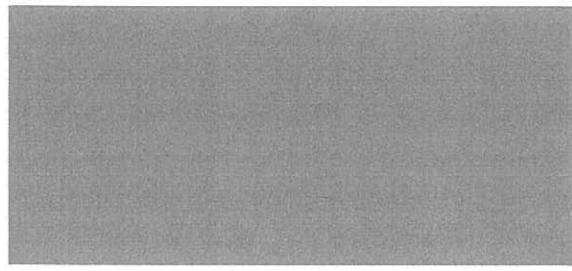


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3rd February 2011

DLA Reform Team
1st Floor
Caxton House
Tothill Street
London SW1H 9NA

Recd 10/2/11

Dear Sir/Madam

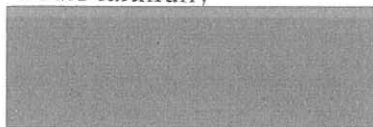
DLA Reform Proposals - Consultation

In order to ensure that you receive my responses, which are attached, I am sending this by Recorded Delivery.

I am a private individual and a carer for my 60 year old husband who currently receives the Medium Rate Care component of DLA.

Kindly acknowledge.

Yours faithfully



Q1 What are the problems or barriers that prevent disabled people participating in society and leading independent, full and active lives?

My Response to Q1: Money; mobility; transport; stigma; social acceptance; understanding; tolerance; the claimant's own physical, mental and communication problems including learning difficulties; plus his/her perception of his/her place in society.

Q2 Is there anything else about DLA that should stay the same?

My Response to Q2: Three care components are essential, because many people fall midway between high and low rate care, and will lose out under the new system.

Q3 What are the main extra costs that disabled people face?

My Response to Q3: Care; transport; heating; medical treatment /drugs; the cost of activities recommended by their doctor, such as swimming.

Under the present system, if a disabled person cannot work, household income is severely constrained, any additional income being often limited to the small amount of money that the carer may earn without affecting their Carer's Allowance.

If I worked full-time, I would not only lose my Carer's Allowance, but also have to pay for a full-time carer, leaving us no better off. We are therefore in the poverty trap.

Q4 The new benefit will have two rates for each component:

(a) Will having two rates per component make the benefit easier to understand and administer, while ensuring appropriate levels of support?

(b) What, if any, disadvantages or problems could having two rates per component cause?

My Response to Q4: (a) No - it is designed specifically to reduce or remove the benefit.

(b) People in receipt of the middle-rate care component, such as my husband, would be forced onto the lower rate or lose out completely. I would therefore lose my Carer's Allowance.

Q5 Should some health conditions or impairments mean an automatic entitlement to the benefit, or should all claims be based on the needs and circumstances of the individual?

My Response to Q5: If a person is diagnosed as disabled he or she should get DLA, but common sense and compassion should apply. Some severe disabilities should automatically qualify, but I accept the need to assess people's needs.

However, re-testing people with lifelong disabilities seems to be not only an insult and source of stress to them, but also a complete waste of government money.

Why should you have to prove how miserable your life is for a second time in order to receive a bit of money?

I suggest that you leave existing DLA recipients with permanent disabilities alone, and apply the new proposals to new claimants only.

Q6 (a) How do we prioritise support to those people least able to live full and active lives?

(b) Which activities are most essential for everyday life?

My Response to Q6: (a) By awarding them the highest components of DLA, and ensuring that this is an automatic gateway to other agencies such as Social Services, Occupational Health etc

(b) Exactly the same as for any able-bodied person.

Q7 How can we best ensure that the new assessment appropriately takes account of variable and fluctuating conditions?

My Response to Q7: The assessor must have a good understanding of the claimant's condition, and listen to the claimant, the carer, and their GP/consultant.

Before my husband was awarded DLA, I received a telephone call from the assessor to seek clarification of his difficulties and needs.

Q8 (a) Should the assessment of a disabled person's ability take account any aids and adaptations they use?

(b) What aids and adaptations should be included?

Should the assessment only take into account aids and adaptations where the person already has them or should we consider those that the person might be eligible for and can easily obtain?

My Response to Q8: (a) Of course it should take account of aids and adaptations, but this should not be used as an excuse to reduce a disabled person's mobility component.

(b) The assessment should highlight aids and adaptations which the claimant may not know about.

However, what happens to the mentally disabled who do not require aids and adaptations, but merely help and support from their carer?

Q9 (a) How could we improve the process of applying for the benefit for individuals and make it a more positive experience? For example:

How could we make the claim form easier to fill in?

(b) How can we improve information about the new benefit so that people are clear about what it is for and who is likely to qualify?

My Response to Q9: (a) The form should allow people to explain their condition - in many cases one cannot give a straight yes/no answer.

(b) Leaflets at libraries, GP surgeries, hospitals etc.

Q10 What supporting evidence will help provide a clear assessment of ability and who is best placed to provide this?

My Response to Q10: The claimant; the carer; medical reports.

My husband has been taking part in studies researching his condition for a number of years, and would hardly be doing this if there was nothing wrong with him.

Q11 (a) An important part of the new process is likely to be a face-to-face discussion with a healthcare professional. What benefits or difficulties might this bring?

(b) Are there any circumstances in which it may be inappropriate to require a face-to-face meeting with a healthcare professional - either in an individual's own home or in another location?

My Response to Q11: (a) Extreme anxiety and difficulties for the inarticulate, people with mental health problems and learning difficulties (especially those on the autistic spectrum) and those whose conditions vary from day to day. This is government-endorsed bullying of vulnerable people.

(b) This should not be necessary if there is sufficient evidence to prove the impact of their disabilities.

Q12(a) How should the reviews be carried out? For example: What evidence and/or criteria should be used to set the frequency of reviews?

(b) Should there be different types of review depending on the needs of the individual and their/impairment/condition?

My Response to Q12: (a) This review breaks the Human Rights Act and is illegal. No review should be necessary for people like my husband on the autistic spectrum, and who have been diagnosed with a permanent condition. This is insulting.

(b) If people do not have a permanent condition, they should surely be claiming another type of benefit.

Q13 The system for P.I.P. will be easier for individuals to understand, so we expect people to be able to identify and report changes in their needs. However we know that some people do not currently keep the Department informed. How can we encourage people to report changes in circumstances?

My Response to Q13: If you have a permanent condition why should you have to report any changes, unless you are getting worse and need more help?

Q14 What types of advice and information are people applying for P.I.P. likely to need and would it be helpful to provide this as part of the benefit claiming process?

My Response to Q14: People can get all the help they need from their GP, Citizen's Advice, or charities that deal with their disabilities. Any system that is a catch-all umbrella can never be specific to a particular person. It is naïve to assume it ever would be.

→ It would be helpful

Q15 Could some form of requirement to access advice and support, where appropriate, help encourage the minority of claimants who might otherwise not take action? If so, what would be the key features of such a system, and what would need to be avoided?

My Response to Q15: This is fine in principle, but needs to be discussed with the claimant, the carer, and GP.

Q16 (a) How do disabled people currently fund their aids and adaptations?
(b) Should there be an option to use P.I.P. to meet a one-off cost?

My Response to Q16: (a) With their DLA.

(b) No - it should be a GP referral to Occupational Health or Social Services to assess you and provide you with the means to meet your needs.

Q17 What are the key differences that we should take into account when assessing children?

My Response to Q17: There is more structured care for children once they are diagnosed, but therein lies the problem.

Q18 How important or useful has DLA been at getting disabled people access to other services or entitlements? Are there things we can do to improve these passporting arrangements?

My Response to Q18: It has been crucial in enabling me to obtain Carer's Allowance, in order to have some semblance of a "normal" life. It has also given us free loft insulation for our 2 bedroom terraced house, enabled my husband to obtain a Disabled Person's Railcard, and allows me to accompany him to the swimming pool free of charge.

Q19 What would be the implications for disabled people and service providers if it was not possible for P.I.P. to be used as a passport to other benefits and services?

My Response to Q19: Extreme anxiety, depression, poverty and possible suicide. We are supposed to be a civilized caring society. We are not going to just quietly accept this. Because of our low income, the DLA and CA are vital.

↓
The importance of DLA

Q20 What different assessments for disability benefits or services could be combined and what information about the disabled person could be shared to minimise bureaucracy and duplication?

My Response to Q20: Leave the system as it is, as being permanently disabled is not the same as being temporarily sick or incapacitated.

Q21 What impact could our proposals have on the different equality groups etc?

My Response to Q21: The question is irrelevant.

Q22 Is there anything else you would like to tell us about the proposals on the public consultation?

My Response to Q22: You have no idea how stressful, insulting, worrying, and humiliating the government's proposals are. Anyone with a diagnosed disability has already endured numerous tests/consultations and found it difficult to obtain DLA in the first place.

The reality is that we do not live in a fair and equal society - taking DLA away is akin to kicking a crutch out from under someone with one leg.

The fear that my husband's DLA may be reduced or withdrawn can only exacerbate his condition.

We use our benefits not only to meet extra expenditure resulting from my husband's condition, but also to help meet everyday living expenses including Council Tax. Our only other income is my husband's ill-health occupational pension of £9K per annum, granted on the basis that he cannot work again. The government needs to realize that permanent disabilities affect peoples' earnings power and income, and that they depend on DLA etc to get by.

Although my husband applied for Incapacity Benefit and passed the medical assessment for this benefit in 2004, he never received one penny of this benefit owing to insufficient National Insurance contributions. All he received were National Insurance Credits, which have been irrelevant since the number of qualifying years for the basic state retirement pension were reduced a couple of years ago.

Finally, only 9 weeks are allowed for this consultation, including Christmas week and New Year, whereas according to the DWP's own website, a minimum of 12 weeks should be allowed.

Short consultation