BRITISH HIP SOCIETY

**BHS SURGICAL STANDARD**

# Dual Consultant Operating & Mentoring

## Background

Consultant Dual Operating and Mentoring should be available to all surgeons undertaking complex primary and revision hip arthroplasty. Provide an opportunity to improve patient care and outcomes while at the same time result in the progression of individual surgeons' experience in complex hip arthroplasty. Particularly useful for complex low-volume hip arthroplasty surgery. Opportunity for newly appointed consultants to develop appropriate new mentors.

### Initial appointment years (including Locum appointment)

1. There should be no single surgeon unit appointment for surgery on complex hip arthroplasty.
2. Pairing with senior consultant should be available for new consultants in their first 5 years of appointment.
3. Pairing subject to mutual agreement and for annual review.
4. A new consultant's initial appointment years case mix should include complex primary cases, metastatic as well as revision hip arthroplasty and periprosthetic fractures.
5. Consultants within the first 5 years of practice must be offered opportunity for dual surgeon theatre operating.
6. Consultants within the first 5 years of practice must be offered opportunity for dual surgeon outpatient clinics.
7. There should be an opportunity for flexibility to extend the above beyond 5 years (for example if the new consultant has a less than full time job plan or periods of extended leave).

### Case Identification

8. The BHS 'complex hip arthroplasty classification' should be used for patient selection.
9. Appropriate patients should be identified at a weekly, locally agreed arthroplasty governance meeting.

### Passport

10. There should be an opportunity to be paired (if required) with surgeon from another hospital for complex cases via a 'consultant passport'.
11. This 'consultant passport' should allow surgeons to consult with and operate on patients across different trusts and should be funded centrally.

### Quality Control

12. There should be provision for paired consultants at relevant MDT meetings to allow discussion and review of complex cases both pre- and post-operatively.
13. For all patients, data should be submitted to appropriate national databases (e.g. NJR, BAJIR, SAP) to monitor performance against national standards.
14. Consultants within first five years of practice should be offered the opportunity to enter their patients for recognition in national registry even if dual operating, with both consultants attributed results including deaths and revisions.

### Job Planning & Funding

15. There should be appropriate job plan changes to permit clinic, operating and clinical governance time for all involved consultants including self-reflective audit.
16. Appropriate funding provisions should be made for administrative support to collate and document decisions from MDT and coordinate scheduling surrounding surgeon availability for dual operating.
17. There should be an opportunity to change the consultant pairing annually as required.