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THE LEG CLUB FOUNDATION

Compendium

This Compendium was kindly facilitated by a grant from the Department of Health.

About this publication

This compendium provides guidance to Leg Club volunteers, nurses and members involved with the running of Leg Clubs, and to other healthcare professionals and agencies who both liaise with and offer services to Leg Clubs and their members.

The Best Practice statements in this compendium have been co-ordinated by a clinician with several decades' work of innovative clinical practice in wound management, and have been developed from observations made while visiting Leg Clubs around England and comparing them with accepted and recorded practice.

Where needed, the statements are qualified by further explanation and, where available, summaries of studies to support the best practice statements can be viewed on the Leg Club website. While the appendices and references are not exhaustive, they provide general support to the best practice statements.

The examples of best practice that appear throughout the compendium come directly from volunteers, members, nurses and Leg Club industry partners (LCIP), who have had direct experience of good practice.

They are therefore more personal in nature, reflecting their enthusiasm for the work that they are describing. The views of volunteers are important; through fund-raising, marketing, manning Leg Clubs, and networking with local community groups and the media, the social model is maintained.

The final section, 'Frequently asked questions', presents answers to some of the questions asked by nurses, commissioners and patients when the Leg Club concept is discussed.

For more information about the Lindsay Leg Club Foundation (LLCF) and the Leg Club network and to access our multimedia resources, go to: www.legclub.org

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Grateful thanks to Leg Club Teams, the Volunteers, Members and Leg Club Industry Partners for their participation. A special thanks to Bradford on Avon Leg Club where photographs were taken.

The idea behind the project

Leg ulceration has been referred to as 'the hidden epidemic'. This phrase has a double meaning as many patients with this disease are virtually hidden away, isolated, depressed and attempting unsuccessfully to self-care. Leg ulceration can lead to prolonged ill-health; the average ulcer duration is 12 months, the recurrence rate, 70%. The condition accounts for 2–3% of total healthcare costs in many countries around the world.

Lindsay Leg Clubs (LLCs) have been treating those suffering from, or at risk of, leg ulceration within a social model of care for over 20 years. In September 2014, the Lindsay Leg Club Foundation (LLCF) was awarded a grant by the Department of Health to produce and disseminate a compendium of Best Practice from within the large network of Leg Clubs currently operating in England. The idea behind the project was to understand, co-ordinate and summarise the best practices undertaken by the volunteers, nurses and members who attend the Leg Clubs every week, and to share that information not only among Leg Clubs, but also around the healthcare community at large.

I am delighted that the Lindsay Leg Club Foundation has been given this opportunity. I have always been an advocate for combining clinical treatment with a need to respect and enhance the social, emotional and spiritual needs of patients, and the Leg Club model has done this very successfully in the many years I have been involved with it. Leg Clubs are inclusive; they enable patients to share their experiences, gain excellent treatment without the need to make an appointment and, most importantly, they address the social isolation that often comes with this condition. But, of course, the importance of high quality professional care to support a Leg Club model has to be there too. Like any model of care, if the professional clinical support is not of the highest standard, then it will not give the results that the model deserves.

This compendium does not just cover clinical support, but also sets out clearly and simply all the elements of best practice that go into treating leg ulceration and conditions of the lower limb within a social model of care from the perspectives of all involved, and is combined with some inspiring case histories from individual Leg Clubs.

There are also many examples that could not be included for reasons of space, and I would like to take the opportunity to thank and applaud everyone who has been involved in this excellent form of care, which resonates perfectly with current strategies, at both national and trust levels, to align community services alongside primary care, improving the support that can be collectively provided to patients.

Ellie Lindsay OBE
Founder
Lindsay Leg Club Foundation

The essence of Leg Clubs

My mission for this compendium of Best Practice for Leg Club service delivery is to define the 'essence' of Leg Clubs. I am a nurse with 25 years experience of wound care, and have owned and managed a private wound healing centre. I have been a supporter of Leg Clubs from their concept in the early 1990s, through to the development and opening of the first Lindsay Leg Club, and finally, the creation of the Lindsay Leg Club Foundation (LLCF) in 2005.

The Leg Club model moves firmly from the 'paternal' model of care delivery in a 'clinical' environment, to delivery in a familiar place of social activity in the community, such as a church hall, village hall or similar. This fosters a friendly and welcoming environment, where the members are motivated and empowered to take ownership of their own care, and encouraged, through this sense of ownership, to become stakeholders in their treatment.

In the Leg Club model, clinical care is provided in an open environment; each member is treated in the company of other members, although of course, as stated in the Leg Club guidelines, may be treated privately if they wish (an offer rarely taken up!). This approach has been demonstrated to help with the healing process, as members discuss their wounds and can become quite competitive. Indeed, concordance is increased as members are in a race to heal before anyone else!

Over the last six months, I have been fortunate to visit Leg Clubs throughout the UK and I never cease to be amazed at the passion shown for the Leg Club model and the excitement that radiates from Club members, volunteers, nurses and staff alike when discussing the care and socialisation in each Club.

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Every Leg Club is different, each having their own individual vision of how they would like to grow. The spirit of a Leg Club exudes as you enter – the noise in the church halls of members chatting, playing cards, knitting, discussing walking groups or playing bingo, demonstrates how much of a heart each Leg Club has acquired. Some Leg Clubs are still learning, still coming together, but will continue to grow – as will the noise!

While nurses and healthcare assistants are central to the clinical care of members, the volunteers are the lynch-pins of the social activities. Often volunteers are themselves members who are so grateful to the Leg Club for alleviating their suffering that they devote time to organising and supporting other members. Social activities take place both within the Club premises and outside, and include excursions, Christmas meals, birthday celebrations (with cakes!) and a myriad of others.

Let me conclude with a couple of examples that demonstrate what I am trying to say…

Despite the variations in approaches to care delivery and social activity I have seen during my visits, members consistently tell me how their lives have changed, how wonderful the nurses are, how wonderful the volunteers are, how many friends they have made in their Club and why they always look forward to attending.

One gentleman, who was very reserved and lonely, is now a volunteer and the life and soul of his Leg Club! He claims he would be there every day if he could, while the nursing staff say that they simply could not cope without him. One lady with lymphoedema required toe-to-thigh bandaging, but consistently refused. During treatment at a Leg Club, she sat next to another member who was extolling her toe-to-thigh bandaging and outlining how it had changed her life. This 'excitement' and sharing of experience led the lady with lymphoedema to request the same bandaging; she was empowered to make her own decision based on the experience of someone with a similar condition.

This is the very essence of Leg Clubs.

Sylvie Hampton, RGN
Wound Care Consultant

The Lindsay Leg Club Foundation and model

THE LINDSAY LEG CLUB FOUNDATION

The Lindsay Leg Club Foundation (LLCF) was registered as a charity in September 2005 to support the growing number of Leg Clubs in the UK. The Foundation has three main objectives:

- To protect and preserve health amongst those experiencing, or who are at risk of, leg ulceration and/or associated conditions
- To facilitate and manage the coordinated growth of the network of Leg Clubs
- To provide Leg Clubs with the information and support they may require.

THE LINDSAY LEG CLUB MODEL

Because usual models of leg ulcer care delivery do not address the social and psychological needs of these patients, the philosophical basis of both the LLCF and individual Leg Clubs is to implement best practice in partnership with healthcare professionals, patients and the local community in a social, non-medical setting. In line with this ethos, people who come to their Leg Club for treatment are members, rather than patients. They are treated collectively and the emphasis is on social interaction, participation, empathy and peer support.

Informal 'drop-in' clinics are held weekly in a community setting. On average, each Club has approximately 1,200 member contacts per annum; 40% for treatment, the balance for assessment, monitoring and advice. Everyone who attends or works with a Leg Club is equally important in terms of facilitating emotional and practical support, alongside clinical care. In addition to leg health, social interaction and wellbeing, Leg Clubs are also a great opportunity for clinicians to monitor the overall health of members attending and initiate clinical interventions such as 'flu vaccination and blood glucose monitoring, as well as social activities for members.

The Leg Club model unites primary care commissioners, nurses, general practitioners, patients and the community in the common objective of improving patients' health and wellbeing, and to date has delivered dramatic improvements in quality of life for hundreds of individuals. Leg Club nurses are collaborators who help patients to become co-producers in their healthcare through a coalition of support from community and voluntary sector organisations. By engaging the community and empowering patients to become involved in their care, the Leg Club model reflects current Government and NHS England policy.

EFFECTIVENESS OF THE LEG CLUB MODEL

The LLCF is currently undertaking a major anonymised data collection exercise, analysing in some detail treatment outcomes among our entire network. However, in terms of overall effectiveness, recent studies suggest the following:

- In the UK, leg ulcers are half as likely to recur in Leg Club members as in the national average (with good concordance)
- Leg Clubs are a cost-effective alternative to traditional models of care
- Leg Clubs provide care in a non-medical setting which improves member quality of life
- Leg Clubs improve the wellbeing of members.

This compendium provides an opportunity to share this effectiveness among our network, as well as the healthcare community as a whole.

Roland Renyi
Past Chairman
Lindsay Leg Club Foundation

LEG CLUB INDUSTRY PARTNERS

The Leg Club Industry Partnership (LCIP) is an alliance between the healthcare industry and the Lindsay Leg Club Foundation. The mission statement of the partnership is:

'Empowering patients through a unique collaboration with industry dedicated to lower limb conditions.'

Building collaborative corporate partnerships has involved identifying opportunities for change, finding the resources to bring about these changes, choosing an effective group structure, and building trust among collaborators. This collaboration has afforded Leg Club nurses the opportunity to work closely with commercial organisations, and is evidenced by nurse involvement in the development of the Leg Club Code of Practice.

Our latest LCIP project has been to produce a generic teaching programme available via the website Leg Club learning zone, which has been approved by the Welsh Wounds Innovation Centre (WWIC).

To ensure protection of both parties, the Lindsay Leg Club Foundation collaborated with the LCIPs to develop a comprehensive Code of Practice that all Leg Clubs adhere to.

CONCLUSION

Since its inception in 1995, the Leg Club movement has made considerable progress, raising the level of awareness of its activities within government, the NHS and with the public at large.

Leg Clubs offer a cost-effective alternative to traditional models of care. Placing nurses in Leg Clubs once a week as opposed to making individual visits to patients can make considerable savings. Furthermore, as the Clubs are operated on a walk-in basis, there are no 'did not attend' (DNA) appointments and little time is wasted.

We believe that this model has great implications outside the specific arenas of leg ulceration and leg health, and, in partnership with trusts, specialist clinicians and general practice, can play its part in improving the lives of patients in several areas of health.

With specials thanks to:

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Smith & Nephew
Urgo Medical

Bradford on Avon Leg Club 'Every town should have one!'

AN INTEGRATED APPROACH TO TREATING PATIENTS WITH LEG ULCERS AND COMBATTING LONELINESS.

In July 2011, the Bradford on Avon Partnership merged with two other smaller practices and became the largest surgery in Wiltshire with approximately 21,000 patients. Of these, there were over 2,500 patients, aged 75 plus, and over 100 people with leg wounds and associated problems.

The Bradford on Avon Partnership had a group of patients with high leg ulcer recurrence rates who spent a lot of time seeing both the doctor and nurses for their leg conditions. Furthermore, the nurses suspected that a number of older males, who had become isolated through living alone, were in fact deliberately hurting themselves to gain attention. There was also a high DNA rate alongside patients booking themselves in to see the emergency nurses for additional dressings. Clinicians were always under pressure to work faster and fit in more patients; they had little time to talk to the patient, or indeed, each other, resulting in only the physical aspect of the patient's biopsychosocial care being met.

The practice's lead leg ulcer nurse read about the Lindsay Leg Club Foundation (LLCF) in the Wounds UK journal. All the nurses were keen to promote holistic patient-centred care and patient advocacy, but did not have the infrastructure to implement it.

Ellie Lindsay, founder and Lifetime President of the LLCF, visited the Bradford on Avon Partnership to present the Leg Club model to an audience of patients and clinicians. Her passion and enthusiasm was infectious and moving, there wasn't a dry eye in the house! The GP partners were amenable to supporting a Bradford on

Avon Leg Club initiative and agreed that a pilot programme could be set up to test whether people would attend this alternative model of wound care.

Initially, the greatest challenge was accessing the funds for the accommodation and equipment in order to set up the Leg Club. A funding request to the primary care trust (PCT) was rejected on the grounds that the initiative would not reduce hospital admissions. We believe that cellulitis and deep vein thrombosis (DVT) admissions have reduced and are working through the cost savings to share with the clinical commissioning group (CCG).

However, our belief in the Leg Club model and our determination to get it up and running was rewarded by charities within the local community who saw the value of what the partnership was trying to achieve. Collectively, they have supported the Leg Club with over £15K of funding to date.

We were also concerned that it would be a challenge to recruit and retain the volunteers who provide the social dimension of the Leg Club, but thanks to our local patient participation group (PPG) we had helpers from the start. Such is the appeal of the Leg Club and the convivial atmosphere that it promotes, they are still working with us today.

The Leg Club model moves firmly from the paternal model of care delivery in a clinical environment, to delivery in a familiar place of social activity. It fosters a friendly and welcoming environment, where Club members are motivated and empowered to take ownership of their own care and encouraged through this sense of worth to become stakeholders in their treatment.

By July 2014 the Leg Club had become so successful, with membership increasing to over 400 members, that we had to relocate from a local care home to a large community hall.

We are truly integrated with staff from the community nursing team, public health, the council walking group and a creative arts facilitator. Running the Club is hard work, but the smiling faces of the members, the improved healing rates, the reduction in recurrence rates and the savings in dressing costs, make it all worthwhile!

Every town should have one!

Amanda Brookes
Business Manager
Bradford on Avon and Melksham Health Partnership

‘Living with a leg ulcer’

Degrading, smelly, unglamorous — these are just a few of the words that Mary-Rose Fawkes uses to describe the leg ulcer which not only threatened her leg, but led to a lack of personal confidence and depression.

Mary-Rose was helping her daughter move and she accidentally slammed the car door on her own leg. Because the wound was triangular in shape, doctors could not stitch it so they tried dressing for two months, hoping it would heal.

‘After eight weeks the nurse told me that the wound was getting better, because I was a nurse as well, I knew it wasn’t,’ she says.

During the treatment she was unable to have a bath or shower in a normal way. The pain was so severe at times that it could only be alleviated by analgesics and sitting with her leg elevated, serving to draw attention to herself when she went out.

‘Imagine how it feels to see one’s leg being eaten away by a seriously weeping wound which does not heal at all, whatever dressing is applied,’ she says. ‘I was now frightened. The future of my mobility was looking bleak.

It was also most debilitating to know that one “smelt” and therefore likely to be offensive to other people. All in all, living with a leg ulcer is like being a leper in public and an unattractive ailment in private. It isolates; it depresses.’

Mary-Rose was lucky that a nurse recommended the Lindsay Leg Club in Worcester as a last resort to try and get the ulcer healed.

‘The nurses gave me a test to make sure my circulation was good enough to have a pressure bandage applied, so that healing could begin from the base and not from the surface,’ she says. ‘The pressure bandage was re-applied regularly and within eight weeks my leg ulcer was healed.

‘Blessed relief! I now have my leg and life back again.’

Mary Rose Fawkes BEM
Cured Patient Representative

BEST PRACTICES
Introduction

'There is a wrong way, and then there is our way' – for too many of us, this sums up what best practices claim to be. They are rigid, unbending and lack the flexibility to change as new information becomes available.

Right from our beginnings, Lindsay Leg Clubs have relied on creating best practices to help members receive the best possible care. As with any developing and innovative model of care, these best practices have evolved over time and will continue to do so.

What we are presenting in this compendium is a series of summaries of our current best practices, but for the latest detailed information, which is constantly updated, please go to: www.legclub.org

When we wanted to summarise our best practices we looked at the three main stakeholders of Leg Clubs – members, nurses and volunteers. We carried out in-depth interviews at each Leg Club and found practices that have consistently shown results superior to those achieved by other means. We found it important to always keep these main stakeholder groups in mind and to realise that because of the dependency each one has on the others for success, a balance needs to be kept among them. For example, it would be pointless to create a best practice that, while wonderful for members, would be impossible for nurses or volunteers to achieve.

Our best practices have been created through sound research among nursing staff, volunteers and members. This has helped to create an approach that leads to a dynamic, inclusive, clinically effective and fun Leg Club.

The advice in this compendium and on the Leg Club website is intended to provide guidance to Leg Club volunteers, nurses and members involved with the running of Leg Clubs, as well as to other healthcare professionals and agencies that both liaise with and provide services to Leg Clubs and their members.

Again, if you are looking for the latest in best practices, guidance documentation, policies and procedures for Leg Club service delivery, these can be found at www.legclub.org. Please do contact us if you have any specific questions about Best Practice that you cannot easily find.

Clinical practice

No matter which Leg Club a member goes to, he or she should expect both optimal clinical care and follow-up prevention advice once the agreed outcome is achieved. This is because The Leg Club model is not just about treatment, but also has a strong focus on preventative care and prevention of deterioration, complications and recurrence. When it is working well, it is a wonderful partnership between healthcare professionals and members, and is at the very heart of the current National Health Service reforms in the UK, where patient satisfaction and feedback are key drivers of the quality agenda.

Members are usually referred to a Leg Club by their GP, district nurse or other clinical specialist. They can also come in on their own via self-referral. While the environment of a GP surgery is necessarily formal and managed by appointment, and while specialist nurses normally have a high volume of patients rapidly passing through, access to clinical care at a Leg Club is without appointment; members are free to 'drop-in' for regular leg treatments without fear of being sent away.

On visiting a Leg Club for the first time, a new member will undergo a full clinical assessment, including his or her leg ulcer, by a qualified nurse. He or she will also be given advice relating to care of the lower limb and a Leg Club member's handbook, so that he or she knows exactly what to expect. During each subsequent visit, a nurse will reassess the leg ulcer, using local wound management guidelines.

The nurses who work in the Leg Club are district nurses, community staff nurses, practice nurses, healthcare assistants and nurses receiving training. Treating so many members in the same place and at the same time cuts down on nurses' travelling time and expenses – a huge saving for the NHS – and enables them to also enjoy the social aspect while treating

members. The atmosphere is friendly and informal, and during conversation, nurses are able to encourage members to adopt a 'well leg' regimen, so that they actually understand how to participate in their own care to get well as quickly as possible.

After each visit, assessments are documented using both local patient records and Leg Club data collection documentation. Part of the reason for the Leg Club data collection is to assess treatments, ensure members are getting the best care, and develop the best practices, which can be used throughout the entire Leg Club network. While in practice Club members should keep their own documentation, there may be reasons, such as dementia issues, when this is not practical and so documentation is given to a carer.

Once the initial assessment has taken place, a plan of care will be determined. One of the key platforms of the Lindsay Leg Club is to have members 'own' their leg ulcer or condition. Thus, the care plan should be discussed and agreed with the member (or carer) to maximise this agreement whenever possible. If a Club is exceptionally busy, it should consider using a volunteer, under a qualified nurse's supervision, to help communicate the care plan to the member and to ensure that it is fully understood.

All members bring their own experiences and attitudes towards treatment. While most members are treated in a group setting, fostering a 'we're all in this together' attitude, a private setting should be available for those who wish for privacy during treatment as stated in the Leg Club guidelines.

Members are actively encouraged to be involved in their care from assessment through to healing, and member education should reflect this. Club members who wish to take care of their own leg wounds with minimal support should be given the training to do so. This training should factor in things such as hand hygiene, bandage removal and dressing changes.

At times, referral to a third party, such as a vascular consultant or social agency, might be required. Because the Lindsay Leg Club philosophy encourages members to both direct and participate in their own care, a member (or carer) should be consulted about the need for referral and be fully informed as to why it is required. Leg Clubs must be aware of the local and regional centres of excellence for wound or other clinical care, so that they can be contacted when needed.

Club members may well require support other than purely clinical care. It is important that each Leg Club is set up to meet social, psychological and spiritual care needs that may impact upon wound healing.

And finally, we mustn't forget that a Club member is a member for life and should be able to self-refer for advice at any time.

Infection control

Everyone involved in a Leg Club must be responsible for prevention and management of infection according to the duties that they undertake.

As part of our philosophy of providing treatment within a social model of care, Leg Clubs are run in non-medical environments such as village/community centres, church halls or meeting rooms. While on the surface replicating the facilities of a medical environment in such social environments may seem challenging, high quality infection control is perfectly possible if all stakeholders follow strict adherence to established guidelines, and Leg Clubs have an excellent overall infection control record.

For volunteers and members, as well as nurses, one of the most important rules to follow is hand hygiene, with the premise being that if something is touchable, it is subject to infection. All Leg Club members, nurses, volunteers, carers and visitors must be familiar with and adhere to official hand hygiene procedures and documented Lindsay Leg Club Foundation infection control policies. In its simplest form this can be broken down to the following maxim: Start Clean; Stay Clean; and End Clean. This information can be found in the LLCF brochure *Infection Prevention & Control Information*. Copies of this brochure must be made available at the reception desk during every Leg Club session and all new members and visitors need to be familiar with the information inside, as well as where all hand sanitisers are located. More formal infection control training needs should be given to all new nursing staff and volunteers, and competencies should be in line with, and assessed against, local trust and Leg Club standards.

In the UK, teams of the local primary care organisations (PCOs) who employ the community and practice nurses undertaking the clinical care in Leg Clubs are available to provide support in initial environmental and procedural assessments, and then guidance during practice. This team needs to be assured that each Leg Club complies with all local policies in order to meet its overall PCO trust compliance with The Health and Social Care Act. Leg Clubs outside of the UK will need to find this equivalence.

All nursing staff (and where appropriate volunteers and members) must be able to recognise the clinical indications of would infection, know when to swab the wound, and instigate appropriate treatment, including referral to the member's general practitioner if necessary. Equipment must be cleaned in accordance with infection control policy and dried before storing, Leg Club premises must also be maintained and cleaned according to this policy.

More and specific information regarding infection control is available at: www.legclub.org

Safety & documentation

All Leg Club team members are responsible for health and safety, both as a general approach and in relation to their particular function within the Club.

In a nutshell, health and safety seems very clear-cut. It is to ensure that the premises and equipment at each Leg Club is fit for purpose and does not represent a danger to Leg Club members, nurses or volunteers. However, putting this simple idea into practice takes some effort.

All members, nurses and volunteers need to be familiar with and adhere to Leg Club policies and procedures (such as infection control, moving and handling, and fire safety), best practice and other external guidance in order to practice safely. Such guidance is included in the How to Set-up a Leg Club document which is available at the Leg Club website.

Much of health and safety is based on simple observation and subsequent action before a problem occurs. For example, many members with leg conditions might find walking difficult, so is there enough space between rows to facilitate this? Are trip hazards quickly removed? Because of isolation and a lack of exercise, some members might be heavyset. Are the folding chairs, which so many community centres use, substantial enough to take the member's weight? Members, too, might have secondary health issues such as Parkinson's disease, which might make it difficult to carry out some tasks. Is there a volunteer available to assist or are they understaffed?

Are nurses forced to work in awkward positions which can place strain on their backs or knees? Do they have a clear path to carry water contaminated from wound dressings to a toilet for disposal, and has one toilet

been set aside specifically for this purpose?

Are volunteers being asked to move heavy folder crates or assist large members who are beyond their ability?

Throughout the UK, Leg Clubs must ensure that the responsible clinical ommissioning group (CCG) has agreed that the environment complies with the Workplace Health, Safety and Welfare regulations, and that public indemnity is in place as per Leg Club guidelines. This includes ensuring that facilities such as the kitchen (certified if required), lavatories and privacy areas are available and fully functioning. The Leg Club lead must liaise with the local environmental health office (EHO) to determine whether a Food Hygiene Certificate is required, and which standards and guidance must be adhered to in respect of food labelling.

While most accidents take place due to human error, most accidents are prevented by human intervention. In all locations, any safety issues or accidents need to be documented, investigated and reported. The cause of an accident must be identified to prevent it from happening again, and this information should be provided to the Lindsay Leg Club Foundation to prevent recurrences in other Clubs, but it is important that a culture of 'finger-pointing' is avoided.

DOCUMENTATION

Documentation can be time-consuming, which the Lindsay Leg Club Foundation is aware of. However, without proper, up-to-date and concise documentation, it is impossible to assess a patient's healing journey. In short, good documentation cannot be overestimated.

Each Leg Club nurse needs to be responsible for their documentation of a member's progress, and ensure that it is done in a timely manner and is kept safe. This will include taking photographs and ensuring their safekeeping, maintaining the member attendance record, returning it to the designated volunteer and providing (where necessary) training for other nurses and volunteers in maintaining these records. In accordance with local PCO trust policy, disclosure and barring service checks should be requested for volunteers. Some members are considered vulnerable and/or require safeguarding, this includes their files.

For more detailed information on how to implement and follow our documentation policies, go to: www.legclub.org.

A Day in the

life of ...

Data collection

Demonstrating the clinical and economic value of the Leg Club model is essential for it to be maintained and grow. Accurate data collection is central to this.

The UK's National Health Service is largely based on a traditional model of health care, where care is provided in the hospital, community centre, or GP practice. Any attempt to move from this model will inevitably arouse concerns. For example, the development of District Diabetes Centres in the 1980s and 1990s attracted similar concerns from the NHS, in that the centres were a move away from the traditional clinic environment.

Thus the Leg Club model will not be sustained if there is no proof of its effectiveness, and it is highly important for the future of the Leg Clubs that there is accurate data to back up our clinical outcomes. For this reason, anonymised data collection for the Lindsay Leg Club Foundation – as distinct from the patient records – must be completed by the Leg Clubs.

Nurses must be fully trained in the Lindsay Leg Club Foundation's clinical data entry system. Data entry must be completed in 'real time' and not retrospectively after a Leg Club session. If a Leg Club lead feels that insufficient training has been provided, or if there remains any continued concerns about how to use the data entry system, it is important to contact the Lindsay Leg Club Foundation as soon as possible and further training will be provided.

It is appreciated that completing and dealing with documentation can be time-consuming, and that initially, data entry can seem like a daunting task. Since they are often the first point of contact for members, volunteers can provide available assistance with this task; but first they must be trained in data protection and confidentiality. However, the trained volunteer can be responsible for detailing the anonymised member attendance summary, completing the registration form for each new patient, and completing the Club member consent form.

For more information on specific information collected, go to: www.legclub.org

Social & individual factors

All members have a right to be treated with dignity and to have their privacy respected.

When the Leg Club model was set up, it was decided that each Club would be run with only a minimal amount of supervision from the Lindsay Leg Club Foundation. This allows costs to be kept down considerably and Clubs to be run with a degree of autonomy.

However, for this to work, each Leg Club must form a committee which will facilitate the smooth running of the Leg Club and address any issues that may arise. Guidance on the setting up and the running of the committee can be found at the Leg Club's website: www.legclub.org. As a matter of good practice, nurses and volunteers should meet on a quarterly basis to discuss all aspects of the Leg Club's running and to address any concerns.

There is a US southern expression which goes: 'When you're up to your neck in alligators, it's easy to forget you came to drain the swamp'. At times at Leg Clubs, with dressings to be changed, new patients registered, data to enter, the important social aspect of a Club may be forgotten or considered less important. But, this is far from the case.

An experience that most members with leg ulcers and other lower leg limb problems share is that they can feel very alone, self-conscious and isolated regarding their situation; they can take these feelings into the Leg Clubs, especially during their first visit. The benefits of mixing with others with the same conditions gives them a feeling of 'we're all in this together', and talk and interaction follows naturally. Time and time again we have seen that good social interaction creates good compliance with treatment as members share their treatment experiences with others. Over cups of tea and coffee, members hear continuous stories of how ulcers are healed by those receiving post ulcer care and progress checks, and this positive feedback inspires members to become stakeholders in their

own treatment. New members should be introduced to other Club members and encouraged to sit with one of the groups of members.

Refreshments are an essential part of Leg Clubs and are generally provided from the individual Leg Club funds and from Club member contributions, as are celebratory cakes or chocolates. Remember for some members, especially those without families, the weekly Leg Club treatment/meeting is their entire social interaction for the week.

All Leg Clubs organise Christmas and Easter celebrations, with respect to other faiths, and have a meal out for all of the Leg Club members who wish to attend. This can be funded by members themselves or through Club funds. No member should ever feel that they cannot afford to attend a Leg Club social event.

What should not be forgotten is that while the philosophy of the Leg Club model is that leg ulcer management is given in a social rather than medical environment, some members may wish to have their wound treated in private, as stated in Leg Club guidelines relating to privacy.

HOUSEBOUND MEMBERS

Because a member or prospective member is housebound, this is not a reason for them to be considered ineligible to join a Leg Club.

To address issues of restrictive mobility, transport may be available through something like a 'Dial-a-Ride' programme, the Red Cross, a council service or volunteers. However, this will depend on the arrangements made between the local Leg Club team and community. It is this aspect of Leg Clubs that enables many 'housebound' individuals to experience the benefits of treatment in an inclusive supportive environment.

Frequently, the nursing team from a Leg Club will provide the service to the totally immobilised housebound member. Importantly, a robust care pathway should be followed wherever the member has the service delivered, irrespective of his or her personal funds, location or resources.

Working with ancillary services

Where appropriate, ancillary agencies will be co-opted to provide support services to the Leg Club.

Ancillary services are an important addition to Leg Clubs, but are offered according to need (and available resources) and are at the discretion of each Leg Club committee.

Examples of both clinical and non-clinical ancillary services include: Dial-a-Ride (providing transport of members to Leg Clubs and back home on clinic days and special events), social service visitors attending on Leg Club days, a podiatrist or chiropodist, dietician, physiotherapist, continence nurse, a local walking group, attendance by an art therapist on Leg Club days, an exercise/movement class, and specialist catering – although it is always expected that tea and coffee will be provided.

The Leg Club lead and volunteers should identify and record appropriate agencies for collaboration and establish a working relationship with each of them. Remember, any outside group that comes into a Leg Club needs to be aware of health and safety issues. Staff from other agencies should be aware of Leg Club and pertinent external policies and procedures, and adhere to them while undertaking their duties.

It goes without saying that staff from ancillary agencies and (where appropriate) Leg Club Industry Partnership (LCIP) staff should follow Leg Club practice in treating members with respect, while maintaining a friendly manner.

Leg Club Industry Partners

The Leg Club Industry Partnership (LCIP) is an alliance between the healthcare industry and the Lindsay Leg Club Foundation. The mission statement of the partnership is:

'Empowering patients through a unique collaboration with industry dedicated to lower limb conditions'.

Building collaborative corporate partnerships has involved identifying opportunities for change, finding the resources to bring about these changes, choosing an effective group structure, and building trust among collaborators. This collaboration has afforded Leg Club nurses the opportunity to work closely with commercial organisations, and is evidenced by nurse involvement in the development of the Leg Club Code of Practice.

Our latest LCIP project has been to produce a generic teaching programme available via the website Leg Club learning zone, which has been approved by the Welsh Wounds Innovation Centre (WWIC)

To ensure protection of both parties, the Lindsay Leg Club Foundation collaborated with the LCIP to develop a comprehensive Code of Practice that all Leg Clubs adhere to.

Lindsay Leg Club Foundation References

Lindsay Leg Club Foundation (2014) How to set up a Leg Club. Available at:

www.legclub.org/how-to-set-up-a-leg-club

PATIENTS COMMUNITY
PRACTICE AND DISTRICT NURSES
LEG CLUB®
www.legclub.org

The volunteer's view

Well, about three years ago, aged 67, I decided to take some action to get my body into shape, in particular, my legs. Over time I had watched my husband, a smoker, gradually deteriorating and complaining about pain in his legs when he walked. Ultimately, he could walk only a few yards before having to stop to relieve the pain, and one day it dawned on me just how important it is to keep our legs in good condition as we age.

From then on, I started walking a mile each morning. I'm fortunate enough to live in the centre of a beautiful town where I could easily set out along the river-side path for half a mile, then join the canal towpath, and return home, within an hour. After a year I had lost a stone in weight, and three inches from my hips, and my balance coming down steps had greatly improved.

In February 2014 I read about a Leg Club being started by our local doctors and, out of curiosity, I attended one of the weekly gatherings. A neighbour had told me of her ulcer, which refused to heal and was causing her great pain and sleepless nights, and which she was treating with honey! And I wanted to know more. What an eye-opener that visit was! In a small room several folk sat around a long table, chatting or reading, waiting for their name to be called to attend one of the five nurses who then washed and dressed their legs. A lady was pouring tea and coffee, and within minutes she had grabbed me and asked me to help with serving and washing up – and that was it – I was in!

By July 2014 we had moved to larger premises because member numbers had increased considerably. The doctors, who were pleased with the success of the Club, continued to release the nurses and administration staff, and the team of volunteers also grew. So, now we have established a fine routine, and the entire operation runs smoothly and professionally.

Between 8 and 9 am the room is set up with patient records and medical supplies, and the kitchen prepared. Five nursing stations are arranged. Screens are positioned for privacy. Behind one, Doppler tests are done. Behind another, a visiting Chiropodist attends to feet. A corner is prepared for a group to discuss their nature walks. A rep from one of the medical supply firms attends to help the nurses. Books for borrowing or buying are set out on a long table, and a weekly raffle is run by a volunteer. By the entrance our bubbly administrator-in-chief has to hand the members' records and is ready to meet and greet. Then at 9 the doors open and we are off!!

I've always said that my role as a volunteer is to dispense tea, coffee and good cheer to one and all (and, of course, biscuits). Over the months as we have got to know each other, so the buzz of laughter and chat has developed, and it is very satisfying to see such warm sociability. Encouragement is a priority. Not every member can say they have improved over the week. Some talk of pain, of falls, of loneliness, sleeplessness and distress. But others talk of companions, helpers, of outings and of healing. Even then, they want to come next week – for a cuppa and a chat!

The last time my doctor MOT'd me, her parting words were 'Keep walking!' and I give those words of encouragement whenever I can as members depart.

Since working at Barnstaple Leg Club my eyes have been opened to the world of health care. Although it may be a small fraction of what is involved in healthcare, it has pumped up my ambition and drive to do something worthwhile with my life and career.

This has spurred me on to apply for college, not just for the medical side but more to do with the personal side. I have never described myself as a people person, but since being at the Leg Club I have learned to see past the 'list of chores' and seen the individual — the personality of each person — and also what a difference, I, and we as a whole, make to these individuals. Everyone has a story! Thanks to the social aspect of the Leg Club they get to share that story! With each other, with us, with you! I am fully aware that we are not a social club, but for some of our clients we are the only other people they see in the week. I know this because I listen and I hear. If you could come in and hear their story, maybe you would understand.

There is also the sad fact that in one case in particular, one of our clients has no home. What will happen to him? Where and who will he turn to? He has a child! Another case is a couple, who don't feel comfortable with people coming into their home.

We don't just offer these people medical care, we provide them with security, empathy, comfort, and, most of all, friendship.

APPENDICES

Appendix I: References, Leg Club research and other papers

REFERENCES

1. Nursing & Midwifery Council (2015) The Code. Professional standards of practice and behaviour for nurses and midwives. Available at: *nmc-uk.org/Documents/NMC-Publications/revised-new-NMC-Code.pdf*
2. Department of Health (2010) *Equity & Excellence: Liberating the NHS* Available at: *gov.uk/government/uploads/system/uploads/attachment_data/file/213823/dh_117794.pdf*
3. Fagervik-Morton H, Price P (2009) Chronic Ulcers and Everyday Living: Patients' Perspective in the United Kingdom. Wounds 21 (12): 318-23
4. Health & Safety Executive (1992) Workplace health, safety and welfare. Workplace (Health, Safety and Welfare) Regulations 1992. Approved Code of Practice and guidance. Available at: *healthandsafetyworksni.gov.uk/workplace_health__safety_and_welfare_acop.pdf*
5. Health & Safety Executive (2004) Control of substances hazardous to health regulations 2002 (as amended in 2004) - General enforcement guidance and advice. Available at: *hse.gov.uk/foi/internalops/ocs/200-299/273_20/*
6. Office of the Public Guardian (2013) Safeguarding Policy. Available from: *gov.uk/government/uploads/system/uploads/attachment_data/file/349100/OPG_safeguarding_policy.pdf*

RESEARCH SUMMARIES

Leg Clubs have demonstrated that non-concordance with treatment and occurrence of infection has been virtually eliminated, many long-standing ulcers have been healed, and an exceptionally low incidence of recurrence has been recorded. An improvement in patients' quality of life in conjunction with substantial savings in the cost of treatment has also been shown.

The following article summaries show how these outcomes have been achieved.

CLINICAL OUTCOMES

Lindsay E, Tyndale-Biscoe J (2011) Leg Clubs: helping nurses improve patient outcomes. *Br J Community Nurs 7: 348-9*

Leg Clubs enable nurses to develop a role by which they can become more involved in the community they serve, supporting patients in shared decision-making.

The Leg Club model encourages nurses to shift from being pure providers to being collaborators, not just with patients, but also with existing voluntary and third sector organisations. This collaborative approach with patients, volunteers and the community helps maintain care delivery, but also bringing creative ideas to life. Patient transportation is a good example – Leg Club nurses have worked with voluntary sector groups such as the Rotary Club or Help the Aged, to ensure members are able to attend.

Leg Club nurses are collaborators who help patients to become co-producers in their health care through a coalition of support from community and voluntary sector organisations. Leg Club nurses also benefit from further education and greater links with research organisations.

Vowden K & Vowden P. (2006) Preventing venous ulcer recurrence: a review. *Int Wound J 3(1): 11-21*

This review article examines the available evidence on both the primary and secondary prevention of venous ulceration, exploring both the individual, social and financial implications of system failures that allow patients to remain at increased risk of recurrent ulceration. The role of both venous disease assessment

and corrective superficial venous surgery are discussed in the light of recently published randomised controlled studies on the role of superficial venous surgery as both an adjunct to ulcer healing and ulcer prevention.

Fagervik-Morton H, Price P (2009) Chronic Ulcers and Everyday Living: Patients' Perspective in the United Kingdom. 21(12): 318-323
Abstract: Our knowledge of patients' concerns with regard to living with chronic ulceration remains incomplete. This cross-sectional survey collected the self-reported views of patients using a specifically designed questionnaire developed from issues relevant to UK patients captured through focus groups. Results were obtained for 196 patients from Wales and England with a mean age of 74.4 years (SD 12.86), and mean wound duration of 25.52 months (SD 56.95). Wound symptoms reported by patients as problematic in every day life were pain, difficulties in bathing, leakage, impaired mobility, odour, and slippage of the dressing or bandage; pain symptoms were reported as particularly distressing. In free text responses, many patients stated that nothing could be done to ease pain at dressing-related procedures either on their own at home or by the healthcare professionals involved in their care. However, many patients were able to identify several factors that were important to them in reducing pain at dressing-related procedures. For example, the way in which the wound was treated was important in reducing the severity of pain, while having consistent quality of care, thorough communication, and rapport was beneficial in easing pain at dressing-related procedures. Being consulted, listened to, and distracted from the procedure itself was helpful. There was a small portion of patients who volunteered that they were satisfied with their current care regardless of pain. These data highlight the importance of gaining insight into which factors and processes aid successful psychosocial adjustment and coping mechanisms associated with chronic ulceration.

QUALITY OF LIFE OUTCOMES

Thompson G (2012) External audits reveal overwhelming support for Leg Club concept. *Wounds UK* 8(1): 116-118
Central to the ethos of the Leg Club Foundation is the idea that members should feel empowered to become stakeholders in their care. Information regarding the opinions of Club members is obtained for a productive annual review.

The Leg Club philosophy considers all those working in or attending a Leg Club to be members. There are three distinct groups of people within the dynamic of the Club:

- Patients/members
- Professional staff
- Volunteers.

Each has distinct but shared roles; Leg Club members find themselves in a social setting that offers health care, and actively promotes and encourages a strong sense of ownership by the members, clinical and volunteer staff.

The ethos, feelings and opinions of the patient members or the level of commitment to the concept by the professional and volunteer members is captured by the annual external audit, which seeks to identify the services within the primary care organisation (PCO) and how these interface with the Leg Club.

These annual audits demonstrate overwhelming support for the Leg Club concept among members, professional staff and volunteers.

Clark M (2012) Patient satisfaction with a social model of care. *Wounds UK* 8(1): 20-6
Background: The Lindsay Leg Club model provides lower limb care delivered by district nurses within a non-healthcare setting, such as a church or community hall. Aims: To assess the effectiveness of Leg Clubs by gathering information from

Club attendees on their levels of acceptability and satisfaction with the Leg Club model, looking specifically at the care they receive and the social interactions they experience. Methods: A member satisfaction questionnaire was developed based on a validated questionnaire to assess satisfaction levels at NHS 'walk-in' clinics. This was piloted across five Leg Clubs in the UK. Results: A total of 124 completed questionnaires were received. Almost half of the first-time attendees visited their GP about their legs in the four weeks before attending a Leg Club. Fewer prior attendees at a Leg Club had visited their GP in the four weeks before the survey. Few expressions of dissatisfaction were offered, the majority of prior and first-time attendees rating themselves to be 'very satisfied' with their Leg Club. As a consequence of visiting their Leg Club, most members considered they were better able to cope with life and most were better placed to keep themselves healthy. The majority of members felt better able to understand their leg problems and most considered themselves better able to cope with them. A high majority of members considered their Leg Club to be 'friendly' or 'very friendly' and most enjoyed the social interactions. Conclusion: The questionnaire identified high levels of Club member satisfaction, regardless as to whether the respondent was an established member or a first-time attendee. A high proportion of respondents reported that they would recommend their Club to family and friends and a high majority would be willing to use a Club again.

Clark M (2010) A Social Model for Lower Limb Care: The Lindsay Leg Club Model. *EWMA J* 10(3) 38-40

The Lindsay Leg Club model is founded upon people with leg problems 'owning' their clinic which is located in a non-medical setting such as a church hall. Lindsay Leg Clubs provide leg ulcer management in a social environment where patients (the members of the Leg Club) are typically treated collectively and where the emphasis is on social interaction, participation, empathy and peer support.

Between the 14th July 2003 and 9th November 2009 data was recorded for 4,171 Lindsay Leg Club members who made 29,132 separate visits to their Leg Club. Membership of a Leg Club to receive advice and preventive care to maintain healthy legs (n=1,595) was more common than attendance for treatment of an active leg ulcer (n=1,193). Many people with lower leg problems made the decision themselves to attend a Leg Club (n=1,142), suggesting that there is large unmet need for help with lower leg problems that may not be seen in GP surgeries or by district nurses.

The incorporation of a well-leg programme of care within the Leg Clubs may have helped contribute to the relatively low proportion of members who entered active leg ulcer treatment from attending the well-leg programme (n=140, 16.1%)

Edwards H, Courtney M, Finlayson K, et al. (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): 1151-9

The negative impact of chronic leg ulcers on quality of life is well documented. The aim of this study was to determine the effectiveness of a new community nursing model of care on quality of life, morale, depression, self-esteem, social support, healing, pain and functional ability of clients with chronic venous leg ulcers.

Venous leg ulcers are slow to heal, frequently recur and are associated with pain, restricted mobility and decreased quality of life. Although chronic wound care consumes a large proportion of community nursing time and healthcare resources, there is little evidence available on the effectiveness of differing models of community care for this population.

This randomised controlled trial recruited a sample of 67 participants with venous leg ulcers referred for care to a community nursing organisation in Queensland, Australia after obtaining informed consent. Participants were randomised to either the Lindsay Leg Club model of care (n=34), emphasising socialisation and peer support; or the traditional community nursing model (n=33) consisting of individual home visits by a registered nurse.

Participants in both groups were treated by a core team of nurses using identical research protocols based on short-stretch compression bandage treatment. Data were collected at baseline, 12 and 24 weeks from commencement.

Participants who received care under the Leg Club model demonstrated significantly improved outcomes in quality of life (p=0.014), morale (p<0.001), self-esteem (p=0.006), healing (p=0.004), pain (p=0.003) and functional ability (p=0.044).

In this sample, the evaluation of the Leg Club model of care shows potential to improve the health and well-being of clients who have chronic leg ulcers.

RESOURCE OUTCOMES

Tyndale-Briscoe J (2012) How Leg Clubs can help commissioners make every contact count. *Wounds UK* 8(3):138-9

There are many reasons why GP commissioning consortia should look to the voluntary and third sectors for help with service delivery. This article examines how the Lindsay Leg Club has proved that it is better placed than most to aid in this process.

Leg Clubs can help commissioners deliver services that meet the healthcare needs of their populations:

- The Leg Club model is cost-effective in terms of nursing resources; providing care in a social environment creates savings in nursing time by cutting down on domiciliary visits
- Leg Clubs provide 'well leg' programmes, which ensure that once healed, individuals can remain problem-free for longer. The well leg programme has helped to reduce recurrence rates to approximately 16%
- Leg Clubs help commissioners make every contact count; services have to dovetail effectively and be responsive, rather than the usual silo approach where patients move from one clinician to another and are treated in isolation. Some commissioners have been working with Leg Clubs to become hubs for other disciplines, such as podiatry, diabetic care and flu clinics
- Leg Club members themselves see significant benefits; patients are empowered to become stakeholders in their own care, thus increasing healing rates and providing enhanced quality of life, a lower level of recurrence, and more positive health beliefs.

Further reading

Lindsay Leg Club Foundation (2014) How to set up a Leg Club. Available at: http://www.legclub.org/how-to-set-up-a-leg-club

Gordon LG, Edwards H, Courtney M,Finlayson K, Shuter P, Lindsay E (2006) A cost effective analysis of two community models of care for patients with venous leg ulcers. J Wound Care 15(8): 348-53

Edwards H, Courtney C, Finlayson K, Lewis C, Lindsay E, Dumble J (2005) Improved healing rates for chronic venous leg ulcers: Pilot study results from a randomized controlled trial of a community nursing intervention. Int J Nurs Practice 11: 169-76

APPENDICES

Appendix II: Foundation Governance Document: Leg Club Committee

Leg Clubs are independent bodies that provide treatment for those suffering from or at risk of leg ulceration within a social model of care. After their setting up and subsequent launches, Leg Clubs become largely self-run and financed through the following factors:

- The assistance of volunteers from the local community, providing services such as administrative support, refreshments and transport, and their formation of a steering committee with Chair, Treasurer, Secretary and other executive roles as appropriate

- The establishment of their own local fundraising committees who will organise fund-raising events, apply for local and possibly national funding and encourage bequests. Fundraising within a Club provides for hiring of premises and the purchase of specialised equipment such as Doppler ultrasound devices and medical cameras, often supplemented by support from the healthcare industry. Clinical commissioning groups recognise that all equipment provided through community fundraising and donations remain the property of the respective Leg Club.

This document provides some introductory notes on forming committees and ensuring that clinical and volunteer staff work in harmony at all times. On the rare occasions when conflict has occurred within Leg Clubs, this has usually been as a result of differences between the clinical and volunteer groups. This can easily be avoided by the following structures:

- At the outset, create a 'constitution' for the Club, and consider all factors pertaining to the Club under all eventualities. For example, in the unlikely event of Club closure, how are the finances and equipment going to be dispersed to the best interests of patients? In the event of conflict, is there a procedure for grievances expressed by any members of the committee? These can be short and simple, but must be clearly stated.

- In order to ensure clear understanding of the role and purpose of setting up a Leg Club with clinical and volunteer committee members, you need to have mutually agreed 'terms of reference', which set out what the committee will do, and ground rules for how (and when) meetings will be run.

- Ensure that roles and responsibilities for both clinical and volunteer staff are clearly stated – this includes roles for greeting and registering

members, for opening and closing the Club, for arranging social events and for providing refreshments as well as clinical treatment and documentation

- We recommend that the Chairperson's role is to jointly represent both the clinical and volunteer groups. In the event of a tied vote the Chairman usually has the casting vote, and this way the vote will be known to be free of any bias from either group
- Good recruitment and working relationships are essential. The right choice of Chair and the right mix of members in the group are the most important factors in the success of the alliance. It is a good idea to look at both skills and personalities, especially as the committee will be working together in a busy atmosphere to create a high quality member experience for many years to come
- The ideas and views of all the committee must be treated with merit and respect. Otherwise, it will be very clear that the alliance is just a token gesture
- It is up to the group meetings to modify any ideas in terms of practicality and potential benefit
- It is important to announce the issues that the group has discussed and the plans that have been decided
- It is important to provide a member's perspective, ensuring services, plans and activities respond to patients' needs and priorities – a 'critical friend'
- All parties must provide collaborative practical support organising health awareness events, etc.
- Both groups must respect their particular roles within the Leg Club and the Leg Club committee. Clinical decisions can only be made by the clinicians and these must be respected by the volunteer team, while clinicians must respect the right of volunteers to run the social aspect of the Leg Club
- If a conflict occurs then all efforts should be made to resolve the issue within the Leg Club committee. If this is not possible and depending on the nature of the dispute, one of the following two actions can be taken:

Non-clinical – Seek advice and support from the Foundation trustee and clinical consultant responsible for your Leg Club

Clinical – Speak to the lead nurse. If there are still concerns seek advice and support from the Foundation trustee and clinical consultant responsible for your Leg Club.

If in doubt as to who to contact, please get in touch in the first instance with Lynn Bullock: lynn.bullock@legclubfoundation.com

Frequently asked questions

A number of factors have to be considered when setting up and maintaining a Leg Club; these include clinical, safety, financial and management issues.

What makes Leg Clubs better than NHS leg ulcer clinics?

Firstly, the standard of clinical care can and should be excellent in both settings (Leg Clubs and NHS clinics). This depends on the experience, training and supervision of staff. If this is not of a high quality, care will be poor irrespective of where it is being provided.

The Leg Club model is unique in the way that it views patients as partners in the care they receive and as experts in their own condition.

It embraces the significant issues of isolation, loneliness and the ability to empower patients through knowledge of their condition and its treatment, with a very direct involvement in care. The Leg Club model is far more than simply the provision of leg care, although this is paramount, but rather a social model that seeks to address the myriad of issues these patients face.

Being able to share care together and support each other is for many patients a very helpful model. Research is clear that leg ulcer patients are socially isolated and have a reduced quality of life. The Leg Club model addresses these issues.

A second important aspect of the model is viewing patients as partners in care and letting them take control. The Leg Club model is not just about treatment, but also has a strong focus on preventative care and prevention of deterioration and complications. When it is working well, it is a wonderful partnership between healthcare professionals and patients and is at the heart of current NHS reforms, where patient satisfaction and feedback are key drivers of the quality agenda.

Why cannot anyone start up a Leg Club along similar lines?

It is important that anyone thinking of starting a Leg Club understands the methodology and standards required for this undertaking. It helps to protect the ethos and methods that have been so carefully developed by Ellie Lindsay and the Lindsay Leg Club Foundation over many years. Poorly developed Leg Clubs would damage the work of the Lindsay Leg Club Foundation. Signing up to the Foundation ensures that new Leg Clubs are supported through their endeavours and provided with new knowledge through a greater understanding of the work involved in a Leg Club. Lack of understanding and knowledge are the single most important threat to the work of the Lindsay Leg Club Foundation, as it is crucial that those involved with setting up Leg Clubs, do so with due diligence and support.

I want to set up a Leg Club. Where do I start?

In the first instance, presentations for nurses, managers and commissioners can be arranged. These will explain the process and provide answers to any questions. Guidance on factors such as choice of venue, volunteer teambuilding, fundraising, and equipment needs will be given by nurses experienced in running Leg Clubs. The Leg Club network also organises regular specialist wound care training and update events for its members.

Standards, guidelines and documentation will be explained, and prospective Leg Club leads will have the opportunity to visit working Leg Clubs to see them in action and talk to staff and patients.

It is of vital importance that the standards established to ensure the success of Leg Clubs are

maintained throughout the network. To maintain Leg Club status, an annual clinical audit in practice is conducted to verify suitability of premises, infrastructure, procedures and documentation, and a qualifying centre issued with an accreditation certificate of one-year's duration. The centre will subsequently be audited each year to ensure standards are being maintained, and a new certificate issued accordingly. Only accredited centres may use the registered Leg Club name and symbol.

Guidance can be found at: http://www.legclub.org/how-to-set-up-a-leg-club

How much time we have to commit?

Without doubt, the long-term sustainability of a Leg Club comes from the commitment of the nurses, volunteers and members, along with all other agencies and statutory bodies who interact with the staff and members. Where that commitment is shared with or initiated by healthcare providers, a Leg Club is likely to have a secure future.

Because Leg Clubs depend on the expertise of the nurses who attend every week, leg ulcer care should be in accordance with local wound management protocols and accepted wound care practice. One important aspect of this is the building of a partnership with the member to develop trust and facilitate involvement in his/her own care.

Therefore, nurses who work in Leg Clubs are required to be skilled wound care practitioners and able to commit to regular attendance at the Club in order to contribute to the social model and build partnerships with the members.

Ros Hughes, District Nursing Sister shares her experiences of setting up a Leg Club on the Lindsay Leg Club Foundation (LLCF) website: http://www.legclub.org/botesdale-leg-club

How do we fund our Leg Club?

The finances of a Leg Cub are the responsibility of its committee, although if you have a large and busy Club, you may wish to set up a fund-raising sub-committee to organise fundraising events, to apply for local and/or national funding and to encourage bequests.

Fundraising provides money for the hiring of premises and the purchase of specialised equipment, so it is imperative that the Leg Club committee's fundraising activities are maintained throughout the year.

For more information and ideas on fundraising, go to www.legclub.org or contact the Lindsay Leg Club Foundation.

How do we identify premises for our Leg Clubs?

Finding premises for a new Leg Club is without doubt a critical step – remember, you are looking for a 'social' environment rather than a traditional 'clinical' one.

Nurses and committee locate appropriate premises, ensuring that environmental, health and safety, and public liability criteria are addressed and that facilities are checked against each of the Best Practice statements listed in this compendium. For example, will the premises be able to offer the seating, catering, privacy and infection control provisions as listed, in addition to the clinical space that is required? Premises can either be too expensive to maintain in the long term or cannot support the type of care being provided, so it is important that the selection and negotiation of adequate premises for a Leg Club are thoroughly researched.

Who runs the Leg Club?

Leg Clubs are independent bodies; after set-up and launch, they become largely self-run and financed through the following:

- The formation of a steering committee with Chair, Treasurer, Secretary and other executive roles as appropriate. The committee is responsible for the overall success of the Club, for ensuring that all LLCF, local and national guidance, policies and laws are implemented, and that sufficient funds, staff and volunteers are available for the future
- The assistance of volunteers from the local community, providing services such as administrative support, refreshments and transport
- The establishment of their own local fundraising committee who will organise fundraising events, apply for local and/or national funding and encourage bequests. Fundraising within a Club provides for hiring of premises and the purchase of specialised equipment.

Isn't it impossible to provide the same infection control principles in a non-clinical environment?

No. It's perfectly possible; these principles are just as important and stringent in a non-clinical environment where patients are being cared for as in a clinical one. The LLCF has worked closely with an expert infection control practitioner, Andrew Kingsley, who has created guidance on all aspects of infection control and management within a Leg Club environment.

It is important however, that all nurses and volunteers understand them, apply them and document actions.

For further information please refer to the supplement on infection control that comes with this compendium, or access it at: www.legclubfoundation.org

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