CONNECTING COMMUNITIES PROGRAMME EVALUATION

Integrated Leg Care Clinic

AUGUST 2023

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Contents

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Connecting Communities Integrated Leg Care Clinic

Executive Summary

This is a report on the evaluation of the Connecting Communities Integrated Leg Care Clinic (ILCC), one of five pilot projects developed by Age UK Bristol (AUKB) for the Bristol, North Somerset and South Gloucestershire Integrated Care System (BNSSG ICS) Ageing Well programme, which ran from April 2022 to March 2023.

Under this programme, a new clinic was set up at the Withywood Centre in South Bristol, where a very high need for the service was identified. It served patients registered at GP surgeries across the Swift Primary Care Network (PCN).

The aim of our evaluation was to assess the impact of the ILCC in reducing the negative impacts of social isolation on older people's health and wellbeing using a mixed methods approach.

Key findings

Wait time for most patients to receive treatment was 0-15 mins. **Treatment time** was most commonly within 20-30 mins. Between 5-14 patients would stay behind after receiving treatment each week, usually for 5-15 mins, to **socialise**.

There were nineteen matched-pair respondents to the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) questionnaire. They reported **better wellbeing at follow-up** than at baseline; however, this improvement was not statistically significant (p=0.057). Improvements in wellbeing were also reported by age and gender, with the bigger positive changes observed for male respondents and those aged 55-64; no statistical tests were performed due to the small sample sizes.

Some aspects of the ILCC model that patients found important were its **convenience** being in a local community setting, its **flexibility** as a drop-in clinic and its **accessibility** with transport being organised by the AUKB Coordinator for those who struggled to get to the clinic.

The ILCC model has proven successful in helping to **combat social isolation**, **improve wellbeing** and **break down the stigma** associated with lower leg wounds.

All the patients interviewed provided **positive feedback** about their experiences with the **clinical staff** and AUKB **volunteers**. The lead nurse recognised the importance of the **Coordinator** in freeing up the nursing team to focus on the clinical aspects of the clinic, as well as providing additional support to patients that the clinical staff did not have time for.

Main learnings

1. The ILCC model enables infection to be identified earlier and medication to be prescribed sooner, prevents complications, and improves healing rates, thus potentially **preventing more costly interventions**.
2. Delivering the service in a **relaxed community setting** helps to reduce stigma and encourage mobility.
3. A **welcoming environment** and **peer support** was beneficial in promoting wellbeing.
4. It takes time for patients and volunteers to **build a relationship** and **develop trust** with a new Coordinator, and subsequently feel ready to open up to other support that could benefit their wellbeing.

5. The Coordinator role is important in helping to **identify other needs** that patients might have as well as their interests, which then enables them to arrange appropriate activities and events.
6. The ILCC model is **replicable** in other areas and for other long-term conditions, and can be delivered successfully by a Voluntary, Community and Social Enterprise (VCSE) organisation that has good knowledge of and links to local support for signposting and referral.
7. Development of a **mutually respectful relationship** between health and voluntary sector staff is important to ensure a good working partnership.

Main challenges or barriers

1. Getting buy-in from the GP practices to **release nurses** to work at the clinic and take the knowledge back to the practices to ensure they are all using the same methods.
2. **Different methods used** at the clinic and at the GP surgery can cause **confusion** among patients who have their legs dressed at both settings, particularly when communication has been inconsistent across the two systems.
3. The increased numbers and complexity of leg conditions since the COVID-19 pandemic means that the clinic is often **very busy**, which can deter patients from staying to socialise.
4. The clinical staff, AUKB Coordinator and volunteers need to be mindful not to add to any **stigma** or **unease** among younger patients (aged under 50) about attending a clinic that could be seen to cater only to older patients.
5. It has been more difficult to **recruit new volunteers** since the COVID-19 pandemic, especially older volunteers who have had leg ulcers.
6. **Existing volunteers need a lot of support** to move out of their comfort zone and support in other ways e.g., with booking patients in and chatting to patients. Consequently, there is added pressure on the Coordinator and interruptions to their work, sometimes resulting in missed opportunities.
7. Health and voluntary sector staff come from **different work cultures**, which can be a challenge to delivering a service together.
8. Not having **transport** is a common barrier to attending the clinic for some patients.

Conclusions and recommendations

This evaluation provides evidence that the Integrated Leg Care Clinic can reduce the negative impacts of social isolation on older people's health and wellbeing, and that this model can be replicated across other Integrated Care Partnerships in the future. However, there are several challenges that will need to be overcome if this initiative is to continue. These mainly revolve around the funding model, partnership working, an integrated approach, having sufficient space, and the ability of the VCSE organisation to recruit appropriate people to posts including a clinic manager, coordinator and volunteers.

Several opportunities for improvement have also been identified. It is recommended that the recording and monitoring of routine clinic data needs to be streamlined to facilitate the reduction of patients' total cycle time and to obtain more accurate healing rates.

1. Introduction

1.1 Background

The Integrated Leg Care Clinic (ILCC), initiated in 2018 was funded through the Bristol Ageing Better (BAB) programme to reduce the negative impacts of social isolation on older people's health and wellbeing. The clinic was delivered by Age UK Bristol (AUKB) in partnership with Bristol Community Health. It was set up as a weekly drop-in clinic for patients with lower leg wounds (ulcers), who would traditionally have been treated at a GP surgery or been seen by a District Nurse at home. It was hypothesised that patients would benefit from receiving treatment in a more relaxed community setting, with the opportunity for social interaction and peer learning. It was also proposed that this model would reduce treatment room costs for individual surgeries since each GP surgery effectively 'pooled' their clinical resources and nurses would treat patients from other surgeries.

The clinic, named by patients as the Healthy Together Clinic, was based at the Withywood Centre in South Bristol, where a very high need for the service was identified. It served patients registered at GP surgeries across the Swift Primary Care Network (PCN). Up to six patients could be seen at the same time for a variety of treatment requirements such as bandaging, maintenance dressings or compression hosiery and wraps. Patients were allowed to linger in the clinic, to chat to each other and form relationships that may lead to mutual support both in terms of leg care and otherwise. Across the corridor from the entrance is an on-site café, which provided further opportunity for patients to socialise after receiving treatment.

AUKB recruited a **Coordinator** that supported the clinical staff in the administration and organisation of the clinic alongside managing a social programme for patients e.g., providing newspapers, dominoes, and craft activities whilst patients were waiting to be seen by the clinical staff. The Coordinator was responsible for identifying and inviting speakers from relevant organisations to inform patients about other projects and activities that were available locally and to encourage them to get involved. Their role also involved signposting patients to other services to receive additional help or support as needed. Besides that, they provided and arranged transport via Uber for patients who struggled to get to the clinic. The Coordinator gathered patients' feedback on how the service could be improved, found out their individual needs and helped communicate these to the clinical staff.

AUKB also recruited two **volunteers** to welcome patients and any accompanying carers or family members when they arrived at the clinic, with free refreshments. The volunteers also helped to encourage patients to engage with the speakers and activities provided, and to interact with each other. The goal was to create an environment where people felt able to share and felt listened to. True to its name, 'Healthy Together', all patients, their carers and family members were encouraged to take part, whenever possible, in deciding how the clinic was run.

An **evaluation** of this test-and-learn pilot yielded very positive results, including faster healing rates and reduced reinfection rates compared to the national average. These outcomes were attributed to the pioneering compression bandaging technique alongside work undertaken on the social engagement, health promotion messages, VCSE[1]-led information and guidance, and peer-to-peer support that patients received at the clinic. The Healthy Together Clinic gained recognition at a national level by winning Runner-Up in the National Association of Primary Care (NAPC) Integrated Innovation Award in October 2018. Unfortunately, the clinic stopped running in 2020 due to the COVID-19 pandemic.

[1] VCSE: Voluntary, Community and Social Enterprise

1.2 The New Way Leg Clinic

The success of the Healthy Together Clinic led to the ILCC being chosen as one of five models to be extended through the AUKB Connecting Communities programme. South Bristol was again chosen as the location for the ILCC due to its socioeconomic factors that can lead to older people living in the area being at higher risk of social isolation. Having re-established the clinic in January 2022, Swift PCN teamed up once again with AUKB in April 2022 to deliver the New Way Leg Clinic at the Withywood Centre, as part of the Connecting Communities programme.

One of the aims of the New Way Leg Clinic was to demonstrate the benefits of this ILCC model and how it could be replicated across other Integrated Care Partnerships (ICPs) in the future. The funding received enabled AUKB to offer a wide range of practical and social support to reduce the negative impact of social isolation on patients who rarely leave home due to lack of mobility, pain and stigma associated with lower leg wounds. A new AUKB **Coordinator** was recruited to post in August 2022 – their role not only enabled consistent monitoring but strategic development, cover of clinic sessions and establishment of a social programme for patients. Prior to that, from April 2022, AUKB had provided support to the clinic from within its staff team. As these staff were not dedicated to this project alone, there was less ability to undertake consistent monitoring and it took some time to agree new processes and a system that worked with clinical staff.

AUKB recruited **volunteers** for the clinic from the GP practice list. Two of the three volunteers had recovered from lower leg wounds themselves and were able to offer peer support and encouragement to other patients attending the clinic. Two of the volunteers had returned to volunteering following hospital discharge. All three volunteers had experienced social isolation following bereavement.

2. Evaluation methods

The aim of our evaluation was to assess the impact of the Integrated Leg Care Clinic in reducing the negative impacts of social isolation on older people's health and wellbeing. The evaluation adopted a mixed methods approach that involved the use of both quantitative and qualitative data that were collected from August 2022 to March 2023. We analysed data routinely recorded by the Coordinator and lead nurse, including patient attendance, number and type of clinical staff on duty, wait time, treatment time and length of stay post-treatment.

We also analysed responses to the Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) questionnaire that patients completed with the Coordinator on their initial visit (baseline) and at least one month after receiving treatment (follow-up). This also helped to initiate conversations with patients about what support they had and what they might require. In addition, one of our researchers recorded her observations from visiting one of the clinic sessions, where she also interviewed nine people – six patients, two volunteers and the lead nurse – about their perspectives on the clinic.

3. Findings from clinic data

There was a total of 34 clinic sessions in the period from August 2022 to March 2023. There were 2-4 nurses on duty at the clinic each week, along with 4-6 healthcare assistants (HCAs). From the end of September 2022, staff on duty sometimes included a paramedic, an emergency care practitioner (ECP) and/or one or two student nurses. On average, there were 7-9 clinical staff on duty every week.

Besides the AUKB Coordinator, there were one or two volunteers from AUKB present in the morning. On nine occasions, there was also a volunteer in the afternoon.

3.1 Patient attendance and characteristics

Patients presented to the clinic primarily to get one or both of their legs dressed, but a few went for other reasons like to pick up dressings. The number of patients who presented at the clinic ranged from 27 to 45 per week (mean = 35).

Table 1: Patient attendance and characteristics

	Weekly attendance		
	Minimum no.	**Maximum no.**	**Mean**
Patients seen in the morning	16	28	22.2
Patients seen in the afternoon	7	18	12.8
Gender			
Female	9	21	14.5
Male	15	28	20.5
Age range			
<50	3	7	5.7
50-59	1	7	3.4
60-69	5	14	9.0
70-79	5	14	8.8
80-89	3	8	5.3
≥90	0	4	2.1
GP surgery			
Grange Road Surgery	3	16	8.9
Crest Family Practice	4	12	6.8
Bedminster Family Practice	4	8	5.9
Lennard Surgery	2	7	5.4
Hartwood Healthcare	2	5	3.2
Merrywood	2	4	3.0
Hillview Family Practice	0	3	1.3
Armada Family Practice	0	1	0.0

As shown in Table 1, patients who needed to get their leg(s) dressed tended to go in the morning (mean = 22) instead of the afternoon (mean = 13). The clinic saw more male (mean = 21) than female patients (mean = 16) each week. The number of legs dressed per week ranged from 37 to 62 (mean = 52). Most patients who presented to the clinic were aged 60-79 years. Patients were registered at one of eight GP surgeries across the Swift PCN with most patients registered at Grange Road Surgery and Crest Family Practice.

Between 1-6 new patients presented to 25 clinic sessions (74%) in this 8-month period, the most common being one new patient (32%) at each of these sessions. There were 16 return patients[2] recorded over 14 clinic sessions (41%). Of the 30 clinic sessions when data was recorded, 14 sessions (47%) had one patient discharged, five sessions (17%) had two discharged, and three sessions (10%) had three discharged. Between 5-11 friends or family members were present at the clinic alongside patients each week.

There were 45 times when patients needed return Ubers arranged to and from the clinic and 44 times when patients only needed the Uber arranged for one way.

3.2 Wait time, treatment time and length of stay post-treatment

Efforts were made to record patients' wait time for treatment, treatment time and length of stay following treatment, during each weekly presentation to the clinic. Most patients had to wait 5-15 mins before receiving treatment (395 records). It was also common for patients to be seen straight away i.e., no wait time (303 records), or to have to wait 20-30 mins before being seen (268 records). There were six clinic

[2] Return patients are patients who were discharged from the clinic but had to return due to reinfection.

sessions where between 1-6 patients had wait times of over 60 mins. The reasons recorded for these long wait times were usually “busy/very busy morning” or “nursing team short-staffed”.

Treatment time was most commonly within 20-30 mins (470 records) or 35-45 mins (322 records). There were 96 records when treatment time took more than 60 mins, coinciding with when the clinic was busy. While most patients left the clinic after being seen, 5-14 patients would stay behind each week usually for 5-15 mins (189 records) to socialise. There were eight clinic sessions when some patients stayed behind for over 60 mins.

3.3 Activities and visitors

From September 2022, the AUKB Coordinator made different **activities** available at the clinic that patients could engage with while waiting for treatment. Regular activities included colouring, games and puzzles. Other activities included making origami cranes and working with air-dry clay (creating and painting).

They also organised themed activities. For example, at the end of October, they got patients involved in making Halloween-themed decorations with a competition where the person with the scariest pumpkin face won a plant. Patients also enjoyed an Elf Day and making Christmas cards and paper chains in December; food was made available to patients on the last clinic day of the year (22nd December 2022). Besides that, AUKB picked a date in October to raise awareness of breast cancer by putting up decorations, wearing pink and raising money for the charity Breast Cancer Now.

The clinic also had visitors from various organisations:

- A member of the **AUKB** Information and Advice service visited to have one-to-one conversations about benefits/allowances, scam avoidance and to support with applications for a cost-of-living grant.
- Community Development workers from **Knowle West Health Park** (KWHP) visited to promote the Live Longer Better falls prevention campaign, Fall Proof, and to promote activity groups run at KWHP.
- Representatives from the **Hartcliffe and Withywood Community Partnership** visited to inform patients about the CATT community bus service and to promote use to increase mobility and reduce isolation. They also determined if there was a need to provide a travel route to Withywood for those requiring treatment at the clinic.
- A representative from **Memory Connections** visited to promote the group to support patients with memory problems.
- A representative from the **AUKB** pilot Trailblazers Training Together visited to demonstrate the benefits of a ‘telepresence robot’ used in one’s own home for support with daily living tasks.
- Representatives from **Avon Fire and Rescue Service** visited to promote home safety and offer home visits to those who would like one.
- Representatives from **Brigstow Institute** visited to speak about type-2 diabetes and local walking groups.
- A representative from Redcatch Community Garden visited to promote their initiative.

4. Findings from the SWEMWBS data

Patients who attended the clinic were asked to complete a SWEMWBS questionnaire to assess their mental wellbeing at their initial visit (baseline) and at least a month after receiving treatment (follow-up). Fifty-eight patients completed the questionnaire at baseline, but only 19 (33%) patients completed the questionnaire at follow-up. This was because the clinic was often busy and the Coordinator was not always able to sit down with patients to complete a follow-up questionnaire in addition to the other tasks that needed to be done.

Table 2 shows that approximately equal numbers of female and male patients responded at baseline and follow-up. Most respondents were aged 65 and over; the average age of respondents in the matched-pair cohort was 73 compared to 69 in the wider cohort. Nine (47.4%) respondents from the matched-pair cohort had been discharged from the clinic compared to 20 (34.5%) from the wider cohort.

Table 2: Demographic characteristics of respondents

Characteristics	Matched pairs (n = 19)		Whole cohort (n = 58)	
	Proportion (%)	Number	Proportion (%)	Number
Gender				
Female	52.6	10	50.0	29
Male	47.4	9	50.0	29
Age range[3]				
40-54	-	-	10.3	6
55-64	31.6	6	29.3	17
≥ 65	68.4	13	60.3	35

As shown in Figure 1, a high proportion (79%) of matched-pair respondents reported already having moderate-high wellbeing at baseline. Table 3 shows that matched-pair respondents reported better wellbeing at follow-up than at baseline; however, this improvement was not statistically significant (p=0.057). Improvements in wellbeing were also reported by age and gender, with the bigger positive changes observed for male respondents and those aged 55-64; no statistical tests were performed due to the small sample sizes. Male respondents and those aged 65 and over reported high wellbeing at baseline and follow-up, while female respondents and those aged 55-64 reported moderate wellbeing at both timepoints.

Figure 1. Self-reported levels of wellbeing at baseline

[3] Age ranges as recommended by Warwick Medical School (2021).

Table 3: Descriptive statistics[4] for matched-pair respondents

		Baseline	Follow-up	Change	Positive change?	Statistically significant change?	Wilcoxon signed rank test p- value
Total no. of responses		19	19				
% Low wellbeing		21%	11%				
% Moderate wellbeing		42%	26%				
% High wellbeing		37%	63%				
Mean score		25.5	27.6	2.11	Yes	No	p>0.05
Standard deviation		5.9	5.0	4.4			
Mean score:							
By gender	Male	27.4	31.0	3.56	Yes		
	Female	23.8	24.6	0.80	Yes		
By age	55-64	20.7	23.7	3.00	Yes		
	65+	27.8	29.5	1.69	Yes		

5. Clinic observations and findings from interviews

A UWE researcher (ED) visited the New Way Leg Clinic on 8th September 2022 when a total of 36 patients were seen – 25 in the morning and 11 in the afternoon – and 55 legs were dressed. Three nurses and four HCAs were working at the clinic that day. The clinic operates from 08:30-16:30 and is closed between 12:30-13:30 for staff to have their lunch break. The researcher arrived at 09:30 and the clinic was already very busy with all six leg dressing stations occupied and around four people waiting to be seen.

5.1 Observations of the New Way Leg Clinic

The clinic was especially busy the morning of the researcher's visit. Usually, there would be an AUKB volunteer supporting the Coordinator, but on that day, volunteer support was only available in the afternoon. It felt as though this support was much appreciated as an extra pair of hands to make refreshments for patients and anyone accompanying them, but also to enable conversations between people whilst they were waiting to be seen. Things at the clinic were just starting to get back to a sense of where they were prior to the COVID-19 pandemic. For example, previously, AUKB provided activities such as cards, dominoes and jigsaws. These had been absent due to infection control measures with COVID-19 but had started to be introduced into the waiting areas again.

That week was the first time the Coordinator had made a change to the way the space was laid out – rather than patients sitting in rows while waiting to be seen by clinical staff, they could sit around two round tables (see Figure 2). Although this provided a more informal waiting area, some patients required reassurance that they had been booked in and were in the 'queue' to be seen.

[4] Levels of wellbeing were defined by the Warwick Medical School (2021) based on total scores from the SWEMWBS: ≤19.5 = low wellbeing; 19.6-27.4 = moderate wellbeing; ≥27.5 = high wellbeing.

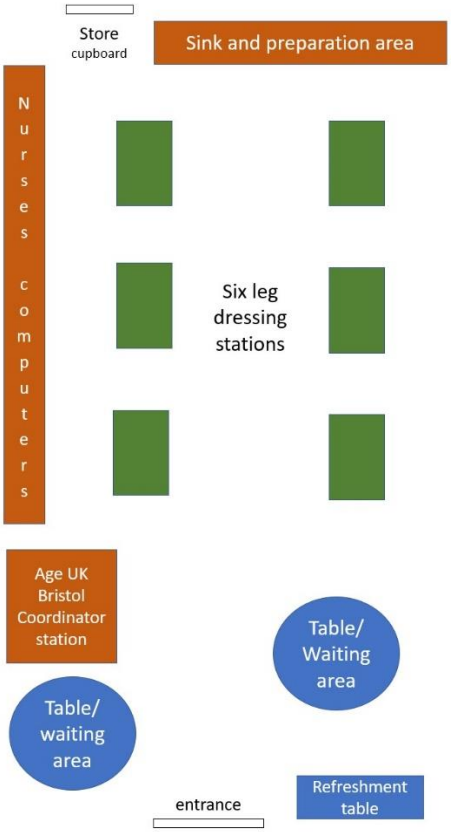

Figure 2. Layout of the New Way Leg Clinic

There were some patients who had been attending the ILCC for several years and were known to one another and thus, were seen talking with each other. There were also a few relatively new patients who sat waiting quietly. At its busiest, the clinic space did feel quite small, especially when there were mobility scooters. One man who provided feedback felt that he was unable to wait in the clinic on his scooter as there was no room and instead, waited outside in the foyer. This meant that he was excluded from the social benefits of the clinic. The Coordinator had enquired with the Withywood Centre about expanding the space but unfortunately, the room next door, which was separated by a removable wall and could be opened up, was already in use by another group at the same time.

An important observation was not particularly in the clinic itself, but during the lunch break. Directly across the clinic is the Megabytes Café. As the researcher went to order some food at the café, she noticed that there was a small number of patients in the café that had attended the clinic that morning and were having lunch or a drink together. It seemed that some patients had stayed on after receiving treatment, and a few had been there for several hours. There was also a man that had come in early to have lunch with the other patients before attending the afternoon session at the clinic.

5.2 Findings from interviews

During her visit, the researcher spoke to nine people – six patients who had their legs dressed, two volunteers and the lead nurse. This section summarises the main themes from these conversations.

5.2.1 Convenience, flexibility and accessibility of the clinic

For some, the **convenience** of having the clinic in a local community setting was important:

> *"It's a lot easier to come here than it is to go to the surgery. It's just round the corner innit. It's easier innit."* (R1)

Another important aspect of the ILCC model was its **flexibility** as a drop-in clinic:

> *"And that's another thing cos you ain't got to make an [appointment]. You could come anytime you want".* (R1)

> *"This flexibility at the moment for us is good because we don't have a car like… you might not get the lift to come at a specific time. But the flexibility of coming in…"*. (R4)

Besides that, the Coordinator's role in organising transport was important to enable **access** to the clinic while also encouraging independence and avoiding the need to rely on friends and family:

> *"It's very helpful because… I have to take two buses. So take one from home to here to […] And then we wait quite a while to come here. But the bus stop that goes back, there's no shelter".* (R4)

5.2.2 Combatting social isolation, improving wellbeing and breaking down stigma

The clinic provides much needed **company** and something patients **looked forward to** every week.

> *"Well, it's company. Cos I got no company at home… so someone to talk to. And I come down to the coffee morning*[5] *on a Tuesday as well, that also gets me out the house a bit. Otherwise, I'm stuck in the house; it's like I'm in a box. I feel happy about coming down here. I shall keep coming to the coffee morning even if I don't have to come to the leg clinic. I think I should miss coming here, at least I could keep the coffee shop going."* (R2)

> *"It's hellish lonely for some; this is the only time some people get out and see people."* (R6 - volunteer and former patient)

Another interviewee had noticed an **improvement in their loved one's wellbeing** in the few weeks since they had been attending the clinic:

> *"This is a very, very good improvement. Yes, he's really happy. He was not talking before, but now he's really happy."* (R4)

The AUKB Coordinator reported an increase in patients talking about feelings of anxiety and depression. Even though it was a drop-in clinic, patients were often seen within 15 minutes of arriving and many would stay afterwards to socialise with other people. She reported that patients were also starting to engage with the activities while they waited to be seen.

Alongside this, the clinic was praised for **breaking down the stigma** around having lower leg wounds and seeing that they were not alone with the condition helped patients feel more at ease and less embarrassed about going out in public.

> *"So because sometimes when you look at your wound you think 'Oh my God, what's going on? Is that only me', but you see different people… in the same boat as you."* (R4).

One interviewee (R5), who had been coming to the clinic for several years, said that she was initially unsure about having her legs exposed and dressed in public, but quickly recognised that it could be a good way to reduce the stigma attached to lymphoedema[6] and swollen, ulcerated legs. How people saw her legs *"played havoc with my mental health for years"*. Being given the time and support at the clinic, as opposed to a quick appointment at the GP surgery, has helped her mental health.

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[5] This refers to the Friends Ageing Better (FAB) Café, another initiative by Age UK Bristol for members to socialise, participate in activities, and listen to talks. One of these FAB Cafes was held at the Megabytes Café at the Withywood Centre.

[6] Lymphoedema: a long-term (chronic) condition that causes swelling in the body's tissues and usually develops in the arms or legs (NHS, 2023).

The lead nurse also reflected on the impact of the clinic - patients would initially not want to leave the house because their legs were painful, and the wounds leaked and smelled. Using their method of compression bandaging enabled the wounds to heal in 14 weeks, thus boosting patient morale.

5.2.3 Positive feedback about the clinical staff, AUKB Coordinator and volunteers

All the patients interviewed reported positive experiences with the **clinical staff** and **volunteers**, saying that *"nothing was too much trouble for them"*.

> *"[The Doctor] reckons it would do you the world of good to come up here and yeah, that's the best move I made."* (R3)
>
> *"Everyone is… when they come in, they are treated special, as you are... And they talk to you nicely and everything. They take their time; they talk to you."* (R4)
>
> *"[You're] made to feel welcome, more like a coffee morning, got chatting to people made me feel good about having legs done. To me it has been a godsend and I can't thank them enough."* (R5)
>
> *"The people at the surgery don't have the expertise of the nurses at the clinic."* (R6)

The lead nurse recognised the importance of the *"brilliant"* **AUKB Coordinator** in freeing up the nursing team to focus on the clinical aspects of the clinic as well as providing additional support that the clinical staff did not have time for, such as support on benefits, house clearance, keeping people safe from fraud, and providing social connections with others. The lead nurse commented that without the Coordinator's input, she was there without her *"lifebuoy"*.

6. Discussion, conclusions and recommendations

This evaluation comprised an analysis of routine clinic data and a pre- and post-assessment of patients' mental wellbeing between August 2022 and March 2023. This was accompanied by observations made by a researcher during a visit to the clinic in September 2022 and insights from her interviews with patients, volunteers and the lead nurse about the ILCC model, the perceived impact on health and wellbeing and their experiences with the clinical staff, AUKB Coordinator and volunteers.

Patients often had to wait no longer than 15 min to receive treatment; treatment time then usually took between 20-30 mins. This means that on average, the **total cycle time**[7] was 20-45 mins. On their busiest days, however, the total cycle time could take up to 3 hours. Treatment time is determined by whether the patient needs one or both legs dressed, and the type of treatment required - bandaging is significantly more time-intensive than compression hosiery or maintenance dressings. However, this information is not currently being captured and monitored. Before appropriate measures can be identified to help reduce total cycle time, improvements first need to be made to the recording and monitoring of routine clinic data. It is therefore recommended that routine clinic data include number of legs dressed and type of treatment required.

Although discharge data can be used as a proxy, more accurate **healing rates** will require capturing information such as the type of lower leg wound, when the patient first reported symptoms to their GP, what treatment was provided before referral to clinic, and whether the patient followed the at-home self-care advice.

With the main aim of the ILCC being to reduce the negative impact of social isolation on patients, it was important that this evaluation found evidence of **patients socialising** with each other. This happened at

[7] Total cycle time: the number of minutes between when a patient arrives at the clinic and when they leave (American Academy of Family Physicians, 2002).

various times – before attending the clinic, while waiting to receive treatment and after receiving treatment. This socialising was not limited to the clinic space but spilled out into the adjacent Megabytes Café; some patients were observed to be at the Withywood Centre for several hours. Patients themselves expressed how much they enjoyed and looked forward to the company of others when they attended the clinic every week. This in turn **improved their wellbeing**, a finding supported by the pre- and post-assessment of the SWEMWBS responses.

It was interesting to note that female respondents to the questionnaire reported moderate wellbeing, while male respondents reported high wellbeing. Platsidaki *et al.* (2017) reported that **female patients** presented with worse quality of life (QoL) because lower leg wounds are visible and can make women feel unattractive and unfeminine, especially when they have to resort to wearing trousers and/or non-preferred shoes to hide or accommodate their swollen or bandaged feet and ankles (Herber *et al.*, 2007). This altered body image and loss of self-identity led to feelings of low self-esteem and self-worth (Douglas, 2001).

SWEMWBS respondents aged 55-64 reported moderate wellbeing while those aged 65 and over reported high wellbeing. This is consistent with a study by Franks and Moffatt (1998) that found that leg ulceration had a higher impact on perceived QoL in **younger patients**. Older patients were better able to cope with the situation and accept themselves as a person with a leg ulcer, which helped them maintain their self-esteem (Herber *et al.*, 2007).

6.1 Main learnings

- The ILCC model enables infection to be identified earlier and medication to be prescribed sooner, prevents complications, and improves healing rates, thus potentially **preventing more costly interventions**.
- Delivering the service in a **relaxed community setting** helps to reduce stigma and encourage mobility.
- The clinic demonstrated the value of a **welcoming environment** and **peer support** in promoting wellbeing.
- It takes time for patients and volunteers to **build a relationship** and **develop trust** with a new Coordinator. Therefore, the Coordinator needs to be mindful not to introduce too many changes before patients are ready to open up to other support that could benefit their wellbeing. For example, it had taken over a month before patients started to take part in the activities provided.
- The Coordinator role is important in helping to **identify other needs** that patients might have e.g., benefits/allowance, social care etc. It is essential for them to listen to patients to determine their interests and needs before arranging appropriate activities and events, which should be a mix of enjoyment and subtle health messaging.
- The ILCC model is **replicable** in other areas and for other long-term conditions. It can be delivered successfully by a locally based voluntary organisation or one for communities of interest such as Age UK Bristol. The main requirement is that the organisation **has good knowledge of and links to local support** for signposting and referral.
- Development of a **mutually respectful relationship** between health and voluntary sector staff is important to ensure a good working partnership.

6.2 Main challenges or barriers

- The clinic was initially set up to ensure equal leg care across the PCN. It has been challenging trying to get buy-in from the GP practices to **release nurses** to work at the clinic and take the knowledge back to the practices to ensure they are all using the same methods.
- **Different methods used** at the clinic and at the GP surgery can cause **confusion** among patients who have their legs dressed at both these settings, particularly when communication has not been consistent across the two systems.
- The increased numbers and complexity of leg conditions since the COVID-19 pandemic means that the clinic is often **very busy**, which can deter patients from staying to socialise.
- Some patients are **under 50-years-old**, so the clinical staff, AUKB Coordinator and volunteers need to be sensitive to their needs and be mindful not to add to any stigma or unease about attending a clinic that could be seen to cater only to older patients.
- It has been more difficult to **recruit new volunteers** since the COVID-19 pandemic, especially older volunteers who have had leg ulcers.
- **Existing volunteers need a lot of support** to move out of their comfort zone so that they are not just making cups of tea, but can support in other ways e.g., with booking patients in and chatting to patients. This has put added pressure on the Coordinator who at times has been interrupted when supporting a patient – an opportunity is lost if that patient is then seen by clinical staff and leaves the clinic.
- Health and voluntary sector staff come from **different work cultures**, which can be a challenge to delivering a service together. It takes time to build understanding and mutual respect, and to learn how to appreciate each other's role in the partnership.
- Not having **transport** is a common barrier to attending the clinic for some patients.

6.3 Future challenges and ambitions

- At present, the clinical and voluntary sector parts of the clinic are funded separately. It is essential that **future funding covers all aspects** of the clinic to make it a truly integrated partnership.
- PCNs are key to **securing commitment** from all GP practices to release nurses to work at the clinic and to ensuring that this way of working is **valued and supported** by the GP and nursing staff in each participating practice.
- There should ideally be a **clinic manager** in post from the outset to oversee the delivery, help with identifying and monitoring health and wellbeing outcomes, and help develop the relationships across all partners.
- Additional funding is required to recruit a **voluntary sector clinic coordinator** to work three days a week, to give them sufficient time to support three half-day clinic sessions in addition to time outside the clinic for monitoring, administration and preparation.
- Funding also needs to be secured to enable the voluntary organisation to continue arranging and providing **transport** for patients who struggle to attend the clinic.
- Obtaining continued **funding for the clinical aspects** of the clinic has also been problematic. If the treatment of leg ulcers was **part of the Quality and Outcomes Framework (QOF)**, then it would be easier to maintain the funding. This would also enable **uniform coding** of leg wounds and ulcers across

the healthcare system which is crucial to ensuring **data accuracy** in highlighting the need across the PCN.

- A **joint volunteer recruitment drive** across all partners is required to enhance the service provided and take some pressure off the coordinator.
- More space is needed to keep the **'community' feel** of the clinic from being overwhelmed by the clinical side. If this cannot be met by the current venue, then a different venue that is large enough, welcoming, and connected to other community resources needs to be identified.
- While most patients needing treatment will be older, there are rising numbers of **younger adults** (under 50) with lower leg wounds, sometimes linked to alcohol/drug misuse. Each half-day clinic can treat approximately 20 patients, but as these are busy sessions, there is a need for **sufficient space** to enable the other practical and social support to take place in an attractive environment.
- The ILCC model can only develop if an **integrated approach** to leg wound care has been prioritised across all Locality Partnerships.
- The limitations of bandaging plus embarrassment deter patients from having their toenails cut, which can further limit mobility and increase their risk of falls. The clinic would benefit from having a low-cost **foot care practitioner** come in to cut patients' toenails when they are having their legs washed and dressed. This would represent a truly personalised approach to person-centred care.
- The issue of social isolation is often seen by some healthcare workers as not their problem. Therefore, it has been challenging for the voluntary organisation to 'sell' this type of intervention to GP surgeries. **Partnering with another healthcare provider** such as Sirona, in the future, may help with the brokering of such services.

7. References

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