The Role of Social Models of Care in Wound Management

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Over the past several years I have seen the Lindsay Leg Club model grow exponentially here in Wales and the effect that it has had on many communities here. This has been accompanied by the growth of the model's reputation worldwide which is in my view completely justified. This paper discusses what a social model of care comprises of within the wound care arena and how Leg Clubs are a perfect example of this model at work. I advocate for Leg Clubs as one of the key forms of long term care for leg wounds in Wales and am delighted that now we have a full explanation of the context behind this model, its purpose and its effectiveness on several levels.

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The social model of care represented by Lindsay Leg Clubs is in many ways as important as the scientific and clinical developments that are taking place in wound care today. The Leg Club model advocates for patients, which I am passionate about, and puts them where they belong; at the centre of the wound management matrix. I am delighted that the model's international recognition continues to grow and I believe that this paper will explain precisely where and how it will help our patients achieve the long term solutions that they need in their treatment journey, and more importantly, address the social isolation that can come with this often overlooked disease.

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Foreword

ELLIE LINDSAY

In a world where populations are ageing, a major challenge is in finding meaningful ways for people to experience good quality of life while continuing to participate in and contribute to society. We understand the human and financial costs of living longer, and the increased likelihood of living with one or more chronic diseases. Of these diseases, chronic wounds often go unnoticed, but they represent a significant burden to patients and healthcare systems.

With a financial cost to the UK's NHS of almost £5.3 billion annually[1] the individual costs are also considerable. These costs include the social stigma, pain and uncertainty attached to problems of the lower limb and leg ulceration. Leg ulcers are a major subset of chronic wounds and frequently lead to clinical depression, social isolation, a marked deterioration in overall quality of life and poor clinical outcomes. Many individuals have lived with open wounds for many years. They have been through endless cycles of healing and breakdown, with each cycle lasting many weeks or months.

Over the past 10 years there has been an abundance of studies and papers on the incidence of leg ulcers and the high cost of management. There is now a consensus that clinical treatment alone (that is to say, without reference to the social environment of the individual patient) can have only a limited effect. On the other hand, a social model of care can provide information and services to individuals to help them make long-term choices about their health, while clinicians and volunteers can provide access to a wider range of community services specific to meet their needs. This has resonated with health trusts and GP surgeries that have recognised the need for innovative social models at a time when finances are under pressure.

The psychosocial Lindsay Leg Club® model of care has been in operation since 1995 and was specifically designed to provide a social model of care for people suffering from or at risk of leg ulceration. Leg Clubs are partnerships between nurses, volunteers, members (the people attending for leg ulcer treatment or prevention) and committed healthcare companies. There are more than 45 Leg Clubs across the UK, Europe and Australia, and the numerous local and national awards for those nurses who have persisted and set up Leg Clubs are a testament to the recognition that the model now enjoys within the wound care community.

In many parts of the UK and Australia the Leg Club model has been recognised by commissioning groups and healthcare providers as a valued part of the ongoing care of the elderly and other members of the community who are at risk of health breakdown.

The Leg Club model demonstrates its effectiveness in four ways; clinical effectiveness, patient satisfaction, wellbeing and cost effectiveness. This paper outlines the latest evidence for that effectiveness and discusses the future role that a social model of care can play within the wound management arena. I believe that the evidence as to the value of this model is significant. Our member cohort alone forms a large single database on leg ulceration, and will ultimately provide a wealth of potential information to study over the coming years.

An entrepreneurial approach to wound management relies on researchers, patients, clinicians and the healthcare industry working together to meet a common objective. We should therefore recognise the unique coalition of healthcare companies who have supported both the Leg Club model and our Foundation since their inception. Medical technology in wound management is continually advancing in new and exciting ways. Several companies have been at the forefront of this research and I am especially grateful to those who have recognised the importance of adding the social model to technological innovation. Staff from these companies are to this day active contributors at individual Leg Clubs while the Leg Club Industry Partnership contributes to a large programme of education on leg ulceration and leg health, including the annual Leg Club conference.

I would also like to recognise the contribution of colleagues around the world who have focussed their clinical work and research on the patient experience in wound management while advocating and lobbying for the voice of individuals to be heard. Many allied organisations, such as the World Union of Wound Healing Societies, support the work of Leg Clubs and I am pleased to belong to the World Union of Wound Healing Societies patient advocacy panel, whose work has informed part of this paper.

Finally, I would like to thank all our stakeholders – our patrons, foundation trustees, colleagues, volunteers, nurses and most significantly our members, who have always been and will be an inspiration for us to maintain and grow our psychosocial Leg Club model, with the goal of making it available to all those who need it.

Background

ROLAND RENYI

The field of wound management raises some interesting questions about modern society, the way that western healthcare is currently delivered and to what extent a reliance on our medical model of care alone can be sustained. In some ways the huge advances in medical science have made us victims of their success, as they have occurred during a period of great social change where the emphasis on the extended family for providing long-term holistic care has been replaced by a reliance on the state and the clinical services that it provides. If a "model of care" broadly defines the way that health services are delivered, the medical model, that prevails today, focuses on the diagnosis and treatment of disease. The problem is that, as healthcare professionals know only too well, there are a number of long-term conditions that are multifactorial, that rely on multidisciplinary teams, and that need to be managed indefinitely as they are impossible to cure, while inevitably causing great suffering and distress to patients.

Wound management is a case in point. It is both multifactorial in origin and multidisciplinary in treatment - multifactorial because a chronic wound is often a marker for an underlying condition such as diabetes or peripheral vascular disease, and multidisciplinary because a group of healthcare professionals and carers, including the patient, will be required to collaborate in order to provide an effective treatment. This can be problematic because the prevailing system of visiting a physician or specialist nurse, being treated and then sent home to take medication in many cases may not provide a sufficient or effective solution for a patient with a chronic wound. Ongoing treatment over several weeks, such as compression, dressing changes, infection control or debridement and even surgery, may be required, which will need concordance, sustained management and a high degree of co-ordination among professionals. The patient, meanwhile, will have to endure the discomfort or pain along with the inconvenience of the wound, the risk of wound recurrence, and the need to attend treatment in several locations. In most healthcare settings, the effective coordination of medical treatment alone may be hard to achieve, while attending to the overall wellbeing of the patient at the same time is a big challenge.

Calculated to be roughly equivalent to managing obesity (and 3% of the overall health budget), the morbidity of long-term or chronic wounds is constantly increasing[1]. Leg ulceration, a major subset of chronic wounds, costs the NHS at least £400 million annually, and carries a very significant human burden[2]. Depending on the aetiology of the wound, with good concordance and appropriate care the average leg ulcer can be healed within 12 weeks, but the chances of a recurrence without ongoing monitoring are high. In this way a patient is at risk of spending several months, if not years, undergoing treatment for non-healing or recurring leg ulcers. We need to ask whether the current medical model of care alone is sufficiently robust to manage this process effectively.

For quite some time wound management clinicians have focussed on addressing the more holistic aspects of wound care, as demonstrated for example in wound bed preparation, and several international working groups and organisations have developed models and algorithms that provide guidance in addressing both the wider causes of chronic wounds and patient-centred concerns[3]. As well as this top-down approach, several general practices, district nursing teams and specialist wound care centres around the world have done spectacular work in close collaboration with their patients, providing not just innovative and effective clinical care but having a measurable effect on quality of life and wellbeing. In spite of the excellent theoretical and practical work being done, and the dedication of a number of healthcare professionals, little has happened in terms of firm policy and practice change.

A social model of care attempts to address the broader influences on health. Its focuses on social, cultural, environmental and economic factors as opposed to just disease and injury. Social models of care have proven effective in several complex therapeutic areas, such as cancer and diabetes, and appear to have a higher success rate when concordance with treatment and informed decision-making are required. Although different in their emphases, in social models of care:

1	Treatment needs to take place at a consistent place and time
2	Appointments should not be necessary, and patients should not feel under any time constraints
3	Addressing patient-centred concerns is a critical component of treatment
4	Education, prevention and patient empowerment are emphasised
5	Both clinical and non-clinical services must be available
6	Patients and their families or carers should have access to the treatment centre, find it easy to reach and feel comfortable there
7	While confidentiality should always be respected, patients should be able to socialise with other people while attending these centres
8	Active participation by patients, ex-patients and volunteers should be encouraged and facilitated

It is clear that a purely medical service would have great difficulty in putting such a structure into operation. However, a collaboration between clinical, community and voluntary services could be a highly effective way of introducing a social model. Companies with a focus on wound care could provide considerable extra support to the day-to-day needs of the centres that provide this model.

But how is a social model of care to be run in the wound management field, and more specifically in the promotion of leg health and the treatment and prevention of leg ulceration? How effective might it be in clinical treatment, prevention of recurrence and promotion of wellbeing? The following sections look at a working example of such a model and the studies that have been made to date on its effectiveness.

Changes to the NHS and their impact on wound care

DAVID FOSTER AND JULIAN TYNDALE-BISCOE

The NHS Five Year Forward View[4] presented a vision for the future of the NHS in England based around the new models of care. It was updated as Next Steps in 2017, which set out a series of practical and realistic steps by which the NHS can deliver better, more joined-up and responsive treatment in England.

The Five Year Forward View identified three key challenges for health and care:

- Address the health and wellbeing gap. If the nation fails to get serious about prevention, then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded out by the need to spend billions of pounds on wholly avoidable illness.
- Address the care and quality gap. Unless we reshape care delivery, harness technology and drive down variations in the quality and safety of care, patients' changing needs will go unmet, people will be harmed who should have been cured, and unacceptable variations in outcomes will persist.
- Address the funding and efficiency gap. If the NHS fails to match reasonable funding levels with wide-ranging and sometimes controversial system efficiencies, the result will be some combination of poorer services, fewer staff, deficits, and restrictions on new treatments.

These three challenges clearly impact on the management of chronic wounds. The Five Year Forward View also states: "As people live longer lives the NHS needs to adapt to their needs, helping frail and older people stay healthy and independent, avoiding hospital stays where possible."

To improve prevention and care for patients, as well as to place the NHS on a more sustainable footing, the NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and residential care homes. Early results from parts of the country that have started doing this are demonstrating slower growth in emergency hospitalisations, with patients spending less time in hospital compared to the rest of the country. The difference has been particularly noticeable for people over 75, who often face a revolving door of emergency admission, delayed discharge and then hospital re-admission.

This is a familiar scenario with venous leg ulcers, as the model of care has not radically changed. According to the Five Year Forward View: "We now want to accelerate this way of working to more of the country, through partnerships of care providers and commissioners in each area (Sustainability and Transformation Partnerships). Some areas are now ready to go further and more fully integrate their services and funding, and we will back them in doing so (Accountable Care Systems). Working together with patients and the public, NHS commissioners and providers, as well as local authorities and other providers of health and care services, they will gain new powers and freedoms to plan how best to provide care, while taking on new responsibilities for improving the health and wellbeing of the population they cover."

These good and radical intentions are not yet being translated into practice leading to care closer to home and in the community rather than around acute NHS hospitals. Whatever they are called, Sustainability and Transformation Partnerships or Accountable Care Systems, the commissioning process continues to focus on a provider delivering clinical outcomes: it is up to that provider to determine the most affordable and effective model of care to deliver their service.

Clinicians, whether they are nurses, allied health professionals, doctors or others, work in a complex health system. Regardless of the size, shape and configuration of that system, clinicians have to make profound clinical decisions about how to care for and manage wounds.

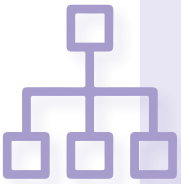
The NHS Evidence website (www.evidence.nhs.uk) hosted by the National Institute of Health and Care Excellence (NICE) includes evidence about acute and chronic wounds. The section on chronic wounds incorporates evidence on venous leg ulcers. Dressing selection should be made after careful clinical assessment but there few randomised controlled trials (RCTs, the most appropriate research method of generating the gold standard of evidence) and many have significant limitations. Although they help clinicians decide on the best dressing for a range of situations, they do not analyse the model of care in which those dressings are applied.

In the Lindsay Leg Club model of social care in the community setting, the membership nature of the Clubs is as important as choosing the right dressing. The Leg Club model not only seeks to treat and manage leg ulcers but it also offers a well leg service to maintain healed legs and prevent recurrence. This programme is aimed at health education, advice, the prevention and maintenance of further leg health once an ulcer has healed. Members that have healed and wish to remain healed attend on a regular 3-monthly basis for a full reassessment, support and advice. Through education and on-going advice and support, members are aware that care and the prevention of recurrence of leg-related problems is for life! And prevention is better than cure. Just as importantly, the programme aims to empower its members to live well and prevent the social isolation so often associated with living with leg ulcers.

This innovative approach to wound care helps to give Leg Club members a greater say in their treatment, which is in line with research and evidence showing that this improves concordance and satisfaction. In 2012, the NHS Confederation published Putting People First Through Shared Decision-making and Collective Involvement. This stated: "Involving and engaging patients and the public in decisions about their health and care improves outcomes, strengthens individual well-being and contributes towards more cohesive and healthier communities."

THE NHS OUTCOME FRAMEWORK

The framework sets out the national outcome goals that the Secretary of State for Health uses to monitor the progress of NHS England. The indicators provide national level accountability for the outcomes the NHS delivers; they drive transparency, quality improvement and outcome measurement through the NHS.



DOMAIN 1 - PREVENTING PEOPLE FROM DYING PREMATURELY
This domain captures how successful the NHS is in reducing the number of avoidable deaths.

DOMAIN 2 - ENHANCING QUALITY OF LIFE FOR PEOPLE WITH LONG-TERM CONDITIONS
This domain captures how successful the NHS is in supporting people with long-term conditions to live as normal a life as possible.

DOMAIN 3 - HELPING PEOPLE TO RECOVER FROM EPISODES OF ILL HEALTH OR FOLLOWING INJURY
This domain captures how people recover from ill health or injury and wherever possible how ill health and injury can be prevented.

DOMAIN 4 - ENSURING THAT PEOPLE HAVE A POSITIVE EXPERIENCE OF CARE
This domain looks at the importance of providing a positive experience of care for patients, service users and carers.

DOMAIN 5 - TREATING AND CARING FOR PEOPLE IN A SAFE ENVIRONMENT AND PROTECTING THEM FROM AVOIDABLE HARM
This domain explores patient safety and its importance in terms of quality of care in the delivery of better health outcomes.

THE WELSH WOUNDCARE MODEL

The Welsh Wound Innovation Centre (WWIC) is the first national wound healing centre worldwide and is the flagship facility for clinical innovation in Wales. WWIC continues to support the established Lindsay Leg Clubs across Wales.

The Lindsay Leg Club model

ROBERT BAWDEN AND ELLIE LINDSAY

The evidenced-based Lindsay Leg Club model of lower limb care was established in 1995 by Ellie Lindsay, who was a district nurse in Debenham, Suffolk[5] at the time. She found that in the course of her work she was visiting a high number of patients with leg ulceration and related conditions, and came to believe that there was room for improvement in the way that these patients were being cared for.

First, as a district nurse she observed that a very large proportion of time was being spent travelling large distances to visit and treat patients with leg ulcers in their homes. Although this gave great insight into her patients' lives, this presented an inefficient use of time, while conditions for treating ulcers were often far from ideal. Second, it became clear how severely many of her patients' lives were affected, not only by the physical effects of pain, immobility and odour, but by the consequences of their symptoms on wellbeing and quality of life. Many patients had become unnecessarily housebound, socially isolated and depressed.

Her determination to offer a framework for high quality clinical care, while at the same time addressing the problems of loneliness and isolation, resulted in the development of the Leg Club psychosocial model, and the creation of the first Leg Club in Suffolk. The model is underpinned by an understanding of how wider social factors, in addition to medical treatment, affect the management of all aspects of the lower limb and venous leg ulcers.

The concept of the non-medical community-based clinic was primarily aimed at integrating individuals with leg ulcers into an environment where they can socialise with others who are experiencing similar problems. In this model of care, patients are referred to as members, since they have a stake in the Clubs. Membership entails an empowered role in an environment based on social interaction, rather than on a typical appointment-based model of clinical care.

Leg Clubs are characterised by four binding principles that differentiate them from conventional clinics.:

1	They are held in a non-medical setting – e.g. community/church/village hall. This avoids the stigma or fear of attending a medical setting and reinforces the community ownership of the Club
2	They are informal, open access and no appointment is required. This encourages opportunistic attendance for information and advice, providing greatly increased opportunities for early diagnosis and leg ulcer prevention, and helps isolated older people reintegrate into their community
3	Collective treatment. People share their experience, gain peer support, and are encouraged to take ownership of their treatment
4	An integrated 'well leg' regime, supporting maintenance of healthy legs, positive health beliefs and broad health promotion

Leg Clubs are independent organisations supported by the Lindsay Leg Club Foundation (an independent charity) and the local community undertakes fundraising.

Each operates within a prescribed framework but with its own constitution and committee. Clubs are community-based and held at fixed times in a non-medical setting, such as a village/community centre, church hall or meeting room. They are run by volunteers, who are very often members who have been successfully treated, or their relatives.

Referrals to Clubs come from a variety of sources, including GPs, self-referral, practice nurses, district nurses and clinical nurse specialists. Members are treated collectively and are able to discuss their symptoms in an open, friendly environment. Refreshments are always provided.

Clinical treatment is undertaken by registered nurses trained in lower limb management. Safety and infection control are given high priority and comprehensive guidelines are provided. The Leg Club nursing teams are employed by NHS local provider services, clinical commissioning groups and GP consortia, and the nurses incorporate the Leg Clubs into their routine practice.

Leg Clubs encourage the presence of additional services such as podiatry, nutritional advice, falls prevention and physiotherapy, and Club sessions are considered a good opportunity to oversee the general health of members. Transport to Club sessions is often available, as provided by the local community. Many Clubs encourage activities such as games, walks, artwork or outings to improve social interaction and to reduce social isolation. They also incorporate a "well leg" regime to support members in the maintenance of healthy legs, offering positive health beliefs and a broad scale of education and health promotion designed to reduce the risks of recurrence.

There are Clubs in the UK, Australia, Germany and Finland. Leg Clubs in the UK have a network of over 13,000 members and the Leg Club Foundation has spent some years developing an integrated data collection system that accurately records treatment cost, healing and recurrence rates. Some of the findings related to this data are discussed in the next section.

There is now a government Minister for Loneliness to address the problems inherent in social isolation in the UK, especially among the elderly. The Leg Club model has long anticipated the problems of loneliness, and its members have benefited from an environment where interaction with others and the possibility of engagement in social activity is a guaranteed part of regular treatment.

Research into the effectiveness of the model

ROBERT BAWDEN, ROLAND RENYI AND JOAN-ENRIC TORRA BOU

Like many successful enterprises, the Leg Club network has grown organically in areas where a local "champion" or team of champions have identified a need in the community for the service. Much Leg Club research has been retrospective and the Leg Club Foundation has spent many years identifying and creating a robust data entry system that is simple to use at the local level and can be analysed in a variety of ways at the national or international level. The Leg Club database may represent one of the largest single repositories of data on leg ulcer progression, so it is hoped that it will become a very useful tool for all those involved in managing the provision of care and treatment in this area.

Since the inception of the first Leg Clubs there have been two priorities in the research arena. The first is that documentation should always be completed, which has in fact been the case. The second is that effectiveness should be examined not only in terms of clinical outcomes but in terms of member (patient) satisfaction, quality of life or wellbeing and cost-effectiveness. In short, there is no use in proposing a social model of care involving multiple stakeholders if one cannot make any conclusions about its effectiveness outside the purely clinical arena. In this section we examine and discuss past and present work in each of these 4 areas:

OUTCOMES

Healing - The majority of healed ulcers within the Leg Club network achieve healing within 2 months
At the beginning of 2014, the Leg Club network initiated a new outcomes data entry and reporting system[6]. Wound progression was examined using accurate reports from the system pertaining to 3,124 members attending 10 Leg Clubs during the second half of 2015. During this period, 4,311 legs underwent treatment, with the remainder currently in the well leg (healed but continuously monitored phase). The analysis at the time confirmed that the majority of healed ulcers achieved healing within 2 months.

More recent reports from the top 20 Leg Clubs in the period 1st October 2016 to 31st March 2017 (exceeding half of all members in the network) confirmed that 64% of all healed ulcers achieved healing within 12 weeks.

Recurrence – Leg ulcers are half as likely to recur at 24-48 weeks in Leg Club members as in other leg ulcer sufferers in the UK
Since the inception of the first Leg Clubs, documentation has been provided and collated by the then Chief Executive of the Lindsay Leg Club Foundation, Professor Michael Clark. At the end of 2013, Professor Clark examined recurrence rates for all UK-based Leg Clubs Healing was reported at 24, 48, 72 and after 96 weeks' treatment, while recurrence was calculated at 24 and 48 weeks – the period when most leg ulcers recur[7,8]. "Recurrence rates in Leg Clubs were markedly lower than reported in non-Leg Club settings", concluded Professor Clark. In fact at 12.5%-15.8%, recurrence levels were just half the national average of 26-33% for this period (with good concordance to treatment) and 56% (poor concordance to preventive care)[8]. The Leg Club's own database (2017-2018) confirms a similar figure of 10% recurrence from 20 Leg Clubs when measured at 25 weeks.

MEMBER SATISFACTION

Leg Clubs provide care in a non-medical setting which improves satisfaction
The most recent reports from the Leg Club database confirms that the main clinical reason for attending Leg

Clubs is not simply treatment of an ulcer but "advice and maintenance". The majority of members (56% in the period 1st April 2017 to 31st March 2018) were in the well leg rather than the treatment bracket, which means that they were being monitored and advised rather than treated. Their continued attendance indicates a certain level of satisfaction with the Leg Club model as treatment is not necessary. The non-medical setting, one would assume, enhances the experience.

These points are corroborated by an Australian study comparing patient satisfaction with care received at Leg Clubs as opposed to at home[9]. Results pointed towards improvements within the – "Leg Club" – cohort with respect to:

- Quality of life with regards to health
- Morale and self-esteem
- Functional ability and leg ulcer healing
- Decreased pain

These findings were built on by a member satisfaction questionnaire, conducted in 2011, on 124 members and piloted across five Leg Clubs in the UK.[10]

Few expressions of dissatisfaction were offered by this member group, with 92.2% and 91.2% of prior and first-time attendees, respectively, describing themselves as 'very satisfied' with their Leg Club. As a consequence of visiting their Leg Club:

67.0% of members considered that they were better able to cope with life

68.1% of members were better placed to keep themselves healthy

75.5% of members felt better able to understand their leg problems

76.8% of members considered themselves to be better able to cope with their legs.

Hight levels of satisfaction with Leg Club nursing staff

A social survey of Leg Clubs conducted in 2017 by the University of Canberra found that[11]:

90.3% of patients were very or extremely satisfied (5 or 6 on a scale of 1 to 6, where 6 represented the highest level of satisfaction) by the frequency with which they were able to have access to Leg Club nurses

96.7% were very or extremely satisfied by the quality of time that they spent with nursing staff

96.7% were very or extremely satisfied with the quality of care provided

94.3% were very or extremely satisfied with the continuity of care provided

95.9% were very or extremely satisfied with the advice being given by Leg Club nurses

WELLBEING

Leg Clubs improve the wellbeing of members

Quality of life and wellbeing are somewhat interchangeable, however it is believed that wellbeing is a more meaningful term in the clinical setting, as it encompasses a person's perceived ability to cope with his or her own personal circumstances. In 2013 and 2014 a team of health psychologists undertook a detailed assessment of levels of and potential changes in wellbeing while attending a Leg Club[12,13]. This research took place over 2 years, and had 3 distinct stages:

- A thorough literature review on quality of life and wellbeing with regards to venous leg ulceration
- Validation of a wellbeing assessment tool for patients suffering from venous leg ulceration (WOWI or Wellbeing with a Wound Inventory)
- Use of the assessment tool among Leg Club members.

At the final stage, repeated measures provided initial evidence that Leg Club attendance impacts wellbeing over time. A significant interaction was found between length of Leg Club attendance and changes in personal resources for people who had attended Leg Club for between 1 and 2 years. The main conclusions from the study were that:

- Leg Club attendance clearly impacts wellbeing for the better
- Social support has an important role to play in this relationship.

Establishing a connection between wellbeing and wound outcomes will complete the picture of effectiveness that the Leg Club model demonstrates, but for the present it is reasonable to conclude that the Leg Club model is an effective solution for providers and clinicians alike, when looking for outcomes, cost-effectiveness, satisfaction and wellbeing in their patients.

COST EFFECTIVENESS

Widespread adoption of the Leg Club model can generate considerable savings in district nursing time
Leg Clubs are held at a fixed weekly time and venue. This can provide considerable savings for district nurses, who can schedule their workload in a more effective way, avoiding unnecessary and time-consuming home visits, as demonstrated in Powys, Wales, in 2014, where an award-winning study was conducted on savings in district nursing time[14]. Powys has approximately 3,000 patients needing treatment for leg ulceration, 2,300 of which are members of the Leg Clubs:

"Based solely upon the average cost of a District Nurse visit at £78, with one visit per week, the gross savings to Powys Teaching Health Board per annum conservatively run at £4,056 per patient, or £932,880" states the study report. "The gross cost of placing nurses in a Leg Club setting, at an average of 5 nurses, once per week, equates to a cost of £227,136 for the 7 Leg Clubs in the health board. This translates to an overall net saving of £705,744, excluding saved travel expenses for the District Nurses." Dressings, equipment and in-patient hospital stays were excluded from the report.

If Leg Clubs were to be introduced across the UK, the total potential savings to the NHS has been estimated at £107 million per year
A review conducted by the Swansea Centre for Health Economics employed national statistics and the available data to construct simple estimates for the change in resourcing and costs to the UK NHS if a Leg Club model of care were to be widely implemented[15]. Bearing in mind the tentative nature of the conclusions inherent with this type of modelling, the estimated cost savings from the Leg Clubs ranged from £95,000 in an urban area with a younger population, to £2.18 million for a rural population with a high proportion of people aged 65 years and older. If Leg Clubs are introduced across the UK, the estimated potential savings to the NHS would be £107 million per year. The review suggested several reasons for the savings, including shorter healing times, lower recurrence rates and improved allocation of resources, such as district nursing times. It is also important to remember that a part of the cost burden is undertaken by the voluntary sector and the community, for example in equipment that might be donated, the cost of premises and in running the clinic with volunteers rather than paid staff.

CONCLUSION

There is more research to be done. The final validation of the outcomes database set up by the Leg Club Foundation, including the integrity of the data entered by individual Leg Clubs, is yet to be achieved, however the conclusions listed above are taken from Leg Clubs whose data have been examined and verified. The indications from all the above is that, in the right circumstances, Leg Clubs are effective.

Discussion and conclusion

ROB BAWDEN, DAVID FOSTER, JULIAN TYNDALE-BISCOE,
JOAN-ENRIC TORRA BOU, ELLIE LINDSAY AND ROLAND RENYI

The paper explains why a social model of care may be relevant in treating long-term, multifactorial conditions such as leg ulcers, and why the medical model alone, might not be sufficient. A social model is a partnership between the community, voluntary and clinical services. It needs the active support and participation of the patient as a stakeholder. There are some common factors for social models of care that need to be in place for the care to be successful, and these are increasingly being adopted by the NHS.

It is no surprise that the NHS's long-term strategies include building and encouraging the type of partnerships that are required by a social model of care. At least 3 of the 5 domains in the NHS Outcomes Framework refer to the importance of the patient experience in a safe positive environment where recovery is promoted. The NHS Five Year Forward View called for better integration of GP, community health, mental health and hospital services, as well as more joined up working with home care and care homes. This is precisely what social models of care have tried to achieve in several therapy areas where patients have long-term conditions which may be difficult to completely cure. Leg Clubs are places where a fragile population can be regularly monitored, not just for lower limb care but for general health, and preventative measures can be put in place for members who are causing concern. The companionship that the Leg Club model promotes may have a potential effect on wellbeing that provides a positive experience of care.

The Leg Club model appears to be effective on several levels. Beginning with outcomes, we have seen that there is a comparatively low recurrence rate after 24 weeks, and also that the majority of healed ulcers achieve healing within 2 months. Nursing treatment and protocols in Leg Clubs are at least equal to the national standard, however it is possibly the regularity of visits, subsequent weekly monitoring and social interaction that are making the important difference here. We need to study outcomes in complex wounds further, as it is likely that more members with complex or hard-to-heal ulcers will be referred to Leg Clubs than the national average.

It is no surprise that this type of model generates high levels of satisfaction among members. Members are active participants in Leg Clubs, with a stake in their success, and this provides feelings of empowerment. The very recent research showing high levels of satisfaction with nursing staff is very encouraging, and hopefully demonstrates that the nursing care members receive is at least as high as it would be in a traditional clinical environment, and that this is recognised by those receiving the care.

Initial work gives the overall impression that the model enhances wellbeing, and that social interaction has a key role to play. The shared experience that members have appears to be the influencing factor here, for which further qualitative research design could be extremely useful.

We need to be more tentative with our conclusions regarding cost-effectiveness. There are clearly potential savings on district nursing time, as has been demonstrated in Powys, a region where there are several Leg Clubs, and one can see why attending a fixed location at fixed times can markedly reduce the time and effort expended in home visits. This was in fact one of the key reasons why the model was developed. Although the economic modelling needs to be developed further, it would seem likely that there are considerable savings to be made in nursing time, the opportunities for sharing resources, the opportunities for preventing major adverse events as members are being regularly observed, and the contributions made by the voluntary sector, taking considerable pressure off a challenged NHS.

It may be a valid exercise to independently define a social model of wound care and see to what extent the Lindsay Leg Club model meets the definition.

From research to date, we can conclude that the Leg Club model is a positive reflection of a social model of care, proven to be effective on several levels and, in the light of current demographic, social and economic conditions, more relevant than ever.

‘Empowering patients through a unique collaboration with industry dedicated to lower limb conditions’

THE LEG CLUB INDUSTRY PARTNERSHIP IS AN ALLIANCE BETWEEN THE HEALTHCARE INDUSTRY AND THE LINDSAY LEG CLUB® FOUNDATION (CHARITY NO.1111259):

- Advocating evidence-based care in a non-medical social environment to Leg Club members (patients), volunteers and communities
- Raising awareness of preventative care relating to all aspects of lower limb disease
- Ensuring that all socio-economic groups are given access to ‘well leg’ management.

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