

The Needs & Provision Complexity Scale (NPCS) for LTNC

Carer self-complete version – 6 months

The NPCS can be used and copied freely,

but please acknowledge the originators in all publications

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NPCS: CARE AND SUPPORT REQUIREMENTS

Today's Date: Day Month Year

Current Rehabilitation and Support Services

- We want to know about the care and support the person you care for currently receives.
- We will ask you about 12 areas where the person you care for could be getting support from either the NHS or social services.
- We are also interested in whether you think that this support is the right amount for them at the moment, or if you think that they need more support or less support in order for them to be happy and lead a good life.

(NB to interviewer – if not the right amount of care, seek to establish what they consider they need (record in their words) and then fit this to the most relevant level on the NPCCS)

For each of the questions below we want to know about:

1. The level of care and support they have received **within the last 6 months**.
2. Please indicate whether this care and support is the right amount, or whether you think they would benefit from more or less care than the level of care received.

If more than one option applies please choose the one nearest the bottom of the list

For example:

4. HELP FOR SOCIAL ACTIVITIES IN THE LOCAL COMMUNITY

We want to know how often they received help to participate in community-based activities e.g. Leisure, work and social engagements

If someone helped them to go out for leisure activities 3 times a week for the last 6 months, then you would mark as follows:

	Yes	No
Did they receive help for community-based activities in the last 6 months?	<input checked="" type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
They received help:	Tick one	
a) Occasionally (1-2 days per week or less)	<input type="checkbox"/>	
b) Regularly (3-5 days per week)	<input checked="" type="checkbox"/>	
c) Frequently (6-7 days per week)	<input type="checkbox"/>	

This section is about how much medical and nursing care they receive

1. MEDICAL CARE

We want to know about **care received from a doctor (GP or specialist) for investigation, monitoring or treatment**

- Specialist Medical input may be from any medical specialty

	Yes	No
Did they receive medical care in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
This included:	<u>Tick any</u>	
a) Visit(s) to GP for monitoring/treatment	<input type="checkbox"/>	
b) Occasional advice/review from specialist doctor	<input type="checkbox"/>	
c) Treatment from specialist doctor	<input type="checkbox"/>	

Which type(s) of specialist doctor?

	<u>Tick any</u>
Neurologist	<input type="checkbox"/>
Rehab doctor	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>
Palliative Care	<input type="checkbox"/>
Other, please specify:	<input type="checkbox"/>

2. SPECIAL NURSING SUPPORT

We want to know about **the level of support / intervention from specially trained or skilled nurses.**

E.g. for wound care, bladder / bowel management / medication monitoring / specialist advice/support/counselling)

	Yes	No
Did they receive support from a trained/specialist nurse in the last 6 months:	<input type="checkbox"/>	<input type="checkbox"/>
If 'Yes':		
Support received:	<u>Tick one</u>	
a) Occasionally (e.g. once a month or less often)	<input type="checkbox"/>	
b) Regularly (e.g. every 1 - 2 weeks)	<input type="checkbox"/>	
c) Frequently (e.g. every day or several times a week)	<input type="checkbox"/>	
d) 2-12 hours per day	<input type="checkbox"/>	
e) 13-24 hours per day	<input type="checkbox"/>	

Which type(s) of nurse?		Tick any
District nurse		<input type="checkbox"/>
Specialist nurse in:		
a) Neurology		<input type="checkbox"/>
b) Mental Health		<input type="checkbox"/>
c) Palliative Care		<input type="checkbox"/>
d) Other, please specify:		<input type="checkbox"/>

Questions 1-2: Is this the right amount of Medical/Nursing care for them?	
Too little	<input type="checkbox"/>
Just right	<input type="checkbox"/>
Too much	<input type="checkbox"/>
If not the right amount, what do they need?	
.....	
.....	
.....	

This section is about the help they receive for activities at home and in the local community		
3. HELP WITH BASIC SELF-CARE AT HOME		
We want to know about: the level of help they received for basic self care tasks in and around the home		
(Self-care refers to dressing themselves, showering/bathing, toileting, eating, meal preparation)		
	Yes	No
Did they receive help for basic self-care tasks in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
They received help:	Tick one	
a) From 1 carer at a time	<input type="checkbox"/>	
b) From 2 or more carers at a time	<input type="checkbox"/>	

If help was received for basic self-care:	
Who provided this help?	
	<u>Tick any</u>
Family member(s)	<input type="checkbox"/>
Paid carer(s)	<input type="checkbox"/>
Other, please specify:	<input type="checkbox"/>

How often was this help provided?	
	<u>Tick one</u>
Occasionally - but not every day	<input type="checkbox"/>
Once a day	<input type="checkbox"/>
2 -3 times every day - but not at night	<input type="checkbox"/>
Most of the time , due to frequent or unpredictable care needs	<input type="checkbox"/>
Constant supervision and/or help several times a night	<input type="checkbox"/>

4. HELP FOR SOCIAL ACTIVITIES IN THE LOCAL COMMUNITY		
We want to know how often they received help to participate in community-based activities e.g. Leisure, work and social engagements		
	Yes	No
Did they receive help for community-based activities in the 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
They received help:	<u>Tick one</u>	
a) Occasionally (1-2 days per week or less)	<input type="checkbox"/>	
b) Regularly (3-5 days per week)	<input type="checkbox"/>	
c) Frequently (6-7 days per week)	<input type="checkbox"/>	

Questions 3-4: Is this the right amount of Personal care for them?	
Too little	<input type="checkbox"/>
Just right	<input type="checkbox"/>
Too much	<input type="checkbox"/>
If not the right amount, what do you need?	
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This section is about the amount and types of therapy/rehabilitation they receive

5. THERAPY

We are interested in how many different types of therapist they have seen, and how often they saw them.

e.g. physiotherapy, occupational therapy ; psychology, speech and language therapy

	Yes	No
Did they receive therapy in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Therapy input received from:	<u>Tick one</u>	
a) A single discipline only (e.g. physio <u>or</u> occupational therapy)	<input type="checkbox"/>	
b) More than one discipline - but working separately , rather than as a team	<input type="checkbox"/>	
c) More than one discipline - working together in a coordinated team	<input type="checkbox"/>	

Which therapy disciplines did they see?

	<u>Tick any</u>
Physiotherapist	<input type="checkbox"/>
Occupational therapist	<input type="checkbox"/>
Speech and language therapist	<input type="checkbox"/>
Dietician	<input type="checkbox"/>
Orthotics / Prosthetics	<input type="checkbox"/>
Psychologist	<input type="checkbox"/>
Counsellor	<input type="checkbox"/>
Psychiatrist	<input type="checkbox"/>
Other, please specify:	<input type="checkbox"/>

If therapy was received:

How often did they see the therapist(s)?

	<u>Tick one</u>
a) Occasionally (one hour per month) or therapy in group sessions only	<input type="checkbox"/>
b) Regular individual sessions - every 1-2 weeks	<input type="checkbox"/>
c) Frequent individual sessions - several times per week	<input type="checkbox"/>

6. SUPPORT TO RETURN TO WORK OR EDUCATION

We want to know about any **vocational support received to return to** full-time or part-time **work or education**.
e.g. disability employment officer, work retraining, access to work scheme

	Yes	No
Did they receive help/support to return to work/education in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Help received:	<u>Tick one</u>	
a) Just for work-related/educational assessment/advice (1-2 sessions)	<input type="checkbox"/>	
b) Ongoing work-related/educational support e.g. access to work scheme	<input type="checkbox"/>	
c) A formal vocational programme for work-related or educational support e.g. work preparation, work retraining, supported placements	<input type="checkbox"/>	

Questions 5-6: Is this the right amount of rehabilitation for them?

Too little	<input type="checkbox"/>
Just right	<input type="checkbox"/>
Too much	<input type="checkbox"/>
If not the right amount, what do you need?	
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.....	
.....	

This section is about the level of social support they receive

7. SOCIAL WORK AND CASE MANAGEMENT

We want to know about their **social work and case management**:

	Yes	No
Did they receive social work or case management in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Help / support received:	<u>Tick one</u>	
a) Available for advice when required	<input type="checkbox"/>	
b) 1-2 appointments	<input type="checkbox"/>	
c) 3 or more appointments	<input type="checkbox"/>	

8. FAMILY SUPPORT

We want to know about the **support received for any family carer**

	Yes	No
Did they receive support for any family carer in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Carer Support received:	<u>Tick one</u>	
a) An assessment only - to see what support may be needed	<input type="checkbox"/>	
b) Some short term carer/family support e.g. for skills training	<input type="checkbox"/>	
c) Ongoing carer/family support e.g. for emotional support	<input type="checkbox"/>	

This section is about respite care, which is to give family carers a break This may be either in a residential or a day care setting		
9. RESPITE CARE a) We want to know about requirements for respite care in a residential setting e.g. a nursing home or hospice		
	Yes	No
Did they receive residential respite care in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Residential respite care received:	<u>Tick one</u>	
a) Once	<input type="checkbox"/>	
b) Twice	<input type="checkbox"/>	
c) 3 or more times	<input type="checkbox"/>	

What type of residential respite care?		<u>Tick any</u>
Home-based live-in care		<input type="checkbox"/>
Residential home		<input type="checkbox"/>
Nursing home		<input type="checkbox"/>
Specialist nursing home		<input type="checkbox"/>
Hospice		<input type="checkbox"/>
Other, please specify:		<input type="checkbox"/>

b) We want to know about requirements for day care e.g. in a day care centre		
	Yes	No
Did they receive day care in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Day Care received:	<u>Tick one</u>	
a) Occasionally (1-2 days per week)	<input type="checkbox"/>	
b) Frequently (3 or more days per week)	<input type="checkbox"/>	

What type of day care?		Tick any
Community day centre		<input type="checkbox"/>
Specialist day centre		<input type="checkbox"/>
Hospice		<input type="checkbox"/>
Other, please specify:		<input type="checkbox"/>

10. ADVOCACY NEEDS	
<p>An advocate is someone who may represent the interests and rights of someone who lacks the mental capacity to make decisions for themselves. In many cases this role is provided by the family - occasionally an independent advocate is required.</p>	
Tick one	
In the last 6 months:	
a) No independent advocate required	<input type="checkbox"/>
b) Received assessment for mental capacity to make decisions regarding care	<input type="checkbox"/>
c) Lacks mental capacity but family support all decision making	<input type="checkbox"/>
d) Lacks mental capacity and received an independent advocate	<input type="checkbox"/>

Questions 7-10: Is this the right amount of social/family support for them?	
Too little	<input type="checkbox"/>
Just right	<input type="checkbox"/>
Too much	<input type="checkbox"/>
If not the right amount, what do you need?	
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.....	
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This section is about aids and equipment, or adapted accommodation

11. SPECIAL EQUIPMENT		
We want to know about their aids and equipment		
	Yes	No
Did they receive aids or equipment in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Aids / equipment received:	<u>Tick one</u>	
a) Basic off-the-shelf equipment e.g. kitchen aids, commode, bed hoist	<input type="checkbox"/>	
b) Special equipment - requiring professional assessment /provision (e.g. Special wheelchair)	<input type="checkbox"/>	
c) Highly specialist /specially-made equipment requiring prescription (e.g. Environmental control systems, communication aids, ventilator)	<input type="checkbox"/>	

What type(s) of equipment?	
	<u>Tick any</u>
Basic lifting/handling equipment	<input type="checkbox"/>
Seating/wheelchair	<input type="checkbox"/>
Standing/postural support	<input type="checkbox"/>
Electronic assistive technology	<input type="checkbox"/>
Communication aid	<input type="checkbox"/>
Assisted ventilation	<input type="checkbox"/>
Other, please specify:	<input type="checkbox"/>

12. ACCOMMODATION		
a) If ABLE to live in their own home:		
We want to know their requirements for adapted accommodation.		
	Yes	No
Do they have adapted accommodation?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Their adapted accommodation is:	<u>Tick one</u>	
a) Ground floor accommodation or reliable lift access	<input type="checkbox"/>	
b) Minor adaptations (e.g. hand rails, ramps)	<input type="checkbox"/>	
c) Fully adapted accommodation (e.g. fully wheelchair accessible)	<input type="checkbox"/>	

OR b) If UNABLE to live in their own home:
We want to know about supported accommodation or residential care.

	Yes	No
Do they live in supported accommodation or residential care?	<input type="checkbox"/>	<input type="checkbox"/>
If 'yes':		
Their supported accommodation or residential care is a:	<u>Tick one</u>	
a) Supervised living arrangement e.g. small group home	<input type="checkbox"/>	
b) Sheltered living accommodation e.g. warden controlled	<input type="checkbox"/>	
c) Residential care home setting	<input type="checkbox"/>	
d) Nursing home	<input type="checkbox"/>	
e) Specialist nursing home	<input type="checkbox"/>	
f) Hospice care	<input type="checkbox"/>	

Questions 11-12: Is this the right amount of equipment/accommodation for them?	
Too little	<input type="checkbox"/>
Just right	<input type="checkbox"/>
Too much	<input type="checkbox"/>
If not the right amount, what do you need?	
.....	
.....	
.....	

13. PRIVATE SERVICES	
Are they currently paying for any private rehabilitation or medical services?	
Please circle:	
	Yes No
If so, what services?	
.....	
.....	

14. WAITING LIST
Are they on a waiting list for any rehabilitation or support services?

Please circle:

Yes

No

If so, what services?

.....
.....

When are they expected to start?

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