External audits reveal overwhelming support for Leg Club concept

In order to maintain best practice, Leg Clubs are required to record basic data which is copied to the Leg Club Foundation. This data is collated and analysed quarterly. Yet, central to the ethos of the Leg Club Foundation is the idea that members should feel empowered to become stakeholders in their care. This article discusses how information regarding the opinions of club members is obtained for a productive annual review.

'The feelings and opinions of the patient members is sought out, as is the level of commitment to the concept by the professional and volunteer members'

GEOFF THOMPSON
External Auditor, Lindsay Leg Club Foundation

It is now 17 years since Ellie Lindsay established her first Leg Club. During this time the Leg Club Foundation has seen the numbers of clubs rise to more than 21 clinics in the UK. The social model of health care delivery for those suffering from leg ulcers was also successfully established in Australia about a decade ago, specifically in Queensland, New South Wales, Adelaide and Southern Australia, as was reported by Edwards (2009) and Shuter (2011). There has also been interest in the concept shown in other countries.

In the last 17 years the NHS in the UK has undergone many changes — financially, structurally and in the provision of services and the deployment of personnel. Resources have become scarcer, stressing the importance of value for money and best-possible practice.

Practitioners should be mindful that the philosophy of the Leg Club Model is one primarily of empowering patients to become stakeholders in their care within a social environment. At their local Leg Club the patients are known as 'members', as are the professional and volunteer staff. This is in contrast to the passive care implied by the traditional label 'patient'. Therefore, there are three distinct groups of people within the dynamic of the club:

- Patients/members
- Professional staff
- Volunteers.

As a tripartite whole, each group has distinct but shared roles. Patients that become Leg Club members should find themselves in both a clinical and social setting that offers health care and promotes and actively encourages a strong sense of ownership by the members. At the same time, a similar sense of shared ownership and common intent is felt by the clinical and volunteer staff.

Such an environment of care should address the:

> ***'...social needs of isolated patients [members]...through mechanisms for social interaction, empathy and peer support, rebuilding self-esteem and self-respect by de-stigmatising their condition'*** **(*Lindsay, 2004).***

For several years NHS organisations have been required to sign up to the concept of Clinical Governance (DH, 1998) the delivery of which involves the practice of clinical audit.

Once established, each Leg Club is required, on a quarterly basis, to send the Leg Club Foundation records of its activities to establish the quality of care being delivered, the outcomes achieved and to discover any gaps in the data (Clark, 2011).

This, however, does not capture how the ethos of the Leg Club concept is being practised by any particular club, the feelings and opinions of the patient members or the level of commitment to the concept by the professional and

Members of one of the many Leg Clubs.

volunteer members. This is, instead, addressed by the annual external audit conducted by the foundation's auditor, which seeks to identify the services within the Primary Care Organisation (PCO) and how these interface with the Leg Club.

Each Leg Club lead nurse is contacted in advance and an audit date is agreed at the manager's convenience. A structured questionnaire divided into eight sections is used to determine:

- People and the environment
- Physical setting of the community Leg Club
- Staff /skill mix
- Health and safety
- Standards and monitoring
- Communication
- Documentation
- Patient satisfaction.

This is performed by a combination of observation and interview.

The auditor has to be mindful of the workload in-hand at each visit and will vary the sequence for data gathering depending on who is most freely available for interview, such as the clinical staff, patient-members, volunteers or other agents (e.g. Social Services, Age UK) providing a service in the club. For example, an exercise therapist, who may be provided by the commercial sector, may only be available for interview for a short space of time.

Capturing data from the club's documentation is relatively straightforward and involves completing the Foundation's questionnaire criteria against the information contained in the Club's records.

The auditor is looking for the quality of practice rather than poor or bad practice. The latter does not need to be sought out as it makes itself apparent as the club's documents are examined.

However, there are two important aspects of the audit which cannot be directly identified just by checking the club's paperwork. These are:

- Whether members 'feel' the environment of the club is positive, dynamic and interactive; what the observed relationship is between the three distinct but linked groups within the club; whether there is an apparent promotion of the social model of patient-member empowerment rather than the medical model of care, which encourages patient dependency
- The feelings and opinions of the patient-members.

References

Lindsay E (2004) The Lindsay Leg Club model: a model for evidence-based leg ulcer management. *Br J Community Nurs* 9(6 Suppl): 15–S20

Clark, M (2011) Leg Club Update. *Wounds UK* 7(2): 115

DH (1998) *A First Class Service: Quality in the New NHS*. DH, London

Edwards H, Courtney M, Finlayson K, Shuter P, Lindsay E (2009) A randomised controlled trial of a community nursing intervention: improved quality of life and healing for clients with chronic leg ulcers. *J Clin Nurs* 18(11): 1541–49

Shuter P, Finlayson K, Edwards H, Courtney M, Herbert C, Lindsay E (2011) Leg Clubs — Beyond the ulcers: Case studies based on participatory action research. *Wound Practice and Research* 19(1): 16–20