

# The scale of repeat prescribing

CONRAD M HARRIS

RICHARD DAJDA

## SUMMARY

**Background.** Repeat prescribing has long been seen as a potential cause of poor clinical care, despite its obvious advantage to both doctors and patients. Previous studies have had no common definition of the term, and have been small in scale, but it is clear that repeat prescribing has increased over the past 25 years with a recent acceleration due to computerization. Managing the process has become more important as the scale has increased. A computer-related standard definition would provide linkage with other information held on the practice computer about the recipients. Using aggregated practice data the current national picture could be ascertained for comparison with that of individual practices. At practice level it will be less important simply to know the scale of repeat prescribing than to make analyses of repeat prescribing of particular drug groups, and of the age and sex groups of the recipients. This could provide a valuable basis for improving clinical care.

**Aim.** To estimate the present scale of repeat prescribing — overall, for specific age–sex groups, and for some specific drug groups; to provide a much needed standard definition of repeat prescribing, now inevitably related to computer procedures; and to show how clinically valuable audits might be simply generated as reports by a practice computer.

**Method.** Repeat prescriptions were defined as those printed by a practice computer from its repeat prescribing program over a period of one year. Prescribing data for a year, with demographic details of the patients involved, were obtained for 115 practices from the IMS MediPlus database. These practices had 750 390 patients and issued 5.82 million prescriptions during the year. Analyses were made of the overall percentages of items and costs due to repeats; the percentage of patients receiving repeats, by age and sex; the percentage receiving repeats, by age and sex, in areas of particular concern; and percentage repeat prescribing in 46 drug groups.

**Results.** No differences were found between fundholding and non-fundholding practices, or between dispensing and non-dispensing practices. The ratio of acute to repeat prescriptions in the practices was stable over four years. Repeats accounted for 75% of all items and 81% of prescribing costs; 48.4% of all patients were receiving a repeat prescription. Many drugs, including hypnotics, were given almost entirely as repeats. The percentage of repeats increased with patients' age, from 36% in the 0–4 year age group to more than 90% for patients aged 85 and over. It was higher overall for males than for females, though this relationship did not hold for older patients.

**Conclusion.** This study gives the best available national picture of the use of repeat prescribing. The definition

employed does not allow any direct conclusions to be drawn about whether the patients involved were being given adequate clinical care, but it permits analyses at practice level that can indicate where special attention may be required. It could usefully be adopted as the much-needed standard definition.

**Keywords:** repeat prescribing; prescribing analysis; computer assisted prescribing.

## Introduction

REPEAT prescribing used to be a field of research for a few interested general practitioners and, occasionally, a concerned social scientist. Recent reports from both the National Audit Office<sup>1</sup> and the Audit Commission<sup>2</sup> have drawn attention to its implications for the quality and cost of drug treatment in general practice, and have made it a major issue for practice management.

Research publications began to appear about 25 years ago. The essential feature of repeat prescribing was usually seen as the absence of contact between doctor and patient, and this could encompass concern both about the hazards of long-term medication without proper review and about situations where drugs were initiated without the patient being seen — even if such drugs were intended for short-term treatment only.<sup>3,5</sup> Some of the authors did attempt to assess the scale as well as the nature of their repeat prescribing, but it is difficult to compare their findings because each defined the subject differently. The studies rarely covered more than a month and usually related to one practice only, or three at the most.

A public survey by Dunnell and Cartwright<sup>6</sup> in 1972 suggested that about a quarter of all prescriptions were repeats, and in 1977 Howie<sup>7</sup> thought that the proportion might be nearly a half. A review of the literature by Drury<sup>8</sup> in 1982 led him to state that earlier estimates ranged from 12.5% to 33%, the most recent tending to be the highest. In 1985, Fraser and Gosling<sup>9</sup> reported a mean value of 36% for a group of practices in Leicestershire, and in 1986 Donald<sup>10</sup> found that 30% of his practice's items and 65% of its prescribing costs were accounted for by repeats. The extent of repeat prescribing for the elderly became a persistent concern.<sup>11–14</sup>

Research generally involved manual data collection, and some of the early studies chose to look only at their repeat prescriptions without also counting their non-repeat items. However, in 1978, Parker and Schreiber<sup>15</sup> arranged with the Prescription Pricing Bureau to have all their practice's scripts for one quarter returned. Those that were repeats had been marked as such, so that the doctors were able to determine that 27.4% of their prescriptions were given to 'unseen' patients. Fraser and Gosling used the same technique in their multi-practice study seven years later. With the advent of Prescribing Analysis and Cost (PACT) reports in 1988, prescribing data became routinely available to all practices in England, and the system could be manipulated to produce an analysis of repeat prescribing using the 'trainee report' facility. There is no published evidence that any practice ever did this.

The use of a computer in the practice for issuing repeat prescriptions provided a new source of data, pioneered in the 1970s by Bain and Haines<sup>16</sup> and Bradshaw-Smith.<sup>17</sup> In the 1980s, practice computers began to become more common, and repeat prescribing by computer quickly became popular, though it was to

Conrad M Harris, MEd, FRCP, professor of general practice and director, Prescribing Research Unit, University of Leeds Research School of Medicine; and Richard Dajda, MSc, NHS Relations Director, Intercontinental Medical Statistics (UK and Ireland) IMS House, Pinner, Middlesex.

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be some years before many practices moved to computerize their acute prescribing too. At practice level, the repeat data and the total data that practice computers can provide have led to little published research, but the possibility has been created for studying the aggregated data of groups of practices operating the same software in the same way. The first attempt to do this was made in 1992 in the GPASS Data Evaluation Project,<sup>18</sup> but the data were incomplete. The evidence about the scale of repeat prescribing quoted in the National Audit Office's report came from two practices using the EMIS system, and it showed that repeat prescribing accounted for 66.4% of their total items and 79% of their prescribing costs. A much more detailed unpublished study, also from the Sowerby Foundation for Primary Care Information Research,<sup>19</sup> went on to analyse the data for seven EMIS practices provided with special software over a period of two months. It found that 65% of items were repeats, and that these were responsible for 75% of prescribing costs.

From this review, it is clear that the lack of common definition makes it impossible to chart the growth in the scale of repeat prescribing with any precision, but also that there has been considerable growth and that it has been accelerated by the use of practice computers — by 1993, about 80% of all practices were computerized.<sup>20</sup> The printing of repeat prescriptions by computer, especially in large batches, makes it less likely that the doctor will spend time thinking critically about each prescription. Thus a new element has been added to the issues about quality that lie at the heart of concern about repeat prescribing: how well the process is managed. The greater the scale, the more important this element becomes.

A standard definition of repeat prescribing has now to be computer-related, and this will enable analyses and reports useful for clinical care to be obtained. We were thus led to define a repeat prescription as one that is printed by a practice computer from its repeat prescribing program within a given period.

This definition has both advantages and disadvantages. The disadvantages must be clearly recognized, because in some ways they shift the focus of concern. It is impossible to tell whether the printing has been done between consultations or during a consultation, so that subsequent analysis can give no evidence either way about whether the patients are adequately reviewed clinically — the chief problem addressed in most earlier studies. Other disadvantages are that the definition cannot be applied to practices without a computer; that there will be some level of inaccuracy if the computer is not used for all repeat prescribing; and that the percentage of prescriptions that are repeats cannot be derived unless acute prescribing is also done on the computer.

The most obvious advantage of our definition is that it is simple to use and practical. Beyond this, however, it allows analyses to be made that incorporate other data held on the computer about the patients involved. For example, it would be easy to look at how many elderly patients are being given hypnotics by repeat prescription, and to audit the effect of any change in practice policy.

This paper attempts to provide the most reliable picture available of the scale of repeat prescribing overall in England in 1993, and also to explore variation with respect both to patients' age and sex and to drug groups. We have analysed the aggregated records of a group of practices far larger than any studied previously, and made use of non-prescribing data about their patients. Repeat prescriptions are defined as those printed by a practice computer from its repeat prescribing program in the course of one year.

## Method

The study data come from the MediPlus database, which is built up from information collected by Intercontinental Medical Statistics (UK and Ireland) from practices using AAH Meditel's System 5 software. A panel of 140 practices contributes to the database on a long-term basis in order to track the drug management of disease over time. It provides data from more than 500 general practitioners, each with an identifiable prescribing code number. Practice registrars' data are included, though they cannot be identified as such because the scripts are written on trainers' prescription forms. The extent to which the panel is representative of practices nationally and the methods of assuring quality control in the system are described elsewhere.<sup>21</sup>

Information is collected daily via the AT&T Istel network. Practice systems dial in each night to upload their activities, and the data are downloaded early each morning by Intercontinental Medical Statistics (IMS). At the initial installation an encryption key is generated at random. This is used to encrypt the patient reference number, so that the number by which IMS knows a patient cannot be related to the number used in the practice system.

The database monitors contributions from all the doctors registered with each practice, and for the year covered by this study there were data from 563 doctors, a small proportion of whom left their practice during the year but continued to provide data until their patients and repeat prescriptions were allocated to someone else.

## Analysis

For this study, only practices of approved quality<sup>21</sup> in England were included. The data, for calendar year 1993, related to 115 practices with 750 390 patients, covering all 14 regions and 48 of the 90 family health service authorities. There was some under-representation of inner London and of the major cities. Analysis of the data was conducted using the MediPlus Workstation, a PC system holding the clinical and prescribing details of more than 1.2 million patients. Data for the calendar years 1991–1993 and the first eight months of 1994 were assembled to assess the stability of the acute-repeat prescription ratio. All other analyses were based on data for the calendar year 1993, in which the practices prescribed 5.82 million items.

## Results

The percentages of repeat prescriptions in 1991–1993 and in the first eight months of 1994 were almost identical (Table 1), indicating that the practices had reached a steady state in the issuing of acute prescriptions by computer. There were no differences between fundholding and non-fundholding practices (74.91:74.52) or between prescribing and dispensing practices (74.78:74.56) in the percentages of repeat prescriptions.

**Table 1.** Repeat prescriptions: percentage of total items and cost annually, 1991–1993, and for the first eight months of 1994.

	Items		Cost	
	Total number (millions)	% repeat	Total £ (millions)	% repeat
1991	4.26	75.30	24.45	83.20
1992	5.06	75.51	32.83	81.83
1993	5.82	74.77	40.84	80.71
1994*	3.81	76.16	28.75	81.72

\*January to August only.

Drugs were coded according to the commercial version of the anatomical-therapeutic-clinical classification system, not the system based on the British National Formulary and used by the Prescription Pricing Authority. Mapping from one system to the other is complex, so Table 2 shows repeat prescribing percentages for 46 defined drug groups (listed under British National Formulary chapter headings) rather than for whole chapters of drugs. All the drug groups chosen had at least 20 000 items prescribed, apart from three that seemed of special interest: barbiturate hypnotics, 4-fluoroquinolone antibiotics, and cerebral and peripheral vasodilators. The remaining tables illustrate aspects of repeat prescribing in relation to patients' age and sex. Table 3 shows the percentages of patients in each age group receiving no prescription, acute prescriptions only, acute and repeat prescriptions, and repeat prescriptions only during the year. The likelihood of receiving no prescription started to diminish in the 45-54 age band, and vanished for patients aged 75 and over. More than a quarter of patients in the highest age band had repeat prescriptions only, and 48.4% of the total population were receiving repeat prescriptions.

Table 4 shows the total number of items in each age and sex group prescribed for patients receiving any prescription, with the percentages that were repeats. These percentages increased with age in both sexes; overall, males had a marginally higher percentage of repeat than females because they started receiving repeats at an earlier age. Table 5 displays the number of anxiolytics, hypnotics and oral non-steroidal anti-inflammatory drugs prescribed for each age and sex group, with the percentages that were repeats. Again, the percentages rose with age, but for each of these three kinds of drug it was the females, overall, who had a higher percentage of repeats.

## Discussion

The definition of repeat prescribing adopted in this study has certain limitations (which were noted in the introduction), but it is practical, easy to apply, and can lead to analyses that draw attention to areas of clinical concern.

Using the aggregated data of a large number of practices, we have been able to provide the best available picture of the extent and composition of repeat prescribing in England in 1993. The headline figures that repeat prescribing accounted for 75% of the items and 81% of the cost of all prescribing, and that 48.4% of all the patients were receiving a repeat prescription, may appear startling, but it is important to remember that these figures in themselves do not prove that the patients' medication was not being adequately reviewed.

Drugs for diabetes, hypothyroidism, epilepsy, parkinsonism, gout and cardiovascular conditions were rarely given except by repeat, which is unsurprising. However, this may mean that achieving a reduction in the now poorly-regarded cerebral and peripheral vasodilators is likely to be difficult. There may also be cause for concern at the very high percentages for hypnotics and the high percentage for oral non-steroidal anti-inflammatory drugs.

At the low end of the scale, the percentages for antibiotics are higher than might be expected. Tetracyclines peak in the 15-24 age band (males 75%, females 65%), as do macrolides (males 40%, females 25%), and presumably this reflects treatment for acne. For the other antibiotics, some of the doctors have told us that patients who suffer recurring infections are put on the repeat prescribing program for the convenience of the doctor, who can then easily issue intermittent acute prescriptions as required. This would account, at least in part, for the high percentages recorded.

Our figures confirm many earlier reports that the percentage of repeat prescribing increases with patients' age, but we had not

**Table 2.** Total number of items with percentage repeats for 46 drug groups, 1993.

Drug group	Total items prescribed (thousands)	% repeat
<b>Gastro-intestinal</b>		
All antacid preparations	124.8	84.7
H <sub>2</sub> antagonists	108.7	89.3
Proton pump inhibitors	32.2	83.7
Antiemetics and antinauseants	42.7	69.4
All laxative preparations	144.5	87.6
<b>Cardiovascular</b>		
Oral anticoagulants	24.7	95.4
Lipid lowering drugs	22.5	97.1
Cardiac glycosides	56.2	98.0
Nitrates and nitrites	106.8	95.4
Group of all diuretics, beta blockers, calcium channel antagonists and ACE inhibitors: plain and in combination	765.7	95.7
Cerebral and peripheral vasodilators	12.5	94.4
<b>Respiratory</b>		
Systemic nasal preparations	21.12	27.5
Systemic xanthines	27.9	93.9
Systemic adrenoceptor stimulants	31.7	61.9
Cough medicines	33.1	44.0
Inhaled adrenoceptor stimulants (plain)	216	92.3
Inhaled corticosteroids	135.4	92.8
Systemic antihistamines	76.7	64.9
<b>Central nervous system</b>		
Non-opioid analgesics	483.4	82.2
Anti-migraine preparations	28.2	77.6
Anti-epileptic drugs	63.1	96.8
Anti-parkinsonian preparations	35.9	97.5
Hypnotics: non-barbiturates	145.4	93.0
Hypnotics: barbiturates	9.1	99.2
Anxiolytics	66.1	87.7
Antidepressants	155.7	83.7
<b>Infections (oral)</b>		
Tetracyclines	59.4	47.8
Broad-spectrum penicillins	189.6	13.8
Medium and narrow spectrum penicillins	70.8	12.0
Cephalosporins	38.6	14.1
Trimethoprim (plain and combination)	51.9	21.5
Macrolides	56.6	18.7
Fluoroquinolones	12.0	20.4
<b>Endocrine</b>		
Insulins	24.5	97.8
Oral antidiabetics	61.6	97.5
Thyroid preparations	73.5	98.0
Oral corticosteroids	57.6	71.9
<b>Gynaecological</b>		
Oral contraceptives	119.4	61.0
<b>Nutrition and blood</b>		
Iron (plain and combination), oral	42.9	78.9
<b>Musculo-skeletal and joint disease</b>		
Non-steroidal anti-inflammatory, oral	245.3	72.3
Topical anti-rheumatics	56.3	69.2
Anti-gout drugs	22.4	97.4
<b>Skin</b>		
Topical anti-fungals	24.6	40.2
Emollients	86.5	77.6
Topical corticosteroids (plain)	104.3	63.1
Topical corticosteroids (combination)	64.8	50.6

**Table 3.** Distribution of acute and repeat prescriptions by age of patient, 1993.

Ages	% receiving no prescription	% receiving acute prescriptions only	% receiving repeat prescriptions only	% receiving both
0-4	33.5	36.8	2.7	27.0
5-14	32.0	38.4	5.8	23.8
15-24	27.5	31.4	9.8	31.3
25-34	31.0	29.2	8.7	31.1
35-44	32.3	28.4	9.0	30.3
45-54	24.4	28.1	11.8	35.8
55-64	21.6	17.2	15.4	45.8
65-74	11.3	11.7	18.4	58.6
75-84	0.0	7.9	21.7	70.4
85 and over	0.0	5.8	25.2	68.9
All ages	25.8	25.8	11.1	37.3

**Table 4.** Age/sex distribution of the total number of items prescribed, with the percentages that were repeat items, for patients who received any prescription.

Ages	Males			Females		
	No. of patients	Total no. of items	Percentage repeats	No. of patients	Total no. of items	Percentage repeats
0-4	25 362	102 090	37.1	24 045	86 952	34.4
5-14	47 451	143 958	47.5	45 493	139 630	43.1
15-24	45 511	123 398	59.4	47 250	212 844	48.0
25-34	59 498	144 265	57.1	60 956	307 803	49.7
35-44	51 504	162 548	63.8	51 549	284 716	59.2
45-54	49 172	233 539	73.7	48 264	376 304	71.4
55-64	36 425	337 537	82.4	36 885	449 166	80.6
65-74	30 625	515 387	86.6	36 466	692 522	86.7
75-84	14 954	371 921	88.5	24 475	633 789	88.9
>84	3 894	123 224	88.7	10 611	375 972	90.6
All ages	364 396	2 257 867	75.3	385 994	3 559 698	74.4

**Table 5.** Age/sex distribution of the items prescribed, with the percentages that were repeat items, for three groups of drugs: anxiolytics, hypnotics and oral non-steroidal anti-inflammatory drugs.

Ages	Anxiolytics				Hypnotics				Non-steroidal anti-inflammatory drugs (plain)			
	Male		Female		Male		Female		Male		Female	
	Total items	% repeat	Total items	% repeat	Total items	% repeat						
0-4	56	46.6	50	34.0	155	72.9	98	74.5	31	41.9	17	17.7
5-14	144	78.5	153	70.6	57	89.5	56	76.8	392	23.0	563	32.3
15-24	423	63.4	670	58.1	503	67.4	597	45.6	3 133	20.4	4 568	24.2
25-34	1 688	69.1	2 307	67.5	2 412	74.5	2 421	61.3	7 477	32.8	8 475	30.9
35-44	3 037	80.3	4 326	75.5	3 305	81.5	4 801	77.4	10 445	47.7	12 796	46.7
45-54	4 093	86.2	6 774	85.4	5 467	88.8	10 012	88.8	15 051	61.8	21 019	63.7
55-64	3 840	89.4	7 617	89.6	7 326	93.0	13 953	93.7	19 066	75.1	26 657	78.1
65-74	4 700	92.8	10 588	93.5	10 174	94.6	25 338	96.4	22 616	84.2	34 813	86.1
75-84	2 582	93.4	8 639	94.6	10 450	96.2	30 882	97.5	13 154	87.9	28 877	89.8
>84	798	95.0	3 611	95.5	5 398	96.6	21 195	98.0	3 760	89.6	12 370	92.9
All ages	21 361	86.6	44 735	88.2	45 247	91.8	109 353	94.1	95 125	69.1	150 155	74.3

previously seen the finding that it is slightly higher for male patients than for females. Since this is more apparent in younger males it may go some way to explain the well-recognized fact that this group consults less frequently than females of the same age.

The three more detailed analyses of the age and sex of the recipients of particular drugs may be taken as examples of what an individual practice may do to investigate its own activities,

and to compare itself with other practices and with the national picture.

Repeat prescribing on the scale shown by our study has major clinical, medico-legal and financial implications. Practice computers have played a significant part in increasing the scale, but they can also be used to prevent some of the consequent dangers. The first essential is that a practice must control its system proper-

ly; the second is that the system must be programmed so that it is easy to obtain reports that reveal areas requiring closer attention.

The definition of repeat prescribing proposed here facilitates analyses that support action for better clinical care, and we hope that it will become the standard definition that has been needed for so long.

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### Address for correspondence

Professor Conrad Harris, 20 Hyde Terrace, Leeds LS2 9LN.

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