INTERVIEW

Sir Bernard Tomlinson

In conversation with Alan Kerr

Professor Sir Bernard Tomlinson was born in 1920. He was educated at The Brunts School, Mansfield and University College Hospital. In 1949 he was appointed as Deputy Director of the Department of Pathology at the General Hospital, Newcastle upon Tyne. In 1972 he became Consultant Neuropathologist at that hospital and Honorary Professor of Pathology at the University of Newcastle upon Tyne. He has been president of the British Neuropathological Society and was the first Chairman of the World Neurological Association's Research Group on Dementia. In 1982 he was appointed Chairman of Northern Regional Health Authority and in 1985 first Chairman of the Joint Planning Advisory Committee (JPAC), Department of Health. In 1990 he was nominated by the Privy Council to be a member of Council of the Royal Pharmaceutical Society. During 1991 and 1992 he was leader of the Inquiry into London's Health Services, Medical Education and Research. Sir Bernard was appointed Commander of the British Empire in 1982 and knighted in 1988. Alan Kerr interviewed Sir Bernard Tomlinson in Newcastle in October 1994.

You were brought up in Nottinghamshire?

Yes, a small town called Huthwaite. I went to the local grammar school, which was at Mansfield, where I also met my wife.

Were there influences within the family which decided you on a medical career?

No, I was the first. My older brother became a doctor after World War II and my twin sisters went into nursing but there had been no medical members in the family before us. My headmaster determined the medical school I went to. My applications to medical school were delayed through illness, and in the autumn he telephoned various schools and fixed up an interview for me with the Dean of Medicine at University College Hospital. This was an unpleasant experience which began with being taken to task for being a late applicant but ended up with being offered a place on condition I started that afternoon. I accepted but, on reaching the Anatomy Dissecting Room without a white coat, was excused and so decided to go to a lecture to fulfil his requirement of starting that day. I spent the remainder of the day buying overnight necessities and finding digs.

Do you recall the period at UCH with affection?

Not really. This was partly because of disruption caused by the War which involved evacuation to Cardiff for part of the time and the need to work outside London, in Watford, for other periods.

After qualifying in 1943, you did a surgical job and were offered a post as trainee pathologist at the Department of Health.

Yes. As a student I had recorded my interest to train in pathology after the War. But what was

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on offer initially in 1943 was in microbiology, which was not what I wanted. I made this clear at the interview and soon after was offered a post in clinical pathology at the Westminster-Charing Cross Sector Laboratory in Ashford, Middlesex. Here, I came under the influence of Gordon Signy, who not only set the highest standards but was a very stimulating teacher.

At that time, to make a career in pathology, acquiring the MRCP was a necessary step. Richard Pratt, who later worked at Queen Square as a neurologist and psychiatrist, was a resident in medicine at the hospital, and agreed to teach me in the evenings on cases I had seen on the wards. After a year of this, I passed the written papers and clinicals and then appeared at the final viva before a panel of around 12 examiners. Having commented on my lack of clinical experience, the questions were all on academic topics. If they had been clinical or practical, such as how to manage an acute pneumothorax, I should have been sunk.

Later you were in the Army as a specialist pathologist with the rank of Major.

Yes. Professionally this was marking time and I was keen to start working in what was to become the National Health Service. I might add that I had previously joined the Socialist Medical Association and, with Gordon Signy and Donald Court, had taken part in electioneering during the 1945 election with the specific aim of supporting the establishment of the NHS.

You moved to Newcastle General Hospital as Deputy Director of the Department of Pathology in 1949. How did that come about?

I had applied for two other posts, both in the south; to one I was not appointed, and the other I withdrew from after a discussion with the Senior Pathologist. I obtained the post in Newcastle and was initially the only medically trained pathologist in the department.

At this time panels appointed by the Regional Health Boards were determining individual gradings of hospital doctors. My post was that of Deputy Director (specialist pathologist) but to my dismay, I was graded a senior registrar rather than consultant. I appealed, unsuccessfully, and then contacted the local Member of Parliament. This led to a furore and an interview with Sir James Spence (Professor of Paediatrics at Newcastle) who advised me not to pursue the matter further. One criterion for grading as consultant was a minimum of eight years post graduation experience, and I had had only six and half years. I was advised to be patient and to apply for a further consultant post which would be advertised within months. That is what happened. I became Director of the Department (in 1955) which then had four consultants and junior staff.

It was as a neuropathologist working with Martin Roth and Garry Blessed that your name first became known among psychiatrists. You developed quantitative measures of a wide range of indices of cerebral pathology which could be related to assessments of cognitive function near to death. How did this research come about?

This was started by Martin asking me to go and talk to him. He said the possibility existed of a correlation between the histological changes in the brains of demented subjects and the degree of clinical abnormality. It immediately appealed to me because I was interested in quantitative changes and indeed I was, at that stage, three-quarters of the way to completing an MD thesis on the changes in the brain, many of which I attempted to measure, that follow subarachnoid haemorrhage.

In the dementia research we initially looked at cellular changes in the hippocampus and quantified plaque and tangle formation in the cortex, and quantified the amount of infarction throughout the brain. Although the commentary on that work has largely been in relation to the changes of Alzheimer's disease, it was a much more extensive study than that and resulted in the conclusion that a good many cases were a combination of infarction and Alzheimer's disease. We also examined in considerable detail the brain changes which can be found in people who were regarded as intellectually normal in old age, and so set some baselines which had not been previously available.

Throughout these investigations the clinical examinations were meticulously carried out by Garry Blessed and protocols strictly adhered to. I went to the States and elsewhere a number of times to talk about the studies and was struck by the cavalier fashion with which dementia and normality in old age were often judged. People would take cases from a nursing home where the notes were desperately scanty and the clinical state

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poorly documented. Differences in methodology were clearly a difficulty in this field at that time, and may still be.

You also became involved in medical administration.

I thought there were interesting things that could be done in medical administration that would help the hospital service run better than it did. Hospital staffs were always looking for somebody who would do this sort of thing on their behalf. I had been on the Management Committee for some time and I took on the job of the first Chairman of the Joint Medical Staff Committee of the Royal Victoria Infirmary and Newcastle General Hospital, and it turned out to be very difficult, probably more difficult than the London inquiry or JPAC (Joint Planning Advisory Committee; see below).

Why was that?

There was such mistrust between the staffs of the hospitals. Nowadays you would call it competitiveness, but it really was a feeling on each side in a number of departments that they didn't want to work with the people at the other end.

You were elected as an honest broker?

I would like to think I was. I had a foot in each camp and I didn't have strong feelings about either side. I thought it made sense that the two hospitals should work together. The idea that a teaching hospital (The Royal Victoria Infirmary) could negotiate directly with the Department of Health and ignore what a regional health authority was attempting to do in terms of development of hospital services was nonsense! My role was to help find a mechanism whereby the two staffs would start to talk together on equal terms about the problems that existed within the hospital service.

You met Richard Crossman (Minister of the DHSS) over the planning of a third (to be Freeman Hospital) General Hospital in Newcastle.

Yes. The regional health authority was planning Freeman Hospital, and the staff at the General thought a third hospital was unnecessary. Three of us, representing the staff, decided, when region was obviously not prepared to change its mind, to go over its head to the Secretary of State. To his credit, and to our astonishment, he took it seriously.

But he decided in favour of the regional recommendation.

Yes, but his reason was curious. He said he thought there was merit in the arguments that we put forward (they related to the difficulties of three separate hospitals, the triplication of departments, the problems of staffing and expense, and so on) but that the scheme had gone too far to be cancelled. It probably had, because the land on which Freeman was built, was, I believe, compulsorily purchased and it would have been difficult to retract. In retrospect it might have been worth it, since we are currently going through the trauma of closing the General.

You were appointed Chairman of the Northern Regional Health Authority in 1982.

Yes. I thought it was astonishing in view of our gross breach of etiquette in going over region's head. That I could be offered the job after such behaviour, I find comforting. I'm sure all these things are recorded in our dossiers in the department. But I was still greatly surprised to be offered the job of Regional Chairman.

How did that come about?

I don't know really but I do know some of the things that happened. The first was that I was telephoned by, I think, the Chairman of the Northern Conservative Party who asked if I would be prepared to have my name go forward. When he and the secretary came to talk to me I said, "first of all, something you must know, I am not a Conservative and have never been a Conservative." To my surprise they said that didn't matter. And when I was interviewed by the Minister of Health, I started the conversation in exactly the same way since I thought it needed to be made plain. He said, "it doesn't matter to me, and I think there is virtue in having people who are not active Conservatives as Health Authority Chairmen, particularly in a region where we are so weak as a party." I thought that was a very encouraging thing to hear.

What was your opinion of the initial Griffiths Report?

My reaction to the change was that it was a very different structure that was going to

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result, that an enormous change was being brought in to achieve something (essentially greater efficiency) that might be achieved by less dramatic and revolutionary means.

Griffiths had been appalled to find that there were no managers in the NHS, only administrators, and precious little management information, particularly on costs. The proposals that there had to be managers with the capability of managing would put the organisation largely into the hands of lay people. Ministers said they wanted as many managers as possible to come from medical staff. They were told by regional chairmen that that was most unlikely and there would be very few of them

Which turned out to be the case.

Indeed. I put forward the notion not long afterwards that if this was to be achieved we had to have a special structure in medical training. Perhaps people could work up to the stage of registrars in medicine and then, if they were committed to management, they should be seconded to take a full university management course.

What do you see as the main achievements over that period, and the main problems in the Northern region?

The main thing I wanted to do when I became Regional Chairman was to see that the facilities available to people in different parts of the region became rather more equal than they were. When you looked at the expenditure in different parts, Newcastle had gobbled up a large amount of it. People had to travel long distances for techniques that had been in for many years and the standard thinking was that if something new wanted to be done or some new specialty had to be developed, then it had to be in Newcastle. That concentration of services in large cities and leading hospitals occurs nationally, and to some extent is inevitable, but it resulted in some places having hospitals in which almost nothing had been done for 30 or 40 years whereas other places had done very well indeed. I did want to see developments elsewhere and we had some success in doing that.

We also tried to help geriatrics and mental health which always got the thin end of any stick. It was almost tradition, if in a general hospital you had a new clinical block, then into it went acute medicine or acute surgery, and into the wards that were vacated by them went geriatrics or an acute psychiatric unit. I had known this over many years, and thought there had been undue dominance of the general acute specialties. I wanted to see the balance altered. To a small extent we were successful. The dominant thinking in the Department was that psychiatry needed few beds and people ought to be eased out into the community. That was never my cup of tea at all. We tried to resist the emptying of psychiatric departments in the Northern region until there were adequate community facilities for their care.

You perhaps don't know but, after Griffiths, regional chairmen were annually reviewed by a Minister, or the Secretary of State. There were usually two or three hours of discussion and questioning and I had one quite stormy session with a Minister who said we were not going fast enough in getting rid of mental health beds. I just had to say – it's not our aim to get rid of the mental health beds, our aim is to provide the best service possible.

Regional health authorities are soon to be abolished. Why do you think this has been decided?

Partly because it's logical. If you're going to rely on trusts which are to be largely removed from the control of the way in which they do their business, then you have lost a good deal of the necessity to have a regional authority. I think it's also cosmetic. The government has been attacked repeatedly for the ever increasing number of managers and removing regions removes a tier of management. They can cut a slice off and publicly make a fuss about it.

Do you have any qualms about the demise of regions?

Oh, enormous, and I have qualms because of the independence of the trusts. That's the main reason now, I think, why the logic is no longer conclusive. We will have a much weakened regional control of services delivered by the hospitals and the absence of a strategic body to look at future developments and their distribution over large tracts of the country. Theoretically, the NHS Executive takes over this role and there will be a peripheral Regional Office, whatever that means, and whatever authority that will have. But the fact is that you begin to disenfranchise the views of people and staff over vast areas of the country. I think strategic thinking and the influence of public opinion will continue to diminish with the growing independence of trusts and the dominance of

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financial circumstances, plus, frankly, the introduction of business methods and in many instances a business ethic instead of a medical one.

At the same time, do you think there is also a trend towards the centralisation of power?

Oh, inevitably. Regions had numerous functions that they had to perform as a result of guidance – silly word – from the Department – they were directives, of course, that you were expected to carry out. But you did have a degree of flexibility in how you did it, and regions could influence the Department over strategic development. Regional chairmen met the Secretary of State every month when they could raise almost anything. I don't know whether it's entirely gone but it's certainly very much weakened because regional chairmen no longer have, and will progressively lose, their detailed knowledge of what goes on in their region. Much else may be lost. Within the Northern region there is a vast amount of information of great historical interest and of much importance in relation to all manner of medical statistics. It will be tragic if collection of such material and its analysis ceases.

Nationally, over the last 30 years there has been an immense decline in the need for acute beds. If you look at the national bed numbers from 1961 to 1991, the decline in beds is almost continuous; at the same time the number of patients treated has gone up almost continuously. The acid test of whether we have had value out of Griffiths and the trusts, and all the rest of it, will be to see, and it will be in retrospect, whether there has been an acceleration in efficiency, counting as efficiency numbers of patients treated per year related to the beds available. You are, of course, not looking at quality here, and increase in day case surgery and other procedures might have a greater effect than increasing hospital efficiency.

You became Chairman of JPAC at its inception. Could you tell us about that period?

JPAC was set up to make more logical the numbers and distribution of training posts in medicine and to align the numbers of trainees with the likely numbers of future consultant jobs. Of course, the numbers of consultant appointments in different specialties would clearly partly depend on the money available.

Did you find being Chairman of JPAC rewarding?

To some extent it was a frustrating job because it took so long to get the baseline information we needed, and then agreement to move things forward. The first difficulty was in knowing exactly what the position was in relation to registrar/senior registrar posts within different specialties because there were large numbers of people in teaching hospitals who didn't have such labels. They were supposed to have been graded but many of them, particularly doing research, or in lecturer or demonstrator jobs, had not fallen into any defined training category. Several people on the committee, when they saw the returns from the teaching hospitals, and I was the same, said "we just know this isn't true." Someone said it was "absolute rubbish, I can name more people in my medical school than are on these lists." So JPAC asked for all the figures to be rechecked. Hospitals and medical schools were told that we knew the first round was inaccurate, please get it right this time because this will be the baseline on which your future establishment will be set.

That should have concentrated the mind.

It did. It revealed around another 600 trainees. Then we tried to produce a method for redistribution. London and some other cities had a greater share of the post-graduate trainees than could be justified on the basis of population and workload. We worked very closely with the Colleges – several College representatives were on JPAC – and every specialty in every College was asked to look at the revised distribution and tell us whether or not they thought it was appropriate. There were instances when the Colleges reported that they felt there was an excess concentration of trainees in a particular place and they would specify places where training was of a very high quality but trainee numbers were inadequate.

JPAC's reports stated the Committee's views on total numbers of trainees, and the specialties in which expansion or reduction should take place. We attempted an analysis of what was needed now and in the future and where the trainees would be best located.

Your recommendations were supported and the funding was made available.

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Yes, there was a lot of support for the increases we recommended, but the reduction of trainees in almost any specialty, and particularly from the Metropolitan Regions was strongly resisted, as you would expect. No-one gives up that sort of privilege easily and I think that went very slowly. Of course, you can't disrupt services by doing things rapidly. Whatever the notion that a registrar/senior-registrar is a trainee, he is nevertheless a very important working member in the majority of units; and sudden changes could wreck rotational training. So you couldn't redistribute people quickly or in large blocks; it had to be done over several years and we worked out a scheme for how many would be lost over a period of time.

In 1991 you chaired the enquiry into London's Health Services, Medical Education and Research. How did that come about?

I frankly don't know how I came to be asked. I had retired as Regional Chairman and I received a telephone call from the Department asking me if I would go and see Mr Waldegrave who was Secretary of State. With some difficulty I learnt that the subject was going to be London. He explained that he wanted a review of London's primary and acute secondary services as well as medical education and research, and consideration of how these would be affected by modern developments and the Health Service reforms; obviously, whatever happens to hospital or primary services has implications for education and research. In retrospect, the changes we recommended were more fundamental than I had originally envisaged but I did realise immediately that the inquiry would be a pretty severe task, particularly as we had to do it within a year.

How did you cope with the opposition to the proposals?

We were concerned with recommending what we felt to be right. I made it clear early on that I was not going to be involved in implementation, so I was back in Newcastle when some of the heaviest opposition was evident. I was not willing to participate in implementation, partly because a year spent mostly in London when you're living in Newcastle isn't the most comfortable thing to do, partly because the time limit was short and increased the intensity of the work, and partly because I thought a new group should look at and argue about our recommendations. We were given a year, there were only four of us, we were given first-class civil service help but it was a very big task.

You met with over a thousand people.

Well over a thousand. I was seized with the need to seek as many opinions as possible. Many facts were available, for instance, the primary care services were greatly hampered by poor premises, and no-one disagreed with that. But over other aspects of the primary and hospital services and medical education there were many opinions about what should or should not be done. In the end the inquiry had to make hard choices. We might hold to a particular view very strongly and be able to back it but it was, nevertheless, an opinion. So I was convinced that if the government was serious and going to do anything about London in a major way then it ought to have an implementation group, part of whose task would be to look with fresh eyes at our recommendations.

What happened?

The Department did set up an Implementation Group. The medical education proposals were accepted generally and quickly by the Department of Education. We said that, with the exception of St George's, the medical schools should be reduced by amalgamation to four and all must be part of one of the multifaculty colleges of the University; they could not be separate entities. It was a matter of opinion but we thought the advantages were self-evident. No isolated school is likely to perform as well as one which is integrated with the University. That was accepted and I think will come about and I understand there has been a lot of common sense applied and not too much fighting over that issue.

What about the improvements in primary care?

The government has put a lot of money into capital developments and into increasing the staff working with general practitioners, practice nurses, health visitors, community psychiatric nurses and so on. Inevitably it's going to take time for these changes to be reflected in results. I recently had a letter of thanks from an FHSA (Family Health Services Authority) chairman saying how different it all

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is now and sending me documentation of the spending of what they had called Tomlinson monies. Another FHSA chairman said more or less the same; they were very grateful and they too are going to send me the documentation of what they have been able to do. So there's no doubt things are happening.

Do you see teaching and research renewing itself in London?

Oh certainly, if the medical schools are integrated into multifaculty colleges and special units are amalgamated into larger and more effective groups. We see teaching and research being better organised and more economic and effective if you use the staff and the facilities of the major University colleges in collaboration with the medical schools. UCH/Middlesex is the only London medical school totally integrated into a world rated multifaculty college where several of the science departments are of very high quality. The combined UCH/Middlesex research scores are the highest in the country, higher than Oxford and Cambridge this last review. I believe, as do many staff at UCH/Middlesex, that much of their research success is dependent on their close association with first-class basic science departments, and that high quality medical research is unlikely to be achieved in any other way in the future.

Why has community care developed so poorly in London?

Many reasons. Our insights into the community situation were greatly helped by having Dr Molly McBride – a London GP, and Pearl Brown, a Community Services Manager, on the Inquiry Group.

The premises from which many general practitioners have had to work have been very inadequate, and improving or purchasing new premises is far more costly than elsewhere. This discourages some GPs from going to London, and indeed, eventually makes some leave who try to establish themselves there. Planning permission for upgrading or extending premises can be a very difficult and lengthy procedure and, of course, living in and bringing up a family in London doesn't appeal to everyone. As a result, the doctors in some practices do not become part of the community they serve but live a good many miles away; in most cases, their links with the hospital services and consultants are not nearly so close or friendly as, for instance, in Newcastle, where consultants and GPs often meet socially. But poor premises (and we have heard complaints about the poor maintenance of health centres as well), are a blight on so many things; providing adequate screening and immunisation services, achieving satisfactory partnerships, building up primary health care teams, taking part in undergraduate teaching or research, or vocational training can all be made impossible. Post-graduate training for GPs is not as well developed as in the provinces and travelling and parking difficulties for meetings discourage attendance. These are just some of the factors.

Community health services have nationally been less well developed, organised and funded than hospital services, and this contrast is probably most extreme in Inner London where the prestigious teaching hospitals have dominated the medical scene for over a century and received the lion's share of finances. Where community and acute hospital services are under the same authority, there is always a tendency for the community to lose out when financial pressures are great; and even when they are not. For that reason we felt that combined acute and community trusts, except in psychiatry, ought not to be permitted, particularly in London where development of community services is so essential; the combined trusts that had been formed, we felt, should be disbanded.

Mental health was specifically mentioned in the report. You forecast that London could do with fewer acute beds and hospitals in general. Did you mean that should apply equally to mental health?

No, we thought the position in psychiatry needed further enquiry, but time made it impossible for us to give a detailed look. What is so evident every time you go to London is that there are large numbers of people on the streets who need help and who are not apparently cared for. We talked to GPs, to psychiatrists and particularly to the Royal College, from where we got many of the facts. One of our number, Michael Bond, is Professor of Psychiatry in Glasgow and he had a number of discussions with people who were familiar with the problems of psychiatry in London.

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Of course there's been this drift of severely mentally ill people to London.

It was a feature that we knew about but were not able to quantify. Visits to the acute hospitals and some recent reports convinced us that insufficient psychiatric beds and community psychiatric facilities were major issues. We were told, for example, that at any one time as many as 80% of patients occupying the beds allocated to psychiatry in the acute hospitals were compulsorily detained. Acute beds could be blocked by psychiatric as well as geriatric patients. There is the revolving door situation when a patient is in with a crisis, goes out after treatment and is quickly back in with another crisis because there are no adequate community facilities. And there have been two reports claiming that up to 10% of a teaching hospital's expenditure in London could be accounted for by emergency admissions of homeless patients, many of whom have severe psychiatric problems.

One recommendation was that efforts should be made to develop fully resourced community mental health teams in the London districts that didn't have them. Have you any information as to whether the money allocated has gone into funding this?

Yes. Most of the money that has been allocated has gone to FHSAs but they have had to produce plans for approval of spending. In the one detailed document I have received, there has been a significant increase in community psychiatric nurses.

Would you recommend others to take on such a taxing task late on in their careers?

When I was asked to do this, I had been retired as Regional Chairman for just over a year and I'd missed it. I was asked to do a job that, when I had listened to the reasons, I thought needed to be done.

But the immediate aftermath of the report was highly unpleasant. There were many personal comments in the London press that were unfair and had nothing to do with the case; we were called vandals, destroyers, government lackeys, etc. So far as I could tell, the majority of comments were made by people who never read the report. They take a bit of swallowing if you're not used to this sort of antagonism. I got numerous telephone calls from the media at all hours of the day, no restrictions, late at night, 6 o'clock in the morning, weekends; Sunday afternoons seemed to be a favourite time, so much so that we went ex-directory three months after the report was published. I have even been stopped in the street in London by people who have recognised me, and been harangued. If you're a politician I suspect you just live with it and it rolls off, but I found it fairly hard to bear. I still think, though, that if I were asked under those circumstances again I would say yes, I will do it.

But the report has led to significant changes.

There was major acceptance of the medical educational changes, acceptance with reservations of the hospital changes and acceptance of the need to tackle primary care in a major way. The educational changes and the primary and community care proposals are being implemented at a speed and with the financial additions to make them possible, in a way I would not have expected. It's gone better than I thought it would.

The hospital changes were clearly going to be extremely difficult and have been made more difficult, though more necessary, by the specialist reviews. We recommended that a number of subjects should be reviewed by specialty groups because we didn't feel we had the knowledge to say more than that there were a lot too many of them, and many were too small for best practice, teaching and research. But the recommendations of some of these specialty groups have made it more difficult to carry out the hospital reorganisation as we suggested, as when the groups have said there should be a major concentration in X hospital and we have said that X is not really in a place which is likely to be able to continue in its present form. Even so, I believe the report, and the deliberations of the Specialty and Implementation Groups, have produced much acceptance that major changes are needed in hospital organisation if patients are to get the best from medical advances. No change, even in the most cherished and entrenched institutions, is not an option, and the 'no change culture' has probably gone for good.

Has the approach of your report been used in looking at the delivery of service in other major cities?

Yes, it has. Since the report was issued I have talked at a number of major places where

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similar reviews are contemplated or taking place.

How did you feel psychiatric and community services should be organised?

We said we did not believe that acute hospital units should be combined with community units in general, but we thought in psychiatry the combination was essential. The case for psychiatry is obvious because they are the same patients coming in and out and they need continuity of care. That isn't the situation in general acute units. What we were afraid of, because there was some evidence in London and I'm sure elsewhere, was that where you have an acute unit combined with the community unit, even if that includes psychiatry, in hard financial times it's the community unit that loses out because people scream when you want to close a bed or delay an operation. It is more difficult for them to see the importance of the development of community services and indeed in London we saw evidence of community units being run down to supplement the finances of the acute unit. So we thought those two cases were separate and I honestly think that what has happened in the last two or three years has justified that view.

How do you keep active now?

I'm a member of the Newcastle City Health Trust. I'm a Steward at Durham Cathedral which is a commitment every fortnight in the summer and every three to four weeks in the winter. And I also have a large garden, and I need to spend more time at home and with my family.

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