Leg Club update

Within the NHS there is an enormous expectation to provide high quality care in an increasingly complex health environment. This is accompanied by budget constraints with providers increasingly accountable for clinically cost-effective care.

Patients with leg ulcers have complex needs and the delivery of care is challenging and costly. For those with venous leg ulceration the cost is an estimated £400m annually in the UK (Bosanquet, 1992). This is dominated by the cost of dressings and nursing visits which falls mainly to primary care.

The literature relating to leg ulceration supports several key aspects of care including the importance of accurate differential diagnosis, the use of Doppler ultrasound, compression therapy for those with confirmed venous disease, the application of hosiery after the ulcer has healed, good skin care, appropriate referrals and audit reporting. Yet, there are several reports within the literature that suggest that care is often less than optimal (Moffatt et al, 2007) particularly in relation to care delivered by practice nurses (Husband, 1995; Schofield et al, 2000; Knight, 2008). It is essential that the care that is delivered to patients can motivate and empower them to take ownership of their care, increase their knowledge, and assist in alleviating their suffering. The aim should be to advance education in all aspects of leg health among sufferers, carers, the general public and the healthcare professions in order to reduce the stigma attached to this condition.

The Darzi report (2008) provides healthcare with the challenge of putting patients at the centre of care delivery and increasing patients' input into their own care. Therefore, it is increasingly important that there is a strategic approach to all aspects of leg ulcer care across all healthcare settings. Commissioning services is on the current agenda with market forces determining the future of healthcare delivery. Therefore decisions made by commissioners will shape future services and must reflect patients' views. While there are several influences on care delivery, it is necessary to provide high quality education and empower staff to be able to implement the education they receive. Also necessary is access to resources including diagnostic equipment such as Doppler ultrasound, pulse oximetry, cameras, bandages, creams and hosiery.

The evidence base

There is a challenge in providing a quality service which is also cost-effective. In 1992 Moffatt et al demonstrated that when patients with leg ulcers were treated with a high compression bandage of four layers in a community-based clinic, progression to healing was improved. Moffatt and Franks (2002) followed up with research on 955 patients by suggesting a rationalisation of leg ulcer services through a total service change which would result in improvements in professional practice, better patient outcomes, and efficient use of current resources. This study highlights the importance of a multifaceted approach for improving practice. Edwards et al (2005) report on a sample of 33 clients with a below-knee venous leg ulcer who were randomised to treatment, either in their own homes or in a community Leg Club®. Treatment was given to all participants by a team of trained wound care nurses following evidence-based assessment and treatment guidelines. The results suggest that a community Leg Club environment provides additional benefits to wound care expertise and evidence-based care. This study provides evidence to guide service delivery and improve outcomes for patients.

Despite the evidence supporting this kind of care for people with leg ulcers — including gold standard randomised controlled trials there remains less evidence of widespread adoption of this type of care. The implementation of Leg Clubs as part of NHS strategy for leg ulcer management and associated conditions in the UK would help achieve the goal of improving clinical outcomes and making financial savings. It is possible to unite healthcare organisations, patients and the community in improving patient outcomes and quality of life and while the motivation behind each group may be different there will still be a common objective.

Commissioning services creates opportunities for change which may include the provision of care by individual healthcare providers, charities and social enterprise organisations. It is essential that an organisation that is seeking a commission can demonstrate that it is achieving positive outcomes, has rigorous clinical governance, robust financial information and is patient-focused. The Leg Club (Lindsay, 2004; 2007) offers a mode of healthcare delivery which can help to prevent fragmentation because of its consistency which can be reproduced by several different providers. The Lindsay Leg Club® has the mission of 'Healthy legs for life' and has the following vision:

- To make Leg Clubs part of government and NHS strategy for leg ulcer management and associated conditions in the UK
- To continue the expansion of Leg Clubs throughout the UK
- To ensure that Leg Clubs are the leading source of information for the general public on the prevention and treatment of leg ulcers and associated conditions
- To continue to implement best practice for the prevention and treatment of leg ulcers and associated conditions in partnership with healthcare professionals, patients and the local community;
- To strive to measure and report all key clinical and economic outcomes achieved through the implementation of best practice in conjunction with the Leg Clubs and its partners.

As a consultant nurse with two Leg Clubs operating within my own primary care trust it has been important to work in partnership with the local Leg Club lead and the Lindsay Leg Club

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Foundation. It is essential that staff are educated for the role they will undertake and staff throughout the trust have been encouraged to undertake an accredited leg ulcer course. The course has been supported by the Leg Club and staff have been given additional appropriate educational support. While the PCT has agreed leg ulcer guidelines, it has been possible to work with the Leg Club and its referral pathways as the documents are similar and they both advocate evidence-based best practice. Importantly, audit is undertaken of the Leg Club and data provided includes patients seen, adherence to guidelines, adherence to referral pathways and cost-effectiveness. Undertaking audit is frequently challenging for busy tissue viability staff and is sadly often overlooked. Audit will be increasingly important as the most influential factors on future leg ulcer care could well be the 'conscious engagement' of commissioners, managers and strategic staff with an agreed strategy that is supported across the wider healthcare setting. The Leg Club provides enormous opportunities, which the wise tissue viability nurse should not ignore. WUK

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