

Private & Confidential

Mrs Alison Mutch
H M Senior Coroner
1 Mottram Street
Mount Tabor
Stockport
SK1 3AG

11 December 2023



Dear Mrs Mutch

Mark Anthony McKessy (RIP)

I refer to the Regulation 28 Report issued following the inquest into the death of Mr McKessy and thank you for contacting the One Stockport Health & Care Board in regard to this matter.

I am sorry to learn of the circumstances of Mr McKessy's death and would ask that you convey sincere condolences to his family.

In your report you highlighted two key areas of concern, for which I will provide a response as follows:-

A lack of recognition by agencies involved with him of his health issues and their inter relationship with his social care and learning disability needs including the extent to which he had capacity. This was compounded by limited Care Act assessments.

Mr McKessy was registered at Cheadle Medical Practice who had regular contact with him. When he consulted with the practice he was always supported by his parents.

Records reflect that Mr McKessy received a Learning Disability Health Check on 24th January 2023 and following his health check he was seen by the Care Co-Ordinator. A role linked to the practice that provides specific support for patients with a learning disability, he was also referred to the Enhanced Care Management Team. This team is within the practice, and is made up of senior clinicians and safeguarding staff. The role of the team is to review on a regular basis, complex cases to agree a way to best support the individual needs of the patient.

Our enquiries into Mr McKessy's support highlighted that whilst there is reference to Learning Disability Reviews and regular contact with Mr McKessy and his parents, the only formal Learning Disability Health Check is the one in Jan 2023. We would expect further health checks for Mr McKessy.

Supporting the completion of annual health checks for people with a learning disability with the health and social care needs is through a programme of work with Stockport Community Learning Disability Team. The team has a primary healthcare facilitator that works closely with GP's and other primary and secondary healthcare services. They support the reviewing of the Learning Disability Registers held by the GP practices and

provide training to the GPs in relation to best practice regarding the health promotion for people with a learning disability.

This role has supported the uptake of the Learning Disability Annual Health Checks with a completion rate of 92.4% for 2022/2023 and a current rolling 12-month performance of 88.3%. The monitoring of the learning disability registers and ongoing support around annual health checks in the future will be undertaken by the new primary care assistant practitioners. Performance will be monitored in locality primary care teams to ensure quality and completion and is reported through to The Greater Manchester ICS.

Recognising the challenge that some people with a learning disability face in accessing their GP, there is a Learning Disability Care-Coordinator in each Primary Care Network. This role further supports individuals with a learning disability accessing their GP and links to other appropriate services. The Primary Healthcare Facilitators meet regularly with the Care Coordinators to discuss individuals' circumstances and the service best to support them.

The NHS provider, Pennine Care NHS Foundation Trust (PCFT) have recently appointed a team of five Primary Care Practitioners, one per borough; their role will be around supporting the offer and uptake of annual health checks (AHC) for people with a learning disability. The team are currently reviewing data to understand whether the registers include the right people who are eligible to receive AHC's and the offer and uptake of AHC's. They are looking at what the data tells us in relation to GP practices and numbers of service users but also demographics such as gender, age and ethnicity to identify where we may need to increase awareness and engagement with specific groups and where we may need to prioritise support to practices where there may be lower uptake.

PCFT aims to develop an understanding around the impact of this new role and gain feedback from service users and their carers and have developed a feedback questionnaire (which includes the Friends & Family Test) that will help in the development and adaptation of the offer in supporting service users.

I hope this provides some reassurance to the work being undertaken by health in respect of people engaging with primary and secondary health services. We appreciate for Mr McKessy more could have been done with the further completion of annual health checks.

In respect of Mr McKessy's contact with adult social care, I can confirm that in the two years prior to Mr McKessy's death, he received an annual Care Act review of his care and support needs. This included two assessments of his Care Act eligible needs; these took place in June 2021 and January 2022.

Mr McKessy was living independently with the support from a strong family network and received low-level support from adult social care. This was primarily to access his local community for recreational purposes.

Regrettably, the covid pandemic impacted on the delivery of this support and in turn on Mr McKessy's wellbeing. The two assessments completed focused on the presenting issues. At the time this was for Mr McKessy; securing support to manage his finances, maintain his flat and to access the community for shopping and recreational activities.

We recognise there were missed opportunities at this time to fully understand his situation and the impact of drinking on his health and social care needs.

We continue to improve front line practice to ensure our frontline teams increase their knowledge and confidence in completing holistic assessments. To ensure management oversight of individual assessments and reviews we are introducing peer discussions to strengthen social work practice. The social care and specialist learning disability health team are co-located to support a joined-up approach to interventions. This is further supported by managers across social care and health meeting on a weekly basis, using the forum to refer individuals for a multi-disciplinary and multi-agency approach.

Following Mr McKessy's passing, analysis of our current offer, from both social care and health is being considered, including how we carry out assessments, provide advice, our signposting for individuals and our support provided people who experience any element of substance mis-use. This will be a standing agenda at the PCFT Quality Meetings; this will support consideration to further information or training for staff is required, whether we have appropriate information and resources to share with individuals and/or their carers.

Regarding Mr McKessy's capacity to make decisions about his healthcare needs, this was regularly considered and assessed by his GP. Records reflect that on each occasion that capacity was considered, he was found to have capacity to make decisions about his healthcare and any referrals made on his behalf. The last referral processed for Mr McKessy was to gastroenterology in October 2022. The option of a Power of Attorney (Health) was discussed and left as a matter for Mr McKessy's consideration.

Poor communication/information sharing between agencies which meant that there was no co-ordination of care and no clear overview of his needs.

Although there was activity at a GP practice level to share information and ensure escalations to any concerns were discussed. There were further opportunities to join up information to support a more holistic approach to Mr McKessy's support.

All Stockport GPs use the Emis Clinical system, including our community and out of hours services. This means that community and out of hours services directly accessing individual patient clinical records. At the current time, Pennine Care NHS Foundation Trust cannot directly access a patient's full clinical history. I can confirm that there is ongoing work within Greater Manchester to extend sharing of information across healthcare services.

To support further learning and the embedding of this learning from Mr McKessy's experience Stockport Safeguarding Partnership are linked with the LeDeR Review process.

There will be a joint learning event in January 2024 in relation to Mr McKessy's life and death. All the agencies involved in supporting people with a learning disability in Stockport will be in attendance and agree a joint action plan to further strengthen information sharing and improvements to practice. We will also liaise with Mr McKessy's family, if they wish to be involved, to share their experiences of the health and social care

interventions. Once agreed, I would welcome sharing this with you with updates from actions to provide further assurances.

I hope the above information is helpful to Mr McKessy's family. We continue to enhance the offer to people with a learning disability in Stockport and are committed to the development of accessible, person centred, co-ordinated care for people with a learning disability in Stockport and across Greater Manchester.

Yours sincerely



Chief Executive and Place Based Lead

