

The Monitor



Devon Doctors

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Issue 18

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Why every little helps

by Chris Wright, chief executive

I'm sorry to start a newsletter with a depressing monologue about money, or rather the lack of it. It's important to let everyone who works for us, and everyone from general practice who supports us, know about our position in these difficult times and how we're meeting the challenges.

Whilst we're due to finish 2010-11 with a balanced budget, we're entering 2011-12 with a projected deficit for the year ahead of about £½ million.

We're in this position because of four main factors:

1. An agreed reduction in our out-of-hours contract of £500,000. This four per cent efficiency saving is in line with the rest of the local NHS.
2. A reduced financial contribution after losing some major non out-of-hours contracts in Plymouth, Somerset and Halton.
3. Our out-of-hours block contract which isn't based on activity (unlike the rest of the NHS) and hasn't been increased in line with inflation or extra workload.
4. A one-off cost to Devon Doctors of funding out-of-hours cover for the royal wedding on Friday 29th April.

Protecting our reserve fund

A £½ million deficit could potentially eat up our entire contingency reserve (built up over ten years) in just one year. This isn't something that the Board or I will allow to happen.

I'm not writing to complain or moan about the above as the rest of the



*Balancing the books:
Devon Doctors must find
ways to maintain its high
quality service despite
economic challenges*

NHS is currently having to make difficult decisions.

It's just a fact that as a private company we have to balance our books and this means we have to do something about a projected overspend.

The Board met recently to discuss this and concluded that in future:

>> We can't afford to put on extra sessions each week over and above the Primary Care Trusts' (PCTs) contractual specifications.

We're carrying about £250,000 of extra shifts in 2011-12.

If the PCTs won't fund them we will need to stop them. I will be talking with GPs affected in the weeks ahead.

>> We can't afford to put on extra sessions each bank holiday over and above the existing specification.

(Last year we put on around £200,000 in shift extensions or short notice extra shifts at busy times).

I've long argued with the PCTs that the existing bank holiday specification is insufficient to cover

demand. Our shared experience over the Christmas and New Year bank holiday has focused the PCTs on this fact.

I'm working with our commissioners to try to get them to increase the number of GPs that they fund us to provide, especially during winter and spring four-day bank holiday weekends.

I'm also happy to work with the PCTs if they choose to ask practices to open at key points over the bank holiday.

I believe that the PCTs do understand that our performance standards will drop if we have insufficient out-of-hours clinical time to meet expected demand.

This will have an impact on EDs, MIUs, ambulance activations and local practices.

So this is an important area for the PCTs to do something. Any support that individual GPs can give us in helping their respective PCTs/GP commissioners do something constructive must surely be good.

>> We have to implement a variety of other cost-saving measures to balance our books.

We've put a recruitment freeze on all new admin and management vacancies, and we're assertively seeking savings with suppliers.

We will continue to pay overtime for shifts worked by GPs but only in blocks of half hours.

However, we will honour our existing two year pay agreement with UNISON, and continue with existing plans to provide training and support for our operational front line services.

I will keep you up-to-date with any progress in next month's issue. As always, please email me if you have any questions, comments or suggestions about what I've outlined above.

chris.wright1@nhs.net

GP practices: please help us by...

Putting your patient's current location on their lab sample

Please label samples for the path lab with the patient's *current* location / demographics.

We've had more incidents where duty doctors have been unable to contact patients about their results because they weren't at their normal home address (they've been staying with a relative or a at nursing home).

This has caused concern for their welfare and the police have been called out to try to gain entry to the patient's home. Understandably we're keen to avoid this waste of resources and police time.

Using special patient messages to highlight allergies

Please provide special patient messages regarding allergies that could cause particular harm such as anaphylactic shock.

Providing special patient messages for palliative care / end of life patients

We don't want to cause distress by sending service questionnaires to patients where it would be inappropriate or insensitive.

One of the Department of Health's requirements is that we survey patients on the service they receive.

This isn't just a tick box exercise – the information we receive from these surveys is an invaluable source of data which the management team reviews in order to look at service improvements.

We appreciate that in certain circumstances it's inappropriate or insensitive for a patient to receive a questionnaire.

We exclude any patients from the mailing list who have calls with:

- a special patient message
- 'Death' as the outcome message
- An age of 12-15, or over 80
- MIU/Ward/WIC/A&E/Surgery priority



Q&A with... Dawn Hookins, driver

Which treatment centres do you work from?

I work mainly in Torquay but also Totnes and Newton Abbot. My contracted shifts are for driving but I also get roped in for the odd OA shift.

What do you enjoy about out-of-hours work?

I've worked for Devon Doctors for five years now and have watched it grow into the empire it is today.

It is always great to hear the public say what a great service we provide and I'm proud to be a part of it.

What do you find challenging?

Although the role can be very challenging at times (especially Christmas), I can honestly say I've never dreaded coming into work as

you never know what you will encounter on a shift.

Any stories you can share with us?

One of my funniest, fondest memories is where I had to drive up a very narrow farm track and the doctor (you know who you are!) had to go ahead of me and chase chickens out of the way, while the owner was panicking and saying: "Don't run them over!"

I would like to take this opportunity to thank the doctors I work with for being patient with me as they know I have a problem with my left and right!



HOW TO deal with frequent callers



Sometimes a caller is going through a period of crisis which means that they're continually ringing the out-of-hours service. They're not abusive but the service has done all it can and the number of calls they're making are putting other callers at risk by tying up phone lines.

Call operators:

- Log the call as normal.
- Pass the call to a clinician for triage – ideally the same clinician for continuity of care.
- Take into account any special patient messages (SPMs).
- Inform the duty shift manager of the situation and follow their instructions.

Clinicians:

If a caller continues to ring, you can do no more and feel that further calls should not be accepted you should:

- Agree a statement with the shift manager that call operators should give the caller.*
- Consider entering a temporary SPM to hold the situation until the next working day.

Duty shift managers:

- If you're aware of a patient causing undue demand on the service, discuss a statement / strategy with the clinician.
- Ensure that information about this caller is handed over to the next shift.
- Ensure that all call operators on duty are aware of the situation, what to say, and not to enter into unnecessary dialogue with the caller (they can hang up once the agreed statement has been delivered).
- Make a log book entry regarding the need for an SPM - to be followed up with the patient's practice the next working day.

***Example of a statement:** "Is there a deterioration in your condition?" ("No")

"As this is the case, and the clinician has spoken to you and given all the assistance they can for the condition you've reported, this call will be terminated."

Full-time nurse practitioner joins our Torbay team

by Jane Moxon, urgent care lead manager

We're delighted to welcome nurse practitioner Linda Hulbert to our Torbay team in March. Linda will work from our Torquay and Paignton treatment centres. We have a great team of nurse practitioners in Torbay who work independently alongside the GPs. Our aim is to enhance their existing skills and provide consistency of skills within the rota.

New rota

We have a new rota in place that will provide the following nurse practitioner cover:

Tuesday evening (TC):	6pm - 11pm
Alternate Friday evening (TC):	6pm - 11pm
Saturday Paignton:	9am - 1pm
Saturday Torquay:	2pm - 8pm
Sunday Paignton:	9am - 1pm

The nurse practitioner will work alongside the mobile GP during the Tuesday and alternate Friday weekday evening shifts.

If the nurse practitioner needs GP/medical support, they will be able to contact the mobile GP in the car (if out), seek A&E advice

or offer patients an alternative treatment centre e.g. Newton Abbot or Totnes.

The weekend shifts will continue to enhance existing GP cover which remains unchanged.

The new rota means additional support on the Saturday evenings in Torquay, with the nurse practitioner continuing their shift until 8pm.

Linda's rota will include some EDGP (formerly Bay Health Centre '8-8') sessions, helping to fill and strengthen this rota with clinical time. She will also be supporting the governance team with its clinical audit targets.

Discussed

The new nurse practitioner rota has been discussed with those currently involved and is being seen as a positive step forward in developing the multi-disciplinary skilled team required for all urgent care settings.

Linda's first week with us will be an induction. During the rest of March she will be working supernumerary to those already

allocated out-of-hours and EDGP sessions.

This will enable us and Linda to review and evaluate any aspects of the new rota, before the full rota starts on 4th April.

Although Linda has rotated shifts, the nurse practitioner team will continue to provide cover to establish the team's consistency for the periods agreed.

A working model

It's always Devon Doctors' style to review and tweak if something does not work first time.

What is *not* happening is a reduction in total clinical cover across Torbay, and the change is not about cost-saving.

One other positive point to consider is that it makes the rota stronger – not forgetting the difficulties we experienced last summer. We would like everyone to feel able to comment on this change in skill mix. We hope that nurse practitioners will all feel supported in their roles across Torbay.

jane.moxon@nhs.net

Clinical focus

>> More on Fentanyl patches

In last month's *Monitor* I discussed the use of Fentanyl patches. It's since become apparent that there some different opinions on this topic. I've discussed this with Tim Harlow, consultant in palliative medicine, at Hospiscare.

Tim advises: "For patients who need a strong opiate for background analgesia and cannot manage the oral route, or are in renal failure, Fentanyl patches can be a good, but more expensive, alternative to morphine.

"They are no good for acute pain as they take too long to equilibrate. Because they act and withdraw slowly there can be problems switching to a syringe driver. This is illustrated by two situations.

"1. Near end-of-life, starting a syringe driver and extra analgesia needed additional to a Fentanyl patch already in place: keep patch on, change every 72 hours as usual, add extra analgesia in driver as needed. Remember if prescribing breakthrough doses of analgesia to allow for total opiate (patch and syringe driver) dose.

"2. Where you want to switch from Fentanyl

with Dr Chris Bastin, medical director

patch to syringe driver completely and stop fentanyl because it seems to be disagreeing or causing rash etc.

"Here we suggest taking off the patch and starting driver at once. The long duration of action of Fentanyl patches will always mean that a switch from them to another background opiate means a bit of instability in analgesia."

>> Invasive group A strep infections

The Peninsula Child Death Overview Panel (CDOP) would like to bring invasive group A strep infections to the attention of all doctors working with children.

A letter with more details from consultant paediatrician Dr Charles Holme is available on the intranet (medicines management >infection).

A few issues have been causing the governance team some headaches:

>> Accurate visit times on Aadastra

Please be accurate when inputting face-to-face consultation times. It's especially a problem for visit consultations.

Responding to complaints and incidents can be difficult without this factual information



Patients don't always offer volunteer information during consultations – they assume the out-of-hours service can access their records

and leaves all involved vulnerable.

>> Asking about allergies

Many patients assume that the out-of-hours service has direct access to their GP practice notes.

They don't always volunteer information about things that they expect us to know, such as allergies to penicillin. We must remember this when obtaining medical history.

It's greatly appreciated when colleagues in daytime practice provide this information via special patient messages.

christopher.bastin@nhs.net

Derriford to host all of our Plymouth operations

by Jane Moxon, urgent care lead manager

All of Devon Doctors' Plymouth-based operations will be located with our existing treatment centre in Derriford Hospital.

As staff are aware, this means moving our current operations at Mount Gould Hospital to join with our Derriford team.

We agreed with NHS Plymouth that this would be sensible following the end of the Plymouth GP Health Centre contract in Mount Gould Hospital.

NHS Plymouth will assist in re-directing walk-in patients who may continue to arrive at Mount Gould Hospital not realizing the service has finished.

It's anticipated that the move to Derriford treatment centre will happen by the start of March 2011. We're just waiting for some IT and telephony work to be completed so

that additional consultation areas can be provided for all of the clinicians.

The move will result in Derriford treatment centre having two operational administrators on duty at our busiest times.

This will help with monitoring and managing base demand, as well as keeping patients informed of potential waiting times.

Contingency resource

The Plymouth half day study days (protected learning) will continue to operate from the Mount Gould Practice, as there's no space available at Derriford Hospital during in-hours periods.

This means that all IT and telephony will remain at Mount Gould and we can use it in the event of ever having to evacuate our Derriford treatment centre.

Devon Doctors' Mount Gould treatment centre will be moving over to Derriford Hospital

The date of the move will be communicated to all staff and clinicians as soon as it's confirmed.

Please email me if you have any issues that you would like to discuss in more detail.



jane.moxon@nhs.net



Why information must be HORUS!

The IG man is back: in his second instalment **Information manager Martin Shaw** explains how a funny acronym can help you protect sensitive information

I've heard the comment "security gone mad" a lot lately.

There are many strands to information governance. They can all feel restrictive if the only reason you ever hear about them is to stop you doing things or to make things more difficult.

As with all rules though, people generally think like that because they don't fully understand them.

HORUS!

The one thing to remember when considering information governance is HORUS. It is probably the ugliest acronym I've ever heard (I was once lectured on the merits of TLAs – three letter acronyms – and how everything important is given an acronym), but hopefully that will help you remember it.



HORUS means that information must be:

- H**eld securely and confidentially
- O**btained fairly and efficiently
- R**ecorded accurately and reliably
- U**sed effectively and ethically
- S**hared appropriately and lawfully

Devon Doctors and its subsidiaries exist to provide high quality health care to local communities.

Part of doing this well involves recording information about patients and storing it securely.

Your responsibility

It's important to remember this every time you access or share information while on duty.

If you access or share patient information for any reason other than to provide health care to the patient, you're probably breaching the Data Protection Act (DPA).

(There are exceptions, especially within our administrative functions. For example, dealing with complaints, prescription charging, and reconciling patient records.)

This means that you're not allowed to look

up that interesting case from earlier to find out what happened, discuss the patient who phoned in earlier with interesting symptoms, or share details about a patient, *without their consent*.

It also means that you must record all relevant information fully and accurately.

This is not an exhaustive list but hopefully you get the idea!

It affects information about you

There are many reasons for this, but it ultimately comes down to safeguarding patient privacy and the confidentiality of their information.

I realise that I've focussed on patients, but our organisation also holds information about staff and contractors so the same rules apply to information we hold about you.

While complying with all of this may seem like a pain sometimes, it ensures that information is treated confidentially, is accurate, and available when needed.

Please check out my page on the intranet (governance > information governance) for more information on this topic.

martin.shaw3@nhs.net

Completing CD registers

Pharmaceutical adviser **Karen Button** explains how to complete this important paperwork

Many of the treatment centres have received new controlled drug (CD) registers for the main CD cupboard and the car box. If not, they're on their way.

The registers are new but the requirement to complete them in this format is not. It's a legal requirement that certain information is recorded when a CD is obtained or administered under the Misuse of Drugs Act.

We're finding that the new registers are being completed incorrectly. In some cases I've had to complete the register entries retrospectively, which isn't ideal for me and certainly not for the clinician on duty for that shift.

There are 'how to' guides accompanying the new registers and I do recommend that you read them, concentrating on the procedures on the **first page** and then only using the more detailed guidance on the second page if you need to.

If you keep the following in mind you won't go far wrong:

➤ Left-hand side is for CDs in, right-hand side is for CDs out. Straightforward for the mobile boxes, slightly more tricky for the main CD cupboard stock as the stock out section starts on the fourth column of the left hand page.

➤ Anyone should, if necessary, be able to trace every ampoule or tablet received by the treatment centre, transferred to the car box and administered by clinicians working at the treatment centre or when out and about.

➤ To be able to do this, the CD's journey through the cupboard and box to the

patient needs to be clear from the entries in the registers. E.g...

- If CDs have been removed from the main CD cupboard to restock the car box; there should be two entries, one in the main CD register as stock out and the other in the car box register as stock in.
- If out-of-date stock in the car box is returned to the main cupboard then, again there should be two entries, one in the car register as stock out and one entry in the main CD register as stock back in, even though this stock is then kept to one side to await the correct destruction i.e. to be witnessed by the PCT. Batch numbers must be recorded.

➤ An entry relating to a transfer of stock may be completed by an OA or driver if they feel confident to do so or, if not, they must prompt the clinician to make an entry. However, the clinician must always print their name and countersign the entry.

➤ An entry relating to administration to a patient must be made and signed by the clinician, an OA or driver must prompt the clinician if an entry has not been made.

➤ The patient's name and address must be added; just the call number is not acceptable.

This system is really not much different in principle from the old one but, as always seems to be the case, more information has to be recorded.

Training is being provided for OA and drivers through staff meetings.

Surprise delivery for Dr Riley

Clinicians and staff never know what to expect when they work out-of-hours. This was certainly the case for Dr Genevieve Riley earlier this month. We asked her to share what happened...

"From the information I could gather during the initial triage call, a patient appeared to be presenting as a miscarriage of ten weeks gestation. However her young age, and an uneasy feeling, spurred me into asking her to attend the treatment centre for review.

"I was just about to see her when Julie [Rickinson, operational administrator] came into my room and asked me to go to the ladies' toilet.

"Upon arrival I immediately noted the patient to be in labour. Her contractions were less than two minutes apart, and she had a uterine size of about 26 weeks gestation. I asked for help, and grabbed some gloves and paper towels.

"I thought the most sensible plan was to transfer the patient to A&E. Julie went for a wheelchair, but when she came back, the patient said she couldn't move. Julie went back to A&E to bring help to us.

"The baby shot out"

"Meanwhile, I remember trying to get the patient in a comfy position for birth, whilst being confined to a toilet cubicle. I remember breathing with the patient. Suddenly she had a big contraction and simultaneously sank down onto the toilet-seat. The baby shot out into the toilet pan. It moved and I immediately picked it up from its 'water-birth'.

"It gasped/cried and opened its left eye briefly as if to say "hello world", but it was blue and premature, and had an obvious abdominal wall defect with intestines exposed.

"Then, summoned by Julie, a crew of paramedics arrived with a blanket. I cut the cord, and we rushed the baby to A&E, followed shortly by a shocked, but happy, new mum.

"The baby, a boy of 32 weeks gestation, was later transferred to the neonatal unit, reportedly breathing spontaneously and without the need for intubation.

"The latest news I received was that mum and baby were doing well. The baby is on CPAP (continuous positive airway pressure) and recovering well from his abdominal surgery, and mum is adapting to life with a new baby.

"Having reflected on the events of that shift, I have to say, I'm grateful to have received medical training of such a standard that I was equipped to deal with a rapidly changing and evolving clinical scenario."

Caller confusion re 0845 / 0843

The governance team has had some patient feedback about phone access to the out-of-hours service. Patients said that after ringing our 0845 patient line they were informed it had changed to an 0843 number. When they dialled this new number they were kept in a loop, being told that they were in a queue and would be connected soon.

We investigated this and it appears that callers initially misdialled to a non-existent number which was intercepted with the message to ring the 0843 number. While this is beyond our control we would like to share this as there are reports of similar patient feedback regarding phone access to hospitals and GP practice. Devon Doctors does not have any 0843 numbers to access its out-of-hours service.



Devon Dental news

Complying with the CQC

What does the Care Quality Commission do and why is it causing us so much work? Damien Mills explains

The Care Quality Commission (CQC) regulates all health and adult social care services in England. This includes the out-of-hours and prison dentistry provided by Devon Dental.

All regulated dental care providers must be registered with the CQC from April to show they're meeting essential, common quality standards. Providers will not be allowed to operate without registration.

As part of the registration process we must evidence our compliance with each of the 16 outcomes across five different areas:

1. Involvement and information
2. Personalised care, treatment and support
3. Safeguarding and safety
4. Suitability of staffing
5. Quality and management

If we're unable to do so we must declare ourselves non-compliant and devise an action plan to remedy the situation.

We have declared ourselves compliant with all but three of the outcomes – one of which (meeting nutritional needs) the CQC has agreed is not applicable to the services we provide.

We're working towards becoming compliant with outcome 10 (safety and suitability of premises) and outcome 16 (assessing and

monitoring quality of service provision) as soon as possible.

Premises present us with a number of complications, mainly because we don't own the spaces we operate from. However we've now commissioned risk assessments at each of our premises. The results should leave us well placed to rectify any resulting concerns.

"This is the first time the CQC has regulated dentistry"

We've also reviewed our questionnaires to ensure they meet the CQC's demands for assessing and monitoring service quality.

The dental team has been working hard to collate the evidence it needs to satisfy the CQC of its compliance with the remaining 13 outcomes.

It's a huge and laborious task, especially because this is the first time the CQC has regulated dentistry.

No-one (including the internal audit team who have been assisting us with this process) knows at this stage exactly what it will be looking for.

We do know that the CQC can take action if we fail to meet these essential quality standards or if it has reason to believe that people's basic rights or safety are at risk.



Devon Dental is asking for the support of staff, dentists and dental nurses to ensure it complies with the CQC's quality standards

It has a wide range of enforcement powers, such as fines and public warnings. It can also apply specific conditions in response to serious risks. For example, it can demand that a dental practice is closed or suspended until the provider meets safety requirements.

It's imperative that we do everything we can to ensure we can evidence our compliance. There are areas where it will be near impossible for us to do this without the support and co-operation of departments which are responsible for what's being done in certain areas.

We're also dependent on the support of everyone working within our services: dentists, dental nurses and receptionists.

We'll be holding a series of staff meetings over the next few weeks to help everyone fully understand the CQC's expectations and what we must do.

Plymouth GP Health Centre: "staff worked so well together"

The Plymouth GP Health Centre at Mount Gould (more commonly known as the 'Plymouth 8 to 8') will close its doors on Monday 28th February following the completion of its contract. All staff involved have been redeployed.

Devon Health director Lee Grant said: "I would like to thank all the staff at both the centre itself and the out-of-hours staff who have worked so well together over the last two years. The centre saw around 19,000 walk-in patients who were incredibly supportive of

such a convenient service.

"The centre also hosted an innovative outreach service working in the community with the city's homeless population. I'm delighted that the PCT has decided to continue with such a valuable service once the centre has closed."



Lee Grant



GP vacancy Exmoor Medical Centre, Dulverton

**24 weeks per year associate GP to cover holidays,
Exmoor Medical Centre, Dulverton. £50,000 per annum**

WE: 3 partner, 4,000 patient practice, Exmoor National Park.

YOU: Capable, unflappable GP, comfortable with working independently. You would like an excellent base level of income in return for covering holidays for us (predominantly during school holidays for the moment).

Find out about us at www.exmoormedicalcentre.co.uk
Contact Dr David Berger by email (daveberger@gmail.com) or by phone Mon, Wed, Fri (01398 323333). A full candidate brief is available to download on our website. Login via the staff login:
Username: Associate GP Password: JOBAD123

Annette's charity challenge

Tesco's in Newton Abbot will be the place to be on Tuesday 12th April when head of governance Annette Hammett takes on a rowing challenge for charity.

Annette has bravely agreed to complete four 15 minute sessions in public to raise money for Get Kids Going. The charity raises money to fund sports equipment, such as specialist sports wheelchairs for disabled youngsters.

Sponsorship is by the mile and Annette expects to complete around four to five miles. Her personal best distance to date is 1.8 miles (3,000 metres) in 17 minutes.

She explains: "I'm doing this as part of the 'new Annette' campaign following my bariatric surgery, with the support of personal trainer Jason Searle of Full Tilt Fitness. If anyone would like to sponsor me or give a fixed sum donation please email me (annette.hammett@nhs.net). If people are willing to Gift Aid their money this will also increase the final sum."

Find out more about Get Kids Going at www.getkidsgoing.com

Keep the sea on the right

Dr Kathryn Shore shares her experience of walking the South West coast path

At the age of fourteen, thirty five years ago and on my first youth hostelling holiday, I saw the start of the South West Coast Path. Almost immediately I decided that, impossibly long as it seemed, one day I would walk along all 630 miles of it.

In addition, there is 115000 feet of climbing – just a little short of walking the height of Mount Everest from sea level four times!

I finally achieved that ambition with 39 days walking starting on 26 October 2010. Other commitments and the Lulworth range firing restrictions stood in the way of walking every day so I finally reached South Haven Point on Sunday 12th December.

As I walked away from my husband's car at Minehead on a dull rainy October morning he reminded me to keep the sea on my right to avoid getting lost.

Little did I realise the adventures awaiting me: gales near Lands' End that literally knocked me over a couple of times, major flooding in Cornwall and passing through Mevagissey and Pentewan during filming of David Cameron's visit, and walking through snow for two days from Beer to Weymouth. In addition to walking the South West Coast Path route, I walked round estuaries at Helford, Percuil, Yealm, Avon, Teign and Exe where there were no ferries.

This added about 50 extra miles to my walk. I was fortunate to reach the Erme at low tide and receive some local route advice from a

dog walker.

Not wanting to get my boots or clothes wet, I carefully stowed boots, socks and trousers away and proceeded gingerly with bare feet and legs.

My feet have never been so cold but crossing to avoid an eight mile detour felt a real achievement.

I'm not sure whether completion was a low or a high point – overall I enjoyed my solitary but not lonely walk so much that I walked slowly along Studland beach not wanting it to end – magnificent scenery which kept changing; unpredictable and challenging weather conditions; the friendly folk I met each day on the path and at the end of each day at the B&B and the pubs.

However, there was certainly a sense of tremendous achievement as I stood by the marker having my photograph taken.

