A social approach to empowering lives with compassion and respect

As practitioners in today's world that is constantly evolving, one thing has remained constant is the steadfast belief that people in our care should be at the heart of everything we do.

From years ago, as a disempowered patient, mature student and qualified practitioner, the author has always held a simple but powerful philosophy: every individual deserves to be seen, heard and supported as a whole person not just a case number in a bed, a diagnosis or a statistic. Hence, championing a person-centric model that has transformed not just the conventional system and services, but individual lives through embracing change and taking lower-limb care into a non-medical environment.

Embracing change

Lower-limb conditions present several challenges to the individual with physical and emotional distress, lack of esteem, depression, self-neglect, social isolation and loss of income all frequently associated with leg ulcers. Furthermore, the persistence and reoccurrence of leg ulcers and their management all has made an impact on the global health economy as associated clinical resource costs are exacerbated by protracted healing time, high recurrence rates and an increased average life expectancy.

During the years the landscape of lower limb care has continued to evolve, driven by the dual forces of demographic change and a renewed emphasis on holistic, person-first approaches. Active involvement and participation in a variety of social settings are known to have health and wellbeing benefits yet globally, there are growing concerns about the rate and consequences of loneliness, especially among the older generation.

Chronic leg ulcers are more prevalent in older adults, and increased incidence has been associated with pain and chronic ill-health, leading to decreased mobility and loss of functional ability. The condition is generally cared for in the community, which combined with the higher prevalence in frail, older adults' demographic changes will further increase demands upon the community nursing infrastructure. The older population is increasing and their healthcare needs are changing and managing lower limb and foot care in the community faces challenges due to inconsistent NHS funding and regional disparities. Often there is little help available in the form of support and advice on maintenance, prevention and the importance of good skin integrity. Plus, individuals requiring professional care experience pain, embarrassment and social isolation when experiencing life living with a lower limb/foot-related problem.

Regardless of age, everyone has an emotional need to be cared for when facing any form of treatment and their needs should be individualised and involve a two-way relationship between persons and professionals where individuals are encouraged to be equal partners. As professionals, we should allow people in our care and their families to have sufficient information to enable them to play an active part in their treatment, providing transparency in information-sharing facilitating an individuals input.

One major challenge in ageing societies today is how to create meaningful pathways for older persons to experience late life living with a wound and simultaneously contribute towards society. However, health systems are slow to embrace the long-term chronic disease management and health promotion approach needed for effective management of older adults with peripheral vascular disease, who experience years of leg ulceration and recurrence cycles.

District Nurses have traditionally operated in an isolated, autonomous and distinct role, supported by managers within a hierarchical structure, distinguishing them as specialists within the local community and isolating them from other nursing and medical colleagues. However, the emphasis today is for the District Nurse to manage and deliver a highly technical service to the local population in the context of a multidisciplinary community nursing team.

Embracing change requires clear evidence of their effectiveness and safety. The objective of setting up a nurse led community lower-limb clinic incorporating the help of the local community was to provide a centre, away from the doctors' surgery, where individuals could visit on a drop-in basis. The emphasis being to ease loneliness by providing congenial surroundings where old friends can meet and new friendships are formed. The clinic was held in a small country village and most people

Ellie Lindsay

Life President and Founder of the Lindsay Leg Club Foundation; Honorary Professor, The College of Phlebology, London; Independent Specialist Practitioner; Visiting Fellow Queensland University of Technology; Visiting Senior Fellow, University of Suffolk; Associate Lecturer CRICP, Thames Valley University, London

Figure 1

Figure 1. First opening pre-fundraising event. Front row: Debenham community nursing teamBack row included: DN student, MacMillian Nurse, Practice nurse and two members from the Healthcare industry.

attending were on the current geographical case load where the venue was identified and attendees were from the village and outlying areas as the main problems for individuals was associated with pain, infection, wound exudate, immobility, loneliness and isolation.

Subsequently a practice review of the caseload responsible and accountable to three general practices (Debenham, Otley and Grundisburgh) in 1994, addressing the cycle of isolation, pain, and reduced mobility that too often accompanies chronic leg and foot problems the author set out to change practice by establish a social lower-limb clinic based on three principles: compassion, respect, and individual empowerment principles in the village of Debenham, Suffolk.

Following research into social isolation, 'Debenham Leg Club' (named by the individuals attending for treatment to reflect their stake holding in this informal, welcoming approach) was conceived as a unique partnership between the District Nurse team, the local community and the patients **[Figure 1]**. The use of a community cottage attached to the village church was negotiated, and a network of volunteers recruited from the local community, to help with fund-raising (for rent and equipment), transport, refreshments clerical work etc.

Leg Clubs are a research-based initiative grounded in Becker's Health Model (Becker, 1974), which argues that people's health behaviours are driven predominantly by psycho-social considerations. The concept based on a framework and rationale to develop a social model to provide community-based care for individuals with leg-related problems that emphasises a holistic approach, including wound management, social support, wellbeing, and public health promotion.

The ethos of this unique approach was to encourage social interaction, enabling people to discuss both the positive and negative effects they have experienced with problems of their lower-limb/wound and therapy. The problems of social isolation and nonconformity was addressed and the concept of the 'Leg Club' was born with the first Leg Club opened in May 1995. Care was delivered in a relaxed, informal atmosphere in which comradeship, empathy and peer support was very evident.

By introducing a new way of working within a non-medical environment it was important to recognise and respect everyone's contributions within the care team. Hence, as a small community skill mix team, our core values were cohesively built around empathy, where listening comes before action, and care being customised to everyone's unique needs, values and aspirations. Over the years, this commitment has helped create safer, more supportive environments that promote healing, growth and community connection. This required respecting cultural identities, supporting personal choices, and acknowledging that individuals are experts in their own experiences. This respectful partnership allowed us to build programs and services that are not only effective but deeply meaningful.

Empowerment has always been more than a goal but a guiding principle. As a team we collectively dedicated ourselves to giving people the tools, opportunities, and support they need to lead self-directed lives. This was achieved through access to resources, personalised care and community team networking, witnessing firsthand how empowering individuals leads to stronger, more resilient communities.

Looking ahead

Person-centred care means valuing and listening to individuals and treating them with compassion, dignity and respect. It plays a key role in motivating stakeholders in their care to ensure the individual's views, experiences and interests are central to treatment decision-making within a multidisciplinary team approach.

It is often cited that poor adherence to treatment is common. However, this may be because treatment methods are not guided by the individuals who have lower limb conditions. A collaborative approach to person-centred care should allow the key stakeholders to play an active role in the care pathway. However, for some individuals it can be challenging either

because of vulnerability or lack of knowledge. A person-centred partnership encourages confidence to contribute to their care from the outset, promoting a sense of ownership and involvement.

Social media offers widespread access to health information, bringing with it the advantages of interactivity, information and anonymity. It is attracting a great deal of attention given its impact on individual healthcare decisions such as where to go for care and what services to seek out. Also, the evolution of technology and electronic devices, such as smart phones, have greatly influenced the way we communicate today, improving the speed and ease of reaching out to others. As an increasingly technological society we rely more on innovation, but alongside technology advances we need to consider preventative health promotion and education hence the importance of working in collaboration.

The introduction of the psychosocial Leg Club model over the past 30 years has shown the positive changes achieved through the commitment and motivation of nurses, multiagency and communities working together. While addressing the social isolation that often comes with this condition, the Leg Club model furthermore confirms its effectiveness in four ways, clinical effectiveness, cost effectiveness, patient satisfaction and wellbeing.

As we celebrate this 30-year journey, we do not just look back, but we look forward, continually evolving, learning and listening, and we remain committed to innovation grounded in humanity.

During economic constraints in health care, nurses must present strong cases for change, as policy alterations are challenging if original policies lack clarity. Improving skill mix effectiveness requires assessing current conditions within community nursing teams and naming specific areas for adjustment.

As we mark 30 years, we not only reflect on our past but also focus on ongoing growth and commitment to innovation, always prioritising systems that serve people effectively.

Conclusion

The psychosocial Leg Club model of lower-limb care has enabled the retiree group to provide a valued and fulfilling role and remain as active as possible. Their enthusiasm, creativity and boundless energy are clear, for example, in their organisation of transport, instigation of friendship clubs, Leg Club café, entertainment and interest groups, and peer support activities where help and advice are offered.

The Leg Clubs have shown positive changes achieved through the commitment and motivation of nurses and communities working together. As a collective team of clinician, volunteers, and the members we are proud to celebrate 30 years of putting people first by transforming lives through compassion, respect, and individual empowerment.

Through these partnerships the aim being to raise awareness of all aspects of preventative management and health promotion to as wide an audience as possible whilst providing guidance, expertise and knowledge to support and ensure good practice in lower-limb care delivery. Meeting these goals while supporting the fundamental principles of equity and ease of access to healthcare resources, stands for a significant challenge.

However, as nurses, we must acknowledge that with innovation and change comes uncertainty. We must recognise that for some practitioners, innovation brings with it professional threats and anxieties. It is important that, not only do we respect but we facilitate and support our colleagues as we implement the reforms and changes.

Also, health prevention and ongoing education is paramount in today's healthcare service. Through the Leg Club network and their NHS providers many innovative teams ensure as part of their care delivery, to address variations in the quality and safety of the care we deliver, the general public's changing needs in a productive way.

Acknowledgement

To everyone who has been part of this journey clinical teams, volunteers, Leg Club Industry Partners (LCIP), advocates and supporters your dedication has helped shape a model that not only has stood the test of time but continues to grow stronger with every individual who attends their Leg Club receiving exemplary care from all involved.

A heartfelt thank you to each one of you who has contributed over the past 30 years. Here's to continuing the important work of creating a more person-centred future.

References

Becker, M. (1974) 'The health belief model and sick role behaviour', Proceedings of the Workshop/Symposium on Compliance with Therapeutic Regimes, McMaster University, Hamilton, Ontario, Canada.