Received 26.1.11

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16/1/11

Dear Sir/Madam,

After about ten years working in an advice centre, I submit these brief comments on your review of the DLA:-

Some people obtain DLA but others with the same medical condition are refused it, so I often have to explain to people that it is the way that a medical condition affects your ability (rather than the condition itself) which determines the outcome ~~i.e~~ your proposal to put this in writing only confirms current practice.

Some people who cannot use a bath are awarded DLA but other in a similar condition are refused it, because they have and are able to use a shower. It would make economic sense for those who would benefit from a shower to be provided with one at state expense and it would have the added benefit of enabling greater independence. Likewise for other aids & adaptations.

Some people are so severely disabled that to stop automatic entitlement would only achieve the same result (entitlement to DLA) at the cost of extra bureaucracy, expense and ill feeling.

Some health care professionals do not do the assessment properly (e.g one of my clients had been marked as "able to use stairs" when he clearly could not and had not even been asked), so a system of checks and appeals is necessary.

Rather than suggesting that the care component of DLA should be reduced from three levels to two in order to bring it in line with mobility component and attendance allowance, you should be asking if the mobility component and attendance allowance need three levels - otherwise it smacks of cost saving.

About ten years ago the aim was to re-assess all awards of DLA (Project 2000) but the money saved was so much less than the cost that the project was abandoned. This must not be repeated.

People who have the mobility component of DLA before 65 can keep it but mobility is not a part of A.A, even though their needs are often greater. This needs to be changed.

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