Department
for Work &
Pensions

Myalgic Encephalomyelitis (or encephalopathy)/Chronic Fatigue Syndrome and PIP Assessments

PIP Core Training and Guidance

November 2024

Foreword

This Learning Pack has been produced by the Department for Work and Pensions (DWP) and forms part of a suite of PIP Core Training and Guidance (TAG) materials. Providers must use core TAG materials to inform the development of training product(s) for their Health Professionals (HPs) who conduct assessments on behalf of the Department for Work and Pensions.

All HPs undertaking assessments on behalf of DWP must be registered practitioners who have also met requirements around training, experience, and competence. The PIP Assessment Guide, which forms an integral part of that training, has been provided by the Department of Work and Pensions (DWP) and is referred to throughout the Learning Pack.

This Learning Pack must be read with the understanding that, as experienced practitioners, the HPs will have detailed knowledge of the principles and practice of relevant diagnostic techniques and therefore such information is not contained in this pack.

In addition, this Learning Pack is not a stand-alone document, and forms only a part of the training and written documentation that the HP receives. The DWP "PIP Assessment Guide" must be read in conjunction with the Learning Packs, as it provides information on the DWP's scope and intention for each of the 12 PIP Activities and corresponding Descriptors in each activity area. As disability assessment is a practical occupation, much of the guidance also involves verbal information and coaching.

Thus, although the Learning Pack may be of interest to non-medical readers, it must be remembered that some of the information may not be readily understood without background medical knowledge and an awareness of the other training given to HPs. It is not intended to cover all the requirements placed on Providers as part of the FAS assessment contracts, their full business processes, or work carried out by DWP to monitor and manage Provider performance.

Document Control

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Case Example 2 – case details updated

Issue Control

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Contents

Introduction

This module is part of the ongoing training programme for Health Professionals (HPs) working as Disability Analysts. It is designed as a learning tool to consolidate HPs understanding of ME/CFS and its relation to PIP. The HP should already be familiar with all sections of the PIP Assessment Guide.

What's in the Module?

The focus for this training is ME/CFS and PIP Assessments to ensure understanding of the condition; appropriate information gathering; appropriate descriptor choice and the reasons for those choices.

The module will guide the HP through clinical information on ME/CFS, before looking at the likely functional impact of the condition in PIP Assessments. There is a module Assessment (MCQ) which will act as a progress and knowledge check.

There are also two full practice case examples of claimants with ME/CFS for the HP to read and select the most appropriate descriptors.

Overall Aim

To enhance knowledge and understanding of ME/CFS in relation to PIP.

ME/CFS

What is ME/CFS?

ME/CFS is a chronic illness with a wide range of symptoms reported by sufferers including headaches, sleep problems muscle pain and problems with concentration. The predominant symptom reported by the majority of people, is extreme fatigue and feeling generally unwell after minimal exertion.

There is no set pattern for how ME/CFS symptoms can occur, and there may be a wide range of variability, from month to month, week to week, day to day, or even in the same day. The severity of symptoms can range from mild through to very severe, where the severe and very severe symptoms can have a huge impact on that person's functional ability and on their families and loved ones.

How common is ME/CFS in the UK?

It's not known exactly how many people have ME/CFS, but the ME Association suggests a figure of around 250,000 people in the UK are likely to be affected. They also point out the following:[1]

'Overall, the current evidence suggests:

- A population prevalence of at least 0.2% – 0.4% (i.e., 2 to 4 per 1000 people).
- A minimum yearly incidence has been suggested of 0.015%.
- The commonest age of onset is early twenties to mid-forties.
- In children, the commonest age of onset is 13–15, but cases can occur as young as five years old.
- ME/CFS is roughly three times as common in women as it is in men.
- It affects all socio-economic classes to a similar extent.
- It affects all ethnic groups – although it is believed to be under-diagnosed in ethnic minority groups.

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[1] The ME Association. Prevalence: Population Estimates. https://meassociation.org.uk/medical-matters/items/prevalence-population-estimates-mecfs/ [Accessed 3rd October 2024].

What causes ME/CFS?

It's not known what causes ME/CFS, but there are a number of theories – for example, it may be triggered by an infection, or certain factors could make someone more likely to develop the illness.

Suggested causes or triggers for ME/CFS include:[2]

- viral infections, such as glandular fever
- bacterial infections, such as pneumonia
- problems with the immune system
- a hormone imbalance
- mental health problems, such as stress and emotional trauma
- Genetics – ME/CFS seems to be more common in some families

Lack of understanding of this and the disease processes associated with this chronic condition can lead to people experiencing profound illness and disability which in turn, impacts on their families and carers.

How is ME/CFS diagnosed?

- **In children and young people** – A diagnosis is made after 3 months of persistent symptoms where other possible diagnoses have been excluded. The diagnosis is made or confirmed by a Paediatrician.

- **In Adults** – A diagnosis is made after 3 months of persistent symptoms where other possible diagnoses have been excluded.

NICE NG[206] guides clinicians to:[3]

1.4.1 Diagnose ME/CFS in a child, young person or adult who has the symptoms in recommendation 1.2.2 that have persisted for 3 months and are not explained by another condition.

1.4.2 Primary healthcare professionals should consider seeking advice from an

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[2] NHS. Myalgic encephalomyelitis or chronic fatigue syndrome (ME/CFS). https://www.nhs.uk/conditions/chronic-fatigue-syndrome-cfs/ [Accessed 3rd October 2024].

[3] NICE Guideline [NG206]. Myalgic encephalomyelitis (or encephalopathy/ chronic fatigue syndrome: diagnosis and management. https://www.nice.org.uk/guidance/ng206 [Accessed 3rd October 2024].

appropriate specialist if there is uncertainty about interpreting signs and symptoms at 3 months and whether further investigations are needed.

1.4.3 Refer adults directly to an ME/CFS specialist team (see below) to confirm their diagnosis and develop a care and support plan.

1.4.4 Refer children and young people who have been diagnosed with ME/CFS after assessment by a paediatrician (based on the criteria in recommendation 1.2.2) directly to a paediatric ME/CFS specialist team (see below) to confirm their diagnosis and develop a care and support plan.

ME/CFS specialist team

Specialist teams consist of a range of healthcare professionals with training and experience in assessing, diagnosing, treating and managing ME/CFS. They commonly have medically trained clinicians from a variety of specialisms (including rheumatology, rehabilitation medicine, endocrinology, infectious diseases, neurology, immunology, general practice and paediatrics) as well as access to other healthcare professionals specialising in ME/CFS. These may include physiotherapists, exercise physiologists, occupational therapists, dietitians, and clinical or counselling psychologists.

Children and young people are likely to be cared for under local or regional paediatric teams that have experience of working with children and young people with ME/CFS in collaboration with ME/CFS specialist centres.

Symptoms and testing to diagnose ME/CFS

There are no specific tests for this condition. The diagnosis is made based on, excluding other disease processes which could account for the symptoms reported.

NICE (2021)[3] advises that healthcare professionals should consider the possibility of ME/CFS if:

- the person has had all of the persistent symptoms in box 2 for a minimum of 6 weeks in adults and 4 weeks in children and young people **and**
- the person's ability to engage in occupational, educational, social or personal activities is significantly reduced from pre-illness levels **and**
- symptoms are not explained by another condition.

All of these symptoms should be present:[3]

- Debilitating fatigue that is worsened by activity, is not caused by excessive cognitive, physical, emotional or social exertion, and is not significantly relieved by rest.

- Post-exertional malaise after activity in which the worsening of symptoms:
    - is often delayed in onset by hours or days.
    - is disproportionate to the activity.
    - has a prolonged recovery time that may last hours, days, weeks or longer.

- Unrefreshing sleep or sleep disturbance (or both), which may include:
    - feeling exhausted, feeling flu-like and stiff on waking
    - broken or shallow sleep, altered sleep pattern or hypersomnia.

- Cognitive difficulties (sometimes described as 'brain fog'), which may include problems finding words or numbers, difficulty in speaking, slowed responsiveness, short-term memory problems, and difficulty concentrating or multitasking.

If ME/CFS is suspected, carry out:[3]

- a medical assessment (including symptoms and history, comorbidities, overall physical and mental health)
- a physical examination
- an assessment of the impact of symptoms on psychological and social wellbeing
- investigations to exclude other diagnoses, for example (but not limited to):
    - urinalysis for protein, blood and glucose
    - full blood count
    - urea and electrolytes
    - liver function
    - thyroid function
    - erythrocyte sedimentation rate or plasma viscosity

  - C-reactive protein
  - calcium and phosphate
  - HbA1c
  - serum ferritin
  - coeliac screening
  - creatine kinase.

    Use clinical judgement to decide on additional investigations to exclude other diagnoses (for example, vitamin D, vitamin B12 and folate levels; serological tests if there is a history of infection; and 9am cortisol for adrenal insufficiency).

Further symptoms may also be present. The following symptoms may also be associated with, but are not exclusive to, ME/CFS:[3]

- Orthostatic intolerance and autonomic dysfunction, including dizziness, palpitations, fainting, nausea on standing or sitting upright from a reclining position.
- Temperature hypersensitivity resulting in profuse sweating, chills, hot flushes, or feeling very cold.
- Neuromuscular symptoms, including twitching and myoclonic jerks.
- Flu-like symptoms, including sore throat, tender glands, nausea, chills or muscle aches.
- Intolerance to alcohol, or to certain foods and chemicals
- Heightened sensory sensitivities, including to light, sound, touch, taste and smell.
- Pain, including pain on touch, myalgia, headaches, eye pain, abdominal pain or joint pain without acute redness, swelling or effusion.

ME/CFS and awareness of prejudice

All HPs should be aware and sensitive to the experiences of claimants with ME/CFS, bearing in mind that the condition can affect all aspects of their lives including family life, relationships, social life, emotional and physical health, work and education and all daily living activities and mobility.

As per NICE [NG206] 1.1.2:[3]

‘Recognise that people with ME/CFS may have experienced prejudice and disbelief and could feel stigmatised by people (including family, friends, health and social care professionals, and teachers) who do not understand their illness. Take into account:

- the impact this may have on a child, young person or adult with ME/CFS
- that people with ME/CFS may have lost trust in health and social care services and be hesitant about involving them.’

Severity of ME/CFS

NICE [NG206][3] explains that the following is a **guide** to the level of impact of symptoms on everyday functioning, as definitions of severity are not clear cut because individual symptoms vary widely in severity and people may experience some symptoms more severely than others.

Mild ME/CFS

People with mild ME/CFS care for themselves and do some light domestic tasks (sometimes needing support) but may have difficulties with mobility. Most are still working or in education, but to do this they have probably stopped all leisure and social pursuits. They often have reduced hours, take days off and use the weekend to cope with the rest of the week.

Moderate ME/CFS

People with moderate ME/CFS have reduced mobility and are restricted in all activities of daily living, although they may have peaks and troughs in their level of symptoms and ability to do activities. They have usually stopped work or education, and need rest periods, often resting in the afternoon for 1 or 2 hours. Their sleep at night is generally poor quality and disturbed.

Severe ME/CFS

People with severe ME/CFS are unable to do any activity for themselves or can carry out minimal daily tasks only (such as face washing or cleaning teeth). They have severe cognitive difficulties and may depend on a wheelchair for mobility. They are often unable to leave the house or have a severe and prolonged after-effect if they do so. They may also spend most of their time in bed and are often extremely sensitive to light and sound.

Very severe ME/CFS

People with very severe ME/CFS are in bed all day and dependent on care. They need help with personal hygiene and eating and are very sensitive to sensory stimuli. Some people may not be able to swallow and may need to be tube fed.

Expected prognosis

Due to the high degree of variability, the chronic nature of the condition, prognosis advice is difficult, but in general it is suggested that:

- Most people will improve over time.
- Some people will recover and be able to resume work/ study and normal activities.
- Some people will continue to experience symptoms or relapse.
- Some people with severe ME/CFS may remain housebound.
- Some people with very severe ME/CFS may remain bed bound.
- For those children and young people who have a diagnosis of ME/CFS, the prognosis is optimistic.
- Some claimants may experience relapses that last for years. Severity and impact must be established for each individual to determine prognosis advice. In such cases HPs **should** discuss their advice.

Are any treatments available for people with ME/CFS?

While there is currently no cure (pharmacological or non-pharmacological) for ME/CFS, there are some strategies which have been shown to be beneficial in helping ME/CFS sufferers. They may not work for every person, but the treatment can be tailored to meet the needs of the individual:[2] [3]

- Energy Management - Also known as pacing. This is self-management strategy led by the individual with input and support from a professional in an ME/CFS specialist team. It is a long-term approach which is flexible and tailored to the individual. It supports an individual by helping them to learn about the energy they use and reduce the risk of worsening their condition.

- Cognitive Behavioural Therapy (CBT) – This is a talking therapy which aims to support people living with ME/CFS to manage their symptoms, improve functioning and reduce the distress of living with a chronic illness.
- Medications may be prescribed to improve and manage the symptoms. However, it is important to note that there is no specific medicine to treat ME/CFS, but it may be used to relieve symptoms such as over the counter pain medications.
- Anti-emetic drugs are usually only prescribed in severe cases of nausea. Dietary advice would be the likely first step.
- Psychological therapies may be recommended for mental health symptoms.
- Dietician input may be necessary for those people undertaking an exclusion diet or dietary manipulation, due to the risks of malnutrition.
- Aids and adaptations such as a stair lift or wheelchair, may be recommended to aid independent living.
- Altered working practices may also be helpful.

Aids and adaptations for moderate, severe or very severe ME/CFS

It’s important to note that NICE [NG206][3] section 1.8.8 has recommendations for 3 specific levels of ME/CFS, in relation to aids and adaptions as below:

‘For people with moderate ME/CFS or severe or very severe ME/CFS, consider providing or recommending aids and adaptations (such as a wheelchair, blue badge or stairlift) that could help them maintain their independence and improve their quality of life, taking into account the risks and benefits. Include these in the person's care and support plan.’

Awareness of severe and very severe ME/CFS and its impact

The following information is taken directly from the NICE Guidelines [NG 206], section 1.17:

1.17.1 Be aware that people with severe or very severe ME/CFS may experience the following symptoms that significantly affect their lives, including their mobility, emotional wellbeing and ability to interact with others and care for themselves:

- severe and constant pain, which can have muscular, arthralgic or neuropathic features.
- hypersensitivity to light, sound, touch, movement, temperature extremes and smells
- extreme weakness, with severely reduced movement
- reduced ability or inability to speak or swallow.
- cognitive difficulties that limit the person's ability to communicate and take in written or verbal communication.
- sleep disturbance such as unrefreshing sleep, hypersomnia and altered sleep pattern.
- gastrointestinal difficulties such as nausea, incontinence, constipation, and bloating.
- neurological symptoms such as double vision and other visual disorders, dizziness
- orthostatic intolerance and autonomic dysfunction, such as postural orthostatic tachycardia syndrome (POTS) and postural hypotension.

1.17.2 Recognise that symptoms of severe or very severe ME/CFS may mean that people:

- need a low-stimulus environment, for example a dark quiet room with interaction at a level of their choice (this may be little or no social interaction)
- are housebound or bedbound and may need support with all activities of daily living, including aids and adaptations to assist mobility and independence in activities of daily living (for example, a wheelchair)
- need careful physical contact when supported with activities of daily living, taking into account possible sensitivity to touch.

- cannot communicate without support and may need to choose someone to be their advocate and communicate for them.
- are unable to eat and digest food easily and may need support with hydration and nutrition.
- have problems accessing information, for example because of difficulty with screens, sound and light sensitivity, headaches affecting their ability to read, or brain fog affecting their concentration.

1.17.3 Personal care and support for people with severe or very severe ME/CFS should be carried out by health and social care practitioners who are:

- known to the person and their family or carers wherever possible.
- aware of the person's needs.

1.17.4 Risk assess each interaction with a person with severe or very severe ME/CFS in advance to ensure its benefits will outweigh the risks (for example, worsening their symptoms) to the person. For people with very severe ME/CFS, think about discussing this with the person's family or carers on their behalf (if appropriate), while keeping the focus of the engagement on the person with ME/CFS.

ME/CFS flare-ups and relapses and PIP Assessments

HPs will come across the terms ‘flare-up’ and ‘relapse’ when assessing claimants with ME/CFS, so it’s important to understand what they mean and identify their differences:[3]

- **A flare-up** – This is likely if the person has worsening of their symptoms beyond their normal day-to-day variation, which lasts for a few days. Some people may be able to identify a specific trigger such as acute illness or overexertion, however there may be no clear trigger for some people.

- **A relapse** – This describes a sustained and marked exacerbation of ME/CFS symptoms, which last longer than a flare-up and requires substantial and sustained adjustment of energy management.

Where a flare-up or relapse cannot be self-managed using strategies in their care and support plan, contacting their named contact in primary care or the ME/CFS specialist team is recommended. This is also the case where someone is worried about new symptoms or a change in symptoms.

The only way to establish whether someone is experiencing either of these condition states and the respective impacts on individual claimants, is to gather the appropriate level of detail needed during assessments. HPs should consider:

- Has a ME/CFS care and support plan been included in the evidence? (Developed by the ME/CFS specialist team based on a holistic assessment. It is the basis for other assessments and plans in areas such as social care, energy management, physical activity, physical functioning and mobility, cognitive behavioural therapy and dietary management. This will provide valuable information which must be considered with all other evidence available.)
- How does a flare-up/ relapse impact on the claimant?
- How do they manage when they have a flare-up?
- How often do they occur?
- When was the last flare-up/ relapse?
- Are there any strategies they use during a flare-up/ relapse which are helpful?
- Is help from others required and if so, who helps, what do they do, how often do they help and how long does the claimant need to be helped for before symptoms ease?

- Are any aids or appliances required during periods of flare-up/ relapse? What do they have, can they use them effectively, or are they currently waiting for them?

For **flare-ups**, Claimants may report management strategies such as:

- identifying possible triggers, such as acute illness or overexertion (in some cases, there may be no clear trigger)
- temporarily reducing their activity levels
- monitoring symptoms, recognising that although flare-ups are transient, some will develop into a relapse.
- not returning to usual activity levels until the flare-up has resolved.

For **relapses**, claimants may report:

- reducing, or even stopping, some activities
- increasing the frequency or duration of rest periods
- reassessing energy limits to stabilise symptoms.

NB: Some claimants may experience relapses which last for years, so establishing the severity of symptoms and the impact it has on them, is essential when providing activity and prognosis advice to the DWP Case Manager.

ME/CFS and PIP Activities 1 – 12

In which of the activity areas may someone with ME/CFS report functional restriction?

Firstly, claimants with multiple conditions causing functional impact may struggle in a number or all activity areas and advice should be given accordingly.

Remember that variability in symptoms and functional level is one of the key features of this group of conditions. It is essential the functional history considers variability and the impact of good/bad periods on the claimant's needs in all relevant areas. Probing questions and actively asking about what is different between good and bad days will be necessary. Simply commenting on variability in activity areas, SOH or FH on the numbers of good and bad days is unlikely to be sufficient.

For each activity area consider:

- The severity of CFS/ ME
- Are there co-morbidities which are adding to the claimant's functional difficulty?
- Are they affected for the majority of days?
- Can they do the task reliably, repeatedly, safely and in a timely manner?

- Is the level of severity claimed consistent with their input, medication, and knowledge of the condition?
- Do they use/ need aids to improve functional ability?

In general terms:

- **Mild ME/CFS** – claimants may report having had to give up on hobbies and social activities as they need to rest in their spare time. This is due to them carrying on with everyday activities but experiencing difficulties which they need time to recover from.
- **Moderate ME/CFS** – claimants may report they have difficulty managing day to day activities; have problems sleeping at night; may report needing daytime naps due to fatigue and their ability to move around may also be affected. In many cases their ability to work or study are so adversely affected, that they have either reduced this activity, or may indeed have stopped it altogether.
- **Severe ME/CFS** – At this level, claimants may report that they are only able to perform very basic tasks such as brushing their teeth or combing their hair. In some cases, they may report that they need help to do this. They may report being housebound or even bed-bound for the majority of days, and the use of a wheelchair for mobility, may be reported. Some claimants may report that talking for extended periods of time can lead to exhaustion. Claimants reporting severe symptoms often report that they need an extended time to recover, which is exacerbated by activities such as going out. They may report problems with taking in new information, recalling existing memories, and concentration. They may also be sensitive to light and/ or noise.
- **Very severe ME/CFS –** As considered earlier, people with very severe ME/CFS are in bed all day and dependent on care. They need help with personal hygiene and eating and are very sensitive to sensory stimuli. Some people may not be able to swallow and may need to be tube fed.

Special considerations for assessing young people

When assessing young people HPs should ensure they are able to communicate the impact ME/CFS has on them by:

- Directing questions to them and not parents, carers etc. to ensure a focussed approach on them – demonstrates respect for their views and experiences.
- Giving them time to respond to questions – they may find it difficult to describe symptoms and how ME/CFS affects them. They may require parents/

guardians/ carers etc. to help them.

- Being aware that they may have experienced prejudice from others and feel vulnerable discussing their condition and its impact.

Now consider each activity area in more detail.

Activity 1 - Preparing food

20.1

[redacted]

21.1 [redacted]

Activity 2 – Taking nutrition

21.2 [redacted]

Activity 3 – Managing therapy or monitoring a health condition

21.3 [redacted]

22.1

[redacted]

Activity 4 – Washing and bathing

22.2

[redacted]

Activity 5 - Managing toilet needs or incontinence

22.3

[redacted]

23.1

[redacted]

Activity 6 – Dressing and undressing

23.2

[redacted]

Activity 7 – Communicating verbally

23.3

[redacted]

24.1

[redacted]

Activity 8 – Reading and understanding signs, symbols and words

24.2

[redacted]

Activity 9 – Engaging with other people face to face

24.3

[redacted]

Activity 10 – Making budgeting decisions

24.4

[redacted]

Activity 11 – Planning and following journeys

24.5

[redacted]

Activity 12 – Moving around

25.1

[redacted]

The importance of probing and activity 12

The functional history is particularly important for gleaning pertinent information on the following areas for Activity 12. Some suggested areas for exploration with the claimant/ during telephone calls for evidence are as follows (this list is not exhaustive):

25.2

[redacted]

26.1

[redacted]

27.1

[redacted]

ME/CFS Module Assessment

Remember to read the questions carefully before answering.

Name:		**Date:**	
		True	**False**
1	28.1 [redacted]		
2	[redacted]		
3	[redacted]		
4	[redacted]		
5	[redacted]		
6	[redacted]		
7	[redacted]		
8	[redacted]		
9	[redacted]		

10	29.1 [redacted]		

Case Examples

Case Example 1

30.1

[redacted]

Is this enough information to address the principle of variability?
What else could the HP ask, to get more information?

Answer:

31.1

[redacted]

Suggestions include (not exhaustive):

31.2

[redacted]

The information above would give a clearer picture of what the claimant experiences on good and bad days and her level of ability during each. This gives a better picture of her routine and the variability she experiences. This is particularly important in ME/CFS as variability can occur over the course of 1 day.

31.3

[redacted]

Consider the following PA4 information:

Planning and following journeys: [redacted]

Moving around: [redacted]

[redacted]

[redacted]

[redacted]

Preparing Food: [redacted]

Taking Nutrition: [redacted]

Managing therapy or monitoring a health condition: [redacted]

Washing and bathing: 33.1 [redacted]
33.2 [redacted]
33.3 [redacted]
33.4 [redacted]

Managing toilet needs or incontinence: 33.5 [redacted]
33.6 [redacted]
33.7 [redacted]
33.8 [redacted]

Dressing and undressing: 33.9 [redacted]
33.10 [redacted]
33.11 [redacted]

Communicating verbally: 33.12 [redacted]
33.13 [redacted]
33.14 [redacted]

Reading and understanding signs, symbols and words: 33.15 [redacted]
33.16 [redacted]
33.17 [redacted]

Engaging with others face to face: 33.18 [redacted]
33.19 [redacted]
33.20 [redacted]
33.21 [redacted]

Making Budgeting Decisions: 33.22 [redacted]
33.23 [redacted]
33.24 [redacted]

Other relevant functional history: 33.25 [redacted]
33.26 [redacted]
33.27 [redacted]
33.28 [redacted]
33.29 [redacted]

33.30 [redacted]
33.31 [redacted]
33.32 [redacted]
33.33 [redacted]
33.34 [redacted]

33.35 [redacted]

34.1

[redacted]

MSE and MSO – Normal findings

Variability mentioned in HOC:

34.2

[redacted]

Now choose descriptors for activities 1 - 12 considering all the evidence available. Remember to consider the principles of variability and reliability when making your choices.

Activity 1 - Which descriptor could apply and why?

Activity 2 - Which descriptor could apply and why?

Activity 3 - Which descriptor could apply and why?

Activity 4 - Which descriptor could apply and why?

Activity 5 - Which descriptor could apply and why?

Activity 6 - Which descriptor could apply and why?

Activity 7 - Which descriptor could apply and why?

Activity 8 - Which descriptor could apply and why?

Activity 9 - Which descriptor could apply and why?

Activity 10 - Which descriptor could apply and why?

Activity 11 - Which descriptor could apply and why?

Activity 12 - Which descriptor could apply and why?

Case Example 2

PIP2 information:

Conditions:

41.1

[redacted]

At assessment -

Social and Occupational History:

41.2

[redacted]

Variability:

42.1 [redacted]

Planning and following journeys:

42.2 [redacted]

Moving around:

42.3 [redacted]

Preparing Food:

42.4 [redacted]

Taking Nutrition:

42.5 [redacted]

Managing therapy or monitoring a health condition:

42.6 [redacted]

43.1 [redacted]

Washing and bathing:

43.2 [redacted]

Managing toilet needs or incontinence:

43.3 [redacted]

Dressing and undressing:

43.4 [redacted]

Communicating verbally:

43.5 [redacted]

Reading and understanding signs, symbols and words:

43.6 [redacted]

Engaging with others face to face:

43.7 [redacted]

Making budgeting decisions:

43.8 [redacted]

Other relevant functional history:

N/A

History of Conditions:

44.1

[redacted]

Medication:

44.2

[redacted]

Informal Observations:

44.3

[redacted]

MSE

45.1

[redacted]

MSO Findings:

45.2

[redacted]

46.1 [redacted]

Choosing descriptors

Now choose descriptors for activities 1 - 12 considering all the evidence available. Remember to consider the principles of variability and reliability when making descriptor choices.

Activity 11 - Which descriptor could apply and why?

Activity 12 - Which descriptor could apply and why?

Activity 1 - Which descriptor could apply and why?

Activity 2 - Which descriptor could apply and why?

Activity 3 - Which descriptor could apply and why?

Activity 4 - Which descriptor could apply and why?

Activity 5 - Which descriptor could apply and why?

Activity 6 - Which descriptor could apply and why?

Activity 7 - Which descriptor could apply and why?

Activity 8 - Which descriptor could apply and why?

Activity 9 - Which descriptor could apply and why?

Activity 10 - Which descriptor could apply and why?

ME/CFS Module Assessment Answers

Name:		**Date:**	
		True	False
1	53.1 [redacted]	[redacted]	[redacted]
2	[redacted]	[redacted]	[redacted]
3	[redacted]	[redacted]	[redacted]
4	[redacted]	[redacted]	[redacted]
5	[redacted]	[redacted]	[redacted]
6	[redacted]	[redacted]	[redacted]
7	[redacted]	[redacted]	[redacted]
8	[redacted]	[redacted]	[redacted]
9	[redacted]	[redacted]	[redacted]

10	54.1 [redacted]

Case Examples – Expected Responses

Case Example 1

Expected descriptor choices

55.1

[redacted]

56.1

[redacted]

Case Example 2

Expected descriptor choices

Activity 11A – Planning and following journeys:

57.1

[redacted]

Activity 12E – Moving around:

57.2

[redacted]

Activity 1B – Preparing food:

57.3

[redacted]

58.1 [redacted]

Activity 2A – Taking nutrition:

58.2 [redacted]

Activity 3A – Managing therapy or monitoring a health condition:

58.3 [redacted]

Activity 4E – Washing and bathing:

58.4 [redacted]

Activity 5B – Managing toilet needs or incontinence:

59.1

[redacted]

Activity 6D – Dressing and undressing:

59.2

[redacted]

Activity 7A – Communicating verbally:

59.3

[redacted]

Activity 8A – Reading and understanding signs, symbols and words:

59.4

[redacted]

60.1

[redacted]

Activity 9A – Engaging with other people face to face:

60.2

[redacted]

Activity 10A – Making budgeting decisions:

60.3

[redacted]

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https://www.nice.org.uk/guidance/ng206 [Accessed 3rd October 2024].

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[End of document]

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