KING'S College LONDON
University of London

The North West London Hospitals NHS
NHS Trust

The Needs & Provision Complexity Scale (NPCS) for LTNC

Patient 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 you currently receive.
- We will ask you about 12 areas where you 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 you at the moment, or if you think that you need more support or less support in order to for you 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 NPCS)

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

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

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

For example:
If the you are under regular follow-up by your GP, and were seen within the last 6 months,
But you also need occasional review by a specialist,
You would mark as follows:

	Yes	No
Do you receive regular medical care?	☒	☐
If 'yes': **Requires medical monitoring/ intervention:**	**Tick one**	
a) Regular visits to GP for monitoring/treatment	☐	
b) Require occasional advice/review from specialist doctor (e.g. 1-2 visits per year)	☒	
c) Require regular treatment from specialist doctor (e.g. 3 or more visits per year)	☐	

This section is about how much medical and nursing care you 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
Do you receive **regular medical care?**	☐	☐

If 'yes':

This includes:	Tick any
a) Regular visits to GP for monitoring/treatment	☐
b) Require occasional advice/review from specialist doctor (e.g. 1-2 visits per year)	☐
c) Require regular treatment from specialist doctor (e.g. 3 or more visits per year)	☐

Which type(s) of specialist doctor?	Tick any
Neurologist	☐
Rehab doctor	☐
Psychiatrist	☐
Palliative Care	☐
Other, please specify: ……	☐

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 you receive **support from a trained/specialist nurse** in the last 6 months:	☐	☐

If 'Yes':

Support received:	Tick one
a) Occasionally (e.g. once a month or less often)	☐
b) Regularly (e.g. every 1 - 2 weeks)	☐
c) Frequently (e.g. every day or several times a week)	☐
d) 2-12 hours per day	☐
e) 12-24 hours per day	☐

Which type(s) of nurse?	Tick any
District nurse	☐
Specialist nurse in:	
a) Neurology	☐
b) Mental Health	☐
c) Palliative Care	☐
d) Other, please specify: ……	☐

Questions 1-2: Is this the right amount of Medical/Nursing care for you?	
Too little	☐
Just right	☐
Too much	☐
If not the right amount, what do you need? **……** **……** **……**	

This section is about the help you 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 you receive for basic self care tasks** in and around the home

(**Self-care** refers to dressing yourself, showering/bathing, toileting, eating, meal preparation)

	Yes	**No**
Did you receive **help for basic self-care tasks** in the last 6 months?	☐	☐

If 'yes':

You receive help:	Tick one
a) From **1 carer** at a time	☐
b) From **2 or more carers** at a time	☐

If help was received for basic self-care: **Who provided this help?**	Tick any
Family member(s)	☐
Paid carer(s)	☐
Other, please specify: ……	☐

How often was this help provided?	Tick one
Occasionally - but not every day	☐
Once a day	☐
2 -3 times every day - but not at night	☐
Most of the time, due to frequent or unpredictable care needs	☐
Constant supervision and/or **help several times a night**	☐

4. HELP FOR SOCIAL ACTIVITIES IN THE LOCAL COMMUNITY

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

	Yes	No
Did you receive **help for community-based activities** in the last 6 months?	☐	☐

If 'yes':

You received help:	Tick one
a) Occasionally (1-2 days per week or less)	☐
b) Regularly (3-5 days per week)	☐
c) Frequently (6-7 days per week)	☐

Questions 3-4: Is this the right amount of Personal care for you?	
Too little	☐
Just right	☐
Too much	☐

If not the right amount, what do you need?

……

……

……

This section is about the amount and types of therapy/rehabilitation you receive

5. THERAPY

We are interested in how many different types of therapist you see, and how often you see them.
e.g. physiotherapy, occupational therapy ; psychology, speech and language therapy

	Yes	No
Did you receive **therapy** in the last 6 months?	☐	☐

If 'yes':

Therapy input received from:	Tick one
a) A **single discipline** only (e.g. physio or occupational therapy)	☐
b) More than one discipline - but **working separately**, rather than as a team	☐
c) More than one discipline - **working together in a coordinated team**	☐

Which therapy disciplines did you see?	Tick any
Physiotherapist	☐
Occupational therapist	☐
Speech and language therapist	☐
Dietician	☐
Orthotics / Prosthetics	☐
Psychologist	☐
Counsellor	☐
Psychiatrist	☐
Other, please specify: ……	☐

If therapy was received: **How often did you see the therapist(s)?**	Tick one
a) Occasionally (one hour per month) or **therapy in group sessions only**	☐
b) Regular individual sessions - every 1-2 weeks	☐
c) Frequent individual sessions - several times per week	☐

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 you receive **help/support to return to work/education** in the last 6 months?	☐	☐

If 'yes':

Help received:	Tick one
a) Just for work-related/educational assessment/advice (1-2 sessions)	☐
b) Ongoing work-related/education support e.g. access to work scheme	☐
c) A formal vocational programme for work-related or educational support e.g. work preparation, work retraining, supported placements	☐

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

Too little	☐
Just right	☐
Too much	☐

If not the right amount, what do you need?

.....

.....

.....

This section is about the level of social support you receive

7. SOCIAL WORK AND CASE MANAGEMENT

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

	Yes	No
Did you receive **social work or case management** in the last 6 months?	☐	☐

If 'yes':

Help / support received:	Tick one
a) Available for advice when required	☐
b) 1-2 appointments	☐
c) 3 or more appointments	☐

8. FAMILY SUPPORT

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

	Yes	No

Did you receive **support for any family carer** in the last 6 months?	☐	☐
If 'yes':		
Carer Support received:	Tick one	
a) An assessment only - to see what support may be needed	☐	
b) Some short term carer/family support e.g. for skills training	☐	
c) Ongoing carer/family support e.g. for emotional support	☐	

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 you receive **residential respite care** in the last 6 months?	☐	☐
If 'yes':		
Residential respite care received:	Tick one	
a) Once	☐	
b) Twice	☐	
c) 3 or more times	☐	

What type of residential respite care?	Tick any
Home-based live-in care	☐
Residential home	☐
Nursing home	☐
Specialist nursing home	☐
Hospice	☐
Other, please specify: ……	☐

B) We want to know about **requirements for day care** e.g. in a day care centre

	Yes	**No**
Did you receive **day care** in the last 6 months?	☐	☐
If 'yes':		
Day Care received:	Tick one	
a) Occasionally e.g. 1-2 days per week	☐	
b) Frequently e.g. 3-5 days per week	☐	

What type of day care?

	Tick any
Community day centre	☐
Specialist day centre	☐
Hospice	☐
Other, please specify: ……	☐

10. ADVOCACY NEEDS 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.	Tick one
In the last 6 months: a) **No independent advocate** required	☐
b) **Received assessment for mental capacity** to make decisions regarding care	☐
c) Lacks mental capacity but **family support all decision making**	☐
d) Lacks mental capacity and **received an independent advocate**	☐

Questions 7-10: Is this the right amount of social/family support for you?	
Too little	☐
Just right	☐
Too much	☐
If not the right amount, what do you need? …… …… ……	

This section is about aids and equipment, or adapted accommodation

11. SPECIAL EQUIPMENT

We want to know about your **aids and equipment**		
	Yes	**No**
Did you receive **aids or equipment** in the last 6 months?	☐	☐
If 'yes': **Aids / equipment received:**	Tick one	
a) Basic off-the-shelf equipment e.g. kitchen aids, commode, bed hoist	☐	
b) Special equipment - requiring professional assessment /provision (e.g. Special wheelchair)	☐	
c) Highly specialist /specially-made equipment requiring prescription (e.g. Environmental control systems, communication aids, ventilator)	☐	

What type(s) of equipment?	Tick any
Basic lifting/handling equipment	☐
Seating/wheelchair	☐
Standing/postural support	☐
Electronic assistive technology	☐
Communication aid	☐
Assisted ventilation	☐
Other, please specify: ……	☐

12. ACCOMMODATION **a) If ABLE to live in your own home:** We want to know your requirements for adapted accommodation.		
	Yes	**No**
Do you have **adapted accommodation?**	☐	☐
If 'yes': **Your adapted accommodation is:**	Tick one	
a) Ground floor accommodation or reliable lift access	☐	
b) Minor adaptations (e.g. hand rails, ramps)	☐	
c) Fully adapted accommodation (e.g. fully wheelchair accessible)	☐	

OR b) If UNABLE to live in your own home: We want to know about supported accommodation or residential care.		
	Yes	**No**

Do you live in **supported accommodation or residential care?**	☐	☐

If 'yes':

Your supported accommodation or residential care is a:	Tick one
a) Supervised living arrangement e.g. small group home	☐
b) Sheltered living accommodation e.g. warden controlled	☐
c) Residential care home setting	☐
d) Nursing home	☐
e) Specialist nursing home	☐
f) Hospice care	☐

Questions 11-12: Is this the right amount of equipment/accommodation for you?	
Too little	☐
Just right	☐
Too much	☐

If not the right amount, what do you need?

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13. PRIVATE SERVICES

Are you currently paying for any private rehabilitation or medical services?

Please circle:

Yes No

If so, what services?

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14. WAITING LIST

Are you on a waiting list for any rehabilitation or support services?

Please circle:

Yes No

If so, what services?

……..……..

……

When are they expected to start? …….

…….