Practice Guidance

Principles and Application of Clinical Peer Review in Audiology

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General foreword

This document presents Practice Guidance by the British Society of Audiology (BSA). Practice Guidance represents, to the best knowledge of the BSA, the evidence-base and consensus on good practice, given the stated methodology and scope of the document at the time of publication. Although care has been taken in preparing this information, the BSA does not and cannot guarantee the interpretation and application of it. The BSA cannot be held responsible for any errors or omissions, and the BSA accepts no liability whatsoever for any loss or damage howsoever arising. This document supersedes any previous recommended procedure by the BSA and stands until superseded or withdrawn by the BSA.

This is a new document. It draws upon more specific guidance provided in the existing BSA Practice Guidance for Principles of external peer review of auditory brainstem response (ABR) testing in babies, 2019.

This document will be reviewed by the date given on the front cover. However, should any individual or organisation feel that the content requires immediate update, review or revision, they should contact the BSA using the email bsa@thebsa.org.uk. Please add 'BSA document revision request' in the title. You will be asked to complete a short form with your reasons and this will be passed to the Professional Guidance Group for assessment. Comments on this document are welcomed and should be sent to:

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1. Introduction and Background

Quality of care is a fundamental pillar of healthcare services that must be underpinned by robust and comprehensive quality assurance systems. Peer review of clinical practice, or clinical peer review is a key measure of quality and safety in healthcare that can usefully feature as part of quality assurance systems (Kaehne et al., 2019). There are different descriptions of peer review in healthcare. One such description is that clinical peer review involves the evaluation of healthcare professionals' clinical performance by their peers (Bion and Alderman, 2023).

Application of clinical peer review can offer benefits to the clinician, healthcare organisation, and the service user. Clinical peer review should be a tool to improve and verify the quality of patient care. It should be supportive rather than punitive, and discussion and reflection can give clinicians confidence in their practice alongside other elements of a quality assurance programme within which they participate.

Beyond Audiology, clinical peer review has been applied by other healthcare professions for various purposes including quality assurance, continued professional development (CPD) and clinical governance (Australian Commission on Safety and Quality in Healthcare, 2010; Strickland, 2015; Halvorsen et al., 2023). In Audiology practice beyond the UK, application of clinical peer review has been described in schemes to maintain professional registration to practice (Audiology Australia Ltd., 2022; New Zealand Audiological Society, 2025a; New Zealand Audiological Society, 2025b).

Within UK Audiology, peer review has been described more specifically by previous BSA Practice Guidance for ABR testing in babies, an area of practice where formal external peer review schemes have been long established (BSA, 2026). Peer review is also mentioned in UK Audiology Quality Standards - Quality Standards in Audiology in Wales and BAA Quality standards and is an expectation of meeting UKAS accreditation (BAA, 2025; NHS Wales, 2025). Additionally, there is reference to peer review in documentation for respective registration bodies for those healthcare professionals practicing in UK Audiology, as an example of CPD activity (HCPC, 2017; AHCS, 2024).

In summary, it is recognised that there are different definitions and goals of clinical peer review described globally in the literature across healthcare as well as a lack of clarity on the aims and components of a peer review scheme(Kaehne et al., 2019). This body of knowledge together with UK experience of clinical peer review in Audiology has been drawn upon to inform the content of this document (BAA, 2025; NHS Wales 2025; BSA, 2026). Given the opportunities offered by clinical peer review described across healthcare, and experience of its application in UK Audiology to date, it is considered timely to ensure that the UK Audiology community is well-informed of the principles and effective application of clinical

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peer review. This will hopefully encourage wider and improved use of this valuable tool by Audiology professionals and organisations delivering services.

The BSA has produced an extensive body of evidence-based good practice guidance material. This document may therefore be regarded as complementary; describing peer review that will support safe and effective application of practice/procedure specific practice guidance.

2. Aims and Purpose

The aims and purpose of this document is to provide concise, high-level guidance for application across UK Audiology practice that:

- Defines clinical peer review in the context of the following mutually supportive goals:
  - improved quality of care and assurance of services and
  - professional support, development and improvement for individual clinicians.
- Describes the core principles of good clinical peer review schemes.
- Promote and inform development of procedure-specific peer review practices, that adhere to guiding principles of peer review.
- Provide practical guidance to encourage a positive regard, efficient implementation and wider application of peer review, including collaborative clinical peer review programmes in Audiology.
- Provide practical materials to support effective introduction of peer review.

This document has not been designed to enforce a rigid way of undertaking peer review across the UK. It is recognised that detailed application of peer review may vary, depending on factors such as available resources and arrangements for professional collaboration. There is also a recognised need to inform and promote good practice in the application of peer review. The aim of this document is to encourage the effective use of this valuable tool to support good clinical practice.

3. Definitions

Reflecting the goals described above and in the UK Audiology context, clinical peer review is defined here as:

“A formal review of clinical practice of a clinician by a peer/s which is referenced to evidence-based good practice standards, of which the outcomes are shared and reported.”

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- A **peer** shall be defined as a professional who performs the same clinical procedures as the individual being reviewed. They need not necessarily be of the same profession or seniority.
- **Review** shall be regarded as an evaluation of practice working to a defined process understood by participants, with reference to good professional practice. This does not have to be a one-to-one review.
- **Good professional practice** shall be described by guidance that is **evidence-based** and/or reflects practice as described by a reputable professional organisation e.g. the BSA, and can include locally agreed upon protocols in the absence of these in any national policy.
- **Outcome** of the peer review should describe the individual clinician's adherence to practice against a prescribed set of measures/standards and should be documented, **shared** and **reported**, adequately for subsequent audit of the peer review process.
- **Peer reviewer** is the person conducting the peer review.
- **Clinician** is the person being peer reviewed.

For the purpose of this document, peer review is **not**:

- coaching by an expert, training, or an opportunity to express opinion.
- a mechanism to check competency of clinical practice of individuals driven by line management, or as part of a performance review process.
- an audit process[1],[2].
- a competency/skills review of a service.

The definition of peer review presented in this document is purposefully broad in scope. It is flexible so that organisations may choose ways to peer review which suit the local service. When a peer review scheme is being designed by an organisation it may be helpful to consider each of the four questions in

[1] NICE defines clinical audit as: "A process for monitoring standards of clinical care to see if it is being carried out in the best way possible (known as 'best practice'). Clinical audit can be described as a systematic 'cycle'. It involves measuring care against specific criteria, taking action to improve it if necessary, and monitoring the process to sustain improvement. As the process continues, an even higher level of quality is achieved." https://www.nice.org.uk/Glossary?letter=C

[2] In contrast to a clinical audit a clinical peer review process concerns the individual clinician's clinical practice rather than of the service or system and should be reciprocal and ongoing. Clinical peer review should also encourage self-reflection by the clinician.

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Table 1 to help define, and categorise how they will undertake peer review. This approach may subsequently help describe the peer review to others. Please see Appendix B for a template.

Question 1. *Timing of peer review*; when is the peer review performed?		
A. Direct/live observation	B. post-event	
Question 2. *Scope within an appointment*; does it consider all elements or selected elements of clinical practice within an appointment?		
A. All elements of clinical practice considered within scope: from briefing through to debriefing, report writing and management decisions	B. specific elements – if so describe	
Question 3. *Scope across appointments*; does it relate to sequential appointments or just one?		
A. Relating to a single appointment	B. More than one appointment within a patient pathway – if so define	
Question 4. *Scope of collaboration*; is the scheme local (to own health organisation), regional or national?		
A. Local organisational level	B. Regional (or multi-center)	C. National

Table 1. Categorisation of peer review.

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4. Principles of Peer Review

From the outset it is considered important that all participants in a clinical peer review scheme should understand the principles and pre-requisites of trust, openness, and readiness to improve one's own practice through engagement with peers. Successful peer review schemes will feature participants who are comfortable and knowledgeable with the principles of peer review. They will recognise that two-way participation, as both reviewers and as clinicians being reviewed has benefits. Opportunity for reflection should also be included. Clinical peer review presents an opportunity for participants to share and learn, particularly for less commonly presenting clinical profiles. For these reasons stated above clinical peer review schemes should feature reciprocal contributions, meaning the reviewers are also subject to individual peer review through the same scheme.

Those establishing new schemes should consider the impact on individual clinicians who are not familiar with reflection and discussion of their clinical work with others, particularly in the context of any challenges to service quality. Aside from briefing on the principles of peer review, participants will need reassurance that the approach being taken within the peer review scheme is supportive and positive for the individual, rather than punitive. Opportunities for participants to contribute to the development of new peer review schemes is advisable. Participants and those co-ordinating peer review schemes should be bound by both personal and organisational governance requirements.

It is the responsibility of the reviewer to declare any conflicts of interest and be alert to any personal bias that may occur during the peer review process, perhaps relating to the seniority of the clinician subject to peer review.

5. Application of Peer Review Schemes

The definition adopted for clinical peer review in this document is broad in scope. Opportunity therefore presents to apply clinical peer review across all areas of practice in Audiology, in different forms described above. Such widespread application is encouraged. Whilst opportunities are widespread, those planning introduction of clinical peer review at service level might wish to consider where and how to prioritise their efforts to introduce clinical peer review, given the range of applications available. It is important to consider the trade-off between potential outcomes/benefits against the effort required to establish a scheme. Factors to consider include:

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- Areas of practice where shortfalls have been identified within the UK Audiology community, even if not necessarily identified within the local service.
- Whether a collaborative network exists to support peer review or an established multi-site peer review scheme is established that could be joined.
- Where a similar clinical peer review scheme and associated materials have been defined elsewhere that can be used or adapted.
- The frequency of activity; particularly where there is low frequency activity and/or where there are small number of clinicians (or just one clinician) who cannot benefit from close working proximity to colleagues performing the same activity – often associated with specialist and highly complex procedures.
- Areas of practice where relevant professional evidence-based practice guidance is available in a form that can be readily incorporated into clinical peer review regimes.

Collaboration between UK Audiology services on the development and application of clinical peer review is strongly advised, whether at a national or regional level between services. This would provide for efficiencies and assurance with respect to delivering schemes that achieve the desirable features set out below. **In general, greater assurance will be afforded by an external or collaborative schemes than a purely internal peer review schemes.** Those considering establishment of clinical peer review schemes should be aware that in the absence of external scrutiny, internal peer review may be more subject to the effects of bias and greater potential for local deviation from national standards of good practice.

6. Desirable Features of Peer Review Schemes

It is recommended that the following features should be considered as desirable by those planning introduction of clinical peer review schemes, although recognising that desirable features may not always be viable or practical to achieve for all schemes:

6.1 **Clear aims/purpose** - set out in a document with reference to professional good practice guidance, a defined patient group, defined element of care (assessment, management decision and treatment) as appropriate and participant clinical staff (tester and reviewer). This should include a statement of the minimum level of knowledge, training and experience for participants. Any limitations to the scheme should be described. Content should be agreed by participants or their professional representatives.

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6.2 **Well-defined documentation** – this should define the process with standardised recording and reporting materials/templates with reference to professional good practice guidance and opportunity for reflection.

6.3 **External element to process** - as an example, bias/impartiality may be mitigated by clinical peer review external to the organisation and periodic rotation of peer reviewers within a scheme.

6.4 **Participants briefed and consent to clinical peer review** – the reviewer should have full awareness of the principles of peer review described above, when and how peer review will be undertaken and by whom. If the patient contact is part of the review their consent should be obtained prior to the review.

6.5 **Well-trained participants** - all peer reviewers should have accessed training in the clinical peer review scheme to help assure competency for participation. Consideration should be given for periodic refresher training particularly as schemes evolve. Training should include familiarity with this document.

6.6 **Peer reviewers independence from line management** – where possible peer reviewers should not be direct line managers of the individual being reviewed.

6.7 **Discussion and reflection time - t**he process should include expected times for submission for clinical peer review (post patient contact) and turnaround times for peer review discussion and review.

6.8 **Managing disagreement –** a process should be in place to resolve any disagreement between the peer reviewer and clinician, that may involve the line manager.

6.9 **Statement of accountability for peer review** – ultimate responsibility for patient management lies with the clinician whose practice is under review, within the local employer's governance framework.

6.10 **Guidance on manipulation and retention of data** - should be compliant with information governance requirements - e.g. anonymising patient details and indicating how long should information be retained.

6.11 **Defining the means of patient/case selection** - use either all patients in category or a sampling approach that is representative and robust against 'cherry-picking'.

6.12 **Anonymising the data** – when reporting the outcome of the peer review, any individual participants within a scheme should be anonymous, not identifying participating clinicians unless consented by the individual.

6.13 **The scheme should be resourced proportionate to the remit/scope** – with commitment, accountability and agreement from all involved, as an under-resourced scheme may provide false reassurance.

6.14 **Resources for co-ordination in place -** for collaborative multi-site clinical peer review schemes a coordinator should be identified/agreed by a nominating body or organisation, working to a

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described role. Consideration should be given for co-ordinator rotation for reasons of good governance and collective ownership of the scheme.

6.15 **A reporting body** - to oversee the peer review scheme and receive reports at specified timings and content should be identified. At a local level, outcomes for the respective scheme should be incorporated into routine reporting through organisational quality assurance arrangements.

6.16 **Collective outcomes and learning** – opportunities should be considered for sharing learning and outcomes, to inform local and national training programmes.

6.17 **Escalation mechanisms** - are described and understood for if practice deviates from professional good practice to a point where the safety of the patient is under question. There should be opportunities for participants to provide individual feedback on the scheme.

6.18 **A set of Key Performance Indicators (KPIs)** - defined for the scheme, approved by the reporting body and reported against on a regular basis for the purpose of audit of the scheme.

6.19 **Reviewing the learning cycle** - the scheme process and KPIs are periodically reviewed to learn from operational experience.

6.20 **Moderation of reviewers** - should occur periodically through a defined process led by the scheme coordinator.

6.21 **Opportunity for external review and/or benchmarking of the peer review scheme** - should be established - e.g. input from a coordinator of an equivalent scheme from another region/country might be invited to evaluate the scheme at point of periodic review, and/or presentation of outcomes for external scrutiny at higher level forums, e.g. UK-level events.

7. Promotion and Further Research

Audiology clinical peer review schemes should be shared and promoted more widely through national Audiology conferences and meetings. The following topics are suggested with a view to informing better practice in clinical peer review in UK Audiology:

- Description and outcomes of clinical peer review schemes.
- What are the attitudes of participants to clinical peer review – before and after participation in peer review schemes?
- What is the impact of collaborative clinical peer review schemes on health and care outcomes?

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8. Appendices

Appendix A

Peer Review Checklist – for use by those developing peer review schemes.

The following questions are based closely on the desired features of peer review described above. Not all may be viable, but to help achieve effective peer review all should be considered and applied where possible when devising peer review schemes.

	Yes	No	Not applicable
Overview of the clinical peer review scheme			
Are there clear aims/purposes of the scheme?			
Do you understand the limitations of the scheme?			
Is there reference to professional good practice guidance or link to the relevant evidence-base (or reference to local guidance where this is missing)?			
Is the patient group defined?			
Are you clear in what element(s) of care are to be reviewed?			
Do you have clear documentation in place for the peer review? Does the documentation provide review elements itemised with reference to professional good practice guidance and opportunity for reflection?			
Are participants briefed and in agreement with the benefits and principles of peer review described in the BSA Principles of Peer Review document?			
The Peer Reviewers			
Do you know which staff group (or individual clinicians) are going to be the peer reviewers?			
Do you know what is the minimum level of knowledge, training and experience for the peer reviewers?			
Have measures have been taken to mitigate bias/impartiality/subjective effects?			
Has assessed training in the peer review scheme been completed by the peer reviewers with reference to this document and the specific scheme? Has this been updated as the scheme has evolved?			

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Clinicians being peer reviewed			
Do you know which staff group (or individual clinicians) are going to be peer reviewed?			
Do the staff having a peer review understand the process before it takes place?			
Do the clinical staff consent to have peer reviews undertaken?			
Is there a statement of accountability within the description of the scheme?			
Discussion and reflection			
Does the review process have clear timelines for discussion and reflection?			
Are mechanisms in place to manage disagreement in outcome should this arise?			
Are mechanisms described for escalation, where practice deviates from professional good practice?			
The data			
Is there guidance on how long peer review outcomes/report and paperwork should be kept for the purposes of audit?			
Is the case selection representative and robust against 'cherry-picking?'			
Has consideration been given to achieving anonymity in identifying participating clinicians?			
Resources			
Is the resourcing of the scheme proportionate to the remit/scope?			
For a collaborative multi-site peer review scheme, has a coordinator(s) been agreed by a nominating body or organisation?			
Is there a reporting body to oversee the peer review scheme and receive reports at specified timings and content should be identified? or At a local level are outcomes for the respective scheme incorporated into routine reporting through organisational quality assurance arrangements?			
Is there a mechanism to identify learning and outcomes of the peer review scheme to inform local or national training needs?			
Has a set of Key Performance Indicators (KPIs) been defined for the scheme, approved by the reporting body?			
Learning from the clinical peer review scheme			

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Are there arrangements to periodically review to learn from operational experience of the scheme?			
Are there opportunities for participants to provide individual feedback on the scheme?			
Have arrangements been made for periodic collaborative events for participants to review outcomes and learning from the peer review scheme e.g. to inform further measures to address any shortfalls in practice such as training or education.			
Have arrangements been made for collaborative review of the efficacy of the peer review scheme by participants?			
Has a process been established for moderation of reviewers to occur periodically, led by the scheme coordinator?			
Have arrangement been made for external review and/or benchmarking of the peer review scheme against similar schemes?			

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Appendix B

Example 1

Balance assessment traces review

Q1	**Post-event**	A review of interpretation of results, e.g. traces from any electrophysiology (Vestibular Evoked Myogenic Potentials, etc), or tests such as video Head Impulse Test (vHIT). This might be done anonymously and without reference to other patient data.
Q2	**Specific elements**	
Q3	**Single appointment OR multiple appointments with same patient**	
Q4	**Local or regional**	

Example 2

Paediatric Visual Reinforcement Audiometry (VRA)

Q1	**Direct/live**	Direct observation peer review of VRA within an appointment by a local team with reference to BSA recommended procedure on VRA. A review of how a specific behavioural based hearing test is conducted, including response interpretation, involving direct observation.
Q2	**All elements**	
Q3	**Single appointment**	
Q4	**Local**	

Example 3

Cochlear Implant (CI) pre-operative assessment case review

Q1	**Post-event**	A case study review looking at the patients history, test results including audiometry, speech testing and other diagnostic testing (if applicable) done as part of the CI assessment. Review of decision/management plan on whether patient is eligible or not and or fully informed to make a decision on CI based on national criteria/quality standards. Use a regional collaborative approach across CI centres to ensure equality and quality of CI pre-operative assessment pathways.
Q2	**All elements**	
Q3	**More than one appointment on a patient pathway**	
Q4	**Regional**	

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Example 4

Auditory Brainstem Response (ABR) review (paediatric/adult)

Q1	**Post-event**	Post event peer review of diagnostic ABR assessment, including analysis, reporting and onward clinical management, as outcomes from an appointment or series of appointments, within a national collaborative peer review scheme.
Q2	**Specific elements**	
Q3	**Patient pathway**	
Q4	**National**	

Example 5

Routine Pure Tone Audiometry (PTA)

Q1	**Direct/live**	Direct peer review of a diagnostic routine pure tone audiometry test on a single patient by peer from local team. Review to include locally agreed components with reference to BSA recommended procedures/practice guidance.
Q2	**Specific elements**	
Q3	**Single appointment**	
Q4	**Local**	

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Appendix C

Template for Document Describing a Clinical Peer Review Scheme

Completion of a document using the sub-headings set out below will help those devising peer review schemes to:

i) describe for the benefit of all participants and

ii) accommodate the desirable features of a peer review scheme set out in the main body of the BSA practice guidance document 'Principles and Application of Clinical Peer Review in Audiology' alongside use of Appendix A - Peer Review Checklist.

Title of Peer Review Scheme

Section 1 - Overview

1.1 Aims/purpose of the scheme

1.2 Summary Categorisation (please refer to Section 3 of guidance document to provide a description based on questions to Table 1)

1.3 Scope and Limitations

1.4 Patient Group

1.5 Elements of practice/care to be peer reviewed

1.6 Reference professional good practice guidance

Section 2 – Peer Reviewers

2.1 Staff group (or individual clinicians) to be the peer reviewers

2.2 Minimum level of knowledge, training and experience for the peer reviewers

2.3 Measures taken to mitigate bias/impartiality/subjective effects

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2.4 Assessed training in the peer review scheme to be completed by peer reviewers

Section 3 – Clinicians Being Peer Reviewed

3.1 Staff group (or individual clinicians) to be peer reviewed

3.2 Arrangements to brief participants on the peer review scheme

3.3 Statement of accountability

Section 4 – Discussion and reflection

4.1 Review process have clear timelines for discussion and reflection

4.2 Mechanisms in place to manage disagreement in outcome should this arise

4.3 Mechanisms described for escalation, where practice deviates from professional good practice

Section 5 - Data

5.1 Data retention: for the purposes of audit of the scheme

5.2 Measures to ensure case selection is robust and representative

5.3 Measures to ensure anonymity and otherwise comply with information governance requirements

Section 6 – Resourcing and Governance

6.1 Arrangement for coordination of multi-site peer review (where applicable)

6.2 Oversight of scheme – details of reporting body or incorporation into local quality assurance system

6.3 Mechanisms to identify learning and outcomes of the peer review scheme, to inform local or national training needs

6.4 Key Performance Indicators (KPIs) defined for the scheme, approved by the reporting body

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Section 7 - Learning from the peer review scheme

7.1 Arrangements to periodically review and learn from operational experience of the scheme

7.2 Opportunities for participants to provide individual feedback on the scheme

7.3 Process for moderation of reviewers

7.4 Arrangement for external review and/or benchmarking of the peer review scheme against similar schemes

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