# Families with Complex Needs and the Impact upon the NHS

## Introduction

This report outlines the financial long term impact of Families with Complex Needs upon the NHS and then upon wider partners. It also highlights some possible key intervention points that need to be explored to identify whether interventions at these points could have prevented the long term high costs. Three family patient journey's are used to illustrate the impact of early years upon the likely pathway for the individuals within the family.

## Community Budgets and Families with Complex Needs

The Community Budgets programme is a national pilot and is working to bring organisations together locally within Leicestershire to make the best use of combined resources and to reduce the overall cost to commissioners. Within this programme a significant focus has been placed upon addressing the needs of families with complex needs.

There is non clear definition within the programme of a family with complex needs although the programme loosely describes the families as having multiple needs often with no adult in employment possibly with health problems and children with problems that have brought them into contact with services. The family journey maps in appendix 1, 2 and 3 highlight the types of needs these families may have.

The health input into the programme has focussed upon identifying the costs to health of these families and whether any options are available to reduce these costs. The annual costs to health are in excess of £600k for the three key individuals within the family. These costs do not include the increased costs of primary care or attendance at A&E or walk in centres that inevitably the families will have. They also do not include the lifetime costs for the families and the reduced life expectancy for them from the lifestyle they lead.

## Development of the Patient Journeys

The patient journeys were developed with commissioners who have expert knowledge of their field and have individual knowledge of cases like these. Whilst these were based upon actual cases some details have been changed to ensure the journey maps are more like the average complex needs family. The journey maps can therefore be generalised to a significant number of families within Leicestershire as whilst many might not have got to this point yet the likely outcome is for some predictable.

Each commissioner provided a timeline for the patient journey that highlighted the main points of contact with services and where the key incidents in the family life occurred that resulted in the problems later in life. Throughout the journey map there are several points of contact with services yet rarely were preventative

measures implemented that would have reduced the likelihood of the issues occurring in later life for some of the children.

During the work the three commissioners involved all stated that the children of families with complex needs will normally become the next family with complex needs. Therefore it is important that all partners work together to agree an approach that reduces the likelihood of the problems escalating.

Family Journey A is fairly typical of the type of family life experienced by individuals who find themselves within high and medium secure. With multiple needs and time spent in care with every effort being made to keep the family together without providing the support to the parents to ensure they have the emotional and psychological ability to manage. By the time Child B is 4 years old the damage is already done with some clinicians clearly of the view that by this age you can predict the likely journey for that individual if appropriate support is not provided. Individuals in High and Medium Secure cost between £150k - £300k per annum and preventative approaches with the family pre-birth and throughout childhood is likely to have prevented the 20 years at the current cost of £300k per annum.

Similar stories can be told with both family journey B and C with limited early support being given to these families. The kind of support needed involves all partners including third sector working together to deliver a co-ordinated package to the family. The role of a community grandparent to provide support to enable the parent child relationship to improve seems to be a good option but needs to be researched to identify the full benefit. Similar support roles have existed in Home Start in the past and need to be considered as a good model of community volunteers supporting families with complex needs, these volunteers need to be experienced parents or cares who can provide practical support to the family.

**Family Pathways in Health**

In order to understand how families navigate or access the service a map of mental health services was developed to help understand why individuals within a family may not get a co-ordinated approach to their health care needs, included in appendix 4. The draft service map shows the links between the various mental health services and clearly shows the complex web of services.

When looking at all partners involved in supporting a family with complex needs the simplification of access and referral may help to reduce the hand-offs and the inevitable drop out from services. Any work on families with complex needs will need to identify how the families are supported to access health services as and when required alongside improving the prevention and early intervention services for these families.

**Financial Impact**
The current service costs for these 3 families for health alone is in excess of £600k per annum. These costs are only the long term costs associated with long term placement for one individual in each family. They do not include increased primary care, mental health, substance misuse and non-elective activity which would need to be mapped to each individual family over a period.

Estimates would suggest that for each family prevention would have saved health alone in excess of £100k as a minimum or £300k per annum in total. If replicated across the county then the savings would be significant.

**Next Steps**
The programme needs sustained input from health as many of the access points for families with complex needs are to health services. Therefore it is recommended that: -

- An individual is identified to continue the work started over the last 6 – 8 weeks.
- The patient journey maps are used to identify options for preventing the long term costs
- Focus is put on preventing the next generation of families with complex needs going down a similar path.

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