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Realist evaluation of social outcomes in community care: the application of affordance theory to the Lindsay Leg Clubs

Abstract

This study uses a scientific realist methodology to explain how social outcomes of community care interventions are produced, sustained and contextually dependent. We evaluate an organisation dedicated to wound care and leg health known as the Lindsay Leg Club network, so far studied mostly from a phenomenological perspective, to demonstrate the generative role of places where Leg Clubs are located, with objects in their environment, and people who organise and run Leg Clubs, with their agency and intentionality. We theorise the explanatory role of these contextual features with the concept of affordances. Our approach shows that the phenomenological findings from community care evaluation are not unequivocal. Instead, researchers should recognise the nuanced nature of causality in social programmes, which requires a consideration of the links between community care interventions, how people respond to them and the conditions under which these responses are enacted.

Keywords: affordance; community care; Leg Club Network; realist evaluation; wound care

Introduction

Recently, phenomenology-based ethnographies have been touted as an innovative approach to understanding people's experiences in modern organisations (Lehn 2019). They underpin much of nursing and social care research, prioritising subjective first-person experiences as avenues to comprehend the social structures of community care knowledge (Ellis 2016; Hughes and Sharrock 2016). In wound care, phenomenological research has provided a rich preview of the experiences of patients with wounds receiving community care (Hopkins 2004; Piggin and Jones 2007; Wellborn and Mocerri 2014). As observed by Hawkins and Lindsay, '[p]henomenology fits particularly closely to the person-centred, humanistic, holistic approach

to health care, which forms the basis of, and informs the nurse–patient relationship’ (2006, S10).

However, Carico et al. (2020, 4) note that exclusive reliance on phenomenological analyses of community health interventions may overlook the role of external factors such as social norms and community assumptions that may shape personal behaviours without individuals fully realising it. Moreover, phenomenological scholars may report knowledge deficits of their study participants as a finding in its own right, without always embarking on an investigation of the causes of these deficits that could help develop solutions and recommendations (e.g. Wellborn and Mocerri 2014). As a result, by focusing mainly on reported lived experiences, there is a risk of leaving everything ‘as it is’ and producing obvious accounts of social life (Moran 2001).

In this paper, we seek to surpass the boundaries of phenomenological descriptions of community care. We report on a multi-site ethnography of a community wound care and leg health organisation, known as the Leg Club network.¹ Extant understandings of the social value of the Leg Clubs are richly grounded in descriptions of users’ subjective experiences and perceptions (e.g. Upton et al. 2015; Seckam 2019). However, there are voices that the value of the network can be further unearthed through a deeper layer of explanation. Even the founder of the Leg Clubs alluded to the importance of understanding Leg Club outcomes through a study of the relations between people and their environments when she argued that Leg Clubs are distinctively made up of unique places and personalities (Lindsay 2018b).

Here, we pick up on this observation and analyse people’s everyday exchanges and communications but also Leg Club localities, objects and established procedures to understand their role in the generation of social outcomes from a realist angle. We side with scholars who

¹ Our evaluation team consisted of social scientists only, which vindicated our focus on the understudied mechanisms of social outcomes, to the exclusion of the healing and recurrence outcomes of the provision of preventative and medical care, documented elsewhere (Gordon et al. 2006; Edwards et al. 2009).

argue that the workings of social programmes, such as Leg Clubs, will vary because the community contexts in which such programmes are implemented also vary in terms of cultural beliefs, structural patterns or relational arrangements (Pawson and Tilley 1994, 298). The contexts are made of people who consciously interact with each other and with their community environments that have real, objective, material and physical properties. These relational conditions can create opportunities for some outcomes, but they can also throw in hindrances for others (Gibson 1986/2015), thus they need to be further explored.

This paper is structured as follows. We start with a comprehensive introduction to the Leg Clubs and an elaboration of the extant phenomenology-based understanding of their social value. Next, we expound on the explanatory value of looking at social outcome generation in Leg Clubs through the lens of the theory of affordances (Gibson 1986/2015). After introducing the scientific realist methodology used in the study (Pawson and Tilley 1994, 1997), we demonstrate the explanatory purchase of a focus on the context, mechanisms and affordances with our empirical Leg Club evidence. We conclude with a discussion of how combinations of Leg Club places and personalities offer a deeper explanation of social outcome generation.

Phenomenological analyses of community care: the case of Lindsay Leg Clubs

The Lindsay Leg Club network is a third sector wound care and leg health organisation based on a psycho-social care model that operates as a community partnership between patients (referred to as members), volunteers from the community and National Health Service (NHS) and General Practice (GP) consortia nurses. As an alternative component within the NHS (Young 2010), Leg Clubs provide community-based treatment, health promotion, education, social engagement and ongoing care in non-medical settings for people who are experiencing, or are at the risk of developing, leg-related problems.

Wound care is delivered in communal spaces, such as social clubs or church halls, on a drop-in basis, with members treated alongside each other in an open area. Medically, each Leg Club operates according to strict guidelines monitored by the Lindsay Leg Club Foundation, like the Standard Infection Control Precautions (HPS 2009, cited in Young 2010, 146). Socially, the organisation of the Leg Clubs follows a freer agenda set up by the volunteers, who establish their Leg Club constitution. The Leg Clubs are a space for interaction and sharing experiences over refreshments, with social activities ranging from games of tombola and piano concerts inside the Leg Clubs to Christmas lunches in local cafes and afternoons in local garden centres. The Leg Clubs are self-funded and raise money to pay for venue rent and refreshments. The Leg Clubs also run a ‘well leg’ programme, under which new and existing members can attend if they do not have a wound but may feel they are at risk of developing or recurring leg ulcers. They can also attend exclusively for social activities.

Evidence on the effectiveness of the Leg Club model is growing. Positive outcomes reported in research include high healing rates and low recurrence rates compared with traditional leg ulcer clinics (Gordon et al. 2006; Edwards et al. 2009), a sense of continued participation in the society (Lindsay 2019b), friendships, sociality and camaraderie (Lindsay 2018b) and destigmatisation (Grogan 2019; Mechen 2019). Due to the relative novelty of the Leg Clubs as a setting for social scientific research, most of these outcomes are reported in member satisfaction questionnaires (Clark 2012; Lindsay 2018a) or anecdotal stories (Mew 2015; Hampton 2016). Extant systematic enquiries into holistic care in the Leg Clubs are in early stages, while scientific reviews of existing primary research note a small quantity of evidence on the outcomes (Abu Ghazaleh et al. 2018; Dhar et al. 2020). It is therefore necessary to conduct more research into understanding Leg Club outcomes (Bawden et al. 2018).

In this context, phenomenological research has been a useful study approach (Hawkins and Lindsay 2006; Ellis 2016). Its apparent fit may stem from the Leg Clubs’ design grounding in

Becker's Health Belief Model (HBM) (1974) that, in itself, has phenomenological underpinnings (see also Lindsay [2019a]). The model argues that people's health behaviours are driven mostly by psycho-social considerations. Firstly, to act, they must feel that a health concern is relevant to them. Secondly, they must fear that they are vulnerable or susceptible to the condition. Thirdly, they must believe that their action is going to bring them some benefits over any likely costs, such as money and time.

The HBM emerged out of concerns with explaining preventative health behaviours oriented towards the avoidance of a disease, rather than its treatment (Rosenstock 1974). Thus, in the Leg Club context, Upton et al. (2015) conducted a phenomenological analysis of open-ended interviews with Leg Club members to understand the significance they placed on their subjective experience of attending the Leg Club. The study revealed the importance of Leg Clubs as spaces for social interaction for the alleviation of social isolation and the enjoyment of practical and emotional support from one another, volunteers and nurses. In another phenomenological study, Seckam (2019) analysed the meaning of holistic care for members, pointing to the sense of autonomy from feeling empowered to participate in their own care through trustworthy education from Leg Club nurses. The phenomenological tradition in Leg Club research justifies the focus of such evaluation efforts on the social gains.

Leg Club research: limitations to phenomenology and a realist relational alternative

However, there may be important social aspects of Leg Clubs that the phenomenological approach cannot sufficiently account for. To start with, the HBM might capture the psychological mechanisms that generate health benefits, but it cannot theorise the unanticipated social gains from the Leg Clubs that fall outside of the purely clinical arena. The fact that each Leg Club is distinctively made up of unique places and personalities (Lindsay 2018b) ties the emergence of social value to social interactions within Leg Clubs' environments. According to

Rosenstock (1974), it is the role of contextual influences that is harder to capture under the HBM parameters which largely disregard the role of external factors from the physical environment. Moreover, cues for action from the external environment, such as interpersonal influences (Freidson 1961, cited in Rosenstock 1974, 333), can be fleeting, easily forgotten and difficult to assess. However, they must be accounted for in evaluative studies of social interventions, because gentle conversations and informal activities are important drivers for people's behaviour in organisations (Courpasson 2017).

One approach that vindicates an explicit focus on people as drivers of other individuals' actions and allows to view contextual influences as an important context within which they take action is the theory of affordances developed by Gibson (1986/2015). The notion of affordance as used by Gibson (1986/2015) refers to what is offered, provided, or furnished to someone or something by an object, its user, or the relationship between the object and its user. According to Gallagher (2018), the theory of affordance has its roots in phenomenology through its concern with people's perception of what can be done with objects. However, Scarantino's (2003) reading of Gibson's earlier work challenges this view, arguing that the language of phenomenology might overlook the complementarity of organisms and environments, which is the cornerstone of the affordance theory. As Gibson explained, 'an affordance is not bestowed upon an object by a need of an observer and his [sic] act of perceiving it' (1979, 139). In this sense, affordances are not a fixed quality of people or places, but they have a relational character (Elder-Vass 2005) that emerges from a relation between the constituent parts of people and places (Bygstad and Bergquist 2018; Lindsay 2018b)

When applied in the Leg Club context, the theory of affordance vindicates a focus on how a rich and complex set of interactions, playing, co-operating or communicating – the very cues for action that are difficult to assess in Becker's (1974) framework – represent a socially significant human reality. Likewise, the emergence of social value within Leg Clubs will be

ties to how their members organise and run it in the context or under conditions of their operations – to the network of social processes including relations of persons to their environments that ‘activate’ the range of social benefits made possible by Leg Clubs.

The theory of affordances provides the theoretical language for speaking with confidence about the social causality that happens amidst the contextual features of people and places.

We see a parallel between Gibson’s (1979, 1986) lens of ‘environment’ and Lindsay’s (2018b) concept of ‘place’ in terms of social norms and community assumptions but also in terms of material organisational arrangements of objects and places. The theory of affordance offers a generative conception of social causality that can add further depth to the scientific realistic research into how social value is generated within the Leg Clubs – for whom and in what circumstances. In this paper, we use affordances as a tool to understand the contextual social processes that, in the words of Pawson and Tilley (1994, 302), ‘fire’ the mechanism to enable the generation of social outcomes.

Methodology and methods

Research approach

This study was part of a larger project classified as service evaluation by the Lindsay Leg Club Foundation Clinical Governance body, which granted ethical approval and permission for undertaking the study on 10th September 2019. The study took a realist evaluation approach developed by Pawson and Tilley (1994, 1997) to understand ‘the mechanism of what works for whom in what circumstances and how programmes worked or did not work in their contextual setting, rather than simply measuring outcomes’ (Wong et al., 2015, p.262).

Thus for a realist evaluator, outcomes (O) are understood and investigated by bringing to the centre of investigation certain hypotheses about the mechanisms (M) through which a programme seeks to bring about change,

as well as considering the contextual conditions (C) which are most conducive to that change. Empirical investigation takes the form of putting into place a rigorous sequence of measures and comparisons so that the evaluator ends up in some position to pronounce on the whys and wherefores of programme effectiveness. (Pawson and Tilley 1994, 300)

According to Pawson and Tilley (1994, 302), ‘more than one of these mechanisms may operate simultaneously’ and ‘[w]hich (if any) mechanisms are fired turns on the context’ in which a social programme unfolds. Therefore, social contexts play a fundamental role in shaping outcomes.

Crucially, the wound care community has voiced a demand for greater use of realist evaluations. According to Samuriwo (2017, 700), wound care is a complex and multifaceted, and requires ‘an understanding of what interventions are effective, how the interventions work, for which individuals the interventions work and in what context the interventions work’. Specifically, ‘realist evaluations in wound care may generate broader insights into how different interventions can be implemented in different contexts to ensure that they are as effective as possible and deliver the best possible patient outcomes’ (Samuriwo 2017, 700).

Research methods

Ethnography is ‘an ideal partner to the realist evaluation framework’ (Dainty et al. 2018, 102) that allows for an understanding of what actually happens in a bottom-up approach (Jones 2018). Our choice to use an ethnographic approach was a nod towards documented ways of studying the Leg Clubs (Lindsay 2018b). We used what Lindsay called ‘a relaxed ethnographic approach’ (2018b, 111): observations of the Leg Clubs along with informal conversations with the members and volunteers focused on their interpretation of their experiences with the Leg Clubs, with sporadic informal conversations with the nursing staff, their work permitting.

Previous Leg Club research deliberately side-stepped in-depth qualitative interviews in favour of informal conversations with the members about their Leg Club perceptions (Stephen-Haynes 2010) or asking a single open-ended question ‘What does coming to the Leg Club mean to you?’ (Upton et al. 2015). Moreover, the first author’s familiarity with the Leg Club setting, developed fortuitously during his/her doctoral research, alerted us to the vulnerability of the Leg Club members; most were elderly, some visually or hearing impaired or with reduced mobility, others suffered from dementia or Parkinson’s disease. We felt that the intensity of in-depth interviewing could curtail participants’ involvement (Stephen-Haynes 2010). Therefore, with advice from the Lindsay Leg Club Foundation Clinical Governance body we used observation and informal unrecorded conversations with members and volunteers.

Research setting and data collection

This study was conducted in six UK Leg Clubs, which are referred to by numbers for confidentiality reasons. The numbers reflect the order in which the first author visited the Leg Clubs. Leg Clubs 1, 2 and 6 were chosen when the first author networked with the Leg Club leads at the Foundation’s annual conference in September 2019. Leg Clubs 3, 4, 5 and 6 were nominated for the study by the Leg Club Industry Partner, who funded this research. Leg Clubs 1 and 2 were recruited in the course of verbal explanation of the service evaluation provided in person by the first author, after which emails and telephone numbers were exchanged. As for Leg Clubs 3, 4, and 5, email contact was made with the Leg Club leads using the details from the Foundation’s website. Explanation of the study was provided along with the research protocol. In the field, a paper copy of the research protocol was provided on the first day to the lead contact with whom the first author had the most interaction.

All the Leg Clubs run on average for 2.5 hours once a week. Altogether, the first author conducted 54 hours of observations. Moreover, she/he held many informal conversations with individuals met in the Leg Clubs. Purposive sampling was used to ensure a breadth of views,

as is common in qualitative wound care research (Varga and Holloway 2016). In addition to plentiful informal conversations, 12 members and 13 volunteers provided written consent to share their stories in this study. Both members and volunteers were recruited directly by the first author in the Leg Club.

The use of documents was a crucial complementary data collection strategy (Bowen 2009). We read documents such as Lindsay Leg Club Foundation press releases, articles in local online news, professional nursing journals, websites of healthcare practices, GP surgeries, local charities and community groups, some Leg Clubs' social media pages, village magazines, and watched videos on the websites of local administrative units and internal Leg Club documents. The documents provided us with an appreciation of the context and social diversity of the Leg Clubs.

Data analysis

The observation was recorded in jottings made in the researcher's field notebook. As the informal conversations with the participants were not audio-recorded, notes were also taken during informal conversations with members and volunteers. The jottings were converted into electronic fieldnotes on the same days that the Leg Clubs visit took place. The documents were treated like fieldnotes, adding a body of information to our observational data.

In the first stage of the analysis, following Caló et al. (2019), our data were read and grouped into statements of outcomes, mechanisms and contexts (in terms of places and personalities). We saw 'outcomes' as social goods that manifest social value from a psycho-social intervention beyond medical benefits; we were facilitated in discerning the outcome categories from our data by existing literature on the Leg Clubs. Like Dainty et al. (2018), we defined 'context' as those aspects of the Leg Club that influence the operation of the mechanism and 'mechanism'

as theoretical drivers that induce change and are embedded in contexts and their social processes.

To explain the workings of the mechanisms we needed to recognise that they operated through different contextual social processes in terms of combinations of norms and values, organisational arrangements and individual relationships. The inability to theorise the said contextual social processes that involved places and personalities and influenced the operations of the mechanisms led us to the theory of affordances, which was discovered in the analytical iteration between data and literature. As indicated by Volkoff and Strong (2013), different affordances arise from a network of social processes inculcated in the exercise of the mechanism(s). Following Volkoff and Strong (2013), we conceptualised affordances as ‘unobservable mechanisms’, which we retroduced in the second stage of the analysis from the observed different variants of broadly similar outcomes with use of theoretical re-description from the Leg Club programme theory.

We asked ourselves: what must the contextual relations between places and personalities (Lindsay 2018b), or environments and organisms (Gibson 1997, 1986/2015) be like for the outcome to be produced? This process enabled us to retroduce the generative mechanisms ‘fired’ from the context (Pawson and Tilley 1994, 302), but also to discern a further set of sub-mechanisms, nested underneath the aforesaid mechanisms and emergent from the contextual relations between people and places that shaped the said ‘firing’ of the mechanism in a distinctive way that moulded the outcomes. Table 1 below, inspired by Bygstad and Bergquist (20018) shows the retroductive analysis involved in discerning and naming the outcomes (O), mechanisms (M), contexts (C) and further sets of underlying sub-mechanisms (m), theorised here as affordances. In fleshing out the analytical steps with our data, Table 1 also gives a preview of our key findings, which are embellished in the remainder of the paper.

[Table 1 near here]

Findings: value of a realist relational perspective on understanding community care

We use illustrative case vignettes to present our findings in a discriminatory way (Delbridge and Edwards, 2013). We highlight selected paraphrased quotes, observations and descriptions that best help illustrate the contextual aspects of the Leg Clubs that we argue are overlooked in phenomenological analyses confined to people's subjective experiences and perceptions. In particular, our vignettes delve into deeper layers of elaboration of two known outcomes of Leg Club community care: Leg Clubs' role in facilitating participation in valued life roles and normalising wounds and wound care.

We introduce each section with a summary of what pertinent literature says on each outcome (O) and how our data confirmed it. We then identify and define the mechanism (M) driving the outcome. Next, we show how the mechanism was variously fired by different Leg Club-specific contextual features (C), afforded by different combinations of places and personalities (m). Because we did not tape-record our interviews, participant quotes we offer below had to be paraphrased from the notes taken during informal conversations. However, we made every effort to report them in the context of their sharing to preserve data integrity. To maintain participant confidentiality, pseudonyms are used in the reporting of this study.

Establishing a valued life role

The Lindsay Leg Club programme theory asserts that Clubs aim to create 'meaningful pathways for older persons to experience late-life living and simultaneously contribute towards modern-day society' (Lindsay 2019b, 34). For this ambition to be completed, certain conditions must exist (Pawson and Tilley 1994). One such condition is the community exclusion of older adults, which the society recognises as a challenge that needs addressing (Lindsay 2020).

Outcome 1 (O₁): self-fulfilment and purpose in late life

The literature documents that an important social outcome of the Leg Club network is a greater sense of purpose in life among its users. According to Lindsay (2019, 34), ‘a facet of the Leg Club is the development of roles for local retirees and Leg Club members (patients) ... Seniors have a wealth of life experience, and they can contribute to Leg Clubs through diverse activities, such as organising and running their Club’. As revealed by our data, for volunteers, the benefit of this Leg Club programme theory was in empowering them to construct a new role in their community, which was a source of self-fulfilment and purpose in late life:

Some say that once they have volunteered, they often feel like a new person, that they learn there is a whole different sphere of life that they can become involved in. They benefit from a sense of involvement, friendships, a sense of having a purpose. They still have something to achieve and something to give. (Volunteer Manager Stacey, November 2019)

Mechanism 1 (M₁): continued societal functioning

Through the application of retroductive steps to the iterative analysis we discerned the ‘continued societal functioning’ mechanism. This means that for the local community members to find a sense of purpose and fulfilment within the Leg Clubs, there need to be roles, functions or positions available to be filled and tasks to be completed to organise and run the Leg Club. Moreover, local community members must be able to see other people taking up these roles and completing these tasks to feel inspired to put themselves forward to use the Leg Clubs not just to receive leg care and advice, but to also enjoy meaningful late life living.

Context 1 (C₁): self-funded community clubs organised and run by members and volunteers

On the first glance, the contextual conditions to fire the continued societal functioning mechanism exist for all Leg Clubs, which must follow the Foundation's guidance on how to set it up. In a nutshell, all Leg Clubs need to be organised and run by the volunteers²; Leg Clubs are run from non-medical, community venues on average once a week; Leg Club volunteers and members (patients) own their Leg Club; and people with wounds are known as members to empower them away from the sick role. However, on closer inspection, we observed that a sense of fulfilment and purpose in life (O₁) manifested differently for volunteers and members. We conjectured that the continued societal functioning mechanism (M₁) was fired, or actualised, differently through a combination of contextual Leg Club features, which, from an epistemological angle, we explained through sub-mechanisms (m_{1a}, m_{1b}) emergent in a relational sphere of people's intentionality and goals and their interactions with what was available within the physical space of the Leg Club locality.

Sub-mechanism 1a (m_{1a}): formalised volunteers' response to local transport infrastructure.

It was the exceptionality of the structure of Leg Club 1 that helped us distinguish sub-sets of contextual forces underpinning the actualisation of the same mechanism. Leg Club 1 stood out among the six Leg Clubs we studied through its formal organisational arrangements, which reflected a collective intention among Leg Club volunteers to run their Leg Club 'as if they were in the workplace' (Volunteer Manager Stacey, November 2019). 'Being a volunteer is a busy *job* [emphasis added]. There are always emails to reply to', said the Leg Club Secretary Camille. For example, this Leg Club was unique in having a formal roster for the volunteers prepared two months in advance and emailed to all the volunteers. As explained by the Leg Club Chair, this helped ensure that the Leg Club would always be staffed. Leg Club 1 was also

² The activities of organising and running the Leg Clubs relate to the social organisation of the Leg Clubs. The core principles of clinical practice and infection control are set regardless of the social environment (Young 2010).

the only one to have volunteers work to job descriptions. These were endorsed by the Lindsay Leg Club Foundation and available on the Foundation's website for other Leg Clubs to adopt and emulate. The job descriptions 'helped ensure that the Leg Club operated in line with its insurance policy' (Volunteer Manager Stacey, November 2019). The insurance was organised by the Chair of the Leg Club in her responsibility for liaising with a local community support organisation.

Because of Leg Club 1's location far from the local public transport network and due to the unavailability of ample car park spaces outside of the Leg Club, helping members travel between home and the Leg Club was supported by a group of its volunteer drivers. New drivers were regularly recruited through informational stands, held every three to four months on a local farmers' market, or via advertisements placed in local village magazines by a volunteer responsible for communication and media relations. The candidates were then interviewed by the Volunteer Manager Stacey. Stacey explained being a volunteer driver for the Leg Club was not just a taxi service. 'You need to remember some of these people may not be very mobile, and you need to be comfortable with some smells [from the wounds]', she explained. Moreover, as the drivers were community individuals, not employees of a professional organisation, to ensure members' safety, the drivers needed to volunteer within a formal framework. Drivers were registered with the Corporation for National and Community Service and were then 'seconded' to provide transport for Leg Club members. Moreover, they had criminal record checks because to carry out their roles, they needed access to members' address to drive them in their own cars. In the case of Leg Club 1 it made sense to organise around formal volunteering roles because the Club had specific contingencies, such as needing dedicated professional drivers to ferry-in members due to its physical location.

Sub-mechanism 1b (m_{1b}): informal organisation and pride in local landmarks. In the other Leg Clubs, a designated role of a volunteer driver was not needed because of the location of the Leg Clubs close to bus stops (Leg Club 3 and 4), deals with local bus companies (Leg Club 6), third-party organisations providing external service (Leg Club 2) or ample car park outside of the Leg Clubs (Leg Club 4, 5 and 6). There was less need for the coordination of this aspect of Leg Club operation due to the physical contingencies, and the adhocatic approached percolated through other aspects of these Leg Clubs' activities.

For example, a committee of volunteers from Leg Club 2 decided to allow volunteers to attend each week out of choice, as they felt that a formal roster could curb their attendance. Moreover, the volunteers did not have clearly assigned responsibilities but relied on their wits to ensure the smooth running of the venue. 'We just sort of come in and know what to do', said Volunteer Cath in Leg Club 2:

What makes the Leg Clubs work is the low level of bureaucracy, because it lets people run the Leg Club in a way that meets their [members'] needs.

(Volunteer Samara, fieldnotes, Leg Club 2, December 2019)

Greater flexibility gave volunteers scope to propose and enact their own initiatives of benefit to the members, that reflected their previous professional expertise and meaningful life experiences. In Leg Club 3, Volunteer Jenny had worked in the field of benefits and wanted to continue using that experience by running a free information session for all Leg Club members. Moreover, her fellow volunteer, Jack, was a member of a community organisation promoting a greater level of understanding around cancer. He used that co-membership to extend his informative activities to the Leg Club venue by placing leaflets on the tables in Leg Club 3, inviting members to take a lead in holding difficult, informative conversations. This is

significant because the scope for volunteer input was built into the informal processes shaping what volunteers felt were possible.

A sense of ‘giving back’ reverberated across the Leg Clubs in a way that stressed the involvement of members as equal parties in ‘giving back’. Members’ ideas on how to organise and run the Leg Club in a bottom-up fashion ‘sounded louder’ in Leg Clubs that had a more informal design. To raise money to fund the Leg Clubs, members would bring their home-made jams (Leg Club 2), hand-made cards (Leg Clubs 2 and 4) and crocheted toys (Leg Clubs 3 and 5) to sell to each other and to volunteers and nurses. People felt able to mobilise in these ways because they were given the ‘space’ to bring to bear their life experiences onto those less fortunate.

The informality in running the Leg Club was also visible in a variety of creative ways in which members stressed their ownership and loyalty to their Leg Club. For example, in Leg Club 2, the Chair, who was also a member, designed the Leg Club headed paper, which he used for communication with the lead nurse to emphasise the sense of his Leg Club’s identity. The logo used the Leg Club model’s own triangular logo, but it also incorporated a local geopolitical symbol that was distinctive of the physical location of this Leg Club. Similarly, in Leg Club 4, one of the members designed a logo for his Leg Club that intended to communicate its unique geophysical identity. This member was not a volunteer himself, but was ‘commissioned’ to design the logo, as he described it, because prior to retiring he had worked as a graphic designer. The logo was a reinterpretation of the Foundation’s official logo – to communicate affiliation – but it also incorporated the key landmarks in the area, such as the local museum, the church that hosted the club along with the main door through which members entered their Club, and the map of the area. As the member explained:

This area is very famous for climbing, so the logo should draw on the meaning and symbolism of the stone. It is to communicate the Leg Club's identity. (fieldnotes, Leg Club 4, December 2019)

Therefore, in the case of Leg Clubs 2 and 4, the physical location played a distinctive role in members' sense of ownership of their Leg Clubs. In the case of Leg Club 1, in turn, the logo recognised and acknowledged the participation of a local community organisation that supported its more formal operation (such as insurance for all volunteers and compliance with the General Data Protection Regulation). However, Leg Clubs 2 and 4 did not yet have their own unique logos, so the volunteers chose to delegate the task to members, who felt a proud sense of identity in their affiliation with the Foundation and their local area and drew on their professional background in completing the task. The combination of less formal procedures, individuals' passion for the distinctiveness of local geography and professional backgrounds again shows a network of social processes that lead to empowerment for members through continued local participation in valued social roles.

Normalising wounds and wound care

One of the objectives underpinning the Leg Club philosophy is to rebuild individuals' self-esteem and self-respect by de-stigmatising their condition. This implies the societal perception of leg wounds as stigmatising and the potential of the Leg Clubs to alleviate it.

Outcome 2 (O₂): reduction in wound stigma

Indeed, we observed that members of the Leg Club spoke of a reduction in the feeling of being stigmatised by their wounds and volunteers implied a better understanding of wound stigma. For example, a male volunteer in Leg Club 1 admitted acquiring an empathetic understanding of why people 'can get a bit nervous and a bit shy at first', baring their legs in a public space. In Leg Club 5, one female member told us that it was 'very reassuring for her to know that

other people had it too and that she was not the only one' because prior to joining the Leg Club she 'didn't know that other people also had diabetic foot ulcers' (fieldnotes, October 2019).

From this, we retrodeduced that the open design built into wound care in Leg Clubs' delivery in non-medical venues had the potential to normalise wounds and wound care through giving Leg Club volunteers a chance to learn about wound care and members a space to share the same physical inconveniences and benefit from the camaraderie. Having learnt that the Leg Clubs can offer de-stigmatisation to its members, and given our interest in 'place' as a contextual Leg Club feature, we grew interested in exploring the role of the physical design of the Leg Clubs for helping members deal with the social stigma of wounds.

Mechanism 2 (M₂): sharing in the wounds inconvenience

When we asked members to comment on their feelings about being treated collectively, no one responded disapprovingly. Indeed, some admitted that, at first, they had used to feel self-conscious about revealing their wounds. However, the feelings of anxiety would promptly subside. As a male member from Leg Club 4 explained, his initial discomfort dissipated upon realising that other members treated at the same time were too preoccupied with their own treatment to cast their gaze on his legs, 'and if anything, everyone has them' (fieldnotes, October 2019). In Leg Club 5, one member's wife explained that collective treatment was 'good' because 'they were all on the same boat'; a male member added it was 'okay because everyone has the same'; and a female member. In Leg Club 1, a male member admitted he did not mind being treated in a collective area because they 'all had bad legs at the end of the day so there was nothing to hide' (fieldnotes, November 2019).

Context 2 (C₂): open set-up: coexistence of medical and social spaces in a single venue

At a basic level of physical Leg Club design, the Leg Clubs were split into two sections – one for collective treatment of members, next to or facing one another, and one for social interaction at shared tables over cups of tea. However, we found that different communal designs that used, or did not use, semi-fixed physical partitions between the social and the communal space changed people's sentiments about leg wounds.

Sub-mechanism 2a (m_{2a}): education through no semi-fixed partition between clinical and social spaces. In most Leg Clubs (3, 4, 5 and 6) the separation was symbolic and consensual. The open set-up of the Leg Clubs rendered wounds visible to other members and volunteers in a way that had an educational function. A common outcome was the expansion of the level of knowledge and understanding about wounds and wound care in casual conversations amongst members and volunteers.

For others, the experience was crudely informative. A female volunteer in Leg Club 1 admitted she had not known how 'horrible legs can be'. Despite the tension between various reactions to similar wounds, the experience was educational for all, nonetheless. As one male member explained, because a lot of people who come to the Leg Clubs generally have got the same concerns, there is an opportunity for everyone to learn from one another (Leg Club 3, fieldnotes, November 2019). This educational function of communal wound care can be seen in the following interaction between two male members in Leg Club 3 awaiting their treatment at the same table (fieldnotes, November 2019):

Member Tom: How can I get these [medicinal compression stockings]?

Member Fred: I had them ordered by the nurses here (he pulls out the stockings from the packaging, stretches them and praises them).

Member Tom: I've been struggling to find them. I used to buy travel socks from Boots, but they were no good and had to be thrown out right away.

Have these got a hole for the toe?

Member Fred: They do.

Member Tom: I was given a pair once in hospital, but I left it there.

Member Fred: The openings around the toes are tight and they are a bit hard to put on, but my wife helps me.

Member Tom: My legs are burning hot.

Member Fred: Burning, yeah... (he nods).

Member Tom: I feel like wanting to put leg down the toilet and flush it... I buy cooling gel bags from ASDA or Wilko and put them on the bed underneath the sheet to cool the bed down, but they are £9.99.

Member Fred: Free on the NHS (he smiles).

The fact that the Leg Clubs were an apt medical setting devoted to the treatment of leg problems in a focused way gave members the confidence to hold straight, open conversations about wounds. Knowing that other people in the room experienced the same problems encouraged members to ask straightforward, factual questions and members validated each other's painful experience and provided first-hand experiential knowledge to remedy any mal-informed techniques.

Sub-mechanism 2b (m_{2b}): inclusion through semi-fixed partition between clinical and social spaces. In other venues, the two sections were markedly separated by medical screens (Leg Clubs 1 and 2), which created a visual partition that kept wound care activities out of sight of members awaiting their treatment in the social area. Although for many, the treatment in a communal area was positive, there were members who appreciated the splitting of the room into a clinical and a social side with screens in between. For example, a female

member in Leg Club 1 liked this arrangement because she ‘didn’t have to see them’. When prompted, she shrugged and added that ‘wounds are not nice to look at’ (fieldnotes, November 2019). Indeed, some members were reluctant to bear their wounds in an open area. For them, the open space had the opposite effect to the one intended by the Leg Club programme theory. The Leg Club guidelines clearly state the requirement to explain collective treatment regime to new members and ensure that private provision is available for individual treatment should it be requested. Nonetheless, members in Leg Clubs 1 and 4 told us of their acquaintances who had not known that private treatment was a possibility. Their apprehensiveness about the collective treatment made it difficult for nurses to get them involved. A nurse in Leg Club 3 added that individuals who were ‘private persons’ and did not like to share were the hardest to encourage to come to the Leg Clubs. ‘[They] could have just asked the nurses to put the screen up’, the member in Leg Club 4 commented.

Discussion and conclusion

This paper has demonstrated the value of realist relational ontology as the philosophical underpinning for research on social outcomes in community care. We have applied a scientific realist evaluation methodology to explain the generation of two positive social outcomes from the literature on the Lindsay Leg Clubs by delving deeper into the mechanisms producing the outcomes and the contexts firing the mechanisms and sustaining the outcomes (Pawson and Tilley 1997). However, having observed different variants of similar outcomes, from an epistemological perspective we needed a more stratified explanation of the context-dependence of the actualisation of the mechanisms.

According to Al-Amoudi, ‘mechanisms are typically nested into one another’ and ‘there is no way of proving ontologically that this nesting has an end and does not lead to infinite regress’ (2014, 196). We therefore carefully analysed the manifestations of the outcomes (O) to

reproduce a range of sub-mechanisms (m) as contextual forces that activated the mechanisms (M) and emerged from the relation between two features of the Leg Club contexts: places and personalities (Lindsay 2018b). Here, we argue that their combinations shape choices and afford capacities that lead to how social outcomes that may appear similar are, in fact, variously experienced by different groups on closer inspection. In this section we vindicate our theorisation of the generative role of these sub-mechanisms with the application of the theory of affordance (Gibson 1986/2015) to illustrate how viewing the Leg Clubs' potentials to facilitate participation in values social life roles and to normalise wounds are afforded differently depending on contextual arrangements of Leg Club places and personalities.

Crucially to our theoretical interpretation, existing literature recognises that both people and places in themselves can act as affordances in the context of social activities. In the analysis of disability care, Dokumaci (2019) proposed the concept of 'people as affordances', arguing that in the absence of non-animate objects that can afford people with disabilities an opportunity to fully participate in the society, other people's choices to co-create sociality can compensate for this lack. In a review of literature on interventions aimed at reducing loneliness, Nasrallah and Pati (2020) argued that place, space and physical design of such intervention, with both fixed and semi-fixed arrangements, can play an important role in gauging their success when they are theorised as affordances.

In our Leg Club case, affordances follow people's choices in the form of rules and the capacities they derive from a distinct set of spatial resources of the Clubs. In Leg Club 1, we saw a distinct manifestation in formal procedures in conjunction with the limited availability of local transport infrastructure to organise leg care. Formalised volunteers' response to local transport infrastructure afforded people a sense of feeling like a new person, a sense of involvement in a different sphere of life, a sense of having a purpose, and a feeling that they can be a part of something for longer for the *volunteers*. In the case of the remaining Leg Clubs,

the organisational structures were more informal and transport solutions arranged by members, their families or third parties. There, the informal organisation and pride in the local landmarks afforded more visible the empowerment of the *members* (i.e. patients), flexibly increasing the scope of their role and spreading the organisation and the running of the Leg Clubs across members and volunteers.

As observed by Volkoff and Strong, affordances have the inherent nature ‘as simultaneously enabling and constraining’ (2013, 831). This contrastive actualisation of the continued societal functioning mechanism as a function of people and their ideas suggests that the same affordance can have variously enabling and constraining features for different groups. Leg Club people belonged to multiple social worlds that presented different opportunities, or what Volkoff and Strong (2013, 828) call, ‘strands of interacting affordances’ that related to these experiences. How they were brought to bear was not simply a question of the individual having the experience but related to the actor-structure relationship. The latter was a consequence of the Leg Club organisational arrangements that enabled those volunteers to activate their capacities within the physical space where the need for certain roles existed (or did not exist) in the context of local infrastructure and where permission to enact some activities existed (or did not exist) by virtual of a formal-bureaucratic or informal-adhocratic design. In other words, organising the movement and inclusion of members reveals a wider network of social processes.

Likewise, we can see from the second vignette that the Leg Clubs had the potential to help members feel less stigmatised by their wounds, but the specific details of how the destigmatisation mechanism was actualised varied depending on the physical design of the Leg Club and people’s personal reactions to wound sight and smell. Therefore, members wishing to see a specialist in private experienced feelings of embarrassment in communal treatment areas, which risked reaffirming the sense of having a stigmatising condition and was a disabling

affordance. Others benefiting from the realisation that they were not alone could consider the open space as an enabling affordance and developed a sense of ‘we-ness’ and ‘shared fate’ around sharing similar frustrations (Pouthier 2017, 760-761).

This is very significant, because it shows that the general de-stigmatisation mechanism has constraining and enabling sub-strands, which are created at the intersection of objects – partitions between the clinical and the social side – and people’s personal attitudes, social preferences and factual knowledge about how care can be delivered. A personal preference for private treatment and lack of knowledge about the possibility of putting screens up creates a constraining affordance, which may have the opposite effect. A sense of stigma may be left intact if a physical partition is raised between a private members and other Leg Club visitors. Finally, stigma may be reduced when members consent to openly sharing what it is like, embracing the open design as an opportunity for collective education rather than a risk to their dignity. Therefore, members had a choice over whether they were treated in a communal area or in a private area, and they had a choice whether to look at what was unfolding on the clinical side, or not.

Our analysis shows the need to talk to people – volunteers and members’ expertise, professional experiences and ambitions – to understand how, exactly, self-fulfilment and purpose in life and reduction in wound stigma are experienced. The analysis also demonstrates how materiality of objects that partition (or not) the venue into a medical and social space may favour or limit the de-stigmatising possibility of the communal design, and how important social processes are to linking affordances to facilitate their actualisation. Based on these examples, we have argued that realist theories can provide community care researchers with theoretical tools that are better equipped to connect data from a variety of lenses in a way that is more sensitive to context. Using a realist relational perspective allows the researchers to go beyond the data

recorded from interviewees and actively scrutinise the data against external theories and knowledge that can supplement actors' potentially incomplete accounts.

A context-sensitive scientific realist evaluation can then allow practitioners to better understand how the outcomes can emerge and remove any barriers, rather than simply awaiting the outcomes to materialise automatically. By looking at community care through the further lens of affordances we can see how the same outcome can be experienced differently by various groups or even by members of the same group, as well as identify solutions and propose recommendations (Volkoff and Strong 2013). Using our example, one barrier to the de-stigmatisation affordance can be removed by explicitly telling Leg Club members that they can be treated in a private area and arranging some tables away from the view of collective treatment for members who might not want to look at wounds. With regards to choosing to run Leg Clubs formally to create valued social roles firmly for volunteers versus informally to spread the valued social role creation loosely across members and volunteers, the barriers were not clear cut. The lack of clarity in the data implies emergent dynamics to be resolved by future research.

Applying a relational and realist conception of affordances as emergent at the intersection of people and places to explaining social outcomes in Leg Clubs enabled us to develop a much deeper, nuanced and complex explanation of outcomes than phenomenological analyses, because it shows the influencing importance of the reality that is beyond people's reported lived experience. Our primary contribution was methodological, to show that the evaluations of community care need to take into account not just the lived experiences, but also contextual features that variously enable and constrain these experiences, as well as the ways in which they relate to each other to generate various outcome possibilities. We used the Leg Clubs primarily as a concrete case for fleshing out our argument about the value of critical realist and relational affordance theory, while capitalising on the novelty of Leg Clubs as sites of social

science research. Therefore, inadvertently, we made a secondary empirical contribution to the study of community care, expanding our knowledge of the Leg Clubs with use of a mid-level theory of affordance.

Limitations

Given the ability of the affordance theory to reveal the breadth of people's practices around materialities the temptation is to think that everything can be explained as opportunities and constraints emerging from people living in, using, thinking of and criticising their places, spaces and objects in their environment. However, as Oliver (2005, 402) reminds us, the theory of affordance originated from 'relatively primitive claims ... made at the level of species about animal-object relationships'. The theory of affordances applied to data on the social outcomes of community care interventions, although explanatory when applied to the potential of physical materialities, will not tell us much about the impact of Leg Clubs on immaterial discursive struggles faced by people with wounds in relation to wound stigma (Grogan 2019; Mechen 2019) and ageism (Lindsay 2020).

Further limitations of this study are empirical. Firstly, the novelty of the Leg Clubs as a site of social science research and the vulnerability of the members meant that we needed to accept that we would not be able to interview them in a standard fashion. Although we had aimed to include the nurses' perspectives in our evaluation, in the field we realised that the nurses were working with a high degree of intensity in the Leg Club before returning to the surgery or continuing with home visits. As a result, they were unable to participate in our service evaluation, despite showing interest in the work. For example, as documented elsewhere, they were unable to step away from direct member care even for a moment to speak to the researcher (Sheard and Peacock 2019). For this reason, we limited our interaction with the nurses during the evaluation to very short, informal exchanges. Future research could compare the medical

value of the ‘well leg’ programme against a community-based wound care where no ‘well leg’ care is provided.

Declaration of interest statement

[to be inserted near here]

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Table 1. Retroductive steps in discerning mechanisms, contexts and affordances in the generation of social outcomes in Leg Clubs

Description of outcomes	Outcome 1 (O ₁): self-fulfilment and purpose in late life Outcome 2 (O ₂): reduction in wound stigma
Identification of key entities	Mechanism 1 (M ₁): continued societal functioning Context 1 (C ₁): self-funded community clubs organised and run by members and volunteers Mechanism 2 (M ₂): sharing in the wounds inconvenience Context 2 (C ₂): open set-up: coexistence of medical and social spaces in a single venue
Theoretical re-description	Leg Club philosophy: members treated collectively, Leg Clubs organised and run by volunteers,
Candidate affordances	Places and personalities
Contextual sub-mechanisms as affordances: interplay between places and personalities	Sub-mechanism 1a (m _{1a}): formalised volunteers' response to local transport infrastructure Sub-mechanism 1b (m _{1b}): informal organisation and pride in local landmarks Sub-mechanism 2a (m _{2a}): education through no semi-fixed partition between clinical and social spaces Sub-mechanism 2b (m _{2b}): inclusion through semi-fixed partition between clinical and social spaces