Lindsay Leg Clubs: clinically effective, cost effective

Leg ulcer management is a major issue in terms of time and cost with regard to community nursing services. In a recent United Kingdom (UK) study, the overall incidence rate of venous leg ulcers among the elderly was estimated at 0.76 per 100 person years for men and 1.42 for women. This estimate was based on patients seeking and/or receiving medical care and is likely to underestimate the true extent of the problem. The financial burden of leg ulcers is highlighted by data from recent studies in the UK, which when combined indicate that 1.5 per cent of total health expenditure is accounted for by chronic leg ulcer treatment.

In the past decade, radical changes have occurred within primary care. The role of the general practitioner (GP) is now focused on commissioning care. In addition, partnerships between health and social care organisations are evolving rapidly. This has important implications for leg ulcer management. As GPs commission consortia ready themselves for the challenge of commissioning health and social care services from April 2013, voluntary and third sector organisations are also preparing for the opportunity to demonstrate they have a significant role to play in the delivery of these services.

Challenges

This is an exciting, challenging time for those involved in treating and preventing leg ulceration; science is increasingly leading clinicians to evidence-based wound healing with the ultimate aim of reducing healing times. Practitioners should be challenged and reassured by the prospect of developing new ways to deliver evidence-based practice in partnership with their patients and colleagues. However, the prospect of changing culture and practice can be daunting in the current business-oriented, market-driven economy of health care.

We have to recognise the dynamic and changing nature of healthcare delivery alongside the public’s expectation and need for preventative health promotion and education. For some practitioners, innovation brings with it professional threats and anxieties. Changing a nursing service from the traditional pattern of organised care delivery to the new philosophy and objectives of a progressive patient care organisation is not an easy task.

In addition, patient empowerment is not an easy concept and it is inevitable that some nurses and managers are uncomfortable with the notion of moving from a ‘nurse dominant / patient passive’ relationship to one of an equal partnership in care. Also, delivering care, for example in a collective environment, exposes clinical practice to a level of scrutiny not experienced in one-to-one treatment.

A cost effective approach for leg ulcer management: The Leg Club model

With demographic changes, we are increasingly seeing the over sixty-five age group living in social isolation as a result of family moves and communities becoming more fragmented. Loneliness and isolation can be a major factor in both an urban and rural community, and people with leg ulcers may experience a further sense of isolation and loss of social contact due to immobility.

The author was a district nurse attached to a general practitioner service who was involved in identifying the social isolation needs of her patients within her caseload. As a result, she proceeded to identify, innovate and set up a community based social clinic, the Lindsay Leg Club.

The Leg Club rationale is based on evidence from literature reviews and a study of established leg ulcer clinics. Nevertheless, obstruction and opposition continue to be a constant factor in changing the model of leg ulcer management within the practice community. The views of nurses and NHS managers can be strongly polarised. One of the greatest barriers to wider uptake has been peer or management scepticism (or even hostility) towards innovative nurses who have sought to implement the model. The
How the Leg Clubs work

The community-based social clinic of the ‘Leg Club’ is primarily aimed at integrating the patients into an environment where they can socialise with others who are experiencing similar problems. There is no appointment system and the ethos is to encourage social interaction. The Leg Club model applies the philosophies of social and health belief models in a framework that addresses the individual’s hierarchy of needs and is founded upon people with leg problems (Leg Club ‘members’) owning ‘their’ community clinic which is located in a social, non-medical setting. The Clubs are supported by committed teams of nurses and the outstanding involvement of community volunteers. The members themselves are delighted to be involved and previously house-bound non-concordant patients have taken on the responsibility of self-management of their condition. This has made a real impact in all areas of their lives, delivered excellent healing rates and notably low recurrence. It also provides an informal support network to carers, family and friends. The nursing teams have built important relationships with other professionals whilst putting the patient at the centre of care delivery.

The ‘Leg Club’ delivers an environment for truly patient-centred holistic care through a synergistic combination of four binding principles:

- non-medical setting – community/church/village hall
- collective treatment – people share their experience
- open access, no appointment required – opportunistic attendance
- integrated ‘well leg’ regimen – maintenance and health promotion

The principal aims of this model were to:

- empower patients to become stakeholders in their own treatment, promoting a sense of ownership and involvement
- meet the social needs of isolated patients by providing a mechanism for social interaction, empathy and peer support
- rebuild patients’ self-esteem and self-respect by destigmatising their condition
- facilitate an informal support network
- achieve compliance to treatment through informed beliefs and modified behaviour
- provide continuity of care and a co-ordinated team approach to its delivery
- minimise recurrence by systematic post-treatment monitoring and ‘well leg’ checks
- adopt a simple, flexible ‘drop in’ approach that encourages attendance for information, advice, facilitating early diagnosis of problems
- provide an informal forum for opportunistic health promotion and education

Leg Clubs are not intended to replace existing care delivery mechanisms but to complement them by responding to both the clinical and holistic, psycho-social needs of the individual. Each Leg Club has its own identity which is shaped by members and each is able to deliver care and treatment in a cost-effective manner with improved healing rates.

Patients and the local community play an active role in running their Leg Club through fundraising and undertaking administration, voluntary transport duties, providing refreshments and producing information leaflets for new patients. The Leg Club logo symbolises the tripartite collaboration of District Nurses, the local community and the patients themselves (Figure 1).

Audit and evaluation

For consistency and quality assurance, written guidelines and procedures, and an audit tool template for data collection to provide feedback for continual improvement are used. A website was created and the Leg Club Forum was formed to provide a mechanism for Leg Club nurses to interact and share best practice.

Data collection is an intrinsic part of the model by which we measure our effectiveness and implement a policy of continual improvement. Our own and independent research metrics have demonstrated significant improvements in a range of ‘quality of life’ indicators for patients attending Leg Club compared to those receiving home treatment. Benefits have been recorded in measures of healing rates, pain levels and patient morale. There are many examples of long-standing conditions being resolved. This has been achieved at lower cost to the healthcare provider.

Progress to date

Disseminating the model more widely through the journals and at conferences led to interest from around the UK and overseas. The author travels extensively to talk to nurses, commissioners and assists them in setting up their own Leg Clubs. Indeed, Australia opened the first Leg Club in Adelaide Hill, Southern Australia in 2002. In addition, a two year randomised controlled trial to determine the effectiveness of a community based Leg Club environment and its impact on improving healing rates of venous leg ulcers was conducted in Queensland. The study design examined the effectiveness of this intervention in improving healing rates, quality of life, health status, functional ability and pain. Very positive outcomes were demonstrated.

By 2005 it was apparent that demand was exceeding the capabilities of an individual and that a supporting infrastructure would be required. Accordingly, the Leg Club Foundation was established, a registered charity set up to promote and further the aims and
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principles of Leg Clubs. These principles and the benefits of community and patient led treatment have now been accepted at the top level of NHS with its policy to introduce commissioning of services to third parties.

From the outset, the proponents of the model have been given invaluable encouragement and support from some leading healthcare professionals and from members of the wound care industry – a relationship that was formalised in 2010 by the formation of the Leg Club Industry Partnership (LCIP), comprising some 15 participating companies. An example of the fruits of this partnership has been the recent launch of an online education and training resource for nurses, available free to Leg Club staff.

Moving forward
Ensuring the Foundation and the Leg Clubs continue to improve the lives of people with chronic leg conditions requires a consistent and systematic approach. It means making sure that the voices of the patient, volunteers and communities are heard. Indeed this collaborative approach between healthcare professionals and the community drives creativity within the network of Leg Clubs. Patient transportation is a good example of nurses working with other community organisations, for example Dial - a Ride and Age Concern.

Better outcomes within the Leg Club model are achieved in many ways; through clinical and demographic audit, formal research and the motivation to strive for constant improvement. However, originality requires commitment, leadership and is a team effort. Most successful transformation occurs at the boundaries of patient-centred care, where problems and needs of users and the potential of modern, cost-effective technologies are linked together. However, despite the positive benefits of the Leg Club model, it has a significant weakness, the opening and closing of individual Leg Clubs rests with the availability of keen individual clinicians, interested volunteers and a committed commissioner or NHS management. The removal of any one of these three corners of the foundation of a Leg Club leaves that Club vulnerable to neglect and ultimately closure.

In addition, the advent of commissioned services for leg ulcer management presents new challenges to their patient-centred, non-medical approach. For example, there are indications that many leg ulcer services may become assimilated within the existing GP surgery framework, where clinics conventionally focus on clinical need, the treatment of ‘sickness’ and the alleviation of symptoms. The formal clinical environment reinforces ‘sick role’, which sees patients attend when they believe they require treatment and in which they assume a passive role in their care delivery. This runs counter to the move towards greater patient empowerment where the emphasis is on individuals being listened to and empowered to make informed choices regarding their treatment and care.

Conclusion
Community nursing tends to be solitary occupation with few occasions for team working. Nursing teams that have taken on this method of care delivery report not only improved patient outcomes, but greatly enhanced team working and morale. Experience has shown that Leg Clubs offer an ideal opportunity for nurses not only to work together with a common goal, but to truly ‘get to know’ the community they serve. There are many examples of enthusiastic motivated teams developing as a result of the shared challenge and satisfaction of setting up and running a successful Leg Club.

The model provides semi-autonomous healthcare which leads to significant practitioner and patient empowerment, as well as relieving pressure on other healthcare providers/services that offer traditional methods of treatment.

Research highlights an improvement in patients’ quality of life in conjunction with substantial savings in the cost of treatment. Leg Clubs have proved to be extremely cost-effective in the use of nursing resources, saving travel costs, reducing need for the duplication of equipment, simplifying planning and administration, and eliminating wasted home visits. Indeed, the Leg Club model has been referenced by the Department of Health in its QIPP programme – as a community owned model shown to improve healing, reduced recurrence and offering a cost-effective framework for the treatment of lower leg problems.

Self-referral is consistently one of the most common sources of attendance at Leg Clubs. The easy access, un-intimidating non-medical setting encourages people of all age groups to seek advice when they might not consider attending a formal clinic or surgery. This presents an ideal environment for opportunistic and early diagnosis, health promotion and prevention of more advanced leg problems. To date some 6,500 members have been encouraged and enabled through the interactive learning process to get to ‘know their own legs’ and with this new knowledge and understanding collaborate in their management.

Member satisfaction surveys have demonstrated that the social approach has enhanced members’ wellbeing by meeting the social needs of isolated patients by providing a mechanism for social interaction, empathy and peer support. The experience of visiting the Leg Club is wholly positive, as many members who rarely venture out of their houses have made new friends and relationships have blossomed.

References