

The role of primary and community care in the assessment and management of COVID-19 in Winter 2023/24

Respiratory infections are very common in winter and can be complex to assess. Infection with SARS-CoV-2, whilst prevalent year-round,¹ is also more significant in winter and this article focuses on the assessment and management of people presenting with COVID-19 illness, as winter 2023/24 approaches.

Helping people to avoid developing severe COVID-19 illness is a key primary care activity. Organising and encouraging people to have immunisation against SARS-CoV-2 is important as this is a highly effective and critical intervention in this regard.² Each UK nation has a slightly different approach when deciding on eligibility for a free vaccine for this winter.

Many clinicians are already seeing patients affected by the impact of austerity measures on their ability to keep warm and well-nourished and the article also explores how inequality factors associated with worse COVID-19 outcomes can be mitigated against.

Before SARS-CoV-2, the clinician assessing someone with respiratory symptoms would have considered possible causes such as influenza virus and pneumonia-causing bacteria because antimicrobial therapies, when used in a timely way, can avoid progression to more severe illness. Pre-pandemic, respiratory antiviral use was indicated specifically for suspected influenza and was available to prescribe once centrally approved by public health experts monitoring circulating flu virus levels and under fairly strict criteria.

The COVID-19 pandemic significantly changed our understanding of antivirals and the rapid advancement in knowledge has demonstrated that early and appropriate use of antivirals has not only helped with reducing the risk of admission of people infected but also prevented the need for intensive care and avoided deaths.³

Subsequently, a further rapid phase of testing COVID-19 antiviral therapies has resulted in new recommendations in 2023 and these are detailed within the updated NICE guideline NG1913. The recommendations now include neutralising monoclonal antibody (nMAB) therapies that target SARS-CoV-2, providing new therapeutic options that have the potential to be prescribed and administered in primary and community care this winter, assuming this comes with appropriate commissioning.

The updated NICE NG191 guidance document highlighting

these therapies now incorporates all the multiple rapid guidelines that were developed during the pandemic into a single more accessible guide. Many of the recommendations made early in the pandemic were based on the consensus of the guideline expert panels with supporting information being limited. These have now been reviewed, again including topic expert opinion but also more recent evidence, with updating of recommendations where needed.

Assessing the patient with suspected SARS-CoV-2 infection

Assessing severity of disease, risk of progression and place of care

When someone presents with symptoms consistent with COVID-19 illness, an assessment of severity will be required. Those presenting in the community with non-severe disease can then be considered for interventions that ease symptoms and for eligibility to have medicines that prevent the progression of the disease. Most people who have been immunised will have mild illness.

Table 1. NICE NG191 signs of severe COVID-19 illness³

Severe shortness of breath at rest or difficulty breathing **
Reduced oxygen saturation levels measured by pulse oximetry *
Coughing up blood
Blue lips or face
Feeling cold and clammy with pale or mottled skin
Collapse or fainting (syncope)
New confusion
Becoming difficult to rouse
Reduced urine output

*NHS England has provided principles and documentation to support the use of pulse oximetry in primary community care including a self-monitoring diary⁴

** NICE advise that assessing shortness of breath is important, but may be difficult via remote consultation. Tools such as the Medical Research Council's scale⁵ can be useful.

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Figure 1. WHO CV-19 illness severity classification

Population

This recommendation applies only to people with these characteristics:



Disease severity

Non-severe	Severe	Critical
Absence of signs of severe or critical disease	Oxygen saturation <90% on room air	Requires life sustaining treatment
	Signs of pneumonia	Acute respiratory distress syndrome
	Signs of severe respiratory distress	Sepsis
		Septic shock

Adapted from an Infographic co-produced by the British Medical Journal (BMJ) and MAGIC7 (a research and innovation programme for digital user-friendly guidelines, evidence summaries and decision aids). Designer Will Stahl-Timmins. <https://www.bmj.com/content/370/bmj.m3379>

Those with severe disease need admission, and those with less severe disease may be (as always) managed in the community, or more recently go to an acute respiratory infection (ARI) hub to assess further or potentially be admitted to a virtual ward.

Table 1 shows the findings within community care indicating the severity and need to follow appropriate local pathways.³

The NICE NG191 guide recommends a diagnostic classification system adopted by the World Health Organisation (WHO) in their 2023 Therapeutics and COVID-19 Living Guideline⁶ (See Figure 1).

General practice is familiar with the categorisation of higher-risk cohorts for winter infection due to the annual call-up to specific groups for influenza vaccination. As new therapies for treating COVID-19 have come online, guidance about the risk for progression of COVID-19 illness has been developed. In March 2023, The Department of Health and Social Care (DHSC) defined the highest-risk clinical subgroups who if exposed to community infection with SARS-CoV-2 should be considered for specific COVID-19 therapies.⁸ This guidance has also been adopted by NICE.⁹

The categories will look familiar to the 'flu cohorts', but the criteria and parameters are narrower than those for flu immunisation eligibility. It should be noted for chronic respiratory disease, that only those with the most severe disease are eligible to receive treatment with these novel antivirals.

The NICE rapid guideline NG191 on managing COVID-19 highlights particular inequality characteristics and recommended actions to support these individuals in managing COVID-19 and any associated complications.

Testing for SARS-CoV-2 winter 2023/24

NHS COVID-19 rapid lateral flow tests are no longer free for most people.¹³ However, free tests can be ordered by people who are identified as eligible to receive COVID-19 treatments (See table 3).

Each nation has web information about testing eligibility and how to obtain them.

England

<https://www.nhs.uk/nhs-services/covid-19-services/testing-for-covid-19/who-can-get-a-free-nhs-covid-19-rapid-lateral-flow-test/>

Northern Ireland

<https://www.nidirect.gov.uk/articles/coronavirus-covid-19-testing-and-stay-home-advice>

Scotland

<https://www.nhsinform.scot/illnesses-and-conditions/infections-and-poisoning/coronavirus-covid-19/coronavirus-covid-19-treatments/>

Wales

<https://www.gov.wales/get-tested-coronavirus-covid-19>

NICE NG191 treatment options for confirmed COVID-19 in primary and community care³

The vast majority of those infected with COVID-19 will not have severe disease and will not be in a higher risk category for severe disease. Immunisation against SARS-CoV-2 is a critical intervention for the most at risk to help avoid severe disease.² Most

Table 2. People at higher risk of progression to severe COVID-19 illness - NICE⁹/DHSC⁸

Adults	Down's syndrome, any chromosomal disorder affecting immunity, specialist diagnosed immunodeficiencies
	Solid cancer higher risk categories - metastatic, lung, recent chemotherapy, radiotherapy or surgery
	Haematological disorders - blood cancers, stem cell transplant, sickle cell disease, thalassemia and rare anaemias
	Renal - transplant, chronic kidney disease stage 4/5
	Liver - Cirrhosis and other severe disease, transplant
	People with organ transplants
	Respiratory <ul style="list-style-type: none"> - asthma if on oral steroids or other immune suppressants - note very small numbers - COPD - most severe disease, defined as on LTOT or NIV, FEV1 <50% predicted and exacerbating (4 courses of oral steroids in 1 year) - note very small numbers - ILD - all patients with idiopathic pulmonary fibrosis, and most people in other ILD groups - Anyone receiving home ventilation - Pulmonary hypertension - more severe disease
HIV/AIDS - untreated HIV (high viral load) AIDS defining illness, CD4<350 or CD4>350 if other factors e.g. alcohol, homeless, age, other chronic disease.	
Neurological - neuromuscular respiratory failure e.g. MND, conditions needing immune suppression e.g. MS, dementia when severe frailty associated,	
Children (Older than 12 and younger than 18 and > 40Kg)	Substantial risk - Complex life-limiting neurodisability with recurrent respiratory infections or compromise - rare
	Significant risk - 2 or more of: <ul style="list-style-type: none"> - Primary immune deficiency - Secondary immune deficiency e.g. chemotherapy, uncontrolled HIV - very rare in primary care - Immune suppressant therapies e.g. chemotherapy recently. Steroids are included in this criterion but NOT inhaled and only very high daily and prolonged doses i.e. corticosteroids > 2mg/kg per day every day for the last month. - Other conditions - includes BMI>95th centile, severe respiratory disease e.g. Cystic Fibrosis, severe disease of e.g. kidney, cardiac, liver. - Asthma - CYP with severe asthma who have had an intensive care admission in the last year

people, once assessed as having mild illness will only need advice about control of symptoms until they settle.

For those assessed and found to not have severe illness but who are at increased risk of progression, there are a number of drugs available.

Since the pandemic, further clarity on the efficacy and safety of those medicines recruited rapidly during the pandemic has resulted in new guidance about use but also new medicines, in particular antivirals and neutralising monoclonal antibodies are emerging, some of which have the possibility of being used in primary and community care settings.

Symptom Control: Cough, fever, breathlessness, anxiety and delirium

Managing cough (NICE NG191) - See Figure 2

- In general people should avoid lying on their backs as this may make a cough less effective.
- Anyone over 1 year of age can use a teaspoon of honey to soothe the symptom of a cough.
- Short-term use of codeine linctus, codeine phosphate tablets or morphine oral solution can be used in those over 18 with

more distressing cough. The PCRS view is that this option should be for very distressing coughs and only if nothing else works due to the risks of sedation with opiates.

Managing fever and dehydration

- Drink fluids to avoid dehydration. People with COVID-19 illness may be at risk of acute kidney injury (AKI) due to dehydration at all stages of the illness.
- Use paracetamol or ibuprofen whilst symptomatic and then stop when symptoms settle.

Managing breathlessness

- Keep the room cool
- Use relaxation and breathing techniques and body position changes
- Improve room air circulation by opening a window or door
- Use a fan over the nose and mouth
- If hypoxia is causing breathlessness but the COVID-19 illness has been assessed as not severe then a trial of home oxygen can be considered after referral to a trained oxygen prescriber

Figure 2. Treatments for managing cough in people 18 years and over³

Treatment	Dosage
Initial management: use simple non-drug measures, for example, taking honey	A teaspoon of honey
First choice, only if cough is distressing: codeine linctus (15 mg/5 ml) of codeine phosphate tablets (15 mg, 30 mg)	15 mg to 30 mg every 4 hours as required, up to 4 doses in 24 hours. If necessary, increase dose to a maximum of 30 mg to 60 mg four times a day (maximum 240 mg in 24 hours)
Second choice, only if cough is distressing: morphine sulfate oral solution (10 mg/5 ml)	2.5 mg to 5 mg when required every 4 hours Increase up to 5 mg to 10 mg every 4 hours as required If the person is already taking regular morphine increase the regular dose by a third

Notes: See the [BNF](#) and [MHRA](#) advice for appropriate use and dosage in specific populations.

All doses are for oral administration.

Consider the addiction potential of codeine linctus, codeine phosphate and morphine sulfate. Issue as an 'acute' prescription with a limited supply. Advise the person of the risks of constipation and consider prescribing a regular stimulant laxative.

Avoid cough suppressants in chronic bronchitis and bronchiectasis because they can cause sputum retention.

Managing anxiety, delirium and agitation

- The NICE NG191 guidance suggests that exploring concerns and anxieties during the acute illness can help manage symptoms.

NICE supports the short-term use of benzodiazepines when social and psychological interventions are not sufficient. This is a very rare last resort that should be approached with care.

Additional considerations for COVID-19 symptoms co-existent with asthma, COPD and or other chronic respiratory illness

People with COPD and asthma are no more likely to get infected with SARS-CoV-2 but are at a higher risk of worse outcomes from COVID-19 compared to the background population and are therefore included in vaccination campaigns and in eligibility criteria for free testing and antiviral drugs.

- Consider whether the features of asthma / COPD / CRD exacerbation are present
- Review their action / self-management plan
- Ensure regular therapies are being taken with appropriate technique if relevant and adjust according to their action / self-management plan.
- Use rescue medication as needed and check spacer use if the device is a pMDI.
- Check supplies of emergency medicines such as rescue antibiotics and oral prednisolone in accordance with their personal self-management plan

Therapies that can reduce progression to severity or treat severe disease

There are four classes of medicine currently recommended and available in the NHS to help avoid progression to severity.

Four (three in Wales) antivirals or nMABs are available for use in primary and community NHS care. More antivirals and nMABs are available for hospital-only care and there are also the options of oral corticosteroids and low molecular weight heparin (LMWH) for hospital use only.

A number of medicines that may have been used during the pandemic such as inhaled budesonide and some antibiotics are not recommended though some have research recommendations and may be used in trials.

Antivirals and neutralising monoclonal antibodies

There are currently three antiviral medicines available for use, all of which are suitable for use outside of hospital. Two of these (remdesivir and molnupiravir) are still under assessment by NICE but with interim use recommendations. There are five nMABs that have been reviewed by NICE, of which three have been approved for use, one of which can be used outside hospital (Table 3). The latest review came in February 2023 with three new approvals.¹⁴

- An antiretroviral combination medicine, *nirmatrelvir plus ritonavir* - known as Paxlovid
- Two nMABs
Sotrovimab - known as Xevudy
Tocilizumab - known as RoActemra

Table 3. Winter 2023/24 eligibility and indications for antiviral and nMAB use.

		NICE Guidance	What this means for primary care
Antivirals	Nirmatrelvir plus Ritonavir	In adults who do not require oxygen and have an increased risk for progression to severe disease* Use within 5 days of onset of symptoms Draft partial review of guidance August 2023 ¹⁶ recommends use additionally in: <ul style="list-style-type: none"> • Aged 70 and over • BMI 35 or more • Diabetes • Heart Failure 	Suitable for use in mild COVID-19 illness in primary care. Both drugs come as tablets, twice daily dose for 5 days.
	Remdesivir	Clinical and cost effectiveness is currently under review ¹⁷ . Final guidance not expected until late 2023 at the earliest. Interim 'conditional' recommendations: 1) Consider a 3-day course for CYP >40kg and adults who <ul style="list-style-type: none"> • do not require oxygen and have • within 7 days of onset • an increased risk for progression to severe disease • Adhere to NHSE criteria¹⁸ 2) Consider a course (up to 5 days) for people with <ul style="list-style-type: none"> • COVID-19 pneumonia • Hospitalised and using low flow oxygen 	Suitable for use outside hospital if NHSE criteria fulfilled and according to their guidance. ¹⁸ Not available in Wales. Powder for infusion. 3-day course if not hospitalised. There are feasibility concerns about setting up an infusion service in primary care.
	Molnupiravir	Clinical and cost effectiveness is currently under review ¹⁷ . Guidance not expected until late 2023 at the earliest. Interim 'conditional' recommendations: Consider a 5-day course for adults who <ul style="list-style-type: none"> • do not require oxygen • within 5 days of symptom onset • an increased risk for progression to severe disease* • Adhere to NHSE criteria¹⁸ 	Guidance awaited with interim conditional use. It has the potential for use in primary and community care. Comes as a hard capsule, 4 capsules twice daily.
Neutralising monoclonal antibodies (nMABs)	Sotrovimab	In people aged 12 and over and >40kg who do not require oxygen and have an increased risk for progression to severe disease* AND they have a contraindication to using Nirmatrelvir with Ritonavir. For use within 5 days of onset of symptoms	Suitable for use in mild COVID-19 illness in primary care. Concentrate for infusion. Single intravenous dose.
	Tocilizumab	Adults requiring systemic corticosteroids and oxygen or mechanical ventilation	Not suitable for primary care use Concentrate for infusion.
	Tixagevimab plus Cilgavimab	Clinical and cost effectiveness is currently under review ¹⁷ . Guidance not expected until late 2023 at the earliest Some studies have suggested this nMAB combination can reduce infection i.e. act as pre-exposure prophylaxis. NICE has however reviewed and does not recommend for this indication ¹⁹ .	Not recommended for use in any setting
	Casirivimab plus Imdevimab	It is highly uncertain that casirivimab plus imdevimab is effective against Omicron variants of COVID-19.	Not recommended for use in any setting.
	Baricitinib	Conditionally recommended (People 2 years and over): People needing oxygen, having oral corticosteroids, no other infection.	Not suitable for primary care use

* See table 2

There is no evidence to support the use of a combination of antivirals and nMABs. NICE NG191 however has recommended research in this area.

Primary Care Respiratory Update

These approvals followed a review of a number of potentially beneficial anti-viral and nMAB treatments. Some that showed initial promise were not approved because new variants may escape susceptibility.¹⁵ As a result, NICE has developed a system to quickly assess and review potential new medicines because COVID-19 variants in circulation change frequently.

Paxlovid and Xevudy are suitable for people with mild COVID-19 illness who do not need oxygen and are at high risk of progression. Xevudy use is restricted to those who cannot take Paxlovid.

Those with COVID-19 suitable for antivirals or nMABs are

limited to those who i) have severe disease and are hospitalised and ii) those with mild disease and categorised as at risk of progression (Table 2).

Table 3 describes the current status, as described by NICE, of a number of antivirals and nMABs. Some have been approved for use in those not requiring hospital care and therefore have the potential to be prescribed and administered in primary and community care. However, they would require locally specific logistics e.g. where the delivery mode is intravenous, it requires daily visits or needs administration in a space suitable for resuscitation.

Table 4. Safety, adverse effects and inequalities for currently available and ‘under review’ novel therapies with potential for use in primary and community care

		Safety / potential adverse events	Inequalities
Antivirals	Nirmatrelvir plus Ritonavir	Diarrhoea, vomiting, dysgeusia (altered taste)	Large number of medicinal contraindications limiting its use in people with multiple drug requiring multimorbidity. Black, Asian and other minority ethnic groups are more likely to have renal and hepatic impairment for which this combination is contraindicated Not suitable in CYP The option of Sotrovimab as an alternative resolve some of this inequality
	Remdesivir	Self-reported and in order of frequency - nausea, headache, cough, diarrhea, dyspnea, fatigue, ageusia (loss of taste), anosmia (loss of smell), dizziness, chills, pyrexia, and COVID-19 pneumonia.	The intravenous mode of delivery for remdesivir could make it inaccessible to subgroups with lower socioeconomic status, mobility impaired, travellers, homeless, carers. Children and young people, those from a minority ethnic family background and pregnant were underrepresented in the main study that has informed this guidance.
	Molnupiravir	Insufficient safety and efficacy data in pregnancy and CYP	This drug has the potential to address health inequality arising from being housebound as it is oral and can be delivered to a household.
Neutralising monoclonal antibodies (nMABs)	Sotrovimab	Hypersensitivity reactions are the most common adverse effects. This includes, rash, contact dermatitis, bronchospasm. Administration will need to be in an environment where resuscitation after anaphylaxis could safely take place	NICE did not highlight any health inequality concern. Those unable to leave their home are unlikely to be suitable due to the logistics of providing a safe environment in case of hypersensitivity reaction.

Delivering greener kind respiratory care

Ensuring timely access to treatment for individuals at risk of exacerbation is crucial not only for a more sustainable approach to respiratory health but also for steering clear of unnecessary hospital admissions

Additional therapies for people hospitalised with COVID-19

Table 5. Other therapies for people hospitalised with COVID-19

	NICE Guidance	Relevance for primary care
Corticosteroids	Oral dexamethasone (hydrocortisone or prednisolone if unavailable) is recommended for people with hypoxia requiring supplemental oxygen.	A 10-day course usually prescribed and people may be completing a course after discharge from hospital or virtual ward. People with asthma or COPD requiring oral steroids for exacerbation should be given as usual even if they have co-existent COVID-19 illness.
Low molecular weight heparin (LMWH)	Nice recommends a standard prophylactic dose of LMWH as soon as possible, and within 14 hours of admission, to young people and adults with COVID-19 who need low-flow or high-flow oxygen, continuous positive airway pressure, non-invasive ventilation or invasive mechanical ventilation, and who do not have an increased bleeding risk.	Treatment should be continued for a minimum of 7 days and so may complete after discharge from hospital or virtual ward.

Therapies that are NOT recommended or recommended for use only as part of a trial to treat COVID-19

Table 6. Therapies that are NOT recommended or recommended for use only as part of a trial to treat COVID-19

	NICE Guidance	What this means for primary care
Antibiotics	Antibiotics should not be used for preventing or treating COVID-19 unless there is clinical suspicion of additional bacterial co-infection	People with asthma, COPD and other chronic respiratory disease that require antibiotics as part of their exacerbation management plan should continue as usual.
Anti-inflammatory antibiotics	Azithromycin and Doxycycline should not be used to treat COVID-19 illness.	People with COPD and other CRDs that require azithromycin or doxycycline, for their anti-inflammatory properties rather than antibacterial ones, as part of their prevention or exacerbation management plan should continue as usual.
Inhaled budesonide	Only use as part of a clinical trial	People with asthma and COPD will commonly be using budesonide. Their treatment plan should not be altered if they have co-existent COVID-19 illness
Colchicine	Colchicine should not be used to treat COVID-19 illness.	
Ivermectin	Do not use ivermectin to treat COVID-19 except as part of an ongoing clinical trial.	
Vitamin D	Do not use vitamin D to treat COVID-19 except as part of a clinical trial.	

Pathways for the management of COVID-19 Winter 2023/24

Each UK nation has a dedicated website that provides advice and signposting for further support. Each site has a page that describes the symptoms, whether free testing is an option and how to self-care. It also provides advice on when to get more help.

Each country has information about the availability of antivirals and provides more information about how to take it, side effects and common questions.

NHS England

<https://www.nhs.uk/conditions/covid-19/treatments-for-covid-19/>

NHS England currently lists availability as nirmatrelvir plus ritonavir (Paxlovid), sotrovimab (Xevudy), remdesivir (Veklury), molnupiravir (Lagevrio).

Anyone previously identified as high risk for severe disease by a clinician and who would be eligible for free COVID-19 tests, immunisations and potentially antiviral therapies who then tests positive is asked to contact 111, their GP, or a hospital specialist.

Figure 3. NHS advice about getting further help when unwell with COVID-19

Ask for an urgent GP appointment or get help from NHS 111 if:

- you're worried about your or a child's COVID-19 symptoms or are not sure what to do
- the symptoms are getting worse or are not getting better
- you or a child have other signs of illness, such as a rash, loss of appetite, or feeling weak
- you or a child have a high temperature that last 5 days or more or does not come down with paracetamol
- a child under 3 months old and has a temperature of 38C or higher, or you think they have a high temperature
- a child 3 to 6 months old and has a temperature of 39C or higher, or you think they have a high temperature

It's particularly important to get help if you're at increased risk of getting ill from COVID-19, such as if you're pregnant, aged 60 or over, or have a weakened immune system.

You can call 111 or [get help from 111 online](#).

Call 999 or go to A&E if you or a child:

- seems very unwell, is getting worse or you think there's something seriously wrong – children and babies in particular can get unwell very quickly
- get sudden chest pain
- are so breathless you're unable to say short sentences when resting or your breathing has suddenly got worse – in babies their stomach may suck in under their ribs
- start coughing up blood
- collapse, faint, or have a seizure or fit for the first time
- a rash that does not fade when you roll a glass over it, the same as [meningitis](#)

Source: <https://www.nhs.uk/conditions/covid-19/covid-19-symptoms-and-what-to-do/>

The site also has links to each of England's integrated care boards (ICBs) and people who consider themselves eligible for antiviral therapy are advised to contact the ICB if their own health service provider has not already provided contacts and a pathway. This would not be an ideal pathway and people considered to be at risk for severe illness should be advised to have a plan in place.

In some areas,²⁰ antivirals are distributed centrally from Covid Medicine Delivery Units (CMDUs). If a patient's first contact is with primary care, they are referred to CMDU for delivery or collection.

HSC Northern Ireland

The same three antivirals and one nMAB available in England are also available in each of the five Health and Social Care (HSC) Trusts in Northern Ireland.

For people where there is coding in the HSC central record system suggesting eligibility for COVID-19 treatment, they should receive a text message, after reporting a positive test, that their local HSC Trust will be told and that medical staff will review their medical records. Those assessed as suitable for treatment will then be contacted to discuss further.

People who do not receive a text message about treatment but consider themselves eligible are asked to contact their GP practice.

NHS Scotland

The same three antivirals and one nMAB available in England and Northern Ireland are also available in Scotland. There is a contact phone number for all fourteen health boards for people to call if they are in a high-risk group and have a positive test. They may reach an answer phone when they call. People who fall ill when away from their home health board are advised to still call the number for the health board where they usually stay.

NHS Wales

NHS Wales currently lists availability as nirmatrelvir plus ritonavir (Paxlovid), sotrovimab (Xevudy), and molnupiravir (Lagevrio). Remdesivir (Veklury) is not approved.

The supply of treatments for COVID-19 in Wales for those not admitted to hospital, with a positive test is being co-ordinated by NHS 111 Wales and delivered at health board level. People who consider themselves eligible with a positive test are asked to use a self-referral portal.

The responsibility for the provision of COVID-19 therapies in the community has recently moved from the All Wales Information Service, National Antiviral Service (now decommissioned) to NHS 111. This means that information for healthcare can currently be situated in both places.

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