Prescribing and Dispensing Newsletter

impact

April 2008

Sending prescriptions to the NHSBSA

The NHSBSA receive prescription batches from over 10,000 pharmacy contractors every month. Although the majority of batches we receive are correctly sorted, and well presented. When we receive ones that aren't it is very time consuming to re-sort them and can delay processing.

Common problems encountered include:

- 'Over-sorting' of prescriptions. The two main bundles of Chargeable and Exempt prescriptions are further divided and secured with elastic bands/paper clips/sticky tape/wrapped in plastic bags etc. We must remove this before we can scan the form. Left in staples and clips will jam the machinery.
- Prescriptions aren't bundled at all and are put loose into their outer packaging so we have to sort all of them.
- Prescriptions are sometimes sticky – either due to a spillage, or because sticky labels have been attached. They aren't easy to spot and prescriptions can become stuck together, causing hold ups in the scanning process.

You can find a copy of our sorting guidance on our website **www.ppa.org.uk/ppa/disp_contract_sorting.htm**

Top Tips for preparing a batch of prescriptions to send to the NHSBSA

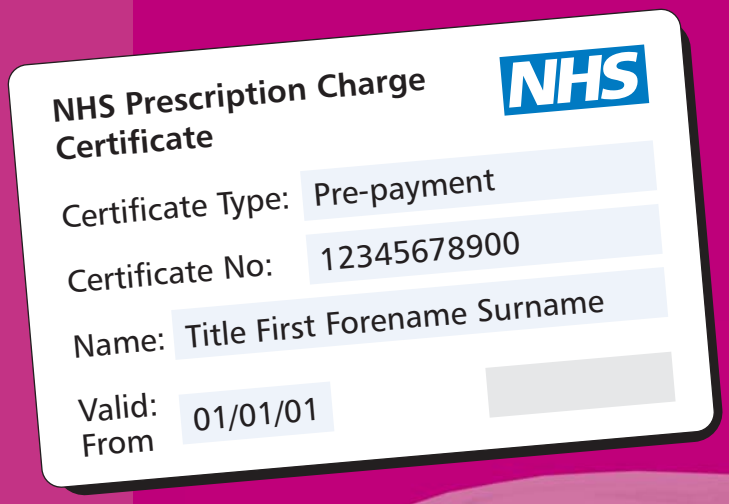
- Follow the guidelines on the submission document FP34C – prescriber order, chargeable or exempt. Separate out the prescriptions with items for broken bulk and calendar pack claims in the exempt and chargeable bundles as appropriate. These do not need to be in alphabetical order.
- Avoid using staples, paper clips, too many elastic bands, string or sticky labels etc.
- Endorse any information on price on the left hand side of the prescription, particularly for special order products.
- Securely wrap the final bundle of prescriptions.
- Write the required endorsements clearly (if smudged, too faint or out of line with the prescribed product information, there is a risk these will be referred back) and do not obliterate the endorsement or age/DOB box with pharmacy stamps, highlighter pen etc.
- When dressings and appliances are prescribed as a number of packs or boxes, please,endorse the box or pack size you have dispensed.
- Use the most recently bar-coded FP34C submission document label when sending prescriptions to the NHSBSA PPD. The bar code tells us which account has sent in the batch and for which dispensing month.

Don't forget!

Unless the patient's age has been automatically printed on the front of the form, the patient or their representative must sign the back of the form to confirm their exempt status. If it's not signed where it should be the form will be classed as paid, not exempt.

Are people in your area missing out on **help with health costs**?

At the NHS Business Services Authority we are always looking to improve patients' access to help with health costs, and this includes making pre-payment certificates more flexible with easier ways to pay.



We know from feedback that pre-payment certificates holders enjoy the convenience of being able to buy pre-payment certificates locally through the PPC Direct scheme that some pharmacies are registered with. Recently, the option for pharmacies to sell pre-payment certificates by post has been re-instated, extending pharmacy sales to a wider patient base throughout the country. We wrote to every pharmacy at the beginning of January to make sure you all have the same opportunity to register for postal sales.

To register, please complete the registration form enclosed with the letter and return it in the pre-paid addressed envelope provided. Once you are registered, we will send you a guidance pack containing everything you need to know about PPC Direct and the appropriate stationery.

Alternatively, you can register your pharmacy to sell pre-payment certificates on-line. To register visit the website www.ppa.org.uk click on pre-payment certificates and go into the 'PPC Direct "On-line" - Registered Pharmacies' area where you'll find a link to the registration form at www.ppa.org.uk and click on pre-payment certificates.

If you have any queries or require further information before registering, please contact us on (0191) 203 4945 (for online sales) or email: terry.luck@ppa.nhs.uk

Find out more!

If you would like to know more about help with health costs, phone 0845 610 1110 to speak with an advisor, or visit our website at www.ppa.org.uk/healthcosts

Key contacts

We are always seeking to make new contacts to make sure information about **Help with Health Costs** is available in the places patients expect to find it. Pharmacies are a vital link in the chain and with your support, up to date information can always be available in your pharmacy. To become a key contact, please get in touch with terry.luck@ppa.nhs.uk

A guide to instalment dispensing prescription forms

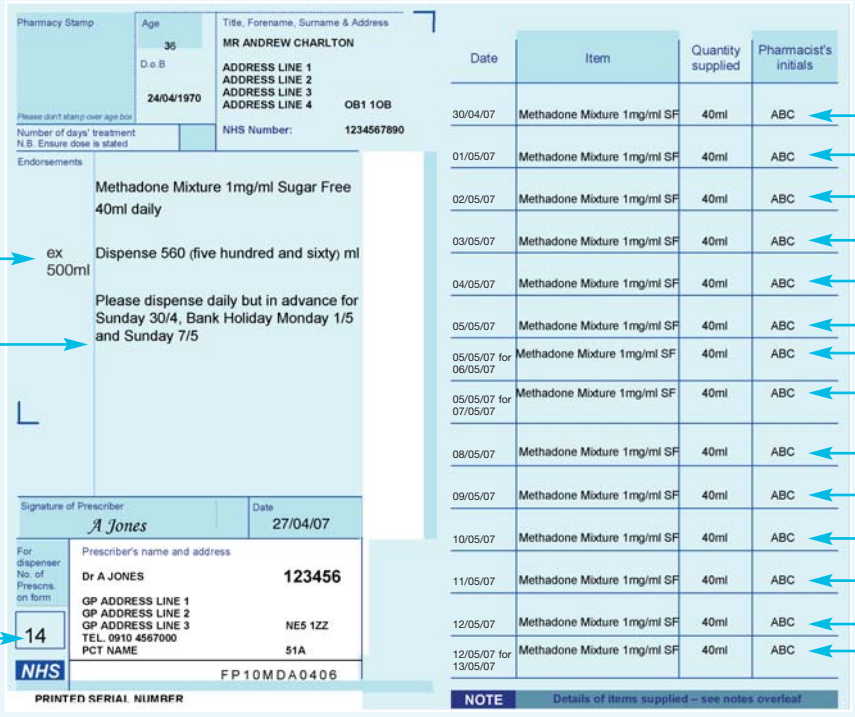
If you dispense items on FP10MDA forms, here is a guide to when and how instalment dispensing fees may be claimed. Separate dispensing fees should be claimed only if the prescriber has indicated that the total amount should be dispensed either in daily instalments or in separate daily dose containers and/or that one or more doses are to be taken as 'supervised consumption'. For example the instruction '80ml daily' is the dose and should not be interpreted as an indication to supply 80ml in separate containers on each day. Below are examples of correctly and incorrectly endorsed FP10MDA forms. Further information can be obtained from www.ppa.org.uk/ppa/fp10mda_guide.htm

CORRECTLY ENDORSED:

Endorsement of pack size/manufacturer/ price as appropriate.

Prescriber has requested daily instalments and supply in advance for closure.

Dispenser endorses the total number of instalments specified by the prescriber minus any missed instalments.



Pharmacy Stamp

Age 36

D.o.B 24/04/1970

Please don't stamp over age box

Title, Forename, Surname & Address

MR ANDREW CHARLTON
ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3
ADDRESS LINE 4 OB1 1OB

Number of days' treatment N.B. Ensure dose is stated

NHS Number: 1234567890

Endorsements

Methadone Mixture 1mg/ml Sugar Free 40ml daily

ex 500ml

Dispense 560 (five hundred and sixty) ml

Please dispense daily but in advance for Sunday 30/4, Bank Holiday Monday 1/5 and Sunday 7/5

Signature of Prescriber: *A Jones*

Date: 27/04/07

For dispenser No. of Prescns. on form: 14

Prescriber's name and address

Dr A JONES 123456

GP ADDRESS LINE 1
GP ADDRESS LINE 2
GP ADDRESS LINE 3 NE5 1ZZ
TEL. 0910 4567000
PCT NAME 51A

NHS FP10MDA0406

PRINTED SERIAL NUMBER

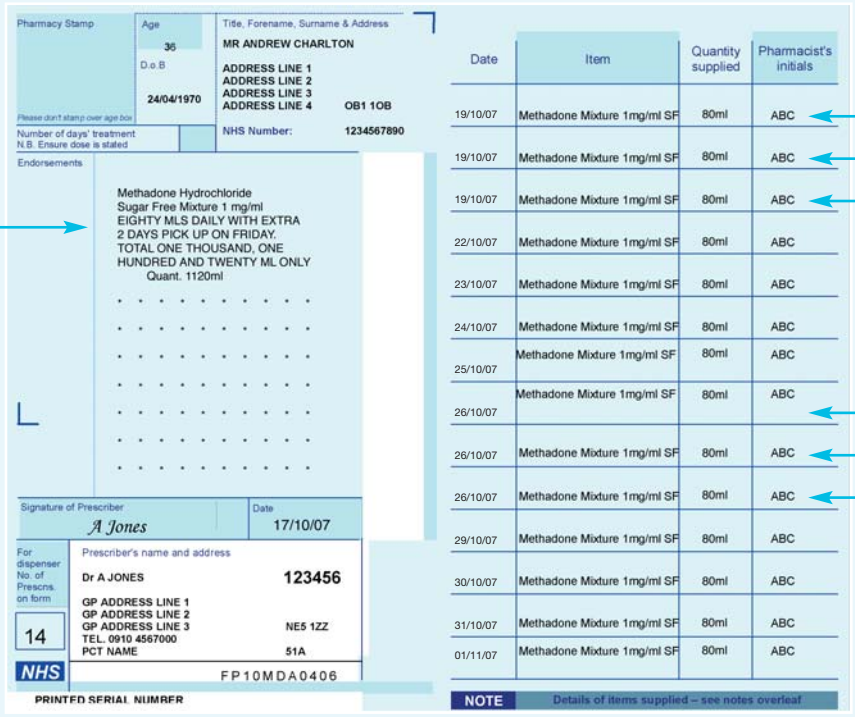
Date	Item	Quantity supplied	Pharmacist's initials
30/04/07	Methadone Mixture 1mg/ml SF	40ml	ABC
01/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
02/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
03/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
04/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
05/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
05/05/07 for 06/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
05/05/07 for 07/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
08/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
09/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
10/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
11/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
12/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC
12/05/07 for 13/05/07	Methadone Mixture 1mg/ml SF	40ml	ABC

NOTE Details of items supplied – see notes overleaf

Where daily instalments have been specified to be supplied in advance by the prescriber **and** the dispenser has supplied these as separate instalments, the endorsement should indicate that separate instalments were supplied. The endorsement should clearly mark the date of supply together with the instalment date.

INCORRECTLY ENDORSED:

Prescriber has not specified daily dispensing.



Pharmacy Stamp

Age 36

D.o.B 24/04/1970

Please don't stamp over age box

Title, Forename, Surname & Address

MR ANDREW CHARLTON
ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE 3
ADDRESS LINE 4 OB1 1OB

Number of days' treatment N.B. Ensure dose is stated

NHS Number: 1234567890

Endorsements

Methadone Hydrochloride Sugar Free Mixture 1 mg/ml EIGHTY MLS DAILY WITH EXTRA 2 DAYS PICK UP ON FRIDAY. TOTAL ONE THOUSAND, ONE HUNDRED AND TWENTY ML ONLY
Quant. 1120ml

Signature of Prescriber: *A Jones*

Date: 17/10/07

For dispenser No. of Prescns. on form: 14

Prescriber's name and address

Dr A JONES 123456

GP ADDRESS LINE 1
GP ADDRESS LINE 2
GP ADDRESS LINE 3 NE5 1ZZ
TEL. 0910 4567000
PCT NAME 51A

NHS FP10MDA0406

PRINTED SERIAL NUMBER

Date	Item	Quantity supplied	Pharmacist's initials
19/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
19/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
19/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
22/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
23/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
24/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
25/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
26/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
26/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
26/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
29/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
30/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
31/10/07	Methadone Mixture 1mg/ml SF	80ml	ABC
01/11/07	Methadone Mixture 1mg/ml SF	80ml	ABC

NOTE Details of items supplied – see notes overleaf

Where daily dispensing has not been specified by the prescriber, dispensers should endorse the total amount supplied on the day as specified by the prescriber.

Drugs used in asthma and COPD

The Prescribing Review report on drugs used in asthma and COPD, available to general practitioners in November 2007, is reproduced here for readers with an interest in patterns and trends of prescribing.

Charts 1 and 2 show trends in prescribing for asthma and chronic obstructive pulmonary disease (COPD). Although the recorded prevalence of asthma is higher (5.4% of registered population versus 1.4% for COPD – quality and outcomes framework registers 2006), COPD has by far the greater impact in terms of hospital admissions and deaths. It was the fifth leading cause of death in 2004, the second most important cause of preventable death in 2005[1] and responsible for up to 12.5% of emergency admissions to hospital. There are striking social inequalities in prevalence and outcomes[2]. Consultation rates for COPD in general practice are reported to be twice as high as for angina. A National Service Framework for COPD is due in 2008.

Chronic Obstructive Pulmonary Disease

Epidemiological studies suggest that the true prevalence of COPD in the UK may be several times higher than recorded and that up to 9% of the population over age 45 may be affected[3]. NICE guidance recommends performing spirometry in all current or ex-smokers over 35 who have a chronic cough, exertional breathlessness, regular sputum production, frequent winter 'bronchitis' or wheeze[4]. The Medical Research Council (MRC) dyspnoea scale should be used to grade breathlessness. Patients with COPD experience a variety of symptoms reflecting the multi-dimensional nature of the condition. The NICE guideline groups these into eight broad problem areas, each of which may require drug therapy: smoking, breathlessness, exacerbations, respiratory failure, cor pulmonale, weight loss, chronic productive cough, and anxiety and depression.

Smoking

Smoking cessation is the most important component of COPD prevention and management. It is the only intervention shown to slow the decline of forced expiratory volume in 1 second (FEV_1). Advice and encouragement should be offered at every opportunity. NICE Public Health Intervention Guideline 1 recommends referral to an intensive support service for all smokers. Prescriptions for nicotine replacement therapy (NRT), buproprion or varenicline are recommended, with appropriate support, for those smokers unwilling or unable to accept referral[5].

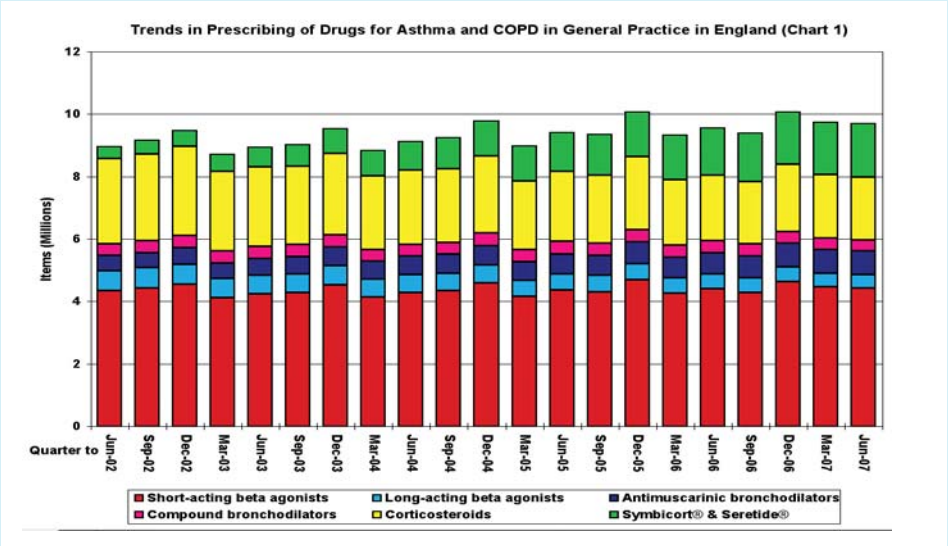
Breathlessness

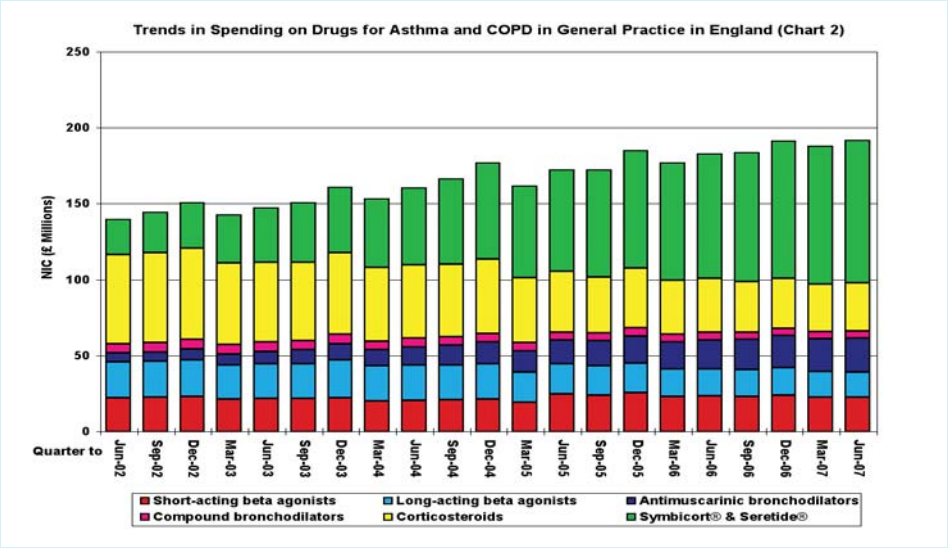
Short-acting bronchodilators (e.g. salbutamol or ipratropium) as needed are recommended for initial empirical therapy for breathlessness and exercise limitation. A Cochrane review found small benefits with respect to quality of life and lung function for ipratropium bromide over short-acting β_2 agonists and recommended conducting 'n of 1' trials to determine the treatment that gives best relief of symptoms[6]. NICE guidance recommends using a variety of measures, such as improvement in symptoms, activities of daily living, exercise capacity, and rapidity of symptom relief, to assess the effectiveness of therapy. Ineffective treatments should be discontinued after 1-2 months. Options for patients who remain symptomatic are combining a short-acting anticholinergic with a short-acting β_2 agonist, or adding a long-acting β_2 agonist (LABA). Theophylline should only be used after trying short-acting and long-acting bronchodilators or in patients unable to use inhalers.

Exacerbations

Long-acting bronchodilators should be prescribed to patients who have two or more exacerbations per year. There is little evidence to suggest clinically significant differences between long-acting anticholinergics and LABAs. Choice of drug should take account of patient response to a trial, side effects, patient preference and cost. Inhaled corticosteroids should be added to long-acting bronchodilators for patients with an $FEV_1 <= 50\%$ predicted who experience two or more

exacerbations requiring treatment with either oral steroids or antibiotics in a 12 month period. The aim is to reduce exacerbation frequency. Recent trials do not support wider use of inhaled steroid therapy. A large trial over 3 years, comparing salmeterol plus fluticasone to salmeterol alone, fluticasone alone or placebo, among people with an FEV_1<60% of predicted, failed to demonstrate a significant difference in mortality rates[7]. Salmeterol alone and combination therapy both resulted in a lower annual rate of hospital admission for severe exacerbations than placebo. Combination therapy showed some advantages over individual drugs in the rates of moderate to severe exacerbations and exacerbations requiring treatment with oral steroids, but there was a significantly higher incidence of pneumonia in the groups treated with either combination therapy or fluticasone alone (NNH = 14 and 17, respectively). A recent case-controlled study of 175,906 patients also found an increased risk of hospital admission for pneumonia among elderly patients with COPD prescribed inhaled corticosteroids[8]. Early use of prednisolone (30mg for 7-14 days) should be considered for treatment of any exacerbation causing a significant increase in breathlessness which interferes with daily activities. Antibiotics may be of benefit when there is an increase in sputum purulence. Where appropriate, patients at risk of having an exacerbation of COPD should be given a course of antibiotic and corticosteroid tablets to keep at home for use as part of a self-management plan that includes adjustment of bronchodilator therapy and advice to contact a healthcare professional if symptoms do not improve.





Oxygen

Although long term oxygen therapy (LTOT) has been shown to improve survival in people with hypoxaemia, inappropriate oxygen therapy can cause respiratory failure. Patients with an FEV_1 < 30% predicted, or with cyanosis, polycythaemia, peripheral oedema, raised jugular venous pressure or oxygen saturations ≤92% when breathing air, should be referred for specialist assessment for LTOT. Short burst oxygen therapy, which can be ordered without specialist assessment, should only be considered for periods of severe breathlessness not relieved by other treatments. Therapy should only continue when there is a documented improvement in breathlessness.

Pulmonary Rehabilitation

Pulmonary rehabilitation has been shown to lead to statistically significant and clinically meaningful improvements in health related quality of life, functional exercise capacity and maximum exercise capacity. A programme of pulmonary rehabilitation, incorporating a programme of physical training, disease education, nutritional, psychological and behavioural intervention, should be offered to all patients who consider themselves to be functionally disabled by COPD.

Asthma

Asthma UK estimates that there are 5.2 million people with asthma in the UK, 1.1. million of whom are children. Although overall mortality rates are low

and have been declining for over 20 years, the rate of decline appears to be slowing[9]. There is some evidence of gaps between current practice and British Thoracic Society / Scottish Intercollegiate Guideline Network (BTS/SIGN) guidelines. A recent study looking at community prescribing for children with asthma in the UK between 2000 and 2006 found evidence of important variations from recommended practice, including a significant number of prescriptions for bronchodilator syrups[10]. BTS/SIGN guidelines do not recommend oral β_2 agonists for children; a pressurised metered dose inhaler (pMDI) plus a spacer, with a facemask if needed, is recommended for children 0-5 years. The proportion of inhaled steroids prescribed as combination products rose to 25% over the same period. The authors point out that this is not consistent with guideline recommendations, asserting that steroid inhalers alone should be the mainstay for the vast majority of asthmatics who require controller medication.

A meta-analysis concluded that LABAs increase both severe asthma exacerbations and asthma-related deaths, and that concomitant inhaled steroids do not adequately protect against adverse effects[11]. BTS/SIGN guidelines have been updated recently[12], partly in response to a trial demonstrating lower exacerbation rates with a budesonide/formoterol device used for both maintenance and relief of symptoms. Subjects randomised to use of a budesonide/formoterol combination inhaler for both maintenance and relief of symptoms were exposed to lower overall doses of LABA[13]. The guidelines point out that doubling the dose of inhaled steroid at the time of an exacerbation has not been shown to be effective and note that it is not clear that adjusting the dose of a budesonide/formoterol combination inhaler according to symptoms is superior to conventional treatment. The two approaches have not been directly compared. The Commission on Human Medicines is carrying out a full review of LABAs. Current advice is that benefits outweigh risks when prescribed appropriately. The following cautions are recommended: only use LABAs when standard doses of inhaled steroids have failed to control asthma adequately; always prescribe an inhaled steroid; do not initiate in patients with rapidly deteriorating asthma; start at low doses; monitor closely for deterioration of symptoms; discontinue in absence of benefit; consider stepping down when good control has been achieved.

There is no difference between the efficacy of inhaled steroids with long-acting beta agonists given via fixed dose combination inhalers or via separate inhalers. Nor have combination devices been shown to improve compliance in the medium to long-term. Fixed dose combinations may have advantages for individual patients, however.

Prescribing Data

(Reporting quarter = April-June 2007, Index quarter = April- June 2002)

Prescribing of short-acting β_2 agonists has not significantly changed over the last 5 years (4.4 million items and £22.4 million, quarter to June 2007), both prescribing and costs increasing by less than 2%. Salbutamol represents 95% of all items for short-acting β_2 agonists and 90% of cost. Prescribing of single preparation LABAs has decreased by just over 30% to 400,000 items at a cost of £16.4 million per quarter. Salmeterol is the most commonly prescribed LABA accounting for approximately 90% of all items and cost.

Prescribing of inhaled corticosteroids as single preparations has decreased by 26% over the last 5 years to 2.0 million items, cost has fallen by 46% to £31.8 million per quarter. Beclometasone is still most commonly prescribed (1.6 million items, £19.1 million). Prescribing of fluticasone has fallen by 47% to 216,000 items while costs have fallen by 57% to £6.8 million. Prescribing and cost of budesonide have decreased by almost half to 180,000 items and £5.5 million, per quarter. Compound corticosteroid preparations account for 46% of all inhaled corticosteroid prescribing and 75% of the cost. Fluticasone with salmeterol accounts for 75% of compound corticosteroid preparations (1.3 million items and £72.7 million).

In the last 5 years, prescribing of antimuscarinic bronchodilators has increased by 60% to 768,000 items while costs have almost quadrupled to £22.5 million. At 466,000 items, tiotropium now accounts for 61% of all antimuscarinic bronchodilator prescribing, and 84% of the cost (£19 million). Prescribing of ipratropium has decreased by 34% to 302,000 items costing £3.5 million per quarter. Compound bronchodilator prescribing has fallen slightly (6%) to 356,000 items, whereas cost has decreased by a quarter to £4.5 million. Over 99% of these items are for Combivent®.

Prescribing of aminophylline and theophylline have decreased by 25% (102,000 items) and 16% (126,000 items) respectively over the last 5 years, costing £348,000 and £543,000 per quarter. Prescribing of leukotriene receptor antagonists has more than doubled in the last 5 years to 239,000 items at a cost of £7.9 million per quarter. Montelukast accounts for 96% of prescribing and spending on leukotriene receptor antagonists. Mucolytic prescribing has increased over the last 5 years to 119,000 items at a cost of £3.5 million per quarter. Carbocisteine is most commonly prescribed (105,000 items).

Key Messages

COPD may be far more common than recorded prevalence suggests. Spirometry should be offered to all current or past smokers over 35 with compatible symptoms.

There is little evidence on which to base the choice between anticholinergics or β_2 agonists in COPD, whether short- or long-acting. "N of 1" trials are recommended.

Inhaled corticosteroids should only be prescribed to reduce the frequency of exacerbations in COPD.

LABAs should only be prescribed to people with asthma when standard doses of inhaled steroids have failed to control symptoms.

Use of a single combination device for both maintenance and relief of symptoms of asthma has not been shown to be superior to conventional treatment.

References

1. Trends in avoidable mortality in England and Wales, 1993–2005. Health Statistics Quarterly 34 (2007)
2. The Burden Of Lung Disease, 2nd Edition. British Thoracic Society (2006).
3. Seamark DA et al. Home or surgery based screening for chronic obstructive pulmonary disease (COPD)? Primary Care Respiratory Journal 2001;10:30-3.
4. CG12: Chronic obstructive pulmonary disease. NICE (2004).
5. PHIG 1: Brief interventions and referral for smoking cessation in primary care and other settings. NICE (2006).
6. Appleton S et al. Ipratropium bromide versus short acting beta-2 agonists for stable chronic obstructive pulmonary disease. Cochrane Database of Systematic Reviews 2006, Issue 2. Art. No.: CD001387. DOI: 10.1002/14651858.CD001387.pub2.
7. Calverley PMA et al. Salmeterol and fluticasone propionate and survival in chronic obstructive pulmonary disease. N Engl J Med 2007;356:775–89
8. Ernst P et al. Inhaled Corticosteroid Use in Chronic Obstructive Pulmonary Disease and the Risk of Hospitalization for Pneumonia. Am J Respir Crit Care Med 2007; 176: 162–66.
9. Where Do We Stand? Asthma in the UK today. Asthma UK (2004).
10. Cohen S, Taitz J, Jaffé A. Paediatric prescribing of asthma drugs in the UK: are we sticking to the guideline? Arch Dis Child. 2007 Oct;92(10):847-9.
11. Salpeter SR et al. Meta-analysis: effect of long-acting beta-agonists on severe asthma exacerbations and asthma-related deaths. Ann Intern Med. 2006 Jun 20;144(12):904-12.
12. British Guideline on the Management of Asthma, Revised Edition. British Thoracic Society / Scottish Intercollegiate Guidelines Network (2007).
13. Kuna P et al. Effect of budesonide/formoterol maintenance and reliever therapy on asthma exacerbations. Int J Clin Pract 2007; 61, 5: 725-736

Controlled drug requisition forms

It is now a legal requirement for prescribers obtaining stock of controlled drugs (e.g. for doctor's bags or hospices) to complete a dedicated controlled drugs requisition form, the FP10CDF, for schedule 2 and 3 controlled drugs. Following changes to the Misuse of Drug Regulations, pharmacy contractors are now required to submit the FP10CDF to the NHSBSA PPD for audit purposes. Contractors should do this through the private controlled drugs submission account regardless of whether the prescriber has used their NHS or private prescription code to order the drugs. The private prescription submission document FP34PCD (available on the PPD website at **www.ppa.org.uk/pdfs/FP34PCD.pdf**) has been updated to include an area to record the number of requisitions submitted.

Use of the FP10CDF is not a legal requirement for the transfer of stock between pharmacies but it is considered good practice. FP10CDFs are available from your local PCT. If you have not yet received a supply, you should contact your accountable officer for controlled drugs at your local PCT.

PPD is... open

The PPD is planning a series of open days where you can come and visit us to see how we process with our new system. If you would like to put your name down to visit us please phone **0845 610 1171**.

New details for contractors who send batches to Sheffield

As of 1 April you **must** send your batch to:

NHS Business Services Authority
Prescription Pricing Division
4th Floor
Wakefield House
Borough Road
Wakefield
West Yorkshire
WF1 3AZ

Contact details for the NHSBSA

For general enquires relating to the NHSBSA, contact the Head Office:

Bridge House, 152 Pilgrim Street, Newcastle upon Tyne, NE1 6SN

0191 232 5371

For all queries relating to the NHS Low Income Scheme, contact Patient Services:

0845 850 1166

For general queries, prior to applying for Prescription Pre-payment, Medical and Maternity Exemption Certificates:

0845 850 0030

For specific queries, after applying for/receiving Prescription Pre-payment, Medical and Maternity Certificates:

0845 601 8076

For queries about NHS Tax Credit Exemption Certificate:

0845 609 9299

For enquiries relating to Pharmacy Processing, Prescription Searches, Personal Administration, Dispensing Doctors and Contractor Payment Information contact the new Prescription Pricing Help Desk on:

0845 610 1171

This number should be used with immediate effect and replaces any existing numbers you currently use.

For enquiries relating to applications for the European Health Insurance Card (EHIC):

0845 605 0707

0191 203 5555 (from outside UK)

Ehicenquiries@ppa.nhs.uk

Enquiries on all PPA Electronic Systems (EPACT, ePACT.net and Prescribing Toolkit) and on the availability and content of reports produced by the PPA:

0191 203 5050

help@ppa.nhs.uk

Our next edition of Impact will be a special edition focusing on our new processing system and is due out by the end of May.

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