

# The Leg Club<sup>®</sup> Model: promoting the health of patients' lower limbs through collaborative working

Traditional methods for treating patients with leg ulcers can result in the reinforcement of the sick role and poor concordance. This article looks at an alternative method for managing problems with patients' lower limbs – the Leg Club Model. This is an innovative, research-based tool, which places an emphasis on social health, i.e. communication, the prevention of isolation and depression, and the creation of a 'social' community within leg ulcer clinics. The author examines the evidence for the Leg Club Model, outlines how it works and discusses some of the resistance that has been encountered.

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## KEY WORDS

Leg ulcers  
Leg Club Model  
Quality of life  
Holistic care  
Patient empowerment

The role of community nurses has broadened recently as their leg ulcer management skills have had to keep pace with the rapid scientific development of wound care products. Nurses have had to recognise the changing nature of medical technology and the general public's increased expectation of health promotion and education.

The achievement of excellence in modern nursing practice demands the reorganisation of nursing services to embrace the concept that care should promote patient empowerment. The benefits of patient empowerment have been widely promoted in documents such as *Our Health, Our Care, Our Say* (Department of Health [DoH], 2006), which places the emphasis on patients being listened to and enabled to make informed choices about their treatment and care.

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Today's community nurse should be a dynamic and educated clinician, able to develop therapeutic relationships that assist patients to move towards a positive state of health. The importance of therapeutic relationships in this process is well documented and Hawkins (2003) and Foster and Hawkins (2005) encourage nurses to develop relationships with patients that are characterised by respect and empathy. Establishing such relationships while attempting to meet the complex social and medical needs of patients who are increasingly health-aware, as well as restructuring service provision to promote patient empowerment, means the load on community nurses is increasing.

This article investigates the development of the Leg Club<sup>®</sup> Model, a method of increasing concordance among patients with leg ulcers by empowering them through collaborative working.

## Patient empowerment

Patient empowerment has many definitions, most of which focus on the concept of patients becoming more knowledgeable about their clinical condition through education and support from healthcare professionals. Increased access to the internet, government public health directives (such as the healthy eating, 'Five a day' programme [DoH, 2005]) plus increasing patient choice and control are major factors in the increase of patient knowledge and empowerment.

Community nurses should give prime consideration to the requirements of patients with leg ulcers. Nurses must evaluate the use of creating a social environment in order to facilitate treatment of these patients as 'whole persons', addressing patient perceptions and expectations relating to leg ulcer management.

Patients prefer to seek effective treatment in an environment that addresses their psychosocial and physical needs and providing this may require nurses to change the structure of the organisation that provides leg ulcer care, moving away from the traditional home or clinic environment, to a social, non-medical, community setting. The Leg Club still treats a wide range of conditions in differing ways ranging from advice to leg ulcer management (*Figure 1*) but does so in a social setting.

According to Russell and Bowles (1992), patients undoubtedly benefit from leg ulcer clinics and it was illustrated that being with and talking to other people who have a similar condition is most beneficial. The Leg Club could take this hypothesis to a higher level and lead nurses to investigate how patients could have more involvement and control over their treatments while enjoying the company of others, with similar conditions, in a social clinic situation. The

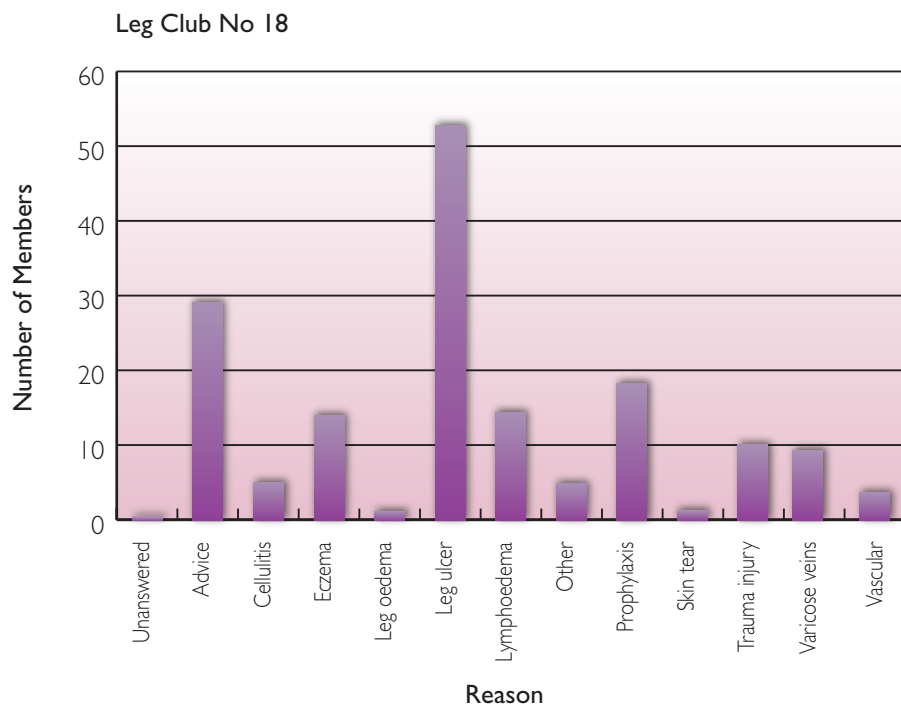


Figure 1. Reasons for attending Leg Club 18 (data from April 2007–March 2008)

ethos of care, social support, friendship and medical treatment is what makes this form of community nursing care so unique (Lindsay and Hawkins, 2003).

Objections to this change in setting may arise. However, in the author's opinion, such objections are usually based on the prejudices and insecurities of healthcare professionals, rather than the needs of patients.

### Confronting barriers to change

Scientific and medical advances, population growth, changes in the average age of the population and improvements in the understanding of wound aetiology have had an impact on the community nursing management of leg ulcers.

Advances include larval therapy, which is re-emerging as a successful therapy, as well as vacuum-assisted wound closure, artificial skin substitutes and growth factors (these are now being manufactured for use on chronic wounds). The available armamentarium for wound care has grown to include over 2,000 dressing products, such as compression hosiery and bandage systems – chronic leg ulcer treatment has been vastly improved by the availability of these products

and techniques (Khachemoune and Kauffman, 2002).

The planning and delivery of nursing care in leg ulcer management is most often a function of the community nurse. It depends heavily on the understanding of human behaviour and skills of observation, data collection and interpretation. The work of Benner throughout the 1980s promoted the concept that nurses can develop skills and an understanding of patient care through sound education and a multitude of experience (Benner, 1984). For example, modern community nurses need not only engage in research themselves, but also bring evidence-based findings into their care in order to legitimise their practice.

However, in spite of the common acceptance of this notion among the nurses, community nurses attempting to merge research and practice are often held back by their peers. In the face of this resistance, changing practice can be problematic (Lindsay, 2005).

In an effort to overcome any such resistance, and with an awareness of the need to underpin any proposal for change with research evidence, the

author presented her colleagues with a new rationale for leg ulcer management in the community. The rationale was based on a literature review, investigation of the demographic factors and patients' circumstances, and a study of the effectiveness of established leg ulcer clinics which the author carried out as part of her dissertation. This rationale for care was called the Lindsay Leg Club Model®.

### What is a Leg Club?

The Lindsay Leg Club Model was originally developed in 1995, when the author was working as a district nursing sister in East Anglia. With the support of nursing colleagues, GPs and the local community, the first UK Leg Club was established. The concept relies on an understanding that patients' health beliefs play an important part in treating and managing leg ulcers.

When treating patients in their own home, one of the main problems is poor concordance with treatment. It is vital that nurses work with patients to achieve concordance with treatment and prevent further leg ulcers developing. The emphasis of the Leg Club Model is to provide a therapeutic, non-medical, clinical environment in which social interaction, participation and peer support can ease loneliness, engender friendship and develop a sense of community — this in turn leads to concordance with leg ulcer management techniques.

The model attempts to unite primary care organisations, nurses, GPs, patients and the community through the common objective of improving patients' health and well-being. It does this by delivering dramatic improvements in patients' quality of life using a community-based venue where patients can meet for treatment (Edwards et al, 2005).

Leg Clubs are not intended to replace existing care delivery arrangements, but rather to complement them by responding to patients' clinical and psychosocial needs. There are four binding principles that differentiate a Leg Club from a

conventional clinic:

- ▶▶ They take place in a non-medical setting, such as a community hall (this helps patients avoid the sick role)
- ▶▶ Leg Clubs provide collective treatment — this allows patients to share their experiences
- ▶▶ Leg Clubs operate an open access policy, with no appointment required — this allows for opportunistic attendance
- ▶▶ They also use an integrated 'well leg' regimen, providing ongoing maintenance and health promotion.

The 'well leg' programme provides education and advice on prevention and maintenance of further leg-related problems once the ulcer has healed. Those that have healed and wish to remain healed attend on a regular three-monthly basis for reassessment. The integrated 'well-leg' regimen promotes positive role models for members and delivers continuity of care that extends beyond healing. In an environment that promotes social interaction, opportunistic attendance, peer support and participation and patient empowerment. Leg Clubs achieve very high levels of compliance to compression therapy, efficient healing rates and a potential for reduced development of new ulceration.

The conceptual framework for a social approach is the 'health belief model' (Becker and Maiman, 1975). This introduces the concept of self-efficacy, and identifies an association between belief in the treatment, motivation and compliance. It assumes that well-being is a common objective for all, and that locus of control is associated with mastery of health information, motivation, effective problem solving, sense of responsibility and desire for active participation in healthcare.

The Leg Club Model applies the philosophies of health belief models in a framework that addresses an individual's hierarchy of needs (Maslow, 1954). Maslow's theory promotes the idea that all human beings have needs that must be satisfied and that those needs will direct individual behaviour until they are satisfied (Kemmer and Close, 1995). Becker (1974) asserts that, even when patients

recognise they are susceptible to illness, they will not take action unless they believe that becoming ill will have physical or social repercussions. With this in mind, nurses should consider the patient's beliefs, attitudes, motivation and social behaviour when looking at the provision of care. The health belief framework assumes that well-being is a common objective of all.

The Leg Club then, is a social model that places an emphasis on social health, i.e. communication, the prevention of isolation and depression, and the creation of a community within the clinic. The objective of creating a community is to maintain the individual's social position and to integrate members into an environment where they can interact with others who are experiencing similar problems.

Collaborative working is the foundation of Leg Club culture. The clinic belongs to the patients (who are known as members) and the local community and members meet the costs of premises and equipment through fund-raising.

### Setting up a Leg Club

Leg Clubs are established by community nursing teams working with their current patients and informing them of proposed changes to the management of leg ulcers and inviting them to participate in establishing, running and being a member of a Leg Club.

To embrace the surrounding community and raise funds, the nursing team normally holds a health promotion coffee morning, involving other community organisations which is usually held at a local venue. Members of the public are invited to attend and receive advice and information on the proposed plans. Funds generated from the event contribute towards the purchase of clinical equipment that the Club will need including posture stools, a hand-held Doppler ultrasound monitor and a treatment couch.

Advertisements in the local paper and other media, plus direct contact with patients and the local community, are used to recruit a volunteer committee,

comprising a chairman, secretary and a treasurer. A club constitution is then developed. Once a committee is formed, a bank account is opened. Funds continue to be generated by volunteers using a combination of local grants, coffee mornings and other events that involve the local community. Volunteers provide clerical services and refreshments. The local primary care trust meets the cost of providing nursing staff and direct treatment.

Receptionists at the Leg Clubs are volunteers who may well have experienced life with a leg-related problem. He or she will take new member's details and will register why they are attending. They will be given a number so they will know when they are going to be seen. The waiting environment is welcoming and the volunteer responsible for refreshments will ensure members have a cup of tea or coffee. The layout of the Leg Club is one of a social club, where people with leg-related problems attend and participate as they wish. Some stay throughout the session after having their own treatment. Treatment is undertaken collectively in a separate area where two or three people can have their legs washed and dressed in the same room. This gives them the opportunity to compare healing and treatments. Members are encouraged to discuss treatment issues with the nursing team and other club members (Figure 2). Of course, each Leg Club also provides private facilities for those who wish to have treatment in privacy.

The club members and nurses should work together in an open environment, where interactive learning is paramount. Shared knowledge allows an open forum, where excellence in practice can be observed, recognised, critically evaluated and provided by all the nurses. This evaluation would take place through the collective treatment where they are openly encouraged to discuss treatment issues with the mixed-skill team, carers and other patients, and this offers them control over their own leg ulcer destiny.

This openness is necessary in order to provide members with a sense of collaboration. In this environment, de-

stigmatisation of leg ulceration occurs, empathy and peer support is developed, positive health beliefs are promoted, and patients take ownership of their condition. They become stakeholders in their care and are educated and empowered to make informed decisions regarding treatment.

Collective treatment gives members the opportunity to follow their peers' progress in healing each week and to communicate freely with members whose ulcers have since healed. Members experiencing a similar condition are able to talk openly about their experience. Most people have found knowing that they are not alone, and that others are experiencing the same or similar conditions to be beneficial and reassuring. Another important part of Leg Clubs' activities is the pastoral care of its members. The nature of this care varies, from the simple provision of tea and coffee at each session, to sending flowers to mark important events or bereavements, to hospital visiting when that is appropriate. It is a significant part of the committee's role to listen to the needs and comments of the members and where possible to meet them.

All potential Leg Club teams should be encouraged to visit existing clubs in other areas of the country in order to see the model in action, liaise with other volunteers, committees and staff members, and observe the organisational structure of the existing club. A mentorship programme is provided ([www.legclub.org](http://www.legclub.org)), where experienced Leg Club leaders and community volunteers support and advise new teams and communication links are established.

### Opposition to change

Change challenges the status quo. In the author's experience, people who require convincing that change is necessary are often those with an interest in maintaining the status quo.

Following the introduction of the Leg Club concept, it soon became apparent that nurses (and higher tiers of management) were strongly polarised in their reaction to the prospect of change. On the one hand, many were open



Figure 2. Leg Clubs' informal nature create an environment where people can share their experiences.

to looking at the evidence and were motivated by the potential for improving care delivery through innovation. These practitioners tended to be leaders within their workplace community or recently qualified nurses with fresh ideas and the motivation to influence those around them.

Conversely, there were those who interpreted any proposal for change as a criticism of their practice. It also appeared to the author that proposed change involved a perceived loss of medical 'status', which was wrongly associated with patient empowerment.

The main barriers to change experienced by the author when setting up a Leg Club have been:

- ▶▶ Indifference from the primary care trust and lack of management support
- ▶▶ 'Not invented here' syndrome – this is the unwillingness on the part of healthcare professionals to adopt an idea that the team or primary care trust did not come up with
- ▶▶ A lack of support from higher management — change can only be successfully implemented and maintained when it is driven by upper management
- ▶▶ When actions do not match the rhetoric — patients and communities must be involved and participate in service change in order to be provided with greater choice and control
- ▶▶ Lack of staff/management continuity – in the absence of senior management support, Leg Clubs depend on the commitment and motivation of individual nurses. Even the most successful club is vulnerable to staff changes. New staff members,

lacking management direction, are unlikely to provide essential continuity

- ▶▶ Reluctance of district nurses to expose their clinical practice to peer review
- ▶▶ Resistance to patient empowerment and fear of loss of medical control/status.

### Comments encountered in the author's experience

In setting up Leg Clubs, the author has received a multitude of feedback, both negative and positive. Some of the most common issues raised are dealt with below.

#### 'We would never introduce that model because of infection control and health and safety concerns'

Health and safety and infection control is a primary consideration within the Leg Club model. It is clearly covered by documented guidelines and risk assessments (EWMA, 2005; Kingsley, 2007).

To date there has been no incidence of an infection being acquired through attendance at a Leg Club. Working practices and lifting protocols (Lindsay, 2004) are audited and approved by local primary care trust representatives. Documentation pathways provide nurses with protocols and policies addressing issues such as infection control, diabetes, vascular and dermatological disease, and referrals. These are incorporated into the comprehensive documentation that is provided to all Leg Clubs in both paper and electronic format.

A handbook is provided by the Leg Club Foundation to be used during practice — this ensures that all staff members working in Leg Clubs have a reference book that is simple and

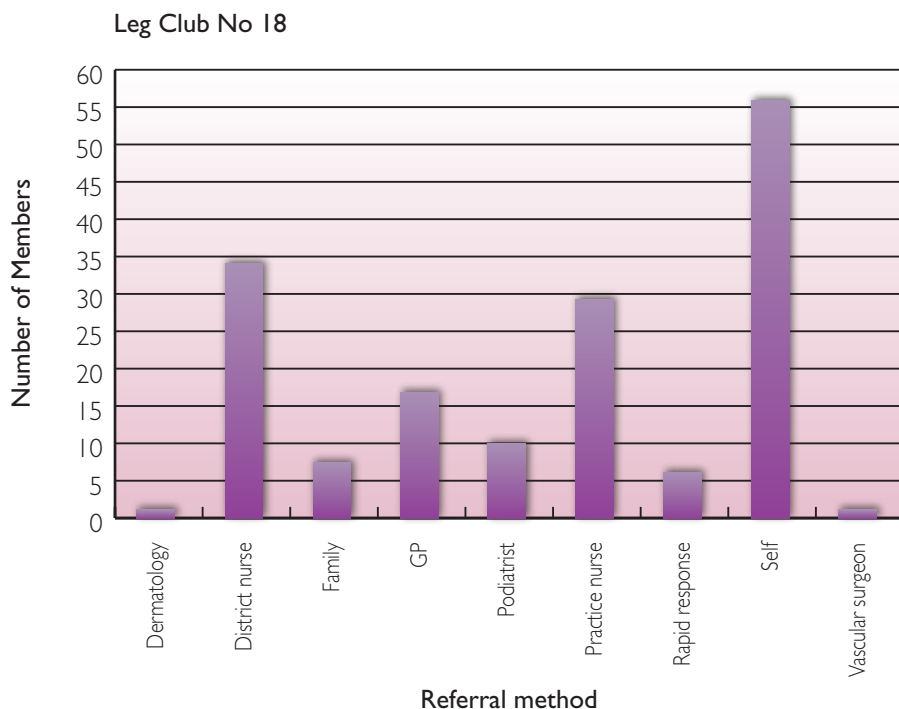


Figure 3. Referrals from Leg Club 18 April 2007–March 2008.

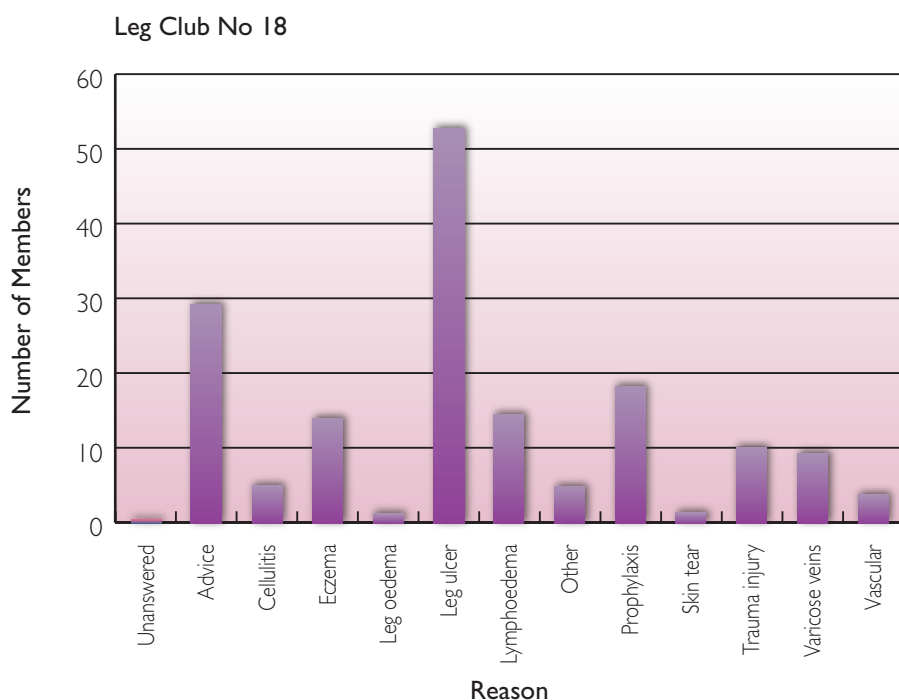


Figure 4. Treatment costs according to data collected at one leg club (no 9) January–December 2007.

instructive. The aim of the manual is to provide informative, educational material to underpin evidence-based practice. Wound management requires nursing skills, including accurate assessment and the use of appropriate interventions. The handbook provides nurses and carers with a rationale for a holistic approach to wound-based care and is an excellent

reference resource for pre- and post-registration students who want to visit a Leg Club.

Although the model has its own documentation, guidelines, and referral pathways, the nursing team must ensure that local primary care trust protocols and procedures are observed. Clinicians

are encouraged to liaise with a tissue viability nurse specialist, consultant vascular surgeon, infection control specialist and the director of the service provider.

**‘Collective treatment in a social environment is unacceptable’**

Collective treatment enables Leg Clubs to evolve through reflective practice and the shared experience of members, which is debated at meetings. Delivering care in a collective environment exposes clinical practice to a level of scrutiny not experienced in one-to-one treatment.

Reservations about collective treatment in a social environment are a major issue for many potential Leg Club practitioners, but the danger is that they are focusing on the building where care takes place rather than patient need (NHS Alliance, 2008). Due to the nature of the non-appointment, non-medical, drop-in facility of Leg Clubs, self-referral remains the dominant source of attendees (Figure 3).

The author’s experience has shown that most Leg Club members do not share the reservations of healthcare professionals regarding collective treatment. The guidelines of the Leg Club Model require that every member must be offered the choice of individual treatment in a private or screened area. However, in practice it is extremely rare for this option to be taken up.

The author’s experience of running Leg Clubs over a 12-year period demonstrates that the majority of members have benefited from the sharing of knowledge and the influence of positive role models that the Leg Club Model provides.

A social survey was carried out in October 2001 with Leg Club members filling out a questionnaire. The findings demonstrated that the concept of the Leg Clubs was that the needs of patients with ulcers and other leg problems were greater than just receiving medical treatment. The survey indicates that this approach is both popular and successful in improving all aspects of a patient’s well-being. In physical terms legs had



been healed, mobility greatly restored, pain reduced. In social terms company had been provided, an awareness of others' problems had been established, and opportunities for service in the community gladly taken. In psychological terms fears had been reduced, anxieties relieved and enjoyment of life restored.

### Outcomes

First and foremost, patient healing rates and quality of life have improved as a result of the Leg Club initiative (Gordon et al, 2006). To date, approximately 21 primary care trust management and community nursing teams have been receptive to running a Leg Club (details of individual Leg Clubs are available at [www.legclub.org](http://www.legclub.org)).

The attitude of patients and local communities to their own health has changed significantly. Data collected since the inception of the Leg Club model illustrates a dramatic increase in concordance and a reduction of prescription costs (Gordon et al, 2006) (Figure 4). Apart from completely housebound patients, home visits for leg ulcer management have been virtually eliminated by certain Leg Clubs, yielding significant savings for the primary care trusts involved.

Partnerships between health and social care organisations are evolving rapidly in the private and primary care health sectors. Commissioning in the NHS is the process by which health and care services are provided most effectively to meet the needs of a population (DoH, 2006). The advent of commissioned services for leg ulcer management in the community presents new challenges to the patient-centred, non-medical approach. For example, there are indications that many leg ulcer services may become assimilated within the existing GP surgery framework, in which clinics conventionally focus on clinical need, the treatment of 'sickness' and the alleviation of symptoms.

However, the formal clinical environment reinforces the 'sick role', where patients attend a surgery when they believe they require treatment and assume a passive role in their care delivery.

### The current status of Leg Clubs

In 2005, the Leg Club Foundation was formed as a registered charity to facilitate and support nurses wishing to set up Leg Clubs. The foundation is a not-for-profit organisation, committed to promoting the well-being of people with leg-related problems, regardless of their age. The charity is an umbrella organisation that exists to promote and support the implementation of the Leg Club Model and monitor adherence to its standards. These standards and guidance on how to follow them are available from the Leg Club Foundation, and include publications and presentations for interested staff and management.

The Leg Club Foundation, in conjunction with Dr Hildegard Charles, an eminent tissue viability nurse consultant, is currently addressing the issue of ensuring the uniformity of educational standards in Leg Clubs through competence-based practice. The foundation continues to ensure that every practitioner involved in a Leg Club is trained to an agreed standard in wound management, audit, data collection and risk assessment, in order to provide quality service delivery. The competency-based, education programme will eventually be approved by universities specialising in wound management.

The Leg Club Model, as previously stated, is an innovative, research-based model for the management of leg-related problems. Latest figures show that the model is a proven alternative to the way this group of people has traditionally been managed.

To date, the key objective of the model has been the management of leg ulcers and the promotion of 'well legs'. International research clearly demonstrate that nurses and club members working together in an open forum partnership, adhering to best practice guidelines, and using interactive teaching and learning, is a highly effective way to provide health promotion and care delivery (Edwards et al, 2005).

In total, over 3,000 Leg Club members have passed through this interactive learning process and have

### Key Points

- ▶▶ Leg Clubs seek to influence beliefs and behaviour by engaging patients to take ownership of their care, empowering patients to be involved in making decisions pertaining to their own treatment.
- ▶▶ The Leg Club concept provides a model that addresses many factors likely to influence healing of chronic leg ulcers, by addressing the effects of social isolation by providing a venue for social interaction and peer support.
- ▶▶ The Leg Club delivers an environment for truly patient-centred holistic care through a synergistic combination of four binding principles: non-medical setting; collective treatment; open accessibility; no appointment required; integrated 'well leg' regimen.
- ▶▶ Research has demonstrated benefits of the model in measures such as quality of life, treatment costs and recurrence rates.

been able to have a say in their own care management. Expansion of the model as a health promotion tool now includes raising awareness of the preventive management of all aspects of lower limb-related problems among the general public.

Leg Club health promotion initiatives, such as healthy leg awareness coffee mornings, have promoted excellence in practice and ensured that patients from widely differing socioeconomic groups have access to 'well leg' management. Education, information and advice, supplemented by client-centred counselling, which form the basis of the day-to-day care delivered by Leg

Club practitioners, are being offered to a wider national audience. Similarly, the health promotion aspect of the Leg Club now includes raising awareness of how lower limb disease can be prevented within the general public via the Healthy Legs for Life leaflets and attending large public events, for example, a health awareness campaign at a major motorcycle show, holding local community healthcare events and maintaining contact with local MPs.

In order to raise awareness and help create high standards in leg care, a national 'Healthy Legs for Life' week was introduced in 2007 to raise the general public's awareness of the issue. The ultimate goal is an annual, national 'Healthy Legs for Life' day, working in partnership with expert patient groups (such as the Knee Foundation), GPs and community nurses.

The Leg Club Foundation has developed an excellent board of consultant advisers, which includes a range of diverse healthcare expertise. Leg Club members are also represented at a Medical Technology Group, which comprises patient charities, research charities and developers/manufacturers. Medical Technology Groups are active coalitions of patients, medical professionals, patient groups and innovators of medical devices, which aim to widen patient access to new developments in care (more information is available at [www.mtg.org.uk](http://www.mtg.org.uk)).

The Leg Club Foundation also has an educational partnership with the Wound Care Society, has become an associated member of the European Wound Management Association and is currently developing an educational partnership with the Knee Foundation, an educational, patient-focused charity supporting management of the lower limb.

### Conclusion

Current research data relating to the Leg Club Model clearly demonstrate the advantages of nurses and members working together in an open forum partnership, adhering to best practice guidelines.

The benefits of patient empowerment have been widely promoted in such documents as *Our Health, Our Care, Our Say* (DoH, 2006), which place the emphasis on individuals being enabled to make informed choices regarding their treatment.

By using their knowledge and motivation to implement change, engage with local communities, expose their practice to peer review and empower patients to participate in care delivery, community nursing teams have responded to the core themes of NHS policy such as *The NHS Plan* (DoH, 2000), *Creating a Patient-led NHS* (DoH, 2005b) and the recent Government white paper on community services (DoH, 2006). Nurses have also been able to provide effective physical and psychosocial care that enhances patients' quality of life.

Regardless of the challenges the author and Leg Club teams have encountered from sceptics, the outcomes have illustrated dramatic reductions in non-concordance and post-healing recurrence of leg ulcers.

Significant economic savings are also evident when costs associated with the use of the Leg Club Model are compared with conventional home visits (Gordon et al, 2006). Indeed, following a two-year randomised control study conducted in Australia, Gordon et al (2006) conclude that the Leg Club Model of care for patients with venous leg ulcers is a more economically efficient option than traditional community and home nursing. **WUK**

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