

Longsight Medical Practice

Inspection report

526-528 Stockport Road

Manchester

Lancashire

M13 0RR

Tel: 01612564488

www.longsightmedicalpractice.com

Date of inspection visit: 19/07/2018

Date of publication: 10/08/2018

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive?

Good 

Are services well-led?

Good 

Overall summary

This practice is rated as Good overall.

This was the first inspection of this GP practice under this registered provider.

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

We carried out an announced comprehensive inspection at Longsight Medical Practice on 19 July 2018. The GP partnership, took over this practice in October 2016 and the registration of the service with the CQC was completed in March 2018.

This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.

- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found telephone access problematic and the practice had installed a new telephone system to try to improve this.
- The practice was responsive to need of vulnerable patients and offered direct telephone access to Citizen's Advice. The practice was a designated homeless friendly and war veteran friendly GP surgery and provided an inhouse food bank service.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider should make improvements are:

- Continue to seek solutions to improve patient access.
- Continue to identify and support patients who are also carers.
- Continue to promote patient participation through the practice reference group.
- Implement the planned improvement to the practice opening hours in line with the NHS contracting arrangements.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

Older people	Good 
People with long-term conditions	Good 
Families, children and young people	Good 
Working age people (including those recently retired and students)	Good 
People whose circumstances may make them vulnerable	Good 
People experiencing poor mental health (including people with dementia)	Good 

Our inspection team

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser.

Background to Longsight Medical Practice

Longsight Medical Practice is located at 526-528 Stockport Road, Manchester, M13 0RR. The practice is part of the NHS Manchester Clinical Commissioning Group (CCG) and provides services under a General Medical Services contract with NHS England. It has 4749 patients on its register. The practice website address is www.longsightmedicalpractice.com

The surgery is provided from a purpose-built health care centre and is in a busy residential and commercial area. The practice provides consultation and treatment rooms on the ground floor and provides good access for those with mobility problems. Patient car parking is available at the health centre.

The practice is a part of a group of nine practices with separate CQC registrations but affiliated to the CQC registered GP partners. The group is referred to by the provider and staff as Beacon GP Care. One GP partner (male) works at the practice and they are supported by one male salaried GP and three long term locum GPs (two male and one female). The staffing complement includes two practice nurses, two health care assistants, one practice manager, an assistant practice manager and a number of administrative and reception staff.

The practice confirmed their opening hours were under review. At this inspection the practice opens Mondays to Fridays from 8.30am to 6.00pm, except Wednesdays when the practice closes at 3pm. The Out of Hours (OOH)

provider Mastercall provides telephone cover between 8 and 8.30am each morning and on Wednesday afternoons the OOH provider Go-To-Doc provide cover for the practice patients. The practice offers morning and afternoon surgeries and extended hours are available with the two practice nurses on Tuesday mornings between 7am and 8am.

The practice offers approximately 90% of appointments on the same day and same day appointments are also available at one of the hub sites for Primary Care Manchester. These are local surgeries who offer extra appointments seven days a week for those patients who have an urgent need to see a doctor on the day. They also offer weekend appointments if preferred.

Information published by Public Health England rates the level of deprivation within the practice population group as one on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice has a higher number of patients under the age of 18 years, 32% compared with the CCG average of 24% and England average of 21%. Conversely, there is a lower number of patients over the age of 65 years (5%) compared with the CCG average (10%). The largest age group of patients registered at the practice are between 15 and 44 years.

The practice has 40% of its population with a long-standing health condition, which is lower than CCG and England averages of 53%. Unemployment at 14.6% is higher than the local average of 8.8% and national average of 5%.

The practice provides, surgical procedures, maternity and midwifery services, treatment of disease, disorder or injury and diagnostic and screening procedures as their regulated activities.

Are services safe?

We rated the practice as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Learning from safeguarding incidents was available to staff. Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.

- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The care records we saw showed that information needed to deliver safe care and treatment was available to staff.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, minimised risks.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- A range of different medicine audits were available and these demonstrated that the practice implemented action to improve prescribing practice and ensure patients received appropriate monitoring and review.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed safety using information from a range of sources.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

Are services safe?

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and acted to improve safety in the practice.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Please refer to the evidence tables for further information.

Are services effective?

We rated the practice and all the population groups as good for providing effective services

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified with three or more coexistence disease processes (co-morbidities) had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People

with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.

- The practice could demonstrate how it identified patients with commonly undiagnosed conditions, for example diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice's performance on quality indicators for long term conditions generally reflected local and national averages.

Families, children and young people:

- Childhood immunisation uptake rates were above the target percentage of 90% for three of the four indicators. One indicator was just below the 90% target. The practice believed this was a data coding error.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

Working age people (including those recently retired and students):

- The national screening programme uptake for cervical screening has a coverage target of 80%. The practice's uptake for cervical screening was 69%, which was above the local average of 65% but below the England average of 72%. The practice was proactive in recalling patients for this screening, including direct telephone calls, text messaging and opportunistic provision.
- The practice's uptake for breast and bowel cancer screening was below the national average. The practice was aware of this and two staff members (one clinical and one non-clinical) had attended training recently and were the practice's cancer champions.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which considered the needs of those whose circumstances may make them vulnerable.

Are services effective?

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

People experiencing poor mental health (including people with dementia):

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis.
- The practice offered annual health checks to patients with a learning disability.
- The published data available regarding the practice's performance on quality indicators for patients experiencing poor mental health including dementia reflected local and national averages. Exception reporting figures were lower than local and national averages. (Exception reporting is the removal of patients from the Quality Outcomes Framework (QOF) calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects.)

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

- Practice performance for quality indicators for 2016/17 measured by the Quality and Outcomes Framework (QOF) was similar to the local and national averages.

- The practice had excepted 8.3% of patients overall, lower than local (10.5%) and national (9.6%) averages.
- The practice used information about care and treatment to make improvements.
- The practice was aware of the challenges of the local population demographics and worked hard to provide care and treatment to patients.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. Staff told us they felt valued and were supported with opportunities to learn new skills. Staff had personal development plans in place.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering care and treatment.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They

Are services effective?

shared information with and liaised with community services, social services, carers for housebound patients and with health visitors and community services for children who have relocated into the local area.

- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which considered the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may need extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.

- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The practice team were developing local community links to seek ways of delivering healthcare education to the local population.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.

Please refer to the evidence tables for further information.

Are services caring?

We rated the practice as good for providing caring services .

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practice's GP patient survey results were generally just below local and national averages for questions relating to kindness, respect and compassion.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff we spoke with had a good understanding and awareness of working with patients to deliver a patient focused service.
- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available as required.

- GPs working at the practice could speak a range of languages which promoted improved communication with patients who did not have English as their first language.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice has a designated Carer's Champion and were working to improve identification of patients who were carers.
- The practice's GP patient survey results were slightly below local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Are services responsive to people's needs?

We rated the practice, and all the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services.
- The practice provided effective care coordination for patients who were more vulnerable or who had complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice promoted continuity of care by trying to ensure patient appointments were with the same clinician.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- Systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances were implemented. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child were offered a same day appointment when necessary.

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, pre-bookable early morning appointments were available with a practice nurse one morning each week.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice was a designated 'homeless friendly' practice. It had made a commitment to provide supportive and welcoming services to those who were homeless, including registration at the practice.
- The practice had a designated Citizen's Advice phone line installed for patients to use for advice and support across a range of initiatives. Citizens Advice also held weekly advice surgeries for patients.
- The practice was a 'war veterans' friendly GP practice and displayed posters to advertise this.
- The practice had recently instigated their own 'food bank' to support patients in need.

People experiencing poor mental health (including people with dementia):

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.

Timely access to care and treatment

Patients could access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.

Are services responsive to people's needs?

- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that telephone access was poor. The practice was aware of this and had installed an upgraded telephone system in April 2018. The practice felt this had improved patient telephone GP access, however data was not yet available to support this belief.
- The GP patient survey results were below local and national averages for questions relating to access to care and treatment. The practice was aware of this and was seeking ways to improve patient access. The practice manager confirmed the practice was considering extending telephone access from 8.30am to 6.30pm Monday to Friday. The practice confirmed they actively promoted the availability of same day

appointments at one of the Primary Care Manchester's hub sites. These are local surgeries who offer extra appointments with GPs and practice nurses seven days a week.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The organisation learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Are services well-led?

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The provider organisation had effective processes to develop leadership capacity and skills. We spoke with staff who explained the organisation provided opportunities to develop along a career pathway.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.

- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Are services well-led?

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were comprehensive arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. There was not an active patient reference group (PRG). This was a virtual group, whereby the practice manager sent out twice yearly questionnaires to seek feedback about the service provided at the practice.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

Please refer to the evidence tables for further information.