these positive outcomes, it tends to under-examine the structural and cultural conditions that shape how mutuality is experienced and how it may be constrained within professional hierarchies.

For example, Bartlett et al. (2023) and Jassim et al. (2022) explore motivations for pharmacists and nurses to act as preceptors, citing leadership development and a desire to contribute to the profession. Yet, these motivations are usually described in personal terms, with limited attention to how workplace pressures or performance targets might influence or even override these good intentions. Assuming that peer support is always a two-way, equal relationship can also obscure the power imbalances that persist, such as between senior and junior staff or across different professional roles.

Nash et al. (2022) offer a more critical perspective through their study of Peer Review Groups (PRGs) among psychiatrists. While participants valued the emotional and professional support offered by these groups, the study also highlights variability in group dynamics, including challenges with member selection, power differentials and the risk of PRGs becoming stressors themselves. This may suggest that mutuality is not a given but must be actively cultivated through trust, safety and shared purpose, which are conditions not always present or easy to maintain.

Across these studies, there is a recurring tendency to relate participation with benefit, implying that engagement in peer roles automatically leads to positive outcomes. What is often missing is a critical examination of the conditions under which mutuality is experienced, disrupted or denied. For example, Bartlett et al. (2023) note that preceptors in rural areas may feel pressure to take on interns due to workforce shortages, thereby compromising the educational experience. Likewise, Jassim et al. (2022) describe how students may revert to traditional supervision models when peer learning is poorly supported, undermining the intended reciprocity.

In addition, while peer support is often credited with breaking down traditional hierarchies through cross-departmental collaboration or shared learning, this claim is rarely investigated. The literature tends to celebrate the potential for flattening hierarchies without critically assessing whether such shifts are sustained or merely symbolic. For instance, while Cunningham et al. (2016) and Rothwell et al. (2021) describe the development of professional friendships over time, they do not fully explore how these relationships are shaped by organisational culture, workload pressures or professional boundaries.

The Covid-19 pandemic catalysed the rapid expansion of peer networks, which were widely praised for supporting staff well-being and resilience (Appelbom et al., 2021; Blake et al., 2021). However, these studies often adopt a crisis-response lens, focusing on short-term benefits without examining the long-term sustainability of such networks. There is also a tendency to treat peer support and resilience-building as interchangeable, which can shift the burden onto individuals to manage their own well-being rather than addressing systemic issues such as staff shortages, burnout or emotional strain caused by the work environment.

Notably, not all mutual benefit is rooted in relationship-building. Basheti et al. (2010) highlight how anonymous peer review among pharmacy students can promote self-reflection and professional development. While this suggests that mutuality can occur even in the absence of direct interpersonal connection, it also raises important questions for interpretivist inquiry: can mutuality be meaningful without relational engagement, or does this reflect a more instrumental view of peer support?

In summary, peer relationships in healthcare can offer significant value by supporting professional growth, developing connections and enhancing well-being. However, these benefits are not automatic. They depend on the surrounding environment, the support systems in place and how roles and expectations are negotiated. While many studies emphasise the positive aspects of peer support, it is equally important to acknowledge the pressures, power dynamics and practical challenges that can undermine these interactions. To ensure that peer support is meaningful and sustainable, it is necessary to examine what enables these relationships to thrive and what may constrain them. Without acknowledging the broader organisational and relational dynamics that shape peer engagement, there is a risk that the GPhC's vision of peer discussion as a reflective, two-way process may not be fully realised in practice.

The next section will explore some of these key ingredients, such as trust, open communication and shared goals, and examine how they influence the quality and impact of peer interactions.

2.7 Dynamics of Effective Peer Relationships

What constitutes successful peer support is often taken for granted in the literature, typically equated with positive interpersonal dynamics, increased confidence or improved learning outcomes. However, such definitions risk oversimplifying a complex and context-dependent process. Rather than interrogating how success is constructed, many studies assume that peer support is effective when it appears harmonious or mutually beneficial. Yet, this can obscure the structural, emotional and institutional

conditions that shape peer interactions. For example, Afshar et al. (2022), Callese et al. (2019) and Forchuk et al. (2020) emphasise the value of shared characteristics in building trust and connection, but they pay less attention to how power imbalances, role ambiguity or organisational constraints may undermine these relationships. Similarly, Jassim et al. (2022) and Markowski et al. (2021) show that while peer learning can promote independence and collaboration, it also introduces challenges, such as competition, uneven participation and logistical barriers, which complicate simplistic notions of success. A more critical approach would be to ask: who defines success in peer support, under what conditions and for whose benefit?

For many healthcare professionals, initial exposure to peer relationships occurs within structured environments, such as preceptorships. These relationships are typically short-lived, lasting only through periods of study or training, where the preceptor acts as an expert imparting knowledge and skills to the trainee (Allinson et al., 2022; Bartlett et al., 2023). However, this model has been critiqued for its limited capacity to develop mutual learning or sustained professional development.

Bartlett et al. (2023), for instance, highlight the tensions preceptors face in balancing educational responsibilities with workplace demands, yet stop short of investigating how these structural pressures might compromise the quality or equity of the learning experience. Moreover, while the study advocates for standardised assessment of preceptor competence, it does not fully address how such assessments might reinforce the top-down pedagogical models rather than support more collaborative approaches.

In contrast, mentor relationships often involve longer-term and more reciprocal interactions, focused on the value of shared experiences and professional identity (Sachdeva, 1996). Yet, this can obscure the power dynamics that persist within mentorship, particularly when extended into interprofessional contexts. Alfaro et al. (2019) present interprofessional near-peer as inherently beneficial, emphasising the value of diverse perspectives and mutual exchange. However, their study also notes that the success of such initiatives depends heavily on careful matching of participants based on clinical exposure and professional identity, suggesting that interprofessional learning is not as universally accessible as often assumed. Furthermore, the informal and unstructured nature of these sessions, while praised for encouraging open dialogue, may inadvertently privilege more confident or experienced participants, thereby reproducing existing hierarchies.

Similarly, Cunningham et al. (2016) report that interprofessional practice-based small group learning between GPs and pharmacists enhanced mutual understanding and collaboration. Yet, their findings also expose underlying tensions: some GP groups

resisted pharmacist inclusion, citing concerns about group identity. This illustrates how perceived threats to professional autonomy or peer solidarity can inhibit open dialogue and collaborative learning. Therefore, while interprofessional initiatives may support surface-level cooperation, their deeper relational impact depends on how well they address the underlying power dynamics and cultural assumptions that shape professional interactions.

A key factor in developing effective peer relationships is the creation of a trusting and psychologically safe environment. MacEachen et al. (2007) rightly emphasise the importance of safe spaces for constructive dialogue, yet many studies fail to account for the structural and interpersonal barriers that inhibit such an environment from forming.

Respectful interactions, characterised by empathy, mutual regard and non-hierarchical communication, are often cited as foundational to reflection and growth (Bochicchio et al., 2021; Cunningham and Zlotos, 2019; Roux, 2020). Whether in peer support, professional learning or feedback contexts, these interactions enable trust, openness and shared learning. Despite their importance, such conditions are rarely guaranteed and are frequently shaped by wider organisational and cultural dynamics.

Indeed, fear and vulnerability frequently undermine peer relationships, even when participants share similar characteristics or social groupings. Wynn et al. (2021) illustrate this tension vividly in their study of clinical nurses, where peer support in the aftermath of errors coexist with anxiety about the repercussions of reporting. This duality of support and surveillance complicates the assumption that peers are always safe collaborators. Similarly, Mak-van der Vossen et al. (2018) and Allinson et al. (2022) highlight how medical students and professionals often resort to anonymous reporting to avoid reputational damage, suggesting that peer relationships are shaped as much by fear of judgement as mutual support. These findings challenge the assumption that shared professional identity or status automatically promotes trust; instead, they reveal how power dynamics, institutional cultures and fear of reprisal can distort peer interactions.

While healthcare sectors such as the NHS have increasingly promoted the idea of a ‘just’ or blame-free culture to encourage openness and learning (NHS England, 2025a; NHS Resolution, 2023), the persistence of fear-driven behaviour suggests that such cultures may be more aspirational than actual. The Being Fair guidance (NHS Resolution, 2023) acknowledges, that supporting psychological safety requires more than policy, it demands consistent, compassionate leadership and a genuine

commitment to equity. Without this, the rhetoric of safety and fairness risks masking the very anxieties if aims to resolve.

This complexity as particularly salient in the accounts describing expert patient peers acting as PSWs, who appeared to be positioned simultaneously as insiders and outsiders within healthcare teams. While their lived experience is valued for its authenticity and capacity to inspire (Barker et al., 2018; McKeon et al., 2021), they frequently encounter scepticism and marginalisation from healthcare professionals (Debyser et al., 2019; Vandewalle et al., 2018). Their dual identity, both as former patients and PSWs, creates ambiguity that can strain relationships. The need to earn credibility from healthcare professional colleagues (Townsend, 2013) reflects a deeper issue: the conditional nature of peer acceptance in hierarchical systems.

Moreover, mismatched peer pairings, whether due to differences in experience, identity or perceived status, can lead to strained relationships and diminished support (Afshar et al., 2022). While peer support is often framed as equal, studies such as Rothwell et al. (2021) illustrate how hierarchical assumptions and incompatible dynamics can reduce peer interactions to tokenistic or performative gestures. This not only undermines the relational quality of peer support but also contributes to burnout, dissatisfaction and disengagement.

In summary, peers, including expert patients and professional colleagues, hold significant potential for enhancing both professional development and patient care. A critical understanding of these dynamics is essential, not only to avoid replicating hierarchical or exclusionary practices under the guise of peer support, but to ensure that such relationships genuinely support reflection, growth and mutual learning.

The next section will explore how these dynamics play out across formal and informal peer engagement, comparing how structured programmes and spontaneous interactions each contribute to building supportive, effective relationships within healthcare settings.

2.8 Comparing the Impact of Formal and Informal Peer Engagement

For many, the first exposure to professional role models occurs through structured relationships, such as those with preceptors and mentors in training and development settings. While preceptorship is sometime informally described as a peer-like relationship due to its close, supportive nature, it is more accurately characterised as a hierarchical, supervisory dynamic. Preceptors, such as the pre-registration tutors described in Allinson et al. (2022), act as experienced practitioners guiding trainees through professional dilemmas during the transition into practice. These relationships

are typically time-limited and focused on the transfer of knowledge, skills and professional norms from expert to novice.

While the literature consistently highlights the value of peer support, the roles peers undertake remain inconsistently defined and often under-theorised. For example, Asad and Chreim (2016) found that PSWs often enter roles with vague job descriptions and minimal training, relying heavily on personal initiative to define their contributions. While this flexibility is sometimes viewed as empowering, the study also describes how ambiguity can lead to role confusion, marginalisation within teams and a sense of tokenism, all of which are significantly problematised in the literature.

Similarly, Debyser et al. (2019) highlight the identity tensions faced by PSWs transitioning from patients to peers, noting that unclear boundaries and a lack of role clarity can undermine both peer and professional confidence in the role. Vandewalle et al. (2018) further complicate the narrative by showing that PSWs are often driven by a desire for normality and self-preservation yet are placed in systems that may inadvertently reinforce stigma or barriers. Their study suggests that PSWs often feel pressure to confirm to professional norms to gain legitimacy, which risks diluting the authenticity of their lived experience. This tension is echoed in McKeon et al. (2021), where peer facilitators in a physical activity intervention valued their experiential knowledge but clearly distinguished their role from that of a healthcare professional. While this distinction helped maintain role integrity, it also highlighted the lack of formal training or support structures, raising important questions about sustainability and safety in peer-led interventions.

Flora et al. (2020) attempt to address this gap by proposing a competency framework for prostate cancer peer navigators. While this framework is comprehensive and well-endorsed by stakeholders, it also highlights tensions between expectations and feasibility. Several competencies, particularly those related to health education and shared decision-making, were less strongly endorsed, with concerns raised about whether peer navigators had the training or authority to fulfil such roles. I interpreted this as reflecting a disconnect between the aspirational framing of expert patient roles and the practical realities of how these roles are implemented within healthcare settings.

Across these studies, a recurring tension is seen between the celebrated flexibility of peer roles and the structural vulnerabilities that such flexibility can mask. The literature often promotes adaptability and informality yet fails to fully grapple with the implications of under-professionalisation, including inconsistent practice standards and role strain.

This raises an important question about whether peer relationships in these contexts are truly informal, or whether they occupy a hybrid space that blends informal lived experiences with formalised expectations. While the relational aspect of peer work often relies on authenticity and shared experience, the increasing use of competency frameworks and institutional oversight suggest a shift towards formalisation. However, this shift is not always accompanied by adequate training or support, creating ambiguity around authority, responsibility and sustainability. The tension between informal connect and formal accountability appears central to how peer roles are negotiated and experienced in practice.

In summary, the literature suggests that peer support in healthcare offers significant benefits, including enhanced patient care and professional development. A key strength of peer engagement lies in its flexibility, particularly within informal models, which allows peers to tailor their support to individual needs and create more personalised, empathetic interactions. However, this adaptability can also lead to inconsistencies in practice, especially when roles are loosely defined or unsupported. Formal peer roles, by contrast, offer structure, training and clearer boundaries, which can enhance legitimacy and integration into healthcare teams. Yet, as several studies caution, over-formalisation risks diluting the authenticity and relational depth that make peer support effective. Balancing the structure of formal engagement with the responsiveness of informal approaches is therefore essential. This balance not only addresses concerns about professional conduct and role clarity but also preserves the relational and experiential strengths of peer support.

2.9 Conclusion: How the Literature Review Shaped the Research

Across the literature, the concept of peer engagement in healthcare is broad, encompassing both horizontal and hierarchical relationships. Peer-to-peer relationships, characterised by mutuality, shared experience and equality, differ significantly from more traditional senior-junior models such as mentoring and preceptorship. While mentoring and preceptorship are valuable for skill development and professional socialisation, they are typically hierarchical, with the mentor or preceptor positioned as the more experienced guide. This distinction is particularly relevant in pharmacy technician training, where formal educational supervision often mirrors these hierarchical models.

Although there is limited published evidence specifically addressing peer support among pharmacy technicians, the broader healthcare literature provides relevant parallels. Pharmacy technicians begin their journey to registration through vocational training, often supported by formal supervisors, and later engage in mentorship and

preceptorship systems similar to those described for other healthcare professionals. Additionally, their ongoing professional regulation includes a formalised peer discussion component as part of revalidation.

This suggests that while peer relationships among pharmacy technicians are increasingly formalised, particularly through mechanisms like registration and revalidation, they may be rooted in earlier informal interactions. The transition from formal collaboration to formalised peer scrutiny could influence how these relationships are experienced, potentially shaping dynamics of trust, openness and perceived authority. Understanding how prior informalities feed into formalised peer discussions may be key to interpreting the relational nuances and tensions that arise in these settings.

By exploring pharmacy technicians' perspectives on peer discussion, particularly how they select and engage with peers, this study seeks to explore how peer engagement is experienced in practice. These insights will help identify opportunities to enhance the peer discussion process so that it supports not only regulatory compliance but also meaningful professional development.

2.10 Research Aim

The research aims to explore the experiences of pharmacy technicians engaging in peer discussions; to understand how suitable peers are identified and to elicit views on the types of support that would be valuable for engaging in peer discussion as part of GPhC revalidation.

2.11 Research Questions

In the context of pharmacy technicians engaging in peer discussion as part of revalidation, this study explores the following questions:

1. What perceptions of the value of peer discussions do pharmacy technicians have?
2. How do pharmacy technicians identify suitable peers to engage in discussions as part of revalidation requirements?
3. What support might pharmacy technicians value for engaging in peer discussions as part of revalidation requirements?
4. What are the implications of these findings for training and supporting revalidation for pharmacy technicians?

These research questions align closely with the literature on peer engagement within healthcare settings. The value of peer discussions, as highlighted in the literature, lies in their capacity to enhance professional development through reciprocal knowledge exchange and reflective practice. The literature also emphasises the importance of

shared experiences, mutual understanding and compatible characteristics in selecting appropriate peers, noting the influence of both informal and formal settings.

Furthermore, my reading of the literature suggests a perceived need for targeted support systems to address inconsistencies in practice and to help alleviate the pressures associated with professional roles. By exploring pharmacy technicians' perspectives, this study seeks to engage with these gaps and develop strategies that reflect the complexities highlighted in the existing literature. This approach ensures that the research contributes meaningfully to both theoretical understanding and practical application within the field.

Given the exploratory nature of these questions and the focus on understanding lived experiences, this study is situated within an interpretivist research paradigm, which will be discussed in the next chapter.

2.12 Chapter Summary

This literature review chapter provides a comprehensive and critically informed analysis of peer interactions within healthcare settings, using a structured approach to explore the various dimensions of peer relationships. The chapter began by outlining the search strategy, including the databases and keywords used to identify relevant studies, as well as the inclusion and exclusion criteria applied during selection.

Definitions of key terms related to peer interactions were provided to ensure conceptual clarity. The chapter then explored the theoretical foundations of peer support within healthcare, drawing on established models to contextualise the role of peers in professional development and reflective practice.

The review examined the mutual benefits and dynamics of peer interactions, highlighting how reciprocal relationships and the exchange of support contribute to both individual growth and collaborative healthcare cultures. It considered both formal and informal peer engagement, illustrating how structured mentorship and spontaneous peer support coexist and interact within healthcare environment.

Throughout, the literature was interpreted through a critical and contextual lens, illustrating the complexities, tensions and structural influences that shape peer relationships. This included attention to power dynamics, role ambiguity and the challenges of sustaining meaningful engagement in hierarchical systems.

Having developed a contextual understanding of the literature surrounding peer interactions in healthcare, the next chapter outlines the methodology used in this study. It details the research design, data collection methods and analytical approach

employed to explore pharmacy technicians' experiences of peer discussions as part of GPhC revalidation.

Chapter 3: Methodology and Methods

3.1 Introduction

The research problems I aimed to explore were:

- How pharmacy technicians engaged in peer discussions.
- How they identified suitable peers for these discussions.
- Which resources were beneficial in supporting these activities.
- What the implications of these findings were in practice.

By examining these areas through the experiences of pharmacy technicians, I aimed to provide insights into this important aspect of pharmacy professional practice.

In my literature review, I explored various approaches to the use of peers in healthcare settings, encompassing a range of professional applications including revalidation processes. Although previous studies investigated the process of revalidating healthcare professionals and explored the associated views and challenges within pharmacy, these were all conducted prior to its mandatory introduction (Jee et al., 2013; Potter et al., 2013; Schafheutle et al., 2013). These studies provided valuable early insights into stakeholder perceptions and the potential barriers to implementation, particularly in relation to appraisal systems and the diversity of pharmacy roles. For example, Jee et al. (2013) highlighted the limited utility of employer-led appraisals for assessing professional competence, especially in community pharmacy settings where appraisals often focused on business performance rather than clinical development. Similarly, Schafheutle et al. (2013) raised important concerns about the feasibility of a one-size-fits-all revalidation model, given the variation in practice settings and professional responsibilities.

A key limitation of this body of work is its pre-implementation timing, meaning it reflects anticipated rather than lived experiences of revalidation. While these studies offer valuable insights into the perspectives of pharmacists, only Schafheutle et al. (2013) explicitly consider pharmacy technicians. However, even in this case, the discussion of pharmacy technician experiences is limited, which constrains an understanding of how revalidation is perceived across the wider pharmacy workforce, particularly in light of the increasing responsibilities and professionalisation of the pharmacy technician role.

While some studies have examined peer discussion in practice, such as Morris and Brooks (2019), which explored case-based discussion with two paediatric pharmacists, there has been little focus on this from the perspective of pharmacy technicians. Despite the small scale of the Morris and Brooks study, it found that case-based discussion facilitated the completion of peer discussion for revalidation and supported

professional development. However, the study also identified the absence of a structured framework for these discussions, suggesting a need for further exploration of how peer discussion is enacted and supported in practice. While Morris and Brooks (2019) identified the absence of a structured framework as a limitation, it is worth considering whether such structure is always beneficial. Adams (2020) highlighted how institutionalising peer support in mental healthcare can lead to unintended consequences, including the erosion of experiential expertise and relational engagement. This suggested that informal or flexible approaches may better preserve the core values of peer discussion, particularly in context where authority and adaptability are key.

Given the increasing complexity and autonomy of the pharmacy technician role, it was important to explore how peer discussion was experienced and understood by this group. Rather than seeking to fill a gap in a positivist stance, this study aimed to offer a contextualised and reflexive account of how pharmacy technicians engaged with peer discussion as part of their ongoing professional development and fitness to practise. It aimed to contribute new insights from the unique viewpoint of pharmacy technicians and sought to advance understanding in this underexplored area of the pharmacy practice.

This chapter outlines the philosophical framework that underpins my study, reflecting on how the taught components of the DClinEd programme have deepened my understanding of my own philosophical stance. I consider how these academic experiences have shaped my approach to research and how they inform the investigation into pharmacy technician experiences.

I describe my approach to the study, detailing how my ontological and epistemological assumptions influence the research design. I provide a rationale for the chosen methodology, data collection methods and participant recruitment strategies, ensuring alignment with the research aims.

Additionally, I discuss the ethical considerations that underpin the study, outlining the steps taken to ensure its integrity and ethical conduct. I conclude the chapter by introducing the data analysis method and describing the limitations of the study design.

3.2 Influence of Professional Values and Experience on Research Design

There was a strong connection between my professional values as a pharmacy technician and my development as a researcher, both of which significantly informed the design and implementation of this study.

My worldview was shaped by my values as a practising pharmacy technician and my role as a leader. Drawing on extensive experience in both the NHS and education and training sector, I participated in peer discussions as part of my own revalidation. I acted as a peer for healthcare professionals across a range of fields, including pharmacy, dentistry and optometry. These experiences laid a solid foundation for this study and held the potential to inform and support the wider pharmacy technician profession, including my own practice, by contributing insights that may enhance professional development and patient care.

As I progressed through my research journey, I moved from a role with an independent training provider into a university position, fulfilling one of the long-term professional goals that had motivated my pursuit of a professional doctorate. At the same time, I continued working in my NHS role within the ICS, maintaining a dual professional identity throughout this period.

This ongoing involvement enabled me to contribute to the delivery of the workforce strategy aligned with the NHS Long Term Workforce Plan (NHS England, 2023), particularly in supporting the development of pharmacy technician roles. It also strengthened my understanding of the strategic direction of the profession and reinforced the importance of enabling pharmacy technicians to grow and lead within evolving healthcare systems.

During this time, I was appointed as a revalidation reviewer with the pharmacy regulator. In this role, I review anonymised revalidation submissions from pharmacy professionals and provide feedback based on the professional standards. This exposure to the revalidation process has deepened my understanding of the expectations set by the regulator, such as demonstrating reflective practice, maintaining up-to-date knowledge and supporting patient-centred care, and how these are applied in real-life contexts. For example, I have observed how pharmacy professionals articulate their learning through CPD entries, reflective accounts and peer discussions, linking their experiences directly to improved benefits for service users. Engaging with these submissions has further informed my perspective on professional development and reflective practice, both of which are central themes in this study.

I remain appreciative of the support provided by my previous employer during my research. They partially funded my doctoral programme as part of my ongoing professional development and offered practical resources, such as printing, alongside encouragement to present at conferences and submit my work for awards. Importantly, they had no influence on the research topic or its outcomes.

Across all these roles, I strive to uphold the professional standards of a pharmacy technician as outlined by the GPhC in Chapter 1. I bring with me values such as integrity, teamwork and person-centred care, alongside a strong focus on innovation and continuous improvement, principles that have been shaped and reinforced by my experiences in both education and practice.

Furthermore, as co-chair of the East Midlands branch of APTUK, and a former Board member, I am deeply committed to supporting pharmacy technicians. I recognise the value of professional networks and the role they play in shaping the development of the profession. This further motivates my desire to contribute through this study. In parallel, I remain focused on developing as a researcher and continue to enjoy my research journey.

3.3 Ontological and Epistemological Considerations

According to Wellington et al. (2005), taking a holistic view of personal journeys allows researchers to reflect on the various aspects of their own positionality. This involves considering the historical context of one's life, the attitudes and expectations that have shaped it, and how these influence the research process. In Chapter 1, I explored my own life journey, which helped me to unpack the concepts of paradigms, methodologies and theories, particularly in the context of this study.

For most of my career, I worked in the scientific world of pharmacy, with my earliest research experience focused on clinical trial medicines. This type of research is typically rooted in hypothesis testing; for example, determining whether medicine A results in better patient outcomes than medicine B. In this context, the researcher adopts a scientific approach, aiming to prove or disprove a theory, with a focus on objective, measurable data. It is predominantly quantitative, relying on numerical indicators such as blood counts, tumour size or other physical measurements. Even when patient experiences are considered, these are often converted into quantifiable metrics, such as pain scales. This reflects a positivist paradigm, where emphasis is placed on observable and measurable phenomena (Bunniss and Kelly, 2010).

However, as this study aims to explore the lived experiences of pharmacy technicians, a singular, objective truth is not attainable. Experiences are inherently subjective and individual, and therefore the positivist paradigm is not suitable for addressing my research questions. Instead, an interpretivist paradigm is more appropriate.

Interpretivism is grounded in the understanding that knowledge in the human and social sciences cannot be approached in the same way as knowledge in the physical sciences. Unlike the physical world, human beings interpret their experiences and act

upon those interpretations, adding complexity to how their experiences are understood (Hammersley, 2012).

An interpretivist approach embraces a relativist ontological position, asserting that there is no single, universal truth. Rather, each individual perspective is considered valid, with truth understood as relative to the individual. This paradigm enables researchers to gain a deeper understanding of phenomena within specific contexts, rather than seeking to generalise findings (Clark et al., 2021).

Given that my research focuses on the individual experiences of pharmacy technicians, the interpretivist paradigm offers the most appropriate lens through which to explore these questions.

In this research, ontology refers to the nature of reality and the assumptions we make about what exists. From an ontological perspective, I recognise that the reality of peer discussions for pharmacy technicians is not fixed or universal. It is constructed through individual experiences and perceptions, which may shift over time and across contexts. Therefore, this study does not aim to present a single, objective truth about peer discussions but rather to explore the diverse, subjective realities of participants. Ontologically, these are seen as socially constructed, with meanings shaped by individuals and shared within specific contexts. This position is reflected in the work of Cunningham et al. (2019), who explored peer learning and development through the experiences of healthcare professionals, including pharmacy technicians. Their approach, like mine, is based on understanding individual and shared experiences, emphasising that reality is shaped by the perceptions and actions of those involved.

Epistemology concerns the nature and scope of knowledge: how we come to know what we know and how knowledge is constructed (O'Leary, 2017). In this study, my epistemological stance is that knowledge is gained through understanding the meanings and experiences of individuals via interaction and dialogue. As an interpretivist researcher, I view myself as actively involved in the knowledge construction process. The knowledge generated through this study is not objective or detached; it is subjective and shaped by my interactions with participants. I understand knowledge as being co-constructed through the dynamic process of discussion, where participants' reflections and insights contribute to a deeper understanding of their experiences (Tavakol and Sandars, 2014). This knowledge is context-specific and dynamic, reflecting the unique experiences of participants at a particular time.

The interpretivist approach allows me to capture the individual and context-rich reflection of pharmacy technicians participating in peer discussion as part of their revalidation. Peer discussions are designed to support reflective practice, aligning with

the interpretivist emphasis on understanding individual perspectives and meanings (Hammersley, 2012). This approach enables me to explore how these discussions influence professional development and practice.

I chose interpretivism over constructivism because it allowed for a deeper exploration of the subjective meanings and interpretations that individuals attach to their experiences (Humphrey, 2013). While constructivism emphasises the active role of individuals in constructing knowledge through social interactions, interpretivism focuses more on understanding the detailed and context-specific meanings that individuals derive from their experiences (Denicolo et al., 2016). This aligns with my research goals of capturing the complexity and richness of participants' perspectives.

However, the interpretivist approach is not without challenges. One critique is that the researcher is not a passive observer but an active participant in the research process. This inherent subjectivity means that the study is not free from bias (Tavakol and Sandars, 2014). Yet, rather than striving for objectivity, my epistemological position acknowledges that my involvement is an integral part of the knowledge construction process (Coe et al., 2017). I do not aim to present knowledge as detached or impersonal; rather, I seek to understand how it is shaped through the lived experiences of pharmacy technicians and my conversations with them during the interview process.

This leads to another important consideration: the challenges and implications of being an insider researcher.

3.4 Insider Researcher: Positionality and Reflexivity

As a practising pharmacy technician with experience of peer discussion as part of my own revalidation, my positionality plays a significant role in shaping the research process. My deep understanding of the study context and my potential contribution to the field, as both a researcher and a practitioner, influence the way I interpret data and engage with participants. This position is often referred to as that of an insider researcher. According to Hellawell (2006, p.484), an insider researcher is someone who "shares cultural, professional or personal ties with the group being studied". In my case, being a pharmacy technician and having direct experience of peer discussion places me in a unique position where trust and openness can facilitate deeper insights into the research topic. However, this insider status also shapes my positionality, as my perspective inevitably influences how I interpret the data and how participants engage with me.

The insider researcher position can present both advantages and challenges. Clark et al. (2021, p.133) describe this position as "privileged", as it can facilitate a level of trust

and openness between researcher and participant. However, it also raises concerns around the trustworthiness and interpretive rigour of the study. In contrast, outsider researchers, are often perceived as more neutral and objective, bringing a fresh perspective but potentially lacking the depth of contextual understanding that insiders possess (Merton, 1972). To engage with the complexities associated with my insider status, I adopt a reflexive stance throughout the research process. This enables me to critically examine how my perspectives and prior experiences may shape the generation and interpretation of data. At the same time, my insider position offers the potential for deeper insight and a more nuanced understanding of the context and lived experiences of pharmacy technicians.

Reflexivity involves critically reflecting on my own experiences, assumptions and interpretations, ensuring transparency in how these factors may influence and enrich the study. As Braun and Clarke (2022) suggest, a reflexive approach allows researchers to document and account for the analytical processes and experiences that inform their interpretations. By doing so, I aim to separate my own preconceptions from the data, supporting a more rigorous and transparent approach. Reflexivity is embedded throughout all stages of data collection and analysis, allowing me to continually revisit and question my interpretations. This approach helps maintain a balance between my insider knowledge and the need for evidence-based analysis.

In line with the interpretivist paradigm and Braun and Clarke's RTA (2006), this commitment to reflexivity supports the overall credibility of the research by demonstrating how interpretations are thoughtfully constructed rather than assumed to be objective. Furthermore, by clearly articulating my analytic decisions and positionality, I aim to uphold transparency as a core principle of qualitative inquiry.

The next sections describe decisions made in relation to the sampling strategy, recruitment of participants, data collection methods, ethical considerations, data analysis techniques and the limitations of the study.

3.5 Research Design

This section outlines the research design and data collection methods used in the study.

The research sought to explore the experiences of pharmacy technicians engaging in peer discussions as part of the GPhC revalidation process. As previously described, pharmacy technicians are employed across a wide range of pharmacy sectors and healthcare settings, with the GPhC currently revalidating all those practising within Great Britain.

Chapter 1 provided an overview of the key sectors in which pharmacy technicians are employed. Enventure Research (2019, p.29) found that pharmacy technicians were mostly employed in community pharmacy (46%), secondary care (41%) and primary care settings (9%). Recent integrated care system plans to expand pharmacy provision within primary care, such as GP surgeries, are expected to influence the current distribution of pharmacy technicians, particularly in comparison to the 2019 data (Department of Health and Social Care, 2021).

To ensure broad participation and equitable representation, the study sought to include participants from all three key sectors. Workforce data indicate that pharmacy technicians in community and primary care settings often work as the sole pharmacy technicians within their pharmacy, whereas secondary care settings typically employ larger teams of pharmacy technicians. This distinction informed the recruitment approach, as opportunities for peer discussion are likely to differ across sectors (NHS England, 2025b; NHS England, 2025c).

Chapter 1 also outlined the supplementary resources available to support revalidation, in addition to those provided by the GPhC. These included CPPE for England, HEIW for Wales and NES for Scotland. As pharmacy technicians in Northern Ireland were not required to register or participate in revalidation at the time of the study, they were excluded from the primary recruitment strategy. However, recognising that some pharmacy technicians may have maintained their registration from Great Britain while practicing in Northern Ireland, the data collection survey included this option for completeness. Although the use of revalidation resources was not mandatory, the study sought to explore the support systems available, making it essential to include participants from each of the three countries in Great Britain.

As of May 2025, the GPhC register included 27,140 pharmacy technicians, distributed as follows: 22,575 in England, 2,609 in Scotland and 1,761 in Wales. Additionally, 90 were registered in Northern Ireland, 52 in the Channel Islands, 28 on the Isle of Man and 15 overseas. This distribution highlighted the predominance of pharmacy technicians in England, while also underscoring the importance of capturing perspectives from across the devolved nations.

The sector of pharmacy and country of practice informed a purposeful sample strategy designed to be both exploratory and representative (Denscombe, 2017; O'Leary, 2017). The study sought to recruit participants from community pharmacy, primary care and secondary care and from England, Scotland and Wales. Employment status and length of experience were also considered to ensure a diverse and information-rich sample.

This study was grounded in the interpretivist paradigm, which values the meanings individuals construct based on their own experiences, perspectives and social contexts. Rather than seeking convergence on a single 'truth' through triangulation, the study adopts crystallisation (Tracy, 2010) to explore the complex and layered realities of pharmacy professionals. Crystallisation allows for the integration of multiple data sources and perspectives, not to validate findings, but to deepen understanding and illuminate the richness and variation within participants' experiences.

Building on this foundation, the following section outlines the data collection methods that support a crystallisation approach, drawing on varied forms of data to reflect the diversity of pharmacy technician experiences across Great Britain.

3.6 Data Collection Methods

As previously outlined, this study sought to explore the experiences of pharmacy technicians through a purposeful sample, considering the country and sector of practice. Given the qualitative approach, the use of an online survey and one-to-one interviews supported the methodological framework (Thomas, 2013).

While surveys are often associated with quantitative research, they can also be used effectively in qualitative inquiry when designed to elicit rich, open-ended responses. As Braun et al. (2021) highlight, online surveys can provide participants with the space and flexibility to express their thoughts, feelings and interpretations in their own words, offering insights into how they make sense of their professional experiences. This approach aligns with the interpretivist emphasis on understanding meaning from the participant's perspective.

In this study, the survey is intended to inform a sampling frame for inviting practising pharmacy technicians from each of the countries of Great Britain, and from each of the three sectors within those countries, to participate in interviews. Each participant group is expected to be included in the sampling frame only once. However, I recognise that some individuals may have experience across multiple sectors or regions due to career transitions or relocations. These overlapping perspectives are anticipated to enrich the data and support the timely completion of the research, particularly given the solo nature of the project.

Survey

The online survey in this study aimed to gather contextual data on revalidation and peer selection practices among pharmacy technicians. While online surveys are sometimes critiqued for producing less detailed or reflective responses, particularly when completed in distracting environments or on mobile devices (Shane et al., 2022),

they can still serve a valuable role in research when designed to elicit both quantitative and qualitative insights.

In this study, the survey includes a combination of closed and open-ended questions, generating descriptive statistics alongside rich, narrative responses. Although it is not the primary site of analysis, the survey functions as a tool to support purposive sampling and to provide contextual insight into participants' professional settings.

Bielska et al. (2024) note that online qualitative surveys occupy a hybrid space between qualitative and quantitative traditions, and their value depends on careful design and alignment with study aims. Reflecting this, the survey incorporates open-ended prompts intended to encourage reflective responses and contribute to the broader crystallization approach by offering one perspective among several. Furthermore, it enables practical and timely data collection across a geographically dispersed population.

Beyond its methodological alignment, the online survey offers practical advantages. It is cost effective, allows for instant processing and facilitates access to participants across Great Britain (Denscombe, 2017). The survey is self-administered and structured to guide participants through the process with clarity. Introductory text provides information about the study, the researcher and purpose of the survey. Each section includes a brief explanation of the rationale for collecting specific data. For example, the eligibility section ensures participants meet inclusion criteria.

Consent is requested at the end of the survey, immediately prior to submission, with participants given the option to download a copy of their responses and the participant information sheet for their records.

Microsoft (MS) Forms was selected as the tool for administering the online survey. This choice was influenced by the NHS's investment in MS tools during the Covid-19 pandemic, leading to the expectation that most participants are familiar with these platforms. Branching logic within MS Forms was utilised to avoid asking irrelevant questions based on previous answers. For example, the survey will not ask participants about the role of the registrant they have acted as a peer for if they previously indicated that they have never acted as a peer. Additionally, the survey included a progress bar to show progression towards completion. These features aimed to reduce what Denscombe (2017) attributes to drop-out rates, namely questionnaire fatigue and loss of enthusiasm.

Participants could complete the survey anonymously, with only those interested in volunteering for future research being asked to provide their name and contact details.

To maximise the number of potential interviewees, three options were provided for participating in further research: no, yes and maybe. The addition of a ‘maybe’ option created a contingency group for contacting potential interview participants if the ‘yes’ group became exhausted.

In addition to collecting quantitative data, the survey gathered qualitative data through open-ended questions. These questions solicited feedback from participants, including details about their experiences with group peer discussions. They also sought the reasoning for non-submission when participants indicated that they did not submit a completed peer discussion for revalidation. Additionally, it gathered insights into factors participants considered when selecting a peer for these discussions.

The use of open-ended questions gave a voice to participants who might shy away from interviews. Given the survey’s focus on professional regulation, it was reasonable to assume that some participants may fear judgement. The ability to answer free-text questions anonymously aimed to provide a safe space for participants to express their views without concern for reprisal or scrutiny of their professional practice (Braun et al., 2021).

Confidence in the accuracy of free-text responses was supported by the participants’ literacy proficiency, a requirement for professional registration. Additionally, the inbuilt spelling and grammar checker in MS Forms enhanced confidence in the clarity and correctness of responses.

Appendix 3 contains a summary of the survey questions, presented without branching logic.

Interview

Interviews are one of the most common forms of data collection in qualitative research and are therefore well suited to this study, which sought to explore opinions and experiences to generate valuable insights (Denscombe, 2017). Accordingly, interviews were selected to provide rich, in-depth understandings of participants’ experiences with peer discussion.

Initially, focus groups were considered, as I had used them previously during an earlier research degree. Focus groups involve group discussion among several participants, with the researcher acting as a “facilitator to those discussions” (Clark et al., 2021, p.453). Their key aim is to explore the interplay between participants, how they respond to one another and the dynamics that occur within the group. However, this was not aligned with the aims of my study, which sought to gather individual

experiences from participants' perspectives and to enable them to speak freely about their views and experiences.

Although there is some evidence that focus groups can elicit data on sensitive issues (Guest, quoted in Clark et al., 2021), it was essential in this study that participants felt able to provide genuine opinions and truthful accounts of their practice. The presence of other pharmacy technicians could influence responses due to peer pressure. As Denscombe (2017, p.206) notes, the success of focus groups relies on establishing a "climate of trust", with a critical emphasis on confidentiality. However, such confidentiality cannot be guaranteed, particularly where disclosures of poor or illegal practice may be subject to FtP regulations, which are discussed later in this section.

For these reasons, focus groups were discounted, and one-to-one, online interviews were selected as the most appropriate method for addressing for the research questions. Online interviews were the only practical option for this study, given the need to recruit participants from across Great Britain. Travel costs and time constraints made in-person interviewing unfeasible. Online interviews offered benefits such as convenience, flexibility and the potential to create a comfortable environment for participants, particularly when discussing professional experiences.

To support accurate data capture, all interviews were conducted via MS Teams and were video and audio recorded with participants' consent. Recordings were transcribed using automated transcription software within MS Teams, after which the transcript was manually reviewed for accuracy. This process included correcting the transcription errors, checking terminology and anonymising identifiable information. These verified transcripts formed the dataset for analysis, supplemented by observational notes taken during and immediately after each interview.

However, online interviews may limit the researcher's ability to observe non-verbal cues and build rapport, which can influence the depth and subtlety of the data collected. To help build rapport, each interview was designed to begin with informal, open-ended questions to put participants at ease and to introduce myself and the study in a friendly, conversational tone. To address the challenge of interpreting non-verbal cues, I planned to re-watch the video recordings alongside the transcripts, making reflective notes on tone, facial expressions and pauses to support a more detailed and context-sensitive interpretation of the data (Carter et al., 2021).

That said, there is growing literature suggesting that online interviews can elicit more open and candid responses, particularly when participants are in familiar and comfortable environments such as their own homes (Lobe et al., 2022). Some studies also indicate that non-verbal cues, including facial expressions, tone of voice and

pauses, can still be observed and interpreted effectively in video-based interviews, challenging the assumption that rapport-building is inherently compromised online (Archibald et al., 2019).

A disadvantage of one-to-one interviews is the limitations on the number of perspectives that can be gathered, due to the time and resource constraints of a solo researcher (Denscombe, 2017). The sampling frame was designed to support this method by ensuring that a range of views, across agreed parameters, could be captured.

A semi-structured approach was selected for the interview, as it aligned well with the qualitative nature of the study and its aims of exploring individual views and experiences. A structured, standardised approach was deemed unsuitable, as it is typically employed in quantitative research where fixed-response questions are required (Clark et al., 2021).

While unstructured interviews offer greater flexibility and allow participants to lead the conversation, they may lack the focus needed to address specific research objectives (Denscombe, 2017). Given the clear focus and defined aims of this study, a semi-structured approach was considered most appropriate. This method provided the flexibility to explore participants' experiences in depth, while maintaining sufficient structure to ensure that all relevant topics were addressed (Clark et al., 2021; Rees et al., 2024).

To support the semi-structured interviews, the interview topic guide, at Figure 6, was created to follow the stages described by Clark et al. (2021, p.428).

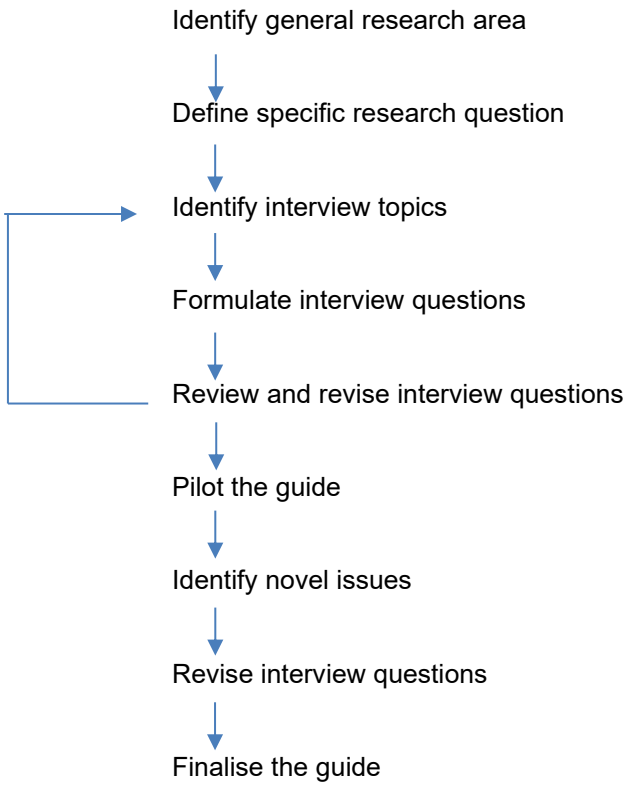

Figure 6: Formulating Questions for an Interview Guide
Adapted from Clark et al. (2021)

The interview guide was structured in three sections. It began with introductory questions designed to put participants at ease and to gather background information about their career journey to date. The central section focused on their experiences of peer discussion, incorporating prompts and suggested follow-up questions to elicit further detail or clarification. The final section invited participants to share any additional reflections and outlined the next steps in the research process. Further detail on the interview procedure is provided in Chapter 5.

The communication strategy, survey and interview techniques were piloted to assess clarity, relevance and feasibility. The interview guide was subsequently refined based on preliminary feedback from these pilot sessions, as well as insights drawn from the analysis of free-text responses in the survey. This iterative process ensured that the guide remained responsive to participant perspectives and was closely aligned with the study's interpretivist framework.

Piloting

I was in a unique position to pilot this research. Although pharmacists were not the primary focus of this study, they complete the same revalidation framework and work within the same sectors as pharmacy technicians. This provided access to a pilot group that closely resembled the target population.

Drawing on pharmacist volunteers from across my professional networks I evaluated the communication strategy, tested the online survey and developed the foundations of the interview guide. These pilot activities provided valuable insight into the clarity and effectiveness of the research methods. Reflecting on feedback, obtained through the pilot, enabled me to identify areas for improvement and refine my approach to support the collection of high-quality data.

Informed by experience from a previous master's degree, I anticipated that interviewing might prove more challenging than expected. Novice interviewers often encounter difficulties such as "unexpected participant behaviours, consequences of the researchers' own actions and subjectivities, phrasing and negotiating questions and dealing with sensitive issues" Roulston et al. (2003, p.648).

I was keen to develop my interview technique to address these challenges and refine the topic guide accordingly. Clark et al. (2021, p.426) note that one of the most demanding aspect of semi-structured interviewing is framing questions in an "open way that allows and encourages the interviewee to articulate a fairly detailed response". With these challenges in mind, I approached the piloting process as an opportunity to practise, reflect and adapt. By engaging in this iterative process, I aimed to be better equipped to navigate the complexities of qualitative interviewing and mitigate common pitfalls.

3.7 Recruitment of Participants

In this section, I outline the recruitment strategy and timeline for data collection.

To support maximum participation in the survey, data collection dates were selected to avoid NHS winter pressure months, as well as traditional and additional Bank Holidays. Consideration was also given to allowing a suitable period following the lifting of Covid-19-related revalidation restrictions, which ended in October 2022 (GPhC, 2020).

In addition, the timing aimed to capture the October to December revalidation window, when many pharmacy technicians, having joined the register during the traditional academic year, are due to revalidate. Accordingly, the survey was open from 20th March 2023 to 28th April 2023.

Email and social media platforms were used to recruit participants. While this approach excluded individuals without internet access or those not using social media, it was considered the most practical method for reaching a geographically dispersed population. Since the Covid-19 pandemic, the use of information technology (IT) and the emergence of professional social media communities have expanded rapidly, with pharmacy technicians increasingly using IT in their daily work (Delgado et al., 2021; Wilson et al., 2021).

The GPhC was approached as a key gatekeeper to support dissemination of the survey. The GPhC assess research requests on a case-by-case basis and only endorse studies that align with its strategic aims. As this research aligned with their priorities, the GPhC agreed to support recruitment.

In addition, APTUK, PCPA and the UK Pharmacy Technicians Facebook group were approached to share the survey via social media and membership email lists. Key NHS contacts in regional teams and the Chief Pharmaceutical Officer's office also agreed to promote the study through meetings and social media.

While regulator and professional body endorsement may lend credibility and encourage participation, it is acknowledged that some individuals may feel apprehensive about engaging with research perceived to be linked with them. Although the regulator and professional bodies did not handle any participant data, and this was made explicit in the participant information, the potential for such perceptions to influence response rates or candour was considered during the recruitment planning.

Participant data was reviewed on a weekly basis to monitor demographic representation. Where under-representation was identified, targeted outreach was undertaken via gatekeepers and social media platforms to encourage participation from those specific groups and promote a more balanced sample.

Interview Selection

Following the closure of the survey, participant data was exported and managed within the university's secure cloud storage, as outlined in the Data Management Plan (DMP) at Appendix 4. Each response was assigned a unique identifier using a 'PT' pre-fix (for pharmacy technician), based on the chronological order of entries into the Excel dataset. For example, the 35th participant was labelled PT35.

Filters were applied to isolate participants who had responded 'yes' to the question about volunteering for interviews and had provided contact details. A second filter was then applied to this subset to stratify the sample by country of practice (England, Scotland and Wales), followed by a third filter for sector of practice (community

pharmacy, secondary care, primary care and other sectors). This stratification created subgroups based on both country and sector.

A random number generator was then used to select participants from each subgroup (Denscombe, 2017). This approach introduced an element of chance into the selection process, helping to reduce the influence of researcher preferences while still operating within a purposive sampling frame.

Although reflexivity underpinned the recruitment strategy, acknowledging and mitigating potential researcher bias, the use of randomisation was a deliberate ‘belt and braces’ decision. It served as an additional safeguard to reinforce transparency and trustworthiness, ensuring that participant selection could not be perceived as selective or biased, even unintentionally.

The resulting sample included participants with varying lengths of time in practice and employment statuses. Had this diversity not been achieved, additional filters would have been applied to ensure a more representative sample.

Selected participants were visually distinguished within the dataset using colour coding. They were contacted via the email addresses provided in the survey and invited to book a convenient time for an online interview. To accommodate varying schedules, a range of dates and times was offered over a six-week period.

To facilitate scheduling, the MS Bookings automated system was used. Participants received an email with details of the interview and a link to the booking system, allowing them to select their own appointment. This system reduced the administrative burden by enabling participants to manage their own bookings. It also provided automated reminders and maintained an audit trail for both researcher and participant.

In summary, the research design and methodologies were carefully tailored to address the research questions effectively. Subsequent sections reflect on the experience of implementing this design, including the practical challenges encountered. The following section considers the ethical dimensions of the study and outlines the measures taken to safeguard participants’ rights and wellbeing.

3.8 Ethical Considerations

In this section, I discuss the ethical considerations related to data collection, which Reid et al. (2018a) describe as both situational (linked to the research context) and relational (concerning the ethical relationship between researcher and participant). Ethical issues related to the dissemination of findings, referred to by Rees et al. (2024, p.59) as “exiting ethics”, are addressed in later sections.

As previously discussed, I occupy the position of an insider researcher, which affords me privileged knowledge of the profession and revalidation processes (Merton, 1972). This position brings advantages, such as familiarity with the language and context of the field, and access to potential participants. However, it also presents challenges, including the potential for prior experiences and assumptions to shape data interpretation, and the possibility of power dynamics influencing the researcher-participant relationship. These complexities are acknowledged and engaged with through a reflexive approach that brings transparency and critical self-awareness throughout the research process.

Additionally, I considered the ethical relationships that may arise during the study and took steps to identify and mitigate any power dynamics. I followed the British Educational Research Association's (2018) ethical guidelines for educational research at all stages of the project, continuously assessing and reassessing ethical considerations as they occurred.

During the "procedural ethics" stage of planning, defined by Rees et al. (2024, p.59) as the planning and approval phase, I used the Health Research Authority (HRA) decision tool to determine whether the study required review by an NHS Research Ethics Committee (NHS REC). As the research involved NHS staff, it was important to assess whether it met the criteria for NHS REC review.

My epistemological stance does not necessitate demographic representation in terms of age, gender or ethnicity, and therefore I would not collect these data. Instead, the demographic information I gathered included country of practice, sector, employment status and length of time in practice, as these variables were considered relevant to the research questions.

While I was confident in securing ethical approval, I also acknowledged, as Reid et al. (2018a, p.70) observed, that this process is sometimes perceived as a "hurdle to be surmounted". A later section will offer further reflections on the ethical dimensions of the study.

In addition to procedural ethics, I now turn to the ethical relationships that may arise during the research process (Reid et al., 2018a). These include safeguarding participants' wellbeing, ensuring the protection of their identities and addressing any perceived power imbalances between myself and the participants.

Wellbeing

The wellbeing of participants in this study was a primary concern. The research explores professional practice and revalidation, topics that may influence participant's

perceptions of their ability to continue practising as a pharmacy technician. I am mindful that participants may need to discuss challenges in practice or experiences of poor professionalism among peers.

As both the researcher and participants are registered professionals, we are all bound by the GPhC FtP Guidelines (GPhC, 2017a). To ensure fully informed consent, participants were provided with detailed information and signposting to the GPhC Standards, as well as the relevant policies for raising concerns. In addition, they were directed to wellbeing support services for healthcare professionals, should they have experienced any distress as a result of participating in the survey or the interview.

Consideration has also been given to the reasonable and practical time commitment required for participation. The online survey is designed to minimise response burden by incorporating a visual progress bar and drawing on insights from the piloting phase to accurately estimate completion time (Denscombe, 2017). For one-to-one interviews, guidance from McGrath et al. (2019) was followed to ensure that interviews do not exceed 90 minutes.

Protecting Identities

The study was designed to encourage participants to share their experiences of peer discussion for revalidation. To support confidence in doing so, participant identities were protected using unique identification codes, as previously described. Additionally, participants could complete the survey anonymously. Those who do not wish to take part in follow-up interviews could choose not to provide their name or contact details and remain anonymous.

Care was taken throughout the transcription process to remove potentially identifiable information, such as company names (including NHS Trusts), job titles, individual names and specific work locations. This approach not only preserves the anonymity of participants but also protects the identities of third parties who may be mentioned during the interviews.

Identifiable data was stored and maintained separately from the main dataset, in accordance with the DMP (Appendix 4).

Power Relationships

In line with McGrath et al.'s (2019), who highlight the importance of acknowledging and addressing power dynamics in qualitative research, careful consideration was given to the potential power relationships that could be perceived between participants and myself. Reflecting on my varied career in pharmacy, including roles with the professional leadership body APTUK, in secondary care and with training providers, I

was mindful that some participants may have known me from these contexts and may perceive a power imbalance as a result.

To mitigate this, the selection of participants for interview was randomised, although I acknowledge that prior relationships cannot be entirely ruled out. To further reduce the potential for power dynamics, third parties were used to distribute email invitations for survey participation. Additionally, although study information was shared via my personal social media accounts, the anonymity of viewers helped to remove any sense of obligation to participate further due to a direct request from me.

Providing study information in advance of both the survey and interviews supported fully informed consent and reinforced the voluntary nature of participation, helping to ensure that no coercion was present.

Having now established the ethical framework that guided this research, the next section will outline my approach to data analysis.

3.9 Data Analysis Introduction

As previously discussed, my philosophical stance and research questions require a method of data analysis that aligns with an interpretivist approach and allows for a comprehensive exploration of individual experiences. In selecting an appropriate analytical method, I was mindful of the need to support an interpretivist framework, one that prioritises understanding participants' perspectives and the meanings they construct. As an insider researcher (Merton, 1972), I also recognised the importance of reflecting on my role in the research process and to ensure rigour and transparency to produce credible and trustworthy findings. This necessitated an approach that was both flexible and capable of generating unanticipated insights (Braun and Clarke, 2006; Braun and Clarke, 2022; Rees et al., 2024).

To prioritise the voices and experiences of pharmacy technicians this study adopted Braun and Clarke's (2006) RTA approach. This approach offered a structured yet adaptable six-phase analytical process that supported deep engagement with the data. It provided a robust framework without imposing rigid rules, enabled flexibility and incorporated the insights I brought as the researcher.

RTA emphasises the importance of making conscious, reflexive choices and maintaining an awareness of the researcher's theoretical positioning and active role in shaping how data is understood and represented (Braun and Clarke, 2022; Braun and Clarke, 2023).

A common limitation of RTA is that researchers do not always describe their use of the method in sufficient detail (Braun and Clarke, 2022; Rees et al., 2024). In response to

this, I planned to structure my analysis chapter using headings that reflected the six phases of RTA and to provide a clear account of the decisions made at each stage. This aimed to ensure transparency and demonstrate how the data were analysed in alignment with the interpretivist paradigm.

Braun and Clarke's (2022, p.35) six-phase process offers a structured yet flexible approach to analysing qualitative data. The phases are summarised in Table 8.

Phase Title	Description overview
1 – Familiarising yourself with the data	Immerse yourself in the data by becoming familiar with its content.
2 – Coding	Identify interesting features of the data and create initial codes.
3 – Generating initial themes	Group initial codes into potential themes.
4 – Develop and review themes	Check if themes work in relation to coded extracts and the full dataset.
5 – Refining, defining and naming themes	Develop a detailed analysis of each theme.
6 – Writing up	Produce the report, weaving together the narrative and data extracts.

Table 8: Six Phases of Reflexive Thematic Analysis
Reproduced from Braun and Clarke (2022)

To manage the data, I initially planned to use NVivo, a well-established computer-assisted qualitative data analysis software (CAQDAS). NVivo supports the coding of free text survey responses and interview transcripts, and facilitates the organisation of data into themes (Thomas, 2013). Anticipating a large dataset, NVivo was selected for its potential to support efficient, accurate and systematic analysis. In future chapters, I will reflect on my experience of using NVivo during the pilot phase and the final decisions made regarding data management.

To summarise, the methodological rigour provided by Braun and Clarke's (2006) RTA offered a robust yet adaptable framework for analysing the data in this study. This approach not only aimed to generate a deep insights into participants' experiences but also to align with the interpretivist paradigm by prioritising the understanding of participants' perspectives and the meanings they construct.

In the final section of this chapter I will reflect on the process of gaining ethical approval for the study.

3.10 Reflection on Ethical Considerations

I was confident in my initial application for ethical approval and was therefore surprised to receive feedback from the University Research Ethics Committee requesting the

collection of participant demographic data, specifically age, ethnicity and gender. The Committee also suggested that NHS REC approval might also be required.

In response, I questioned the requirement to collect demographic data that did not align with my epistemological stance. My research does not seek to obtain representation based on age, gender or ethnicity. Instead, the demographic variables I considered relevant were sector of practice, country of practice, employment status and length of time in practice, as these were judged to have a potential impact on access to peers and experience of peer discussion. I argued that these were the only demographic data necessary for the study and that collecting additional personal data without intent to process it would be inconsistent with the principles of the General Data Protection Regulation (GDPR) (*Data Protection Act* 2018).

I had used the HRA decision tool to determine that NHS REC approval was not required, as the study involved NHS staff but did not meet the criteria for NHS REC review. However, I had not included evidence of this in my original submission. As a result, I was asked to either provide this evidence or apply for NHS REC approval. I subsequently repeated the HRA decision tool process for England, Scotland and Wales, and this time saved copies of the results to include in my resubmission.

Following these revisions, I obtained University ethical approval which is included in Appendix 5.

3.11 Chapter Summary

This chapter has outlined the methodological framework underpinning my study, with particular emphasis on the ontological and epistemological considerations inherent in my role as an interpretivist and insider researcher. The research design and data collection methods, comprising an online survey and semi-structured interviews, were carefully developed to capture the nuanced experiences of pharmacy technicians.

Recruitment strategies and interview selection processes have been described to ensure a diverse and information-rich participant pool. Ethical considerations were prioritised throughout, with attention given to participant wellbeing, confidentiality and the mitigation of power dynamics. The introduction to Braun and Clarke's RTA provided an overview of the analytical approach, highlighting its alignment with the interpretivist paradigm and its capacity for rigorous, reflexive engagement with the data.

Reflecting on my own experiences and the methodological decisions made has offered valuable insight and laid a strong foundation for the forthcoming analysis.

The next chapter will examine the survey data, reflecting on the collection method and detailing the creation of the sampling frame. It will also present the quantitative findings and analyse the qualitative data drawn from the survey responses.

Chapter 4: Survey

This chapter explores the survey dataset with a dual focus: first, using quantitative data to construct a robust sampling frame for subsequent interviews and second, drawing on the qualitative responses to inform the development of the interview guide. These initial insights helped refine the interview prompts, enabling a more targeted exploration of areas that participants appeared to find particularly significant in their accounts.

4.1 Data Collection

This section outlines the data collection process, including reflections on piloting the survey, recruiting participants and factors that influenced data collection.

Piloting

As previously described, I piloted all aspects of my study to refine them. Eight pharmacists formed the pilot group and initially participated in a focus group to provide feedback on the draft communication and survey completion.

A focus group was chosen for the pilot as I wanted to observe interactions between participants, to assess whether any specific feedback or questioning caused discomfort in a group setting (Denscombe, 2017). I approached this with an awareness of my dual role as both a pharmacy professional and the interviewer, recognising that this positioning might influence participants' responses.

The group discussed the survey questions that elicited varied or unexpected answers in detail. Volunteers were asked to describe their understanding of each question to identify any confusion, clarify its purpose and, where necessary, agree on rewording.

Questions that were ambiguous or did not contribute meaningfully to the research aims were removed. For example, questions about the location of peer discussions were excluded. The pilot group found the terms 'internal' and 'external' confusing, as they interpreted them inconsistently. This prompted a broader discussion about the rationale for the questions and their relevance to the research questions.

Additionally, several questions were revised from multiple-choice to free-text format, allowing participants to provide more detailed responses.

Recruitment of Participants

Following approval from the Chief Executive and Registrar, the GPhC agreed to promote the study on the basis that it aligned with their statutory objectives and existing strategic aims. In line with policy, this required collaboration with colleagues in the information governance, research and communications team, enabling the GPhC to act as gatekeeper for the recruitment process. The GPhC subsequently distributed the

survey link to pharmacy technicians in their database and promoted it through their social media channels. At the time of data collection (March 2023), the GPhC did not publish a monthly register snapshot. The closet available figures indicates that 25,555 pharmacy technicians were registered as of June 2023 (Professional Standards Authority, 2023).

Data was downloaded, from the MS Form survey, on a weekly basis to monitor responses and target underrepresented groups. This process informed my recruitment strategy by allowing me to adapt outreach efforts in real time. A summary of this weekly data is presented in Appendix 6 to illustrate how sampling was monitored and adjusted.

Concurrent Influences on Data Collection

During the survey data collection window, several other projects were simultaneously targeting pharmacy technicians. These included:

- An HEE (Health Education England) and NHSE (NHS England) commissioned research project was undertaken by the Centre for Pharmacy Workforce Studies (CPWS) at the University of Manchester to understand pharmacy technicians' motivations for joining the profession and the factors contributing to attrition from the GPhC register. Although the survey link was distributed by CPPE, the study was conducted by CPWS.
- A request for pharmacy technicians to submit an expression of interest in joining the newly created pharmacy technician professional advisory forum.
- An HEE-commissioned research study on the impact of the education and training for pharmacy technicians to support workforce development. This study targeted pharmacy technicians, managers and trainers.
- A study by a Midlands University, which invited community pharmacy staff to participate in focus groups exploring how they support older people. Vouchers were offered for participation in a one-hour, online session.
- A South-West University workforce survey, which targeted all pharmacy staff working in UK healthcare settings.

There was no prior indication that pharmacy technicians would become the focus of multiple research projects during my data collection window. Hammersley (1995, p.112) describes how research can have a material effect in which "participants' lives may be affected by involvement in reflecting on their experiences". At this time, I became concerned about research fatigue and the potential of pharmacy technicians to feel over-researched (Clark, 2008), a factor that could have influenced participation in my study.

To address these concerns, I modified my social media posts in response to the release of other surveys. I emphasised that I was a pharmacy technician conducting research on pharmacy technicians, highlighting this unique aspect of the study. Additionally, I adjusted the tone of my posts to appeal for help and support from fellow pharmacy technicians.

The survey was completed by 345 individuals between 20th March and 28th April 2023, with an average completion time of eight minutes. Given the presence of other surveys and requests directed at pharmacy technicians during the same period, the strong response rate to my survey may reflect a high level of interest in the subject matter and a motivation to share their perspectives. This level of participation affirms the relevance and importance of the study to the pharmacy technician community.

The following section provides a detailed examination of the collected data, highlighting key trends, patterns and insights that were constructed through interpretation of the responses.

4.2 Informing the Sampling Frame

Following closure of the survey, data were extracted into an Excel spreadsheet to support the identification of a representative sampling frame for the subsequent interviews.

Of the 345 responses, twenty individuals were not eligible to participate, either because they were not pharmacy technicians, (2 out of 345; 1%) or they had not completed a peer discussion as part of their own or others' revalidation (18 out of 343; 5%). These individuals were automatically informed of their ineligibility upon completion of survey question one or two and were automatically exited from the survey with an explanation and a thank you for their time and interest.

As a result, 325 valid responses were included in the data analysis.

The quantitative data derived from these responses offered substantial insights into participants' experiences, establishing a robust foundation for the sampling frame across country and sector of practice, employment status and years of experience.

Country of Practice

To understand the geographical distribution of participants, and to ensure that the sampling frame reflected the diversity of practice contexts across Great Britain, respondents were asked to indicate their country of practice. This was defined as the country in which they worked most of their hours, as the pilot study revealed that some individuals worked across national boundaries.

This information was important for three reasons. First, it supported the development of a sampling frame that included voices from across England, Scotland and Wales, each of which offers different forms of support for pharmacy technicians undertaking revalidation. Second, it provided contextual insight into participants' experiences, which is relevant to one of the research questions exploring what support they would find helpful. Third, it enabled the formulation of recommendations that are relevant to the profession as a whole, across all three countries of Great Britain, rather than being limited to a single national context.

Most participants were based in England (234 out of 325; 72%), followed by Scotland (47 out of 325; 14%) and Wales (42 out of 325; 13%). Two participants (2 out of 325; 1%) selected 'other' as their country of practice. No responses were received from pharmacy technicians working in Northern Ireland, which is likely due to the role not being registered in that country.

Figure 7 illustrates the distribution of participants by country of practice. It provides a visual overview of the demographic spread of the survey sample, which informed the purposive sampling strategy for the interview phase.

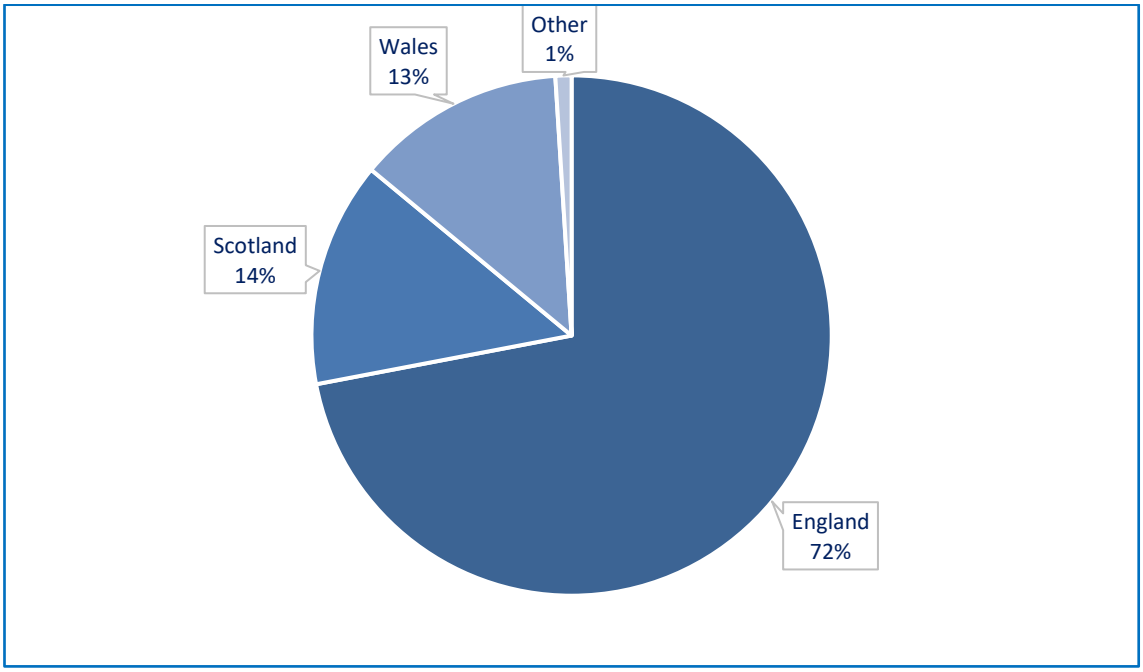

Figure 7: Country of Practice of Survey Participants
The 'other' category includes one participant working in the armed forces in Cyprus and another working remotely from Wales for an organisation based in England.

Sector of Practice

Participants were asked to select all sectors in which they had worked during the submission of a peer discussion for revalidation. As a result, those with varied

portfolios or who had changed roles may have selected more than one sector, leading to a total of 452 responses across ten sector options.

This information was important for understanding the professional contexts in which peer discussions were taking place. As outlined in the research design section in Chapter 3, the study sought to include participants from across the three main sectors: community, primary and secondary care, to ensure broad participation and equitable representation. This approach was informed by the assumption that pharmacy technicians in secondary care may have greater access to peers for discussion, whereas those in community or primary care settings may be the sole pharmacy technician in their workplace.

Figure 8 presents the distribution of responses by sector. It visually demonstrates the varying levels of participation across different sectors of practice, offering a comprehensive overview of the professional backgrounds represented in the survey. These insights were used to inform the purposive sampling strategy for the interview phase and to ensure that the interview guide reflected the realities of practice across diverse settings.

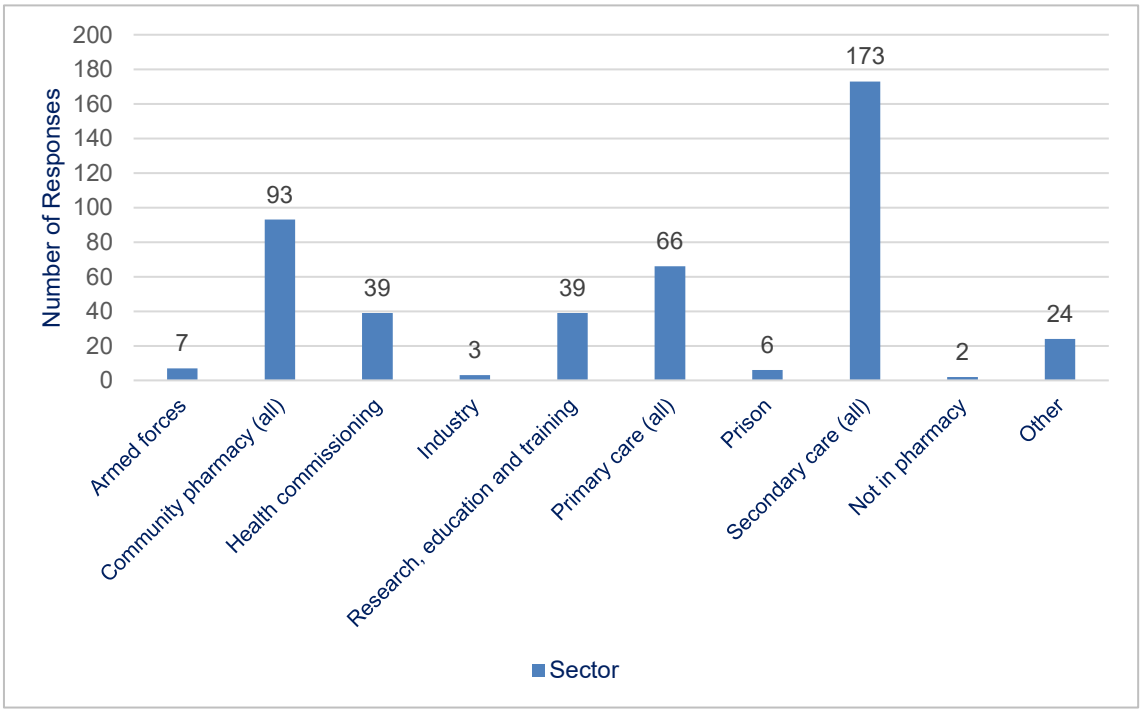

Figure 8: Number of Responses by Sector of Practice
Participants could select more than one sector, resulting in a total of 452 responses across ten categories.

Employment Status

To understand the employment status of the participants, they were asked to indicate whether they were employed in a pharmacy role full-time (30 hours a week or more), part-time (29 hours a week or less) or in another capacity. This information was used to

inform the sampling frame, ensuring that the interview phase reflected the diversity of employment arrangements across the profession.

Understanding participants' employment status was also important for contextualising their experiences of peer discussion. For example, those working part-time may face distinct challenges in accessing peers for revalidation, such as limited time on-site, reduced exposure to professional networks or fewer opportunities for informal peer interactions. These constraints can differ significantly from those experienced by full-time staff in traditional settings, where peer access may be more consistent and embedded in daily practice.

Figure 9 provides a visual overview of the employment status of survey participants.

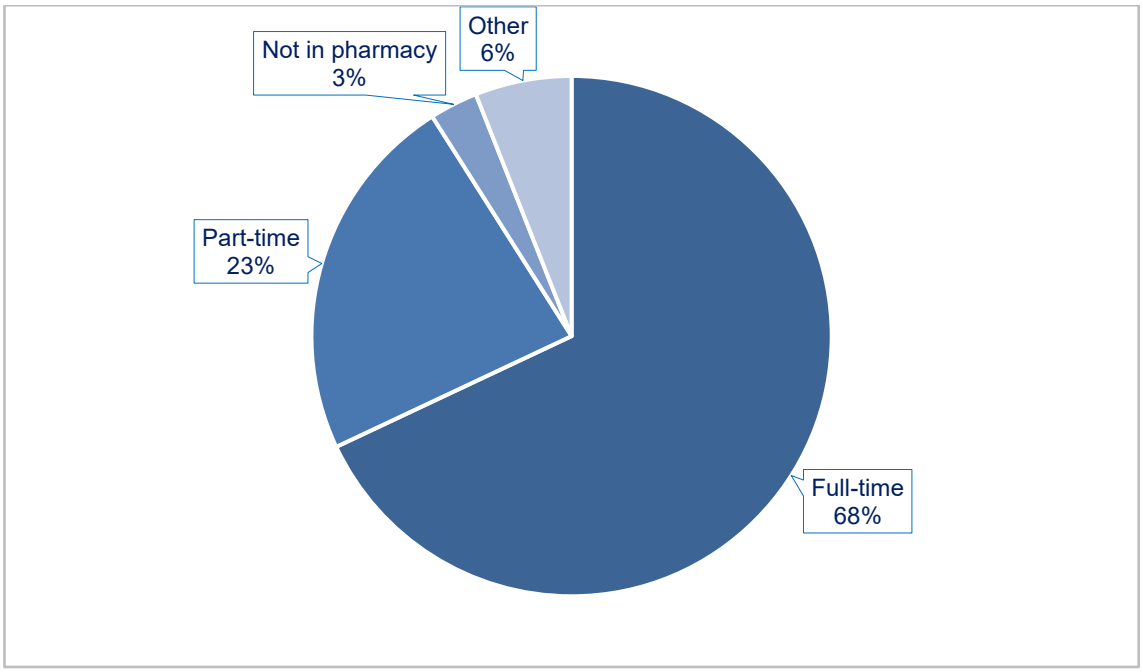

Figure 9: Employment Status of Survey Participants
The 'other' category included three participants in part-time roles within primary care and three in full-time roles within education and health boards. Additional responses in this category included locums, retired and self-employed individuals.

Experience as a Pharmacy Technician

Participants were asked to indicate their total length of time in practice as a pharmacy technician. As there is no standardised framework from NHS England or the GPhC defining pharmacy technician career stages by years of experience (GPhC, 2019), this study adopted a pragmatic categorisation to reflect different phases of professional development. The categories shown were developed to support meaningful analysis of peer discussion experiences across a diverse workforce.

This approach aligns with broader workforce research principles, such as those found in the Civil Service's Success Profiles framework, which recognises experience as a key factor in professional developmental and role suitability (Cabinet Office, 2025).

- Newly Qualified: 0-2 years of practice
- Early Career: 3-5 years of practice
- Mid-Career: 6-19 years of practice
- Experienced: 20-39 years of practice
- Final Stages of Career: 40-49 years of practice
- Retired: 50+ years of practice

This information was instrumental in developing a robust sampling frame for interview phase, ensuring that the qualitative analysis would reflect a diverse and representative cross-section of the pharmacy technician profession.

Respondents represented a broad spectrum of career stages, from newly qualified to those classifying themselves as retired, but remaining on the register. Figure 10 illustrates this distribution, which informed the selection of interview participants alongside volunteer expressions of interest. The detailed process of interview selection is described in Chapter 5.

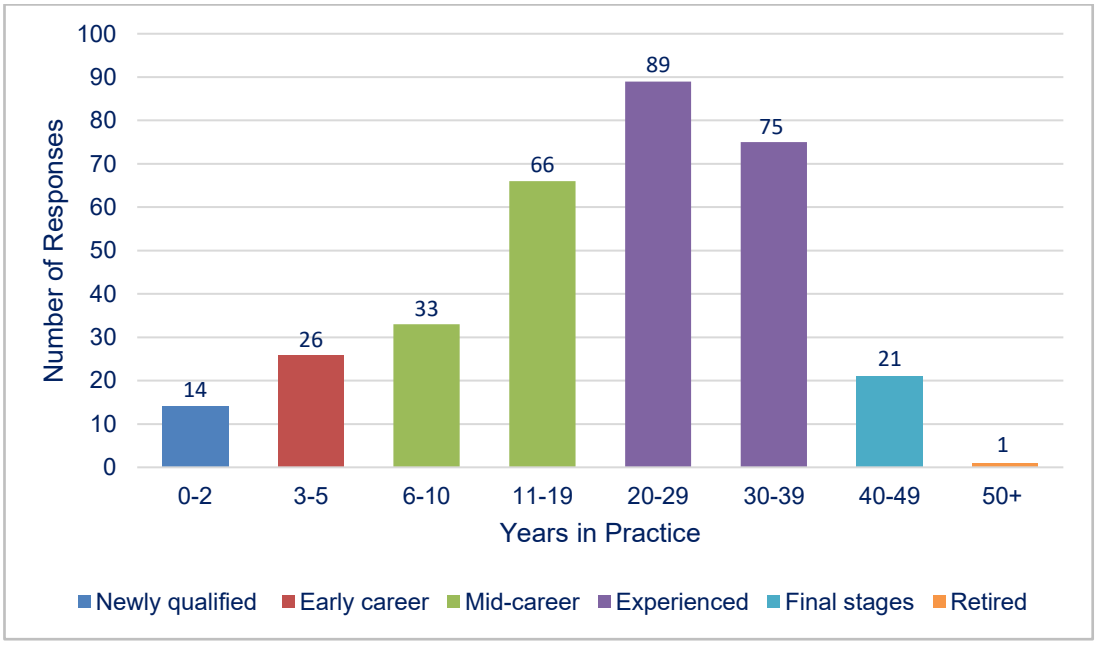

Figure 10: Survey Respondents Years in Practice
Colour depicts stage of pharmacy technician career

4.3 Participation and Roles in Peer Discussions

This section analyses the quantitative data collected from the survey on the submission of peer discussions, the roles participants played as peers and their interactions with

the revalidation framework. This analysis offers a comprehensive overview of how pharmacy technicians engage in peer discussions, both as contributors and recipients. By exploring who has acted as a peer for participants and the networks of support formed, valuable insights are gained into the collaborative and reflective practices within the profession.

The following data explain the extent of participation in peer discussions. Notably, some respondents selected more than one option or referred to multiple peer discussions or professions, resulting in totals exceeding 100%.

Almost all the respondents (291 out of 325; 90%) had completed their own peer discussion for revalidation. Of these, 97% (283 out of 291) had undertaken a one-to-one peer discussion, while 19% (56 out of 291) described experiences with group peer discussions indicating that some individuals had engaged in both formats.

Pharmacy professionals were most frequently selected as peers, with pharmacy technicians being the most common (193 out of 291; 66%), followed closely by pharmacists (172 out of 291; 59%). Nurses or midwives were the third most frequently selected healthcare professionals, with 6% (18 out of 291) of respondents having engaged them in peer discussions. It was striking that none of the respondents had used expert patients as peer suggesting this option may be unfamiliar, inaccessible or simple not preferred.

Half of the participants (161 out of 325; 50%) had acted as a peer for a pharmacy professional completing revalidation. Of these, 84% (136 out of 161) had supported another pharmacy technician.

Among those who had both completed a peer discussion and acted as a peer for another, 85% (121 out of 143) had reciprocal arrangements. In over half of these cases (77 out of 121; 64%), the respondent acted as the peer for the same individual who had supported them. Furthermore, 64% (49 out of 77) of these reciprocal discussions occurred within the same meeting, while 36% (28 out of 77) were arranged as separate sessions.

Not all completed peer discussions were submitted to the GPhC. Forty-six respondents reported having completed a discussion but choosing not to submit it. This decision was often influenced by contextual factors such as the temporary suspension of requirements during the Covid-19 pandemic. PT19 explained, “Was not required due to Covid changes in revalidation”, while PT273 noted, “Reduction in requirement to submit peer discussion due to Covid”. These responses reflect a practical response to evolving regulatory guidance, where participants completed peer discussions in good

faith but later could not submit them due to temporary changes introduced during the Covid-19 pandemic.

Other participants expressed dissatisfaction with the quality or relevance of the discussion. For example, PT62 shared, “On reflection I felt it didn't cover everything I wanted it to…another opportunity for peer discussion arose that I felt made for better CPD and development”. While PT265 commented on the limitations of peer understanding, stating, “The peer didn’t understand my role sufficiently to provide any value to the discussion”. I interpreted these reflections as highlighting the importance of role familiarity and perceived value in peer interactions.

The data also suggests that peer discussions are a frequent and embedded part of professional practice, with only the most relevant being selected for submission. PT44 explained:

> I have several peer discussions each year but the most useful tend to be with other pharmacy technicians therefore those are the discussions I submit. I learn a lot from peer discussions with other health care professionals but not necessarily sufficient for submission.

Others echoed this sentiment, noting the routine nature of such discussions: “It is something I do every month and don’t need to submit every one” (PT49). Similarly, PT75 reflected “I have peer discussions all the time within work to improve practice. I do not need to document all of them”. Participant PT122 simply stated, “I have peer discussion regularly and only choose one”, reinforcing the selective and reflective nature of submission.

These accounts highlight the preferences and behaviours of pharmacy professionals regarding peer discussion for revalidation. Participant narratives appeared to emphasise the importance of one-to-one interactions and the reliance on peers within the pharmacy profession. While the temporary suspension of revalidation requirements during Covid-19 influenced some respondents’ decisions not to submit, my interpretation of the data suggests that peer discussions remained a regular feature of professional practice, though not always within the formal context of revalidation.

This understanding of current practices and preferences sets the stage for the qualitative data analysis that follows.

4.4 Thematic Analysis and Insights

In addition to the quantitative data collected, the survey included questions to elicit free-text responses from participants, giving a voice to those who might not have wished to undertake an interview or were not selected for one. In this section, the findings and analysis of that qualitative data are explored.

Data Management

I had initially planned to use NVivo to analyse data from both the survey and interviews, and uploaded pilot data into NVivo to assess my ability to use the system. However, when comparing the pilot datasets exported from MS Forms into Excel (v.2508) with those in NVivo, I found that I could analyse the data more efficiently in Excel. Additionally, the insights function in MS Forms provided categorisation of the dataset in both table and graph formats.

I also encountered difficulties categorising within NVivo, likely due to my limited familiarity with the software, and found Excel and MS Forms to be more efficient and intuitive for my needs. After weighing the options, I decided not to use NVivo for data analysis in this study.

Instead, I used an Excel download from the MS Form survey to obtain the characteristics of the dataset. All data were stored and annotated within the university's OneDrive account in the cloud, in accordance with the DMP found at Appendix 4.

Familiarisation

Phase one of Braun and Clarke's (2006) RTA involves familiarising oneself with the data. To achieve this with the survey's free-text responses, I organised the data for each question into a table in a Word document. This table included the participant identification number, the survey question and the corresponding free-text response. An example of this can be found at Appendix 7.

Immersing myself in the data, I read through the responses twice and considered the following reflective questions:

- How were peers being characterised?
- What assumptions about peers and revalidation were being made?
- What value did peer discussion hold?

Making notes of my initial reflections, it became apparent that respondents were eager to share their experiences with only a small proportion (32 out of 325; 10%) leaving mandatory questions blank. Additionally, 70 comments were submitted in response to the optional questions, demonstrating a strong motivation of participants to provide further insight into their experiences with peer discussions.

I also observed that references to patients or person-centred care were rare, with only seven mentions across the entire dataset. This absence may suggest that peer discussions are often framed more around professional identity and practice than direct patient outcomes. Furthermore, the language used by participants reflected a sense of complexity and challenge, terms such as "challenge", "struggle" and "unclear"

appeared frequently, indicating that peer discussions are not always straightforward or easily navigated.

Coding

Phase two of Braun and Clarke's (2006) RTA involves systematically coding the data by identifying and labelling segments of text relevant to the research questions (Byrne, 2022). In this phase, I used the comments function in Word to highlight and code segments of text from the survey, an approach that allowed me to stay close to the data while beginning to organise it into meaningful categories. These initial codes shaped my early understanding of the data and supported the construction of areas I considered meaningful within the data. This developing analytic focus informed the design of the interview topic guide, allowing for a more nuanced and responsive exploration of participant perspectives.

Searching for Themes

In phase three, I began to construct broader themes by actively interpreting and grouping the initial codes in ways that reflected patterns of meaning across the dataset. Applying the first three phases of Braun and Clarke's (2006) RTA to the qualitative survey responses supported the development of initial codes and interpretive insights, some of which aligned with expectations, while others prompted new lines of inquiry. These developing patterns informed the design of the interview topic guide, ensuring that the interviews would explore a rich and nuanced understanding of the topic.

Peer Selection Criteria

Through my interpretative engagement with the survey responses, I identified a range of practices and preferences in how participants described selecting peers. These accounts reflected diverse ways in which pharmacy technicians made sense of peer discussions and the qualities they valued in a peer.

Some respondents expressed a desire to be challenged, valuing critical feedback and external perspectives. For instance, PT01 emphasised the importance of having a peer independent of their practice, often choosing someone outside the pharmacy profession to gain beneficial challenges and insights. Similarly, PT07 described seeking peers who were open-minded and capable of constructively challenging their views.

In contrast, other participants appeared to prefer affirmation of their practice, selecting peers who were familiar with their roles and could offer supportive feedback. PT65 highlighted the need for a professional who could comment on their performance and professionalism, while PT288 valued a comfortable, non-judgemental environment for discussion.

These accounts illustrate a spectrum of preferences in peer selection, from those who seek critical engagement to those who favour supportive affirmation. I interpreted this diversity as reflecting the varied professional identities, experiences and expectations within the pharmacy technician community. It also suggests that peer discussion may serve different functions depending on the relational and contextual dynamics involved.

Participants also shared assumptions and uncertainties about who qualified as a peer. Several responses reflected a narrow interpretation of the term, often assuming that peers must be from within the pharmacy profession or hold a healthcare registration. For example, PT106 assumed peers should be pharmacy professionals, while PT129 believed they should have similar professional experience. PT309 was unaware that peers from other medical specialties could be considered, and PT117 and PT214 echoed similar sentiments, emphasising the need for peers to be registered health professionals or pharmacy colleagues.

These interpretations informed the development of the interview topic guide, prompting the inclusion of expanded questions related to peer selection. The revised guide explored the factors influencing peer choice and invited participants to reflect on their understanding of the term ‘peer’ within the context of revalidation.

Constructed Meanings Beyond the Expected

This section explores how my interpretive engagement with the data led to the construction of meanings that extended beyond initial assumptions about peer discussion.

While peer discussion for pharmacy revalidation is often framed around reflection on practice, my engagement with the survey responses led me to interpret additional layers of meaning particularly around the desire for learning through peer interactions. Many participants described selecting peers not only for reflective purposes but also based on their perceived expertise or recognition within specific fields of practice, suggesting that peer discussions were valued as opportunities for targeted professional development. Some respondents actively sought out peers whose practice they admired and whom they believed could support their development as a pharmacy technician.

I also interpreted the availability of a peer as a meaningful influence on peer selection. Several respondents referred to the practicalities of choosing someone who was accessible and easy to coordinate with, indicating that logistical considerations shaped how peer discussions were enacted in practice.

These interpretations prompted further reflection on how learning opportunities and practical constraints intersect in peer selection. These areas will be explored in greater depth during the interviews, where participants will be invited to elaborate on how they navigate these dynamics in real-life settings.

4.5 Chapter Summary

This chapter has provided an interpretive overview of the survey dataset, focusing on how 325 pharmacy technicians described their experiences of peer discussion for revalidation. My reading of the demographic data suggested a diverse range of roles and experiences, which supported the purposive sampling strategy for interview selection.

Through reflexive engagement with the free-text responses, I constructed several preliminary patterns of meaning that informed the development of the interview topic guide. For example, I expanded questions related to peer selection and included prompts to explore participants' understandings of the term 'peer' within the context of revalidation.

I also interpreted several factors as shaping peer selection in practice, such as the desire for challenge, affirmation, learning opportunities and the practical consideration of peer availability. These areas will be explored further in the qualitative interviews to deepen the understanding of how pharmacy technicians navigate peer discussions in practice.

Chapter 5: Interviews

5.1 Data Collection

This section outlines the interview data collection process, including reflections on piloting and developing the topic guide, recruiting participants and engaging with the interviews. It concludes with a transition into the data analysis section.

Piloting

Building on earlier input from the pharmacist focus group, I developed an initial draft of the interview topic guide. This was followed by a series of pilot interviews, designed to refine the guide, enhance my interviewing technique and familiarise myself with conducting interviews in an online setting.

The first pilot interview involved a mid-career pharmacist working four days a week, with a background spanning community pharmacy and education. The interview was conducted on MS Teams, using the same communication and booking system intended for the main study. This allowed me to test the logistical workflow, including scheduling, consent procedures, recording and transcription. The session was recorded and automatically transcribed, enabling me to evaluate the technical setup and the clarity of the transcript output.

This initial pilot highlighted several areas for reflection. I was unclear about procedures for obtaining verbal consent and recording. In response I began the session by reading the consent statements without offering an introduction or explanation, and I had not shared the statements with the volunteer beforehand. The volunteer noted that the consent process felt overly long and impersonal. During the interview, I found it challenging to balance open dialogue with the structure of the topic guide, particularly when the conversation diverged from the expected sequence. At times, I struggled to avoid unintentionally leading participants and recognised missed opportunities to explore less immediately engaging topics. I also became aware that some of my affirmations may have reflected my own assumptions, a realisation that prompted deeper reflexivity about how my positionality shaped the co-construction of meaning during the interviews. The conversation occasionally felt awkward and I found it difficult to sit with silence, which may have limited the depth of some responses.

Following this initial pilot, I reflected on the process in discussion with the volunteer and, through a collaborative exchange, deepened my understanding of the relational dynamics at play. I shared the transcript with my supervisors and consulted key literature on qualitative interviewing (Clark et al., 2021; Denscombe, 2017; Kvale,

2006). I also presented my progress to peers and incorporated their feedback to further refine my approach.

The second pilot involved the original volunteer from pilot one, along with two additional pharmacists. These included a newly qualified pharmacist (under one year post-qualification) working in a hospital setting and an experienced pharmacist with a background in community and primary care now working in education. Two of the three volunteers worked part-time. The second pilot took place online but was not recorded. This pilot provided a broader range of perspectives and allowed me to test the revised topic guide across different career stages and practice settings.

In preparation for the second pilot, I revised the interview guide and took time to familiarise myself thoroughly with its content. To support the development of my interviewing style, I engaged with Kvale's (1996) ten qualities of a successful interviewer: being knowledgeable, structuring, clear, gentle, sensitive, open, steering, critical, remembering and interpreting. This framework offered a lens through which to reflect my evolving practice, rather than as a checklist for evaluation.

As Clark et al. (2021, p.433) observed, the piloting process supported a more balanced and responsive approach and I became more comfortable with silence and more attuned to the rhythm of the conversation, which in turn nurtured richer exchanges and deeper engagement.

The pilot phase was conducted prior to transfer, the formal progression point into the research stage of the DClinEd, and ethical approval, as pharmacists were not the primary focus of the research and the pilot data were not intended for inclusion in the final study. Nonetheless, the experience enriched my transfer discussions by offering experiential insights into both survey and interview practices.

Developing the Interview Guide

In developing the interview guide for my semi-structured interviews, I drew on feedback from the pilot phase alongside reflections generated through engagement with the qualitative survey results. These interpretive insights prompted several refinements to the topic guide, including the expansion of questions related to peer selection.

Specifically, I introduced probes to explore participants' interpretations of the term 'peer' within the context of the study. Feedback also highlighted the perceived importance of learning opportunities and the practical implications of peer availability, prompting the inclusion of questions designed to explore these areas in greater depth.

Through this iterative and reflexive process, the interview guide became more attuned to the nuances of participants' accounts and the relational dynamics shaping the

experiences. Rather than seeking to improve the guide in any objective or standardised sense, these refinements supported a more dialogic and situated approach to co-construction understanding within the interview space. A summary of the final version of the interview guide, reflecting these developments, is provided in Appendix 8.

Recruitment of Participants

Following the closure of the survey, I reviewed participants' responses to identify individuals for potential interview participation. Of the 325 respondents 81 (81 out of 325; 25%) expressed a clear interest in being interviewed, while a further 51 respondents (51 out of 325; 16%) indicated potential interest. This resulted in a total of 132 volunteers (132 out of 325; 41%) entering the sampling frame, as outlined in Section 3.7.

In the first round of recruitment, three participants from each sector and country of practice were invited to take part in interviews. Invitations were sent via email on 2nd May 2023, accompanied by participant information and a MS Bookings link, followed by a reminder four weeks later. By the end of this round, only pharmacy technicians from England had scheduled interviews. However, one Welsh and one Scottish pharmacy technician, both from community settings, responded separately to request alternative interview dates due to annual leave.

A second round of recruitment began on 12th June 2023, using the same process, with the aim of supporting the sampling frame's intended distribution. In total, nine individuals booked interviews across all three sectors and countries of practice. The first interview was conducted on 24th May 2023, and the final interview took place on 19th June 2023.

Interview participants brought a wide spectrum of professional experience, ranging from newly qualified pharmacy technicians with less than two years in practice to those with over 50 years in the profession. This diversity supported the study's aim of capturing varied perspectives across careers stages. Full demographic details, of the interview participants, are provided in Appendix 9.

Reflections on Interviews

Reflecting on the interview process, I found it both demanding and mentally taxing particularly when conducting multiple sessions in close succession. Maintaining focus and distinguishing between individual conversations became increasingly difficult, prompting me to recommend limiting interviews to one per day to allow space for transcription and reflective engagement.

My interviewing approach developed progressively over time. Analysis of early transcripts found that verbal interjections such as "yes" or "interesting" occasionally

disrupted the conversational flow. However, when reviewing the video recordings, I observed that participants remained engaged despite these comments. This observation, supported by Rees et al. (2024), encouraged me to adopt more non-verbal forms of feedback, which helped preserve the natural rhythm of the dialogue. I also became more confident in gently steering conversations back to the topic of revalidation when participants diverged.

Participants joined the interviews using a variety of devices and settings, which raised some concerns around privacy. In some cases, virtual backgrounds obscured their actual environments, limiting my ability to interpret contextual cues. While I could not visually confirm whether participants were in private spaces, the overall tone and openness of their responses suggested they were comfortable. Most interviews were conducted at home, typically after working hours, which may have contributed to a sense of ease and familiarity.

Despite these challenges, the use of MS Teams enabled a geographically diverse sample, with participants ranging from Bristol to the Scottish Highlands. Technical issues were rare and typically involved brief disconnections, occurring no more than twice in a single session involving a mobile device. These were quickly resolved and had minimal impact on the overall flow of the conversation.

More broadly, the use of online interviews offered notable advantages in terms of accessibility, flexibility and convenience, both for me and for participants. Many appreciated the opportunity to join from a familiar environment, which may have contributed to a sense of ease when discussing professional experiences. While building rapport can be more challenging in virtual settings, this was mitigated by asking participants to keep their cameras on, and the video quality remained consistently high throughout (Rees et al., 2024). Some studies suggest that rapport and non-verbal communication can still be effectively established online, particularly when video is used and participants are engaged (Archibald et al., 2019; Lobe et al., 2022). Nonetheless, the absence of physical presence limited the ability to fully interpret subtle non-verbal cues which are often valuable in qualitative interviewing. This made it essential to revisit the recordings while reading the transcripts, allowing me to attend more closely to communicative dynamics such as intonation, silences and body language (Carter et al., 2021).

Interviews averaged 39 minutes in length, aligning well with the 90-minute upper limit suggested by McGrath et al. (2019). Following their tenth tip, which highlights the value of transcribing interviews promptly to preserve contextual detail and support early interpretive engagement, I aimed to complete transcription shortly after each session.

The transcription software proved efficient, particularly as I refined my technique to reduce interruptions, making the process significantly smoother than manual transcription.

Overall, these reflections highlight the importance of adaptability, reflexivity and ongoing development in conducting qualitative interviews.

5.2 Analytical Approach: Reflexive Thematic Analysis (RTA)

Building on Braun and Clarke's (2022) framework for RTA, the following sections detail the analytical process undertaken to engage with the interview dataset. Through thoughtful and reflexive engagement with the six phases of the framework, I moved from initial familiarisation with the data towards the development and refinement of themes that reflected the complexity and nuance of participants' accounts.

This iterative and interpretive process supported a rich and situated exploration of meaning, allowing for the construction of themes that were coherent in relation to the dataset and resonant with the broader research aims. The flexibility of the RTA framework enabled ongoing reflexivity, encouraging continuous questioning, re-engagement and attentiveness as to how my own positionality shaped the analytic process.

The subsequent sections detail each phase of the analysis, illustrating how themes were actively developed through sustained interpretive engagement with the data.

Phase One (Familiarisation)

This section outlines my experiences during the initial phase of data analysis, with attention to key reflections and limitations encountered throughout the process.

Following each interview, I began the familiarisation phase by watching the recording within 24 hours, deliberately avoiding the transcript at this stage. This approach enabled a more direct engagement with participants' tone, pacing and expressions. I recorded reflective notes and cross-referenced relevant free-text responses from the survey to consider how the interview format shaped the nature and depth of participants accounts. In line with McGrath et al.'s (2019) twelfth tip for conducting qualitative interviews, which advocates for early analytic engagement, this immediate interaction supported a more nuanced and situated interpretation of the data. Notably, both datasets reflected similar patterns of content and omission, with limited references to person-centred care or the perceived benefits of peer discussions for patients.

I then re-engaged with the recordings through audio-only review and examined the transcripts. I corrected transcription errors and anonymised any identifiable information. A final review incorporated non-verbal cues such as gestures, after which the

transcripts were finalised. This familiarisation process was completed within one week of each interview, supporting a more grounded and reflexive transition into the coding phase.

To explore potential tools for analysis, I initially uploaded pilot interview transcripts into NVivo to familiarise myself with its features. However, I observed a tendency to reuse existing codes, a pattern that risked shaping theme development prematurely. To maintain a more inductive and reflexive approach, I chose not to use NVivo for the main analysis.

Instead, I used an Excel export from MS Forms to manage dataset characteristics and a Word export of MS Team transcripts for manual coding. All data were securely stored and annotated within the University's OneDrive cloud environment, in accordance with the DMP at Appendix 4.

Phase Two (Coding)

After familiarising myself with the data and recording initial reflections, I began generating initial codes, drawing on the step-by-step approach outlined by Sullivan and Forrester (2019), which emphasises active engagement, reflexivity and iterative coding. I used the comment function in MS Word to annotate segments of the interview transcripts that I found conceptually or emotionally resonant, applying descriptive code labels to support early interpretative engagement with participants' accounts.

I approached coding with an open and exploratory mindset, aiming to develop a broad understanding of my fellow pharmacy technicians' experience. In line with Merton's (1972) insider-outsider concept, I remained mindful of my own professional positioning and sought to avoid interpreting the data solely through the lens of my own practice. Instead, I focused on what was present in participants' narratives, allowing their voices to guide the analytic process.

Initially, I applied codes to a single transcript, working iteratively through the narrative. However, I found that overly brief code labels lacked clarity and made it difficult to engage meaningfully with the data. I revised my approach, refining the labels to more accurately reflect the content and context of each coded segment.

Transcripts were coded in the order they were saved in OneDrive. A second pass through the data allowed me to refine and consolidate the code labels. At first, I generated 285 unique codes, a volume that proved unwieldy and difficult to manage. Following discussion with my supervisors, I revisited the coding process with a more focused lens, attending to data that was meaningfully connected to the research questions and paying particular attention to contradictory or divergent codes. This

reflexive step, supported by Clark et al. (2021), helped me ensure that less dominant, yet potentially valuable, insights were not overlooked.

To streamline the coding process, I developed a macro to extract code labels and their corresponding data extracts from the Word transcripts. This automated approach generated a colour-coded Excel spreadsheet, offering a clear and organised visual overview of the coded data. By structuring the output into three columns: code label, data extract and transcript reference, and applying colour coding, I was able to manage and navigate the dataset more efficiently. This method proved particularly valuable in supporting my workflow as a part-time student, allowing for quick access and systematic analysis.

An example of the macro-generated output is presented in Figure 11, illustrating how the data were structured and visually represented in Excel.

C	D	E
Code Label	Participant	Quotation
Ideas develop with unknown peers	PT191	I was looking for someone at this at the same level as me, but quite new in their role as well
Informal formality	PT314	informal really really works for me .
Informal formality	PT208	it is formal, but at the same time we try and keep it as informal as we can and just have a chat
Informal formality	PT208	it's a cup of tea chat and an official write down on a piece of paper

Figure 11: Data Extracted Using Macro
Colour denotes the interview participant

Upon further review, I recognised that my initial coding was overly granular, which limited my ability to interpret broader patterns across the dataset. To address this, I recoded the interview transcripts using larger data extracts, allowing for a more contextualised understanding of meaning with participants' narratives. This shift in approach enabled me to better assess the significance of each code in relation to the wider analytic story. By merging duplicate codes and consolidating similar ones, I reduced the number of unique code labels from 285 to 67. This refinement marked a key transition into Phase Three of Braun and Clarke's framework, where I began developing initial themes from the collated codes.

Phase Three (Generating Initial Themes)

Braun and Clarke (2022, p.35) emphasise that themes are actively created by the researcher through "deep and sustained engagement" with the data. Guided by this principle, and following my supervisors' advice, I stepped away from digital tools and printed out the code labels. I physically arranged the codes on the dining room table, manually grouping them in ways that reflected my developing interpretations. Some groupings felt intuitively connected, while others required more deliberate reflexive considerations to construct meaningful patterns and relationships.

Using large sheets of paper, I clustered codes and annotated them with possible themes and subthemes, as illustrated in Figure 12. These images are included to demonstrate the analytical process visually; the text within them is not intended to be read, as the full, legible coding tables are provided in Appendix 10. To further develop these groupings, I transferred the codes onto larger cards using the reverse side to record interpretive notes, reflections and developing ideas about possible meanings. These cards were then reviewed for shared concepts and thematic coherence, in line with Braun and Clarke's (2022) guidance on theme development.

Figure 13 presents the initial iteration of themes, subthemes and associated codes across the dataset. Again, the purpose of this figure is to illustrate the development process rather than provide readable data; the full, legible coding tables are provided in Appendix 10. Colour coding supported the visual organisation: yellow cards represented research questions, green indicated theme ideas, blue denoted codes that were also constructed during analysis of the survey dataset and white represented codes drawn from interview transcripts only.

Figure 12: Physical Coding on Dining Room Table
Illustrative image showing the manual grouping of codes. Text not intended to be legible; iterations of code development in Appendix 10.

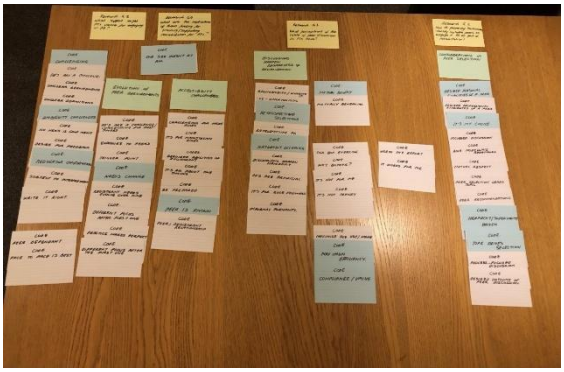

Figure 13: Initial Iteration of Themes

Illustrative image showing early theme development. Text not intended to be legible; iteration of theme development in Appendix 10

Transcripts and developing themes were shared with my supervisors, who offered feedback and critical reflections. These discussions informed subsequent analytic decisions, including summarising themes, revisiting subthemes and exploring patterns of thematic commonality across the dataset.

While concurrently conducting my literature review, I engaged with published examples of coding and thematic analysis (Attride-Stirling, 2001; Byrne, 2022), which helped shape my analytic approach. Attride-Stirling's (2001) thematic network framework offered a structured way of visualising themes and their interconnections, while Byrne's

(2022) reflexive account provided insight into the iterative and interpretive nature of theme development. These works supported my understanding of how to move beyond surface-level coding to develop rich, nuanced themes grounded in participants' accounts.

I repeatedly returned to the data to ensure that the themes and subthemes remained grounded in participants' narratives. I also shared developing ideas with my mentor and fellow postgraduate researchers during developmental meetings. Over the course of five months, the themes and subthemes evolved through several iterations, culminating in a version I felt confident to carry forward into Phase Four: developing and reviewing themes.

Phase Four (Developing and Reviewing Themes)

Braun and Clarke (2022) emphasise that themes are not discovered but actively created by the researcher through deep engagement with the data and that it is common for themes to evolve throughout the analytic process. In line with this, and following continued reflection and supervisory feedback, I revisited the transcripts and critically reviewed the initial themes and subthemes. As Braun and Clarke (2022, p.35) encourage, I was prepared to "let things go", reassessing the character of each theme and focusing on its central organising concept.

The initial theme of 'influences when selecting peers for peer discussion', began to feel more like a code than a theme. It lacked the conceptual scope to capture the broader patterns of meaning constructed through the analysis. Participant accounts reflected wider strategies for forming meaningful peer connections, shaped not only by selection criteria but also by factors such as registrant abilities, working environments and job roles.

Similarly, the theme of 'perceived value of peer discussions' appeared to mirror the research question rather than reflect the analytic story constructed from the data. It did not capture what Braun and Clarke (2022, p.112), describe as the "essence of the theme". I interpreted the associated codes as reflecting strategies for meaningful engagement and a desire for professional development. This led me to rework the theme to focus on both structured and unstructured forms of engagement, as well as the perceived value of using evidence effectively.

The initial theme of 'regulator rules' was also reconsidered. Upon review, the codes related to compliance were redistributed across other themes, reflecting the regulator's influence as a cross-cutting concept rather than a standalone theme.

This iterative process, supported by ongoing discussions with my supervisors and continuous reflexive engagement, ensured that the final themes and subthemes more accurately represented the analytic story constructed from participant's accounts. After several rounds of revision, I moved confidently into Phase Five to continue reviewing and refining the themes.

Phase Five (Refining, Defining and Naming Themes)

Building on the interpretive insights developed during Phase Four, Phase Five focused on reviewing and refining the themes and subthemes to ensure they accurately reflected the analytic story constructed from participants' accounts and meaningfully addressed the research questions. This phase involved a detailed and iterative process of fine-tuning, during which I revisited the coded data to assess the coherence and distinctiveness of each theme. Related codes were consolidated, and theme and subtheme names were revised to better reflect their central organising concepts. This process supported the development of a thematic structure which was both conceptually robust and grounded in the participants' narratives.

Although the second iteration of the themes and subthemes more closely reflected the analytic direction, I remained uncertain about the clarity and resonance of some theme names. To address this, I revisited Braun and Clarke's (2022, p.111) guidance on naming themes which recommends using "informative, concise and catchy phrases" that capture the essence of each theme. During this whole process, I developed tables to document the evolution of the themes and subthemes, which are presented in Appendix 10 and Appendix 11.

The refined themes and subthemes were then aligned with the research questions to ensure a cohesive and reflexively constructed analysis that remained attentive to participants' perspectives.

Figure 14 illustrates the third iteration of the thematic structure, using colour-coded cards to visually represent the analytic framework: yellow for research questions, pink for themes, green for subthemes, blue for codes also constructed across both the survey and interview datasets and white for codes unique to the interview transcripts. This figure is included to demonstrate the analytic process visually; the text within the image is not intended to be read, as the full, legible thematic tables are provided in Appendix 11.

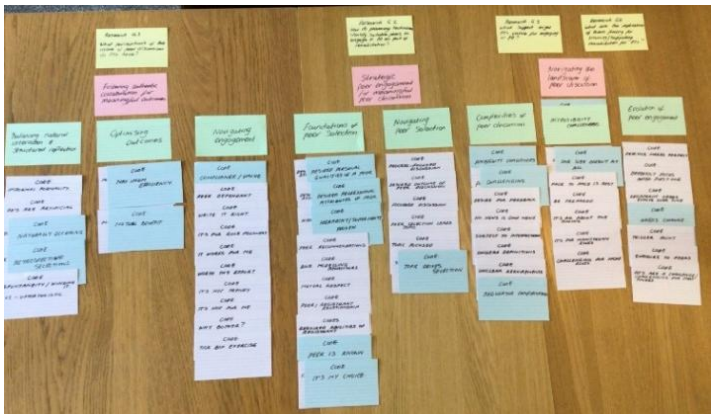

Figure 14: Third Iteration of Themes
Illustrative image showing the refinement of the thematic structure. This text is not intended to be legible; full thematic tables are provided in Appendix 11.

Finally, I developed a thematic map to visually represent the interrelationships between the refined themes and subthemes (Figure 15: Thematic Map, presented on the following landscape page). These interconnections are central to understanding the dynamics underpinning effective peer discussions for revalidation.

Key	Themes	Subthemes	Relationship to Theme	Interrelationships

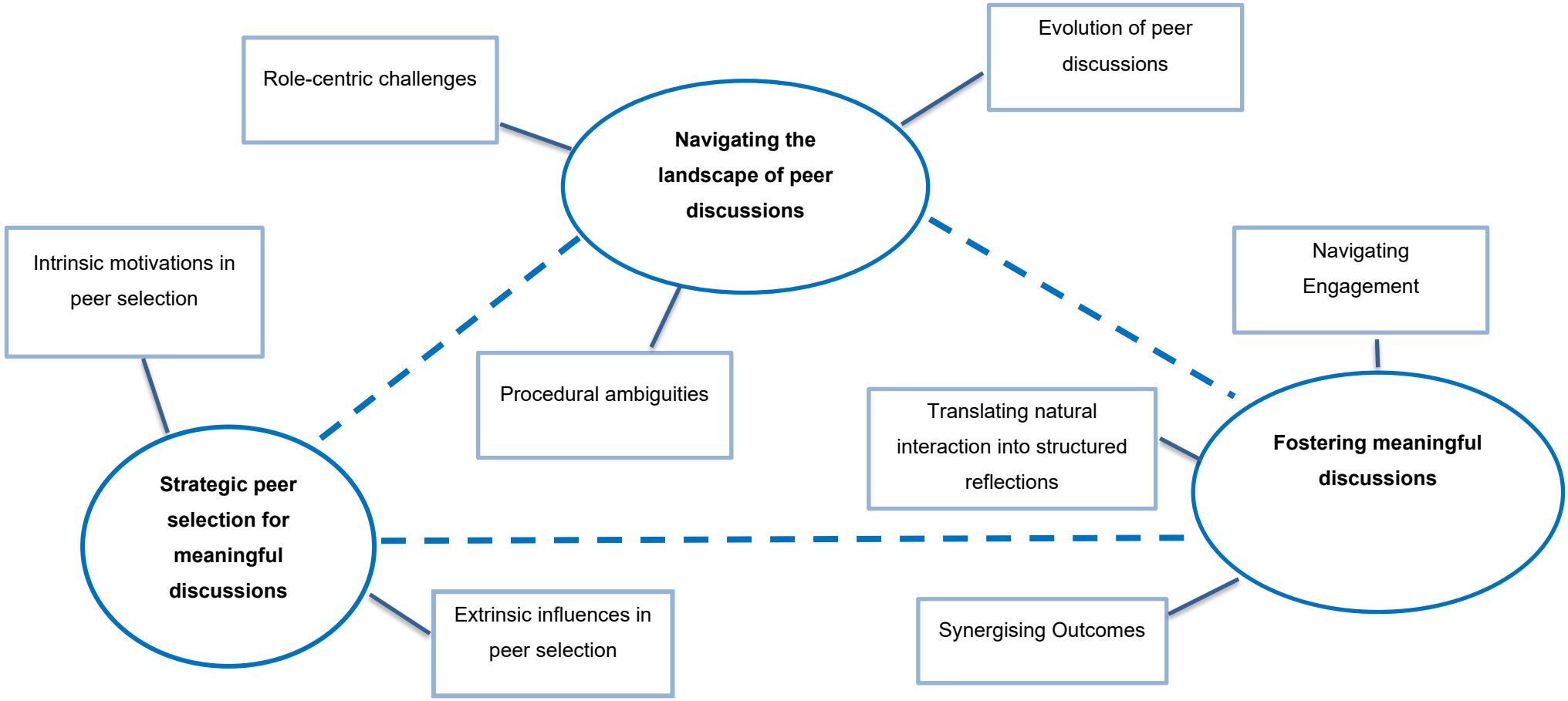

Figure 15: Thematic Map

The success of peer discussions appears to be shaped by the dynamic interplay of multiple thematic elements, each reinforcing and amplifying the others. For instance, fostering meaningful discussions was contingent on the presence of a supportive and well-managed environment. Without this foundation, opportunities for rich, reflective dialogue were diminished. Likewise, strategic peer selection enhanced the depth and relevance of discussions by ensuring that participants could contribute valuable insights and experiences.

The interplay between these themes created a synergistic effect, where each theme informed and strengthened the others, contributing to a more impactful and sustainable peer discussion process. These final themes are explored in detail in Chapter 6, where they are discussed in relation to the study's findings.

5.3 Chapter Summary

This chapter has provided a reflexive account of the interview dataset, highlighting key insights constructed through engagement with the narratives of nine pharmacy technicians. Using Braun and Clarke's (2022) RTA framework, I developed themes and subthemes that were aligned with the research questions and visually represented through thematic mapping. The analytic process supported the dynamic and evolving nature of theme development, ensuring that the final thematic structure was both conceptually coherent and grounded in participants' account.

In the next chapter, I will move into Phase Six of Braun and Clarke's (2022) framework, where I weave together the analytic narrative with illustrative data extracts. This synthesis will offer a detailed and interpretively constructed account of the findings, presenting a narrative that reflects my engagement with participants' experiences and the patterns of meaning developed through the analytic process.

Chapter 6: Analysis and Interpretation of Findings

Following, Phase Six of Braun and Clarke's (2022) RTA, this chapter presents an interpretative account of the themes developed through my active and reflexive engagement with participants' narratives. The analysis reflects not only how participants made sense of peer discussion within their professional practice, but also how I, as the researcher, interpreted those accounts through an iterative process.

The chapter is organised around the themes and subthemes that were constructed during the analytic process described in Chapter 5. Each theme is presented as a coherent story, supported by illustrative quotations and interpretative commentary that seeks to capture the complexity and nuance of participants' experiences. While subthemes are presented as distinct categories for clarity, they often contain layered patterns and overlapping ideas. In some cases, finer-grained groupings were developed within subthemes, reflecting the diversity of perspectives and contexts shared by participants.

To support the writing of this chapter, I returned to data extracted from the interview transcripts using the macro described in Chapter 5. By applying filters within the macro-generated spreadsheet and specifically filtering for codes attributed to themes and subthemes, as detailed in Appendix 11, I was able to identify key participant transcripts for closer examination. This approach proved time-efficient and enabled a focused reengagement with the data to ensure that the selected quotations were both representative and analytically meaningful.

6.1 Theme 1 - Fostering Meaningful Discussions

This theme reflects my interpretation of how pharmacy technicians perceived the role and value of peer discussions. Participants described these conversations not only as opportunities for learning and support but also as spaces where professional identity, confidence and shared understanding could be shaped.

The following subthemes offer insight into the varied ways participants engaged with peer discussions, from how informal exchanges were translated into formal reflections, to navigating the relational and contextual factors that shaped their participation. In this chapter, I use relational to describe the emotional and psychological dimensions of professional relationships, not just communication or social skills, but the deeper dynamics of trust, vulnerability and identity that influence how individuals connect and reflect with one another.

Subtheme 1.1 - Translating Natural Interactions into Structured Reflections

Many participants described submitting incidental conversations that occurred during their everyday work, as their peer discussion for revalidation. These interactions were valued for their immediacy and authenticity, offering real-time support, shared problem solving and emotional reassurance. Within this subtheme, participants' accounts reflected a range of relational dynamics, from spontaneous exchanges with trusted colleagues to more tentative interactions shaped by organisational culture and role boundaries. These variations are explored throughout the analysis, illustrating how informal conversations can carry different meanings and impacts depending on context

Some participants recognised, in the moment, that these informal exchanges could be used for revalidation. PT73 reflected: "It was more of an incidental peer discussion, to be honest, that I used… it wasn't planned". Similarly, PT150 recalled mid-conversation thinking: "Oh, we could use this as our peer discussion".

Others described asking for permission retrospectively, as PT275 explained: "Would you mind, can I use this as my peer discussion"? Whereas PT314 described a more fluid process:

> The peer discussion, you know, comes out naturally as a part of my learning and then from that I'll think, oh I could use that, so that's how it goes for me.
>
> I've never gone, 'Oh right, we need to do this for a for a peer discussion, you know. Let's think about this for a peer [discussion]', that's never happened to me.

These discussions were often described as frequent and embedded in daily practice. PT191 noted, "We have these conversations all the time, don't we?" While PT276 added, "We do have peer discussions that are occurring naturally", though they acknowledged that revalidation discussions required more structure, as the incidental conversations "don't do the reflection and planning bit".

While many valued the spontaneity of these interactions, some expressed discomfort with the formalisation of what felt like natural conversations. PT307 shared:

> I think I have found it beneficial having those conversations…[but] stilted conversations…too structured. Is it a little bit forced maybe?
>
> Making it quite a formalised process as opposed to a descriptive process of something that happened.

Some described retrospectively selecting conversations and framing them as peer discussions. PT73 admitted: “I read that [the guidance] after the fact and thought, yeah it [the discussion] probably it does fit the criteria”. Whereas PT314 described the pressure of revalidation deadlines on selection:

> And then I find myself sort of four months towards the end, OCD kicking in, 'Oh right, now I need to write’ and then I'm having to really think. ‘Could I use that? Will they [GPhC] say yes. Is it going to be enough?

The process of formalising these reflections, especially when prompted by revalidation requirements, could feel artificial or disconnected from the original intent. PT208 described it as: “A cup of tea, chat and an official write down on a piece of paper”. PT307 echoed this sentiment:

> You’re almost doing, you’re reflecting... you’re choosing something that could be... but it might not be [meaningful] because you have to do it.

These narratives appeared to suggest a tension between the regulatory expectations of peer discussion as a planned, purposeful and reflective activity and the ways in which participants often engaged with it in practice. Rather than initiating discussions with revalidation in mind, many participants retrospectively identified everyday conversations as suitable for submission. This retrospective approach could create discomfort or uncertainty, particularly when participants questioned whether their chosen examples would meet the GPhC’s criteria.

While participants often valued the spontaneity and authenticity of peer conversations, the process of retrospectively framing these interactions for revalidation, particularly under the pressure of deadlines, could feel uncomfortable or forced. This tension did not necessarily undermine the value of the conversations themselves but rather highlights the challenge of aligning naturally occurring dialogue within the formal expectations of regulatory documentation.

Subtheme 1.2 - Synergising Outcomes

Despite the tensions described in in the previous subtheme, many participants sought to make peer discussions both efficient and meaningful. One strategy involved aligning them with existing professional activities, such as annual appraisals, training reviews or service development meetings. This integration allowed peer discussions to serve multiple purposes, reducing duplication and enhancing perceived relevance. These accounts reflect varied approaches to integration, shaped by participants roles and working contexts and are explored in the analysis that follows.

As PT208 explained: “I am aware that I need a peer discussion and it falls lovely in time with my appraisal”. PT276 described a similar approach, using a reflection on a

workforce project to meet the peer discussion requirement, “Tick off two things at once” and PT191, seeking feedback on a quality improvement project, described combining this with their peer discussion, “Two birds, one stone”.

I interpreted this approach as reflective of how pharmacy technicians often work holistically seeking to maximise value and efficiency across tasks. Rather than viewing peer discussion as an isolated requirement, participants appeared to embed them within broader professional conversations, enhancing both relevance and practicality.

Beyond efficiency, participants also described peer discussion as meaningful when they were mutually beneficial. When well-matched, both the registrant and the peer could gain insight, support and professional growth. PT191 described a discussion with a nurse colleague as “mutually beneficial”, noting that the exchange offered fresh perspectives and helped validate their own practice.

PT275 also chose a nurse as a peer, explaining:

> I think we chose, it was weight management and the issue was weight management, and we both thought that, because I think she used that for her CPD as well.

Although this would not meet the requirements for nursing revalidation, which stipulate that the peer must be another NMC registrant, it highlights how participants valued reciprocal learning and shared reflection.

PT73’s peer was in a similar management role, and the topic discussion was “Sort of introducing him to [the department] so he he'd been here a couple of weeks or months and he knew basically what we did”, suggesting that the conversation was beneficial for both parties, particularly in terms of orientation and role development.

Peer discussions were also described as confidence-building. PT96 reflected that before their first peer discussion, they were: “Not sure there’s really much value in this” but after completing it, they felt it was:

> Probably more useful than a lot of CPD that I’ve done because it then actually triggered bits of CPD as well…it gave me more confidence in what I was doing and that I was doing the right things for revalidation as well.

PT191 similarly noted “It's [peer discussion] supported my confidence more than anything”. While experienced pharmacy technician PT307 shared: “It's given me confidence” but acknowledged: “I might well have asked that person that question anyway”. I understood these accounts to reflect that the value lay in the conversation itself, rather than the formal peer discussion process.

Through my analysis, I understood participants narratives as reflecting how pharmacy technicians actively shaped peer discussions to align with their professional context and values. Rather than treating them as a bureaucratic task, many found ways to embed them meaningfully into existing practices, enhancing their utility.

Subtheme 1.3 - Navigating Engagement

Engagement with peer discussions varied widely across participants, shaped by individual motivations, working environments and perceptions of value. While some pharmacy technicians described the process as empowering and affirming, others were more hesitant, questioning its purpose or treating it as a procedural requirement. Within this subtheme, participants' accounts reflected a spectrum of engagement, from enthusiastic adoption to reluctant compliance, shaped by factors such as confidence, organisational culture and previous experiences with reflection. These nuances are explored in the analysis that follows, highlighting the diverse ways peer discussion was understood and enacted in practice.

Several participants spoke positively about the experience. PT314 described feeling "influenced" after a particularly supportive exchange, while PT276 saw peer discussion as, "A nice way of doing something different and it's catering to different learning styles".

Additionally, PT191 valued the opportunity to learn from others: "It's always good to hear how other people have dealt with separate situations as well".

In contrast, others expressed uncertainty or disengagement. For some, the purpose of peer discussion was unclear, or felt like a "tick-box" exercise. PT73 reflected: "I probably thought tick box, this'll do". Interestingly, PT314 offered a more conflicted perspective while describing peer discussion as influential, they also admitted: "So, I just followed the guidelines, the guidance and submit and then you know, that's fine. You're on the register another year".

I interpreted these accounts as illustrating that engagement is not automatic, it is shaped by how meaningful and relevant the process feels to the individual. PT307 raised concerns about the relational nature of peer discussion, asking: "Obviously, it [peer discussion] could be quite short-lived. So how do you build up that that rapport over a short period of time"?

The format of the discussion also influenced participants' comfort and perceived value. Several expressed a preference for face-to-face conversations, describing them as more personal, honest and conducive to trust. PT191 noted, "I find the Teams [virtual] very difficult. I really do. I find it very impersonal". They also described

a well-being suite where face-to-face peer discussions took place: “We've got a lovely well-being suite, but it's very, quite fancy, you know. It's nice, big comfy chairs…it’s got a fancy coffee bar and everything”, which they felt made the discussion, “more informal for me”.

Others, particularly those in remote or part-time roles, found remote discussions more practical. PT96 explained that their peer discussion took place on MS Teams, “Purely based on geography and convenience” though they added: “I always prefer face-to-face but I think that’s just preference rather than feeling either way is better”.

PT150 had completed a face-to-face but noted: “Not averse to Teams [virtual] because we use it a lot now…it’s actually become the norm”.

PT307 used the telephone for their discussions. They worked remotely and are in the later stages of their career and reflected on the narrowing of their professional network:

> As you advance in your career in your, [I] suppose your scope of practice narrows a little bit…you're not [as] exposed to a wider number of people.

I interpreted the availability of suitable peers as often driving the format used. Regardless of preference, this availability was a key factor in shaping how and with whom discussions occurred.

Across the interviews there was a sense that peer discussions were valued by participants. PT150 described how peer discussion helped them: “Provide a better service to both the staff and the customers…be a better person and better employee”.

PT96 reflected on the importance of continuous development:

> Standing still…you’re at risk of all sorts of patient safety things…the whole revalidation thing is about making sure you’re always up to date…being the best you can be and making sure patients are safe.

These were among the few references to patient safety across the dataset, which I interpreted as suggesting that while peer discussions were often framed in terms of personal or professional growth, their potential impact on patient care was less frequently in the foreground.

Some participants described a snowball effect, where peer discussion prompted further learning. PT275 noted: “Actually, since that peer discussion on that, I went back and did another planned CPD to update my knowledge on it”. I understood these accounts to reflect how CPD and peer discussion requirements were experienced as intertwined and mutually reinforcing.

PT73 spoke about the value of the discussion itself as “The process of talking through something… a conversation that we enjoy”. Over the course of the interview, this participant appeared to reflect more deeply in the role of peer discussion in their practice. Initially, they described it as:

> Probably the part of CPD that holds the least value for me… I don't know how much value I hold when it comes to the revalidation,

but later acknowledged:

> I think it’s valuable, but I think it's probably poignant for me to say that now I've placed that value on it, to make sure that I'm having the right peer discussion (PT73).

I interpreted this shift as the interview itself serving as a reflective space, prompting the participant to reconsider how they approached peer discussion and what influenced their engagement. However, it is noteworthy that at the end of the interview, this participant asked whether the interview could be used as their peer discussion and requested to list me as their peer. I declined this request, as the conversation had not begun with the intention of fulfilling the GPhC peer discussion requirements. My role in this context was that of a researcher conducting an interview, not a peer engaged in a structured revalidation discussion. To maintain the integrity of both roles, I felt it was important to preserve that distinction.

Thematic Summary

This theme reflects my interpretation of how pharmacy technicians made sense of peer discussions as both a regulatory requirement and a meaningful professional interaction. Across the subthemes, participants described how informal, everyday conversations were retrospectively framed as peer discussions, introducing tensions around structure, purpose and authenticity. While some found this process confidence-building and professionally affirming, others experienced it as procedural or disconnected.

Participants also described strategic efforts to embed peer discussions within existing professional routines, such as appraisals, enhancing their relevance and creating opportunities for mutual benefit. However, engagement was not uniform. It was shaped by individual motivations, experiences and access to peers. These accounts suggest that the value of peer discussion is not fixed or inherent, but constructed through contextually situated practices that balance authenticity, efficiency and regulatory compliance.

This theme contributed to answering research question one: “What perceptions of the value of peer discussions do pharmacy technicians hold”? Offering insight into how

value is constructed through everyday practices, shaped by both professional context and regulatory expectations.

6.2 Theme 2 - Strategic Peer Selection for Meaningful Discussions

This theme presents my interpretative account of how pharmacy technicians constructed the act of choosing a peer for revalidation. Selection was shaped by trust, familiarity and shared understanding, yet participants also navigated hierarchal dynamics, professional expertise and contextual constraints in making these decisions.

Rather than treating peer selection as incidental, participants frequently framed it as purposeful anchored by a desire to engage in psychologically safe and professionally enriching dialogue. Decisions were guided by personal motivations and situated factors such as the topic of reflection, the peer's experience and the quality of the working relationship.

The following subthemes explore how pharmacy technicians negotiated this interplay between internal drivers and external forces, describing how peer selection is not a fixed or uniform practice, but a socially situated one, constructed through experience, availability and evolving interpretations of what it means to be a peer.

Subtheme 2.1 - Intrinsic Motivations in Peer Selection

Participants frequently described peer selection as rooted in personal values, particularly trust, mutual respect and familiarity. These attributes were constructed as key enablers of psychological safe discussions. Within this subtheme, participants' accounts reflected varied interpretations of what made a peer "safe", from long-standing professional relationships to shared roles, informal rapport or perceived emotional intelligence. These distinctions are explored through the examples that follow, illustrating how peer selection was shaped by relational dynamics and individual judgement.

PT208 reflected, "Trust is the biggest part, to feel safe to have that conversation with the individuals", further noting a reluctance to choose someone with whom they lacked a strong working relationship. Interestingly, they also expressed discomfort with selecting someone they were "too close to", suggesting that emotional proximity could compromise objectivity and limit meaningful reflection. I understood this as a nuanced balancing act, where emotional safety had to be weighed against critical distance.

For some, unfamiliarity offered a different kind of safety. PT191 chose a peer from outside their immediate team, explaining:

> I think you take that feedback much easier from people you don't know…I feel I take it better [from] people I don't know rather than [my] own team.

They added:

> I think she [the peer] was more honest than I felt my own team would have been.

I understood this as a response to possible power dynamics within their workplace, where their managerial position may have impacted psychological safety with known colleagues.

This emphasis on emotional security was echoed by PT314, who described an empowering exchange with a peer who, “Never makes you feel like an idiot”, and by PT150 who explained their selection as, “She never makes me feel stupid or [like I am] asking silly questions”. I interpreted these accounts as illustrating how the quality of interpersonal relationships shaped the depth and openness of reflective dialogue. PT276 extended this view, identifying their peer as someone “Good at synthesising their thoughts…knowledgeable…[and a] good listener”, and who could help them “develop [their] knowledge and understanding”.

Shared professional experience was also constructed as a motivating factor, with many participants selecting a peer who knew them and their role in practice well, believing that this common ground promoted a more relevant and supportive exchange. PT96, whose peer was recommended by their line manager, reflected: “I'm gonna [sic] get the most out of a peer discussion with someone that has similar qualities”, while also recognising the value of difference in provoking new insights.

Openness to alternative viewpoints was further developed by PT275, who sought a peer that would “suggest something different to what I’ve said would make me think…outside the box”. PT191, similarly selected a nurse from outside pharmacy, reasoning that “they’re the best people to bounce back off...cause [sic] they’ve got lots of ideas or they don’t know it’s always been done like this”. PT314 added that working with someone from a different professional context helped them “shortcut” their learning and gain new perspectives. These narratives appeared to suggest selections as strategic attempts to stimulate reflection by inviting disruption to established thinking. These interview accounts echoed sentiments in the survey where several respondents described seeking peers outside of pharmacy. For example, PT01 and PT07 described intentionally selecting non-pharmacy colleagues to gain fresh insights and constructive challenge.

In some cases, particularly among participants in senior roles, the direction of selection was reversed, whereby colleagues approached them for support. PT276 described being frequently asked to act as a peer due to their experience in education and CPD, noting that they could “help [others] find a peer as well”. PT307 reflected on having acted as a peer throughout their long career, sharing that they had never declined the opportunity: “the topics that I’ve been asked to be a peer for have always been within my scope of practice”. This positioned pharmacy technicians not only as participants but also as facilitators of peer discussion, further reinforcing the relational significance of peer selection.

Subtheme 2.2 - Extrinsic Influences in Peer Selection

While many participants described personal preferences within peer selection, they also acknowledged the influence of practical constraints and organisational dynamics. External factors such as job role, timing, team structures and workplace norms, often shaped who was available, accepted or willing to engage in peer discussions. Within this subtheme, participants’ accounts reflected a range of negotiations between ideal and available peers, from strategic choices based on trust and familiarity to pragmatic decisions driven by accessibility and workplace expectations. These nuances are explored in the analysis that follows, highlighting how peer selection was shaped by both relational values and contextual realities.

PT314, a remote and part-time worker, described peer selection as “not an easy process…I find it a struggle”, particularly when facing imminent deadlines. They explained that they were frequently “four months towards the end” of the revalidation window, having to “really think” about both the topic and potential peer. I understood these account as illustrating how time pressure and availability could override preference making peer choice more about access than autonomy.

In other cases, selection was driven more by convenience than relevance PT208 noted: “Mine is always due end of October so it might sort of be August/September that I might start looking at peer discussion”, adding that it “falls lovely in time with my appraisal”.

Similarly, PT73 recalled a conversation that “just coincidentally happened at the time when I needed to revalidate”, remarking, “oh brill”. These accounts reflect that peer discussions were sometimes aligned with existing organisational rhythms, creating efficiency but limiting intentionality.

For some, the topic of reflection shaped peer selection more than the relationship itself. Participants identified subjects, such as a new services, leadership challenges or improvement initiatives, before seeking peers with relevant expertise. PT275

explained, “I think about a topic that I want to do and then I think, who’s going to be the best person?” I understood this topic-led approach as reflecting strategic intent, where contextual relevance took precedence over familiarity.

Across these accounts, participants’ understanding of the term peer appeared fluid. Some viewed it as someone of similar professional standing. PT275 described a peer as: “on the same level as you that knows about your role and knows what we should be doing in our role and can give you feedback or you can give them feedback”.

Similarly, PT314 defined it as “my level, my equivalent…someone the same band as me”, and PT276 shared the view: “it's those that work at same level as me”. These definitions indicate that the concept of peer was not fixed but shaped by organisational cues and individual interpretation.

In some cases, peer discussion was reframed as a managerial tool. Senior pharmacy technicians described acting as peers in a supervisory capacities, using the discussion to support or evaluate registrants. PT191 organised a group peer discussion for staff they managed, encouraging participants to “write it up as a peer discussion”, though they acknowledged the dynamic was uneven: “a few members of the group that don't participate as much as others”, and described difficulties in managing the session when “they were all shouting at you at the same time”.

PT150 described a discussion that emerged from resolving concerns about a pharmacists’ practice, characterising it as an “all-round sort of resolution”. In this case, PT150 acted as the registrant’s peer for revalidation. I understood these examples as blurring the boundary between reflection and oversight, suggesting that organisational roles could reshape the intent of the discussion.

Thematic Summary

Through my reflexive thematic analysis, I interpreted peer selection as a situated and relational practice, shaped by the interplay of personal motivations and external structures. Many participants described making deliberate choices grounded in trust, comfort and perceived psychological safety. However, these decisions were often filtered through workplace dynamics, limited access to suitable peers and the shifting definitions of who qualifies as a "peer".

Across the dataset, participants framed peer selection as an opportunity to engage in meaningful dialogue, although their capacity to enact this intention varied. In some cases, autonomy was evident, with participants actively seeking peers whose insight or experience could enrich their reflection. In others, constraints such as availability, access and deadlines limited their choices, leading to opportunistic or convenience-

based selection. Senior participants often assumed dual roles as peer and manager, further blurring the boundaries between developmental conversation and performance oversight.

This theme contributes to answering research question two, “How do pharmacy technicians identify suitable peers to engage in discussions as part of revalidation requirements”? by offering insight into how peer selection was shaped not only by relational qualities but also by professional norms, organisational structures and individual priorities.

6.3 Theme 3 - Navigating the Landscape of Peer Discussions

This theme explores what support pharmacy technicians valued when engaging in peer discussion for revalidation, my analysis focused on how participants made sense of the structures, resources and conditions that shaped their experiences. Rather than perceiving support as a one-size-fits-all solution, participants described a range of needs, both the practical and emotional, that reflected their roles, working context and levels of confidence.

Support was framed in terms of clarity around expectations, access to relevant guidance and access to a peer network. While some participants described the process as becoming more familiar and valuable over time, others continued to encounter challenges, including unclear expectations, evolving needs and role-specific barriers.

I constructed this theme through reflexive engagement with participants’ narratives to explore how they experienced the support available to them, and how they interpreted what was needed to make peer discussion more meaningful, feasible and sustainable in practice.

Subtheme 3.1 - Procedural Ambiguities

Participants often framed peer discussion as an uncertain and ambiguous process. Across their accounts, I interpreted recurrent confusion around the level of formality required, expectations for structure and the documentation process itself. This ambiguity frequently led to hesitation and diminished confidence, particularly among those new to revalidation or operating in environments with limited support. Within this subtheme, participants expressed uncertainty in varied ways, from procedural confusion to deeper questions about legitimacy and professional boundaries. This uncertainty was also described in the survey responses, where participants such as PT106 and PT129 assumed peers must be pharmacy professionals, reflecting the narrow interpretations of the guidance.

Reflecting on their first peer discussion, PT96 shared: “I didn’t really prepare anything because…looking at the guidance from the GPhC it seemed to be quite, very kind of very bare bones”. In contrast, PT307, more experienced in the process, described a deliberate and informed approach: “I've used the GPhC guidance and resources…looked at policy documents…done a little bit of research myself before I've had the peer discussion”. I understood this contrast as demonstrating how engagement with regulatory guidance could vary depending on familiarity, professional confidence and individual interpretation.

Several participants described navigating uncertainties by relying on informal advice or interpreting the guidance through their own lens. PT150 recalled that during their first attempt, “I don’t think anybody understood what it was and what you have to do”, adding that even after consulting colleagues, “nobody really knew what to talk about and how to go about it”. PT275 echoed this, recalling early confusion: “When we first had to do it [peer discussion], I was like ‘What's a peer’? [and] ‘Do know what I'm doing’”? I understood these accounts as constructing a landscape of uncertainty, where normal expectations were poorly established and individuals were left to negotiate meaning independently.

In response, participants turned to a range of resources for reassurance. The GPhC website was the most frequently cited source, often consulted to confirm basic procedural expectations. PT150 explained they “usually check to see if any of [the examples] are updated… just to check that I’m on the right track”, while PT314 described the guidance as their go-to reference: “the one where I’m like, right. Am I doing this right? Am I understanding this right”? I understood these accounts to reflect that while regulator guidance provided a starting point, its perceived vagueness prompted further sense-making on the part of registrants.

Some participants drew on wider regional and professional resources to supplement their understanding. PT275 described attending a CPPE event where “the penny dropped then… it doesn’t have to be a pharmacy professional”, challenging initial assumptions about who qualified as a peer. PT150 explored HEIW examples, while PT314 recalled that a NES-affiliated colleague “was instrumental in helping me get the knowledge” to navigate a new platform. In Scotland, the TURAS national digital platform was described by PT191 as prompting peer discussion planning within annual reviews.

Despite these efforts, several participants felt that available resources did not offer sufficient clarity or reassurance, particularly those new to revalidation. PT276 described how some colleagues reacted like a “rabbit in headlights” despite guidance

being available. I interpreted these accounts to consider that resources can provide a foundation but that they may need to be supplemented by more tailored, accessible and context-sensitive support.

Formatting and writing were described by several participants as integral to their confidence in successfully completing revalidation. PT191 expressed concerns about entering information into MyGPhC due to limited technical confidence, remarking that their “IT skills are not the best”. PT314 felt spelling and grammar were important components of a credible submission, gaining confidence through the MyGPhC automatic features: “They've got the spell checker in which is great…cause [sic] it automatically amends it now, which is great”. This technological reassurance appeared to reduce the pressure of presentation, especially when working quickly.

Several participants described the impact of the Covid-19 pandemic on their experience of peer discussion. PT150 and PT208 recalled disruption during the suspension of full revalidation requirements. PT275 reflected on the loss of professional networks: “With lockdown and everything I've not been [to an event]…I used to get to them”. PT191 suggested that “trying to build that in for everybody, it's got to be a real conscious effort”, implying that momentum had been interrupted. These narratives appeared to be describing both immediate and long-term consequences of the pandemic on peer discussion practice, disrupting continuity, access and confidence.

A notable gap in participants’ experience was the lack of feedback following submission. Although the GPhC framework outlines that personalised or summary feedback will be provided depending on whether records are selected for review, most participants had not received any response. I interpreted this absence not merely as procedural silence but as a missed opportunity for affirmation and learning. PT307 reflected: “CPD is one of the reasons [I might come off the register] ... not because I can’t do it ... but what is the point of it”? PT314 added: “They’ve [GPhC] never told me it’s wrong”, expressing a desire for validation. PT150 found the lack of feedback “frustrating”, explaining: “I don’t think there’s necessarily been enough feedback…you don’t really know if you’re doing it right or not”. I understood feedback not merely as a procedural add-on, but as a validation of effort and a potential motivator for deeper engagement.

Subtheme 3.2 - Evolution of Peer Discussions

Participants frequently described peer discussion as a process shaped over time, one in which experience, professional development and exposure played key roles in building confidence and understanding. I interpreted these accounts as constructing

peer discussion not simply as a one-off activity, but as a dynamic practice that evolved through repeated engagement and growing familiarity. Within this subtheme, participants described varied developmental trajectories, from initial uncertainty and procedural compliance to more confident, reflective engagement, shaped by factors such as role maturity, organisational support and previous experiences with revalidation. These nuances are explored in the analysis that follows.

For many, initial struggles gave way to greater ease. PT96 reflecting on developing confidence after completing their first peer discussion: “a bit more confident going forward now”. PT73 described a shift from incidental engagement to planned reflection, saying they were “Planning to have a discussion about innovative practice…[which] will then be more meaningful to me”. PT276 spoke positively of the format itself: “I quite like it... it’s [peer discussion] a nice way of doing something different and it’s catering to different learning styles”.

This sense of evolution from a procedural task to a personally enriching experience, was often linked to time spent in the profession. Longer-serving pharmacy technicians described having more opportunities to build trusted networks and cultivate reflective habits. PT307, who had worked across multiple sectors, shared: “I’m used to that type of discussion with people... I’ve done it with students, peers and senior people”. Similarly, PT276 reflected that their role in training contributed to their confidence: “With the training background, I feel a lot more comfortable with that [peer discussion] sort of environment as well”. These accounts suggest that embedded experience and exposure to a range of professional conversations, enhanced comfort and fluency with the peer discussion process.

However, accessing peers was not always straightforward. PT307 acknowledge the interpersonal challenge some registrants face: “It could be quite challenging actually approaching someone…if you were quite shy…it could be very difficult asking somebody to be a peer”. They added that those “new to the profession…could be quite a challenge”. Several participants identified pharmacy technician trainees undertaking the 2017 IET standards as better prepared. PT150 supported a trainee completing a peer discussion as part of their inclusivity module. PT208 remarked: “I know they [students] do peer discussions now for the university, whereas in the old course they didn’t”, describing development as “really good”. PT314, an experienced pharmacy technician, found the new IETs resources helpful for their own learning: “There was a very good explanation there [new IET course materials] on a peer”. I interpreted these accounts as positioning newly trained pharmacy technicians as

more familiar with the concept, while those educated under previous frameworks had to adjust to live implementation.

Confidence, however, was not solely a function of time. The quality of early experiences appeared to shape future engagement. Positive, supportive discussions helped build momentum, whereas unclear or overly casual exchanges risked disengagement. PT150 remarked: “It [peer discussion] helps with confidence. And sometimes it helps to be pushed a little bit”. PT208 noted that some colleagues defaulted to asking friends to act as peers, potentially missing the opportunity for critical reflection. PT314 emphasised the importance of beginning well: “Get off on the right foot…pick up mistakes, in a constructive supportive way”. I understood these comments as signalling a need for intentional, scaffolded support, particularly for those newly registered, where the peer interaction could reinforce reflective confidence rather than diminish it.

Subtheme 3.3 - Role-Centric Challenges

Across settings, participants made sense of peer discussion as a varied and sometime challenging process, shaped by their sector, scope of practice and level of professional isolation. Within this subtheme, participants described differing experiences, from those working in well-supported teams with regular opportunities for reflection, to those in isolated roles where peer engagement felt more difficult or tokenistic. These variations are explored in the analysis that follows, highlighting how context shaped both the feasibility and perceived value of peer discussion.

Those in niche or geographically dispersed roles often described difficulties in identifying suitable peers who understood their professional context. PT314, working remotely in a specialist education role, shared that selection was “not an easy process… particularly working remotely”. PT96 explained that within their ICB, there were “about three other technicians…but we have three unique and individual roles”, resulting in limited options and reliance on a line manager recommendation for peers. I interpreted these reflections as illustrating how structural isolation, whether spatial or role-based, could constrain relational opportunities for meaningful peer discussion

Participants also described how role relevance affected engagement. PT96 noted that their specialised position made it difficult to identify topics that felt appropriate. In contrast, PT191, described their role as naturally collaborative, remarking: “We have these conversations all the time, don’t we”?

Mainstream roles, such as those in hospitals or large team settings, were often constructed as more conducive to engaging in peer reflection. The participants acknowledged that peer access was not uniformly distributed. PT307, an experienced pharmacy technician, observed:

> Peer discussion is probably the most challenging aspect of revalidation for somebody that is removed more from the patient

adding that

> as you advance in your career…your scope of practice narrows a little bit limiting peer options.

PT276 reflected on sector-based privilege, noting: “Maybe if you're working in smaller say community pharmacy… I think you know, finding a peer for some people could be difficult”, while describing their own secondary care role as resource-rich: “We're lucky because of the environment we work in…we have a lot of peers and it's easy for us to find a peer”. I interpreted these accounts as highlighting inequities across sectors, where a one-size-fits-all approach to peer discussion may disadvantage pharmacy technicians based on context.

Thematic Summary

This theme presents my interpretative account of how pharmacy technicians navigated the landscape of peer discussions. Across participants’ accounts, support was understood as multifaceted, comprising procedural clarity, relational confidence and role-sensitive resources.

Participants described ambiguity and inconsistency in how peer discussion was enacted, particularly around formality, structure and submission. While regulatory and developmental guidance was valued, it was often perceived as insufficient, prompting calls for more accessible and practical resources, alongside clearer engagement from the regulator. Engaging reflexively with these accounts, I understood participants to make sense of support in both practical and emotional terms, constructing it as a condition that enabled or inhibited confident engagement with peer discussion.

Engagement with peer discussion was frequently described as evolving over time. Repeated participation, exposure to constructive dialogue and access to trusted colleagues appeared to develop greater confidence and reflective depth. However, this growth was uneven. For some, early confusion or lack of relational support led to ongoing uncertainty or disengagement. These accounts highlight that confidence is not a fixed trait but is shaped through experience, interpersonal support and the quality of previous interactions, suggesting that meaningful peer discussion depends on structures that actively enable trust and learning.

Participants also described role-centric challenges that impacted their ability to participate. Sector, setting and scope of practice influenced access to suitable peers and the relevance of available discussion topics. These accounts challenge the assumption that peer discussion functions uniformly across the workforce. Instead, they signal the need for inclusive, adaptable models that respond to variations in professional context.

Together, these subthemes contribute to answering research question three, “What support might pharmacy technicians value for engaging in peer discussion as part of revalidation requirements?” by illustrating the types of support participants prioritised. These included clear guidance tailored to different practice settings, constructive relational input from trusted peers, opportunities to build confidence over time and systems that facilitate equitable access to relevant networks. I interpreted support not simply as a resource but as an enabling condition, one that must be emotionally responsive, procedurally clear and professionally inclusive to sustain meaningful engagement.

6.4 Interrelationships Across Themes and Subthemes

While each theme and subtheme has been presented separately to provide clarity and focus, the analysis recognises that these elements are deeply interconnected. The experiences shared by pharmacy technicians do not occur in isolation, they are shaped by a complex interplay of personal, relational and contextual factors that cut across thematic boundaries.

For example, the intrinsic and extrinsic influences on peer selections are closely tied to the confidence and clarity participants feel when engaging in discussion. Similarly, the perceived value of peer discussions is influenced not only by the nature of the interaction itself, but also by the support structures, role-specific challenges and peer relationships that surround it. Ambiguity around expectations, the impact of hierarchy and the importance of trust and familiarity all interact to shape how pharmacy technicians approach, experience and reflect on peer discussions.

Participants’ accounts also shed light on how peer discussions can serve multiple functions, not only as reflective tools but also as acts of leadership, mentorship and professional stewardship. Several participants described how acting as a peer for others reinforced their own learning and contributed to a sense of professional responsibility. PT275, for example, noted that supporting a colleague through a peer discussion “helped [them] reflect on how far [they had] come”, while PT307 described being approached as a peer as a sign that others “trusted [their] judgement”. Group peer discussions also featured in several accounts, offering opportunities for shared

learning but raising challenges around participation and confidentiality. As PT191 explained, the group enabled information to be “cascaded” efficiently, but “not everyone participated”. These dynamics reflect my interpretation of how peer discussions are shaped by broader relational and organisational contexts.

Rather than viewing each theme as a discrete finding, they are better understood as overlapping and mutually reinforcing aspects of a broader narrative, one that captures how pharmacy technicians navigate the peer discussion process. This interconnectedness highlights the need for flexible, inclusive and context-sensitive approaches to supporting reflective practice across the profession. Yet, with this rich tapestry of interconnected themes, certain dimensions remain conspicuously quiet, raising important questions about what is left unsaid or unexplored.

6.5 What Remains Quiet – Understated Dimensions of Peer Discussion

While much of the data analysis illuminated my interpretations of how pharmacy technicians selected peers, choose topics and navigated the logistics of peer discussion, certain dimensions remained notably subdued. These quieter themes, though less frequently voiced, offer valuable insight into the implicit boundaries of current practice. Based on the GPhC’s emphasis on reflection that benefits people using pharmacy services, I had anticipated more explicit connections between peer discussion and patient care. Similarly, given the professional discourse around feedback as a tool for learning and development, I expected participants to describe receiving or offering feedback as part of the process. Instead, participants spoke only occasionally about the impact of peer discussion on patient care, reflecting more on the mechanics than the meaning of the process and rarely describing feedback interactions. These absences do not suggest a lack of value but rather point to areas where the potential of peer discussion may not be fully achieved.

The Elusive Patient

Across the dataset, participants rarely articulated how peer discussions influenced patient care, despite the GPhC’s emphasis on this connection (GPhC, 2018b). Where the topic did surface, its presence was typically implicit. PT96 reflected on peer discussion as a mechanism for development and a way to avoid “standing still”, something they felt was essential to “being the best you can be and making sure patients are safe”. PT275 noted the need for peer feedback to gain assurance, posing questions such as “How does it [the peer discussion] benefit me?” and “How does it benefit the service users”. Although participants acknowledged patients and service users, the emphasis appeared to remain primarily on themselves.

Even when participants discussed quality improvement, the focus tended to centre on internal reassurance or team dynamics. For instance, PT150 recalled a discussion with a pharmacist about service delivery, suggesting that “it helps me provide a better service to both the staff and the customers… I think it just helps to make you a better person”. The patient’s experience, though seemingly central to the incident, was not explicitly engaged with.

This apparent absence may reflect how person-centred care is so deeply embedded in practice that it becomes invisible in reflection. Alternatively, it might indicate a structural limitation in how peer discussions are framed and facilitated, one that marginalises the patient voice in favour of practitioner-centred narratives. Although the GPhC (2018a) emphasises that peer discussions should support reflection for the benefit of people using pharmacy services, typically patients or their carers, this intention was not always evident in participants accounts. The lack of explicit reference to patients may suggest a disconnect between regulatory aims and how peer discussions are enacted in practice.

Reflection as Process, Not Practice

Reflection was frequently mentioned yet often framed as a procedural step rather than a transformative act. Participants described preparing notes, drafting entries and aligning their discussions with appraisal cycles, activities indicative of compliance more than contemplation. PT96, for example, described how their peer “did a very good job of… pulling the information out of me and making me realise that actually, I knew a lot more of things than I was thinking about”. The learning was apparent, yet the reflection was retrospective and instrumental, rather than critical or exploratory.

Similarly, PT73 reflected how peer discussion was “probably the part of CPD that holds the least value for me”, noting that despite having many valuable conversations throughout the year, the one selected for revalidation felt more like a “tick box”. This tendency to treat reflection as a task, something to be completed rather than inhabited, may limit the developmental potential of peer discussion. It also raises questions about how reflection is modelled and supported within pharmacy education and practice.

Feedback and Follow-Through: A Missing Loop

While many participants described peer discussions as helpful or empowering, few mentioned receiving feedback from their peers or offering it in return. These interactions were frequently framed as a one-off events, with little indication of follow-up or ongoing dialogue. PT314 acknowledged that they had “never actively gone up

to someone and said, right, we need to do a peer discussion", suggesting that these conversations often arise opportunistically rather than intentionally.

Even when discussions were planned, they tended to be self-contained. PT96, for instance, described minimal preparation and reliance on their peer to guide the exchange, yet gave no indication that the conversation was revisited or its impact reflected upon over time.

PT307 described peer relationships for peer discussion as "short lived" and questioned how a rapport could be established "over a short period of time". This points to a broader interpretative concern: the absence of continuity and feedback loops. I understood this as a lack of follow-up with peers, which might limit the depth and development potential of these conversations. Viewed through Kolb's (1984) ELT, this absence suggests a break between reflection and active experimentation, where insights from peer discussion are not consistently translated into changes in practice. Instead, peer discussion was often framed as structured, in-the-moment occurrence, with limited forward planning or revisiting of outcomes.

Such absences may reflect structural constraints with limited time, hierarchy or uncertainty about roles. However, they may also suggest a missed opportunity. Without feedback, reflection risks becoming circular, looping without leading to meaningful change. Without follow-through, peer discussion risks becoming performative, a gesture towards engagement without the depth required to support the behavioural change at the heart of revalidation.

6.6 Chapter Summary

Having actively constructed the key themes and subthemes through RTA, this chapter offers an interpretive account of the nuanced, contextually embedded ways in which pharmacy technicians make sense of peer discussions within the revalidation process. This interpretation was shaped not only by participants' interview accounts, but also by reflective insights captured in the survey dataset. These interpretations suggest a dynamic interplay between individual motivations, relational dynamics, organisational structures and sector-specific constraints.

In the following discussion chapter, I will further explore these interpretations though theoretical lenses and situate them within the body of literature.

Chapter 7: Discussion

7.1 Introduction

This chapter builds on the analysis presented in Chapter 6 by interpreting them through the lens of theoretical frameworks and relevant literature. It considers how pharmacy technicians experience peer discussion in the context of professional revalidation and ongoing learning.

Although Braun and Clarke (2022) advocate integrating the traditional findings and discussion sections during phase six of RTA, I have chosen to separate these chapters to ensure clarity and manageability as a novice researcher. Instead of organising this chapter around the themes constructed in analysis, I drew on guidance from Weaver-Hightower (2018) and structured the discussion around the research questions that guided the study.

This approach facilitates an interpretative exploration of how participants' experiences respond to the study's core questions and situates these insights within the wider academic and professional debates. In line with the interpretivist paradigm, the discussion remains reflexive and theory-informed, highlighting the implications for pharmacy education, professional development and revalidation practice.

7.2 Perceptions of Peer Discussion: Fostering Meaningful Engagement

Introduction

This section explores research question one related to how pharmacy technicians perceive the value of peer discussion in relation to their professional roles and regulatory responsibilities. Drawing on the theme Fostering Meaningful Discussions, I interpreted participants' accounts as positioning peer dialogue as a relational and situated practice, often embedded in the rhythm of everyday work, rather than the structured format prescribed by revalidation guidelines.

While the GPhC (2018b) frames peer discussions as formal, pre-planned exercises to support professional reflection, participants often described more organic, spontaneous exchanges rooted in trust, shared context and immediacy. These informal conversations were perceived as emotionally resonant, professionally affirming and directly relevant to the reality of their roles.

Similar patterns are evident in other professions, where reflective dialogue often occurs informally and in response to real-time challenges. Studies in nursing and medicine show that practitioners frequently value spontaneous, relational conversations over more structured reflective formats prescribed by regulators, which

can feel disconnected from everyday practice (Bradbury et al., 2010; Nash et al., 2022).

However, I also considered tensions in how participants navigated the space between these informal practices and the structured expectations of regulation. For many, translating spontaneous learning into formalised documentation felt artificial, raising concerns about the authenticity and developmental purpose of peer engagement. This section critically examines those perceptions, considering how pharmacy technicians make sense of peer discussion both as a professional asset and as a procedural requirement.

Interpretations and Theoretical Integration

I interpreted participants' accounts as suggesting that peer discussions were most valuable when they occurred spontaneously, in response to real-time challenges or shared experiences. These informal exchanges supported reflection, reassurance and professional growth. However, when participants were required to formalise these discussions for revalidation, the process could feel disconnected from the original learning context, raising questions about the authenticity and developmental value.

Kolb's (1984) ELT frames learning as a cycle of four stages: concrete experience, reflective observation, abstract conceptualisation and active experimentation. Participant's narratives appeared to reflect that pharmacy technicians engaged readily in the initial stages of Kolb's model, especially through informal peer discussions that allowed them to share and reflect on real-life experiences. These exchanges often developed organically within trusted relationships and emotionally resonant contexts, illustrating how concrete experience and reflection can be embedded in everyday practice.

However, progression into conceptualisation and experimentation was more fractured. The retrospective format imposed by revalidation, documenting an experience after the fact to meet external criteria, sometimes disrupted the flow of learning, limiting how insights were theorised or applied. Rather than moving sequentially through Kolb's cycle, participants appeared to loop reflexively through experience and reflection.

This echoes Bassot's (2016) earlier critique of Kolb's model, introduced in Chapter 2, who challenges its overly linear and prescriptive nature. I interpreted participants' learning experiences as aligning with this critique, particularly in how the documentation requirements for revalidation disrupted the fluid movement through Kolb's stages. Rather than completing a sequential cycle, pharmacy technicians

described a more relational, iterative process that did not always culminate in abstract conceptualisation or active experimentation. This suggests that experiential learning within pharmacy practice may be less about systematic progression and more about embedded reflection shaped by interpersonal and contextual factors.

These tensions around linear progression within Kolb's model invite consideration of alternative conceptualisations of reflective practice. Schön's (2017) distinction between reflection-in-action and reflection-on-action offers a more responsive and contextually grounded framework that aligns with participants' lived experiences.

Reflection-in-action, spontaneous, emotionally resonant dialogue occurring during real-time problem-solving, was consistently described by participants as authentic, impactful and embedded in everyday practice. These moments often arose within trusted peer relationships, allowing individuals to process challenges as they unfolded. In contrast, reflection-on-action, exemplified by the GPhC's revalidation process, required structured, retrospective consideration of past events outside their original context. While this format aligns theoretically with Schön's model, it was often experienced by participants as disjointed, performative or disconnected from genuine learning.

This suggests a difference between the intention of structured reflection and its enactment in pharmacy practice, where time pressures, emotionally resonant and contextual constraints complicate meaningful engagement. Schön's model, although more flexible than Kolb's, still assumes that learners have the reflective capacity, support and time to engage meaningfully with their past experiences, conditions not always present in busy clinical environments.

While reflection-on-action can support meta-reflection, defined as the process of critically examining one's own reflections, assumptions and decision-making frameworks (Thompson and Thompson, 2023), this potential was not always realised. Meta-reflection moves beyond describing what happened; it involves interrogating why it happened, what it reveals about professional values and how it might shape future practice. When peer discussions were framed primarily as compliance tasks, I came to view that opportunities for this deeper level of reflection were often lost.

These findings suggest that while individual reflection, whether retrospective, real-time or anticipatory, is an important dimension of learning, it does not occur in isolation. The relational, emotionally grounded nature of participants' peer discussions points toward learning as a fundamentally social process. This shifts the focus from individual reflection to shared professional learning, where dialogue and emotional connection encourage mutual development and practical insight.

Lave and Wenger's (1991) original work on CoPs provides a broader theoretical frame for understanding how learning occurs through social participation. Although their model was originally grounded in apprenticeship contexts, I understood participants' accounts as reflecting core CoP principles, mutual engagement, shared repertoire and joint enterprise. These informal interactions supported professional identity and reflective habits, even when they fell outside the formal structures of revalidation. However, the GPhC's emphasis on planned, individualised peer discussion may inadvertently marginalise these informal learning spaces.

The GPhC's rationale for requiring planned peer discussions assumes that preparation enhances the quality of reflection. Comparable regulatory expectations exist in nursing and medicine, where structured supervision or appraisal conversations are intended to promote focused reflection. However, research suggests that these formalised approaches may overlook the value of situated, relational learning that practitioners experience as more authentic and meaningful (Bartlett et al., 2023; Nash et al., 2022). The GPhC guidance (GPhC, 2018b) proposes that pre-planned discussions support structured, focused engagement, yet this position may overlook the value of spontaneous, situated learning that is already embedded in practice. By privileging planned over emergent reflection, the framework risks excluding the kinds of learning that I interpreted as most valued by participants, those that are emotionally grounded, contextually relevant and socially co-constructed.

Taken together, these theoretical perspectives suggest that the current revalidation model may under-value the richness of informal, relational learning. To support meaningful engagement, professional development frameworks may need to acknowledge that learning often occurs in ways that are non-linear, emotionally grounded and embedded in the social fabric of practice.

Situating the Findings in Literature: Relevance to Research Question

This section interprets how pharmacy technicians perceived the value of peer discussions, specifically as relational, emotionally grounded and contextually embedded practices. These interpretations align with two key strands of literature: the mutuality of peer relationships and the tension between formal and informal peer engagement.

As discussed in Chapter 2, peer interactions within healthcare are often grounded in reciprocity, trust and shared professional identity (Debyser et al., 2019; Forchuk et al., 2020). These qualities support mutuality, where both parties benefit through knowledge exchange, emotional support and affirmation of professional roles. I

interpreted participants' accounts as resonating with these ideas, particularly in their emphasis on trust and shared understanding. Peer discussions were described as most valuable when they occurred within familiar, supportive relationships.

These informal exchanges reflect Lave and Wenger's (1991) concept of CoP, where learning is co-constructed through mutual engagement and situated within real-life challenges (Nash et al., 2022). In this context, peer discussions functioned less as isolated or scripted events, and more as socially embedded learning moments.

While Lave and Wenger's (1991) original model focused on apprenticeship settings, typically involving senior–junior dynamic, the accounts in this study suggest horizontal learning among colleagues of similar status. I positioned these experiences as an extension of CoP theory, where learning is distributed across shared experience rather than defined by hierarchy. This interpretation aligns with contemporary applications of CoP in healthcare, which recognise that mutual learning can occur among peers as well as between novices and experts (Clutterbuck, 2023; Nash et al., 2022; Schindel et al., 2019).

The formalisation of peer roles presents potential risks. Bartlett et al. (2023) and Bradbury et al. (2010) caution that when reflective practices are reframed as compliance tasks, they may lose authenticity and developmental purpose. I noted resonance between this and participants' accounts, which may extend this critique, many described adapting informal exchanges to fit formal criteria, or selecting discussions that feel more genuine than rehearsed. These accounts suggest that regulatory framing may not always support the forms of reflection pharmacy technicians find most meaningful.

Consideration of these theoretical constructs is valuable in interpreting the findings. Firstly, this profession-specific study highlights the relational and situated nature of reflective practice and raises questions about how regulatory structures might shape, constrain or enable meaningful engagement. Secondly, it contributes to a growing body of literature that challenges hierarchical models of learning in healthcare, instead positioning peer discussion as a form of horizontal, context-sensitive professional development.

7.3 Identifying Suitable Peers: Navigating Professional and Relational Judgements

Introduction

This section responds to the second research question: How do pharmacy technicians identify suitable peers to engage in discussions as part of revalidation requirements? Drawing on the theme of Strategic Peer Selection for Meaningful

Discussions, I interpreted participants' approaches as intentional and emotionally formed. Peer selection was described not as a procedural formality but as a considered decision, shaped by professional relevance, interpersonal trust and psychological safety.

Participants commonly sought out colleagues who understood the realities of their roles, those able to offer empathetic insight, constructive challenge and contextually relevant reflection. These choices reflected a clear desire to promote genuine dialogue rather than simply to meet regulatory expectations. This emphasis on trust and relational fit mirrors findings in other healthcare professions, where effective reflective dialogue is consistently linked to psychological safety, shared understanding and emotional resonance rather than formal role designation (Eby and Robertson, 2020; Nash et al., 2022). At the same time, these accounts appeared to reflect constraints arising from organisational culture, time pressure and limited availability, which shaped and at times restricted these decisions.

The discussion that follows considers how pharmacy technicians navigated these relational and contextual dynamics to identify peers capable of supporting reflective engagement within the revalidation framework.

Interpretations and Theoretical Integration

I engaged with these accounts by viewing peer selection not as a neutral or administrative task, but as a relational and context-sensitive decision. This choice played a significant role in shaping the depth, authenticity and quality of reflective discussions. Participants' narratives suggested that these decisions were often guided by trust, familiarity and shared understanding, qualities that enabled open, honest dialogue. In this way, peer discussions frequently resembled informal mentoring relationships, grounded in mutual respect rather than formal hierarchy.

This interpretation aligns with contemporary understandings of coaching and mentoring in healthcare, which increasingly recognise the value of horizontal, peer-based learning. Unlike traditional mentoring models, such as Clutterbuck's (2023) sponsorship model, which assumes a senior guiding a junior, many of the peer relationships described in this study were collaborative and non-hierarchical. This reflects a shift towards developmental or peer mentorship, where learning is mutual and shaped by shared roles and experiences. For pharmacy technicians, whose roles are evolving and becoming more autonomous, this kind of flexible, peer-based support appeared particularly valuable. It enabled reflection that was relevant to their specific responsibilities and stage of professional development, and supported the

construction of professional identity through shared understanding and mutual engagement (Oelofsen, 2012; Wenger, 1998).

Participants often selected peers with similar roles or experience, individuals they believed would better understand the realities of their work. This aligns with Wenger's (1998) concept of mutual engagement within a CoP, as I understood it through participant's accounts where learning is co-constructed through shared experiences and sustained interaction. Within this context, peer discussion held the potential to go beyond the fulfilment of revalidation requirements.

When participants felt confident in their choice of peer, someone who 'gets it' and resonates with the emotional and professional nuances of their role, these conversations became opportunities for situated, reflective learning (Oelofsen, 2012). Rather than diminishing the value of regulatory peer engagement, this interpretation highlights how the selection of the right peer can enhance its relevance and impact.

However, the findings also highlighted a gap between the intentions of the GPhC guidance (GPhC, 2018a; GPhC, 2018b) and the realities of practice. While the guidance encourages pharmacy professionals to choose their own peer and engage in open, honest conversations, this ideal was not always achievable. Time pressures, staffing shortages and organisational routines often led to last-minute decisions, where participants had to choose whoever was available, rather than someone they felt was the best fit. In some cases, peers were assigned or selected out of convenience, which could reduce the depth and authenticity of the discussion.

Some participants actively chose managers as reflective partners, perceiving this as a way to uphold confidentiality, validate good practice and, in some cases, fulfil appraisal requirements. For others, peers were often selected, particularly when their specific expertise aligned with the focus of the discussion. These decisions reflected an intentional engagement with the reflective process, where participants made strategic choices to support their professional development.

Yet, these selections were not always straightforward. Hierarchical dynamics, whether grounded in formal roles or perceived authority, could shape the tone and purpose of reflection. In several instances, peer discussion as part of revalidation was used not only as a developmental conversation but as a mechanism for assessing staff and managing competence. This dual function introduced ambiguity and, at times, a sense of surveillance, which appeared to compromise the psychological safety participants might have otherwise experienced. Similar concerns have been documented in medical appraisal and nursing supervision where hierarchical pairings can inhibit openness and shift reflective conversations towards performance

management rather than developmental training (Chesluk et al., 2015; Eby and Robertson, 2020). These dynamics echo concerns in the mentoring literature, where hierarchical relationships can limit psychological safety and provoke conformity (Eby and Robertson, 2020). Similarly, they resonate with challenges identified in preceptorship models, where supportive intentions may be undermined by role confusion, time constraints or uneven power distribution (Bartlett et al., 2023).

Overall, I interpreted that peer discussions worked best when grounded in trust, relevance and mutual respect, core principles of effective mentorship. While the GPhC's current guidance provides flexibility in who can act as a peer, participant accounts suggested that this flexibility is not always sufficient to support confident or informed peer selection. The findings highlight a tension between the autonomy encouraged by the framework and the structural or relational constraints experienced in practice. This suggests a need to better understand how pharmacy professionals navigate peer selection and how the framework is interpreted and enacted across different settings.

Situating the Findings in the Literature

This section interprets how pharmacy technicians identified suitable peers for professional discussions as part of the revalidation process. These selections were shaped by both relational criteria, such as emotional safety, relevance and trust, and contextual constraints like availability, organisational culture and power dynamics. These interpretations align with two key strands of literature: the significance of relational dynamics in effective peer learning and the influence of structural factors on mentoring and preceptorship models.

The findings resonate with the literature exploring the relational dynamics that support effective peer reflection, particularly the role of trust, shared experiences and psychological safety (Afshar et al., 2022; Forchuk et al., 2020; McKeon et al., 2021). Across these studies, there is a common emphasis on how relational qualities, such as openness, empathy and mutual respect, shape the depth and authenticity of professional dialogue, often more so than formalised structures. Notably, while all three reference the importance of 'meaningful' conversations, the term is used with varying nuances: Afshar et al. (2022) focus on emotional resonance, Forchuk et al. (2020) explore relational depth and McKeon et al. (2021) emphasis perceived relevance and impact. In this study, I interpreted 'meaningful' peer discussions as those that felt personally relevant, emotionally safe and professionally useful to participants.

The findings also intersect with the research on mentorship and preceptorship, where the quality of the relationship, rather than the model itself, often determines the effectiveness of learning and reflection (Bartlett et al., 2023; Oelofsen, 2012). Participants in this study described selecting peers based on familiarity, shared roles and emotional safety, criteria that mirror the foundations of effective mentoring relationships (Eby and Robertson, 2020). These accounts reflect a shift away from traditional top-down mentoring models towards more collaborative, horizontal relationships, aligning with Clutterbuck's (2023) concept of developmental mentoring. This is particularly relevant for pharmacy technicians, whose roles are increasingly autonomous and situated across diverse practice settings.

However, these findings also resonate with Chesluk et al. (2015), who highlight how power dynamics and identity formation can influence the mentoring relationships. In my study, participants occasionally selected more senior peers for their expertise, but this sometimes introduced discomfort or inhibited openness, echoing concerns about the tension between guidance and autonomy. These accounts suggest that while hierarchy can add value, it may also constrain the authenticity of reflective dialogue if not carefully managed.

In addition, the findings reflect challenges seen in preceptorship models, where structured support is intended to guide development but can be affected by time constraints, unclear roles or uneven power dynamics. As discussed in Chapter 2, the literature on coaching, mentoring and preceptorship often presents these models in idealised terms, overlooking how structural and relational factors, such as hierarchy, workload or organisational culture, can limit their effectiveness. In this study, participants described similar tensions when peer selection was shaped more by availability or convenience than by trust or relevance.

Together, these findings contribute a profession-specific perspective to the literature on peer engagement in healthcare. They illuminate how pharmacy technicians navigate and interpret relational and structural factors when selecting peers; highlighting the nuanced complexity behind what may otherwise appear a routine process. These interpretations extend current understandings of how reflective practice is supported, negotiated and sometimes constrained within everyday healthcare contexts.

7.4 Engaging in Peer Discussions: Navigating the Landscape

Introduction

This section considers the complexities pharmacy technicians encountered when engaging with peer discussions, with particular attention to how support was

understood, accessed and enacted. Rather than interpreting peer selection as a routine or administrative step, participant accounts revealed a nuanced and evolving process, shaped by relational trust, contextual pressures and varying levels of procedural clarity.

Participants reflected on how their engagement with peer discussion developed over time, often through trial and error and informal learning, particularly in the absence of consistent guidance or feedback. These accounts reflect both the emotional dimensions of confidence-building and the practical realities of workplace culture, staffing levels and role diversity.

This section addresses the third research question by exploring what support pharmacy technicians might value for engaging in peer discussion. In doing so, it draws attention to how confidence is shaped through experience, how inclusivity is linked to practice setting and how perceived value rests not only in guidance but in the presence of emotionally responsive and context-aware systems.

Interpretations and Theoretical Integration

In interpreting participants' accounts, I constructed a picture of variable experiences with peer discussions across the pharmacy technician workforce. While the GPhC guidance encourages open and honest reflection and allows flexibility in how peer discussions are conducted, I interpreted this flexibility as a source of confusion for some participants. Several described focusing on completing the peer discussion form correctly yet were unsure what kind of content was expected in each section. I understood these accounts to emphasise the structure and formality as sometimes taking precedence over meaningful reflection on the discussion itself or its impact on practice. I came to view these experiences as pointing towards a lack of consistent support and guidance, which left some participants feeling uncertain about how to approach the process and less confident in its value as a reflective tool.

These reflections led me to consider the developmental nature of peer learning as particularly evident in the accounts of participants who had engaged in multiple peer discussions. These individuals described growing confidence and a deeper understanding of the process over time. I understood this progression as aligning with Kolb's (1984) ELT, which conceptualises learning as a continuous cycle involving four stages as described in Chapter 2. This developmental trajectory is also reflected in other revalidation systems, where practitioners report that confidence in reflective discussion grows only after repeated engagement, particularly when guidance is perceived as ambiguous or overly procedural (Chesluk et al., 2015; Jassim et al., 2022).

In this context, I interpreted peer discussions as supporting not only individual reflection but also broader professional development. Participants who had engaged in multiple discussions appeared to move through these stages iteratively, refining their understanding and becoming more confident in their ability to reflect meaningfully.

I also drew on Lave and Wenger (1991) theory of situated learning to interpret how peer discussions contributed to participants' sense of professional identity. Those who described increased confidence and engagement over time appeared to be moving from peripheral participation towards fuller membership within their professional community. In this sense, peer discussions were not only reflective exercises but also relational practices that helped pharmacy technicians feel more connected to others in their field.

However, I did not interpret this developmental journey as equally accessible to all. Participants in specialist, remote or less supported roles often described difficulties in identifying suitable peers who understood their context. I interpreted these accounts as challenging the assumption, implicit in the GPhC's model, that a single, standardised approach to peer discussion can serve a diverse and evolving workforce. These participants often described feeling excluded from the kinds of relational and developmental benefits that others experienced. Comparable challenges are noted in other professions, where practitioners working in isolated or highly specialised settings often struggle to access suitable reflective partners, highlighting the limitations of one-size-fits-all models of supervision or peer support (Oelofsen, 2012).

Taken together, I understood these findings as highlighting the importance of both relational and structural support in enabling meaningful peer discussions. I interpreted that being able to take part with confidence was not the same for everyone, it depended on having trusted peer relationships, feeling understood in specific work settings and having clear guidance on expectations. In this way, peer discussion seemed to sit between individual effort and wider organisational responsibility. This includes recognising the different professional settings pharmacy technicians work in and understanding that support needs to be adapted to help everyone take part in meaningful reflection.

Situating the Findings in the Literature

In interpreting the findings, I understood pharmacy technicians' experiences of peer discussion aligning with existing literature on peer-to-peer support (P2P) and peer-assisted learning (PAL) as described in Chapter 2. These approaches often involve a

blend of formal expectations, such as structured discussions or documentation, and informal, relationship-based learning that develops through shared practice. As discussed in the literature review, PAL and preceptorship models typically include structured support, but their effectiveness depends heavily on the clarity of expectations and the quality of the relationship between participants (Bartlett et al., 2023; Jassim et al., 2022). I interpreted participants' accounts as suggesting that their experiences of peer discussion were shaped not only by the guidance provided, but also by how accessible and adaptable that guidance felt in practice.

I also interpreted a learning curve in how they approached peer discussions. Many described initial uncertainty, followed by increased confidence and reflective depth over time. This aligns with the theoretical perspectives discussed earlier in relation to Theme 1. Kolb's (1984) ELT supports the idea that learning is refined through repeated cycles of experience, reflection, conceptualisation and experimentation. Wenger's (1998) theory of CoPs also helps explain how repeated engagement with peer discussion can support not only learning, but also a stronger sense of professional identity, particularly for those who described growing in confidence and a deeper understanding of their role.

However, I did not interpret this progression as equally accessible to all. Participants in remote, specialist or less supported roles often described difficulties in accessing suitable peers or expressed a sense that the process was not designed with their context in mind. I interpreted these accounts as challenging the assumption, often implicit in formal models such as preceptorship, that a single, standardised approach can meet the needs of a diverse workforce. However, it is important to acknowledge that the GPhC's revalidation framework does not prescribe a narrow model of peer selection. On the contrary, the guidance explicitly promotes flexibility and inclusivity, encouraging pharmacy professionals to choose peers from a wide range of backgrounds, including those outside the pharmacy profession, provided they understand the registrant's role. From this perspective, I interpreted the challenges described by participants as reflecting how the guidance is understood and applied in practice, rather than a limitation of the framework itself. This interpretation is supported by concerns raised in the literature about the limitations of rigid structures in supporting reflective practice, particularly when guidance is vague or inconsistently applied (Chesluk et al., 2015).

These findings contribute to the literature by highlighting the need for inclusive, flexible frameworks that recognise the diversity of pharmacy roles and settings. I understood these accounts to suggest the value of peer discussions as residing not

only in the act itself, but in the quality of the relationship between peers and the clarity of the systems that support them. These insights suggest that educational and regulatory models must evolve alongside practitioners, offering support that is both structured and adaptable to individual needs and contexts.

7.5 Reflections on the Scope and Boundaries of the Study

This study has boundaries and limitations that are important to acknowledge in order to support a reflexive and transparent account of the findings. It explored the experiences of pharmacy technicians engaging in peer discussions for revalidation, using an interpretivist approach that values individual perspectives and context. The findings reflect not only how participants made sense of their experiences, but also how I, as the researcher, interpreted those accounts. My professional background as a pharmacy technician shaped how I engaged with the data and made sense of participants' narratives. I may have been more attuned to certain experiences, such as challenges in revalidation or feeling isolated in specialist roles, because they resonate with my own professional context. This familiarity also helped me to build rapport during interviews and brought depth to the analysis, but I acknowledge that it may have narrowed my perspective in some ways. Different researchers, especially those outside the pharmacy field, may have interpreted the same accounts differently. Recognising this, I aimed to remain reflexive throughout the study and to present a thoughtful and honest interpretation of the findings.

Although the study generated rich insights, several methodological boundaries shaped what was possible. The number of interviews was predetermined due to time and resource constraints, which limited the opportunity to expand the sample once I began constructing patterns of meaning across the dataset. While the survey supported broader participation, some sectors, particularly community pharmacy technicians, were represented in smaller numbers than others. This uneven distribution influenced the range of experiences available for interpretation.

The study also combined survey and interview data within a single reflexive thematic analysis. The survey responses were analysed descriptively and were intended to signpost to key concepts and areas of interest across a wider group of participants. However, I recognised that written survey comments do not offer the same depth or dialogic richness as interview data. For this reason, the thematic analysis was predominantly grounded in the interpretation of the interview accounts, where conversational process allowed for deeper exploration, clarification and interpretation. Integrating these two forms of data required careful attention to ensure that the

breadth offered by the survey informed, but did not overshadow, the depth generated through interviews.

These methodological boundaries do not diminish the value of the findings, but they shape the scope of what can be claimed and highlight areas where further research would be beneficial.

Context-Specific Focus

This study focused on pharmacy technicians working within the GPhC's revalidation framework (2018b). While pharmacists follow the same framework, and some insights may be relevant to them, the findings are situated within the specific context of pharmacy technician practice. The GPhC model differs from revalidation frameworks used by other healthcare regulators. For example, the GMC and NMC require peer engagement to be undertaken with trained professionals from within the same register, often as part of a formal appraisal process. In contrast, the GPhC offers a more flexible and inclusive approach, allowing pharmacy professionals to choose their own peer from a wide range of backgrounds, including those outside the profession. The unique structure and expectations of the GPhC framework may shape experiences in ways that do not reflect broader healthcare settings.

Interpretivist Approach

This study was grounded in an interpretivist paradigm, which prioritises understanding how individuals construct meaning within their own contexts. The findings are not intended to be generalised or predictive, but rather to offer situated insights that may resonate with others in similar roles or settings. The knowledge produced is co-constructed through the interaction between the participants and me as the researcher.

These interpretations, developed through close engagement with participants' accounts, reflected recurring themes such as uncertainty about peer discussion guidance, the importance of relational trust, and the developmental nature of reflective practice.

Transferability Challenges

In qualitative research, transferability refers to the extent to which findings may be relevant in other contexts. I have provided detailed descriptions of the research setting, participant characteristics and analytic process to support readers in making their own judgements about relevance. However, pharmacy technicians work across a wide range of roles and settings, and participants in this study described different experiences depending on their context. For example, those in remote, specialist or

less supported roles often described challenges that differed from those in more traditional settings.

These differences suggest that a single, standardised approach to peer discussion may not meet the needs of all pharmacy technicians equally. This reflects one of the key insights from the findings: that meaningful engagement in peer discussion is shaped by the context in which it occurs. Participants described how their roles, settings and access to support influenced their experiences, with some feeling excluded or uncertain due to limited guidance or a lack of peer understanding. In this way, the challenges of transferability are not only theoretical but are borne out in the accounts shared by participants, highlighting the importance of flexible, responsive approaches to professional reflection. While these findings are context-specific, they suggest underlying principles, such as the value of adaptability, relational engagement and practitioner-led refection, that may be relevant across other professional settings.

Participant Representation

The sampling strategy was designed to include a broad range of pharmacy technicians, based on factors likely to influence their experiences of peer discussion. While this approach supported diversity within the sample, I recognise that some groups may still have been underrepresented. For example, pharmacy technicians in highly specialised roles or those new to the profession may not have been included in proportion to their presence in the wider workforce. Additionally, participation was voluntary, and those who chose to take part may have had more experience or stronger views about peer discussion. From an interpretivist perspective, this does not introduce “bias” in the positivist sense, but it does shape the kinds of experiences and perspectives that were available for interpretation.

Limited Longitudinal Perspectives

This study captured participants’ reflections on one or more peer discussions, it was not designed to follow individuals over time. As such, it does not offer insight into the long-term impact of peer discussion on professional identity, development or reflective practice. It is also important to consider the disruption caused by the Covid-19 pandemic. During this period, the GPhC temporarily suspended the full revalidation requirements, reducing the annual submission to a single reflective account (GPhC, 2020). As a result, some pharmacy technicians experienced a break in practice, while others, particularly those newly registered, delayed engaging with peer discussions altogether. I interpreted some participants’ accounts as reflecting this disruption, with several describing uncertainty about when and how to resume the

process. Others reported having completed peer discussions but choosing not to submit them, citing the temporary changes in requirements. These shifts may have influenced how participants engaged with peer discussion and how they interpreted its purpose and value. While some described peer discussions as continuing informally during this period, the absence of formal requirements may have affected the consistency and perceived legitimacy of these interactions. A longitudinal study would offer further insight into how these experiences evolve over time and how temporary regulatory changes shape longer-term engagement with reflective practice.

Understanding the Bigger Picture

While participants frequently described uncertainty or inconsistency in how peer discussions were understood and applied, this study did not explore in depth how wider systems, such as training, regulation or workplace culture, may contribute to these experiences. For example, although the GPhC guidance is intentionally flexible and inclusive, I interpreted some participants' accounts as reflecting narrower interpretations of who is considered a "suitable" peer. This suggests that professional norms or local expectations may shape how the guidance is enacted in practice. Further research could explore how these wider influences support or constrain reflective engagement.

Informal Peer Interactions

This study focused primarily on formal peer discussions as required by the GPhC. However, several participants described informal conversations with colleagues that they later used to meet the peer discussion requirement, sometimes without realising that this may not fully align with the GPhC's expectations. Others chose not to use informal interactions in this way, reflecting different interpretations of the guidance. While these informal exchanges were mentioned, they were not explored in depth. I interpreted this as a potential area for further inquiry, particularly given the importance of informal learning and relational support in professional development. Exploring how informal peer interactions contribute to reflective practice could offer a more complete understanding of how learning happens in everyday pharmacy settings.

7.6 Implications of these Limitations

These limitations do not diminish the value of the findings but help to situate them within the specific focus and scope of this study. As the aim was not to produce generalisable conclusions but to explore how pharmacy technicians made sense of their experiences with peer discussion, it is important to interpret the findings as contextually grounded and co-constructed. The insights offered here are shaped by

the participants' accounts and my own interpretive lens as a researcher working within an interpretivist paradigm.

The limitations also point to areas where further research could extend and deepen understanding. For example, informal peer interactions were mentioned by several participants but not explored in depth. Future studies could examine how these everyday conversations contribute to reflective practice and professional learning. Similarly, while this study focused on pharmacy technicians within the GPhC framework, comparative research across other healthcare professions, such as those regulated by the GMC or NMC, could offer insight into how different models of peer engagement shape professional identity and development. Unlike the GPhC, which allows for flexible peer selection, the GMC and NMC frameworks require peer engagement with trained professionals from within the same register. Exploring how these structural differences influence the experience and perceived value of peer discussion would be a valuable area for further inquiry.

The impact of the Covid-19 pandemic also warrants further exploration. During this period, the GPhC temporarily suspended the full revalidation requirements, reducing the submission to a single reflective account. Some participants described breaks in practice or delays in engaging with peer discussion, particularly those newly registered. Others reported completing discussions but choosing not to submit them due to the temporary changes. These disruptions may have influenced how participants interpreted the purpose and value of peer discussion, and how confident they felt in re-engaging with the process. A longitudinal study could offer insight into how these experiences evolve over time and how temporary regulatory changes shape longer-term engagement with reflective practice.

By acknowledging these limitations, the study remains grounded in its context and open to further development. Rather than presenting the findings as definitive or complete, this approach supports a reflexive and situated understanding of peer discussion as experienced by pharmacy technicians within a specific regulatory and professional landscape.

In considering these limitations, it is also important to situate the findings within wider evidence from healthcare settings, where similar challenges have been identified in how reflective and peer-based activities are understood and enacted. Research on clinical supervision shows that the quality of reflective engagement is shaped by relational trust, organisational culture and the clarity of expectations, with supervision becoming less effective when it is experienced as procedural rather than developmental (Rothwell et al., 2021; Turner and Hill, 2011a; Turner and Hill, 2011b).

Studies of appraisal and revalidation in pharmacy and medicine also highlight concerns that reflective processes can become compliance focused when documentation requirements overshadow meaningful dialogue (Schafheutle et al., 2013; Schafheutle et al., 2011a; Schafheutle et al., 2011b; Tzortziou Brown et al., 2020). These patterns echo participants' accounts of uncertainty about what constitutes a valuable peer discussion and their reliance on trusted colleagues to create a sense of psychological safety. At the same time, literature on mentoring and peer learning emphasise the importance of collaborative, contextually grounded relationships in supporting professional development (Chesluk et al., 2015; Eby and Robertson, 2020). Taken together, this wider evidence strengthens the interpretation that pharmacy technicians' experiences reflect broader tensions across healthcare professionals in balancing regulatory expectations with authentic reflective practice, and it supports the need for clearer guidance and supportive structures to ensure peer discussion retains its developmental purpose.

7.7 Chapter Summary

This chapter has presented a critical and interpretive analysis of the study's findings, developed through the lens of Braun and Clarke's RTA (2006). Rather than emerging passively from the data, the findings were actively constructed through my engagement with participant's accounts, shaped by my professional background, assumptions and interpretative lens. The analysis addressed the research questions through three thematic areas: fostering meaningful discussions, strategic peer selection for meaningful discussions and navigating the landscape of peer discussion. Each theme represents a patterned response to the questions posed in the study and was developed through a reflexive, iterative process that highlighted participants' diverse experiences and perspectives.

In constructing these interpretations, I considered how participant's experiences speak to broader issues within revalidation practice and how these accounts align with, extend or challenge existing assumptions. Particular attention was given to the tensions between formalised structures and the more informal, situated practices described by participants. These interpretations were situated within relevant literature, including critiques of reflective models, peer learning and the GPhC guidance on revalidation.

This chapter also reflects the scope and boundaries of the study and considered how these may have shaped the analysis. These reflections are not presented as disclaimers but as part of a transparent and reflexive account of the research process. In keeping with the RTA approach, I acknowledge that my interpretations are

one possible reading of the data, shaped by my positionality as an insider researcher and the decisions I made throughout the analytical process.

Finally, the chapter sets the stage for the next, which will offer a series of recommendations. These will be grounded in the interpretations developed here and will suggest ways forward for regulation, policy, practice and future research. These recommendations are not intended as definitive solutions but as contextually situated suggestions that may support further dialogue and development.

Chapter 8: Recommendations

8.1 Introduction

This chapter presents a series of recommendations developed through reflexive engagement with the study's findings. These recommendations respond directly to the study's research questions, including considerations of how peer discussion is experienced, what support pharmacy technicians value and the wider implications for training and revalidation support. Rather than offering prescriptive solutions, these recommendations are situated within the lived experiences of pharmacy technicians and reflect the meanings they attributed to peer discussion as part of the GPhC revalidation process.

In keeping with the interpretivist paradigm underpinning this research, the recommendations do not claim generalisability or universality. Instead, they are offered as context-sensitive insights that may inform the ongoing development of revalidation policy, professional support and educational practice. They are grounded in the themes constructed through reflexive thematic analysis and shaped by my own positionality as a pharmacy technician and insider researcher.

Three priority recommendations are presented, each offering a different lens through which to consider how pharmacy technicians experience and engage with peer discussion. While distinct in focus, I have interpreted shared tensions and possibilities that extend across practice contexts. These common threads are drawn together in a final section, implications for practice, which outlines collective actions that may enhance confidence, authenticity and inclusivity.

The recommendations are intended to support pharmacy technicians, educators, professional leadership bodies and the GPhC in adopting more meaningful, inclusive and sustainable approaches to peer discussion. They also consider the ethical dimensions of dissemination and the importance of co-constructing knowledge with those most affected by regulatory processes.

8.2 Clarify the Purpose and Flexibility of Peer Discussion

Recommendation

It may be helpful to offer clearer explanations of the purpose of peer discussion and to explore ways of supporting flexible approaches to its implementation.

Rationale and Connection to Findings

This recommendation is shaped by participants' reflections on how they interpret and experience peer discussion within revalidation processes. While several participants described the activity as empowering and affirming, others viewed it as a procedural

obligation or expressed uncertainty about its intent. These varied interpretations suggest that the purpose of peer discussion is not consistently understood and that the flexibility intended by current guidance is not always felt as such in practice.

Participants navigated peer discussion in diverse ways, some aligning it with appraisals or service reviews, while others selected retrospective conversations based on availability or convenience. Although this adaptability was welcomed by some, others expressed concern about whether their chosen approach was appropriate or met expectations. Such uncertainty appeared to shape perceptions of value, with some pharmacy technicians disengaging when the process felt unclear or misaligned with their role.

These reflections highlight the importance of clarifying what peer discussions is intended to achieve and how flexibility can be meaningfully supported in practice.

8.3 Support Pharmacy Technicians in Navigating Peer Selection

Recommendation

Practical, context-sensitive guidance tailored to different practice settings, levels of responsibility and organisational structures could support pharmacy technicians in making confident and meaningful peer selections.

Rationale and Connection to Findings

This recommendation is grounded in participants' accounts of how peer selection was experienced as a relational and, at times, challenging process. Although the GPhC guidance encourages autonomy in choosing a peer, participants described a range of factors influencing their decisions, including trust, familiarity, perceived relevance and availability. For some, selection was a deliberate and strategic act; for others, it was shaped by time constraints, organisational expectations or limited access to suitable colleagues.

These accounts suggest that autonomy, while valued, may not be sufficient to support confident or meaningful peer selection. Participants expressed uncertainty about who could act as a peer, with some making choices based on convenience rather than reflective fit. This tension was particularly evident in roles involving professional isolation, such as those working across multiple settings or in non-traditional environments.

Recognising peer selection as a context-sensitive and relational decision points towards a need for more practical and accessible support mechanisms.

8.4 Acknowledging Sector-Specific Realities

Recommendation

Peer discussion guidance could be adapted to reflect the diverse contexts and constraints of pharmacy technician practice.

Rationale and Connection to Findings.

This recommendation is constructed from participants' accounts of how sector, setting and scope of practice shaped their engagement in peer discussion. Although the revalidation framework applies uniformly across the pharmacy professions, participants described varied experiences that reflected the diversity of their roles. Those in isolated, specialist or remote environments frequently encountered barriers to identifying suitable peers, while others noted that role-specific factors influenced the relevance and depth of peer conversations.

These reflections suggest that a single model of peer discussion may not sufficiently account for the realities of pharmacy technician practice. The assumption that all registrants have equal access to peers, or that reflective conversations can be easily arranged, does not align with the experiences shared in this study. Participants often adapted the process to suit their context, yet many expressed a desire for more inclusive and responsive approaches that recognise both constraints and opportunities within different sectors.

Acknowledging sector-specific realities offers a route towards enhancing engagement for all pharmacy technicians, regardless of setting or circumstance.

8.5 Implications for Practice

To translate the recommendations into meaningful change, the following suggestions may enhance pharmacy technicians' experience of peer discussion within revalidation:

- Offering clearer guidance that explains the purpose of peer discussion, who may act as a peer and the range of acceptable formats.
- Providing more varied illustrative examples that reflect the breadth of pharmacy technician roles and settings, including both formal and informal approaches such as retrospective conversations.
- Exploring opportunities to co-design support materials with pharmacy technicians so that resources resonate with real-life practice and encourage a sense of ownership.
- Developing reflective tools or guiding questions that may help pharmacy technicians identify peers who can support meaningful dialogues.
- Creating and strengthening virtual communities, regional networks and interprofessional forums that could connect pharmacy technicians across geographical and sector boundaries.
- Acknowledging non-traditional peer relationships in contexts where conventional access is limited, such as lone working, remote practice or specialist roles, by validating alternative forms of reflective engagement.

These actions respond directly to the fourth research question, by offering interpretive insights into how pharmacy technicians might be better supported through training, guidance and organisational infrastructure. They highlight the importance of embedding flexibility, relevance and inclusivity into future developments.

Ultimately, strengthening peer discussions in revalidation requires more than procedural clarity, it calls for a shift towards co-designed, context-aware support that reflects the realities of pharmacy technician practice. By involving pharmacy technicians in shaping these resources, the profession can move closer to bridging the gap between policy ambition and everyday experience.

8.6 Closing Reflections

In developing these recommendations, I have remained mindful of the ethical dimensions of dissemination. As Rees et al. (2024) highlight, ethical considerations do not end with data collection, they extend into how knowledge is shared, interpreted and taken up by others. This notion of "exiting ethics" (Rees et al., 2024, p.59) has shaped my approach to presenting these recommendations, particularly given that

pharmacy technicians, including myself, are currently engaging in peer discussions as part of revalidation.

These recommendations are not intended to critique or diminish the peer discussions already taking place, nor to suggest that the current model is fundamentally flawed. Rather, they are offered as contextually situated insights, constructed through reflexive engagement with participants' accounts and shaped by my own position as an insider researcher. As Reid et al. (2018a) remind us, ethical dilemmas in qualitative research often arise in the spaces between interpretation and representation. I have sought to navigate these spaces with care, acknowledging the complexity of peer discussion in practice, the diversity of pharmacy technician roles and the importance of supporting change that feels both respectful and realistic.

By sharing these interpretations, I hope to contribute to ongoing conversations about how peer discussion is understood, supported and experienced by pharmacy technicians. Notably, the GPhC has recently commissioned a survey to gather feedback from pharmacy professionals on the current revalidation model, including peer discussion (Pharmacy Business, 2024). While the findings are not intended for public release, they will inform internal discussions about potential improvements. The commissioning of this survey indicates a willingness to engage with practitioner perspectives and consider refinements to the existing approach.

The recommendations presented in this chapter have been constructed through reflexive engagement with the experiences of pharmacy technicians and shaped by my own position as a practitioner-researcher. They are offered not as prescriptive solutions, but as context-sensitive insights that may support more meaningful engagement with peer discussion across the profession.

In the final chapter, I turn inward to reflect on the personal, professional and academic journey of completing this research and the Doctorate in Clinical Education. This reflection considers how the process has shaped my understanding of research, my identity as a pharmacy technician and educator, and my hopes for the future of the pharmacy technician profession.

Chapter 9: Reflections on the Research Journey

This chapter continues that reflective stance by exploring how I have come to understand myself as a researcher, how I have navigated the ethical and methodological complexities of insider research and how the DClinEd has influenced my professional identity.

This programme began during the Covid-19 pandemic in October 2020, a time of significant uncertainty across healthcare and education. However, this context offered unexpected affordances: lessons delivered online meant that I could engage fully in the programme without the logistical challenges of travelling to university. This accessibility supported my participation at a time when in-person learning might have been more difficult to manage, allowing me to embed the DClinED into my working life from the outset.

This chapter also considers the emotional and intellectual effort involved in conducting research within one's own profession and the responsibilities that come with representing the voices of peers and colleagues.

This reflection is not intended as a conclusion, but as a continuation of the interpretive process that has shaped this study. It provides a space for me to consider what has been learned, what remains uncertain and how this journey may inform future practice and professional contribution.

9.1 Navigating Insider-Research

Throughout this study, I have occupied the position of an insider researcher, conducting research within my own profession and among peers with whom I share language, values and lived experience. This positioning brought both opportunities and challenges. On one hand, my insider status enabled a deeper understanding of the context and nuances of pharmacy technician practice. I was able to interpret participants' accounts with a level of familiarity that may not have been accessible to an external researcher. On the other hand, this closeness required ongoing reflexivity to ensure that my interpretations were grounded in the data, rather than shaped solely by my own assumptions or experiences.

As Merton (1972) and others have noted, insider research requires careful attention to the boundaries between shared understanding and critical distance. I found myself continually negotiating these boundaries, particularly when participants described experiences that resonated with my own. In these moments, I was reminded of the importance of remaining open to difference and of resisting the temptation to assume commonality where it may not exist.

Reflexivity became a central part of my research practice. I documented my analytic decisions, questioned my interpretations and remained attentive to how my positionality shaped the construction of meaning. Braun and Clarke's (2006) RTA provided a framework that supported this reflexive stance, encouraging me to engage deeply with the data while acknowledging my own role in the analytical process. Rather than striving for neutrality, I embraced the interpretive nature of qualitative inquiry and sought to be transparent about how knowledge was co-constructed through the research process.

Navigating insider research also raised ethical considerations, particularly in relation to representation and responsibility. I was acutely aware that the participants in this study were not only research subjects, but colleagues and members of a shared professional community. This awareness shaped how I approached data collection, analysis and dissemination and reinforced my commitment to presenting participants' experiences with care, respect and integrity.

9.2 Professional Identity

Engaging in this research has had a profound impact on how I understand and inhabit my professional identity. As a pharmacy technician, I have often found myself working in spaces where our profession is underrepresented, particularly in research, higher education and national policy conversations. This study has not only deepened my understanding of peer discussion and reflective practice but has also shifted how I see my role within the wider professional landscape.

Pharmacy technicians remain significantly underrepresented in research, both as participants and as researchers. This is not necessarily a reflection of disinterest or lack of value but may instead reflect the relatively recent professionalisation of the role. Since registration with the GPhC became mandatory in 2011, pharmacy technicians have been navigating a transition from supported roles to recognised healthcare professionals with defined responsibilities and accountabilities. As such, our professional identity is still evolving, shaped by regulatory change, expanding scope of practice and increasing engagement with multidisciplinary teams.

These structural and cultural shifts may help explain why pharmacy technician-led research is still emerging. Through this study, I have sought to contribute to that development, not only by focusing on the experiences of pharmacy technicians, but by taking up the role of researcher myself.

This journey has opened unexpected opportunities. I have been invited to contribute to national conversations about pharmacy technician research, including joining the

Pharmacy Research Action Group (PRAG) and contributing to studies led by the National Institute for Health and Care Research (NIHR) Pharmacy Incubator. This work led to a voluntary role as a manuscript reviewer for the International Journal of Pharmacy Professional Practice (IJPP), the first pharmacy technician reviewer for them. I was honoured to receive the APTUK Katherine Miles Award for a poster introducing my study and had an opportunity to showcase my work at the APTUK conference in a section on pharmacy technicians in research, alongside colleagues. I have also written articles for the Pharmacy Technician Journal, sharing insights from this study and research journey with a wider professional audience. These experiences have reinforced the value of pharmacy technician-led research and the importance of creating space for our voices within academic and policy settings.

Perhaps most significantly, in August 2025 I began a new Associate Professor role at a Midlands-based university. This appointment represents a major milestone in my career, one that I had hoped might come later but which has been made possible through the DClinEd and this research. It marks a transition into higher education and academia, spaces where pharmacy technicians are still rare. I do not take this lightly. I recognise the responsibility that comes with being visible in these spaces and I hope that my presence might encourage others to see research and academia as possible and valuable parts of a pharmacy technician career.

This research has not only shaped how I see myself, but how I see the profession. It has reinforced my belief in the value of pharmacy technicians' contributions, and the importance of creating structures that support our development, leadership and learning. I hope that this study, and the journey it represents, can serve as one example of what is possible when pharmacy technicians are supported to lead, reflect and research from within their own practice.

9.3 Developing as a Researcher

My development as a researcher has been shaped by the iterative, reflexive and often uncertain nature of this study. While I had previously completed a Master of Education, the DClinEd has deepened my understanding of qualitative research and introduced me to new ways of thinking about knowledge, meaning and interpretation. Engaging with interpretivism and RTA has challenged me to move beyond procedural approaches to research and to embrace the complexity and subjectivity of analysis.

At the outset, I was drawn to RTA because of its flexibility and its alignment with my values as a practitioner. As I progressed, I came to appreciate the depth of reflexivity it demands. I learned to document my analytic decisions, to question my assumptions and to remain open to the unexpected. Rather than seeking to validate findings

through triangulation, I came to understand the value of crystallisation, of seeing the data from multiple angles and allowing my interpretations to develop through sustained engagement.

This process was not always comfortable. There were moments of doubt, where I questioned whether I was “doing it right”, or whether my interpretations were sufficiently grounded. But over time, I came to trust the process, and to trust myself. I learned that rigour in qualitative research is not about detachment or neutrality, but about transparency, reflexivity and care.

The DClinEd has also helped me to develop a more confident academic voice. Through supervision, peer feedback and engagement with the literature, I have learned to situate my work within wider conversations and to articulate my contributions with greater clarity. I have come to see research not as a separate activity, but as an extension of my professional practice, as a way of making sense of the world, of contributing to my profession and of supporting others to do the same.

This development has been both personal and professional. I now feel more confident in my ability to design, conduct and communicate research. I also feel more connected to the research community, both within pharmacy and beyond. As I move into a new portfolio career, combining a system-wide NHS leadership role with a higher education appointment, I carry with me not only the skills I have developed, but a renewed sense of curiosity, responsibility and possibility. This dual role offers a rare opportunity for a pharmacy technician to bridge practice, education and research, and I hope to use it to continue contributing to the profession in meaningful and inclusive ways.

9.4 Looking Ahead

As I complete this research and the DClinEd, I find myself reflecting not only on what has been learned, but on what lies ahead.

I hope to continue building on the work started here, supporting pharmacy technicians to engage in research, to reflect meaningfully on their practice and to see themselves as contributors to professional knowledge. I also hope to use my position to advocate for greater visibility and representation of pharmacy technicians in academic and policy spaces. This research has shown me what is possible when our voices are centred, and I am committed to creating more opportunities for that to happen.

This journey has not been without difficulty. During this doctorate, I experienced the profound personal loss of both my father and my younger sister. Their absence has been deeply felt, and there were times when continuing the research felt almost

impossible. Yet, in those moments, I found a kind of solace in the work, a space to think, to write and to make sense of things. The research became a quiet companion during some of the hardest periods of my life and completing it now feels like a tribute to the resilience, support and love that carried me through.

This thesis does not mark an end, but a beginning. It is the culmination of a journey that has shaped who I am as a pharmacy technician, a researcher and a person. It is also an invitation, to me and to others, to keep asking questions, to keep reflecting and to keep contributing to a profession that continues to evolve. I am proud to have added my voice to that conversation.

To continue this work, I intend to disseminate my findings through pharmacy-specific conferences, including the Clinical Pharmacy Congress, the Pharmacy Education Conference and APTUK. I plan to create posters, deliver presentations at APTUK branch meetings and publish a follow-up article in their journal, building on my previous work and the recognition through the Katherine Miles Poster Award. I will also explore opportunities to publish in professional, peer-reviewed journals to reach wider academic and practitioner audiences. These dissemination activities will help ensure that the insights from this research contribute meaningfully to ongoing conversations in pharmacy education and practice.

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Appendices

Appendix 1: Literature Search Table

Resource type	Database or website	Number of articles found
Academic – health and education related	EBSCO databases - CINAHL (nursing and health), ERIC, British Education Index	1062
Academic – health related	Web of Science (social and physical sciences)	984
	Ovid databases – Embase, Medline, Psycinfo and Global Health (health and medicine), HMIC	1436
	Scopus	490
Pharmacy Professional	GPhC website	245
	HEE website	115
	HEIW website	46
	NES website	25
	The Department of Health and Social Care	770
	APTUK website	11
	RPS website	94
e-Thesis online	EThOS	170
Total publications		5448
Duplicates (removed)	-2445	**3003**
Irrelevant title/abstract (removed)	-2824	**179**
Duplicates identified at first evaluation (removed)	-5	**174**
Irrelevant after first evaluation (removed)	-22	**152**
Removed following CASP/COREQ review	-84	**68**
Hand searching (added)	+8	**76**
Search notification articles (added)	+19	**95**

Appendix 2: Literature Summary Table with Examples

CASP ref / COREQ score	Theme / comments	Citation	Title	Setting	Design	Sample and Sample size
001	Good general discussion of use of peers in CPD Similar research method to me **Peer-to-peer**	Abdul Samad et al., 2014	Malaysian private general practitioners' views and experiences on continuous professional development: A qualitative study.	GPs from urban area of Malaysia	Qualitative, semi-structure interviews and focus groups	n=7 (interview) n=10 (focus groups)
002	Linked to **professional isolation**. Limited data for me.	Adams et al., 2019	The implications of isolation for remote industrial health workers.	Industrial health workers in semi-remote or remote areas of Australia	Phenomenological study, interviews.	n=7
005	Initialising peer support for mental health patients in USA **Peer support workers**	Adams, W.E., 2020	Unintended consequences of institutionalizing peer support work in mental healthcare.	Peer support workers for mental health	Mixed methods, online survey and semi-structure interview	n=49

Adapted from McLoughlin et al. (2018)

Appendix 3: Survey Questions (Summary)

Section 1

Eligibility

1. Are you a pharmacy technician registered with the GPhC? (Yes/No)
2. Have you participated in peer discussion as part of GPhC revalidation? (Yes/No)

Section 2

Demographic data

3. In which country do you PRACTISE pharmacy? (Drop-down selection)
4. What stage of your pharmacy technician career are you in? (single choice)
5. Employment status (full/part time/not employed)
6. In which of the following pharmacy settings have you been employed in, when participating in peer discussion? (Multiple choice)

Section 3

Your experience of peer discussion for revalidation

7. Have you submitted your own peer discussion as part of your revalidation with the GPhC? (Yes/No)
8. Have you ever participated in a group discussion to meet the requirements for your peer discussion as part of your revalidation? (Yes/No)
9. Please detail, in your own words, your experience of a group peer discussion. (free text)
10. Have you undertaken a peer discussion on a 1-to-1 basis to meet your revalidation requirements? (Yes/No)
11. Which of the following have undertaken the role of peer for you, as part of your discussion(s) for revalidation? (multiple choice)
12. Please detail, in your own words, what you consider when identifying a peer(s) for peer discussion(s). (free text)
13. Have you ever undertaken a peer discussion and then **not** submitted it for GPhC revalidation? (Yes/No/Not sure)
14. Please detail, in your own words, why you did not submit the peer discussion. (free text)
15. Have you ever received feedback on your revalidation submissions from the GPhC? (Yes/No/Not sure)
16. What was the result of the feedback you received? (multiple choice)

Section 4

Your experience of acting as a peer

17. Have you ever acted as a peer for a pharmacy registrant as part of their GPhC revalidation? (Yes/No/Not sure)
18. What was the pharmacy profession of the registrant you were a peer for, as part of their revalidation? (multiple choice)
19. Have you acted as the peer for the same individual who acted as your peer? (Yes/No/Not sure)
20. How soon after your initial peer discussion did you switch roles? (immediate/later)

Section 5

This section will collate data on any support used in revalidation.

21. Which of the following resources have you used to support you with peer (multiple choice)
22. Additional comments (free text)

Appendix 4: Data Management Plan

Researcher Name	Gail Hall
Project Title	Peer discussion in practice – Experiences of pharmacy technicians in the participation of revalidation for registration.
Faculty	Leeds Institute of Medical Education (LIME)
KRISTAL Reference Number (if applicable)	
Supervisor(s) name (if applicable)	Prof. Anne-Marie Reid, Dr Mary-Claire Kennedy, Dr Naomi Quinton
Funder	
Scheme	Clinical Education Doctorate
Research Start Date	01.10.2022
Research End Date	01.12.2023
Ethical review number	MREC 22-008
DMP review due	

Date	Version	Author	Change notes
15/04/2022	1	Gail Hall	
21/01/2023	1.1	Gail Hall	Ethics reference added
15/09/2025	1.2	Gail Hall	Title updated

Please provide a brief overview of your project including proposed research methods

The study aims to gather data on the experiences of pharmacy technicians participating in peer discussion as part of revalidation with the General Pharmaceutical Council. A interpretivist approach will be used to collect data using an online, self-administered questionnaire using Microsoft Forms. Entering data into a sampling frame will identify a minimum of nine individuals to interview through Microsoft Teams videoconferencing software. Transcriptions of recordings will be used for thematic analysis of the data.

1. **What data will be produced? What data will be used from other sources?**

Qualitative and quantitative new data will be generated from respondents to the questionnaire. Qualitative new data will be generated from the semi-structured interviews of participants volunteering to participate further, at questionnaire, and meeting the sampling frame requirements.

Data from the General Pharmaceutical Council (GPhC) survey of registered pharmacy professionals will be used to inform the sampling frame for interviews. This information is in the public domain and is not the original dataset. There is no plan to use any external datasets.

2. **Where will data be stored? How will data be structured? Include file formats and approximate volume.**

Data will be stored within the University of Leeds (UoL) OneDrive and manipulated in the Cloud. A consistent system of file naming and an organised folder structure within OneDrive will enable easy retrieval of documents. This will involve creating meaning, but brief, file names and maintaining a strict version control system.

Folders will include; raw data (datasets containing identifiable data including video recordings), piloting datasets (containing data from pilots), questionnaire datasets (containing anonymised responses to the MS Forms questionnaire), Interview datasets (containing anonymised data of full transcriptions and thematic analysis data), Thesis (containing Word version of thesis write up).

3. **Access to data during the project. Give details of collaborators and any controls.**

Only the supervisors, named on this form, will have access to the datasets for the purpose of supporting the researcher with their programme of learning. Shared access links will be sent directly to supervisors from the UoL OneDrive and will include the level of access i.e. non-editing rights, a password and expiry date for access.

4. Ethics and legal compliance: are there any 'special' requirements for your data? Any contractual or consent issues? Key policies (internal and external)

There are no special requirements for this data.

The data will not contain any highly confidential information and, as such, storage on the UoL OneDrive will not require encryption.

Consent will be obtained by the participants of the questionnaire and interviews as detailed in the ethical approval documentation.

5. **How will data be documented and described? Methodologies and protocols**.

Quantitative and qualitative data will be collected using an online questionnaire in Microsoft Forms, using the UoL Office 365 account. Data will be exported into an Excel spreadsheet, stored in the UoL OneDrive and manipulated in the Cloud.

Qualitative data will also be collected using semi-structured interviews. Interviews will take place using the UoL MS Teams account and will be recorded to aid the purpose of transcription only. Recordings will be digitally stored in MS Teams and saved as an MP4 backup into the UoL OneDrive account. MS Teams transcription data will be stored digitally in the UoL MS Teams account and exported and saved as a Word version in the UoL OneDrive. Recordings and transcriptions will only be accessed in the Cloud. Once transcription has fully occurred the recordings will be deleted from MS Team and OneDrive.

Identifiable data will be held in a separate folder to the anonymised data.

6. Training and support

Research Data Management course attended – 02/12/2020.

I have extensive experience of using MS products but will require additional training on the use of Excel which I aim to get from LinkedIn learning packages.

7. What are the plans for data sharing beyond project partners? Include justification if some of your data needs to be restricted. Include data and code. Include repository.

As this is a student led project there is no expectation of the data being publicly available. Research findings will be shared with key stakeholders identified as interested parties, along with participants of the research (where requested) in the form of a short report. When sharing findings all participants will be pseudonymised and direct quotations will be anonymised.

8. What Intellectual Property will be generated? How will IP be protected and exploited?

The intellectual property of the data generated will remain with the University of Leeds.

9. Who is responsible for managing the data? What resources will you need?

I will have overall responsibility for implementing the data management plan.

10. Ongoing data curation / data housekeeping - you may find it useful to include a retention table

The data management plan will be monitored in meetings with my mentor and supervisors.

Data will be kept for two years after publication.

End of Project

At the end of a project and/or before you leave the institution, you should ensure that data and research materials are deposited with the School or a trusted data repository and documented in such a way that they can be found and understood.

Dataset name	Location	Person responsible

Appendix 5: Confirmation of School of Medicine Research Ethics Committee Approval

The Secretariat
University of Leeds
Leeds, LS2 9JT
Email: fmhuniethics@leeds.ac.uk

UNIVERSITY OF LEEDS

Gail Hall
Leeds Institute of Medical Education
Faculty of Medicine and Health
University of Leeds
Leeds, LS2 9JT

09 January 2023

Dear Gail

MREC 22-008 – Peer discussion in practice - Experiences of pharmacy technicians in the participation of revalidation for registration: A descriptive exploratory study

I am pleased to inform you that the above research ethics application has been reviewed by School of Medicine Research Ethics Committee and I can confirm a favourable ethical opinion based on the documentation received at date of this email.

The reviewers had some comment(s) for your consideration which are below, these do not impact your approval. If you decide to update any documents in response to these comments please submit these to this email address for storage.

1. ***Whether by identifying yourself by name, could participants work out their role etc*** *(for consideration)*

Please retain this email as evidence of approval in your study file.

Please notify the committee if you intend to make any amendments to the original research as submitted and approved to date. This includes recruitment methodology; all changes must receive ethical approval prior to implementation. Please see http://ris.leeds.ac.uk/downloads/download/179/amendment_form or contact the Research Ethics & Governance Administrator for further information (fmhuniethics@leeds.ac.uk) if required.

Ethics approval does not infer you have the right of access to any member of staff or student or documents and the premises of the University of Leeds. Nor does it imply any right of access to the premises of any other organisation, including clinical areas. The committee takes no responsibility for you gaining access to staff, students and/or premises prior to, during or following your research activities.

Please note: You are expected to keep a record of all your approved documentation, as well as documents such as sample consent forms, risk assessments and other documents relating to the study. This should be kept in your study file, which should be readily available for audit purposes. You will be given a two week notice period if your project is to be audited.

If you require this confirmation in letter form, for example to show to external funders, then please do email me. I am happy to provide this if required.

It is our policy to remind everyone that it is your responsibility to comply with Health and Safety, Data Protection and any other legal and/or professional guidelines there may be.

I hope the study goes well.

Yours sincerely

Rachel de Souza, the Secretariat
On behalf of Dr Naomi Quinton, SoMREC Chair

CC: Anne-Marie Reid

Appendix 6: Summary of Cumulative Weekly Survey Completion Data

Week ending 31.03.2023				
Country of practise	**Community sector**	**Secondary Care**	**Primary Care**	**Other sectors**
England	37	65	20	53
Scotland	3	11	10	2
Wales	8	14	2	7
Targeted Wales and Scotland via APTUK and NPTGS. Week ending 07.04.2023				
England	40	75	21	57
Scotland	6	13	11	2
Wales	8	14	2	8
Cyprus (MoD)	0	0	0	1
Targeted primary care via the PCPA. Social media push for Easter break. Week ending 21.04.2023				
England	51	88	24	66
Scotland	6	14	13	3
Wales	10	17	2	8
Cyprus (MoD)	0	0	0	1
Final week. Targeted Scotland and Wales via APTUK and social media. Week ending 28.04.2023				
England	53	89	24	68
Scotland	7	20	15	5
Wales	13	19	2	9
Cyprus (MoD)	0	0	0	1

Appendix 7: Examples of Survey Free Text Data Responses

ID	Q12 - Please detail, in your own words, what you consider when identifying a peer(s) for peer discussion(s).
PT01	A peer who is Independent of my practice is very important, will always consider peer from outside of pharmacy profession as I find this beneficial in challenging my practice and bringing outside profession perspective. Will choose my peer based on any previous experience and encounters that have led me to believe that they would provide good peer discussion and challenge.
PT02	Someone with specialist knowledge I will learn from
PT03	A person working in the pharmacy field in any setting. Ideally within the same practice type as myself i.e community or PCN.
PT04	To be honest it is a tick box exercise and of little value. So it is a case of choosing someone e convenient

ID	Q14 - Please detail, in your own words, why you did not submit the peer discussion.
PT05	There are so many scenarios that happen that could be potential peer reviews in day-to-day practice, not planned but where a scenario necessitates further discussion, support, next steps and reflection.
PT06	Not necessary
PT19	Was not required due to Covid changes in revalidation
PT21	Had already untaken discussion
PT29	We have peer discussions quite regularly working in a large teaching hospital. It's not possible to record them all!

Appendix 8: Interview Guide (Summary)

Section 1: Background and Professional Role Tell me about yourself: - Time in pharmacy and as a qualified pharmacy technician - Current role and AfC banding - Level of responsibility e.g. managerial - Professional training completed - Sectors of pharmacy worked in e.g. primary, secondary, education, community etc.
Section 2: Understanding of Peer Discussion What does 'peer' mean to you in the context of revalidation? - Influences on your understanding
Section 3: Selecting a Peer What do you consider when identifying a peer? - Influence of topic, peer's views, professional background What is your experience of selecting a peer? - Criteria e.g. qualifications, familiarity, workplace - Ease or difficulty of finding a peer
Section 4: Planning the discussion Choosing the topic: - Influences and sequence (topic Vs peer) Nature of discussion: - Structure, formality, ability to speak freely Location of discussion: - Online, workplace, other settings
Section 5: Use of Resources Resources used for preparation, discussion or write-up - Types of resources, usefulness, workplace policies - Support for writing into MyGPhC
Section 6: Impact and Reflections Development from peer discussions: - Changes in practice, perceived value or limitations - Views on peer discussion as part of revalidation
Final Prompt Is there anything else you would like to share about peer discussion as a pharmacy technician completing revalidation?

Appendix 9: Demographics of Interview Participants

ID	Country of practice	Years in practice	Employment status	Sectors
PT73	Wales	0-2	FT	Primary
PT96	England	11-19	FT	Health Commissioning
PT150	Wales	20-29	FT	Community
PT191	Scotland	20-29	FT	Secondary
PT208	Wales	20-29	PT	Secondary
PT275	England	30-39	FT	Armed forces Prison Community
PT276	Wales	30-39	FT	Secondary
PT307	England	50+	Self-employed	Secondary Research, education and training
PT314	Scotland	30-39	PT	Research, education and training

Appendix 10: Theme Development Across Three Iterations

Iteration 1		Iteration 2		Iteration 3	
Theme	**Subtheme**	**Theme**	**Subtheme**	**Theme**	**Subtheme**
Influences when selecting peers for peer discussions	Qualities Accessibility	Meaningful discussions	Foundations of peer selection Navigating peer selection	Strategic peer selection for meaningful discussions	Intrinsic motivations in peer selection Extrinsic influences in peer selection
Perceived value of peer discussions	Outcomes / consequences Value Preparation and timing	Outcomes	Structured Vs unstructured Optimising outcomes Navigating engagement	Fostering meaningful discussions	Translating natural interactions into structured reflections Synergising outcomes Navigating Engagement
Regulator rules	Compliance Guidance	Navigating peer discussions	Guidance and support Evolution of requirements Accessibility challenges	Navigating the landscape of peer discussions	Procedural ambiguities Evolution of peer discussions Role-centric challenges

Appendix 11: Iteration Three Theme, Subtheme and Codes Linked to Research Questions

Research Question	1. What perceptions of the value of peer discussions do pharmacy technicians hold?			2. How do pharmacy technicians identify suitable peers to engage in discussions as part of revalidation requirements?		3. What support might pharmacy technicians' value for engaging in peer discussions as part of revalidation requirements?		
Overarching theme	**Fostering meaningful discussions**			**Strategic peer selection for meaningful discussions**		**Navigating the landscape of peer discussions**		
Subtheme	**Translating natural interaction into structured reflections**	**Synergising Outcomes**	**Navigating Engagement**	**Intrinsic motivations in peer selection**	**Extrinsic influences in peer selection**	**Procedural ambiguities**	**Evolution of peer discussions**	**Role-centric challenges**
Codes	Spontaneity / opportunistic Retrospective selections / PDs Discussions happen naturally PDs are artificial/staged Informal formality	Maximum efficiency Maximise the use / value Mutual benefit Shared experience Goal orientated Opportunity to build confidence Knowledge enhancement Affirms practice Problem-solving opportunity	Tick-box exercise Why bother? It's not for me It's not trendy Worth the effort It works for me It's for rule followers Peer dependant It's for geeks Face to face is best	It's my choice Required abilities of registrant Peer/registrant relationship Role modelling behaviours Desired personal/ professional qualities/attributes of a peer Insecurities Worth/Value Peer is known Seeking alternative viewpoint	Topic-focussed Topic leads peer selection Peer selection leads topic Focussed discussions Meaningful to them Process-focused discussion Peer recommendations Hierarchy / superiority driven Power relationships Time pressures/constraints Availability	PDs are challenging Unclear requirements unclear definitions subject to interpretations no news is good news desire for feedback Guidance required Timing Be prepared Write it right	PDs are challenging for first timers Exposure to peers Trigger point Needs evolve over time Registrant needs evolve over time Perspectives evolve Different focus after the first one Practice makes perfect	Challenging for niche roles It's for mainstream roles One size doesn't fit all Easier to achieve for some than others